# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# Guideline

# Pelvic floor dysfunction: prevention and non-surgical management

## Draft for consultation, June 2021

**This guideline covers** the prevention, assessment and non-surgical management of pelvic floor dysfunction in women aged 12 and over. It recommends interventions based on the specific symptoms women are experiencing (such as urinary or faecal incontinence), to ensure they get the best possible support. The guideline aims to raise awareness of the condition, so that women understand how to reduce their risk of pelvic floor dysfunction and women with symptoms are aware of the benefits and drawbacks of all non-surgical management options.

### Who is it for?

- Healthcare professionals
- Commissioners and providers
- Education providers
- Women using services, and their families and carers.

### What does it include?

- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

This guideline uses the term 'women' throughout, but this should be taken to include those who do not identify as women but who have female pelvic organs.

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# Contents

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

'Pelvic floor dysfunction' covers a variety of symptoms and disorders. This guideline covers the following symptoms and disorders, when they are associated with pelvic floor dysfunction:

- urinary incontinence
- emptying disorders of the bladder
- faecal incontinence
- emptying disorders of the bowel
- pelvic organ prolapse
- sexual dysfunction
- chronic pelvic pain.

The 3 most common and definable symptoms are urinary incontinence, faecal incontinence and pelvic organ prolapse.

## 1.1 Raising awareness of pelvic floor dysfunction for all women

1.1.1 When producing resources on pelvic floor dysfunction, include:

- the symptoms of pelvic floor dysfunction
- visual aids to help identify potential causes of symptoms (for example, by showing the anatomy of pelvic organs)
- when to get help

- where to go for help (including self-referral to community-based multidisciplinary teams, where available)
- an outline of risk factors, prevention and management options (including non-surgical management and lifestyle changes).

1.1.2 Consider providing information on pelvic floor dysfunction in the following formats and settings:

- Formats
  - magazine adverts
  - leaflets in the community (for example at GP surgeries, family planning clinics and exercise classes)
  - videos and information on social media
  - interactive online tools (for example the NHS app).
- Settings
  - as part of general exercise programmes
  - in leaflets on gynaecological cancer treatment or hysterectomy
  - contact with a healthcare practitioner with pelvic floor dysfunction knowledge
  - giving advice to people with contacts in the community (such as exercise instructors and teachers), so they can provide information on pelvic floor dysfunction themselves
  - on community and health trust websites
  - information provided by healthcare charities
  - covering pelvic floor dysfunction in the syllabus for trainee nurses, physiotherapists, doctors, midwives and teachers.

1.1.3 Tailor information about pelvic floor dysfunction for different age groups and characteristics (for example pregnancy).

1.1.4 Local authorities should consider designing pelvic floor dysfunction information programmes for specific communities when there is evidence of healthcare inequalities (for example access to services). This can be done by:

- finding more effective ways to provide information (for example by attending community meetings)
- involving members of the community as champions
- using webinars to reach women who are unable to attend meetings in person.

1.1.5 For women using maternity services, include information on pelvic floor dysfunction symptoms and how to access local services:

- in the booking information pack or patient portal
- at all midwife consultations and reviews.

1.1.6 Health visitors, midwives and GPs should discuss pelvic floor dysfunction with women at each postnatal contact.

1.1.7 Teach young women (between 12 and 17 years) in school about pelvic floor anatomy, pelvic floor muscle exercises and how to prevent pelvic floor dysfunction.

1.1.8 Provide information on pelvic floor dysfunction for older women within primary and intermediate care services, and within care homes and supported living communities. This could be done:

- when women ask for advice about menopause
- as part of general health assessments
- as part of comprehensive geriatric health assessments.

1.1.9 For guidance on tailoring communication, information and shared decision making for people using health and social care services, see:

- the NICE guideline on patient experience in adult NHS services
- the NICE guideline on people's experience in adult social care services
- the NHS Accessible Information Standard (in particular for guidance on making information accessible).

1.1.10 For guidance on planning and developing digital and mobile tools to provide tailored information, see the NICE guideline on behaviour change: digital and mobile health interventions.

For a short explanation of why the committee made these recommendations see the rationale and impact section on raising awareness of pelvic floor dysfunction for all women.

Full details of the evidence and the committee's discussion are in evidence review A: raising awareness of pelvic floor dysfunction.

## 1.2 Risk factors for pelvic floor dysfunction

1.2.1 When discussing the risk of pelvic floor dysfunction with women, advise them that their risk is higher with any of the characteristics in box 1.

**Box 1 Risk factors for pelvic floor dysfunction**

### Modifiable risk factors

- A body mass index (BMI) over 25 kg/m$^2$
- Smoking
- Lack of exercise
- Constipation
- Diabetes

### Non-modifiable risk factors

- Age (risk increases with increasing age)
- Family history of urinary incontinence, overactive bladder or faecal incontinence
- Gynaecological cancer and any treatments for this
- Gynaecological surgery (such as a hysterectomy)
- Fibromyalgia
- Chronic respiratory disease and cough (chronic cough may increase the risk of faecal incontinence and flatus incontinence)

Related to pregnancy:

- Being over 30 years when having a baby
- Having had any children before their current pregnancy

Related to labour:

- Assisted vaginal birth (forceps or vacuum)
- A vaginal birth when the baby is lying face up (occipito-posterior)
- An active second stage of labour taking more than 1 hour
- Injury to the anal sphincter during birth.

1.2.2 For pregnant women with pelvic floor dysfunction that started before or during their pregnancy, advise them that there is an increased risk that their symptoms will get worse during their pregnancy and that they may persist after this (see the sections on preventing pelvic floor dysfunction

and non-surgical management of pelvic floor dysfunction for more guidance).

For a short explanation of why the committee made these recommendations see the rationale and impact section on risk factors for pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in:

- evidence review B: risk factors for pelvic floor dysfunction
- evidence review C: co-existing conditions
- evidence review D: prediction tools.

## 1.3 Preventing pelvic floor dysfunction

### Exercise and diet

1.3.1 Advise women that exercise and a healthy diet can help prevent pelvic floor dysfunction.

1.3.2 On levels of exercise, advise women to follow the standard advice, as covered by:

- the UK Chief Medical Officers' physical activity guidelines
- the NICE guideline on physical activity: brief advice for adults in primary care
- the NICE guideline on physical activity: walking and cycling.

1.3.3 On diet, advise women to:

- have a balanced diet (following Public Health England's Eatwell Guide), and in particular to eat enough fibre, as this can improve stool consistency and prevent symptoms of faecal incontinence
- modify their fluid intake (increasing if it is too low, decreasing if it is too high).

1.3.4 For guidance on training to help health and social care practitioners recognise and respond to diet, exercise and hydration needs in older people with social care needs and multiple long-term conditions, see the

section on training health and social care practitioners in the NICE guideline on older people with social care needs and multiple long-term conditions.

### Weight loss, stopping smoking and managing diabetes

1.3.5 For guidance on weight loss, see the NICE guideline on managing obesity, and (if relevant) the NICE guideline on weight management before, during and after pregnancy.

1.3.6 Give advice on stopping smoking, using the NICE guidelines on:

- stop smoking interventions and services
- smoking: stopping in pregnancy and after childbirth
- smoking prevention in schools
- smoking: harm reduction.

1.3.7 For guidance on managing diabetes, see the NICE guidelines on:

- type 1 diabetes in adults
- type 2 diabetes in adults
- diabetes (type 1 and type 2) in children and young people.

For a short explanation of why the committee made these recommendations see the rationale and impact section on exercise and diet and other modifiable risk factors.

Full details of the evidence and the committee's discussion are in:

- evidence review B: risk factors for pelvic floor dysfunction
- evidence review E: lifestyle factors for the prevention of pelvic floor dysfunction.

## Pelvic floor muscle training

### All women

1.3.8 Encourage women of all ages to do pelvic floor muscle training, and explain that it helps to prevent symptoms of pelvic floor dysfunction.

1.3.9 Encourage women to continue pelvic floor muscle training throughout their life, because long-term training continues to help prevent symptoms.

**During and after pregnancy**

1.3.10 Explain to women who are pregnant or who have recently given birth that pelvic floor muscle training helps prevent pelvic floor dysfunction.

1.3.11 Offer a 3-month programme of supervised pelvic floor muscle training:

- from week 20 of pregnancy, for pregnant women who have a first-degree relative with pelvic floor dysfunction
- during postnatal care, for women who have experienced any of the following risk factors during birth:
  - assisted vaginal birth (forceps or vacuum)
  - a vaginal birth when the baby is lying face up (occipito posterior)
  - injury to the anal sphincter.

1.3.12 Before discharging women from maternity services, and during routine postnatal care, encourage them to do pelvic floor muscle training.

1.3.13 When designing a pelvic floor muscle training programme, see the NICE guideline on behaviour change for relevant recommendations:

- recommendation 7: use proven behaviour change techniques when designing interventions
- recommendation 8: ensure interventions meet individual needs.

**Supervising pelvic floor muscle training**

1.3.14 Pelvic floor muscle training programmes should be supervised by a physiotherapist or other healthcare professional with the appropriate expertise in pelvic floor muscle training.

1.3.15 Supervision should involve:

- assessing the woman's ability to perform a pelvic floor contraction

- tailoring the pelvic floor muscle training programme to the woman's ability to perform a pelvic floor contraction, any discomfort felt, and her individual needs
- encouraging the woman to complete the course, because this will help to prevent and manage symptoms.

For a short explanation of why the committee made this these recommendations see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## 1.4 Communicating and providing information to women with pelvic floor dysfunction

### Communication

1.4.1 Agree consultation formats (for example, in person, video or telephone) with each woman with pelvic floor dysfunction, taking into account the need for physical examinations.

1.4.2 When discussing pelvic floor dysfunction:

- be aware that women may feel embarrassed discussing their symptoms, and they may believe that healthcare professionals will also be embarrassed
- take particular care around terminology:
  - for example, avoid using 'faeces' if a woman better understands 'poo'
  - be aware that women may not know the precise technical terms for parts of their pelvic anatomy, so may use incorrect terms
- tailor information to each woman's level of understanding of anatomy and of the causes of pelvic floor dysfunction.

1.4.3 For general guidance on communicating with patients, see the communication section in the NICE guideline on patient experience of adult NHS services.

1.4.4 When providing information to women with pelvic floor dysfunction and cognitive impairment, ask them if they want their family, carers and other people to be involved, to support them (as appropriate) and to help reinforce and support management plans.

### Information for women with pelvic floor dysfunction

1.4.5 Help women with pelvic floor dysfunction to understand their condition by giving clear and concise information. This should include:

- the anatomy of the pelvic floor and pelvic organs (using visual aids when helpful)
- possible causes of their symptoms
- management options and possible outcomes
- an explanation that interventions will be focused on their symptoms, rather than on pelvic floor dysfunction in general
- other medical conditions and treatments that can cause or exacerbate their symptoms (see risk factors for pelvic floor dysfunction).

1.4.6 Tailor information to each woman's age, level of understanding and circumstances, because pelvic floor dysfunction can affect women differently at different stages of life. For example:

- young women (between 12 and 17 years)
- women who are pregnant or who have given birth
- women who have gone through menopause
- women with comorbidities or frailty.

1.4.7 Consider digital information sources, for example apps or videos, to support women with pelvic floor dysfunction (for guidance on developing digital tools, see the NICE guideline on behaviour change: digital and mobile health interventions).

For a short explanation of why the committee made these recommendations see the rationale and impact section on communicating with and providing information to women with pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review G: information valued by women and evidence review H: effective ways of providing information.

## 1.5 Assessment in primary care

1.5.1 At initial assessment in primary care, take a general history from the woman about current and past symptoms or disorders associated with pelvic floor dysfunction, such as:

- urinary incontinence
- emptying disorders of the bladder
- faecal incontinence
- emptying disorders of the bowel
- pelvic organ prolapse
- sexual dysfunction
- chronic pelvic pain.

1.5.2 Depending on the symptoms described, carry out a focused history, clinical examination and investigations to exclude other causes, such as:

- pelvic masses
- neurological disease
- urinary tract infection
- adverse effects of medication
- diabetes
- cancer (for further information see the NICE guideline on suspected cancer: recognition and referral)
- fistula
- inflammatory bowel or bladder conditions
- mobility and cognitive impairment.

1.5.3 Ask women who have recently given birth about symptoms of pelvic floor dysfunction during routine postnatal care, in hospital and in the community.

1.5.4 For woman who are taking multiple medications, conduct a medication review. For guidance on how to do this, see the section on medication review in the NICE guideline on medicines optimisation.

1.5.5 Depending on the symptoms, consider other clinical examinations. For example:

- inspecting the woman's vulva and vagina for atrophy
- asking them to bear down, to check for visible vaginal or rectal prolapse
- rectal examination to check for impaction, for women at risk of this.

1.5.6 For more guidance on assessing urinary incontinence and pelvic organ prolapse, see the NICE guideline on urinary incontinence and pelvic organ prolapse in women.

1.5.7 If the woman has symptoms of faecal incontinence, follow the recommendations on baseline assessment in the NICE guideline on faecal incontinence.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on assessment in primary care.

Full details of the evidence and the committee's discussion are in evidence review I: assessment in non-specialist care and evidence review G: information valued by women.

## 1.6 Non-surgical management of pelvic floor dysfunction

### Community-based multidisciplinary teams

1.6.1 Following initial assessment in primary care, consider a community-based multidisciplinary team approach for the management of pelvic floor dysfunction.

1.6.2 The community-based multidisciplinary team should have competencies related to assessing and managing pelvic floor dysfunction, such as:

- carrying out initial assessments (see the section on assessment in primary care)
- awareness of the psychosocial implications of pelvic floor dysfunction
- identifying risk factors
- interpreting urinalysis
- conducting and interpreting bladder scans to measure post-void residual volume
- conducting routine digital assessments of the pelvic floor and pelvic floor muscle contractions
- training women and their families and carers in behavioural interventions for pelvic floor dysfunction (such as bladder retraining)
- prescribing and reviewing medications, and knowledge of interactions related to pelvic floor dysfunction
- supervising a pelvic floor muscle training programme (see the section on supervising pelvic floor muscle training)
- managing the use of pessaries and intravaginal devices
- training other care providers to assess and manage pelvic floor dysfunction
- identifying which women need referral to specialist care.

1.6.3 Discuss and agree a management plan with women who have suspected or confirmed pelvic floor dysfunction.

For a short explanation of why the committee made these recommendations see the rationale and impact section on community-based multidisciplinary teams.

Full details of the evidence and the committee's discussion are in evidence review R: community-based multidisciplinary teams.

## Lifestyle changes

### Encouraging women to make lifestyle changes

1.6.4 When discussing lifestyle changes with women who have pelvic floor dysfunction:

- motivate them to make changes by focusing discussions on how this will improve their symptoms
- give them regular encouragement to keep up the changes, because it may take weeks or months before they notice a benefit.

For a short explanation of why the committee made this recommendation see the rationale and impact section on encouraging women to make lifestyle changes.

Full details of the evidence and the committee's discussion are in evidence review G: information valued by women.

### Weight loss

1.6.5 Advise women with a body mass index (BMI) over 30 kg/m$^2$ that weight loss can help with the following symptoms associated with pelvic floor dysfunction:

- urinary incontinence
- overactive bladder
- pelvic organ prolapse.

1.6.6 For guidance on weight loss, see the NICE guideline on managing obesity, and (if relevant) the NICE guideline on weight management before, during and after pregnancy.

1.6.7 Refer women for weight loss support following the NICE guideline on lifestyle services for weight management in overweight or obese adults and the NICE guideline on lifestyle services for weight management in overweight or obese children and young people.

1.6.8 Do not wait for women to lose weight before starting other pelvic floor dysfunction management options.

For a short explanation of why the committee made these recommendations see the rationale and impact section on weight loss.

Full details of the evidence and the committee's discussion are in evidence review J: weight loss interventions.

**Diet**

1.6.9 For all women with pelvic floor dysfunction:

- explain how a balanced diet (following Public Health England's Eatwell Guide) and appropriate fluid intake can improve stool consistency, which can help with their symptoms
- follow guidance on maintaining healthy bowel habits in recommendation 1.3.2 of the NICE guideline on faecal incontinence in adults (including for women under 18 or with symptoms other than faecal incontinence).

1.6.10 Advise women with overactive bladder or urinary incontinence associated with pelvic floor dysfunction to:

- reduce their caffeine intake
- modify their fluid intake (increasing if it is too low, decreasing if it is too high).

For a short explanation of why the committee made these recommendations see the rationale and impact section on diet.

Full details of the evidence and the committee's discussion are in evidence review K: dietary factors.

### Exercise

1.6.11 For women who are doing supervised pelvic floor muscle training and want to exercise, advise them that supervised exercise (for example yoga or pilates classes) may help with their symptoms.

1.6.12 Advise women with pelvic floor dysfunction that there is no evidence that unsupervised exercise (such as walking or swimming) will improve or worsen their symptoms.

For a short explanation of why the committee made these recommendations see the rationale and impact section on exercise.

Full details of the evidence and the committee's discussion are in evidence review L: physical activity.

## Pelvic floor muscle training

### For pelvic organ prolapse

1.6.13 Consider a programme of supervised pelvic floor muscle training for at least 4 months for women with symptomatic pelvic organ prolapse that does not extend beyond the hymen upon straining.

### For stress urinary incontinence or mixed urinary incontinence

1.6.14 Offer a programme of supervised pelvic floor muscle training for at least 3 months to women (including pregnant women) with stress urinary incontinence or mixed urinary incontinence.

### For faecal incontinence with co-existing pelvic organ prolapse

1.6.15 Consider a programme of supervised pelvic floor muscle training for at least 4 months for women with faecal incontinence and co-existing pelvic organ prolapse.

### Group and individual training

1.6.16 For women who are doing a supervised pelvic muscle floor training programme, offer the choice of group or individual sessions.

### Supervising pelvic floor muscle training

1.6.17 See supervising pelvic floor muscle training in the section on preventing pelvic floor dysfunction.

### Review

1.6.18 When providing a programme of pelvic floor muscle training, offer at least 1 review to assess progress during the programme, and 1 review at the end of the programme.

### Supplementing pelvic floor muscle training

1.6.19 For women who are unable to perform an effective pelvic floor muscle contraction, consider supplementing pelvic floor muscle training with biofeedback, electrical stimulation or vaginal cones.

### Continuing pelvic floor muscle training

1.6.20 If the programme is beneficial, advise women to continue pelvic floor muscle training after the supervised programme ends.

For a short explanation of why the committee made these recommendations see the rationale and impact section on pelvic floor muscle training for managing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review M: pelvic floor muscle training for management of pelvic floor dysfunction.

## Intravaginal devices and pessaries

### Intravaginal devices for urinary incontinence

1.6.21 Consider a trial of intravaginal devices for women with urinary incontinence, if other non-surgical options have been unsuccessful.

### Pessaries for symptomatic pelvic organ prolapse

1.6.22 Consider pessaries for women who have symptomatic pelvic organ prolapse.

1.6.23 Before starting treatment with a pessary for women with symptomatic pelvic organ prolapse:

- discuss with the woman how a pessary could help, and explain it may not help with their urinary and bowel symptoms
- explain that a pessary will only help with their pelvic organ prolapse symptoms while it is in place, and the symptoms will come back when it is removed
- explain that reducing the prolapse with a pessary may cause new stress urinary incontinence.

See recommendation 1.7.8 in the NICE guideline on urinary incontinence and pelvic organ prolapse for further discussions to have with women before starting treatment with a pessary.

1.6.24 If women using a pessary experience new stress urinary incontinence, offer them a choice of treatment for the incontinence or removal of the pessary.

1.6.25 For more guidance on pessaries for women with symptomatic pelvic organ prolapse, see the section on pessaries in the NICE guideline on urinary incontinence and pelvic organ prolapse.

### Review

1.6.26 For women who are self-managing their intravaginal device or pessary, explain how they can seek advice from a healthcare provider if they have problems.

1.6.27 For guidance on reviewing pessaries for women who are at risk of complications, for example because of a physical or cognitive impairment, see recommendation 1.7.9 in the NICE guideline on urinary incontinence and pelvic organ prolapse.

For a short explanation of why the committee made these recommendations see the rationale and impact section on intravaginal devices and pessaries.

Full details of the evidence and the committee's discussion are in evidence review N: physical devices.

## Psychological interventions

1.6.28 Discuss the psychological impact of their symptoms with women who have pelvic floor dysfunction. Take account of this impact when developing a management plan.

1.6.29 For more guidance on psychological management, see the NICE guidelines on:

- antenatal and postnatal mental health
- depression in adults with a chronic physical health problem.

For a short explanation of why the committee made these recommendations see the rationale and impact section on psychological interventions.

Full details of the evidence and the committee's discussion are in evidence review O: psychological interventions.

## Behavioural approaches

1.6.30 Offer supported bladder retraining (combined with other interventions, such as pelvic floor muscle training) to women with urinary frequency, urgency or mixed incontinence.

1.6.31 For women with faecal incontinence, see the section on diet, bowel habit and toilet access in the NICE guideline on faecal incontinence in adults.

1.6.32 When choosing a behavioural intervention, take into account that prompted toileting and habit training may be particularly suitable for women with cognitive impairment.

For a short explanation of why the committee made these recommendations see the rationale and impact section on behavioural approaches.

Full details of the evidence and the committee's discussion are in evidence review P: behavioural approaches.

### Medicines

1.6.33 Do not offer vaginal diazepam to treat pelvic floor dysfunction, even for women with high muscle tone.

1.6.34 For guidance on medicines for urinary incontinence and faecal incontinence associated with pelvic floor dysfunction, see the NICE guideline on urinary incontinence and pelvic organ prolapse in women and the NICE guideline on faecal incontinence in adults.

For a short explanation of why the committee made these recommendations see the rationale and impact section on medicines.

Full details of the evidence and the committee's discussion are in evidence review Q: pharmacological interventions.

## Recommendations for research

The guideline committee has made the following recommendations for research.

### Key recommendations for research

#### 1 How to provide pelvic floor muscle training

What is the most effective way to provide pelvic floor muscle training (covering the type of training, the timing, and who should supervise it), to improve adherence and prevent pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## 2 Pelvic floor muscle training for preventing pelvic floor dysfunction in children and young women

Is pelvic floor muscle training for children and young women (between 12 and 17 years) effective in preventing pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## 3 Pelvic floor muscle training for preventing pelvic floor dysfunction during pregnancy for women in higher-risk groups

How effective is pelvic floor muscle training in preventing pelvic floor dysfunction during pregnancy in women who are in higher-risk groups?

For a short explanation of why the committee made this recommendation see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## 4 Lifestyle factors to reduce the risk of pelvic floor dysfunction

What lifestyle factors reduce the risk of developing pelvic floor dysfunction (for example diet, reducing carbonated drink and caffeine intake)?

For a short explanation of why the committee made this recommendation see the rationale and impact section on exercise and diet.

Full details of the evidence and the committee's discussion are in evidence review E: lifestyle factors for the prevention of pelvic floor dysfunction.

## 5 Prediction tools

What is the effectiveness of prediction tools for identifying women who are at risk of pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on tools to predict pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review D: prediction tools.

## 6 Pelvic floor muscle training for preventing pelvic floor dysfunction in older women

Is pelvic floor muscle training effective in preventing pelvic floor dysfunction for older women (over the age of 60), and women in the perimenopausal or postmenopausal phases?

For a short explanation of why the committee made this recommendation see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## 7 Co-existing long-term conditions

What co-existing long-term conditions (for example chronic respiratory disorders) are associated with a higher risk of pelvic floor dysfunction?

For a short explanation of why the committee made these recommendations see the rationale and impact section on risk factors for pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review C: co-existing conditions.

# Other recommendations for research

## Lifestyle factors to reduce the risk or pelvic floor dysfunction

What are the long-term effects of different types, intensities and frequencies of exercise for preventing symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on exercise and diet.

Full details of the evidence and the committee's discussion are in evidence review E: lifestyle factors for the prevention of pelvic floor dysfunction.

## Universal postnatal pelvic floor muscle training for preventing pelvic floor dysfunction

Is universal postnatal pelvic floor muscle training effective in preventing pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## Pelvic floor muscle training for preventing bowel symptoms associated with pelvic floor dysfunction

How effective is pelvic floor muscle training in preventing bowel symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction.

## Weight loss for managing pelvic floor dysfunction

Can weight loss reduce symptoms of pelvic floor dysfunction in women who are overweight or obese?

For a short explanation of why the committee made this recommendation see the rationale and impact section on weight loss.

Full details of the evidence and the committee's discussion are in evidence review J: weight loss interventions.

## Diet for managing pelvic floor dysfunction

What changes in diet can improve symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on diet.

Full details of the evidence and the committee's discussion are in evidence review K: dietary factors.

## Weight training to improve symptoms of pelvic floor dysfunction

How effective is weight training at improving symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on exercise.

Full details of the evidence and the committee's discussion are in evidence review L: physical activity.

### Unsupervised exercise to improve symptoms of pelvic floor dysfunction

How effective is unsupervised exercise (such as walking or swimming) at improving symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on exercise.

Full details of the evidence and the committee's discussion are in evidence review L: physical activity.

### Psychological interventions to manage symptoms of pelvic floor dysfunction

How effective are psychological interventions (either on their own or combined with other interventions) in the management of pelvic floor dysfunction?

For a short explanation of why the committee made this recommendation see the rationale and impact section on psychological interventions.

Full details of the evidence and the committee's discussion are in evidence review O: psychological interventions.

### Raising awareness about pelvic floor dysfunction

Are community-based strategies effective in raising awareness about the prevention of pelvic floor dysfunction?

For a short explanation of why the committee made these recommendations see the rationale and impact section on raising awareness of pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review A: raising awareness of pelvic floor dysfunction.

## Information valued by children and young women with pelvic floor dysfunction

What are the experiences and information needs of children and young women (between 12 and 17 years) with pelvic floor dysfunction?

For a short explanation of why the committee made these recommendations see the rationale and impact section on communicating and providing information to women with pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review G: information valued by women.

## Effective ways of supporting women to start and continue interventions for pelvic floor dysfunction

What is the best way to support women to start and continue interventions for pelvic floor dysfunction (for example apps, decision aids, or behavioural change techniques)?

For a short explanation of why the committee made these recommendations see the rationale and impact section on communicating and providing information to women with pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review H: effective ways of providing information.

## Effective ways of providing information to women with pelvic floor dysfunction

What are best ways to provide information about pelvic floor dysfunction to children and young women (between 12 and 17 years), and to groups defined by protected characteristics under the Equality Act?

For a short explanation of why the committee made these recommendations see the rationale and impact section on communicating and providing information to women with pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review H: effective ways of providing information.

## Medicines for pelvic floor dysfunction

Is vaginal oestrogen effective at treating the symptoms of pelvic floor dysfunction?

For a short explanation of why the committee made these recommendations see the rationale and impact section on medicines.

Full details of the evidence and the committee's discussion are in evidence review Q: pharmacological interventions.

## Community-based multidisciplinary pelvic floor dysfunction teams

What roles are needed in a community-based multidisciplinary pelvic floor dysfunction team?

For a short explanation of why the committee made these recommendations see the rationale and impact section on community based multidisciplinary teams.

Full details of the evidence and the committee's discussion are in evidence review R: community based multidisciplinary teams.

## Intravaginal devices and pessaries combined with pelvic floor muscle training for managing pelvic floor dysfunction

How effective is a pessary or intravaginal device combined with pelvic floor muscle training for managing pelvic floor dysfunction, compared with pelvic floor muscle training alone?

For a short explanation of why the committee made these recommendations see the rationale and impact section on pelvic floor muscle training for managing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review M: pelvic floor muscle training for management of pelvic floor dysfunction.

### Virtual and in-person contact time for pelvic floor muscle training

How effective is virtual contact with a trainer, compared with in-person contact, for pelvic floor muscle training?

For a short explanation of why the committee made this research recommendation see the rationale and impact section on pelvic floor muscle training for managing pelvic floor dysfunction.

Full details of the evidence and the committee's discussion are in evidence review M: pelvic floor muscle training for management of pelvic floor dysfunction.

### Anal plug devices and rectal irrigation for the management of bowel symptoms in women with pelvic floor dysfunction

How effective are anal plug devices and rectal irrigation for bowel symptoms in women with pelvic floor dysfunction?

For a short explanation of why the committee made this research recommendation see the rationale and impact section on intravaginal devices and pessaries.

Full details of the evidence and the committee's discussion are in evidence review N: physical devices.

## Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

## Raising awareness of pelvic floor dysfunction for all women

Recommendations 1.1.1 to 1.1.10

### Why the committee made the recommendations

The evidence was limited to 1 study, so most of the recommendations were based on the committee's knowledge and experience. However, this study did show that teaching pelvic floor health in school improved young women's understanding of their pelvic floor anatomy.

Improving women's knowledge of pelvic floor health is important because this increases the chance they will take action to prevent pelvic floor dysfunction (for example, through lifestyle changes and pelvic floor muscle training). The range of communication formats and strategies recommended is broad, because pelvic floor dysfunction can happen to any woman, so different strategies will be more effective for different groups of women. The committee discussed what the content of this information should be and decided that this would need to be tailored to the individual and the situation in which it is provided (for example, they noted that information provided during school lessons would likely have a different focus to information provided at a local community group). However, to ensure information is accurate and useful, it should include the topics highlighted in recommendation 1.1.1. The committee acknowledged that there can be groups of women that experience inequalities (for example in access to services). When there is evidence of this, the committee noted that local authorities should consider designing information programmes that increase awareness of the condition, with the aim of advancing equality in healthcare provision and fostering good relations with communities.

The committee believed it was particularly important to raise awareness in maternity services, this is when symptoms can first occur, when risk factors can be identified and when prevention strategies can be started. The recommendations could lead to midwives providing information about pelvic floor dysfunction many times during a woman's pregnancy. However, the committee believe this is reasonable, because it gives the midwife an opportunity to normalise the topic and time to discuss it in detail. Normalisation is important, because embarrassment often gets in the way of

discussions about pelvic floor dysfunction. The committee also noted that frequent discussions would reinforce the message and improve adherence to prevention or management, which is key to their effectiveness.

Because of the sparsity of evidence, and the potential benefits of raising awareness of pelvic floor dysfunction, the committee made a research recommendation on this topic.

### How the recommendations might affect practice and services

Pelvic floor dysfunction is not currently covered in the school curriculum. However, sex and relationship education is already a compulsory part of the curriculum, and pelvic floor dysfunction could be covered as part of these classes.

Return to recommendations

## Risk factors for pelvic floor dysfunction

Recommendations.1.2.1 (box 1) and 1.2.2

### Why the committee made the recommendations

Interpreting the evidence was difficult, because there was a lot of variation in how the studies were conducted, the way risk factors were defined, and which symptom each risk factor affected. However, the evidence did consistently reflect the committee's experience.

The evidence suggested a number of modifiable and non-modifiable risk factors. The committee recommended advising women of these, so they are aware of their risks and (for modifiable factors) can take steps to reduce them.

While some risk factors are non-modifiable (such as age or familial history), the committee agreed that it is still useful for women to be told about these. This is because if women know about their risks, they may be encouraged to reduce any modifiable risk factors and use preventative interventions (such as pelvic floor muscle training). Women with some of these risk factors will also be offered supervised pelvic floor muscle training (see the recommendations on pelvic floor muscle training).

### Co-existing conditions

There was evidence for a variety of physical co-existing conditions associated with pelvic floor dysfunction. There was variation in the quality of the evidence because in some studies the inclusion criteria were not clearly described. In addition, while some conditions were shown to increase the risk of pelvic floor dysfunction, there was uncertainty around how large this increase is. Because of this, the committee did not list every condition identified in the studies. Instead, they highlighted the conditions that have a direct impact on the pelvic floor muscles, where the risk of pelvic floor dysfunction in the evidence aligns with their own experience.

For some conditions that may increase the risk of pelvic floor dysfunction (such as hypermobility, neurological disease and mental health problems), there was little evidence on their effect. In addition, there was only limited evidence on the effect of respiratory disease and chronic cough on the full range of symptoms, and this is particularly important because of the COVID-19 pandemic. A research recommendation was made to address these evidence gaps.

### Tools to predict pelvic floor dysfunction

There are groups of women who have an increased risk of developing pelvic floor dysfunction. There are also interventions that can help prevent pelvic floor dysfunction (see the sections on exercise and diet and pelvic floor muscle training). Because of this, it would be useful to have an effective tool for predicting pelvic floor dysfunction so that women at higher risk can be prioritised for pelvic floor muscle training programmes. However, there was no evidence on the effectiveness of existing tools. The committee agreed this was an important area for further study, and made a research recommendation on prediction tools.

## How the recommendations might affect practice

The recommendations will standardise the information and advice that is provided to women, to enable better shared decision making. There are no significant costs associated with this, because providing information is already standard practice. The costs of the time taken to give this information would be outweighed by better satisfaction with services and the potential for avoiding future pelvic floor dysfunction.

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## Exercise and diet and other modifiable risk factors

Recommendations 1.3.1 to 1.3.7

### Why the committee made the recommendation

The evidence suggested that exercise, healthy diet and appropriate fluid intake help to prevent pelvic floor dysfunction. The quality of the evidence was low because some studies did not account for other factors that could potentially explain the findings. However, it reflected the committee's experience in clinical practice and was in line with standard UK diet and exercise guidance.

One of the risk factors for pelvic floor dysfunction is constipation, and in the committee's experience this can be addressed by adjusting fluid intake. Public health guidance does not clearly define ideal levels of fluid intake, and there are differences in the fluid needs of individuals (for example, people need more fluid if they are doing a lot of exercise). The committee therefore decided not to give their own definition of appropriate fluid intake.

The committee recognised that there were other modifiable risk factors, body mass index (BMI) over 25 kg/$m^2$, smoking and diabetes and referenced relevant NICE guidance for management strategies for these which would help prevent pelvic floor dysfunction.

There was only limited evidence on specific dietary factors, such as caffeine and carbonated drinks. To address this, the committee made a research recommendation.

No evidence was found on the impact of other lifestyle factors that can prevent symptoms associated with pelvic floor dysfunction (such as pelvic organ prolapse, emptying disorders of the bladder or bowel, sexual dysfunction, or chronic pelvic pain syndromes). However, in the committee's experience, exercise that involves repetitive pelvic floor loading (such as weight training) can improve pelvic floor muscle strength and so prevent symptoms. The committee agreed that more research is needed to support this, particularly in relation to the intensity of exercise needed, so they made a research recommendation.

### How the recommendations might affect practice

Currently, lifestyle advice is given to women to help with the management of symptoms of pelvic floor dysfunction. However, lifestyle advice is rarely considered as part of pelvic floor dysfunction prevention, because these women are symptom free. Therefore, these recommendations will help standardise the advice women receive on preventing pelvic floor dysfunction.

Return to recommendations

## Pelvic floor muscle training for preventing pelvic floor dysfunction

Recommendations 1.3.8 to 1.3.15

### Why the committee made the recommendations

The available evidence covered women in 3 settings: community, antenatal, and postnatal. It specifically addressed pelvic floor dysfunction and associated symptoms (including urinary incontinence, pelvic organ prolapse and sexual dysfunction).

In addition to the research evidence, the committee also took account of the Independent Medicine and Medical Devices Safety Review and the NHS Long Term Plan, which made recommendations on pelvic floor muscle training.

Pelvic floor muscle training was shown to prevent symptoms of pelvic floor dysfunction in all 3 settings. Evidence was not available for some symptoms (such as faecal incontinence and pelvic pain). The training was most effective in the short term. The committee noted that most studies looked at pregnant women (antenatal and postnatal). However, all healthcare professionals can provide encouragement to all women doing pelvic floor muscle training in all settings. Since there are particular obstetric risk factors associated with pelvic floor dysfunction (see the section on risk factors for pelvic floor dysfunction), pelvic floor muscle training could be particularly beneficial for pregnant women. The evidence supported this, because pelvic floor muscle training was shown to be effective in preventing pelvic floor symptoms when started during or after pregnancy.

Most of the evidence was for a narrow age range of women in their twenties or thirties. However, there was a consistent pattern of risk reduction across this group.

The committee believed that this supported them in making recommendations for women of all ages.

An economic analysis showed that supervised pelvic floor muscle training is likely to be cost effective for some groups of pregnant women. In particular, women who have a first-degree relative with pelvic floor dysfunction are at particularly high risk, so will see the most benefit relative to the cost of the training. The committee also identified 3 risk factors related to labour that they thought would pose the highest risk. They did not include 'an active second-stage labour taking more than 1 hour' in this recommendation because it is quite common (so would have a high potential cost), and the evidence on this was inconsistent (some studies showing an increased risk when labour was longer than 1 hour, but others did not show increased risk when it was longer than 20 minutes).

In all the studies, pelvic floor muscle training was supervised by a trained healthcare professional. The committee agreed that this is important for ensuring that pelvic floor muscle contraction is done correctly. In their experience, it is also important to tailor the training for each woman, to ensure that the exercises are manageable.

There was limited evidence on long-term effectiveness, as only 2 studies had a longer follow-up period (12 months in 1 study and 8 years in the other). However, all the studies showed that adherence decreased over time. In the committee's experience, continuing with the training is key for continued prevention of symptoms, and they agreed that low long-term adherence is likely to explain the limited evidence for long-term effectiveness. To address adherence problems, the committee made the recommendation on encouraging women to continue pelvic floor muscle training.

The committee made research recommendations to investigate several gaps in the evidence:

- Most effective ways to provide training: the studies did not give much detail on how training should be conducted.
- Younger women: there was no evidence on training for young women (between 12 and 17 years).
- Older women: there was only 1 study supporting training for women over 60.

- Women who are pregnant and at particular risk of pelvic floor dysfunction: there was little evidence specific to women who are pregnant and have particular risk factors.
- Faecal incontinence and emptying disorders of the bowel: there was no evidence on whether pelvic floor muscle training improves these symptoms (which can be particularly distressing).

The Independent Medicine and Medical Devices Safety Review recommended 'that the NHS adopts the French model for universal postnatal pelvic floor rehabilitation', to help prevent pelvic floor dysfunction. This model includes 10 sessions of routinely prescribed perineal rehabilitation sessions (pelvic floor muscle training with manual internal techniques, biofeedback and electrical stimulation) starting at least 8 weeks after birth, regardless of symptoms. The committee did not think the evidence (in particular the cost-effectiveness evidence) was strong enough to support this for all women during or after pregnancy. Instead, they identified the risk factors that put women at the greatest risk, for which pelvic floor training was most likely to be cost effective. They also made a research recommendation to investigate further.

### How the recommendations might affect practice

Currently, pelvic floor muscle training is rarely used for prevention, and is usually only considered and taught to women when they develop symptoms (such as urinary incontinence). Therefore, the recommendations for pregnant women with family history of pelvic floor dysfunction or other risk factors are likely to have a significant resource impact (particularly given the size of the population who would be eligible). Some of this cost is likely to be offset by savings from preventing or delaying pelvic floor dysfunction.

Pregnant women receive information on pelvic floor muscle training. However, this is usually general advice rather than specific instructions or supervised sessions. Women are not routinely told about how pelvic floor muscle training can help prevent sexual dysfunction during and after pregnancy. The recommendations ensure that all women are getting information on the benefits of pelvic floor muscle training to prevent pelvic floor dysfunction. This will standardise practice.

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# Communicating and providing information to women with pelvic floor dysfunction

Recommendations 1.4.1 to 1.4.7

## Why the committee made the recommendations

Qualitative evidence showed that women with pelvic floor dysfunction perceived some communication styles as unhelpful. It also indicated that some women are not given enough information to understand their symptoms, diagnosis, investigations or treatment. The quality of the evidence was mixed, due to concerns about methodological limitations in the design of the studies. The committee also made recommendations based on their own experience, in areas where there was no evidence (such as video and telephone consultations).

The recommendation on asking women if they want their family, carers or other people involved is particularly important for addressing potential barriers to support for women with cognitive impairments.

Pelvic floor dysfunction is a complex condition, with particular communication issues (such as embarrassment). Based on the evidence and on their experience, the committee highlighted key issues to take into account when discussing pelvic floor dysfunction with women.

Because of the COVID-19 pandemic, many services are being provided remotely. In the committee's experience, this has been well received by some women. A particular benefit of remote services can be reduced embarrassment (both for women and for healthcare professionals), which makes women more willing to discuss problems. However, even though this may be the case for some women, the committee acknowledged that it may be harder for the healthcare professional to identify whether symptoms may not be reported due to embarrassment during a remote consultation.

The committee made research recommendations in areas where there was no evidence:

- effective ways of providing information for young women (between 12 and 17 years) and women with protected characteristics (such as physical or learning disabilities)
- effective ways of supporting women to start and continue with interventions for pelvic floor dysfunction
- information valued by children and younger women with symptoms of pelvic floor dysfunction.

### How the recommendations might affect practice

Healthcare professionals already discuss pelvic floor dysfunction with women and provide information on this. However, the information given and how it is communicated can vary, and these recommendations will standardise the process. As the symptoms of pelvic floor dysfunction are often distressing and embarrassing, communication and sensitivity are very important for all healthcare professionals to ensure good care is provided.

Services already use translation services as needed to overcome communication barriers. However, there may be an impact in areas where video consultation or digital information aids are not currently available.

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## Assessment in primary care

Recommendations 1.5.1 to 1.5.7

### Why the committee made the recommendations

There are a number of signs and symptoms associated with pelvic floor dysfunction. However, there was no evidence on which assessments are needed in non-specialist care to identify these signs and symptoms. Because of this, the committee made recommendations based on their clinical expertise, highlighting the investigations they use in their practice and the most important signs and symptoms to look out for.

There was evidence that healthcare professionals may overlook symptoms of pelvic floor dysfunction in women who have recently given birth. The evidence also

highlighted that there are common misconceptions about pelvic floor dysfunction during and after pregnancy, which can prevent women from seeking care early. To address this the committee emphasised that women who have recently given birth should be asked about symptoms.

In the committee's experience, many medications can impact on symptoms of pelvic floor dysfunction. In addition, this impact is often larger for people who are taking multiple medicines. Because of this, a medication review is important.

A focused history is important for identifying the likely cause of any symptoms, because many of the symptoms of pelvic floor dysfunction can be caused by other conditions as well.

The committee highlighted some of the examinations that would be needed to clarify whether symptoms are likely to be associated with pelvic floor dysfunction or not.

### How the recommendations might affect practice

Pelvic floor dysfunction is a complex condition, and there is currently variation in how it is assessed. These recommendations will ensure consistency in the initial assessments that are performed in primary care.

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## Community-based multidisciplinary teams

Recommendation 1.6.1 to 1.6.3

### Why the committee made the recommendations

There was limited evidence on team-based approaches for managing pelvic floor dysfunction. However, the available evidence reflected the committee's experience in practice. They decided that the range of competencies needed could not be covered by one healthcare professional alone, and so a multidisciplinary team approach should be considered. This team would need to be community-based, to ensure it is accessible to all women with pelvic floor dysfunction.

Adherence and satisfaction with care are important factors in effective management of pelvic floor dysfunction, and the committee agreed that these would also be improved by community-based multidisciplinary teams.

The experience and training of multidisciplinary team members is likely to vary widely in different areas. Because of this, the committee made a recommendation on competencies, based on their own experience of the key knowledge and experience that is needed in the team to implement the other recommendations in this guideline.

The committee did not recommend including specific roles (such as specialist incontinence nurses) in the team, because community healthcare professionals can be trained to carry out non-specialist assessment, and because including specific specialists in every team could have substantial costs.

When agreeing a management plan it is important to involve the woman with pelvic floor dysfunction, to ensure the plan takes account of her needs and preferences.

### How the recommendations might affect practice

Community-based multidisciplinary teams may represent a change to current practice, because there is variation in their availability. Pelvic floor dysfunction is a common condition, and other services (such as community-based continence services) could form the basis of these teams. The committee decided that the benefits of good pelvic floor dysfunction management would outweigh potential costs associated with setting up community-based multidisciplinary teams.

There is currently variation in the competencies that community-based multidisciplinary teams have on assessing and managing pelvic floor dysfunction. There would be upfront costs for training healthcare professionals in the competencies recommended in this guideline, but these costs would be outweighed by better long-term outcomes (improved identification of symptoms and better management as a result).

Return to recommendations

# Lifestyle changes

## Encouraging women to make lifestyle changes

Recommendation 1.6.4

### Why the committee made the recommendation

The evidence showed that positive communication improves patient motivation and adherence to lifestyle changes. This was also consistent with the committee's experience. It can take time for women to see a benefit from lifestyle changes, so the committee believed it was important to emphasise encouraging and motivating women in the recommendation.

### How the recommendation might affect practice

All healthcare professionals communicate with women and this recommendation will raise awareness that this communication should not only be framed in a negative way but provide positive messages when appropriate.

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## Weight loss

Recommendations 1.6.5 to 1.6.8

### Why the committee made the recommendations

The evidence showed that in women with a body mass index (BMI) over 30 kg/m$^2$, weight loss helped with urinary incontinence and overactive bladder. In the committee's experience, weight exacerbates these symptoms by putting pressure on the pelvic floor muscles and organs, so weight loss will be particularly beneficial. The evidence did not show any effect from weight loss on symptoms of pelvic organ prolapse. However, the committee still believe that weight loss may be beneficial in the early stages of pelvic organ prolapse, because less weight would press on the pelvic organs and this could improve symptoms.

The committee recommended against delaying other management options until women have lost weight because:

- there was no evidence on the impact of weight loss for many symptoms of pelvic floor dysfunction **and**
- there are other interventions that could benefit women with pelvic floor dysfunction.

As other NICE guidelines cover helping people to lose weight, the committee referred to these guidelines rather than making new recommendations on weight-loss interventions.

The committee made a research recommendation to address the lack of evidence on many symptoms associated with pelvic floor dysfunction.

#### How the recommendations might affect practice

Weight loss referral related to pelvic floor dysfunction differs across the country. The recommendations would reduce variation and promote consistency in care.

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### Diet

Recommendations 1.6.9 and 1.6.10

#### Why the committee made the recommendations

There was some evidence suggesting that reducing caffeine intake helps with urinary incontinence and overactive bladder, and this was supported by the committee's experience in practice.

No evidence was found on other symptoms associated with pelvic floor dysfunction. However, the committee agreed that in their experience, addressing fluid intake can help with symptoms by promoting an ideal stool consistency. Public health guidance does not clearly define ideal levels of fluid intake, and there are differences in the fluid needs of individuals (for example, people need more fluid if they are doing a lot of exercise). The committee therefore decided not give their own definition of appropriate fluid intake.

A balanced diet also reduces the risk of constipation and so would indirectly reduce the risk of pelvic floor dysfunction. This is particularly important for women with pelvic

organ prolapse, faecal incontinence, emptying disorders of the bowel and chronic pelvic pain syndromes.

The committee believed that more research specific to pelvic floor dysfunction related to food rather than fluid intake is needed, and made a research recommendation to address this.

**How the recommendations might affect practice**

These recommendations are in line with current clinical practice. Clinicians will already be familiar with the practical details of lifestyle changes that can be made to promote pelvic floor health, and lifestyle changes are a common aspect of management for symptoms of pelvic floor dysfunction.

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## Exercise

Recommendations 1.6.11 and 1.6.12

**Why the committee made the recommendations**

There was some evidence on urinary incontinence, overactive bladder and pelvic organ prolapse. The evidence showed that exercise could improve these symptoms, but the exercise programmes in these studies were supervised and included pelvic floor muscle training as part of the interventions.

The physical activity interventions covered were yoga, pilates, weight training and aerobic exercises. However, it was not clear from the studies what type of exercises the women were doing, so the committee did not recommend specific exercises. The committee know from their own experience that women often ask whether physical activity could improve or worsen their symptoms. Because of the evidence that showed some improvement, they made a recommendation in favour of supervised exercise. ‘Supervised’ exercise is specified because certain exercises, if done incorrectly, can weaken the pelvic floor by increasing intra-abdominal pressure. This could worsen symptoms of pelvic floor dysfunction.

There is no evidence that unsupervised exercise improved or worsened symptoms of pelvic floor dysfunction. The committee acknowledged that there are general health

benefits associated with having an active lifestyle. Therefore, they also made a research recommendation on unsupervised activities (in particular, common exercises such as walking and swimming).

Heavy lifting has been considered a risk factor for damaging the pelvic floor by increasing intra-abdominal pressure. The NICE guideline on urinary incontinence and pelvic organ prolapse in women recommends minimising heavy lifting. However, a more recent study showed that weight training combined with pelvic floor muscle training could improve symptoms of urinary incontinence. Since there was uncertainty around the evidence and it was not entirely consistent with the committee's experience, they made a research recommendation to investigate this further.

### How the recommendation might affect practice

The recommendation covers providing information, which is part of current practice, so there should be no cost to services. These recommendations will ensure women are educated on exercises they can do to improve their symptoms and those that are not harmful. In addition, the recommendations will standardise the information being provided.

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## Pelvic floor muscle training for managing pelvic floor dysfunction

Recommendations 1.6.13 to 1.6.20

### Why the committee made the recommendations

The evidence showed that pelvic floor muscle training improves several symptoms of pelvic floor dysfunction (pelvic organ prolapse, stress and mixed urinary incontinence, and faecal incontinence with co-existing pelvic organ prolapse). There was greater uncertainty around the findings on faecal incontinence with co-existing pelvic organ prolapse, because there was much less evidence in this area.

For pelvic organ prolapse, the evidence showed a benefit from pelvic floor muscle training for prolapse that does not extend beyond the hymen on straining. This

matched the committee's experience, as they agreed that more extensive pelvic organ prolapse would be managed in specialist care.

The recommended lengths of time for the training programmes are based on the most common time points used in the studies for assessing the benefit of training. This was 16 weeks for pelvic organ prolapse and faecal incontinence, and 3 months for urinary incontinence. The committee noted that this would give enough time to assess whether the training improved symptoms. This is also consistent with the recommendations on pelvic floor muscle training in the NICE guideline on urinary incontinence and pelvic organ prolapse in women.

In addition to the research evidence, the committee also took account of the Independent Medicine and Medical Devices Safety Review and the NHS Long Term Plan, which made recommendations on pelvic floor muscle training.

See the rationale for pelvic floor muscle training for preventing pelvic floor dysfunction for an explanation of the recommendations on supervising pelvic floor muscle training.

For additional therapies, such as weighted vaginal cones, biofeedback and electrical stimulation, the evidence was inconsistent. Some studies showed benefits, and others showed no effect. Some of the evidence suggested that these interventions could help women with pelvic floor muscle training by improving their ability to contract their pelvic floor muscles. In the committee's experience, effective pelvic floor contractions are important for improving pelvic floor dysfunction symptoms and that most women are able to do this as part of a supervised pelvic floor muscle training programme. However, the committee believed that supplementing pelvic floor muscle training programme with biofeedback, electrical stimulation or vaginal cones could be cost-effective in the subgroup who make little progress during supervised pelvic floor muscle training. These additional therapies are particularly likely to be cost effective if using them allows women to avoid the need for surgical intervention.

Based on their experience, the committee thought it would be important that women are advised to continue doing pelvic floor muscle training and that they have the opportunity to discuss progress in regular reviews during the initial training

programme. The committee believed that reviews with a healthcare professional improve adherence, which is important for the long-term effectiveness of pelvic floor muscle training.

There was some evidence suggesting that training in a group improved adherence and symptoms, but it was not consistently found to be more effective than individual training. This was supported by the committee's experience, as some women benefit from peer support while some feel more motivated with one-to-one supervision. To take account of this, the committee recommended giving women a choice of group or individual training. One-to-one supervision is more expensive than group training, but the difference in cost is relatively small and so the approach favoured by each woman is likely to be cost effective.

It was unclear whether using a pessary or intravaginal device would be effective when combined with pelvic floor muscle training, so the committee made a research recommendation for this. The development of remote clinical practice during the COVID-19 pandemic also made the committee curious about the effectiveness of virtual pelvic floor muscle training, so they recommended research into the effectiveness of this.

### How the recommendations might affect practice

The recommendations will standardise practice. Pelvic floor muscle training is a key intervention for managing the symptoms of pelvic floor dysfunction and is already widely used in the NHS. However, access to group pelvic floor muscle exercise classes differs across the country. While some healthcare services may need to change practice, group pelvic floor muscle exercise classes are less expensive, so the committee did not anticipate a significant resource impact.

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## Intravaginal devices and pessaries

Recommendations 1.6.21 to 1.6.27

## Why the committee made the recommendations

The evidence on intravaginal devices was unclear, with variance across outcomes. For example, there was no measurable reduction in urinary leakage, but women reported that their symptoms improved. However, the committee noted that a subjective improvement in symptoms was still important, as it is an indication of the woman's perception of the device's success. The committee were also aware from their experience that these devices can help to prevent urinary leakage in certain circumstances (for example during exercise). Based on the limitations of the evidence and the potential complications, the committee recommended trialling intravaginal devices if other non-surgical options have been tried and have been unsuccessful, so that women could decide whether they were beneficial before using them long term.

This differs from recommendation 1.4.23 in the NICE guideline on urinary incontinence and pelvic organ prolapse, which recommends against the use of intravaginal devices. However, the committee noted that recommendation 1.4.23 had not been updated since 2006. Most of the evidence they reviewed for this guideline has been published since 2006. Even though the findings from the evidence were not entirely certain, they decided that these devices should not be ruled out if other non-surgical options were unsuccessful. This would provide another option that may prevent the need for more invasive treatment.

The evidence on pessaries indicated that they help with symptoms of pelvic organ prolapse, and this is in keeping with the committee's clinical experience. However, there was a lack of long-term evidence on the effectiveness and potential complications of pessary use. Because of the uncertainty around pessaries, the committee specified particular benefits and harms to discuss with women, based on the evidence that was available and their clinical experience. This will help women to make an informed decision on whether a pessary is right for them.

In the committee's experience, women with physical or cognitive impairments may have difficulty in managing an intravaginal device or pessary and are at higher risk of complications. Because of this, these women should have regular appointments to check for complications. The committee also recommended telling women how to self-refer if they are managing the device themselves, so that they know how to get

help if they are having problems or if their intravaginal device or pessary does not help.

There was a lack of evidence on the physical devices available for managing faecal incontinence (which is a particularly distressing symptom). The existing evidence consists of studies in mixed populations of men and women, so it could not be used to make recommendations for the population of this guideline. To address this, the committee made a research recommendation.

### How the recommendations might affect practice

These recommendations are in line with current practice on pessaries. There is variation in the use of intravaginal devices, but the recommendations would not involve major changes to practice since it would be an option only if other options had not been successful. Even though this may increase the general use of intravaginal devices, they are already used in some areas. They may also prevent more invasive options (such as surgery) which are more costly.

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## Psychological interventions

Recommendations 1.6.28 and 1.6.29

### Why the committee made the recommendations

The evidence showed a psychological impact from the symptoms of pelvic floor dysfunction. However, the committee noted that there was a lot of uncertainty about this evidence and made recommendations based on their experience and expertise. They made a recommendation emphasising this because women with pelvic floor dysfunction often do not seek help with the psychological impact of their symptoms, and healthcare professionals do not always ask them about it.

Some therapies were shown to improve distress associated with pelvic floor dysfunction, but the studies were very small. There was also evidence that psychological therapy could help with vaginismus, but it was not clear from the studies whether the participants' symptoms were related to pelvic floor dysfunction.

The committee decided that they could not recommend therapies based on this evidence.

As other NICE guidelines cover identifying and managing mental health problems for people with a chronic health condition, the committee referenced these guidelines instead of making new recommendations on specific psychological interventions.

There was some evidence showing that psychological interventions improved attendance and adherence to pelvic floor muscle training. However, there were several limitations to this evidence:

- it did not show whether the improvement in attendance and adherence was sustained in the long term
- while some of the interventions improved the mental health of participants, it was not clear whether the interventions also had an impact on symptoms (which could mean that the improvement in mental health may not be sustained in the long term)
- the studies were small.

These limitations meant that the committee could not make a practice recommendation. However, they do believe that better attendance and adherence to training improves the benefit of pelvic floor muscle training. Because of this, they made a research recommendation on ways to improve adherence for women who are having this training.

### How the recommendations might affect practice

The committee agreed that there is variation in practice in how well psychological factors related to pelvic floor dysfunction are considered when planning treatment. The recommendations would not involve major changes to practice, but would standardise current good practice.

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## Behavioural approaches

Recommendations 1.6.30 to 1.6.32

## Why the committee made the recommendations

There was evidence about behavioural techniques including bladder retraining and lifestyle education, provided under direct supervision by a trained healthcare professional. The studies usually included pelvic floor muscle training as part of the interventions. The symptoms covered in the studies included urinary incontinence, urinary urgency and frequency and faecal incontinence. Evidence was not available for some symptoms (such as emptying disorders of the bladder and bowel).

The evidence was difficult to interpret because there was variation in the quality of the research and a mixture of different interventions and comparators, which made it difficult to combine results. This meant that it was not clear which aspects of interventions were directly improving the symptoms of pelvic floor dysfunction.

The evidence showed that behavioural techniques in combination with pelvic floor muscle exercises improved these symptoms, which was in keeping with the committee's experience in clinical practice. The committee noted that bladder retraining consists of advice about when or how frequently to go to the toilet to encourage a routine that can help prevent incontinence episodes.

There was some limited evidence suggesting that a combination of behavioural techniques and pelvic floor muscle exercises was associated with improved adherence and satisfaction. The committee agreed that motivation and adherence were key to long-term benefit. The committee were conscious that behavioural techniques should be tailored to the individual, as ability may differ based on other co-existing conditions (such as cognitive impairment).

## How the recommendations might affect practice

Behavioural techniques involve a wide range of techniques that can be used to change behaviour and teach women skills to reduce symptoms of pelvic floor dysfunction. These techniques are already used by most services, so the recommendations will reinforce current practice.

Bladder training can easily be provided in conjunction with a pelvic floor muscle training programme and would not add significant costs.

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## Medicines

Recommendations 1.6.33 and 1.6.34

### Why the committee made the recommendations

There was limited evidence on medicines for general pelvic floor dysfunction. However, the evidence available did show that intravaginal diazepam was not effective at improving symptoms. Although this evidence was based on a small population, the committee were also concerned about the risk of dependency from diazepam usage. Because of this risk and the lack of evidence for any benefit, the committee recommended against intravaginal diazepam.

The NICE guidelines on urinary incontinence and pelvic organ prolapse in women and faecal incontinence in adults make recommendations on medicines for symptoms that can be associated with pelvic floor dysfunction. The committee recommended following these recommendations for women with pelvic floor dysfunction, because the medicines recommended are likely to be effective even if the underlying cause of symptoms is different in the other guidelines.

Topical intravaginal oestrogen is currently used in clinical practice for managing pelvic floor dysfunction. However, no evidence was identified for this, so the committee made a research recommendation.

### How the recommendations might affect practice

The recommendation on intravaginal diazepam will not change current practice, since this is not currently used in the NHS. Since the other recommendation cross refers to other NICE guidance it will reinforce current guidance and will not have any significant resource impact.

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# Context

Pelvic floor dysfunction covers a variety of symptoms. In this guideline, the following symptoms are addressed as long as they are associated with pelvic floor dysfunction: urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual

dysfunction and chronic pelvic pain syndromes. The 3 most common and definable conditions are urinary incontinence, faecal incontinence and pelvic organ prolapse.

Prevalence of pelvic floor dysfunction is high. For example, on examination prolapse is present in up to 50% of women. This can have a significant impact on quality of life, reducing social engagement and ability to exercise.

This guideline makes recommendations on common risk factors and on preventative interventions. Ideally, women who are most at risk of pelvic floor dysfunction would be identified early and offered interventions to prevent symptoms developing. This would reduce the impact on women and the NHS.

When pelvic floor dysfunction is diagnosed, there is variation in the availability of non-surgical management options, such as pelvic floor muscle training. Women have no clear and effective strategies available to prevent worsening of the condition. This guideline provides a more community-based pathway to address these problems and to reduce the number of women who develop complex symptoms that need specialist care (including surgery).

## Finding more information and resources

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on gynaecological conditions and uterine prolapse.