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Pelvic Floor Muscle Training to Manage Overactive Bladder and Urinary Incontinence

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Urinary incontinence (UI) is defined by the International Continence Society as any involuntary leakage of urine (Haylen et al., 2010). UI is a chronic debilitating condition for both men and women, but it is more common in women, with more than half of American women reporting UI (Markland, Richter, Fwu, Eggers, & Kusek, 2011). UI is characterized as stress, urge, or mixed incontinence. Stress incontinence occurs when the muscles that control the urethra, mainly the detrusor muscle, are not able to hold urine in times of increased stress on the bladder (e.g., coughing, sneezing, laughing, jumping; Rogers, 2008). Urge UI, also known as overactive bladder, is a sudden need to urinate in which leakage occurs before making it to the bathroom (Abrams, Artibani, Cardozo, Dmochowshi, &

Abstract Overactive bladder (OAB) and urinary incontinence (UI) are common chronic conditions that can negatively affect women's quality of life. Pelvic floor muscle training is the first-line treatment. Two recent Cochrane Reviews examining pelvic floor muscle training for the treatment of UI and OAB are summarized here to provide women's health nurses with current recommendations for UI and OAB management. This column also identifies practice improvement education in the area of pelvic floor muscle training and treatment for OAB and UI. http://dx.doi.org/10.1016/j.nwh.2016.12.004

Keywords Kegel | overactive bladder | pelvic floor muscle training | urinary incontinence

van Kerrebroeck, 2009). Mixed incontinence is a combination of stress and urge UI.

Overactive bladder (OAB) is currently defined as urinary urgency, frequency, and nocturia, with or without UI (Abrams et al., 2009, 2003; Haylen et al., 2010). OAB is characterized by urgency and frequency of urination with nocturia and can be with incontinence episodes (wet OAB) or without incontinence (dry OAB). Wet OAB, or urge UI, is particularly problematic to treat because not only is the detrusor muscle involved, as in stress UI, but there is also an altered state of neural regulation of the bladder (Banakhar, Al-Shaiji, & Hassouna, 2012). The National Association for Continence (2015) reports that more than 17% of women over the age of 18 years report signs of OAB, making the prevalence of both UI and OAB higher than other chronic conditions, including diabetes at 9.3% (Centers for Disease Control and Prevention, 2014b) and asthma at 7.7% (Centers for Disease Control and Prevention, 2014a). Prevalence of OAB and UI is thought to be dramatically underreported because of embarrassment and the false belief that symptoms are a normal part of aging (Irwin et al., 2006; Milsom et al., 2001; Wallner et al., 2009).

The muscles of the pelvic floor support the urethra, vagina, and rectum and play a role in sexual function

The first-line treatment recommended by the American Urological Association and the International Continence Society is behavior modification, which includes a toileting schedule, avoiding bladder irritants, and pelvic floor muscle training (PFMT; Duomulin & Hay-Smith, 2010; Gormley et al., 2014). Arnold Kegel made PFMT a popular treatment for stress UI in 1948 (Kegel, 1948). The muscles of the pelvic floor support the urethra, vagina, and rectum and play a role in sexual function.

This column takes a second look at two recent Cochrane Reviews that examine PFMT in the treatment of UI. Both reviews summarized here are classified as Level I evidence (see Box 1).

The First Review

The purpose of the systematic review by Dumoulin et al. (2014) was to assess the use of

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