Appendix Table F85. Effectiveness of nonpharmacological treatments on stress UI in women (results from poorly reported randomized controlled clinical trials)

Reference	Aim	N	% Women	% With UI	Treatment	Duration	Population	Results
Hahn, 1991[628]	To evaluate the function of the pelvic floor and urethral sphincters before and after Contelle device	20	100	100	Pelvic floor training and electrical stimulation with Contelle device (the device was to used for 8-10 hours/night at maximally tolerable intensities)	6 months	Women with genuine stress incontinence	Very few reliable correlations between symptomatic improvement and urodynamic improvement were found

Appendix Table F85. Effectiveness of nonpharmacological treatments on stress UI in women (results from poorly reported randomized controlled clinical trials (continued)

Reference	Aim	N	% Women	% With UI	Treatment	Duration	Population	Results
Laycock, 1993[629]	To evaluate the effect of transcutaneous, pre-modulated interferential stimulation on the symptoms of female stress incontinence, by two prospective clinical trials	46 in first trial and 30 in second trial	100	100	Interferential pelvic floor therapy using an Endomed 433 (Enraf Nonius, Delft, Holland) for 15 minutes (on average ten sessions). Instructions: Pelvic Floor Exercises.	6 weeks	Women with urodynamically proven GSI and sterile urine. In the first trial, women were randomized into 2 groups: group 1 received a course of interferential stimulation and group 2 a course of PFMT and weighted vaginal cones therapy. In the second trial, women were randomized into active interferential stimulation and placebo groups.	There was no significant difference in severity of urinary incontinence between the two groups in trial 1 (p=0.4851). In trial 1: 43.5% of patients receiving IFT (n=23) were improved or cured (objectively measured), and 60.9% subjectively classified improved or cured. In trial 2: In the active IFT group: Pad test results showed: 6.7% worse, 6.7% no change, 60% improved, and 13.3% cured, and in the placebo group: 36.4% were worse, 0.7% showed no change, 45.5% improved, and 0% cured. For subjective assessment: in the active IFT group: 6.7% were worse, 60% showed no change, 33.3% improved, and 0% cured and in the placebo group: 54.5% were worse, 18.2% showed no change, 27.3% improved, and 0% cured. For difference in VAS score: in the active IFT group: 26.7% were worse, 0% no change, 73.3% improved, and 0% cured and in the placebo group: 36.4% were worse, 9.1% showed no change, 54.5% improved, and 0% cured
Borello-France, 2010[630]	To describe adherence to PFMT, barriers, and predictors of exercise	154	100	100	Either tolterodine tartrate extended release capsules 4 mg daily or tolterodine tartrate extended release	10 weeks	BE-DRI trial: Secondary data analysis. Community-dwelling women with pure or predominant UUI , recruited through the	At 12 months 42% (41) of total women had difficulty to find time to do all of the exercises; 56% (54) had difficulty remembering to exercise; 30% (28) perceived exercises did not help. During

Appendix Table F85. Effectiveness of nonpharmacological treatments on stress UI in women (results from poorly reported randomized controlled clinical trials (continued)

Reference	Aim	N	% Women	% With UI	Treatment	Duration	Population	Results
	adherence in women with urge-predominant UI.				capsules 4 mg daily combined with a behavioral intervention		investigators' clinical practices, study announcements, advertisements, and referrals, had post-void residual volume of less than 150 mL and the ability to contract their PFMs, had to show 7 or more episodes of UI on a 7-day baseline diary, and had to self-report persistent UI for at least 3 months, no current use of antimuscarinic or other medications that could affect UI, and no history of neurologic diseases or conditions (e.g., Parkinson disease, multiple sclerosis, spina bifida, spinal cord injury) or systemic diseases known to affect bladder function.	the intervention period: Adjusted regression coefficient: Total number of reported barriers to exercise adherence: -2.0 (95% CI=-3.1, -0.9) p-value=0.0007; Barrier: Difficult to find time to do all of the exercises: -7.7 (95% CI=-11.1, -4.4) p-value=<0.001; Barrier: Difficulty remembering to exercise: -7.5 (95% CI=-10.8, -4.2) p-value <0.001; Barrier: Perceived exercises do not help: 4.2 (95% CI=0.4, 8.0) p-value 0.03; Barrier: Other: -4.0 (95% CI=-8.1, -0.03) p-value=0.048. During the followup period: Adjusted Regression Coefficient: Barrier: Difficult to find time to do all of the exercises: -2.5 (95% CI= -4.7, -0.2) p-value=0.03. (Adjusted for age, education, race/ethnicity, Medical, Epidemiological, and Social Aspects of Aging Questionnaire (MESA) urge index, MESA stress index, volume of fluid intake pretreatment, and clinical site. Regression coefficient is the change in contractions per day per unit increase in total barriers or for endorsement of individual barrier versus no endorsement of that barrier)

Appendix Table F85. Effectiveness of nonpharmacological treatments on stress UI in women (results from poorly reported randomized controlled clinical trials (continued)

Reference	Aim	N	% Women	% With UI	Treatment	Duration	Population	Results
Griffiths, 2009[631]	To explore the concerns and expectations of women invited to attend group physiotherapy sessions for the management of female UI and whether the experience changed their views; and to gather recommenda-tions from women attending group sessions on the design and delivery of these sessions	22	100	100	Group treatment	3 weeks	Women who had participated in a randomized clinical trial comparing individual and group treatment, who had stress, urge or mixed incontinence and were recruited to one of five physiotherapy centers in the West Midlands of the UK. Of these women those who had expressed a preference for individual sessions, but were randomized to group sessions and attended at least one session were recruited for an interview study.	It is necessary to consider reducing embarrassment and uncertainty in women who attend group sessions run in physiotherapy departments for urinary incontinence prior to their attendance

Appendix Table F85. Effectiveness of nonpharmacological treatments on stress UI in women (results from poorly reported randomized controlled clinical trials (continued)

Reference	Aim	N	% Women	% With UI	Treatment	Duration	Population	Results
Engberg, 2009[632]	To examine the feasibility of recruiting women into a clinical trial designed to examine the efficacy of acupuncture in treating urge and mixed UI and the feasibility of performing the planned study procedures	11	100	100	Acupuncture: 12 treatments over 6 weeks. Control group was given sham acupuncture treatment	6 weeks	Women, aged 40 to 70 years of age, having urge or mixed urge and stress urinary accidents at least twice a week on average and have been incontinent for at least 3 months	Subjects randomized to true acupuncture group had a mean 67.47% (median=75.76%) reduction in daytime accidents/day at 4 weeks post acupuncture, whereas the mean reduction in daytime accidents was 16.67% (median=0%) at 4 weeks post-sham acupuncture. There were no significant group differences in changes in the scores on the quality-of-life measures. Subjects' perceptions about whether they had received the true or sham acupuncture were not significantly better than one would expect by chance.
MacDiarmid, 2010[633]	To examine percutaneous tibial nerve stimulation on U I (ORBIT trial)	100	90%	Not reported	Weekly 30 minute treatment	12 weeks followed by therapy at tapered intervals for 9 months	Ambulatory adults with AOB symptoms, with or without a history of previous anticholinergic drug use, with at least 8 voids per 24 hours documented by history and physical and voiding diary	Subjects received as low as 1.2 treatments monthly to sustain symptom improvement throughout 12 months. The response to PTNS therapy achieved following 12 weeks of treatment demonstrates excellent durability through 12 months of followup with 94% sustained improvement from 12 weeks. Analysis of number of treatments needed to sustain therapeutic effect appears acceptable

Appendix Table F85. Effectiveness of nonpharmacological treatments on stress UI in women (results from poorly reported randomized controlled clinical trials (continued)

Reference	Aim	N	% Women	% With UI	Treatment	Duration	Population	Results
Dunn, 2002[634]	To evaluate the short- and medium-term effectiveness of an intraurethral device (FemSoft Insert, Rochester Medical Corporation, Stewartville, Minnesota) in the treatment of exercise-induced incontinence in women	6	100%	100%	Urethral insert	3 months+	Female patients 18 years and older, having stress incontinence during exercise that required pads or clothing changes, being able to perform regular aerobic exercise, and having adequate manual dexterity and intelligence to use the device and complete the subject questionnaires.	This pilot study found that urethral insert is effective and feasible for unsupervised home use. After 3 months, mean satisfaction scores for ease of use were 2.09 for insertion and 1.18 for removal; for comfort, the scores were 2.18 for insertion, 2.05 while wearing, and 1.36 during removal (on a 5-point scale, 1 = very comfortable/satisfied, 5 = very uncomfortable/unsatisfied).
Borello-France, 2010[630]	To examine adherence to exercise therapy and barriers for adherence	154	100%	100%	Behavioral intention: Pelvic floor muscle training, bladder training, and individualized fluid management for those with excessive urine output (>70 oz per day)	10 week study with one-year followup	Adults with OAB	By end of one-year followup period, only 32% of women were exercising at least 5 to 6 days per week. The barriers to exercise adherence were: 42% had difficulty finding time to do all of the exercises; 56% had difficulty remembering to exercise, and 30% perceived exercises did not help.