



Urinary Incontinence in Women Indicator Report

TOOL DEVELOPMENT AND SURVEILLANCE WORKGROUP

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Table of Contents

How to Use This Report	4
Background	6
Risk Factors for Developing UI	9
Burden of UI	10
Identifying UI	13
When to Screen	14
How to Screen	14
Diagnosis of UI	16
Treatment Strategies	18
Treatment for SUI	22
Treatment for UUI	25
Treatment Follow-Up.....	29
Conclusion: A Pathway to Enhanced Quality of Life	30
References	31
Survey Process.....	37
NAFC Patient Tools	38

Abbreviations Used in This Report

3IQ – Three Incontinence Questions

AUA – American Urological Association

AUGS – American Urogynecologic Society

BMI – Body Mass Index

CDC – Centers for Disease Control and Prevention

FDA – Food And Drug Administration

GSM – Genitourinary Syndrome of Menopause

HCP – Healthcare Provider

HHS – Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

I-QOL – Incontinence Quality of Life Questionnaire

IAD – Incontinence-associated Dermatitis

ICIQ-SF – International Consultation on Incontinence Questionnaire - Short Form

IIQ-7 – Incontinence Impact Questionnaire

ISQ – Incontinence Screening Questionnaire

KHQ – King's Health Questionnaire

M-ISI – Michigan Incontinence Symptom Index

MUI – Mixed Urinary Incontinence

MUS – Midurethral Sling

NAFC – National Association For Continence

OAB – Overactive Bladder

PCP – Primary Care Provider

PFME – Pelvic Floor Muscle Exercises

POP – Pelvic Organ Prolapse

PTNS – Percutaneous Tibial Nerve Stimulation

PVR – Post-Void Residual

QOL – Quality Of Life

SNM – Sacral Neuromodulation

SUFU – Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction

SUI – Stress Urinary Incontinence

UA – Urinalysis

UDI-6 – Urogenital Distress Inventory

UI – Urinary Incontinence

UTI – Urinary Tract Infection

UUI – Urge Urinary Incontinence

The Urinary Incontinence In Women Indicator Report contains current information gathered by field experts in conjunction with the National Association For Continence (NAFC) and the Centers for Disease Control and Prevention (CDC). This report is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$1,125,000 with 100% funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by CDC/HHS or the U.S. Government.



How to Use This Report

Urinary incontinence (UI) can affect women in very different ways depending on their age, symptoms, health history, and stage of life. This report is designed to serve as both an educational resource and a practical guide for healthcare professionals, caregivers and other interested parties seeking a deeper understanding of urinary incontinence and its impact.

If you are new to the topic or looking to better understand how common urinary incontinence is, begin with the **Background** section. This chapter provides a brief overview of the condition and sets the landscape for the more detailed, clinically relevant information that follows.

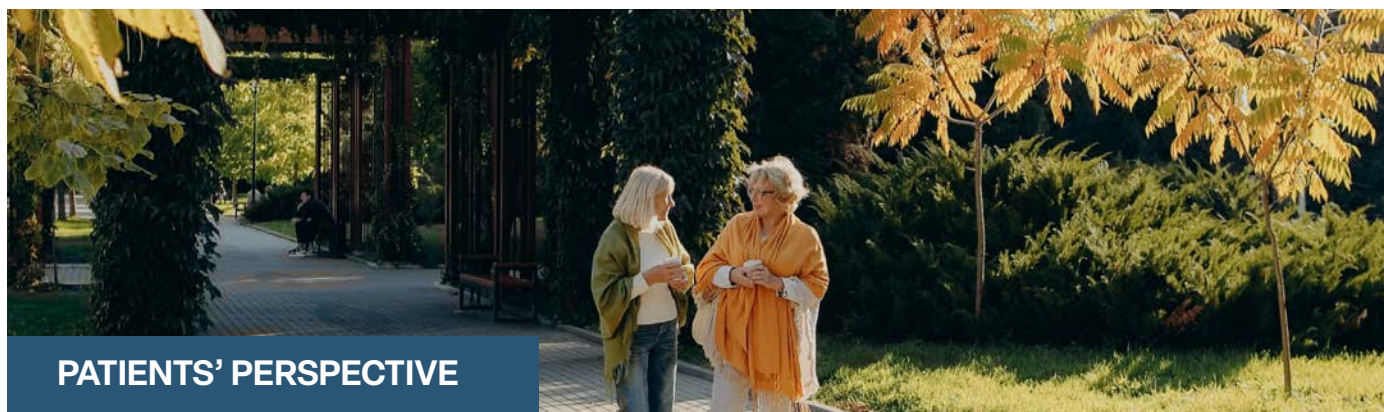
The **Risk Factors for Developing UI** section provides a general review of the epidemiology behind UI and individual factors that can contribute to the development of the condition, while the Burden of UI section provides a more personal perspective on the physical, emotional, social, and financial toll that UI can take on patients.

The **Identifying UI** section provides practical information about the screening process, including recommendations, evaluation strategies, and links to validated questionnaires, all of which are designed to help improve identification of UI conditions and enhance patient engagement.

The **Diagnosis of UI** section addresses the key steps in the diagnostic process, including a discussion of the variety of testing options available to clinicians to best identify the particular conditions their patients are dealing with.

Readers interested in treatment options can navigate directly to the **Treatment Strategies** section, which outlines both conservative and advanced approaches for Stress Urinary Incontinence (SUI) and Urgency Urinary Incontinence (UUI). These sections review supportive management techniques, pelvic floor therapy, behavioral modifications, medications, minimally invasive therapies, and surgical interventions, while emphasizing shared decision-making and individualized care.

Whether you are looking for clinical guidance, patient education, practical management strategies or a better understanding of the broader public health impact of urinary incontinence, this report is intended to help you navigate the condition with greater awareness, knowledge, and confidence.



PATIENTS' PERSPECTIVE

Throughout this report, you will see orange boxes like this one highlighting perspectives from real patients.

These insights draw on results from a survey conducted by Phreesia and NAFC between Feb 13, 2025, and March 20, 2025.

The survey was administered electronically to women ages 35+ using the Phreesia platform to check in for an upcoming doctor's appointment.

Individuals using the Phreesia platform were given the choice to allow access to their health information under the Health Insurance Portability and Accountability Act (HIPAA). The information of

those who consented was analyzed, and those who qualified were given the opportunity to complete the survey.

Women with symptoms of UI with and without a formal diagnosis of UI qualified for the study. The International Consultation on Incontinence

Questionnaire Short Form (ICIQ-SF) was included at the beginning of the survey to screen for and assess symptom severity across both of these populations. The survey was voluntary and was completed by 2,787 women.

Background

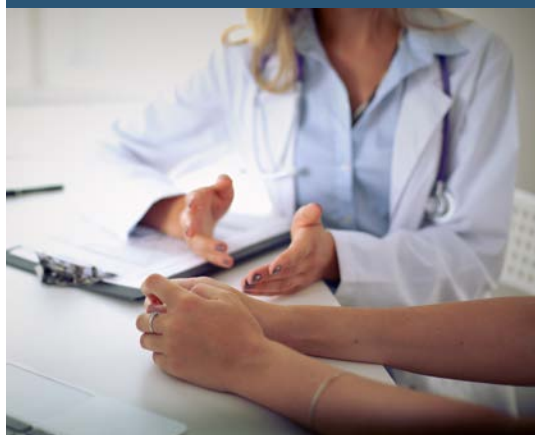
Urinary incontinence (UI) – defined as the involuntary leakage of urine – is a common health condition affecting millions of women in the United States. Although it is often thought of as a normal part of aging, it can occur at many stages of life and for a variety of reasons. Despite how common it is, UI is frequently underreported and undertreated, even when symptoms significantly affect daily life.

The *Urinary Incontinence in Women Indicator Report* provides a broad overview of the epidemiology, diagnosis, self-management, and treatment of UI in women. In addition to clinical and population-level data, the report includes both qualitative and quantitative findings drawn directly from patient surveys, offering insight into what living with UI is like. Because many women and health-care providers hesitate to raise the topic, increased awareness is critical for improving identification and management of this condition. By supporting earlier recognition and informed care, this report aims to help women with UI achieve better health and quality of life.



*UI affects an estimated
67–80 million women in
the United States.*

PATIENTS' PERSPECTIVE



UI often goes unspoken in medical settings: more than half of symptomatic, undiagnosed women (53%) have never discussed their condition with a health-care provider – even though most (61%) report moderate or severe symptoms. Alarming, more than a quarter of women with severe symptoms (28%) still say they've never raised the issue with a clinician.

At the same time, 83% of undiagnosed women report hearing others talk about UI in everyday life. Therefore, incontinence is openly acknowledged socially but remains largely undiscussed in the doctor's office.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

UI Overview

UI affects an estimated 67–80 million women in the United States.¹⁻³ While national studies clearly demonstrate the widespread nature of the condition, comprehensive data describing regional differences within the U.S. remain limited. Even so, the overall burden of UI is substantial and represents an important public health concern.

Despite the significant impact UI can have on daily life, it often goes unspoken in medical settings.



UI Definition

UI is defined as the involuntary loss of urine. The main types of UI are stress UI, urgency UI, and mixed UI. Understanding the differences between these types is important, as treatment approaches often depend on the specific form of incontinence a person experiences.

Stress urinary incontinence (SUI), sometimes referred to as activity-related incontinence, involves leakage that occurs during physical effort such as coughing, sneezing, laughing, lifting, or exercising. This type of incontinence typically results from weakened support of the urethra or reduced ability of the urethral sphincter muscle to remain closed, leading to urine leakage during increases in abdominal pressure.⁴

Urgency urinary incontinence (UUI) is characterized by a sudden, intense urge to urinate, followed by involuntary leakage. This form of incontinence is often caused by involuntary contractions of the bladder muscle during the bladder filling phase.⁵ In many cases, no specific cause is identified, though UUI may be associated with neurologic conditions or bladder abnormalities. Urgency incontinence is commonly referred to as overactive bladder (OAB), a broader syndrome that includes urinary urgency with or without leakage and is often accompanied by increased urinary frequency and nighttime urination.

Mixed urinary incontinence (MUI) refers to the presence of both stress and urgency symptoms. Many women experience features of both SUI and UUI, and one type may be more prominent or bothersome than the other. Identifying the dominant symptom pattern is important for guiding appropriate treatment decisions.

Several less common forms of UI also exist. Overflow incontinence typically presents as continuous leakage or dribbling due to incomplete bladder emptying, often related to bladder muscle underactivity or obstruction. Nocturnal enuresis refers to involuntary urine loss during sleep, while insensible incontinence occurs when leakage happens without the individual being aware of it. Coital incontinence involves urine leakage during sexual activity and may occur either during penetration or at orgasm. Functional incontinence occurs when physical or cognitive limitations prevent a person from reaching the toilet in time, even when bladder function itself is otherwise normal.⁶ Multiple types of UI can occur simultaneously in the same individual.

PATIENTS' PERSPECTIVE



Women with UI struggle to understand their diagnosis – about 2 in 5 diagnosed women say they aren't sure about the type of incontinence they have (41%), highlighting an opportunity for deeper patient education to better support women in their symptom and disease management.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

The Range of Incontinence Conditions

SUI – Stress Urinary Incontinence

Leakage from physical exertion

UUI – Urge Urinary Incontinence

The sudden, intense urge to urinate

MUI – Mixed urinary incontinence

Having both SUI and UUI symptoms

Overflow Incontinence

Continuous leakage/dribbling

Nocturnal Enuresis

Involuntary urine loss during sleep

Insensible Incontinence

Loss of urine without patient awareness

Coital Incontinence

Urine leakage during sexual activity

Functional Incontinence

Leakage caused by physical/cognitive limitations

Risk Factors for Developing UI

There are several risk factors that contribute to the development of UI. Some risk factors are modifiable, while others are not.

Three common modifiable risk factors for UI are obesity, smoking and the use of artificial sweeteners. Obesity significantly increases the risk of UI, with obese women being nearly three times more likely to experience UI compared with those with a healthy weight⁷. Obesity is also significantly associated with an increased prevalence of nocturia (the need to wake up twice or more at night to urinate)⁸. Smoking similarly contributes to an increased risk, particularly for urgency incontinence. Both current and former smokers show a heightened likelihood of developing UI⁹. Additionally, the consumption of artificial sweeteners has been linked to UI; individuals who consume one or more servings daily face a 10% increased risk¹⁰.

MODIFIABLE UI RISK FACTORS:

1. Obesity
2. Smoking
3. Use of artificial sweeteners



Non-modifiable risk factors include age and parity. The prevalence and severity of UI tend to increase with age¹¹⁻¹³. It is especially widespread in nursing home populations, with rates of UI as high as 77%. Some research, however, suggests that when accounting for comorbid conditions, age alone may not be an independent risk factor for UI¹⁴.

There is also a strong association with UI in women who have given birth – particularly those who have given birth more than once.¹⁵ Beyond the number of childbirths, the mode of delivery plays a role; vaginal delivery has been linked to a higher risk of OAB and SUI later in life¹⁶. Moreover, forceps-assisted deliveries are associated with an increased risk of OAB five to ten years after delivery¹⁵.

Additionally, the dropping levels of estrogen in women going through menopause can lead to genitourinary syndrome of menopause (GSM), a condition characterized by symptoms such as urgency, frequency, and incontinence. These symptoms are common, often persistent, and may worsen over time in the postmenopausal period¹⁷⁻¹⁹. Epidemiologic and cohort studies indicate that the menopausal transition is associated with an increased risk of developing UI, particularly stress and urgency types, but the relationship is complex. Some studies demonstrate that perimenopausal and postmenopausal women have higher odds of developing incontinence compared with premenopausal women, but the transition itself is not consistently associated with worsening of established incontinence; age, weight gain, parity, and comorbidities such as diabetes are significant contributors²⁰⁻²⁵.

Burden of UI

UI has a significant and measurable impact on many aspects of a woman's life. Research consistently shows that women living with UI experience lower quality of life compared with those without symptoms, particularly in emotional well-being, physical functioning, and social participation.^{26,27} A large systematic review and meta-analysis of 23 studies involving nearly 25,000 participants, mainly women, found that UI was associated with poorer outcomes across multiple quality-of-life domains when assessed using validated measurement tools.

Women with OAB often report higher levels of depression, anxiety, and embarrassment than women without bladder symptoms.²⁸

All types of UI, including SUI, OAB, UUI, and MUI, have a significant and measurable impact on QOL. For example, women with overactive bladder (OAB), especially those who experience urgency UI, often report higher levels of depression, anxiety, and embarrassment than women without bladder symptoms. The severity of emotional distress tends to increase as urinary symptoms worsen, and studies have shown a direct relationship between the intensity of OAB symptoms and the severity of depressive symptoms.²⁸ Social impacts are also common. Evidence from observational studies indicates that UI is associated with increased social withdrawal, as women may avoid activities, travel, or social situations due to fear of leakage or odor.²⁹ The emotional burden of UI can extend beyond the individual, affecting family members and caregivers who may experience distress related to their loved one's condition.³⁰

PATIENTS' PERSPECTIVE



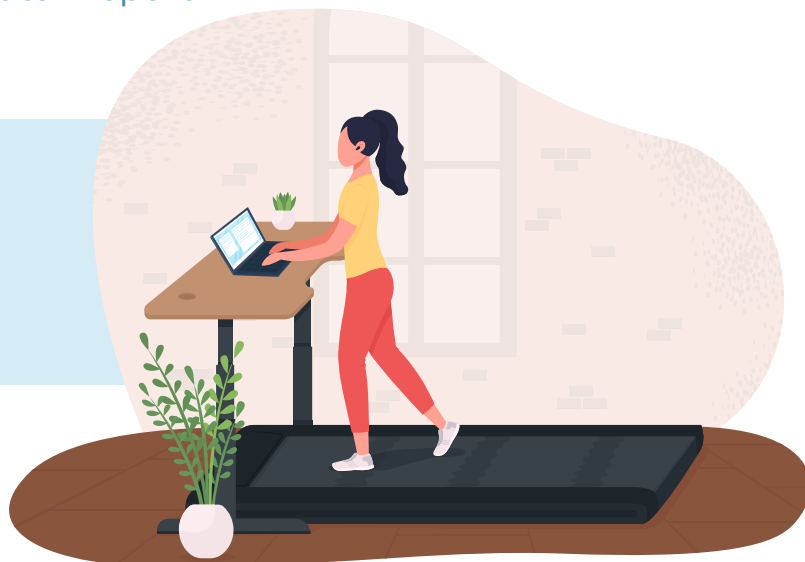
UI burden extends beyond symptoms with management itself being a struggle. Over two-thirds of women with moderate or severe incontinence report difficulty managing their condition, underscoring the persistent and disruptive nature of the condition.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

UI can also contribute to other health complications. Women with UI are more likely to experience mobility limitations and face an increased risk of falls.³¹⁻³⁴ These risks are particularly concerning for older adults, as falls can lead to serious injuries and loss of independence. In addition, overactive bladder is strongly associated with sleep disruption. Up to 70% of women with OAB report poor sleep quality, often due to frequent nighttime urination or episodes of nocturnal incontinence.^{35,36} Poor sleep can further worsen physical health, mood, and daytime functioning.

Incontinence is also linked to higher rates of skin irritation and infection. Women with UI have an increased risk of urinary tract infections and skin conditions related to prolonged moisture exposure.³⁷⁻³⁹ Over time, these complications can lead to increased health-care use and reduced quality of life.

Physical activity levels are often lower among women with UI.⁴²



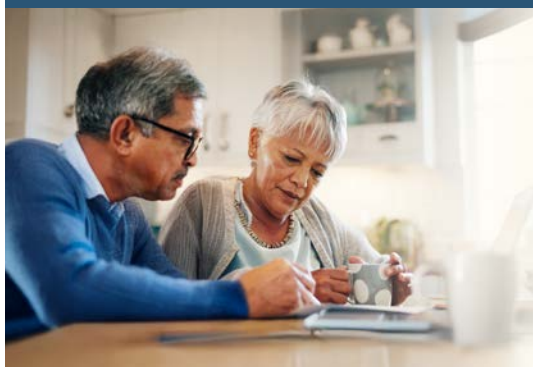
Importantly, UI has also been identified as a predictor of increased mortality, particularly among older adults. A systematic review and meta-analysis found that UI was associated with a higher risk of death, with risk increasing alongside symptom severity.⁴⁰ Among nursing home residents, UI has been linked to a 20% increased risk of death.⁴¹

Physical activity levels are often lower among women with UI. Women with SUI may avoid exercise because physical activity can trigger leakage, and women with overactive bladder are also less likely to meet recommended levels of moderate to vigorous physical activity.⁴² Reduced physical activity can further contribute to declines in physical health, mobility, and overall well-being.

Sexual health is frequently affected as well. Leakage during sexual activity occurs in up to one-third of women with UI⁴³, and both stress and urgency incontinence can negatively impact sexual function due to leakage, fear of leakage, or body image concerns.^{30,44-46}

The financial burden of UI is substantial and increases with symptom severity. On an individual level, women with severe UI spend approximately \$900 per year on routine incontinence care. Costs are not distributed equally: Black women face expenses that are, on average, 2.4 times higher than those incurred by white women. Women with urgency UI also tend to have higher costs, spending approximately 65% more than women with stress UI.⁴⁷

PATIENTS' PERSPECTIVE



The financial burden of UI is a significant concern for women. Nearly two-thirds of women with severe symptoms express strong worry about how much they spend on absorbent products, with Black women more likely to say they are concerned about costs. The recurring nature of these expenses, limited insurance coverage, high prices and a lack of awareness of available assistance programs drive cost concerns.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

The total cost of OAB in the United States is estimated to range from \$24.9 billion to \$36.5 billion annually, with direct medical costs accounting for \$22.3 billion to \$33.5 billion of that total.⁴⁹



UI can also affect employment and economic stability. Women with overactive bladder experience more medically related work absences, losing an average of 2.2 additional workdays per year. Overactive bladder is also associated with a higher risk of disability, with female employees more likely to be affected than male employees.⁴⁸

SIGNIFICANT FIGURES

Among undiagnosed, symptomatic women: 37% of all undiagnosed, symptomatic women are concerned about expenses for absorbent products; this jumps to 64% among those with severe symptoms.

Among diagnosed women: 56% are concerned about expenses on absorbent products; this jumps to 74% among those with severe symptoms. Additionally, 40% report spending more than \$50 per month on absorbent products, which jumps to 57% of women with severe symptoms.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

At a societal level, the economic impact of UI is considerable. The total cost of overactive bladder in the United States is estimated to range from \$24.9 billion to \$36.5 billion annually, with direct medical costs accounting for \$22.3 billion to \$33.5 billion of that total. The financial burden is particularly high among adults under the age of 65, reflecting the impact of UI on individuals during their working years.⁴⁹

Taken together, these findings reflect the real-world challenges reported by women living with UI, including social isolation, reduced physical activity, emotional distress, financial strain, and diminished quality of life. The wide-ranging effects of UI underscore the importance of early recognition, appropriate treatment, and ongoing support to reduce its overall burden and improve long-term outcomes.

Real-World Challenges:



Identifying UI

Screening for UI should be a routine part of medical care. Many patients are hesitant to bring up bladder health due to embarrassment, lack of awareness about treatment options, or fear of side effects. National survey data suggest that among women who discussed UI with a health-care provider, fewer than 10% did so because the provider initiated the conversation.^{50, 51} In other words, the vast majority of women were left to raise the issue themselves, highlighting a significant gap in routine screening and missed opportunities for earlier diagnosis and treatment.

PATIENTS' PERSPECTIVE



Too often, women only bring up UI when symptoms have already become overwhelming. Frustration, interference with life, and worsening symptoms are the top reasons women first talk to a provider, rather than early recognition or prevention. Nearly 2 in 5 diagnosed women waited more than 3 years before getting a diagnosis, meaning opportunities for early intervention are missed. By the time conversations happen, quality of life is already deeply affected.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

When to screen

While patients are typically asked about incontinence in their later years, it is important to consider UI in patients of all ages, as it is not limited only to older adults. OAB can develop at a young age, with a prevalence of 5–12% in children aged 5–10 years and 0.5% in adolescents aged 16–18 years⁵². Childbirth is another critical time to address incontinence. Many women experience UI for the first time during pregnancy or in the postpartum period, making this an important opportunity for screening as UI is a dynamic condition, with severity often fluctuating over time⁵³. Therefore, it is important to screen for incontinence not just once but at multiple time points.

How to screen

To facilitate discussion around UI, providers can use validated questionnaires to open the conversation. The Women's Preventive Services Initiative recommends annual screening for UI in all women and emphasizes the use of brief clinician- or self-administered questionnaires, which have shown high accuracy in primary care settings^{54,55}.

Several effective screening tools are available. The Michigan Incontinence Symptom Index (M-ISI) has demonstrated high sensitivity and specificity for stress, urge, and mixed incontinence (<https://medschool.umich.edu/sites/default/files/2025-03/Urology-M-ISIArticle.pdf>)⁵⁶.

Another useful tool is the Incontinence Screening Questionnaire (ISQ), which has a sensitivity of 66% and specificity of 80% for any type of incontinence, making it a useful screening instrument in primary care (<https://pmc.ncbi.nlm.nih.gov/articles/PMC5926645/>)⁵⁷.

Additionally, the Three Incontinence Questions (3IQ) tool allows providers to start with just one question and, if needed, include the second and third questions to better identify the type of UI (<https://docs.google.com/document/d/1DknSGXB-vvEScuSp61QBxQdxGad5R8Vy/edit>)⁵⁸. This tool is used in initiatives such as the American Urogynecologic Society (AUGS) EvidenceNOW project, which supports primary care physicians (PCPs) in screening for and managing UI.

Approaching the discussion from the patient side, encouraging women to discuss UI with their doctor involves patient-directed education and communication strategies. One effective method is using posters in primary care settings, which has been shown to significantly improve screening rates⁵⁹. These

PATIENTS' PERSPECTIVE



Currently, the burden of diagnosis often falls on women themselves. Most diagnosed patients say they had to initiate conversations with their provider to receive care, and among undiagnosed women, only half have ever raised UI with a healthcare professional (HCP). When these conversations do occur, the onus is largely on patients: 72% report initiating the discussion about symptoms, rising to 80% among Black women.

Misconceptions are often a barrier to conversation, with nearly half of women who stay silent believing their symptoms are not serious enough. These patterns underscore the importance of provider-led screening to reduce missed care opportunities.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

simple interventions help address the stigma around UI and encourage patients to initiate conversations about this often-overlooked condition.

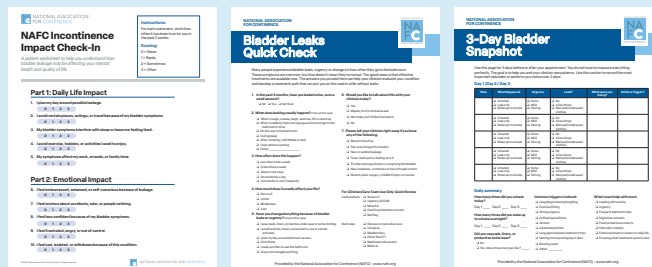
Once a patient's diagnosis has been established, there are tools that exist to help follow the severity of a patient's symptoms over time. While many of these tools are used for research, some practices have adapted them to follow patient's symptoms clinically, as shown in the chart below.

Selected Validated UI Symptom Severity Tools

All of the tools below are designed to be self-administered by patients and may be distributed in waiting rooms, on digital intake platforms, and through patient portals.

Useful Tools for In-Office Screening

NAFC has developed three easy-to-use tools to help patients and clinicians in the evaluation of incontinence:



**Incontinence
Impact
Check-in**

**Bladder Leaks
Quick Check
Questionnaire**

**3-Day Bladder
Snapshot**

Each of these tools can be found at the end of this report.

Test	Available Format	Languages	Time to Complete
<u>I-QOL</u> (Incontinence Quality of Life Questionnaire)	Paper and digital use	50+	5–7 minutes
<u>KHQ</u> (King's Health Questionnaire)	Digital use	60+	10–15 minutes
<u>IIQ-7</u> (Incontinence Impact Questionnaire)	Paper and digital use	Multiple	3–5 minutes
<u>UDI-6</u> (Urogenital Distress Inventory)	Paper and digital use	Multiple	3–5 minutes
<u>ICIQ-SF</u> (International Consultation on Incontinence Questionnaire – Short Form)	Digital use	85+	1–2 minutes

Diagnosis of UI

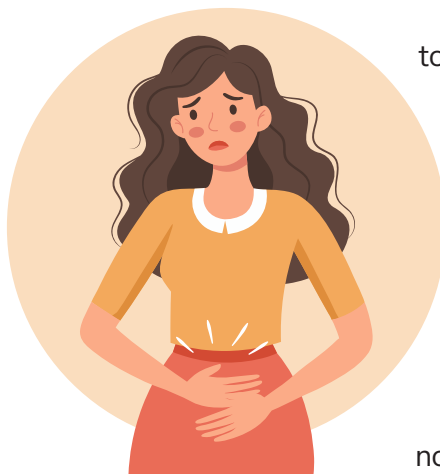
Patient History

Diagnosis of UI starts with a focused history. It is important to ask patients about the frequency, volume, timing (day/night) and severity of incontinence episodes, as well as any specific triggers. Additionally, providers should inquire about symptoms related to incomplete bladder emptying, such as urinary hesitancy, a slow or intermittent stream, straining to void, and the sensation of not fully emptying the bladder. These questions help identify the type of incontinence and guide appropriate treatment decisions.



Understanding a patient's fluid intake is another key part of the history. Understanding the quantity and types of liquids consumed, including water, alcohol, caffeine, and artificial sweeteners is important. This information is particularly useful when discussing lifestyle modifications that can help manage UI, as certain beverages can irritate the bladder or increase urine production.

Expanding to a detailed pelvic floor history can also uncover factors that could contribute to or worsen incontinence. Questions regarding dysuria (painful urination), hematuria (blood in the urine), flank pain, and fever are important for identifying urinary tract infections or other urological conditions. Asking about bowel symptoms, such as constipation, or signs of pelvic organ prolapse (POP) can uncover underlying pelvic floor disorders that may contribute to incontinence.



A broader medical history can also be informative for complex patients. Past medical conditions, such as diabetes, lower extremity edema, and obstructive sleep apnea, can contribute

to or worsen UI, and managing these conditions may lead to improvements in symptoms. Assessing a patient's functional status, mobility, and cognitive function is critical, as these factors can lead to incontinence when patients have difficulty reaching the bathroom on time, even if their bladder function is otherwise normal. Additionally, a history of pelvic floor surgery, radiation therapy, or neurologic disorders may warrant referral to a specialist for further evaluation. A comprehensive review of the patient's medications is essential, as certain drugs, such as diuretics, can exacerbate UI. Also, a comprehensive obstetrical history can uncover pelvic floor disorders from prior deliveries.

If the patient's history does not provide enough information to determine the type of incontinence, a [voiding diary](#) can be a valuable tool. Patients should use a voiding diary to record their fluid intake, urinary frequency, and any incontinence episodes over at least a 24–72 hour period. This helps the clinician determine the type of incontinence, evaluate fluid intake, and assess the severity of symptoms. These simple-to-use tools help minimize patient burden and increase compliance while providing critical information⁶⁰.

Physical Exam

While a general physical exam is recommended, not all women with UI require a pelvic examination; this means that health-care providers who do not routinely perform pelvic exams can be involved in the diagnosis and treatment of this condition. The American Urological Association (AUA) guidelines on telehealth also support the idea that pelvic exams are not always necessary for diagnosing and managing UI. A pelvic exam should be considered in patients presenting with atypical symptoms, showing signs suggestive of pelvic pathology, or experiencing inadequate results to initial therapy. In addition to the pelvic exam, another speciality exam that can be considered is a neurologic examination for patients with concerns about a potential neurologic disease. This exam should include an assessment of sensation and motor function in the perineum, as well as an evaluation of motor function in the lower extremities, which can help identify underlying neurological issues.

Laboratory Tests

Routine laboratory tests for patients with UI should begin with a urinalysis (UA) for all individuals. A urine culture is recommended if abnormalities are noted in the UA or if there is suspicion based on history of a urinary tract infection or hematuria. Additional lab tests should be tailored based on the individual patient's

history and clinical presentation. For example, tests may be needed to assess for conditions such as diabetes or other systemic issues that could contribute to UI.

Other Diagnostic Tests

Several additional diagnostic tests are not routinely indicated but may be useful in evaluating UI. The cough stress test is commonly used to assess for SUI. A post-void residual (PVR) measurement is another key test, which determines the amount of urine left in the bladder after voiding. This can be done using a bladder scan with ultrasound or through straight catheterization, depending on the availability of equipment. Urodynamic testing, which evaluates bladder storage and emptying, can also be considered; however, a referral to a specialist is usually needed for this. Urodynamic testing is not typically needed in the initial phases of diagnosis in treatment of straightforward UI.

Red Flags & Specialist Referrals

Certain red flags should prompt specialist referral or further investigation. Patients with UI refractory to initial treatments, or those with concerning findings from the patient's history, physical exam, or diagnostic tests should be referred to a specialist for advanced management.

Red flags for specialist referrals include:

- Unexplained hematuria
- Pelvic organ prolapse
- Neurological deficits
- Signs of malignancy

These referrals are important to ensure that any underlying or serious conditions are appropriately addressed, and treatment plans are tailored accordingly.

Treatment Strategies

A variety of treatment options exist for UI, each differing in route of administration, effectiveness, and side-effect profile. Selecting the right therapy should be a shared decision-making process in which clinicians consider the patient's medical history, values, lifestyle, preferences, and goals.

Treatment for UI depends on the type of UI, which is why diagnosis is so important. The treatment pathways for the two most common types of UI (SUI and UUI) both begin with supportive management, behavior modifications and pelvic floor muscle exercises (PFME) but diverge after that into two different treatment pathways. For the third common type of UI, MUI, clinicians typically start with the treatment pathway of the predominant type of incontinence (either SUI or UUI).

Importantly, patients do not need to progress linearly in each treatment pathway from conservative to procedural therapies. They can start with the option that best fits their lifestyle and priorities. Reviewing the full treatment pathway of all available treatments not only helps patients understand all their options but also helps ensure patients understand what the next steps could be should their initial choice prove ineffective.

TREATMENT PATHWAY FOR SUI AND UUI

Supportive Management



Behavior Modification



Pelvic Floor Muscle Exercises



**SUI
Devices**



**UUI
Medications**



**Procedural
& Surgical
Options**

(See page 22
for details)



**Minimally
Invasive
Therapies**

(See page 25
for details)

PATIENTS' PERSPECTIVE



From the patient perspective, most women are not aware of - or are not using - the full range of available treatments for UI. Absorbent products remain the default: nearly a third of undiagnosed women do nothing to manage their symptoms at all and over half rely only on pads or liners. Awareness of medical or behavioral therapies is strikingly low: 6 in 10 undiagnosed women have never heard of Kegels and two-thirds are unaware of lifestyle changes as options. Disparities compound these gaps, with Hispanic and Black women more likely to say they haven't heard of any treatments.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

Supportive Management

Use of incontinence products such as pads, diapers, and barrier creams is often the first thing that a patient will try to manage their symptoms. High-quality adult absorbent products play a critical role in preserving skin integrity, reducing infection risk, and potentially lowering long-term health-care costs for individuals managing UI. Some data suggest that high-quality absorbent products, specifically those that are disposable and contain superabsorbent materials, are more effective in preserving skin integrity than their alternatives, potentially mitigating the substantial cost burden of managing skin complaints, although evidence comparing product categories remains limited.⁶¹ Improved pad design—such as frontal absorbency and rewetting prevention—has also been linked to faster healing of incontinence-associated dermatitis (IAD) in older adults when compared with those who do not use such pads⁶². These outcomes not only improve comfort and quality of life but also help prevent complications like pressure injuries, which can add to the discomfort and expense that the patient has already experienced.

While high-quality absorbent products may carry a higher upfront cost, their use as part of a comprehensive continence care and skin management program is associated with lower overall treatment costs by reducing complications and shortening the duration of care. Effective management requires not only appropriate absorbent products, but also timely product changes and routine skin care to maintain skin integrity and prevent moisture-related damage. When used properly, absorbent products and skin maintenance regimens can help reduce the risk of skin breakdown, infection and other complications associated with urinary incontinence. Estimates suggest that the daily cost of quality absorbent products and skin care systems ranges from \$0.57 to \$1.08 per patient, substantially less than the downstream costs associated with treating preventable skin injuries and infections.^{63,64}

Behavior Modifications for UI

Behavior modifications are low risk interventions that should be offered to all patients with UI, as they can benefit individuals across various types of UI.

Fluid management—both in terms of quantity and quality—can improve UI control. For women who consume excessive fluids (greater than 64 ounces per day), it is recommended that they normalize their fluid intake, unless there

is a medical reason to increase consumption. A reduction of about 25% in fluid intake has been shown to help decrease urinary frequency and urgency⁶⁵. Cutting down on caffeine can also be helpful as caffeine intake of ≥ 204 mg/day (approximately two cups of coffee) is associated with increased UI⁶⁶. Additionally, daily consumption of beverages containing artificial sweeteners has been linked to a 10% increased risk of mixed UI¹⁰.

For women who are overweight, weight loss can also significantly improve UI symptoms. In a randomized controlled trial, patients with a body mass index (BMI) >25 who lost an average of 8% of their body weight experienced a 50–70% reduction in UI symptoms⁶⁷.



Pelvic Floor Muscle Exercises (PFME)

PFME are the central elements of a structured exercise program to strengthen the muscles that support the bladder, bowel, and pelvic organs to help improve control, reduce leakage, and enhance pelvic health.

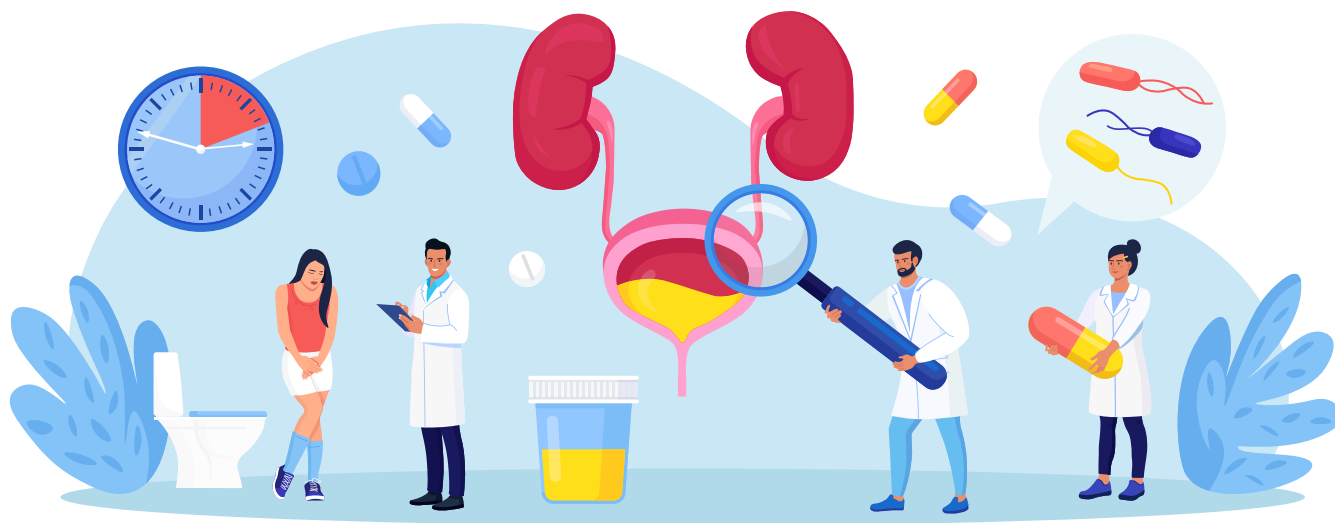
PFME are effective for both SUI and UUI, though the focus of the exercises differs between the two conditions. For SUI, the primary goal is to strengthen the muscles that support the urethra, often through Kegel exercises and abdominal strengthening to improve urethral closure. In UUI, PFME help people better control the urge to urinate by training the pelvic floor muscles to respond when urgency occurs. This often involves PFME aimed at deferring the sensation to urinate.

Some women can perform PFME effectively with brief instructions, while others may require additional support. For those who need assistance, supervised pelvic floor physical therapy for individuals or groups may be helpful. Access to such therapy may be limited, however, due to factors such as insurance coverage, scheduling conflicts, or geographic limitations. Women who cannot attend supervised physical therapy can try weighted vaginal cones as a home-based alternative. Patients can get these cones without a prescription. They can insert a cone into the vagina, contract the pelvic floor muscles, and keep the cone in place. A 2013 systematic review found that these devices were more effective than no treatment, although there was no conclusive evidence to suggest they were superior to traditional pelvic floor exercises⁶⁸.

Another useful supplement to pelvic floor muscle training is biofeedback, which uses vaginal pressure sensors to provide real-time feedback on pelvic floor contractions. Biofeedback is especially helpful for patients who struggle to isolate the correct pelvic floor muscles for strengthening. Systematic reviews have concluded that pelvic floor muscle training is superior to sham or no treatment, but there is no single method (whether performed alone or with biofeedback or cones) that has been definitively proven to be more effective than the others. All techniques have shown improvement in symptoms and quality of life^{69,70}.



With PFME, there is no single method that has been definitively proven to be more effective than others. All techniques have shown improvement in symptoms and quality of life^{69,70}.



Bladder Retraining

For SUI, PFME directly strengthen the muscles that support the urethra. For UUI, however, PFME are used as part of a larger bladder-retraining program, a key low-risk intervention recommended by the AUA/SUFU (the Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction)⁷¹. Bladder retraining is a proven program that involves timed voiding and urgency suppression techniques to improve the symptoms of UI. Timed voiding establishes a regular urination schedule, starting with short intervals and gradually increasing the time between voids to train the bladder to hold urine for longer durations at a time. Urgency-suppression techniques use relaxation methods — such as deep breathing, distraction, or pelvic floor muscle contractions — to delay urination when the urge arises⁷².

A 2023 Cochrane review of 15 trials with 2,007 participants (nearly 90% of whom were women) suggested that more participants would see improvements in OAB if they received bladder training than if they had received no treatment. Bladder training may be more effective than medication in curing or improving OAB, and possibly with fewer adverse events⁷³. Similarly, some evidence suggests that mindfulness interventions can significantly improve UI symptoms in older women⁷⁴. Both the AUA and SUFU recommend mindfulness for OAB due to its safety, and minimal adverse effects⁷¹.

Beyond the above conservative treatment for UI, treatment pathways for SUI and UUI begin to diverge.

Treatment for SUI

Anti-Incontinence Devices

Vaginal anti-incontinence devices provide an additional conservative option to treat SUI. These devices are an option for patients to self-start or start under the supervision of a primary care provider or gynecologist as offering them as treatment does not require subspecialty training.

The longest used vaginal anti-incontinence devices are pessaries. Originally designed for POP, pessaries have been modified for incontinence. Options include a continence ring or continence dish. They are designed to increase urethral closure and resistance during times of increased intraabdominal pressure. They do require supervision by a provider to ensure adequate fit. In a large randomized controlled trial, 40% of patients using a pessary for SUI reported that their symptoms were “much better” or “very much better” at 3 months⁷⁵.

Additionally, there are newer vaginal anti-incontinence devices on the market that have been specifically designed to treat SUI. Several reusable devices^{76, 77} and at least one single-use device⁷⁸ have been shown to reduce stress urinary leakage. In clinical studies, 60% to 85% of patients using these devices achieved at least a 50% reduction in stress incontinence. Some of these newer devices do not require a prescription and can be self-fit by the patient without provider supervision.

Procedural and Surgical Options

Procedural and surgical options for SUI treatment include urethral bulking or surgery.

Bulking procedures offer a less invasive option for patients when compared to traditional surgery. This procedure can occur in the office under local anesthesia or in an operating room with light sedation. Under direct visualization using a camera, bulking agent is injected directly into the urethra to increase the resistance of the urethra and prevent SUI.

Historically, particulate agents such as these have been used: glutaraldehyde crosslinked bovine collagen, carbon-coated zirconium oxide beads suspended in a water-based gel, crosslinked polydimethylsiloxane, and calcium hydroxylapatite suspended in a water and glycerin gel. More recently, however, non-particulate material, such as polyacrylamide hydrogel, has shown better efficacy and is now the most commonly used material.

SUI TREATMENT PATH

Supportive Management



Behavior Modification



Pelvic Floor Muscle Exercises



Anti-incontinence Devices

Pessaries (continence rings, continence dishes)

Vaginal anti-incontinence devices



Procedural & Surgical Options

Urethral Bulking

Midurethral Slings



Once the polyacrylamide gel is injected, host cells migrate into the hydrogel to form a network of fibers that anchor the gel, which in turn provides cushions for the urethral lumen. Large, randomized controlled trials suggest 40% of patients reported zero stress incontinence episodes, and more than three-quarters of the patients considered themselves to be cured or improved⁷⁹. Follow-up after two to seven years showed sustained improvement in approximately 60% of patients with 20% requiring repeat injections^{80,81}. Common side effects included urinary tract infections (3.5%), urinary retention (1.6%), and prolonged bladder emptying times^{80,82}.

The safety profile and the in-office procedural nature of urethral bulking makes it a favorable option for many patients. However, it is important to note that the cure rates for urethral bulking are generally lower compared with midurethral sling (MUS) procedures. For instance, a systematic review and meta-analysis found that MUS procedures have higher overall and objective cure rates compared with urethral bulking agents⁸³. Although data suggests a persistent effect of bulking of up to 8 years in some long-term studies, urethral bulking is not designed to be permanent and patients may require retreatment, particularly when compared to MUS, which have longer term efficacy and were designed to be a more permanent fix⁸⁴.

The MUS was introduced in the 1990s and is the most common and most widely studied surgical option for SUI with over 15 years of follow-up data. During this surgery, a small strip of monofilament polypropylene mesh is placed under the mid-urethra. The efficacy of midurethral slings for the treatment of SUI in women has been extensively studied. The subjective cure rates for MUS range from 62% to 98% in the short term (up to one year) and from 43% to 92% in the long term (over five years)⁸⁵. In women with mixed urinary incontinence (MUI), MUS surgery reliably improves the stress component of symptoms (85–97% cure), while improvement in urgency UI symptoms is more variable, with reported cure rates ranging from approximately 30% to 85%⁸⁶. In these studies, “subjective cure” or improvement refers to patient-reported resolution or reduction of symptoms, typically measured using validated questionnaires or global patient-reported outcome measures, although definitions varied across trials.

There are many different types of MUS that vary in incision, approach and design. Retropubic and transobturator are most common. During these two procedures the mesh is placed through the vagina under the mid-urethra and exits from 2 small sites in either the suprapubic or groin area.

PATIENTS’ PERSPECTIVE



Surgical interventions remain the least-used option. Among diagnosed women, 15% have used surgical options. Among those undiagnosed, only 1 in 5 know that surgery is an option for treating UI.

While not appropriate for all, surgery is rarely discussed until later stages, leaving many women unaware of it as a potential option. HCPs can ensure that appropriate candidates are counseled early about surgical pathways as part of a comprehensive treatment plan.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

Although concerns about surgical mesh have received significant media attention, the safety and effectiveness of midurethral slings for stress urinary incontinence are well established. For many women, they remain the gold standard surgical treatment when conservative therapies are not enough.



At 2 years, both retropubic and transobturator approaches demonstrated similar objective success rates, indicating statistical equivalence⁸⁷. Longer-term follow-up shows retropubic demonstrated superior long-term efficacy compared with transobturator approaches^{88,89}.

Newer single-incision slings represent a less invasive surgical option for the treatment of UI. While they have demonstrated similar efficacy to full-length MUS, it is important to note that studies supporting their use generally have shorter follow-up periods and involve fewer patients, limiting the robustness of the long-term data.

Some patients may express concerns regarding mesh products that they may have heard mentioned in the media. Media attention and litigation surrounding Food and Drug Administration (FDA) announcements on transvaginal mesh for POP have resulted in confusion between transvaginal mesh used to treat POP and the mesh MUS used to treat SUI. This may have led to a negative perception of the MUS. In 2019, the FDA reaffirmed the findings of its safety panel and literature review stating that the safety and effectiveness of the full-length MUS is well-established⁹⁰. In patients who do want to avoid the use of mesh but would still like a sling, there is the option of a pubovaginal sling. This is autologous fascia harvested from the abdomen or leg placed below the urethra for support. However, these are more morbid and invasive procedures with often more side effects. Because of this, they are often reserved for refractory SUI or cases where mesh cannot be used.

Treatment for UUI

For UUI, conservative therapy overlaps with some SUI options. However, beyond this, the treatment pathways begin to diverge.

Medications for UUI

Medications primarily fall into three categories: **anticholinergics**, **beta-3 adrenergic agonists**, and **vaginal estrogen**.

Anticholinergics

The available anticholinergics include darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, and trospium. These medications work by blocking muscarinic receptors that would otherwise be stimulated by acetylcholine. This reduces smooth muscle contraction in the bladder, ultimately increasing bladder capacity and decreasing urgency. In terms of efficacy, studies show improvement rates of 40–80%⁹¹⁻⁹⁴. Patients with more severe symptoms tend to experience greater reductions in symptoms, while those with lower baseline symptom levels may achieve complete symptom relief. Notably, there is no strong evidence indicating a significant difference in efficacy among the various anticholinergic medications. Thus, choice of anticholinergic medication often comes down to insurance coverage and side effect profile.

Common side effects of these medications include dry mouth, constipation, dry eyes, blurred vision, dyspepsia, urinary tract infections, urinary retention, and impaired cognitive function. The severity of dry mouth and constipation can vary depending on the specific anticholinergic prescribed. Extended-release formulations are generally preferred due to their lower risk of side effects and the convenience of once-daily dosing, which may improve patient compliance. Some individuals may successfully

manage side effects while continuing their medication. To alleviate constipation, patients can increase dietary fiber intake and fluid consumption, incorporate psyllium-based supplements, and maintain regular exercise and bowel habits. To combat dry mouth, patients can use oral lubricants, avoid mouthwashes containing alcohol, take frequent small sips of water, use sugar-free hard candies, or chew sugar-free gum.

Although OAB can occur in adults of any age, its prevalence increases with age. Because older adults may metabolize medications differently and may be more susceptible to adverse effects, it is prudent to start at the lowest dose and increase as tolerated.



UUI TREATMENT PATH

Absorbent Products



Behavior Modification



Pelvic Floor Muscle Exercises



Medications

Anticholinergics

Beta-3 adrenergic agonists

Vaginal estrogen



Minimally Invasive Therapies

Neuromodulation

Chemodenervation

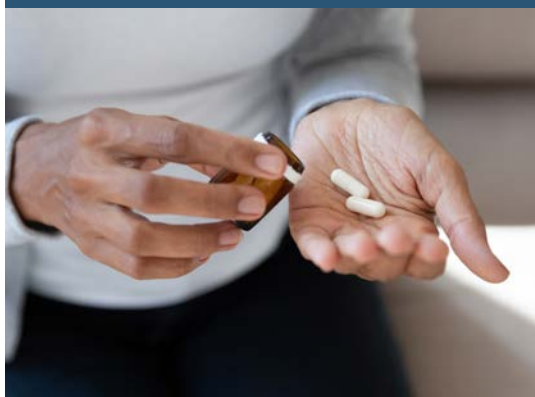
Anticholinergics are contraindicated in patients with narrow-angle glaucoma and should be used with caution in those with delayed gastric emptying, on oral potassium chloride, experiencing urinary retention, or taking other anticholinergics such as tricyclic antidepressants, acetylcholinesterase inhibitors, and medications for Parkinson's and Alzheimer's diseases.

Additionally, anticholinergic medications used for OAB may impact cognitive health because the receptors they target in the bladder are also widely distributed throughout other organ systems, including the central nervous system. The brain contains all muscarinic receptor subtypes (M1–M5), several of which, particularly M1, can play key roles in attention and long-term memory consolidation. Antagonism of these receptors provides a biologically plausible mechanism for the cognitive effects observed with anticholinergic exposure in some studies. Evidence for these effects has been strengthened by several major epidemiologic studies. Two landmark population-based analyses, Richardson et al. (2018) and Coupland et al. (2019),^{95,96} demonstrated an association (not causation) between cumulative anticholinergic burden and increased risk of cognitive decline and dementia.

A more recent meta-analysis by Pieper et al. (2020)⁹⁷ further confirmed this relationship across multiple cohorts. When examining OAB-specific anticholinergics, Gray et al. (2015)⁹⁸ identified elevated dementia risk among older adults exposed to bladder antimuscarinics, while Welk and McArthur (2020)⁹⁹ provided additional evidence showing differential cognitive risk across specific OAB anticholinergic agents. Collectively, these mechanistic insights and converging lines of clinical evidence suggest that anticholinergic therapy—especially when chronic or high-burden—may impact cognitive health, underscoring the need for careful risk–benefit assessment in susceptible populations. Although available research has not conclusively demonstrated that anticholinergics cause dementia, these observational studies have raised concern about a possible association with cognitive impairment and incident dementia. As a result, several professional societies recommend caution. The AUA/SUFU guidelines advise clinicians to discuss these potential cognitive risks with patients taking anticholinergics⁷¹, and AUGS recommends caution and avoiding anticholinergics when possible in patients older than 70 years¹⁰⁰.



PATIENTS' PERSPECTIVE



Oral medications are the mainstay treatment beyond absorbent products: over half of diagnosed women (52%) rely on them, making them the default medical option for UI. Yet adherence and satisfaction are limited. About 1 in 5 women stop oral medications due to side effects and only 15% of those with severe symptoms say they are very satisfied with oral medications. Topical medications are used by fewer than 1 in 10 women (6%) and remain an underutilized treatment. Given that most patients stop at pads or oral medications, clinicians have an opportunity to revisit treatment plans regularly and guide women toward additional therapies when oral medications fall short.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

Beta-3 Adrenergic Agonists

The second class of medications for UUI is beta-3 adrenergic agonists, which includes mirabegron and vibegron. These medications work by stimulating the beta-3 receptors in the bladder, promoting smooth muscle relaxation. While the efficacy of beta-3 adrenergic agonists and anticholinergics is similar, their side effects differ¹⁰¹. The most common side effects of beta-3 adrenergic agonists are hypertension (11.3%), urinary tract infections (6.6%), and headaches (5.5%)¹⁰². Compared with anticholinergics, beta-3 adrenergic agonists have a lower incidence of dry mouth and constipation. Notably, beta-3 adrenergic agonists also do not carry the same risk of dementia that has been associated with anticholinergics^{99,103}.

Medication Selection

A 2020 study on OAB treatment patterns found that 96.5% of women had tried anticholinergics, whereas only 30% had tried a beta-3 adrenergic agonist before advancing to third-line therapy¹⁰⁴. While some of this discrepancy may be due to provider knowledge regarding a newer prescription drug, a large part of it is thought to be related to more limited insurance coverage and less overall affordability of the beta-3 adrenergic agonists.

Combination Medication Therapy

Although these two classes of medications work through different mechanisms, they can be used together. Studies show that combination therapy significantly improves UI symptoms compared with using either medication alone¹⁰⁵. Additionally, co-administration of both drugs appears to have no significant impact on their pharmacokinetics¹⁰⁶.

Choosing the Right Medication

A 2018 insurance-claims analysis found that mirabegron accounted for 12% of dispensed OAB prescriptions in 2015, while antimuscarinic medications accounted for the remainder¹⁰⁷.

Practice patterns can be influenced by a variety of factors, including side effects, insurance coverage, provider knowledge of treatment options, and affordability.

Vaginal Estrogen

Vaginal estrogen has been shown to be a possible treatment for women with UI. Many women experience a loss of estrogen as they age, especially as they go through menopause. The application of vaginal estrogen is thought to help restore estrogen to the thinning vaginal/urethral tissues, improving their thickness, elasticity and blood flow, which helps to reduce UI, urgency, and frequency.

In one review of 19,000 women, significantly more women who received vaginal estrogen for incontinence reported that their symptoms improved compared with placebo¹⁰⁸. These findings



suggest that local vaginal estrogen can be an effective option for improving UI symptoms in postmenopausal women.

Minimally Invasive Therapy for UUI

Outside of conservative treatment and medication, there are options for minimally invasive therapy for UUI which include percutaneous tibial nerve stimulation (PTNS), chemodenervation and sacral neuromodulation (SNM).

PTNS is a neuromodulation therapy where stimulation gets delivered retrograde to the S2–S4 nerve roots and sacral plexus via the posterior tibial nerve. The nerve is stimulated by a needle electrode inserted above the ankle and the needle is stimulated electrically. The exact mechanism of how the electrical stimulation works is unknown, but it is thought that it may have a direct effect on the bladder or on the micturition centers of the brain. Patients usually undergo 12 weekly sessions, each lasting 30 minutes. Patients with improvement after the 12 sessions may choose to continue monthly therapy to maintain treatment effect¹⁰⁹.

Evidence suggests PTNS can ease urgency and UUI symptoms in 50%–70% of patients^{109,110}.

When compared with medication, PTNS shows superior efficacy in patient-reported outcomes and similar efficacy in clinically observed outcomes¹¹¹.



Chemodenervation (also known as bladder Botox) is the use of a neurotoxin that is produced by the *Clostridium botulinum* bacteria to prevent muscular contraction of the detrusor muscle by inhibiting acetylcholine release at the neuromuscular junction. This is usually an office-based procedure with use of local anesthesia, where the neurotoxin is injected into the bladder via a needle under direct cystoscopy. Side effects include urinary tract infections (UTIs) (33–35%) and urinary retention requiring intermittent catheterization (5–8%). While the possible side effect of urinary retention can be distressing to some patients, it is a rare side effect that typically resolves after 6 weeks. When compared, both anticholinergics and chemodenervation were associated with similar reductions in the frequency of daily episodes of UUI. Chemodenervation, however, was more likely to have complete resolution of UUI¹¹².

SNM is a therapy that stimulates the S3 sacral spinal nerve root to modulate the neural pathways to treat UUI. It is a two-part procedure with the first test phase occurring in the office or operating room. A thin electrode is inserted into the lower back by the sacral nerves, and this is connected to an external temporary stimulator which delivers mild stimulation to the sacral nerves. If the patient reports 50% improvement, they proceed to the second phase, which occurs in the operating room where a

PATIENTS' PERSPECTIVE



Only 11% of diagnosed women have tried minimally invasive or device-based options such as Botox injections, nerve stimulation, or bulking agents, and 6% are currently using them. Yet satisfaction is highest among these users, with more than half reporting they are very satisfied. Clinicians should broaden treatment discussions to introduce minimally invasive therapies earlier in the treatment pathway.

Source: NAFC/Phreesia Survey, 2025. For details, refer to survey methodology outlined on page 5.

permanent neurostimulator is placed. There are both rechargeable devices and non-rechargeable devices. Rechargeable devices are smaller but generally require recharging once per month. The rechargeable devices can have extended battery life of 15 years or more. Non-rechargeable devices are slightly larger but do not require charging. While they can also have a life span of 15 years or more, their battery life is typically shorter than the rechargeable devices.

Side effects of SNM include pain at the implant site (15%), lead migration (16%), infection (5%), wound problems (7%) and adverse effects on bowel function (6%)¹¹³. The need for device revision occurs in 33% of patients and the need for removal entirely occurs in 14% of patients¹¹⁴. When compared with chemodenervation, SNM has slightly more statistically significant efficacy that is of unknown clinical significance (3.3 vs 3.9 less episodes of UI a day). Given the variety of treatment options — all with differing side effects and efficacy — patients should discuss their goals, concerns, and needs with their treatment team, so they can make the decision that's most appropriate for them.



Treatment Follow-Up

Regular, structured follow-up is a critical component of effective UI management, ensuring that treatment benefits are sustained and that patients can transition smoothly through the care continuum as their needs evolve. Evidence shows that patients who receive ongoing monitoring, whether through periodic clinical evaluations, symptom assessments, or the use of clinical care pathways report better symptom control and higher adherence to therapy¹¹⁵. Best practices include scheduling timely post-treatment visits to reassess outcomes, adjust medications or behavioral strategies, and reinforce self-management skills. Clinicians should also encourage patients to track their symptoms, triggers, and responses to therapy, as these tools provide valuable insight for tailoring care. Importantly, follow-up allows providers to identify when a patient may benefit from escalation to alternative therapies or referral to a specialist such as a urogynecologist or urologist. By maintaining consistent oversight and clear communication, the health-care team supports a seamless progression from diagnosis through advanced therapeutic options, improving both patient experience and long-term outcomes.

Conclusion: A Pathway to Enhanced Quality of Life

UI is a widespread, deeply impactful condition that affects tens of millions of women across the United States. As detailed throughout this report, its burdens extend far beyond physical discomfort, fundamentally disrupting patients' emotional well-being, financial stability, social engagement, and overall quality of life. Despite these profound challenges, UI remains a heavily underreported condition due to pervasive social stigma and communication gaps between patients and healthcare providers. Addressing this silent public health crisis requires an active shift toward more consistent, routine screening of adult women at appropriate points across the life course, utilizing validated tools to bridge the diagnostic gap and connect women with early, effective care.

Ultimately, managing urinary incontinence is not a rigid, linear journey, but rather a dynamic and highly individualized process. From low-risk behavioral modifications and pelvic floor physical therapy to advanced pharmacologic, minimally invasive, and highly effective surgical interventions, modern medicine offers a diverse spectrum of treatment pathways tailored to unique patient profiles and specific UI subtypes. By prioritizing shared decision-making, patient education, and structured clinical follow-up, healthcare providers can empower women to navigate these options successfully. Continued research, enhanced surveillance, and dedicated advocacy remain critical to optimizing therapeutic guidelines, eliminating barriers to advanced care, and helping affected individuals achieve longer, healthier, and more fulfilling lives.

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Survey Process

Eligible individuals reviewed additional information describing the purpose of the survey and how results would be used prior to initiating the survey. Participation was voluntary, and respondents could exit the survey at any time. Severity of incontinence was measured using the ICIQ-SF scale.

The survey was voluntary and was completed by 2,787 women: 1,217 symptomatic, undiagnosed women and 1,570 diagnosed women. Across symptomatic, undiagnosed women, the mean age was 61.5 years; 74% were White, 8% were Black, 2% were Asian, and 17% identified as other/unknown race. 6% identified as Hispanic, 78% as not Hispanic, and 16% as other/unknown.

Across diagnosed women, the mean age was 65.2 years; 59% of women were ages 65+, 76% were White, 10% were Black, 1% were Asian, and 12% identified as other/unknown race. Five percent identified as Hispanic, 82% as not Hispanic, and 12% as other/unknown.

NAFC Incontinence Impact Check-In

A patient worksheet to help you understand how bladder leakage may be affecting your mental health and quality of life

Instructions:

For each statement, circle how often it has been true for you in the past 2 weeks.

Scoring:

0 = Never

1 = Rarely

2 = Sometimes

3 = Often

Part 1: Daily Life Impact

1. I plan my day around possible leakage.

0 1 2 3

2. I avoid certain places, outings, or travel because of my bladder symptoms.

0 1 2 3

3. My bladder symptoms interfere with sleep or leave me feeling tired.

0 1 2 3

4. I avoid exercise, hobbies, or activities I used to enjoy.

0 1 2 3

5. My symptoms affect my work, errands, or family time.

0 1 2 3

Part 2: Emotional Impact

6. I feel embarrassed, ashamed, or self-conscious because of leakage.

0 1 2 3

7. I feel anxious about accidents, odor, or people noticing.

0 1 2 3

8. I feel less confident because of my bladder symptoms.

0 1 2 3

9. I feel frustrated, angry, or out of control.

0 1 2 3

10. I feel sad, isolated, or withdrawn because of this condition.

0 1 2 3

Part 3: Relationships and Coping

11. I hide my condition from other people.

0 1 2 3

12. My symptoms affect intimacy or closeness in my relationship.

0 1 2 3

13. I feel unsupported by family, friends, or my partner.

0 1 2 3

14. I spend a lot of mental energy thinking or worrying about my bladder.

0 1 2 3

15. I feel like I am coping mostly by avoiding things rather than feeling in control.

0 1 2 3

Part 4: Outlook and Quality of Life

16. I worry my symptoms are getting worse.

0 1 2 3

17. I worry about having an accident I cannot hide.

0 1 2 3

18. I worry about losing independence because of my symptoms.

0 1 2 3

19. I worry about the financial or emotional burden of managing this condition.

0 1 2 3

20. Overall, incontinence is affecting my quality of life.

0 1 2 3

Score Summary

Add your total: _____ / 60

Suggested interpretation

0–14: Mild impact

Your symptoms may be affecting some parts of life, but the burden appears lower right now.

15–29: Moderate impact

Your symptoms may be affecting daily function, emotional well-being, or confidence in a meaningful way.

30–44: High impact

Incontinence appears to be significantly affecting your mental health and/or quality of life.

45–60: Very high impact

Your symptoms may be having a major emotional and quality-of-life impact and deserve prompt discussion with a healthcare provider.

Evaluating Your Results

Even if your score was on the lower side, consider discussing your results with your doctor if your leaks are impacting your day to day life.

Bring This to Your Appointment

What I want my doctor to know:

- The biggest way this affects my daily life is: _____
- The biggest way this affects my mental health is: _____
- What I worry about most is: _____
- What I have tried already: _____
- What I want help with most: _____

Questions I want to ask:

- What type of incontinence do I likely have?
- What treatment options do I have beyond pads or lifestyle changes?
- Could pelvic floor physical therapy help me?
- Are there medications, procedures, or newer treatments I should know about?
- Should I also get support for anxiety, sleep, or emotional stress related to this?

This worksheet is an educational self-assessment inspired by patient-reported survey findings. It is not a diagnosis or a substitute for medical or mental health care. If you are feeling overwhelmed, hopeless, or unable to cope, seek support from a healthcare professional.

Bladder Leaks Quick Check

Many people experience bladder leaks, urgency or changes in how often they go to the bathroom. These symptoms are common, but that doesn't mean they're normal. The good news is that effective treatments are available now. The answers you provide here can help your clinician evaluate your condition and develop a treatment path that can put you on the road to a life without leaks.

1. In the past 3 months, have you leaked urine, even a small amount?

- ☐ No ☐ Yes ☐ Not Sure

2. When does leaking usually happen? *Check all that apply.*

- ☐ When I cough, sneeze, laugh, exercise, lift or stand up
☐ When I suddenly feel a strong urge and cannot get to the bathroom in time
☐ On the way to the bathroom
☐ During sleep
☐ After urinating, I still dribble or leak
☐ I leak without warning
☐ Other: _____

3. How often does this happen?

- ☐ Less than once a week
☐ A few times a week
☐ About once a day
☐ Several times a day
☐ Constantly or very frequently

4. How much does it usually affect your life?

- ☐ Not at all
☐ A little
☐ Moderately
☐ A lot

5. Have you changed anything because of bladder leaks or urgency? *Check all that apply.*

- ☐ I wear pads, liners, protective underwear or extra clothing
☐ I avoid exercise, travel, social events, sex or certain activities
☐ I plan my day around bathroom access
☐ I limit fluids
☐ I wake up often to use the bathroom
☐ I have not changed anything

6. Would you like to talk about this with your clinician today?

- ☐ Yes
☐ Maybe, but I'm embarrassed
☐ Not today, but I'd like information
☐ No

7. Please tell your clinician right away if you have any of the following:

- ☐ Blood in the urine
☐ Pain or burning with urination
☐ New or sudden leakage
☐ Fever, back pain or feeling very ill
☐ Trouble starting urination or emptying the bladder
☐ New weakness, numbness or loss of bowel control
☐ Recent pelvic surgery, childbirth injury or trauma

For Clinician/Care Team Use Only: Quick Review

- Likely pattern: ☐ Stress UI
☐ Urgency UI/OAB
☐ Mixed UI
☐ Overflow/retention concern
☐ Red flag

- Next step: ☐ Discuss conservative care
☐ Urinalysis
☐ Bladder diary
☐ Pelvic floor PT
☐ Medication discussion
☐ Referral

3-Day Bladder Snapshot

Use this page for 3 days before or after your appointment. You do not have to measure everything perfectly. The goal is to help you and your clinician see patterns. Use this section to record the most important episodes or patterns you notice over 3 days.

Day 1 / Day 2 / Day 3

Time	What Happened	Urgency	Leak?	What were you doing?	Drink or trigger?
	☐ Urinated ☐ Leak only ☐ Woke up to urinate	☐ None ☐ Mild ☐ Strong	☐ No ☐ A few drops ☐ Wet pad/underwear/clothes		
	☐ Urinated ☐ Leak only ☐ Woke up to urinate	☐ None ☐ Mild ☐ Strong	☐ No ☐ A few drops ☐ Wet pad/underwear/clothes		
	☐ Urinated ☐ Leak only ☐ Woke up to urinate	☐ None ☐ Mild ☐ Strong	☐ No ☐ A few drops ☐ Wet pad/underwear/clothes		
	☐ Urinated ☐ Leak only ☐ Woke up to urinate	☐ None ☐ Mild ☐ Strong	☐ No ☐ A few drops ☐ Wet pad/underwear/clothes		
	☐ Urinated ☐ Leak only ☐ Woke up to urinate	☐ None ☐ Mild ☐ Strong	☐ No ☐ A few drops ☐ Wet pad/underwear/clothes		

Daily summary

How many times did you urinate today?

Day 1: _____ Day 2: _____ Day 3: _____

How many times did you wake up to urinate overnight?

Day 1: _____ Day 2: _____ Day 3: _____

Did you use pads, liners, or protective underwear?

- ☐ No
☐ Yes: About how many per day? _____

Common triggers I noticed:

- ☐ Coughing/sneezing/laughing
☐ Exercise/lifting
☐ Strong urgency
☐ Coffee/tea/caffeine
☐ Alcohol
☐ Carbonated drinks
☐ Long gaps between bathroom trips
☐ Getting home/putting key in door
☐ Running water
☐ Other: _____

What I want help with most:

- ☐ Leaking with activity
☐ Urgency
☐ Frequent bathroom trips
☐ Nighttime urination
☐ Pads/protective products
☐ Odor/skin irritation
☐ Embarrassment or impact on daily life
☐ Knowing what treatment options exist