



# Pessary and pelvic floor exercises for incontinence—are two better than one?

**NO** This randomized, controlled trial of 446 women found that the combination of instructed pelvic floor exercises and use of an incontinence pessary is no more effective than either therapy alone.

In addition, when behavioral therapy and use of a pessary were compared head to head, behavioral therapy produced greater patient satisfaction and fewer bothersome incontinence symptoms after 3 months of therapy. These differences disappeared by 12 months, however, after which the two modalities were roughly equivalent.

*Richter HE, Burgio KL, Brubaker L, et al, for the Pelvic Floor Disorders Network. Continence pessary compared with behavioral therapy or combined therapy for stress incontinence: a randomized controlled trial. Obstet Gynecol. 2010;115(3):609-617.*

## ▶ EXPERT COMMENTARY

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**B**ecause we will all be seeing more patients with stress urinary incontinence and other urogynecologic issues, it is critical that we keep abreast of the treatment options available—and their relative effectiveness.<sup>1</sup>

In this exploration of nonsurgical approaches to stress incontinence, Richter and colleagues started with the premise that a combination of instructed pelvic floor exercises and an incontinence pessary would be better than either treatment alone. They (very appropriately) designated the following as primary outcome measures:

- patient-reported improvement
- symptoms of stress incontinence
- patient satisfaction, as measured using validated instruments.

As reported above, combination therapy did not prove to be superior to single-modality intervention. And although behavioral therapy was superior to a pessary at 3 months, by 12 months the modalities were roughly equivalent, and only about half of patients were still using the prescribed therapy: pessary (45%) or pelvic floor exercises (57%).

## This is *not* a real-world study

Most women who have stress incontinence and who select nonsurgical therapy choose only one option—pelvic floor exercises (if very motivated), a vaginal pessary or other device (if not so motivated), or another conservative option such as radiofrequency therapy (if even less motivated). In this study, women enrolled in behavioral therapy paid four visits (at roughly 2-week intervals) to



The combination of a pessary and instructed pelvic floor exercises did not prove superior to either therapy alone

## WHAT THIS EVIDENCE MEANS FOR PRACTICE

Many patients seek to avoid surgery, either because they believe that their stress incontinence is not severe enough to warrant it, or because they are unwilling to take the 6 to 8 weeks of relative inactivity required for the sling to settle in.

In the absence of approved pharmacotherapy for stress incontinence, I tell patients that they 1) can expect their symptoms to become worse over time and 2) should designate a period of time for a trial of conservative therapy—usually, 3 months. If their condition has not improved to their satisfaction over that period, I recommend that they identify a 6-week window during which they can avoid the gym and the golf course, as well as sexual activity, to allow for un-stressed healing from a sling procedure.

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approved “interventionists,” who instructed them in the technique for pelvic floor exercise and explained other skills and strategies to prevent urge and stress incontinence.

Many women find it difficult to attend the four to eight physiotherapy sessions that are necessary for behavioral intervention and are unwilling to devote 1 year to a therapy that they don’t find effective early on. (Physiotherapy is effective but requires a motivated patient.) Other women dislike inserting a vaginal device on a regular basis.<sup>2</sup>

What’s more, very safe minimally invasive slings are available that offer more definitive therapy to patients who have stress incontinence. That said, a sling procedure should not be undertaken lightly. Patient selection should be based on preoperative testing, including an assessment of urethral function, for the transobturator sling.<sup>3</sup> A retropubic sling requires a greater degree of expertise to tension appropriately but is suit-

able for a wider range of severity, including intrinsic sphincteric deficiency. The role of single-incision slings is unclear.

### **Bottom line: Individualize care**

The authors’ concluding statements are right on the money: “Individualization of care should continue to be the cornerstone of our approach to [stress incontinent] patients.” These women have several effective options available. We should help them make an educated choice based on symptom severity, lifestyle, and willingness to enroll in self-help intervention versus surgical therapy. 📌

### **References**

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3. Guerette N, Bena J, Davila GW. Transobturator slings for stress incontinence: using urodynamic parameters to predict outcomes. *Int Urogynecol J Pelvic Floor Dysfunct.* 2008;19(1):97–102.