Pelvic floor dysfunction: prevention and non-surgical management
Consultation on draft guideline - Stakeholder comments table
28/06/2021 to 09/08/2021

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association for Continence Advice	Guideline	001	002	Those aged 12 – 18 are not women they are girls. Wording should be changed to reflect this	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.' Generally we have avoided being specific about ages because the committee decided that tailoring information to individual circumstances is more important, for example a focus on symptoms rather than age or about pregnancy regardless of age and similarly with menopause. However, we have acknowledged that there is a lack of evidence for 12 to 17 year old people and have therefore made specific research recommendations for this group (see the prioritised research recommendation 2 – details of which are in appendix L of evidence review F, as well as a research recommendation on information valued by this age group – details of which are in appendix L of evidence review G). To ensure that young women are seen by the appropriate specialists the committee added to the last bullet in

					recommendation 1.6.2 the 'community multi-based multidisciplinary teams' section that one of the competencies of the team should include '• identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric and adolescent gynaecology services)'.
Association for Continence Advice	Guideline	001	003	The wording should be changed to reflect that it is talking about girls as well as women. This continues throughout the paragraph	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.'
Association for Continence Advice	Guideline	002	004	Use of women when the guidance includes girls	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning

					of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.
Association for Continence Advice	Guideline	004	004	No mention of Sacral neuromodulation or Tibial Nerve stimulation as treatment options for faecal incontinence or faecal urgency. Should there be a link at the end of the document to surgical treatment options such as this.	Thank you for your comment. This is a guideline specifically addressing non-surgical management options. The committee therefore agreed that linking to surgical treatment would be confusing.
Association for Continence Advice	Guideline	004	007	Faecal incontinence should also cover passive faecal incontinence and faecal leakage - as different treatment options are available.	Thank you for your comment. The committee used faecal incontinence as an umbrella term and the committee would not have excluded evidence related to passive faecal incontinence and faecal leakage. Limited evidence was identified specifically related to these symptoms.
Association for Continence Advice	Guideline	004	015	Use of word women – this continues throughout the document and should be considered each time it occurs	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.

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Association for Continence Advice	Guideline	005	001	Most MDT teams will not accept referrals for those under 18 years of age. This group needs to be considered in where to go for help	Thank you for your comment. We have amended the final bullet point of recommendation 1.6.2 which is related to the competencies in the community-based multidisciplinary team '• identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services).'
Association for Continence Advice	Guideline	005	013	Settings suggested do not include schools and colleges, which is where those aged 12 -18 will most likely be	Thank you for your comment. The committee decided to make a specific recommendation 1.1.7 related to teaching because it contained both the age group and what to teach. Adding schools and colleges to the list of settings in 1.1.2 would be out of context and not specific enough in isolation because this would suggest it would be useful for any age group in schools and the committee did not look for evidence for this.
Association for Continence Advice	Guideline	005	023 - 024	If those aged 12-18 are to be included then there needs to be training for school nurses, children's continence nurses and paediatricians as well as paediatric physiotherapists	Thank you for your comment. The recommendation related to covering pelvic floor dysfunction in the syllabus for trainee nurses, physiotherapists, doctors, midwives and teachers which could refer to any nurse, physiotherapist, doctor or teacher regardless which can include professionals who deal with this age group.
Association for Continence Advice	Guideline	005	026	Tailored information gives example of pregnancy, however, those aged under 18 and certainly those as young as 12-14 will need tailored information, as will those with learning disability	Thank you for your comment. The committee decided that one example in this recommendation is sufficient. The section contains recommendations that cross-refer to other guidelines that are dedicated to people's experience with healthcare services. We have added a cross reference to guidance for young people aged 12 to 17 years old (to the NICE on babies,

					children and young people's experience of healthcare services (2021)).
Association for Continence Advice	Guideline	006	001 - 0026	Women and girls with learning disability should also have targeted information provided for them. There is NHS guidance on this at https://www.england.nhs.uk/wp-content/uploads/2018/06/LearningDisabilityAccessCommsGuidance.pdf	Thank you for your comment. Recommendation 1.1.10 links to other NICE guidance that include recommendations on how information should be tailored to different age groups and different needs including people with learning disabilities.
Association for Continence Advice	Guideline	006	009	Developing the role of the midwife antenatally for prevention and postnatal for prevention and early detection of dysfunction.	Thank you for your comment. The committee emphasised that women using maternity services as well as women at each postnatal contact should be made aware of pelvic floor dysfunction. This is aimed to not only improve awareness but would also support early detection. The recommendations in this section refer to all women regardless of symptoms whereas recommendations in section 1.5 focus on assessment of symptoms and recommendation 1.5.3 states that women who have recently given birth should be asked about pelvic floor dysfunction during routine postnatal care which would also lead to early detection and management.
Association for Continence Advice	Guideline	006	012	This is a significant suggestion and is very welcome, but some in this age group will also be in college, so how about adding this or using the term ‘educational establishments’ rather than school?	Thank you for your comment. We have amended it to 'educational settings' to widen it out to any educational setting that this age group may be in.
Association for Continence Advice	Guideline	009	009	It would be good to highlight that the CMO’s guidance on physical activity includes all ages	Thank you for your comment. The NICE guideline on physical activity: walking and cycling also covers all ages. We have added in the preamble to the guideline that: 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to ‘women’ without specifying an age range, that means they cover this entire population.' When we refer to women in

					this recommendation this therefore is applicable to the entire age group.
Association for Continence Advice	Guideline	009	013	Would it be appropriate to include guidance on the governments recommendations that are at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/618167/government_dietary_recommendations.pdf as these include the under 18s?	Thank you for your comment. The Eatwell Guide link takes the reader to the Eatwell guide web landing page which includes links to various documents with relevant guidance on nutrition, including the suggested publication. So the committee decided that this was already covered even if it was not directly referred to.
Association for Continence Advice	Guideline	011	023	There needs to be some consideration of who will teach pelvic floor muscle exercises to the under 18s as currently this service is lacking	Thank you for your comment. The supervised pelvic floor muscle training programme is recommended for groups of women at higher risk of pelvic floor dysfunction specifically related to pregnancy regardless of age. In recommendation 1.3.14 it is made clear that supervision should be by 'physiotherapist or other healthcare professional with the appropriate expertise in pelvic floor muscle training'. People with this expertise would know how to teach pelvic floor muscle training in the context of pregnancy regardless of the age of the women and were therefore considered to be best placed. For all other age groups pelvic floor muscle training is to be encouraged but the committee was not prescriptive about who should be doing that since that would vary according to the particular circumstances.
Association for Continence Advice	Guideline	012	008	Consideration needs to be given as to how those under 18 will be communicated with, and particularly for those who are under 13 as they will need parental consent and support to engage	Thank you for your comment. We have included a cross reference to the communication and information section of the NICE guideline on babies, children and young people's experience of healthcare to recommendation 1.4.3 which would cover this age group.
Association for	Guideline	015	013	The guidance is only relevant to those over the age of 18 – this should be made clear	Thank you for your comment.

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Continence Advice					Whilst it is true that the guidelines that are cross referred to in this section are for adults, the committee thought that the principles related to assessment could be extrapolated to the younger age group. The recommendations were amended to make this clearer by adding '(the recommendations in this guideline may also be relevant for women under 18)'.
Association for Continence Advice	Guideline	015	016	The guidance is only relevant to those over the age of 18 – this should be made clear	Thank you for your comment. Whilst it is true that the guidelines that are cross referred to in this section are for adults, the committee thought that the principles related to assessment could be extrapolated to the younger age group. The recommendations were amended to make this clearer by adding '(the recommendations in this guideline may also be relevant for women under 18)'.
Association for Continence Advice	Guideline	016	002	Rectal irrigation is only mentioned in areas for Research but should be offered in the community and specialist centres as a treatment for constipation / difficult defecation, faecal incontinence or problems with a rectocele.	Thank you for your comment. No evidence was identified for rectal irrigation in the context of pelvic floor dysfunction and therefore the committee was unable to comment on this in a recommendation and decided that further research is needed to clarify the effectiveness of this (see appendix L of evidence review N).
Association for Continence Advice	Guideline	016	002	No mention of referring women into specialist pelvic floor centres if community teams and/ or Gp are unable to offer further support.	Thank you for your comment. One of the competencies listed in the community-based multidisciplinary team section is '• identifying which women need referral to specialist care or other services (including in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services where available)' . Since women with pelvic floor dysfunction are a very diverse group it is hard to be prescriptive about who, when and where to refer to.
Association for	Guideline	016	007	Those under 18 should be cared for by those with training in their needs. This should be reflected in the competencies	Thank you for your comment.

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Continence Advice					The committee added to the final bullet related to competencies: • identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services where available).
Association for Continence Advice	Guideline	019	001	Could there be more emphasise on prevention and how to deliver the teaching of pelvic floor exercises? - increasing the focus on prevention should reduce some of the need for cure.	Thank you for your comment. The aim of this section is on management of pelvic floor dysfunction. The committee thought that prevention clearly is very important and that is why they dedicated an entire section of the guideline to it (see section 1.3 'preventing pelvic floor dysfunction' which includes encouraging women to do pelvic floor muscle training).
Association for Continence Advice	Guideline	019	001	Could there be a structured process for triggers/prompts within healthcare services to reinforce/ remind individuals to do pelvic floor exercises or seek help if needed? – we know individuals forget to do pelvic floor exercises and many wait/delay seeking help	Thank you for your comment. The section 'Raising awareness of pelvic floor dysfunction for all women' includes various formats and settings in which information could be provided including information and encouragement to do pelvic floor muscle training. Whilst this is not a 'structured' process it provides various opportunities to disseminate and reinforce the messages related to pelvic floor dysfunction with the aim to motivate women to be more aware of what they can do to prevent or manage pelvic floor dysfunction.
Association for Continence Advice	Guideline	022	015 - 017	This may also be particularly suitable for younger girls	Thank you for your comment. The committee decided based on consensus that this was particularly useful for women with cognitive impairments. There was no evidence identified for an age group of young women (12 to 17 years old) and there was insufficient consensus that these techniques would be effective so the committee decided not to comment on this.
Association for	Guideline	023	004 - 007	There is no guidance for medication in under 18s with urinary incontinence. NICE should consider producing some. There is	Thank you for your comment.

Continence Advice				guidance on constipation in children – consideration should be given to referencing this here, as it frequently causes faceal incontinence	The committee agreed that some of the medications in the NICE guideline on urinary incontinence may be generalisable to a younger age group, as long as they are licensed for this age group. Management of constipation is outside the scope of the non-surgical management section. We have added a link to the NICE guideline on constipation in children and young people: diagnosis and management to the prevention section. The committee also made recommendations on physical activity, diet and fluid intake which can improve stool consistency.
Association for Continence Advice	Guideline	035	010 - 011	This is not the case for children and young people with constipation, where NICE clearly states that laxatives are first line treatment for constipation. Although adjusting fluid intake may help reduce the risk of constipation developing specific advice is needed for schools as they often restrict access to fluids during the day. Hence the guidance at https://www.bbuk.org.uk/wp-content/uploads/2021/01/Managing-Continence-Problems-in-Schools-2019-.pdf was produced	Thank you for your comment. We have added a cross-reference to the NICE guideline on Constipation in children and young people: diagnosis and management to the prevention of pelvic floor dysfunction section. The committee decided that the promotion of a healthy diet and fluid intake would improve stool consistency and have revised the rationale to explain that fluid intake is only one of the ways of addressing this. The resource that the comment refers to is focused on bowel and bladder symptoms without a clear association to pelvic floor dysfunction and can therefore not be included.
Association for Continence Advice	Guideline	039	014	But also for those who are under 18 years old and certainly for those under the age where they are assumed to have competence to consent (under 16)	Thank you for your comment. The committee decided based on consensus that this was particularly useful for women with cognitive impairments. There was no evidence identified for an age group of young women (12 to 17 years old) and there was insufficient consensus that these techniques would be effective so the committee decided not to comment on this.
Association for	Guideline	042	004 - 007	It would be good if the committee would recommend competencies that relate specifically to the needs of those under 18	Thank you for your comment.

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Continence Advice					The committee added to the final bullet related to competencies: • identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services where available).
Association for Continence Advice	Guideline	053	010	There is a gap in guidance in that NICE does not have guidance for urinary incontinence in the under 18s	Thank you for your comment. Whilst it is true that the guideline that is cross referred to in this section is for adults, the committee thought that the principles related to medicines could be extrapolated to the younger age group. The recommendations were amended to make this clearer by adding '(the recommendations in this guideline may also be relevant for women under 18)' and this was also noted in the rationale section.
Association for Improvements in the Maternity Services (AIMS)	Evidence Review B	025	008	AIMS questions the risk factor 'second stage of labour lasting longer than one hour' as the committee states the evidence is inconsistent. It would also be more meaningful to show what the absolute risk is.	Thank you for your comment. Across studies and symptoms there was an association that a longer lasting second stage of labour was a risk factor so the committee decided to list it in box 1. However, they did not list it in the risk groups of women who would be considered to receive preventative supervised pelvic floor muscle training because (1) it is quite common and therefore would lead to a greater resource impact and (2) there was more uncertainty in the findings than for the other risk factors listed. We agree that estimation of absolute risk would be useful, but to be meaningful to an individual woman this would require consideration of multiple factors together which would usually be done in a risk prediction tool. We looked for evidence on prediction tools for pelvic floor dysfunction risk but no suitable prediction tool was found and instead a research recommendation was made (see appendix L of evidence review D).

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Association for Improvements in the Maternity Services (AIMS)	General	001	006	Especially given the importance and focus on the **prevention** of pelvic floor dysfunction, we are concerned that this draft guideline seems to be primarily conceptualised as a guideline on pelvic floor dysfunction per se rather than more generally about pelvic floor health (with dysfunction being a subset of this). We worry that this bias could undermine its effectiveness, and that an explicitly salutogenic approach would be more effective. That said, we welcome elements of the guideline that seek to build awareness of the importance of a healthy and strong pelvic floor.	Thank you for your comment. This guideline is focused on pelvic floor dysfunction as outlined in the scope. Therefore, the committee was unable to change this to pelvic floor health since this would encompass wider topics with pelvic floor dysfunction as a subset. The committee thought that generally the condition was not well understood and awareness of it low so they wanted to focus on this throughout to improve this.
Association for Improvements in the Maternity Services (AIMS)	Guideline	General	General	As AIMS is specifically interested in maternity related guidelines, we are surprised there is no mention of pelvic girdle pain management during and after pregnancy. Surely this goes hand-in-hand with pelvic floor health? Therefore we recommend information to be included whilst raising awareness of, preventing and non-surgical management of PFD.	Thank you for your comment. There was no evidence that pelvic girdle pain is a risk factor for pelvic floor dysfunction. The committee also agreed that pelvic girdle pain is not a symptom of pelvic floor dysfunction. Therefore the treatment of it is outside the scope of this guideline. The NICE antenatal care guideline (2021) includes a recommendation on pelvic girdle pain to consider referral to physiotherapy services for exercise advice and/or a non-rigid lumbopelvic belt. The committee agreed that raising awareness of pelvic floor dysfunction is important (see section 1.1).
Association for Improvements in the Maternity Services (AIMS)	Guideline	001	006	We suggest an introduction to the guideline with a change of wording 'The guideline aims to raise awareness of the condition, so that women understand how to **increase their chances of maintaining pelvic floor health** and women with symptoms are aware of the benefits and drawbacks of all non-surgical management options.' Please see comment 1.	Thank you for your comment. This guideline is restricted to dealing with pelvic floor dysfunction as outlined in the scope. Therefore the committee was unable to change this to pelvic floor health since this dysfunction is associated with a specific set of symptoms which would be unclear if the terminology 'pelvic floor health' is used.
Association for Improvements in the	Guideline	004	014	We are concerned when raising awareness of a dysfunction that it will be dismissed and not be addressed as something that is not of importance until it actually happens. This is why we offer the recommendation to consider changing the wording to attract	Thank you for your comment. This is a guideline about pelvic floor dysfunction and all symptoms associated with this. The committee knew based

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Maternity Services (AIMS)				everyone, ie how to keep a healthy pelvic floor, where more people will be interested. Please see comment 1.	on their expertise that not enough people are aware of this condition and the associated symptoms. Therefore, they decided to emphasise this rather than pelvic floor health.
Association for Improvements in the Maternity Services (AIMS)	Guideline	005	013 - 024	We wonder why the secondary school setting is missing in this section, since it is covered below as a setting (p6, lines 12-14). Maybe the heading of this section needs revising, as it isn't comprehensive in terms of settings and is thus confusing.	Thank you for your comment. The committee decided to make a specific recommendation 1.1.8 related to teaching because it contained both the age group and what to teach. Adding schools and colleges to the list of settings in 1.1.2 would be out of context and not specific enough in isolation because this would suggest it would be useful for any age group in schools and the committee did not look for evidence for this.
Association for Improvements in the Maternity Services (AIMS)	Guideline	006	006	AIMS suggests including pelvic floor health in all antenatal class materials, especially how to prevent PFD during the second stage of labour by raising awareness of the risk factors.	Thank you for your comment. This guideline is restricted to dealing with pelvic floor dysfunction as outlined in the scope. Therefore the committee was unable to change this to pelvic floor health since this would not encompass the focus on the symptoms that define the condition. The evidence was not searched for in this way. Therefore we could not amend the guideline as suggested. There were recommendations raising awareness of pelvic floor dysfunction in maternity services at all midwife reviews, in booking information and in all postnatal contacts. The committee therefore agreed that this was sufficiently covered.
Association for Improvements in the Maternity Services (AIMS)	Guideline	006	007	Is information on symptoms sufficient, or should this be general information about the condition as well as information on prevention and symptoms?	Thank you for your comment. We amended this recommendation accordingly.
Association for Improvem	Guideline	006	009 - 011	Is it really worthwhile, reasonable and practicable to raise this issue at every (time-limited) antenatal or postnatal consultation as suggested here? We very much appreciate the rationale	Thank you for your comment.

ents in the Maternity Services (AIMS)				given later in the document (p22/23), but would query whether the committee has properly tested this recommendation, for example by considering the recommended average length of such appointments and all of the various issues that will need to be discussed at these appointments. Where is the expert advice on this specific point, please? We would also question whether discussions during maternity appointments can replace the need for improved strategies to encourage this issue to be addressed constructively in society more generally.	The committee were aware that a downside of their recommendation is that women could be provided information about pelvic floor dysfunction many times during their pregnancy. However, as discussed in the rationale and impact, the committee believed this was reasonable because this is a time when symptoms often first occur and that it helps "normalise" these discussions in a context where embarrassment may be a barrier to effective communication.
Association for Improvements in the Maternity Services (AIMS)	Guideline	006	019	Can it be clarified here whether or not information and discussion about Pelvic Floor Health is recommended to be built into the 5-yearly NHS Health Check for women aged 40 and over, which seems to be the most appropriate universal vehicle available at least in England?	Thank you for your comment. We have included in recommendation 1.1.2 a bullet: 'as part of existing programmes for example, cervical screening or NHS national or local health checks'.
Association for Improvements in the Maternity Services (AIMS)	Guideline	008	001	Box 1 It would be beneficial to have links to easily accessible evidence-based information on each of the risk factors here, especially related to pregnancy and labour. We question if birthing big babies is a risk factor as it seems to be a common reason presented to women who experience pelvic floor dysfunction in later life? Also why is 'directed pushing' especially with epidurals not considered a risk factor for PFD?	Thank you for your comment. The evidence (see evidence review B) on big babies was not clear and not significant (see Fritel et al. 2008) with an OR for birthweight below or above 4 kg of OR 0.74 (0.26, 2.07). It can also be a confounding factor since a heavier baby applies more intra-abdominal pressure and also could be associated with tears when delivered vaginally. There was no evidence identified in relation to 'direct pushing' and the committee therefore did not comment on this.
Association for Improvements in the Maternity Services (AIMS)	Guideline	009	017	We suggest an evidence-based link to this, otherwise how does one know what is too much or too little fluid intake?	Thank you for your comment. The committee were aware that commonly 6 to 8 glasses of fluid are recommended. However, they commented in the rationale that this was very much dependent on the circumstances (be they environmental or activity related) so they did not want to be prescriptive about this.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	010	011 - 012	Section on Pelvic Floor Muscle Training. Can you please clarify why there is a very narrow focus here on the isolated training of the pelvic floor muscles, when it is increasingly recognised that pelvic floor health is improved and protected by paying attention to improving the strength of the lower back, the diaphragm and the abdominal muscles (the core), in addition to the pelvic floor itself? Did this crucial issue get discussed by the committee? Is the approach set out in the guidance sufficiently holistic, including from a preventative perspective? What does the basic science around human physiology suggest on this issue? Are we sure that the recommendations for further research are sufficiently broad to address this issue? See also page 16, lines 21-22.	Thank you for your comment. We did not identify any evidence that a focus on the core muscles alone without specific additional focus on the pelvic floor muscles would prevent pelvic floor dysfunction or help in managing symptoms. The committee therefore did not recommend this.
Association for Improvements in the Maternity Services (AIMS)	Guideline	011	013	For consistency, if you state 4 non-modifiable risk factors during labour, then the same 4, not only 3, should be offered the same support for postnatal recovery programme.	Thank you for your comment. In evidence review B there was some evidence that highlighted a second stage of labour of more than an hour as a risk factor. However, since this would affect a very large number of women (leading to a significant resource impact) and the evidence related to this was more uncertain than the evidence related to the other 3 risk factors, the committee decided against listing this in recommendation 1.3.11.
Association for Improvements in the Maternity Services (AIMS)	Guideline	015	007	Can you please consider ‘offering’ these examinations? Our concern is that women will not initially reach out for help if invasive examinations are the norm.	Thank you for your comment. We have added that 'the woman's preferences and circumstances' should be taken into account to this recommendation.
Association for Improvements in the	Guideline	016	027	We would like to see ‘considering all options’ added to this sentence.	Thank you for your comment. The committee decided that a discussion and agreement would include a consideration of the various options available

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Maternity Services (AIMS)					to the women. It would be potentially confusing to state 'all options' because it would not be clear what was meant by this since the guideline focuses on non-specialist options only.
Association for Improvements in the Maternity Services (AIMS)	Guideline	023	General	It is reassuring to see so many research recommendations on this important topic, but we are concerned at the closed nature of the first three research recommendations (see comment 7 above) and also some of the 'other research recommendations' where the recommendations are focussed specifically on pelvic floor muscle training.	Thank you for your comment. Research recommendations in NICE guidelines are drafted for the topics that were covered in the guideline to address gaps in the evidence. There were gaps identified for almost all topics covered in the guideline. That is why the questions are specific to overcome the gaps in the current research so that such research can inform future updates of this guidance.
Association for Improvements in the Maternity Services (AIMS)	Guideline	023	General	Research recommendations: is there a research recommendation that would be useful to add in terms of an assessment of contemporary discourse on urinary incontinence, in particular that promoted by manufacturers of urinary incontinence products? We are concerned that the promotion of these products might work to undermine public health messages about the possibility of effective treatments/ interventions for pelvic floor dysfunction and to undermine the efforts of services set up to offer these treatments/interventions. A better understanding of this issue could help shape more effective public health promotion interventions and treatment take up, as well as underpin a strengthened partnership between the private and public sector in this area.	Thank you for your comment. Research recommendations in NICE guidelines are drafted for the topics that were covered in the guideline to address gaps in the evidence. A synthesis of contemporary discourse on urinary incontinence was outside the scope of the guideline and therefore a research recommendation could not be drafted for this.
Association for Improvements in the Maternity Services (AIMS)	Guideline	023	General	Pelvic floor dysfunction is a highly prevalent health concern amongst women, with a wide range of impacts - including impacts that work to significantly limit women's everyday lives. As such, we welcome the production of guidelines on this issue and look forward to seeing an improvement in women's everyday lives as more effective health promotion and treatment/interventions are rolled out. Recognising our concern that a salutogenic approach is likely to	Thank you for your comment. Research recommendations in NICE guidelines are drafted for the topics that were covered in the guideline to address gaps in the evidence. The suggested questions, even though interesting, were not covered by specific evidence reviews in this guideline and therefore it is difficult to identify where

				be worthwhile in this area (comment 1), and struck by the notion that pelvic floor prolapse prevalence in the UK could be as high as 50% (p54, 3-4)), we are keen that a better understanding is developed of what we should be aiming for in terms of pelvic health outcomes. Is there a sense that pelvic floor dysfunction is an inevitable side-effect of aging for many women, for example, or should we be striving to eliminate this health problem? What can we learn from examining prevalence in other countries, and from examining the possible rationale for varying prevalence? We would request that the Committee considers the case for including further research recommendations to address these important questions.	exactly the gap in the knowledge is so they could not be added.
Association for Improvements in the Maternity Services (AIMS)	Guideline	029	003 - 004	There is a research recommendation to look at the following question: "What are the experiences and information needs of children and young women (between 12 and 17 years) with pelvic floor dysfunction?" To ensure that good information can be developed, we wondered whether there should also be a specific research recommendation to look at this question: "What are the information needs of girls and young women (between 12 and 17 years) about pelvic floor health?" (ie, not limited to the information needs of girls and young women already experiencing pelvic floor dysfunction)	Thank you for your comment. The guideline is about the topic of pelvic floor dysfunction and raising awareness of the various symptoms associated with this is one of the aims of this guideline. The terminology pelvic floor health may also suggest wider aspects of pelvic floor related issues which would not have been searched for. The committee therefore decided that the research recommendation wording should remain as is.
Association for Improvements in the Maternity Services (AIMS)	Guideline	034	029	We are concerned about the issue of cost/benefit. Whilst we endorse the overall judgement that such information giving is important and cost effective, we are concerned that the costs and benefits fall in different parts of the system and more broadly. For example, we would suggest that maternity services are likely to see a net cost to following these guidelines, especially in terms of staff time: it is really important that this is taken into account when maternity tariffs and safe staffing levels are set. If the guidelines don't flag this issue, then we are concerned that they will contribute to unsafe maternity services where resources are not reallocated to take account of this extra activity.	Thank you for this comment. Whilst the committee recognised that there may be some resource implications with regard to staff time involved in information provision, the committee considered that providing information on risk factors is standard practice. Therefore the committee did not consider that these recommendations would have a significant resource impact to the NHS. Furthermore, the committee considered that their recommendations would help standardise the information provided thereby facilitating better satisfaction with services

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					and potentially avoiding "downstream" costs associated with pelvic floor dysfunction.
Bladder & Bowel UK	Guideline	001	002	Those aged 12 – 18 are not women they are girls. Wording should be changed to reflect this throughout the whole document	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.' Generally we have avoided being specific about ages because the committee decided that tailoring information to individual circumstances is more important, for example a focus on symptoms rather than age or about pregnancy regardless of age and similarly with menopause. However, we have acknowledged that there is a lack of evidence for 12 to 17 year old people and have therefore made specific research recommendations for this group (see the prioritised research recommendation 2 – details of which are in appendix L of evidence review F, as well as a research recommendation on information valued by this age group – details of which are in appendix L of evidence review G). To ensure that young women are seen by the appropriate specialists the committee added to the last bullet in

					recommendation 1.6.2 the 'community multi-based multidisciplinary teams' section that one of the competencies of the team should include '• identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric and adolescent gynaecology services)'.
Bladder & Bowel UK	Guideline	002	004	Use of women when the guidance includes girls	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.
Bladder & Bowel UK	Guideline	004	015	Use of word women – this continues throughout the document and should be considered each time it occurs	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses is from ages 12 years and over. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. To make this clearer we have added to the beginning

					of the guideline 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.
Bladder & Bowel UK	Guideline	005	001	To check if adult MDT teams will accept referrals for those under 18 years of age ? This group needs to be considered in where to go for help	Thank you for your comment. We have amended the final bullet point of recommendation 1.6.2 which is related to the competencies in the community-based multidisciplinary team '• identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services).'
Bladder & Bowel UK	Guideline	005	013	Settings suggested do not include schools / colleges, which is where those aged 12 -18 may also be	Thank you for your comment. The committee decided to make a specific recommendation 1.1.7 related to teaching because it contained both the age group and what to teach. Adding schools and colleges to the list of settings in 1.1.2 would be out of context and not specific enough in isolation because this would suggest it would be useful for any age group in schools and the committee did not look for evidence for this.
Bladder & Bowel UK	Guideline	005	023 - 024	If those aged 12-18 are to be included then there needs to be training for health professionals e.g school nurses, children's continence nurses and paediatricians as well as paediatric physiotherapists.	Thank you for your comment. The recommendation related to covering pelvic floor dysfunction in the syllabus for trainee nurses, physiotherapists, doctors, midwives and teachers which could refer to any nurse, physiotherapist, doctor or teacher regardless which can include professionals who deal with this age group.
Bladder & Bowel UK	Guideline	005	26	Tailored information gives example of pregnancy, however, those aged under 18 and certainly those as young as 12-14 will need tailored information, as will those with learning disability	Thank you for your comment. The committee decided that one example in this recommendation is sufficient. The section contains recommendations that cross-refer to other guidelines that are

					dedicated to people's experience with healthcare services. We have added a cross reference to guidance for young people aged 12 to 17 years old (to the NICE on babies, children and young people's experience of healthcare services (2021)).
Bladder & Bowel UK	Guideline	006	001 - 026	Women and girls with learning disability should also have targeted information provided for them. There is NHS guidance on this at https://www.england.nhs.uk/wp-content/uploads/2018/06/LearningDisabilityAccessCommsGuidance.pdf	Thank you for your comment. Recommendation 1.1.10 links to other NICE guidance that include recommendations on how information should be tailored to different age groups and different needs including with people with learning disabilities.
Bladder & Bowel UK	Guideline	006	012	This is a significant suggestion and is very welcome, but some in this age group will also be in college, so could you consider adding or using the term 'educational establishments' rather than school?	Thank you for your comment. We have amended it to 'educational settings' to widen it out to any educational setting that this age group may be in.
Bladder & Bowel UK	Guideline	009	009	It would be good to highlight that the CMO's guidance on physical activity includes all ages	Thank you for your comment. The NICE guideline on physical activity: walking and cycling also covers all ages. We have added in the preamble to the guideline that: 'this guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population.' When we refer to women in this recommendation this therefore is applicable to the entire age group.
Bladder & Bowel UK	Guideline	009	013	Would it be appropriate to include guidance on the governments recommendations that are at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/618167/government_dietary_recommendations.pdf as these include the under 18s?	Thank you for your comment. The Eatwell Guide link takes the reader to the Eatwell guide web landing page which includes links to various documents with relevant guidance on nutrition, including the suggested publication. So the committee decided that this was already covered even if it was not directly referred to.

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Bladder & Bowel UK	Guideline	011	023	There needs to be some consideration of who will teach pelvic floor muscle exercises to the under 18s , currently this service is lacking.	Thank you for your comment. The supervised pelvic floor muscle training programme is recommended for groups of women at higher risk of pelvic floor dysfunction specifically related to pregnancy regardless of age. In recommendation 1.3.14 it is made clear that supervision should be by 'physiotherapist or other healthcare professional with the appropriate expertise in pelvic floor muscle training'. People with this expertise would know how to teach pelvic floor muscle training in the context of pregnancy regardless of the age of the women and were therefore considered to be best placed. For all other age groups pelvic floor muscle training is to be encouraged but the committee was not prescriptive about who should be doing that since that would vary according to the particular circumstances.
Bladder & Bowel UK	Guideline	012	008	Consideration needs to be given as to how those under 18 will be communicated with, and particularly for those who are under 13 as they will need parental consent and support to engage	Thank you for your comment. We have included a cross reference to the communication and information section of the NICE guideline on babies, children and young people's experience of healthcare to recommendation 1.4.3 which would cover this age group.
Bladder & Bowel UK	Guideline	015	013	The guidance is only relevant to those over the age of 18 – this should be made clear	Thank you for your comment. Whilst it is true that the guidelines that are cross referred to in this section are for adults, the committee thought that the principles related to assessment could be extrapolated to the younger age group. The recommendations were amended to make this clearer by adding '(the recommendations in this guideline may also be relevant for women under 18)'.
Bladder & Bowel UK	Guideline	015	016	The guidance is only relevant to those over the age of 18 – this should be made clear	Thank you for your comment. Whilst it is true that the guidelines that are cross referred to in this section are for adults, the committee thought that the

					principles related to assessment could be extrapolated to the younger age group. The recommendations were amended to make this clearer by adding '(the recommendations in this guideline may also be relevant for women under 18)'.
Bladder & Bowel UK	Guideline	016	007	Those under 18 should be cared for by those with training in their needs. This should be reflected in the competencies	Thank you for your comment. The committee added to the final bullet related to competencies: • identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services where available).
Bladder & Bowel UK	Guideline	022	015 - 017	This may also be particularly suitable for younger girls	Thank you for your comment. The committee decided based on consensus that this was particularly useful for women with cognitive impairments. There was no evidence identified for an age group of young women (12 to 17 years old) and there was insufficient consensus that these techniques would be effective so the committee decided not to comment on this.
Bladder & Bowel UK	Guideline	023	004 - 007	There is no guidance for medication in under 18s with urinary incontinence. NICE should consider producing some. There is guidance on constipation in children – consideration should be given to referencing this here, as it frequently causes faceal incontinence	Thank you for your comment. The committee agreed that some of the medications in the NICE guideline on urinary incontinence may be generalisable to a younger age group, as long as they are licensed for this age group.. Management of constipation is outside the scope of the non-surgical management section. We have added a link to the NICE guideline on constipation in children and young people: diagnosis and management to the prevention section. The committee also made recommendations on physical activity, diet and fluid intake which can improve stool consistency.
Bladder & Bowel UK	Guideline	035	010 - 011	This is not the case for children and young people with constipation, where NICE clearly states that laxatives are first line	Thank you for your comment.

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				treatment for constipation. Although adjusting fluid intake may help reduce the risk of constipation developing specific advice is needed for schools as they often restrict access to fluids during the day. Hence the guidance at https://www.bbuk.org.uk/wp-content/uploads/2021/01/Managing-Continence-Problems-in-Schools-2019-.pdf was produced	We have added a cross-reference to the NICE guideline on Constipation in children and young people: diagnosis and management to the prevention of pelvic floor dysfunction section. The committee decided that the promotion of a healthy diet and fluid intake would improve stool consistency and have revised the rationale to explain that fluid intake is only one of the ways of addressing this. The resource that the comment refers to is focused on bowel and bladder symptoms without a clear association to pelvic floor dysfunction and can therefore not be included.
Bladder & Bowel UK	Guideline	039	014	But also for those who are under 18 years old and certainly for those under the age where they are assumed to have competence to consent (under 16)	Thank you for your comment. The committee decided based on consensus that this was particularly useful for women with cognitive impairments. There was no evidence identified for an age group of young women (12 to 17 years old) and there was insufficient consensus that these techniques would be effective so the committee decided not to comment on this.
Bladder & Bowel UK	Guideline	042	004 - 007	It would be good if the committee would recommend competencies that relate specifically to the needs of those under 18	Thank you for your comment. The committee added to the final bullet related to competencies: • identifying which women need referral to specialist care (in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services where available).
Bladder & Bowel UK	Guideline	053	010	There is a gap in guidance in that NICE does not have guidance for urinary incontinence in the under 18s	Thank you for your comment. Whilst it is true that the guideline that is cross referred to in this section is for adults, the committee thought that the principles related to medicines could be extrapolated to the younger age group. The recommendations were amended to make this clearer by adding '(the recommendations in this guideline may also be relevant for women under 18)' and this was also noted in the rationale section.

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British Society of Urogynaecology	Appendix L	General	General	Research recommendations Research recommendations for review question: Risk factors for pelvic floor dysfunction ***No research recommendations were made for this review question*** **Why have no research recommendations been made? For example, there is conflicting evidence about the effect of waterbirth on PFD risk; this is an important research question.** **Less stress urinary incontinence after waterbirth:** Liu, Y., Liu, Y., Huang, X. *et al.* A comparison of maternal and neonatal outcomes between water immersion during labor and conventional labor and delivery. *BMC Pregnancy Childbirth* 2014;**14:** 160. https://doi.org/10.1186/1471-2393-14-160 **Higher incidence of OASI after waterbirth:** Preston HL et al. Does water birth affect the risk of obstetric anal sphincter injury? Development of a prognostic model. Int Urogynecol J 2019 Jun;30(6):909-915.	Thank you for your comment. The evidence base for risk factors was larger than for other review questions in this guideline, and was also directly relevant to pelvic floor dysfunction as a condition, a constellation of a number of symptoms (rather than specific individual symptoms). Research recommendations are typically made when evidence is lacking and for this review evidence was available for most of the risk factors listed in the review protocol (see appendix A of evidence review B). The committee recommended that the risk of pelvic floor dysfunction should be explained to women when planning mode of birth antenatally - but making specific recommendations about water birth versus non-water birth would be outside the scope of this guideline as such a choice depends on more than risk of pelvic floor dysfunction alone. For this review only studies referring to pelvic floor dysfunction as a condition, a constellation of a number of symptoms (rather than specific individual symptoms) were included and this is why Liu 2014 and Preston 2019 were not included. For information, the committee have added a study about multiple pregnancy as a risk factor because some missing evidence was identified by a stakeholder. However, even after inclusion of this evidence it was unclear whether this was a significant risk factor because the evidence was limited. So a research recommendation was made to address this (see appendix L of evidence review B)
British Society of	Evidence Review B	General	General	"Risk factors for pelvic floor dysfunction" - the searches look as though they are set up to capture all possible risk factors for all possible PFDs, but in fact the included studies all have the term	Thank you for your comment.

Urogynaecology				"pelvic floor" in the title. The vast majority of studies of urinary or faecal incontinence, and indeed studies of prolapse alone, are mistakenly excluded.	Pelvic floor dysfunction is usually a constellation of a number of symptoms, and for intervention questions it made sense to consider symptoms in isolation since treatments are usually directed at specific symptoms so studies were included even if they only considered a single symptom. This was not the case for the evidence review on risk factors for pelvic floor dysfunction because it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor dysfunction" studies because these were the most relevant to our guideline.
British Society of Urogynaecology	Evidence review B	General	General	Risk factors for pelvic floor dysfunction **Maternal Age** is included as a non-obstetric risk factor but the evidence suggests that older age at first delivery is a risk factor for pelvic floor dysfunction. This should be emphasised further as the average age of first pregnancy in the UK has increased ((Office National Statistics UK 2011). It is stated that*: The evidence suggested that a number of obstetric risk factors increased a woman's risk of pelvic floor dysfunction.* ***This included, maternal age over 30 years****, which increased the risk of developing overactive bladder, urinary incontinence and pelvic organ prolapse.* References not included: Rahmanou P, Caudwell-Hall J, Kamisan Atan I, Dietz HP.The association between maternal age at first delivery and risk of obstetric trauma. Am J Obstet Gynecol. 2016 Oct;215(4):451.e1-7. doi: 10.1016/j.ajog.2016.04.032.	Thank you for your comment. We identified evidence that maternal age is a risk factor for pelvic floor dysfunction and this is noted in Box 1 of the guideline as "being over 30 years when having a baby". The studies listed in your comment were also found in our literature searches. Rahmanou 2016 and Waldentrom 2017 were not included because they looked at risks for obstetric trauma rather than pelvic floor dysfunction. Leijonhufud 2011 was not included because it was concerned with risk factors for stress urinary incontinence or pelvic organ prolapse surgery. Quiroz 2017 was excluded as a study measuring pelvic floor strength rather than pelvic floor dysfunction itself.

				Waldenström U, Ekéus C. Risk of obstetric anal sphincter injury increases with maternal age irrespective of parity: a population-based register study. .BMC Pregnancy Childbirth. 2017 Sep 15;17(1):306. Leijonhufvud A, Lundholm C, Cnattingius S, et al. Risks of stress urinary incontinence and pelvic organ prolapse surgery in relation to mode of childbirth. Am J Obstet Gynecol 2011;204:70.e1-6. Quiroz LH, Pickett SD, Peck JD, Rostaminia G, Stone DE, Shobeiri SA. Increasing Age Is a Risk Factor for Decreased Postpartum Pelvic Floor Strength. Female Pelvic Med Reconstr Surg. 2017 Mar/Apr;23(2):136-140. Urbankova I et al. The effect of the first vaginal birth on pelvic floor anatomy and dysfunction. *International Urogynecology Journal* 2019; 30:1689–1696.	Urbankova 2019 was included as evidence.
British Society of Urogynaecology	Evidence review B	General	General	Risk factors for pelvic floor dysfunction **Maternal height** Should be included • Mothers ≤160cm who delivered a child with birthweight ≥4000g had a doubled prevalence of POP symptoms compared with short mothers who delivered an infant weighing <4000g (24.2 versus 13.4%, OR 2.06; 95% CI 1.19–3.55)	Thank you for your comment. The committee were presented with some evidence (see evidence review B) of a small decreased risk of pelvic floor dysfunction for every cm increase in height (Urbankova, 2019). However, there was no evidence to suggest a height threshold to classify women as low or high risk. There was a greater body of evidence for height when combined with weight (as BMI) or as waist/height ratio. That is why BMI featured in Box 1 rather than weight or height alone. The

				Gyhagen M, Bullarbo M, Nielsen TF, Milsom I. Prevalence and risk factors for pelvic organ prolapse 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery. BJOG. 2013;120(2):152-60. • One centimeter increase in maternal height was associated with a 2% decrease in OASIS incidence at the first vaginal delivery. Raisanen S, Vehvilainen-Julkunen K, Cartwright R, Gissler M, Heinonen S. A prior cesarean section and incidence of obstetric anal sphincter injury. Int Urogynecol J. 2013;24(8):1331-9.	evidence on big babies was not clear and not significant (see Fritel et al. 2008) with an OR for birthweight below or above 4 kg of OR 0.74 (0.26, 2.07). It can also be a confounding factor since a heavier baby applies more intra-abdominal pressure and also could be associated with tears when delivered vaginally. In the evidence review on risk factors for pelvic floor dysfunction it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor dysfunction" studies because these were the most relevant to our guideline. The studies listed in your comment were not included as evidence because they were concerned with risk factors for pelvic organ prolapse (Gyhagen 2013) or obstetric anal sphincter injury (Raisanen 2013) rather than for the constellation of pelvic floor dsyfunction symptoms as a whole.
British Society of Urogynaecology	Evidence review B	General	General	Risk factors for pelvic floor dysfunction **VBAC:** a risk factor for OASI Should be included See D'Souza JC, Monga A, Tincello DG. Risk factors for obstetric anal sphincter injuries at vaginal birth after caesarean: a retrospective cohort study. Int Urogynecol J. 2019 Oct;30(10):1747-1753.	Thank you for your comment. Pelvic floor dysfunction is usually a constellation of a number of symptoms, and for intervention questions it made sense to consider symptoms in isolation since treatments are usually directed at specific symptoms so studies were included even if they only considered a single symptom. This was not the case for the evidence review on risk factors for pelvic floor dysfunction because it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor dysfunction" studies because these were the most relevant to our guideline..This is why D'Souza (2019) was not included.

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					The committee agreed that injury to the anal sphincter is a risk factor for PFD and it is listed with other risk factors in Box 1 of the guideline. Risk factors for injury to the anal sphincter, however were outside the scope of the guideline.
British Society of Urogynaecology	Evidence review B	General	General	Risk factors for pelvic floor dysfunction **Forceps: a high risk factor for obstetric pelvic floor injury** Should be included **See:** Friedman T, Eslick GD, Dietz HP. Delivery mode and the risk of levator muscle avulsion: a meta-analysis. *Int Urogynecol J.* 2019;30:901-907. **Higher risk of OASI compared with Ventouse; this should be highlighted.** Appendix L – Research recommendations Research recommendations for review question: Risk factors for pelvic floor dysfunction ***No research recommendations were made for this review question*** **Why not?** **For example, there is conflicting evidence about the effect of waterbirth on PFD risk; this is an important research question.** **Less stress urinary incontinence after waterbirth:** Liu, Y., Liu, Y., Huang, X. *et al.* A comparison of maternal and neonatal outcomes between water immersion during labor and conventional labor and delivery. *BMC Pregnancy Childbirth* 2014;**14:** 160. https://doi.org/10.1186/1471-2393-14-160	Thank you for your comment. Studies of risk factors for obstetric pelvic floor injury were not included as this area is covered in the NICE guideline on Intrapartum care for healthy women and babies (CG190). This is why Friedman (2019) and Liu (2014) were not included as evidence. There was evidence that obstetric pelvic floor injury and assisted vaginal birth are risk factors for pelvic floor dysfunction and these are listed in Box 1 of the guideline.

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British Society of Urogynaecology	Evidence review D	General	General	**Prediction tools for pelvic floor dysfunction** We would strongly support UR-CHOICE as a research recommendation to predict and potentially provide individual risk assessment in pregnancy, as alluded to: ***Importance to 'patients' or the population Having an effective tool that can accurately predict if a woman is likely to be at an increased risk of developing pelvic floor dysfunction would enable preventative strategies to be offered with the aim of preventing pelvic floor dysfunction developing.*** Jelovsek, J. E., Chagin, K., Gyhagen, M., Hagen, S., Wilson, D., Kattan, M. W., Elders, A., Barber, M. D., Areskoug, B., MacArthur, C., Milsom, I., Predicting risk of pelvic floor disorders 12 and 20 years after delivery, Am J Obstet Gynecol, 218, 222.e1-222.e19, 2018 ***Development of prognostic models to estimate risk of developing PFD***	Thank you for your comment. We are aware of UR-CHOICE and utilised it when developing the health economic model on preventative pelvic floor muscle training for this guideline. However, an existing published prediction model would not constitute a study design that met the inclusion criteria and it was therefore excluded (see appendix K of evidence review D). The committee recognised the importance of prediction tools such as UR-CHOICE, so decided to prioritise this for a research recommendation for this topic (see appendix L - 'What is the effectiveness of prediction tools for identifying women at risk of pelvic floor dysfunction?'). We have added UR-CHOICE to the details of the proposed research design as an example of one such tool.
British Society of Urogynaecology	Evidence review J	General	General	**Weight loss interventions** A reference not included: Auwad W, Steggles P, Bombieri L, Waterfield M, Wilkin T, Freeman R**.** Moderate weight loss in obese women with urinary incontinence: a prospective longitudinal study. Int Urogynecol J Pelvic Floor Dysfunct. 2008 Sep;19(9):1251-9.	Thank you for your comment. The Auwad 2008 study was picked up by our searches, but was excluded at the title and abstract screening stage because it is not a randomised controlled trial and therefore would not meet inclusion criteria.
British Society of Urogynaecology	Guideline	General	General	Introduction The Guideline states "***Women with risk factors would benefit from information on lifestyle changes and advice about other healthcare decisions that could prevent or reduce the symptoms of pelvic floor dysfunction.***	Thank you for your comment. The committee highlighted a number of risk factors but also advice on how they (particularly the modifiable) can be addressed. So for example lack of exercise and a high BMI can be addressed by giving advice about exercise, physical activity, diet and weight loss as outlined in recommendations

				However, recommendations on how this information should be given needs clarification. For example evidence suggests that this does not happen even in higher risk women eg S. Rachaneni, I. Gurol-Urganci, M. Basuc, R. Thakar, A. Sultan, R. Freeman. Short statured primigravidae: Options for the obstetric management from a survey of UK obstetricians. European Journal of Obstetrics & Gynecology and Reproductive Biology 2021; 256 (2021) 379–384	1.3.1 to 1.3.5 (other advice is also included in recommendations). There are also whole sections on raising awareness, communication and information provision to outline the advice and how it should be given (altogether 17 recommendations). The cited studies would not have met inclusion criteria because they are on the wider issues associated with giving advice and not specifically related to pelvic floor dysfunction.
British Society of Urogynaecology	Guideline	General	General	Should there be a definition of PFD at the start rather than the conditions it includes?	Thank you for your comment. The committee added the following to the beginning of the guideline: Pelvic floor dysfunction is a condition where the pelvic floor muscles around the bladder, anal canal, and vagina do not work properly. The committee decided that it is important to also keep the list of symptoms associated with this.
British Society of Urogynaecology	Guideline	General	General	Does this guideline distinguish between PFD caused by non-pregnancy related causes.	Thank you for your comment. There are some sections of the guideline that specifically refer to pregnancy but others are general recommendations for all women with or without symptoms. This follows the evidence that was identified which was sometimes restricted to maternity settings and other times had unspecified or non-pregnant participants. Since the general focus of the guideline is on tailoring the interventions, either preventative or non-surgical management, to the individual woman and her symptoms the committee did not agree that there is a clear division between non-pregnancy and pregnancy related pelvic floor dysfunction and have therefore not organised or divided the guideline in that way.

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British Society of Urogynaecology	Guideline	006	006	NHSE have already commissioned services for all pregnant women to enable every pregnant woman to see a physiotherapist antenatally for education and instruction. This should be made clear in the document as pilot sites (Early implementer sites) are already providing this service and by 2022, all units providing maternity care are expected to do the same.	Thank you for your comment. This new initiative is welcomed by the committee but it only refers to short term contact, so even though it would support the recommendations in the guideline it would not be the same as a full pelvic floor muscle training programme. The committee reflected on their recommendation on supervised pelvic floor muscle training for the prevention of pelvic floor dysfunction and noted that a routine offer of this would have a significant resource impact. The committee therefore decided to not make this a routine offer but consider this for pregnant women in the categories previously specified based on need and availability. This could potentially have an overlap with this new initiative.
British Society of Urogynaecology	Guideline	011	006	Why is the recommendation to offer supervised PFMT from 20 weeks only in pregnant women with a first degree relative of PFD rather than everyone? Also why are only select women with risk factors are during labour advised PFMT? (1.3.11)	Thank you for your comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is.
British Society of Urogynaecology	Guideline	014	002	Assessment in primary care : who is expected in primary care to carry out this assessment?	Thank you for your comment. The committee did not want to be too prescriptive about the particular role in primary care who would provide the assessment because they noted that this would depend on

					the type of symptoms the women would present with, the severity and any other relevant circumstances. However, the committee has amended the 'assessment' section heading to ' Assessment in primary care or community-based services'. The have also amended recommendation 1.5.1 to: 'initial assessment in primary care or community-based services (which may include assessments by physiotherapists, bladder and bowel team members and continence advisors)' to highlight that this could be done by other professionals rather than being restricted to GPs.
British Society of Urogynaecology	Guideline	014	007	There is little mention of defecatory problems which can present in this population as the main complaint of PFD.	Thank you for your comment. This is a broad list of symptoms used to define pelvic floor dysfunction which was part of the guideline scope. Defecatory problems could feature under emptying disorders of the bowel.
British Society of Urogynaecology	Guideline	015	011	Why is a rectal exam being advised for impaction? Surely this can be obtained from the patient's history?	Thank you for your comment. Depending on the symptoms that were reported and potentially to rule out other causes it may be advisable to have such an examination. This would therefore not apply to all women. However, we have amended this point to read 'rectal examination to check for impaction, for women who are at risk of this and who cannot give an accurate history of their symptoms (for example women with cognitive impairments or dementia)' to clarify this point.
British Society of Urogynaecology	Guideline	016	003	What is meant by a community based multidisciplinary team approach for the m/m of PFD? Who is expected to undertake 1.6.2 as this may be overly ambitious.	Thank you for your comment. There is a wide range of potentially relevant professionals that could be part of the team or team(s). As highlighted in the rationale section the committee did not want to be prescriptive about the roles that should be included because this could be associated with considerable costs. It is clear that these competencies are unlikely to be filled by a single

					role but that the types of roles could vary according to available resources, practicalities and what the emphasis of the particular service consists of (for example if the emphasis is on Pelvic floor dysfunction related to pregnancy the make-up may be very different to Pelvic floor dysfunction related to older women). Some of the existing services like continence advice services could also be used to cover some pelvic floor dysfunction community-based multidisciplinary team work. To clarify that this would be done by different members the preamble to the list was amended to 'The community-based multidisciplinary team (or teams) should have members with competencies related to assessing and managing pelvic floor dysfunction, such as…'.
British Society of Urogynaecology	Guideline	019	009	Why is the duration of PFMT recommended different for POP (4 mths), SUI (3 mths) and FI (4 mths).	Thank you for your comment. There as a large evidence base for pelvic floor muscle training and the length of the recommended programme is consistent with length of the programme that showed it to be effective. This varied by symptom.
Caesarean Birth	Guideline	General	General	Page 54 of the NICE draft reads (my bold): "This guideline makes **recommendations on common risk factors and on preventative interventions**. Ideally, women who are most at risk of pelvic floor dysfunction would be identified early and **offered interventions** to prevent symptoms developing. This would reduce the impact on women and the NHS." Given this statement, my organisation is very concerned that planned, prophylactic caesarean birth is not appropriately represented or discussed in this draft guideline. In fact, despite numerous references to childbirth, risk factors, and an emphasis on communication and providing information, 'caesarean birth' is not mentioned even once. Decades of scientific evidence on pelvic floor damage and its association with different modes of	Thank you for your comment. The committee wanted to emphasise that decisions about mode of birth are multifactorial and women should make informed choices based on benefits and risks (of which symptoms of pelvic floor dysfunction would be part of the consideration). The committee have added a new recommendation which makes a cross reference to the section on benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth so that women can make an informed decision that is not restricted to symptoms of pelvic floor dysfunction.

				birth is barely acknowledged. Particularly in light of the Montgomery Supreme Court judgment in 2015, and NICE's commitment to "standardise the information and advice that is provided to women, to enable better shared decision making", can the NICE committee please explain this oversight (or reason for conscious exclusion of references to this birth mode) in the proposed guideline? Thank you.	Pelvic floor dysfunction is usually a constellation of a number of symptoms, and for intervention questions it made sense to consider symptoms in isolation since treatments are usually directed at specific symptoms so studies were included even if they only considered a single symptom. This was not the case for the evidence review on risk factors for pelvic floor dysfunction because it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor dysfunction" studies because these were the most relevant to our guideline.. The committee considered evidence identified on modes of birth relating to a number of symptoms of pelvic floor dysfunction. Although none of the studies used the term "planned caesarean", the evidence did include "elective caesarean" and "caesarean with no labour" which were compared with "natural vaginal birth" or "non-operative vaginal birth". The evidence also included comparisons of "spontaneous vaginal birth" with "caesarean section". The GRADE tables for evidence review B (see appendix F) on risk factors included 80 study outcomes related to comparisons of birth/mode of birth, including caesarean, and the committee's consideration of this evidence was reflected in the box of pelvic floor dysfunction risk factors. This box included risk factors directly related to vaginal birth.
Caesarean Birth	Guideline	General	General	The draft guideline highlights the importance of 'tailoring information to each woman's age' (page 13), and includes 'being over 30 years when having a baby' (page 8) as a risk factor for pelvic floor dysfunction. Again, given evidence such as that cited in the study below, why is there not more specific information and/or recommendations	Thank you for this comment. The study cited (Rahmanou, 2016) did not meet the inclusion criteria for our review as it focused on a single symptom. Pelvic floor dysfunction is usually a constellation of a number of symptoms, and for intervention questions it made sense to

				on the information about different birth mode plans to be communicated to pregnant women? (2016) The association between maternal age at first delivery and risk of obstetric trauma (https://pubmed.ncbi.nlm.nih.gov/27131580/) There is a significant association between the risk of major pelvic floor injury and increasing maternal age at first delivery.	consider symptoms in isolation since treatments are usually directed at specific symptoms so studies were included even if they only considered a single symptom. This was not the case for the evidence review on risk factors for pelvic floor dysfunction because it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor dysfunction" studies because these were the most relevant to our guideline. Our evidence review did find that maternal age over 30 years, increased the risk of developing overactive bladder, urinary incontinence and pelvic organ prolapse (Fritel, 2018) and the committee believe this is adequately addressed in the recommendations for discussing risk factors for pelvic floor dysfunction. Mode of birth plans were out of the scope of the guideline.
Caesarean Birth	Guideline	General	General	In the context of informing women appropriately, and offering interventions to prevent symptoms developing, did the NICE committee consider *any* evidence on the prophylactic benefits of planned caesarean birth for women's pelvic floor health? If not, why not, and if yes, why was it excluded?	Thank you for this comment. The review on risk factors was intended to provide evidence based information on risk factors for pelvic floor dysfunction which could be communicated with women. The search for this review question was designed so as not to limit the number of risk factors identified. The committee wanted to emphasise that decisions about mode of birth are multifactorial and women should make informed choices based on benefits and risks (of which symptoms of pelvic floor dysfunction would be part of the consideration). The committee have added a new

					recommendation which makes a cross reference to the section on benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth so that women can make an informed decision that is not restricted to symptoms of pelvic floor dysfunction. The committee considered evidence identified on modes of birth relating to a number of symptoms of pelvic floor dysfunction. Although none of the studies used the term "planned caesarean", the evidence did include "elective caesarean" and "caesarean with no labour" which were compared with "natural vaginal birth" or "non-operative vaginal birth". The evidence also included comparisons of "spontaneous vaginal birth" with "caesarean section". The GRADE tables for evidence review B (see appendix F) on risk factors included 80 study outcomes related to comparisons of birth/mode of birth, including caesarean, and the committee's consideration of this evidence was reflected in the box of pelvic floor dysfunction risk factors. This box included risk factors directly related to vaginal birth.
Caesarean Birth	Guideline	General	General	My organisation was surprised to note the absence of macrosomia as a risk factor for pelvic floor dysfunction, especially as it is an association that has been cited in numerous studies. For example: (2013) Vaginal childbirth and pelvic floor disorders (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3877300/) “Several studies have linked vaginal childbirth to pelvic organ prolapse. ...In one study, history of a single vaginal delivery was associated with a tenfold increased likelihood of developing prolapse. …Among vaginally parous women, observational studies have identified certain obstetrical factors that may increase the risk of PFDs. These factors include operative vaginal delivery, prolonged second stage of labor, **fetal**	Thank you for this comment. Pelvic floor dysfunction is a constellation of a number of symptoms, and for intervention questions it made sense to consider symptoms in isolation since treatments are usually directed at specific symptoms so studies were included even if they only considered a single symptom. This was not the case for the evidence review on risk factors for pelvic floor dysfunction because it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor

				macrosomia and perineal lacerations. These risk factors often occur in clusters, and may impact pelvic floor outcomes synergistically." In the list of 'non-modifiable risk factors related to pregnancy' on page 8, NICE includes 'assisted vaginal birth (forceps or vacuum)' and 'injury to the anal sphincter during birth', but not 'large baby'. Can the committee provide the reason for this please? Also, please consider this recent news story: (2021) First-time mother gives birth to 13lbs baby girl - the second biggest in the UK - after her bump was so big doctors thought she was having twins and her skin stretched so much it bled (https://www.dailymail.co.uk/femail/article-9520151/Mum-astonished-gave-birth-13lbs-baby-girl-second-biggest-UK.html) It would suggest the bar for offering women a planned caesarean birth (or even discussing it) is currently too high within some NHS hospital teams, and this results in mothers living with injuries they might choose to avoid. In this case, the maternity team eventually decided to allow an emergency caesarean birth, but it is clear that even though macrosomia was more than evident at two weeks overdue in the pregnancy, their primary plan was to aim for vaginal birth (through induction), which included the possibility of a forceps delivery, and therefore increased risk of pelvic floor damage. The above is not an isolated case, and if the NICE committee needs further evidence, organisations like Caesarean Birth, the MASIC Foundation and Birth Trauma Association could provide further examples of women who were not informed of the pelvic floor risks associated with having a large baby, and now live with (often life-changing) damage to their bodies. It is imperative that	dysfunction" studies because these were the most relevant to our guideline. Our evidence review did not find any evidence of macrosomia as an independent risk factor which is why it was not included. Handa (2011) which was included in our review, controlled for macrosomia in their analysis of pelvic floor disorders after obstetric avulsion of the levator ani muscle as a confounding variable. This confounding might explain why our review did not find evidence on macrosomia as a risk factor as association does not imply causation. Generally, it is not possible to identify macrosomia until after birth and NICE guidelines are not intended to cover every conceivable clinical scenario. NICE does not consider news stories as a source of evidence but rather relies on systematic reviews of the published literature according to a pre-specified protocol (for details see appendix A of any evidence review). The interpretation of the included evidence is then supplemented by the experience and expertise of the committee.

				the lived experiences of these mothers are reflected in this guideline, and that NICE does not ignore or discount the evidence, and does not withhold information about different birth mode choices that some women may otherwise not know about.	
Caesarean Birth	Guideline	General	General	NICE asks, “Would implementation of any of the draft recommendations have significant cost implications?” My organisation would answer this by highlighting the significant cost implications of NICE **not** including (and implementing communication of and information about) planned caesarean birth as part of its draft recommendations. - Most importantly, there is the human cost (physical and psychological) experienced by women who only find out about their individualised risk of pelvic floor damage with a planned vaginal birth in hindsight (with and without instrumental delivery), after the damage has occurred. They realise too late that other women (including doctors) had knowledge, information and access to birth plan choices that they did not, and must deal with the injustice of this inequity in addition to the pelvic floor damage itself. - There is a financial cost for these mothers too; incontinence products, pessaries and private physiotherapy (for example) can be lifetime expenses, even when treatment improves their symptoms. - There is a cost to the NHS of treating the mother’s injuries, which can include psychological support, physiotherapy and/or rehospitalisation should surgery be needed. - There is also the litigation cost associated with maternity care in the NHS, of which pelvic floor damage is increasingly significant.	Thank you for this comment. The committee recognise that costs vary according to mode of birth but choices about mode of birth are outside the scope of this guideline. The recommendations in this guideline are not intended to favour any particular mode of birth although they do recognise that birth can impact on pelvic floor function. However, a new recommendation has been added which makes a cross reference to the section on the benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth. The committee’s aim was that their recommendations, in conjunction with other NICE guidance, will make women better informed to make choices related to mode of birth but they do not anticipate that their recommendations would have a significant impact on the rate of planned caesarean or any other mode of birth

				Almost a decade ago, in 2012, an NHS Resolution (then NHSLA) report said that for claims concerning women, "**perineal trauma is one of the largest areas of litigation**" (https://resolution.nhs.uk/wp-content/uploads/2018/11/Ten-years-of-Maternity-Claims-Final-Report-final-2.pdf), and notably, this was three years before Montgomery. Awareness of the issue has grown even more since then, and it is not uncommon to see mothers advising each other on social media to contact a solicitor when they are injured during childbirth. What was once accepted as a 'normal sequelae of childbirth' is being re-examined in light of Montgomery and the recognition in law (and increasingly, culturally) of an alternate birth mode that may reduce the risk of severe pelvic floor injuries. Both women and lawyers are taking note. A 2019 Australian article about litigation following birth trauma notes: "In the wake of significant court cases here and overseas, law firms are reporting a steady increase in the number of women starting proceedings against hospitals and doctors over **lack of information, following injuries sustained during vaginal births**." (https://www.illawarramercury.com.au/story/6219328/they-didnt-respect-me-as-a-mum-women-sue-doctors-over-birth-trauma/) In January 2020, the law firm Leigh Day tweeted: "The RCOG estimates that over 85% of women who have a vaginal birth will suffer some degree of perineal trauma. Where negligence can be proved, our team represents clients who have suffered 3rd and 4th degree tears. #BirthInjury…" (https://twitter.com/LeighDay_Law/status/1148917399661481991) None of this is to suggest that all women would or should plan a caesarean birth, and it is important to emphasise that surgery	

				(especially for women planning larger families) also introduces risk of serious maternal injuries, but the key point here is that information about both modes of birth must be communicated to all women in order for them to make an informed decision. It is the women who will be living with the health outcomes of the plan they choose, and since preferences and tolerances vary in different people, NICE guidance cannot be seen to be biased one way or the other.	
Caesarean Birth	Guideline	General	General	Throughout this feedback, my organisation has presented the view that planned caesarean birth needs to be included in a guideline that includes potential actions women may take to prevent serious pelvic floor damage. Below is an exchange on Twitter that supports this view; it is between the MASIC Foundation charity and a doctor who chose a caesarean birth. *The MASIC Foundation (June 2019):* Maternal injury causes lifelong sexual dysfunction, prolapse, chronic pain, faecal and urinary incontinence. Maternal injury ruins lives. **Maternal injury can be prevented**. #avoidableharm #informedconsent #RCOG2019 https://twitter.com/masic_uk/status/1141025986999463936 *Doctor responding:* It also causes problems with further pregnancies. The cervix injuries my mother suffered from her #forceps delivery led to my premature birth years later (my brother didn"t survive his birth). I'm so sorry for my mum they didn't make a safe #caeserian https://twitter.com/BernadetNemeth/status/1141097233108090880 "**It is important that women can choose. I could because I'm a doctor myself. Most mothers can't**". (June 2019) https://twitter.com/BernadetNemeth/status/1141217703996383232	Thank you for this comment. NICE does not consider Twitter as a source of evidence but rather relies on systematic reviews of the published literature according to a pre-specified protocol (for details see appendix A of any evidence review). The interpretation of the included evidence is then supplemented by the experience and expertise of the committee, made up of various health care professionals and lay members. The committee do not wish women to plan a caesarean birth in order to prevent pelvic floor dysfunction, as decisions about mode of birth concern a balance of benefits and risks that extend beyond pelvic floor function. However, a new recommendation has been added which makes a cross reference to the section on benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth.

Pelvic floor dysfunction: prevention and non-surgical management
Consultation on draft guideline - Stakeholder comments table
28/06/2021 to 09/08/2021

				2 *The MASIC Foundation responding:* "An important point. **Doctors can seemingly choose to have a caesarean fully informed of risks, whilst the rest of us can't? This clearly indicates that risks of vaginal birth going wrong ARE known by medical community**. Shocking." https://twitter.com/masic_uk/status/1141245177203494912	
Caesarean Birth	Guideline	General	General	Below are some examples of studies relevant to Caesarean Birth's proposed changes and/or additions to this draft guideline, which I hope the committee will consider. Thank you. (2021) Pelvic Floor Morbidity Following Vaginal Delivery versus Cesarean Delivery: Systematic Review and Meta-Analysis https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8070303/ **Vaginal delivery is directly related to the appearance of pelvic floor disorders**, mainly UI, POP, and AI. The risk of POP should be taken into higher consideration after vaginal delivery and postpartum follow-up should be performed, to identify and/or treat it at the earliest stages. (2020) Evolution and risk factors of anal incontinence during the first 6 years after first delivery: a prospective cohort study (https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.16322) Among women, **childbirth is one of the most persistent and important factors for developing pelvic floor disorders** such as anal (AI) and urinary incontinence. Only women with first deliveries complicated by OASIS or instrumental intervention had increased prevalence of postpartum AI at 6 years. Mode of first delivery modified AI prevalence during the 6-year period (2019) The effect of the first vaginal birth on pelvic floor anatomy	Thank you for this comment and for the list of suggested studies. The date of the last search for the evidence review on risk factors was 20 November 2019 and therefore we did not consider studies published after this date. Pelvic floor dysfunction is a constellation of a number of symptoms, and for intervention questions it made sense to consider symptoms in isolation since treatments are usually directed at specific symptoms so studies were included even if they only considered a single symptom. This was not the case for the evidence review on risk factors for pelvic floor dysfunction because it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction symptoms, so for this question any studies focusing only on a single symptom were excluded. It was important to focus on the "pelvic floor dysfunction" studies because these were the most relevant to our guideline. Urbankova (2019) and Blomquist (2018) were included in our evidence review.

				and dysfunction (https://link.springer.com/article/10.1007/s00192-019-04044-2) Though maternal characteristics at birth such as **age or BMI** increase the risk of PFD, **labour and birth factors play a similarly important role**. The most critical risk factor for MLA avulsion was **forceps delivery**, while an epidural had a protective effect. (2018) Association of Delivery Mode With Pelvic Floor Disorders After Childbirth (https://jamanetwork.com/journals/jama/article-abstract/2718794) Compared with spontaneous vaginal delivery, **cesarean delivery was associated with significantly lower hazard for stress urinary incontinence, overactive bladder, and pelvic organ prolapse**, while **operative vaginal delivery was associated with significantly higher hazard of anal incontinence and pelvic organ prolapse**. A **larger genital hiatus** was associated with increased risk of pelvic organ prolapse independent of delivery mode. (2018) Long-term risks and benefits associated with cesarean delivery for mother, baby, and subsequent pregnancies: Systematic review and meta-analysis (https://pubmed.ncbi.nlm.nih.gov/29360829/) When compared with vaginal delivery, cesarean delivery is associated with a reduced rate of urinary incontinence and pelvic organ prolapse, but this should be weighed against the association with increased risks for fertility, future pregnancy, and long-term childhood outcomes. This information could be valuable in counselling women on mode of delivery. (2017) Psychological consequences of pelvic floor trauma following vaginal birth: a qualitative study from two Australian tertiary maternity units	Skinner (2018) is a qualitative study and therefore does not meet the inclusion criteria of the review protocol (see appendix A of evidence review B). Vergeldt (2015) focuses on a single symptom and not on a constellation of pelvic floor dysfunction symptoms and therefore although our search identified this study it did not meet the inclusion criteria. Mazouni (2010) focuses on risk factors for forceps delivery which is not a symptom of pelvic floor dysfunction. Patel (2006) is a review/opinion article and therefore although our search identified this study it did not meet the inclusion criteria

				(https://pubmed.ncbi.nlm.nih.gov/29256069/#:~:text=Women%20who%20sustain%20LAM%20damage,the%20severity%20of%20this%20damage) Vaginal birth may result in damage to the levator ani muscle (LAM) with subsequent pelvic floor dysfunction and there may be accompanying psychological problems. This study examines associations between these somatic injuries and psychological symptoms. A qualitative study using semi-structured interviews to examine the experiences of primiparous women (n = 40) with known LAMtrauma was undertaken. Participants were identified from a population of 504 women retrospectively assessed by a perinatal imaging study at two obstetric units in Sydney, Australia. LAM avulsion was diagnosed by 3D/4D translabial ultrasound 3–6 months postpartum. The template consisted of open-ended questions. Main outcome measures were quality of information provided antenatally; intrapartum events; postpartum symptoms; and coping mechanisms. Thematic analysis of maternal experiences was employed to evaluate prevalence of themes. Ten statement categories were identified: (1) **limited antenatal education (29/40)**; (2) **no information provided on potential morbidities (36/40)**; (3) conflicting advice (35/40); (4) traumatized partners (21/40); (5) long-term sexual dysfunction/relationship issues (27/40); (6) no postnatal assessment of injuries (36/40); (7) multiple symptoms of pelvic floor dysfunction (35/40); (8) **"putting up" with injuries (36/40)**; (9) symptoms of posttraumatic stress disorder (PTSD) (27/40); (10) dismissive staff responses (26/40). Women who sustain LAM damage after vaginal birth have reduced quality of life due to psychological and somatic morbidities. PTSD symptoms are common. **Clinicians may be unaware of the severity of this damage. Women report they feel traumatized and abandoned because such morbidities were not discussed prior to birth or postpartum.**	

				(2015) Risk factors for pelvic organ prolapse and its recurrence: a systematic review (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4611001/) this systematic review showed that **parity, vaginal delivery, age, and BMI** were confirmed risk factors for the development of POP (2010) Risk factors for forceps delivery in nulliparous patients (https://obgyn.onlinelibrary.wiley.com/doi/10.1080/00016340500500782) **Age over 35 years and induction of labor** (2006) Childbirth and pelvic floor dysfunction: An epidemiologic approach to the assessment of prevention opportunities at delivery (https://www.sciencedirect.com/science/article/pii/S0002937806000767?via%3Dihub) The overall model for the development of PFD in women includes factors that predispose (eg, **family history of PFD**), incite (eg, vaginal delivery through its effect on nerve damage, muscle damage, and tissue disruption),	
Caesarean Birth	Guideline	General	General	There are seven references to embarrassment in this draft guideline, though I would suggest there has been a marked increase in women speaking out publicly about their pelvic floor injuries in recent years (including the mesh scandal). Would the committee agree that pelvic floor injury appears to be less of a taboo subject than it was previously?	Thank you for this comment. The committee did not review evidence on temporal changes in levels of embarrassment experienced by women in relation to pelvic floor dysfunction but did find evidence with respect to embarrassment which they think supports the related recommendations
Caesarean Birth	Guideline	General	General	Might the NICE committee consider renaming this guideline (or parts of it)? While clinically and medically appropriate, the word “dysfunction” can be jarring at times, especially in a guideline that outlines	Thank you for this comment. This guideline was originally given the title "Prevention and non-surgical treatment of pelvic floor failure" but this was changed as a result of comments received by NICE during

				modifiable behaviours and actions by women that could help prevent their body being 'dysfunctional', but may suggest that if these personal modifications are not made, women are therefore partially responsible for their bodies' dysfunction. Possible suggestions for alternatives throughout include "damage", "injury" or "disorder".	scoping. Pelvic floor dysfunction reflects terminology used in the NHS (e.g. https://www.england.nhs.uk/2021/06/nhs-pelvic-health-clinics-to-help-tens-of-thousands-women-across-the-country/) and also aligns with the general research terminology on this topic.
Caesarean Birth	Guideline	General	General	Thank you very much for the opportunity to comment on this draft guideline.	Thank you for your comments.
Caesarean Birth	Guideline	009 - 012	003	Re: Section 1.3 Preventing pelvic floor dysfunction There is no mention of planned caesarean birth as a way of preventing this, despite significant numbers of medical professions making this birth choice with the intention of protecting their pelvic floor and reducing the risk of damage. The omission does not provide balanced information, but rather adds another layer of withholding information from lay pregnant women that medical professionals have the privilege of knowing through their personal network, higher education, training and clinical experience. 1.3.11 suggests offering prophylactic measures for women "following risk factors during birth", yet planned caesarean birth is not mentioned (even for women in a second pregnancy who have experienced pelvic floor damage during their first birth and who may be living with subsequent long-term dysfunction as a result). Furthermore, the information provided on these pages places the responsibility for prevention of pelvic floor dysfunction on the woman; actions *she* should take and consistently follow through with. A reader might interpret that it therefore follows the *woman* is to blame if *dysfunction* is not prevented or relieved. My organisation does not suggest this is NICE's intention, but it is how it may come across, especially in the absence of a	Thank you for this comment. The committee wanted to emphasise that decisions about mode of birth are multifactorial and women should make informed choices based on benefits and risks (of which symptoms of pelvic floor dysfunction would be part of the consideration). The committee have added a new recommendation which makes a cross reference to the section on benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth so that women can make an informed decision that is not restricted to symptoms of pelvic floor dysfunction. . The committee did not think the wording of the recommendations would be interpreted by most readers as implying that the woman is to blame if pelvic floor dysfunction is not relieved or prevented. The committee recognise that there are measures that women can take to reduce their risk of pelvic floor dysfunction and the recommendations encourage them to do so, as well as outlining the responsibility of health care professionals to provide advice.

				prophylactic action (planned caesarean birth) that is only available to some.	The recommendations also recognise that there are non-modifiable risk factors.
Caesarean Birth	Guideline	010 - 011	018 - 020 & 001 - 002	Re: Pelvic floor muscle training… Encourage women of all ages to do pelvic floor muscle training… Encourage women to continue pelvic floor muscle training throughout their life, because long-term training continues to help prevent symptoms Suggest modifying this slightly, to warn against the dangers of overzealous pelvic floor strength training, which can cause an overly tight pelvic floor (bands or knots of tight, painful muscle fibers can also cause debilitating pain).	Thank you for your comment. The recommendation referred to is about general encouragement the details of which should be tailored to the individual women. The aim is to motivate more women to do this and adding a caution to this would potentially discourage women when currently not enough women regularly do such training. Furthermore, no evidence of harm was identified in the included studies so the committee was unable to comment on this in the guideline.
Caesarean Birth	Guideline	040 - 041	028 - 029	Re: There was evidence that healthcare professionals may overlook symptoms of pelvic floor dysfunction in women who have recently given birth. …To address this the committee emphasised that women who have recently given birth should be asked about symptoms. This is an important inclusion in the guideline, and one that is supported by evidence in qualitative research: (2017) "Clinicians may be unaware of the severity of this damage. Women report they feel traumatized and abandoned because **such morbidities were not discussed prior to birth** or postpartum." https://pubmed.ncbi.nlm.nih.gov/29256069/#:~:text=Women%20who%20sustain%20LAM%20damage,the%20severity%20of%20this%20damage)	Thank you for this comment in support of the guideline.
Caesarean Birth	Guideline	032 - 033	031 & 001	Re: Normalisation is important, because embarrassment often gets in the way of discussions about pelvic floor dysfunction. There may be potential benefits of normalising knowledge and discussion about pelvic floor anatomy, but again, normalising	Thank you for this comment. The committee did not consider that this wording implied that 'dysfunction' was being normalised but rather this 'normalisation' referred to discussions about problems that

				dysfunction has potential risks.	might arise with the pelvic floor and how these problems may be mitigated. Whilst pelvic floor anatomy is part of that discussion that does not in itself capture the inability to contract the pelvic floor or the measures that can be taken to improve pelvic floor function.
Caesarean Birth	Guideline	001	006	Table Re: It recommends interventions based on the specific symptoms women are experiencing (such as urinary or faecal incontinence) Please **add pelvic organ prolapse** here (lines 12-13 on page 4 state: The 3 most common and definable symptoms are urinary incontinence, faecal incontinence and pelvic organ prolapse).	Thank you for your comment. We have removed the examples because the committee agreed that listing only 2 would potentially be confusing and adding all symptoms would be too detailed for this section.
Caesarean Birth	Guideline	004	018	Re: visual aids to help identify potential causes of symptoms Suggest: visual aids to help identify potential **reasons for** symptoms	Thank you for this comment. Whilst 'causes' and 'reasons' are synonyms the committee considered it was more common to refer to 'causes' and therefore retained the original wording for this recommendation.
Caesarean Birth	Guideline	005	013	Re: Settings Suggest adding social media here too.	Thank you for this comment. Social media is included under "formats" and therefore would represent duplication. Furthermore, "websites" are included under the "settings" sub-heading and interpreted broadly this would include social media web pages.
Caesarean Birth	Guideline	006	009	Re: at all midwife consultations and reviews Please change to: at midwife **and/or obstetrician** consultations and reviews (deleting “all”). It is not clear why it would be necessary for ‘information on pelvic floor dysfunction symptoms and how to access local services’ to be discussed at “all” consultations and reviews. This could make some women feel as though they are being pressured to plan a caesarean birth, while others may find repeated reassurances an attempt to downplay the risk of pelvic floor damage with a planned vaginal birth. It is also important to include obstetricians	Thank you for this comment. The committee were aware that a downside of their recommendation is that women could be provided information about pelvic floor dysfunction many times during their pregnancy. However, as discussed in the rationale and impact, the committee believed this was reasonable because this is a time when symptoms often first occur and that it helps "normalise" these discussions in a context where embarrassment may be a barrier to effective communication.

				here as well as midwives; many women have obstetrician-led care and/or may have very specific questions for a doctor (e.g. if this is their second pregnancy and they were injured during their first birth).	
Caesarean Birth	Guideline	006	010 - 011	Re: Health visitors, midwives and GPs should discuss pelvic floor dysfunction with women at each postnatal contact Suggest: Health visitors, midwives, **obstetricians** and GPs should discuss pelvic floor dysfunction with women at each postnatal contact Again, it is important that obstetricians are identified and recognised in this guideline; they have a role and responsibility in maternity care too. Also, does the NICE committee agree that it is important for these discussions to avoid simple messaging such as “do your kegels” (which can do more damage than good in some cases)?	Thank you for this comment. The committee would agree that discussions should avoid simple messaging and would expect these discussions to reflect the guideline's recommendations on "Communicating and providing information to women with pelvic floor dysfunction". Obstetricians have been added to the bullet list of this recommendation.
Caesarean Birth	Guideline	006	012 - 014	Re: Teach young women (between 12 and 17 years) in school about pelvic floor anatomy, pelvic floor muscle exercises and how to prevent pelvic floor dysfunction. My organisation welcomes this recommendation in principle (pelvic floor anatomy and how to prevent pelvic floor dysfunction more so than pelvic floor muscle exercises), but considers age 12 to be too young (see comment #33). There are also concerns about its delivery in practice, as there may be a danger of trying to influence birth mode choices. This is an example of proposed education about childbirth in schools in Canada: (2017) Providing women with early knowledge about childbirth could help reduce unnecessary caesareans (https://www.news-medical.net/news/20170920/Providing-women-with-early-knowledge-about-childbirth-could-help-reduce-unnecessary-cesareans.aspx)	Thank you for this comment in support of the guideline recommendation. It is usual in NICE guidelines for the age group 12-17 years to be classified as "young people" or, in the context of this guideline, "young women" (see the NICE style guide). It is specified in the guideline scope that the groups that will be covered in the guideline are "women, including young women aged 12 years and older". Evidence was found (see Evidence Review A) that "that introducing a pelvic floor health curriculum within schools improved the knowledge of young women aged 13-17 years". Whilst this was low quality evidence, the committee considered it important as preventative action could be taken early in life to prevent pelvic floor dysfunction in the future. The committee considered that educating young women (aged 12 to 17) about pelvic floor dysfunction would certainly not do any

				Cesarean deliveries in most developed countries, including Canada, are at least 10 to 20 per cent higher than recommended by the World Health Organization, and many efforts to decrease unnecessary C-sections have failed. But a new University of British Columbia study suggests that **providing women with early knowledge about pregnancy and childbirth could help reduce these numbers**. UBC researcher… studied young women from eight middle and high-income countries and found that at least 10 percent would prefer to deliver via cesarean even when the procedure is medically unnecessary, largely out of fear. Eight out of 10 women surveyed cited worries about labor pain, and **six out of 10 were anxious about perceived physical damage from labor and birth**. But having sufficient information on childbirth seemed to make a difference. Of the 2,043 women who were **sufficiently comfortable in their birth knowledge**, only nine percent said they would prefer cesarean in a healthy pregnancy. Among the 1,346 women who **lacked that confidence**, the proportion rises significantly to 14 percent. …The study found that **young women who preferred cesarean delivery had several knowledge gaps and misperceptions about childbirth that could be addressed through education**. "We should be providing women and men with information about childbirth early on, as early as elementary or secondary school, **before their attitudes towards birth become too influenced** by media dramatizations and other sources that aren't evidence-based,"… she will test a promising midwife-led childbirth education program,.. for primary school children in Canada. Physical damage is described as “perceived” and the women who preferred a caesarean as lacking in confidence, with “knowledge gaps and misperceptions”. It is really important that any pelvic floor education NICE recommends is not permitted to influence childbirth plans later in life, and since the pendulum	harm. It would also contribute to a wider discussion and increase knowledge about the topic which would serve them well at different stages in their lives (such as in relation to pregnancy) and perhaps would also provide an opener for conversations about this with older siblings or mothers. In addition the guideline recommends that information provision would need to be tailored for this age group to reflect their level of understanding and circumstances.

				could easily swing either way, perhaps NICE could include a statement that this is *not* the intention and should be consciously avoided. Something similar to its inclusion of “this communication should not only be framed in a negative way but provide positive messages when appropriate” (on page 43, lines 12-12)?	
Caesarean Birth	Guideline	008	001	Box 1 Re: Modifiable risk factors: Lack of exercise Did NICE look at evidence of the opposite being true too (e.g. hypertonic pelvic floor or strain through weightlifting)?	Thank you for this comment. Weightlifting was included as one of our search terms in the review but we did not find evidence that met our inclusion criteria for this factor. However, there was evidence identified in evidence review L on weight training which was not associated with a worsening of symptoms. Therefore, the committee made a research recommendation to address this (see appendix L of evidence review L). No evidence was identified specifically relating to hypertonic pelvic floor. Although not directly related to your comment the committee agreed that it was not sufficiently clear that pelvic floor muscle training could include relaxation and they have therefore provided a definition for pelvic floor muscle training: 'Exercise to improve pelvic floor muscle strength, endurance, power, relaxation or a combination of these.' The assessment on how well the pelvic floor muscles can relax was also added to recommendations 1.3.16 and 1.6.2.
Caesarean Birth	Guideline	008	001	Re: Non-modifiable risk factors: Family history of urinary incontinence, overactive bladder or faecal incontinence Suggest adding pelvic organ prolapse here too.	Thank you for this comment. The evidence for family history of urinary incontinence, overactive bladder or faecal incontinence were identified from one high quality study. Evidence for the family history of pelvic organ prolapse meeting the criteria of our review protocol (see appendix A of evidence review B) was not identified.

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Caesarean Birth	Guideline	008	001	Re: Related to labour: Suggest adding: emergency caesarean birth, vaginal birth, macrosomia.	Thank you for this comment. Evidence review B showed that some vaginal births had a higher risk than others so the committee decided to list these. Fetal macrosomia cannot be identified until after birth (e.g. Shakya, 2015) and therefore the committee did not consider it was useful to add it to the factors related to labour.
Caesarean Birth	Guideline	008	001	Re: Related to labour: Injury to the anal sphincter during birth Suggest adding: perineal tearing, especially 3rd or 4th degree tears.	Thank you for this comment. The committee preferred to keep the broader term of 'injury to the anal sphincter during birth' which includes perineal tearing
Caesarean Birth	Guideline	011	004 - 005	Re: During and after pregnancy - Explain to women who are pregnant or who have recently given birth that pelvic floor muscle training helps prevent pelvic floor dysfunction Again, see previous comment.	Thank you for your comment. We have responded to your previous comment but are unsure which exact previous comment this is referring to and are therefore unable to reply to this.
Caesarean Birth	Guideline	011	006	Re: Offer a 3-month programme of supervised pelvic floor muscle training This is a very welcome recommendation, thank you.	Thank you for this comment in support of the guideline. However, a number of stakeholders queried the practicalities of implementing this recommendation. The committee, having re-visited the evidence, decided to revise the recommendation so that it now reads: “Consider a 3-month programme of supervised pelvic floor muscle training"
Caesarean Birth	Guideline	012	019 - 020	Re: be aware that women may not know the precise technical terms for parts of their pelvic anatomy, so may use incorrect terms Suggest: be aware that women may not **use** the **medical/** technical terms for parts of their pelvic anatomy, **and** may use **lay or technically** incorrect terms My organisation would also suggest the committee adds something similar to this statement (to shift the emphasis of where the problem and responsibility lies): Mutual understanding	Thank you for your comment. We have amended this to ‘be aware that women may not use the precise technical terms for parts of their pelvic anatomy’.

				is important if communication and treatment is to be effective.	
Caesarean Birth	Guideline	012	021 - 022	Re: tailor information to each woman's level of understanding of anatomy and of the causes of pelvic floor dysfunction Suggest: tailor **communication** to each woman's level of **knowledge** of anatomy and of the causes of pelvic floor dysfunction **so that she understands the information provided** It is important that the *information* women receive is not tailored, but rather the *communication* of that information. This is an important distinction.	Thank you for this comment. The committee decided that the information provided would vary according to understanding and the causes of pelvic floor dysfunction and not only the communication of this.
Caesarean Birth	Guideline	012	17-18	Re: for example, avoid using 'faeces' if a woman better understands 'poo' Suggest: for example, avoid using 'faeces' if a woman **prefers to use** 'poo' (or just) **prefers 'poo'**	Thank you for this comment. The committee add 'prefers' to this bullet so that it reads 'if a woman better understands or prefers 'poo'.
Caesarean Birth	Guideline	013	006 - 007	Re: to help reinforce and support management plans. Suggest deleting the words "reinforce and" here (to read: **to help support management plans**).	Thank you for this comment. The committee included the term "reinforce" in this recommendation as they wanted to convey the importance of giving weight/prominence to the management plan as well as "support".
Caesarean Birth	Guideline	013	009 - 010	Re: Help women with pelvic floor dysfunction to understand their condition by giving clear and concise information Suggest: Help women with pelvic floor **damage/injury** to understand their condition by giving clear and concise information.	Thank you for this comment. Given the title of this guideline the committee preferred the term "pelvic floor dysfunction" in this context. In addition they thought the terms "damage/injury" could be slightly confusing as pelvic floor dysfunction can be caused by a number of events or conditions that weaken the pelvic floor muscles, not only damage or injury.
Caesarean Birth	Guideline	013	017 - 018	Re: other medical conditions and treatments that can cause or exacerbate their symptoms Suggest adding 'a subsequent [or 'another'] vaginal birth' here (or	Thank you for this comment.

				in the list that the link goes through to).	This recommendation is intended to be used in conjunction with the box listing risk factors for pelvic floor dysfunction, which does not include subsequent vaginal birth.
Caesarean Birth	Guideline	014	019 - 025	Re: Tailor information to each woman's age, level of understanding and circumstances, because pelvic floor dysfunction can affect women differently at different stages of life. Is it possible for NICE to make it clearer whether tailoring information according to "level of understanding and circumstances" is only meant in the context of the different categories listed in the bullet points (lines 22-25), and it does NOT mean information should be tailored within the same group of women (e.g. "women who are pregnant or who have given birth" should all receive the same information, regardless of their age or whether English is their second language, for example). Or, does NICE intend tailoring of information to occur within each group (for example, women with higher risk factors for pelvic floor damage in the "pregnant or who have given birth" group are to be given different information than those considered 'low risk')?	Thank you for this comment. This recommendation implies that information should always be tailored to women's understanding and circumstances. The bullets are examples, highlighting groups where understanding and circumstances may systematically differ. These examples are not intended as an exhaustive list as indicated in the stem.
Caesarean Birth	Guideline	014	022 - 025	In the context of "different stages of life" this list needs to include an older age group (e.g. women aged 60 or 65+) and possibly immobile/disabled women too.	Thank you for this comment. As noted in the stem the bullets are examples and the committee did not think it practical or helpful to produce an exhaustive list. The committee also noted that being disabled is not a particular stage in people's lives.
Caesarean Birth	Guideline	014	025	Re: women with comorbidities or frailty It is unclear what "frailty" refers to here; suggest changing this to a more specific term.	Thank you for this comment. "In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care" (https://www.england.nhs.uk/blog/frailty/) and therefore the committee considered this a good example of when

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					information may need to be tailored at different stages of life since many old and frail women also have symptoms of pelvic floor dysfunction and being frail would put them more at risk from this condition.
Caesarean Birth	Guideline	015	001 - 002	Re: Ask women who have recently given birth about symptoms of pelvic floor dysfunction during routine postnatal care, in hospital and in the community. This would benefit from being more specific than simply 'asking' the women about their symptoms. Very often, even when these symptoms *are* discussed with women who have recently given birth, women are assured that their symptoms are a normal sequelae of childbirth (particularly during the 6-week postpartum period when these discussions are taking place). The draft guideline suggests "leaflets in the community (for example at GP surgeries, family planning clinics and exercise classes)" (page 5, lines 9-10), so perhaps NICE could add "postnatal care" to this list too, and a leaflet (with contact details) might be produced for women to refer back to, if needed, after their postnatal visits have ended.	Thank you for this comment. The committee considered that this recommendation, along with other recommendations in the section "Assessment in primary Care", were intended to ensure that any symptoms of pelvic floor dysfunction were identified to facilitate appropriate further investigation and management. The examples of where leaflets in the community may be provided is not intended as an exhaustive list. However, maternity services and postnatal care are specifically referred to in recommendations 1.1.6 and 1.1.7 as settings and opportunities where pelvic floor dysfunction can be discussed.
Caesarean Birth	Guideline	015	007 - 008	Re: Depending on the symptoms, consider other clinical examinations. For example: Should ultrasound be listed here?	Thank you for this comment. This list was not intended to be exhaustive as indicated in the stem. The list reflects just some of the examinations that would be needed to clarify whether symptoms are likely to be associated with pelvic floor dysfunction or not.
Caesarean Birth	Guideline	020	020 - 021	Re: Consider a trial of intravaginal devices for women with urinary incontinence, if other non-surgical options have been unsuccessful. Could this ever be a first preference?	Thank you for your comment. Although the evidence relevant to this aspect of the guideline was in keeping with the committee's clinical expertise and experience, they noted that the quality of the evidence was low meaning they decided not to recommend that intravaginal devices should be a first option.

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Caesarean Birth	Guideline	022	009	Re: Behavioural approaches Suggest: Management approaches.	Thank you for this comment. “Behavioural approaches” was used here because it has a specific meaning not reflected by the broader term "management approaches". The guideline scope identified "behavioural approaches" as a key area to be covered under the non-surgical management of symptoms associated with pelvic floor dysfunction. An evidence review (Evidence Review: P) was undertaken on "behavioural approaches" and the recommendations in this sub-section relate to that evidence review.
Caesarean Birth	Guideline	024	004 - 005	Re: Is pelvic floor muscle training for children and young women (between 12 and 17 years) effective in preventing pelvic floor dysfunction? I am not a paediatric expert, but age 12 seems very young for this suggested intervention. The average age of women having their first baby in England and Wales is 28.9, and the average age of all women giving birth in is a record 30.7 (latest 2019 figures). Also, in the NICE evidence F, there is a study that includes 15 year-old girls, and a brief read online suggests that 15 years of age is often used as the definition for young adult (or similar). Can NICE explain the reasoning and/or evidence for suggesting age 12 here? Would NICE consider changing this to age 15 (or even the age range 16-18, and the topic could be discussed in Years 12-13)?	Thank you for this comment. It is usual in NICE guidelines for the age group 12-17 years to be classified as "young people" or, in the context of this guideline, "young women" (see the NICE style guide). The research recommendation is aimed to investigate whether pelvic floor muscle training is effective in this age group as a preventative strategy (not necessarily related to pregnancy). Even though a relatively wide age range, the committee did not want to be too prescriptive about the exact ages in this research which could cover any age in this range.
Caesarean Birth	Guideline	024	008 - 009	Re: How effective is pelvic floor muscle training in preventing pelvic floor dysfunction during pregnancy in women who are in higher-risk groups? Could NICE include a research recommendation for comparative planned caesarean birth and vaginal birth outcomes?	Thank you for this comment. Research recommendations reflect gaps in the evidence base when a guideline evidence review has not found any. As this question was not part of our evidence review it is not possible for the committee to make such a recommendation.

					Furthermore, the risk and benefits of different modes of birth are not limited to pelvic floor and therefore any research question comparing them would be expected to take a broader perspective on outcomes. The consideration of broader outcomes would be outside the scope of this guideline.
Caesarean Birth	Guideline	025	003 - 004	Re: What is the effectiveness of prediction tools for identifying women who are at risk of pelvic floor dysfunction? This is a very interesting research question. Thank you for including it.	Thank you for this comment in support of the guideline.
Caesarean Birth	Guideline	025	011 - 012	Re: What co-existing long-term conditions (for example chronic respiratory disorders) are associated with a higher risk of pelvic floor dysfunction? Would NICE consider including damage experienced in a previous (usually first) birth as a co-existing condition?	Thank you for this comment. The list of potential co-existing long-term conditions could be a very long one and this text is intended as a summary of the research question outlined in Appendix L of Evidence Review C.
Caesarean Birth	Guideline	032	008 - 009	Re: Improving women's knowledge of pelvic floor health is important because this increases the chance **they will take action** to prevent pelvic floor dysfunction The biggest risk factor for severe pelvic floor damage is instrumental vaginal birth (especially forceps), and the action many women take to prevent this damage (including doctors) is to plan a caesarean birth. This statement feels disingenuous in a guideline that currently fails to mention this action, and instead emphasises women's personal responsibility for 'behavioural' actions. Moreover, my organisation is aware of countless examples of women who did everything 'right' in terms of taking personal action to prevent pelvic floor damage. They were perfectly fit and healthy before experiencing a traumatic vaginal birth. I would again urge the NICE committee to please reconsider whether the knowledge of pelvic floor health it needs to improve	Thank you for this comment. The committee did not consider this wording disingenuous as the evidence suggests that lifestyle changes and pelvic floor muscle training, for example, can help prevent pelvic floor dysfunction. It is outside the scope of the guideline but the committee do not wish women to plan a caesarean birth in order to prevent pelvic floor dysfunction, as decisions about mode of birth concern a balance of benefits and risks that extend beyond pelvic floor function. However, a new recommendations has been added which makes a cross reference to the section on 'Benefits and risks of caesarean and vaginal birth' of the NICE guideline on Caesarean birth for guidance on all outcomes related to mode of birth

				for women goes beyond that which is contained in this draft guideline.	
Caesarean Birth	Guideline	032	021 - 023	Re: the committee noted that local authorities should consider designing information programmes that increase awareness of the condition, with the aim of advancing equality in healthcare provision This is an excellent recommendation. However, my organisation remains concerned that this cannot happen in maternity care while some groups of women have greater access to choices in their healthcare provision that others. This is an extract from a letter published in the British Medical Journal back in 1999, written by a female doctor: “I am very insulted that I am not allowed to make an educated choice to elect for a C-section. My decision not to undergo spontaneous vaginal delivery is made based on my own personal experiences with traumatic deliveries while in medical school: **rectovaginal tears**, emergency C-sections with death of newborn, fetal distress during labor, etc.” She goes on to cite a survey of obstetricians in London in which 31 percent of female doctors said they would choose a planned caesarean birth in an uncomplicated pregnancy, and she concludes, “**Obviously when it is your own pelvic floor that is at risk it affects one’s decision making**.” There are numerous studies in which doctors cite concerns about their pelvic floor as reasons for choosing a caesarean birth. For example, ‘avoidance of incontinence and pelvic organ prolapse,… preservation of sexual function’, and ‘fear of fecal and urinary incontinence’ with larger birth weights. We also know that the rates of planned caesarean birth are higher in private hospitals in England, and in Ontario, Canada, researchers	Thank you for this comment in support of the NICE guideline Mode of birth is outside the scope of this guideline.

				recently reported that women who chose a planned caesarean birth (and had one) “were more likely to be **white, older (35+)**, first-time mothers and more likely to have had anxiety, to gain excess weight during pregnancy, to have **more education** and to have conceived by IVF” (https://theconversation.com/requests-for-caesarean-birth-brushed-aside-despite-guidelines-to-respect-maternal-choices-162310). Advancing equality will require ensuring all women are made aware of the same information and choices.	
Caesarean Birth	Guideline	032	025 - 026	Re: The committee believed it was particularly important to raise awareness in maternity services, this is when symptoms can first occur Is there a missing word in this sentence (between services and this)? Also, with respect, this statement is ironic in the absence of information on planned caesarean birth (or even a reference to NICE NG192).	Thank you for this comment. We have amended the statement to read "The committee believed it was particularly important to raise awareness in maternity services, as this is when symptoms can first occur". A new recommendation has been added to the section on risk factors which cross refers to the section on ‘Benefits and risks of caesarean and vaginal birth’ of the NICE guideline on Caesarean birth (NG192)
Caesarean Birth	Guideline	032	027 - 031	Re: The recommendations could lead to midwives providing information about pelvic floor dysfunction many times during a woman’s pregnancy. However, the committee believe this is reasonable, because it gives the midwife an opportunity to normalise the topic and time to discuss it in detail. This statement is worrying, and reflects some of my organisation’s concerns outlined above. Can the NICE committee recognise potential problems in seeking to “normalise” pelvic floor *dysfunction* in maternity antenatal care?	Thank you for this comment. The recommendations are not intended to "normalise" pelvic floor dysfunction itself but rather the discussion of the "topic". Given the actual wording of the recommendations, which refer to the provision of information about symptoms, and the fact that they were included in a sub-section "Raising awareness of pelvic floor dysfunction for all women" the committee did not think the meaning of the recommendations was ambiguous.
Caesarean Birth	Guideline	033	001 - 003	Re: The committee also noted that frequent discussions would reinforce the message and improve adherence to prevention or	Thank you for this comment.

				management, which is key to their effectiveness. The language here reminds me of maternity care messaging around normal birth. There is a menu of prescribed actions and maternal choices in this draft guideline, similar to the 'place of birth' choices that were ardently promoted in maternity care for decades, but when the information about choices is incomplete, this is a problem.	The guideline text referred to in this stakeholder comment is intended to justify recommendations which encourage discussions on several occasions, such as at all midwife consultations or reviews. We were not able to identify a particular concern with the recommendations in this comment.
Caesarean Birth	Guideline	033	019	Re: The evidence suggested a number of modifiable and non-modifiable risk factors. Avoiding forceps delivery is a modifiable factor and should be included here. Spend five minutes in any social media group or chatroom attended by women with pelvic floor injuries, and forceps delivery is always mentioned. That is not to say the *only* action to avoid forceps is a planned caesarean birth (there is evidence suggesting improvements for how women are cared for in labour during a planned vaginal birth too), but given the numbers of injured women who go on to plan a caesarean for their subsequent birth, there is no doubt this is an action they take to modify risk.	Thank you for this comment. Whilst the committee recognised that the use of forceps can be controversial, it would not typically be classed as a modifiable risk factor because there would be a medical indication for assisted birth.
Caesarean Birth	Guideline	035	2 & 023 - 024	Exercise and diet and **other modifiable risk factors**… No evidence was found on the impact of other **lifestyle factors** that can prevent symptoms associated with pelvic floor dysfunction (such as pelvic organ prolapse,… This is also ironic, as caesarean birth choice has often been described as a "lifestyle choice". Here for example, in 2002, when a private health company said it would no longer fund them: http://news.bbc.co.uk/2/hi/health/2391843.stm.	Thank you for this comment. The lifestyle modifications outlined in the guideline scope are weight loss, dietary factors and physical activity. This was reflected in the evidence reviews undertaken for this guideline

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Caesarean Birth	Guideline	036	08 & 011 - 012	Re: Pelvic floor muscle training for preventing pelvic floor dysfunction… The available evidence covered women in 3 settings: community, antenatal, and postnatal. Did the NICE committee examine the available evidence in an antenatal setting in the context of birth plan decision-making to prevent pelvic floor dysfunction? And postnatal in the context of discussing birth plans for a subsequent pregnancy?	Thank you for this comment. This text seeks to explain the rationale for recommendations about the use of pelvic floor muscle training to prevent pelvic floor muscle training. These recommendations are based on the evidence review F: pelvic floor muscle training to prevent pelvic floor dysfunction. The studies did not specify whether this was in the context of birth plan decision making (e.g. Reilly 2002) or discussing birth plans for a subsequent pregnancy.
Caesarean Birth	Guideline	038	001 - 003	Re: Women who are pregnant and at particular risk of pelvic floor dysfunction: there was little evidence specific to women who are pregnant and have particular risk factors. Given the association between risk factors such as maternal age and macrosomia (for example), and forceps delivery, and the association between forceps delivery and pelvic floor injuries, it is unclear why the NICE committee found “little evidence” of risk factors during pregnancy. Can NICE explain this further please? Thank you.	Thank you for this comment. This specifically reflects the prevention of pelvic floor dysfunction and so the population would be women in higher risk groups but without pelvic floor dysfunction. Whilst there is evidence of the relationships between risks and pelvic floor dysfunction there is little evidence on the effectiveness of preventative pelvic floor muscle training in those who have not developed pelvic floor dysfunction.
Caesarean Birth	Guideline	038	027 - 030	Re: Women are not routinely told about how pelvic floor muscle training can help prevent sexual dysfunction during and after pregnancy. The recommendations ensure that all women are getting information on the benefits of pelvic floor muscle training to prevent pelvic floor dysfunction. This will standardise practice. Women are also not routinely told about different birth mode choices, including planned caesarean. A minority of women choose homebirth (place of birth choice), yet its communication in maternity care is standard practice. Does the committee agree that this situation needs to change?	Thank you for this comment. The scope of this guideline does not include place of birth.
Caesarean Birth	Guideline	039	005 - 008	Re: Qualitative evidence showed that women with pelvic floor dysfunction perceived some communication styles as unhelpful.	Thank you for this comment.

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				It also indicated that some women are not given enough information to understand their symptoms, diagnosis, investigations or treatment. There is also qualitative evidence that specifically cites women's frustration at not receiving communication about the very possibility of severe pelvic floor damage during vaginal birth. They also feel they were not given enough information. Does the NICE committee agree that the information provided in this draft guideline may also be perceived by many women as unhelpful?	The statement referred to is intended to explain the committee's recommendations on communication and these recommendations are for women with existing pelvic floor dysfunction. This comment seems to relate to communication with women who go on to develop pelvic floor dysfunction at a later stage. The committee agreed that raising awareness in maternity services is very important so they recommended (see recommendation 1.1.6) that information should be provided 'on pelvic floor dysfunction, how to prevent it, the symptoms, and how to access local services'. This would improve communication about pelvic floor dysfunction in this setting. It would also empower women to spot the risk factors or symptoms and take preventative action or access services if she develops symptoms.
Caesarean Birth	Guideline	039	015 - 016	Re: Pelvic floor dysfunction is a complex condition, with particular communication issues (such as embarrassment). It would also be helpful to mention midwives' concerns around not wanting to exacerbate women's fears about vaginal birth, and that this adds to the complexities in communicating this condition. This is a really important issue, and a delicate one too. Without doubt, criticism of normal birth at any cost and caesarean birth rate targets is more than justified, but care needs to be taken that the pendulum does not swing too far in the other direction.	Thank you for this comment. This text in the rationale and impact section (see rationale and impact related to communication) was explaining a recommendation that was made with respect to difficulties women may face when discussing their symptoms, for example due to embarrassment. Therefore, the committee did not think the suggestion of adding fears related to vaginal birth would help explain the rationale behind that particular recommendation.
Caesarean Birth	Guideline	042	004 - 005	Re: The experience and training of multidisciplinary team members is likely to vary widely in different areas This is an important point to acknowledge in this guideline.	Thank you for this comment in support of the guideline.
Caesarean Birth	Guideline	042	013	Re: ensure the plan takes account of her needs and preferences This is an excellent inclusion in the guideline.	Thank you for this comment in support of the guideline.

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Caesarean Birth	Guideline	054	003 - 004	Re: Prevalence of pelvic floor dysfunction is high. For example, on examination prolapse is present in up to 50% of women. This can have a significant impact on quality of life, reducing social engagement and ability to exercise. This highlights the scale of injuries women experience, and the often devastating effect on their lives. It is crucial that this NICE guideline helps make a real difference going forward, and that these injuries are reduced.	Thank you for this comment in support of the guideline.
Coloplast Limited	Comments Form Questions	Q5	General	Question 5 above on this Comments Form In terms of Question 5, we don't feel it would prove beneficial for clinicians on the front-line managing patients with bowel symptoms and incontinence to amalgamate all the various sub-speciality NICE Guidelines as stated above. This could limit the practical implementation clinically of these different guidelines and may not be considered user-friendly to clinicians on the front-line who would potentially have to read and decipher through multiple guidelines to find the relevant information for the patients they would be trying to manage. The current method of cross-referencing the guidance signposts clinicians as appropriate.	Thank you for your comment. The interactive flowchart that NICE produce alongside of the guideline will make navigation between guidelines easy. We will discuss further work on possible integration with colleagues from NICE.
Coloplast Limited	Evidence Review N	149	005 - 007	Coloplast welcome this research recommendation and would endorse that the response to transanal irrigation in particular should be studied in this patient cohort, as NICE MTG36 has concluded Peristeen, ® a trans-anal irrigation system, to be cost-effective intervention in mixed patient cohorts. If proven, it would provide patients with an additional cost-effective intervention to support the management of bowel symptoms (faecal incontinence) in women with pelvic floor dysfunction. Coloplast would ask that NICE encourage the research to focus on transanal irrigation systems that offer a proven cost-effective solution for the NHS and have been through the rigorous assessment for NICE guidance such as Peristeen. ®	Thank you for your comments. As the studies cited included mixed cohorts they would not have met inclusion criteria. Any new research in line with this research recommendation would need to be conducted in this particular population to inform future guidance to make it directly applicable (see appendix L of evidence review N).

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Coloplast Limited	Evidence Review N	149	015	Coloplast would like to see recognition of NICE guidance MTG36 given the importance of focusing on cost-effective solutions for the NHS referenced as a point to note under “other comments” as part of the research recommendation rationale.	Thank you for your comments. One randomised controlled trial (Christensen et al. 2006) featured in our search using MTG36 device. However, this study did not match our protocol (see appendix A of evidence review N) as it was a randomised controlled trial of transanal irrigation versus conservative bowel management in spinal cord-injured patients (in a mixed population of men and women), not specifically women with pelvic floor dysfunction which is therefore not applicable to the context of this guideline. This is why we cannot cross refer to MTG36. Any new research would need to be conducted in this particular population to inform future guidance (see appendix L of evidence review N).
Coloplast Limited	Evidence Review N	149	017	Coloplast would like to point out that there may be an opportunity under outcomes on the PICO to consider impact on “other” Health Care Resource utilisation, i.e fewer visits to GP/Bladder and Bowel Services/Reduced Consumption of Continence Pads etc. Is there also an opportunity to consider Patient Preference/Patient Choice for device versus standard bowel care intervention assuming standard bowel care would be including DRE/DRF? Finally, should there also be consideration of the patients’ body image/impact on their mental health and well-being as part of the outcomes for this RCT or will this be covered by the validated tool and assessment in the Quality of Life outcome?	Thank you for your comments. Although important outcomes, these were not measured in the studies identified. As the prioritised studies to be included were randomised in design, patient preference/patient choice would not be measured as patients would be randomised to the intervention or control. Impact on mental health and wellbeing would be covered by a number of validated questionnaires such as the SF-12 and the SF-36. However, the research recommendation is intentionally broad (see appendix L of evidence review N) and any future research can include further outcomes such as measures of mental wellbeing if applicable.
Coloplast Limited	Guideline	031	004 - 007	Coloplast welcome this research recommendation and would endorse that the response to transanal irrigation in particular should be studied in this patient cohort, as NICE MTG36 has concluded Peristeen, ® a trans-anal irrigation system, to be a cost-effective intervention in mixed patient cohorts. If proven, it would provide patients with an additional cost-effective intervention to support the management of bowel symptoms	Thank you for your comments. As the studies identified included mixed cohorts they were excluded and not used for evidence. Any new research would need to be conducted in this particular population to inform future guidance.

				(faecal incontinence) in women with pelvic floor dysfunction. Coloplast would ask that NICE encourage the research to focus on transanal irrigation systems that offer a proven cost-effective solution for the NHS and have been through the rigorous assessment for NICE guidance such as Peristeen. ®	
Department for Education	Guideline	006	012 – 014	recommendation 1.1.7 Pupils need to know how to be safe and healthy, and how to manage their academic, personal, and social lives in a positive way. This is why we have made Health Education compulsory in all state-funded schools in England alongside making Relationships Education (in primary schools) and Relationships and Sex Education (in secondary schools) compulsory from September 2020. The statutory guidance can be accessed here: https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education . We have also produced teacher training modules, which aim to help teachers identify the core knowledge pupils may be taught as part of RSHE, and to share this through peer training. These have been developed with subject matter experts and teachers. The guidance and modules for 'Changing adolescent body', 'Intimate and sexual relationships' and 'Health and wellbeing' all make reference to the need for pupils to be taught to recognise the importance of exercise and how to recognise early signs of physical illness and changes to their bodies, key facts about the changing adolescent body and the menstrual cycle, and that emphasis should be given to the steps pupils can take to protect and support their own health and wellbeing. We are not able to include specific content on teaching about the pelvic floor in the RSHE curriculum because we cannot cover all the problems and issues pupils may encounter with their bodies.	Thank you for your comment. Evidence was found (see Evidence Review A) that introducing a pelvic floor health curriculum within schools improved the knowledge of young women aged 13-17 years. Whilst this was low quality evidence, the committee considered it important as preventative action could be taken early in life to prevent pelvic floor dysfunction in the future. Therefore, the committee noted that this should be taught to young women (between 12 and 17) . The publication of the guideline may encourage the development of resources for teachers to use in lessons.

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				Teachers may however include material about the pelvic floor and pelvic floor dysfunction in their lessons if they choose to do so. If others wish to produce relevant resources for schools it is also open to them to do so, working together with Public Health England (PHE) and/or the PSHE Association	
Dorset CCG	Comments Form Questions	Q1	General	*Q1: which areas will have the biggest impact on practice and be challenging to implement?* Please say for whom and why. A: The need for physical intimate examinations is imperative and this is welcomed BUT there is a capacity issue within NHS buildings. These examinations require privacy, and depending on local policy, chaperones. Noted are many clinical spaces being used for phone calls. Many closed rooms are used to examine an elbow or finger where a cubicle might suffice. Serious national regard needs to be given to use of clinical space. I cannot get a clinic room to undertake an intimate examination because I am not a consultant. This attitude must end if this care pathway is to be delivered to women. Biggest impact will be Specialist Physios who currently recognise a correct pelvic floor contraction. With the NHS E perinatal programme this may ripple to others who will be asked to examine the pelvic floor muscles. Room space to do this will be a pressure. 'Visiting' units might be needed (eg a mobile clinical space) The recommendation to teach PFX from 20 weeks (and not from booking) greatly limits the provision of care and compresses the window. Why not from booking? Any stage ? A: 3 month programme for ALL women who are pregnant will need support from an app eg squeezy but to supervised, will also need a physical examination (see above).	Thank you for your comment. The committee recognised that having a private space for these examinations is important and is current practice even if space within NHS buildings is limited. However, the clinical examinations in recommendation 1.5.5 can be considered based on symptoms and may not be needed for every woman but could be particularly important if other causes would need to be urgently ruled out. Chaperones are not routinely used in all trusts for all appointments for an intimate clinical examination and the committee was aware that policies vary. Your comments related to this as well as your comments on online teaching resources and use of an app will be considered by NICE where relevant support activity is being planned. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is.

				I would suggest tendering for an online sequence of teaching sessions.	To start pelvic floor muscle training from 20 weeks antenatally was chosen to be consistent with the evidence and also because of resourcing. However, preparation and referral could be started from booking so that the woman can be enrolled and starting the programme at 20 weeks. The guideline committee could not make a recommendation to provide all pregnant women with a 3 month supervised pelvic floor muscle training programme. The consultation version stated that this ought to be routinely made available to women • from week 20 of pregnancy, for pregnant women who have a first-degree relative with pelvic floor dysfunction • during postnatal care, for women who have experienced any of the following risk factors during birth: a) assisted vaginal birth (forceps or vacuum), b) a vaginal birth when the baby is lying face up (occipito posterior), c) injury to the anal sphincter. However, the committee reflected on this and decided that the potential resource impact of this would be too large. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. This would make the impact on staffing levels more manageable.
Dorset CCG	Comments Form Questions	Q2	General	*Q2 Would implementation of any of the draft recommendations have significant cost implications?* A: To OMIT constipation and ODS from this guidance would be very costly. It is a significant contributor and once remedied, invariably leads to improvement and reduction of symptoms. The endemic of constipation is costly. https://bowelinterestgroup.co.uk/resources/cost-of-constipation-report-2020/	Thank you for your comment. The committee did recognise that constipation is a risk factor associated with pelvic floor dysfunction (as is listed in Box 1 in the guideline). The committee decided that commonly constipation can be caused by diet or fluid intake and made general recommendations about diet and fluid which would not only contribute to general wellbeing but would also improve stool consistency. A cross reference to the NICE guideline on constipation in children and young people: diagnosis and management (CG99) was added to the

				A: In order to provide all pregnant women with a 3 month supervised programme will take an increase in workforce capacity within specialist Physio. This is entirely possible and with a 12-18 month lead in plus more funding than the Perinatal project allows for, possible. In Dorset we have 5000 deliveries. If every woman has just one 30 minute examination appointment, this is 2,500 hours PA which, over 42 working weeks is 59.5 hours per week = 2 WTE staff members dedicated to this task. It is possible, but needs staffing. A: to OMIT FAST deliveries/ 4kg baby size/ face/hand presentations etc from the risk factors will miss a large cohort who will present later with chronic problems. A Unless NHS E considers the absolute CORRECT approach to MOTIVATE behaviour change, they will fail to deliver this brief – a costly failing and a chance to get it right first time.. I would recommend consulting with The Behaviour Insights team for guidance. https://www.bi.team/	prevention section. However, there is no NICE guideline on constipation for adults and since the management of constipation is outside the scope of the guideline the committee were unable to make recommendations for dealing with constipation in adults. The guideline does not make a recommendation to provide all pregnant women with a 3 month supervised pelvic floor muscle training programme. The consultation version stated that this ought to be routinely made available to women • from week 20 of pregnancy, for pregnant women who have a first-degree relative with pelvic floor dysfunction • during postnatal care, for women who have experienced any of the following risk factors during birth: a) assisted vaginal birth (forceps or vacuum), b) a vaginal birth when the baby is lying face up (occipito posterior), c) injury to the anal sphincter. However, the committee reflected on this and decided that the potential resource impact of this would be too large. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. This would make the impact on staffing levels more manageable. The risk factor review (evidence review B) included many studies but it did not cover every conceivable risk factor. However, having a large baby 4kg and over was not found to be a significant risk factor. With regards to labour it was longer labour that was found to be a risk factor rather than very quick labour. No evidence was identified for face / hand presentations.

					In relation to motivating behaviour change and The Behaviour Insights team your comment will be considered by NICE where relevant support activity is being planned.
Dorset CCG	Comments Form Questions	Q3	General	*Q3 What would help users to overcome any challenges?* To engage behavioural change gain advice and guidance from; https://www.bi.team/ A: national Chaperone policy – as well as needing to undertake MORE intimate examinations, there are policies which require a chaperone at every appointment – this requires a WTE staff member to be available and trained. National wording for consent/ national guidance on VE and chaperones will help Trusts to be efficient and avoid spending hours on policy making that is prohibitive to care. I do not have a chaperone for my smear. Why are some trusts making a Pelvic health physio have one for a VE? Development of national resources through the Perinatal health project should then be extended to include the 12 years – elderly catchment. Good ideas scaled up with leadership support from the NHS academy in leading largescale change.	Thank you for your comment. Your comments related to the behavioural insights team, chaperone policies and need for national teaching and training resources will be considered by NICE where relevant support activity is being planned.
Dorset CCG	Comments Form Questions	Q4	General	COVID-19 considerations and implementation challenges COVID-19 put pregnant women in the 'moderate-risk' category due to the risk of complications in pregnancy (NHS 2021). Women spent an increasing amount of time at home as a result. Deaths from domestic abuse in the UK doubled between March and April 2020 which were directly linked to the pandemic and lockdown restrictions (Bradbury-Jones and Isham 2020). 60% of survivors of domestic abuse using support services are mothers and one in fifteen are pregnant women (Midwives 2020). Phone use became a lifeline for these women. Isolation and disability in	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. Your comments highlight the benefits and challenges of telemedicine and the problems of adherence to PFMT. These themes were raised in guideline committee discussions and we have made recommendations that consultations could be by video/telephone and that digital information sources such as apps or videos, could be used to support women. The committee has also made a research recommendation to

				pregnant women make regular outpatient appointments challenging to attend. According to (Gurr 2014) “pregnant women spend time using traditional and new social media to seek information about health behaviours.” Telemedicine may prove a cost-effective way of supporting and empowering women through their pelvic floor muscle training. The results from the on-going APPEAL study show that pelvic floor muscle exercises are not well adhered to by women (NIHR 2021). Information alone is not enough to engage women in pelvic floor muscle training. There is a lack of understanding about why this is the case. The determinants of health app adoption in a younger population include entertainment and communication, ease of use and a reminder function (Cho et al. 2014 and Chan & Chen 2019). Successful behaviour change strategies to improve exercise adherence include ‘adding objects’ e.g download phone applications (Powell and Thomas 2021) . A systematic review and meta-analysis of behaviour change strategies at engaging obese people in physical activity found that goal setting and self-monitoring were effective behavioural change strategies in the short and long term. Use of goal-orientated reminders and in app self-monitoring may requires further research The national women’s health physiotherapy service does not have the capacity to support the number of pregnant women with their pelvic floor rehabilitation. The pandemic has made attending antenatal appointments even more challenging for this population. Telemedicine offers an innovative and cost-effective way of using particular behavioural change strategies in order to support women with their pelvic floor muscle training. References	evaluate virtual consultations (see appendix L of evidence review M). We have also cross referenced to the NICE guideline on behaviour change: digital and mobile health interventions (see recommendation 1.1.11). Your comment is supported by references - we want to confirm these specific studies were not included in our guideline evidence reviews because (apart from the APPEAL study) they are not directly related to pelvic floor discussion. The APPEAL study is ongoing and may be included in a future update of this guideline. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

				NHS 2021 https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/pregnancy-and-coronavirus/ Bradbury-jones and Isham 2020 Bradbury-Jones, C. and L. Isham (2020). "The pandemic paradox: The consequences of COVID-19 on domestic violence." 29: 2047-2049. Midwives, T. R. C. o., 2020. Domestic Abuse. Gurr, B. A., 2014. Reproductive justice : the politics of health care for Native American women. NIHR 2021 https://arc-swp.nihr.ac.uk/research/projects/appeal-antenatal-preventative-pelvic-floor-exercises-and-localisation-delivery-of-pelvic-floor-muscle-exercise-education-for-wom/#:~:text=The%20overall%20aim%20of%20APPEAL,of%20urinary%20incontinence%20after%20birth. Chan and chen 2019 https://mhealth.jmir.org/2019/1/e11836/ https://doi.org/10.2196/11836 http://www.ncbi.nlm.nih.gov/pubmed/30698533 Cho et al. 2014 Determinants of adoption of smartphone health apps among college students, American journal of health behavior 2014 Vol. 38 Issue 6 Pages 860-870 Powell, A. J. and Thomas, S., 2021. How the LiveWell Dorset lifestyle behaviour change service influences older adults' physical activity behaviour: A generic qualitative study. Public Health in Practice, 2, 100164.	
Dorset CCG	Guideline	General	General	There is a significant omission: The impact of constipation and the symptom of obstructive defaecation (caused by pelvic organ prolapse POP, but often POP is CAUSED by straining to open bowels) and has NOT been mentioned. This is the backbone of first line care and if ignored at this critical point in NHS care focussing on pelvic health and prevention of future problems it will be a costly oversight.	Thank you for your comment. Constipation is listed in Box 1 as a risk factor for pelvic floor dysfunction (there was some evidence in evidence reports B and C that supported this). There are related recommendations in the 'prevention' and 'non-surgical management' sections of the guideline that give some relevant advice on diet and fluid intake that would improve stool consistency (such as recommendations 1.3.3 and recommendation 1.6.9). We have now referred to

					constipation specifically in the rationale and added a cross reference to the two recommendations to the rationale section to make the relationship between these recommendations more explicit. A cross reference to the NICE guideline on constipation in children and young people: diagnosis and management was also added to the prevention section.
Dorset CCG	Guideline	General	General	Very simply, constipation affects 1 in 4 adults in the UK. Standard advice is to 'eat more fibre' which can make this worse if no guidance is given regarding which fibre, or the addition of sufficient fluids. Constipating medications are routinely prescribed with no regard for additional laxative help, particularly codeine. Straining daily to open bowels weakens the pelvic floor muscles, descends the pelvic organs and can cause full thickness rectal prolapse. Most pelvic floor dysfunction patients need advice regarding this. Only 1 in 10 have faecal incontinence.	Thank you for your comment. Constipation is listed in Box 1 as a risk factor for pelvic floor dysfunction (there was some evidence in evidence reports B and C that supported this). The management of constipation is outside the scope of this guideline and even though some recommendations are relevant to preventing constipation (with diet and fluids) we did not carry out a specific evidence review about the treatment or prevention of constipation. Therefore, the committee were unable to recommend any specific treatments for constipation (such as laxatives or codeine).
Dorset CCG	Guideline	004	012	Section 1 4 Recommendations: This should read, 'The 4 most common and definable symptoms … UI, FI, POP and ODS.'	Thank you for your comment. The committee decided to keep this as is because there are many sub-categories of urinary and faecal incontinence and saying that those are more definable than other associated symptoms is questionable.
Dorset CCG	Guideline	005	013	1.1	Thank you for your comment. These two opportunities to provide information were specifically highlighted because they were identified as risk

				'Cancer treatment and hysterectomy' are very narrow representations of opportunities to educate. ADD in 'practice nurse appointments / smear tests / well woman checks.'	factors (see Box 1 and evidence review B). We amended the wording of this bullet to directly correspond to the wording in Box 1. The committee included 2 further bullets related to contact with a healthcare practitioner with pelvic floor knowledge and including pelvic floor dysfunction in the syllabus of trainee nurses, physiotherapists, doctors, midwives and teachers. Therefore, it could happen in practice nurse appointments, smear tests and well women checks where appropriate. The list is not exhaustive. However, they have added a further bullet recommending that awareness could be raised 'as part of existing programmes, for example cervical screening or national or local NHS health checks'.
Dorset CCG	Guideline	006	010	1.1.6 ADD in physiotherapy practice nurses	Thank you for your comment. Recommendation 1.1.5 emphasises that all women using maternity services should receive information about pelvic floor dysfunction without specifying who ought to provide this. The list is not exhaustive therefore other health professionals than those listed could provide it, such as physiotherapy practice nurses.
Dorset CCG	Guideline	008	001	Box 1 Risk Factors – Modifiable risk factors – ADD in constipating medication Related to having a baby – ADD in weight of baby / fast delivery trauma /short stature / baby trauma Erbs / torticollis – mother usually has an injury too / hand to face presentation / face presentation.	Thank you for your comment. The risk factors listed in Box 1 came from evidence identified in evidence reports B and C. The committee therefore was unable to list factors for which no evidence was identified (such as constipation medication) or where evidence was shown not to be significant (weight of baby above 4kg).

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Dorset CCG	Guideline	009	007	1.3.2 Exercise and Diet – suggestion – research recommends that we move away from the terminology 'Exercise' and use language 'Activity' instead. It is more motivating and engages the patient. Levels of activity should include: https://www.absolute.physio/wp-content/uploads/2019/09/returning-to-running-postnatal-guidelines.pdf	Thank you for your comment. With regards to taking back running after birth, the suggested publication would not have come up in our search because it is not published in a way that would be indexed in our search databases. We checked the included studies related to running and they would not have met inclusion criteria because they referred to general benefits of running and exercise after pregnancy rather than pelvic floor dysfunction. Other studies that were looked at in the publication were included in our evidence reviews particularly those related to pelvic floor muscle training. We have now referred to 'physical activity' rather than 'exercise' throughout.
Dorset CCG	Guideline	009	013	1.3.3 INCLUDE ODS, do not just focus on FI.	Thank you for your comment. The evidence identified in relation to this was for faecal incontinence rather than ODS so the committee specified this rather than widening it to other symptoms.
Dorset CCG	Guideline	011	007	1.3.11 From 20 weeks [with a first degree relative with PFD] – this brief is too narrow, from booking is preferable. The first degree relative will cause confusion and anxiety. Simply include everyone.	Thank you for your comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is.

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Dorset CCG	Guideline	018	007 - 019	1.6.9 Diet - INCLUDE ODS do not focus on FI INCLUDE ODS / constipation not just FI .	Thank you for your comment. The second bullet of recommendation 1.6.9 reads '• follow guidance on maintaining healthy bowel habits in recommendation 1.3.2 of the NICE guideline on faecal incontinence in adults (including for women under 18 or with symptoms other than faecal incontinence).' This means that even though not explicitly stated the committee believed that the 'healthy bowel habits' guidance would be applicable to more than faecal incontinence. However, the focus of the evidence review related to this was on management of symptoms of pelvic floor dysfunction not on the management of risk factors. Management of constipation is outside the scope of this guideline.
Dorset CCG	Guideline	019	002 – 007	1.6.11 Exercise - vague and ambiguous – time to stop giving women poor advice such as this.	Thank you for your comment. The recommendations are based on the evidence that was identified which related to supervised physical activities. There was no evidence to suggest a particular way of exercising (for example level of intensity) so the committee decided that they could not comment on this. However, they made a couple of research recommendations (one on weight lifting and the other on unsupervised exercise – see appendix L of evidence review L) which can inform future updates of this guideline.
Dorset CCG	Guideline	019	017	1.6.15 For FI with POP, this is very RARE – usually woman has ODS.	Thank you for your comment. The evidence that underpins this recommendation related to a study of women with faecal incontinence with co-existing pelvic organ prolapse. The committee made the recommendation to be consistent with this.
Dorset CCG	Guideline	021	004	1.6.23	Thank you for your comment.

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				Pessaries and POP. Before starting treatment discuss … constipation and ODS to improve these prior to wearing a pessary (that might come out if they strain opening the bowel – ADD this in	No studies were identified with regards to physical devices to manage emptying disorders of the bowel, therefore the committee did not comment on this.
Dorset CCG	Guideline	022	009	1.6.30 Behavioural approaches – ADD in constipation and attitudes to bowel opening.	Thank you for your comment. The evidence review that was conducted for this section looked at the effectiveness of behavioural approaches rather than attitudes about it. Constipation was not part of the symptoms that this effectiveness review addressed because constipation is a risk factor rather than a symptom of pelvic floor dysfunction and recommendation 1.6.30 in the management rather than the prevention section of the guideline. However, the recommendations on lifestyle advice such as exercise, diet and fluid intake would also improve stool consistency.
Dorset CCG	Guideline	023	002	1.6.33 ADD in laxatives should be offered / advised where drugs are constipating.	Thank you for your comment. There was no evidence identified for the use of laxatives in the context of pelvic floor dysfunction and the committee therefore did not comment on this.
Elizabeth Bryan Multiple Births Centre	Evidence review B	General	General	It appears from the search terms for obstetric factors that multiple pregnancy was not included. If this was the case could a further search be conducted? Many of the included studies detailed in Appendix D excluded multiple births. We are aware that there is a paucity of evidence about pelvic floor dysfunction in multiple births and it would be helpful to include a research recommendation about this. The following publications may be of interest. https://pubmed.ncbi.nlm.nih.gov/30293167/ https://pubmed.ncbi.nlm.nih.gov/30007113/ https://pubmed.ncbi.nlm.nih.gov/30291380/ doi: 10.1007/s00404-019-05311-9	Thank you for your comment. Multiple pregnancy was not a specific search term, but studies on multiple pregnancy as a risk factor for pelvic floor dysfunction was picked up by our searches. It was not excluded as a risk factor in our protocol (see appendix A of evidence review B). Of the studies hyperlinked in the comment: For the evidence review on risk factors for pelvic floor dysfunction it became clear during screening that studies were available on risk factors for the constellation of pelvic floor dysfunction

					symptoms, so for this question any studies focusing only on a single symptom were excluded. De tayrac (2018) and Hutton (2018) were not included as they looked at risk of urinary incontinence alone rather than pelvic floor dysfunction as a condition with a constellation of symptoms. Bechard (2019) was not included because it reported only univariate analyses which were not adjusted for other confounders. We have added Bodner-Adler (2019) which was in the search but had not been identified, to the evidence review. There was a reported association between multiple pregnancy and pelvic floor dysfunction but there were uncertainties about this finding (which meant it was rated as low quality evidence). The committee was not confident enough about this to list it as a risk factor in box 1 but added a research recommendation for multiple pregnancy as a risk factor for pelvic floor dysfunction to the guideline (for further details related to the research recommendation see appendix L of evidence review B).
Elizabeth Bryan Multiple Births Centre	Guideline	General		Thank you for the opportunity to comment on the draft guideline. We note that there is no reference in any part of the guideline to women with a multiple pregnancy. We acknowledge that the scope of the guideline includes all women with no exclusions so would like to suggest that the inclusion of multiple pregnancy and birth is made clear in the guideline. However as it appears that the evidence review did not include multiples, this may not be appropriate and the fact that they were excluded equally made clear. Please see next comment	Thank you for your comment. Women with multiple pregnancy were not excluded from the guideline. However, in the risk factor review 3 included studies excluded women with multiple pregnancy (2 studies from 1 research group and 1 from another). The other studies did not specifically refer to multiple pregnancy as one of their considered risk factors. One study was added to evidence review B which did report an association between multiple pregnancy and pelvic floor dysfunction. However, there were some uncertainties related to the finding (resulting in it being rated low quality) and the committee therefore was not confident enough to list it in box

					1 as a risk factor. They made a research recommendation so that this is investigated further (see appendix L of evidence review B).
EVB Sport & Core	Evidence review N	006	016	V brace is given as an example of Support Garments. I respectfully point to other products, including EVB™ Sports Shorts. I custom-designed it using engineering principles in 2013 for women with stress urinary incontinence: its varying elasticity provides compression to gluteal muscles and thighs while giving nonelastic compression uplift and support to pelvic floor muscles. This is achieved mechanically by suspending the central section of the garment from the high waistband, resulting in a hammock/sling effect secured during motion. The mix, panelling and layering of the fabrics act together to encourage the pelvis into a neutral, aligned position and this impacts posture positively. Three small (7,16 and 34 women) crossover studies of EVB™ on urinary incontinence (2014, 2015, 2017), and a gait project on EVB™ which gained a Masters of Biomedical Engineering (2019), were carried out at Royal College of Surgeons in Ireland, University College Dublin, Trinity College Dublin, and Dublin City University. The 2015 study found higher confidence ratings ($p<0.001$), and fewer participants reported no leakage ($p<0.03$) wearing EVB™ compared to generic shorts: the other studies' findings though positive, did not achieve significance. The gait study found a reduction in contralateral hip drop ($p=0.04$) with EVB™. These together with preliminary translabial ultrasound findings by a physiotherapist (2020) showing bladder neck elevation were accepted/presented at Live Sessions to European Urogynaecological Association December 2020. I posited that proprioception, genital hiatus length, gait/posture changes, offloading of intra-abdominal pressure, pressure on lumbar	Thank you for your comment. Support garments were included in our search strategy and one study was identified (Okayama 2019), which showed no important difference between a support garment and pelvic floor muscle training in terms of urinary incontinence symptoms and a benefit with a support garment compared to no treatment in some, but not all, measures of urinary incontinence symptoms. The cited studies would not be included as they are not randomised in design and other randomised controlled trial evidence had been identified through the search. For further details, see the review protocol in appendix A.

				sacrum activating the common sacral nerve root supply, and allowing women become more active, are other potential mechanisms of action. The Engineering/Physiotherapy/Gynaecology team at EVB™ is currently in discussion with the Gynaecologist/Obstetric department in The Rotunda Hospital (Europe's oldest Hospital 1745) regarding a larger trial of efficacy. The Trustpilot rating of our garments is 94% excellent/great of 285 reviews. and at a significant proportion of our ladies are return customers. EVB™ is attractive to women as it has the appearance of conventional sportswear. Finally, our product is more readily available that the V – brace.	
EVB Sport & Core	Evidence review N	015	035	'useful in certain populations for example women with cognitive impairment'. High impact movement can raise intraabdominal pressure which applies greater force to the pelvic floor and can cause involuntary loss of urine (Elisson et al 2005). Exercise and movement regarded as impacting particularly on urinary incontinence include jogging, fast running, trampoline, bouncing, horseriding, gymnastics and jumping jacks (Bo et al 2011). (Nygaard et al 2005) found 1 in 7 women experienced urinary incontinence during exercise and/or physical activity and in in 8 perceived leakage to be a barrier to exercise and changed their exercise/movement because of leakage. 2 studies Brown and Miller in 2001 found that approximately one quarter of women avoided sport and exercise or decreased their involvement with physical activity because they leaked. The avoidance of physical activity because of UI is especially worrying as it is key to maintaining optimum weight and fitness and is necessary to reduce BMI. Interventions like support garments which enable women who leak urine to feel confident, comfortable, secure and help to reduce or illuminate the	Thank you for your comment. In evidence review L- "What types of physical activity can increase or decrease symptoms of pelvic floor dysfunction?" the committee focused on evidence from randomised controlled trials only, therefore, the cited studies were not included as evidence. Limited randomised controlled trial evidence on the effect of exercise on the symptoms associated with pelvic floor dysfunction was identified, particularly with high impact exercise which increase intra-abdominal pressure such as weight lifting. Therefore, a research recommendation has been made to address this (see appendix L of evidence review L). Further research on support garments in combination with exercise was not prioritised by the committee as a topic for further research since they already made many research recommendations that they considered to be higher priority.

				propensity to leak and off load the pelvic floor muscles would be highly advantageous. Consideration should be given at this time for a research recommendation to understand the improved outcomes wearing support garments during high impact sport can have in keeping women with pelvic challenges moving and also what role they play as a preventative measure for all women.	
EVB Sport & Core	Evidence review N	149	017	Table 38. Research recommendation Intervention – should include support garments. Support garments can help keep women moving and exercising who otherwise would stop because of their challenge. Following is a quote from Prof Michael Keighley President of the MASIC Foundation 'The MASIC Foundation is the only organisation committed to support women who have suffered severe perineal trauma after childbirth which has resulted in anal incontinence. Anal incontinence after childbirth is an unspoken taboo. Women might reluctantly talk about imperfect control of urine, but being in a mess from faecal loss because they are unable to reach the toilet in time is never spoken about. As a consequence these women are afraid to leave the house, they struggle to do the supermarket shop, they are unable to share their intimate problem with their partner, the relationship with their baby is compromised, in fact many are afraid to have another baby. Sadly many of the women affected by this type of birth injury enjoy physical exercise, visiting the gym or have jobs involving heavy lifting where control of their most intimate function is made worse by exercise and certain daily tasks.	Thank you for your comments. The committee considered making a research recommendation for support garments. Throughout the guideline there was little evidence for interventions specifically related to faecal incontinence and therefore they wanted to address this directly and made a research recommendation for anal plug devices and rectal irrigation rather than focus on support garments.

				EVB Sport have a product that they have developed which provides protection for women who enjoy physical activity after this sort of injury. A number of the women known to the MASIC Foundation are empowered by being able to run marathons, attend the gym and undertake contact sports, so that they feel normal again. The EVB Sport product is used by a number of women that the charity is aware of whose lives as a result have been restored, giving the person a much greater sense of confidence whilst minimising the stigma of this dreadful condition.'	
Femeda Ltd	Evidence Review M	006	General	**Full text of publication** **Title** Effects of a disposable home electro-stimulation device (Pelviva) for the treatment of female urinary incontinence: A randomised controlled trial **Authors** Professor Jackie Oldham, Faculty of Biology, Medicine and Health, University of Manchester, Manchester Academic Health Science Centre Ms Julia Herbert, Ellesmere Physiotherapy Clinic, Lancashire Dr Jane Garnett, JG Technology Management Ltd Dr Stephen A Roberts, Centre for Biostatistics, Division of Population Health, Faculty of Biology, Medicine and Health, University of Manchester, Manchester Academic Health Science Centre **Corresponding Author** Professor Jackie Oldham, University of Manchester Innovation Factory, 46 Grafton Street, Manchester, M13 9NT.	Thank you for your comment. The Oldham 2021 RCT was not included in our evidence review because it was published in August 2021 - after our literature search cut-off date of February 2021. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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Femeda Ltd	Evidence review M	006	General	We have been aware of the need to increase the evidence base in controlled trials for muscle stimulation, and hence commenced a randomised controlled general practice trial in late 2019. The trial ran in the early part of 2020 though unfortunately had to be curtailed due to Covid. However, despite significantly reduced numbers vs the planned protocol a statistical significant results were achieved. Below is confirmation from the journal (received 4/8/21) of forthcoming publication. On 04/08/2021, 15:25 em.arch.0.7517d7.7d4d6e03@editorialmanager.com on behalf of Archives of Gynecology and Obstetrics (ARCH)" <em.arch.0.7517d7.7d4d6e03@editorialmanager.com on behalf of em@editorialmanager.com> wrote: Dear Professor Oldham, We are pleased to inform you that your manuscript, "Effects of a disposable home electro-stimulation device (Pelviva) for the treatment of female urinary incontinence: A randomised controlled trial", has been accepted for publication in Archives of Gynecology and Obstetrics. Please remember to quote the manuscript number, ARCH-D-21-01305R1, whenever inquiring about your manuscript. With best regards, Olaf Ortmann	Thank you for your comment. The Oldham 2021 RCT was not included in our evidence review because it was published in August 2021 - after our literature search cut-off date of February 2021. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Frimley	Evidence Review D	Risk tool	Risk tool	We found a generic Australian one, the Australian PF questionnaire and then a German paper by Metz, modified it to be pregnancy/obstetric related.	Thank you for your comment.

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					The Australian PF questionnaire is a measure of current pelvic floor dysfunction symptoms rather than a tool to predict risk of pelvic floor dysfunction in future. The Metz (2017) study is reporting a questionnaire measure of current pelvic floor dysfunction symptoms and also included assessment of risk factors but it did not review a prediction tool for risk of pelvic floor dysfunction.
Frimley	Guideline	General	General	Pt need to take responsibility for their health. Money talks. Pay £10 to see GP/AHP reduce DNA and comply with advice- diet & exc. Please link with POGP & Perinatal pelvic health sites	Thank you for your comment. A number of the recommendations in the guideline give advice that supports people to take responsibility for their health. However, there are a number of risk factors for pelvic floor dysfunction that women would be unable to modify (see Box 1 in the guideline). Therefore, it is not all down to individual responsibility alone but there is a balance in what the individual woman can do and how healthcare professionals can support her. With regard to website resources your comments will be considered by NICE where relevant support activity is being planned.
Frimley	Guideline	027 - 028	001	Weight loss & psychology are key	Thank you for your comment. Weight loss and psychological impact have been addressed in this guideline in the prevention as well as in the non-surgical management of pelvic floor dysfunction sections. However, there was evidence that pelvic floor muscle training was effective in prevention and non-surgical management so whilst weight loss and & psychology are important other factors play also an important role.
Frimley	Guideline	005	007	Formats- TV advertising	Thank you for your comment. We have added TV adverts to bullet point 1.

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Frimley	Guideline	006	010	All health professionals that come into contact with women during pregnancy should be able to advise or have awareness as this is not just midwives - GPs, health visitors , obstetricians, physios & maternity support workers.	Thank you for your comment. Recommendation 1.1.5 emphasises that all women using maternity services should receive information about pelvic floor dysfunction without specifying who ought to provide this. Therefore it could be other health professionals.
Frimley	Guideline	006	012	& refresher in Universities-experimental years!	Thank you for your comment. Evidence was found (see Evidence Review A) that introducing a pelvic floor health curriculum within schools improved the knowledge of young women aged 13-17 years. Whilst this was low quality evidence, the committee considered it important as preventative action could be taken early in life to prevent pelvic floor dysfunction in the future. We have recommended elsewhere that information should be tailored to different age groups and characteristics (see recommendation 1.1.3).
Frimley	Guideline	006	012	Earlier in schools as bad habits form when children avoid using the school toilet/aren't permitted to make a visit during lessons (age 5).	Thank you for your comment. Children up to age 12 were not included in the scope of the guideline and therefore the committee could not comment on this.
Frimley	Guideline	006	012	Health visitor groups with new borns/toddlers toileting to minimise constipation in childhood. Obesity and constipation are both risk factors for PFD.	Thank you for your comment. Children up to age 12 were not included in the scope of the guideline and therefore the committee could not comment on this.
Frimley	Guideline	006	012	There would be funding issues- could be done with bitesized videos and local pelvic health physios to answer questions. This would double-up and aid recruitment into this field.	Thank you for your comment. The committee did not want to be prescriptive about how this teaching would be implemented but other recommendations in this section refer to potential formats that could be used, including videos (see recommendation 1.1.2).

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Frimley	Guideline	006	012	Could be incorporated into current educational programmes used to teach PHSE / Health and Well being in schools such as the Jigsaw Framework https://www.jigsawpshe.com/	Thank you for your comment. The committee did not want to be prescriptive about the details of how and in which part of the curriculum this would be implemented.
Frimley	Guideline	006	012	Information needs to be balanced to ensure that messaging does not result in girls holding their pelvic floor muscles all day and inducing pelvic floor tension related conditions such as pelvic / vulval pain. Needs to explain equal importance of good habits with bowels, not ignoring urge, allowing time to use toilet in morning routine, teach optimal defaecation positioning, eating / drinking / exercise on rising in the morning, importance of fluids / fibre in diet, voiding at 3-4 hourly intervals across the day ie not holding all day at school, sitting on the toilet properly not hovering.	Thank you for your comment. The committee was unable to comment on the details of this teaching since evidence related to this was limited.
Frimley	Guideline	008	001	Box 1 Modifiable risk- amount on feet (airport/hairdressers), lifting, trampolinists, acid/oxalate diet Non-modifiable risk genetic- hypermobility & anatomy -----small perineal body. Coughing!- can use meds Pregnancy related-BMI, lifting when pregnant	Thank you for your comment. Some of these, like BMI and coughing, are listed. However, evidence for the other factors such as amount on feet and lifting was not identified. The committee therefore was unable to comment on this.
Frimley	Guideline	009	007	Low impact exc if dysfunction- swim/aqua/pilates/tai chi. Use postnatal running guidelines. Discourage front baby carriers- extra load!	Thank you for your comment. Section 1.3 is general information related to prevention and therefore is not advice for women with symptoms of pelvic floor dysfunction. We did not identify evidence related to swimming, aqua, pilates or tai chi in the prevention of pelvic floor dysfunction neither did we identify any evidence related to 'front baby carriers' as a risk factor and the committee therefore did not comment on this.
Frimley	Guideline	010	019	10sec x10 x 3 a day….squeezy/kings nhs app as reminders	Thank you for your comment.

					The committee emphasised that such training would need to be tailored to the 'the woman's ability to perform a pelvic floor contraction and relaxation, any discomfort felt, and her individual needs and goals'. They therefore did not specify the details of this exercise.
Frimley	Guideline	011	025	Supervised PFM training is ideal, may need some group work as most hospitals only have 1-3 pelvic physios. There is a recruitment shortage of trained pelvic floor physios. We need all Physio undergrads to learn about this field and national support to accelerate training for mature students/ahp upskilling.	Thank you for your comment. The committee agreed that further physiotherapists may be needed and the aim of the guideline is to raise awareness of the condition and also by recommending supervised programmes it will encourage the recruitment and training of such physiotherapists. One of the recommendations 1.1.2 recommends to include pelvic floor dysfunction in the syllabus for physiotherapists. The committee reflected on this and decided that this could be given greater focus and took it out of the bullet list to make it a separate recommendation.
Frimley	Guideline	011	025	As recommended by International Consultation on Incontinence 6th edition 2017 clinicians should offer and provide the most intensive health professional-led PFMT programme possible within service constraints. The success rate of PFMT for SUI varies between 60-75% when performed in the outpatient setting under the supervision of a physiotherapist, whereas home training is less effective (9-17%). A purely home based PFMT programme does not have a 50% cure and 70% significantly improved success rate. Supervision is vital to these outcomes. This needs to be emphasised in the guidelines.	Thank you for your comment. This section refers to pelvic floor muscle training as a preventative strategy. Therefore the women that this section of the guideline focuses on are asymptomatic. It would be a significant resource impact to give every non-symptomatic woman supervised pelvic floor muscle programmes. The committee did therefore not recommend it in this section but recommended it for a subgroup of women at higher risk where this may be a good option. In the management section of the guideline supervised pelvic floor muscle training is recommended for women with pelvic organ prolapse, stress urinary incontinence or mixed urinary incontinence as well as faecal incontinence with co-existing pelvic organ prolapse. The committee emphasised that these programmes need to be tailored to each woman and her symptoms and her ability to contract or relax her pelvic floor

					muscles, rather than being prescriptive about how intense it should be.
Frimley	Guideline	011	6	Usually 4 months. Use resources. www.pogp.csp.org.uk/booklets its not just PF exc	Thank you for your comment. The identified evidence used 3 months of pelvic floor exercise programmes. The committee decided that this would be sufficient and that 4 months of supervised pelvic floor muscle training would be a significantly higher resource impact and would therefore not be cost-effective.
Frimley	Guideline	014	002	GPs could be supported by Advanced Physio Practitioners in Pelvic Health as First Contact Practitioners for these assessments and for postnatal mum checks? I think we let mums down here- missed opportunity. Training would be needed so that physios could aid with contraceptives or signpost to family planning clinic. Pelvic Health FCP may attract more expertise to the field……..many leave the nhs and work privately.	Thank you for your comment. The committee added '(which may include assessments by physiotherapists, bladder and bowel team members and continence advisors) to 'at initial assessment in primary care' to emphasise that this could be done by a variety of roles in primary care not only GPs or practice nurses.
Frimley	Guideline	014	002	As recommended by International Consultation on Incontinence 6th edition 2017 women should be referred by GP directly for specialist review if they present with complicated incontinence. Complicated incontinence is defined as incontinence that presents in combination with a history or presentation of: Pain Haematuria Recurrent infections Suspected or proven voiding problems Significant post void residual Significant pelvic organ prolapse Previous incontinence surgery Persistent or recurrent incontinence after pelvic irradiation Radical pelvic surgery Suspected fistula Pelvic mass	Thank you for your comment. Recommendation 1.5.1 focused on the specific list of symptoms that are described as pelvic floor dysfunction symptoms in the scope of the guideline (which are also listed at the beginning of the guideline). The committee decided that a general history should be taken about these symptoms. These are intentionally kept brief and broad so that a general conversation can develop rather than giving very specific details of each potential subcategory of symptoms. Recommendation 1.5.2 is then a 'focused history' to exclude other causes and 'fistula' and 'pelvic mass' feature in that list but the list is not exhaustive.

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Frimley	Guideline	018	008	Healthy bowel habits should include - not ignoring urge, allowing time to use toilet on rising from sleep and not rushing out the door, teach optimal defaecation positioning, eating / drinking / exercise on rising, importance of fluids / fibre in diet, sitting on the toilet properly not hovering.	Thank you for your comment. This recommendation cross refers to the faecal incontinence guideline that includes a section on 'healthy bowel habits' which would therefore not be repeated. No evidence related to the details of 'healthy bowel habits' in the context of pelvic floor dysfunction was identified so the committee decided that the general guidance of the faecal incontinence guidance could be generalised to the relevant bowel symptoms associated with pelvic floor dysfunction.
Frimley	Guideline	019	005	Pt often report long walks worsen prolapse symptoms……can be 1-2 days to realise this	Thank you for your comment. The recommendations are based on the evidence that was identified which related to supervised physical activities. There was no evidence on the impact of long walks on prolapse so the committee decided that they could not comment on this. However, they made a couple of research recommendations (one on weight lifting and the other on unsupervised exercise – see appendix L of evidence review L) which can inform future updates of this guideline.
Frimley	Guideline	020	021	A pessary with a knob (incontinence dish pessary) could be beneficial to a woman with urinary incontinence Noblett et al 2008	Thank you for your comment. Evidence surrounding continence pessaries was identified from two studies (Nygaard 1995, Richter 2010). The committee were unable to extrapolate useful clinical outcomes to the evidence question as continence pessaries were not compared to no treatment. The committee were presented with three different comparisons on the effectiveness of continence pessaries in the management of urinary incontinence. The evidence favoured the use of pelvic floor muscle training in combination with continence pessaries in order to improve symptoms of urinary incontinence; but the evidence was unclear and not sustained in the long-term (12 months). Therefore, the

					committee decided not to make a recommendation for their use (see evidence review N for further details). As the study outcomes evaluated by Noblett et al 2008 were not relevant to the review protocol (see appendix A of evidence review N) it was not identified or included.
Frimley	Guideline	022	002	Psychology is a major factor with prolapse and faceal incontinence, Urinary Urgency and we need more in every MDT++++	Thank you for your comment. This recommendation will raise awareness of the psychological impact that symptoms of pelvic floor dysfunction could have on women and that this should be taken into considerations. The committee agreed that this would address the point that was raised.
Frimley	Guideline	023	010	Recommendations for research…..use of ultrasound for teaching PF- suitable for kids, minimal undressing. 2021 quote X3 portable U/s and training £16k……must be able to negotiate a better deal and use NHS in house training	Thank you for your comment. The committee made some general research recommendation about pelvic floor muscle training and how it should best be provided (see research recommendation 1 – details of which can be found in appendix L of evidence review F). This could include the use of ultrasound as a way of providing this if applicable (the PICO table in evidence review F is broad to allow multiple ways in which this question could be addressed).
Frimley	Guideline	025	002	Prediction tool- Maternity Metz and original Australian tool for generic risks	Thank you for your comment. Neither of these would be classified as a risk prediction tool: The Australian PF questionnaire is a measure of current pelvic floor dysfunction symptoms rather than a tool to predict risk of pelvic floor dysfunction in future. The Metz (2017) study is reporting a questionnaire measure of current pelvic floor dysfunction symptoms and also included assessment of risk factors but it did not review a prediction tool for risk of pelvic floor dysfunction.

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Frimley	Guideline	028	001	Use of Tens/tibial nerve stimulation- these were 'accepted' by patients during the pandemic and underutilised. Prevention is better than cure, and so once symptoms self-management with min harm is key	Thank you for your comment. The committee did not look for tibial nerve stimulation because this was considered to be something used in specialist care. TENS was included as a potential intervention but no evidence was identified in the context of pelvic floor dysfunction and the committee therefore did not comment on it.
Frimley	Guideline	030	006	Pessary investment as the surgery doesn't work/causes more harm than good	Thank you for your comment. The committee recommended to offer women with symptomatic pelvic organ prolapse a pessary so this should increase the availability and access to this management option.
Frimley	Guideline	034	016	There are evidence based tools available to predict pelvic floor dysfunction such as UR-CHOICE Wilson et al 2014 and Jelovsek et al 2018, There is also the Jelovsek et al 2013 prediction tools for postpartum urinary and faecal incontinence. I would recommend discussing this topic with Taryn Hallam in Australia about this topic. There is good data to predict the risk of an OASI – perineal body length, older women, women with family history, asian women, smaller women with low BMI. Currently risk is discussed with women based on population data not individual risk which is misleading to women, especially those that would fall into a high risk group. We also know that women with a large levator hiatus are at greater risk of POP symptoms (Dietz et al 2008) and that levator avulsion correlates with a larger levator hiatus. Avulsion is significantly associated with objective prolapse. Handa et al (2020) found that the strongest association with risk of levator avulsion was forceps delivery, followed by woman who were older at the time of first vaginal birth, more likely to have delivered a macrosomic baby, second stage >2 hours.	Thank you for your comment. Wilson 2014 was excluded from our evidence review because it is a narrative review on the UR-CHOICE tool. Jelovsek 2014 was not included because it reported a prediction tool for development of urinary incontinence, tool for use in women who already have pelvic organ prolapse. Jelovsek 2018 was not included because although it reports the development of a relevant risk prediction tool for pelvic floor dysfunction (UR-CHOICE) - it does not evaluate whether use of the tool improves outcomes for women. Dietz 2008 was not included in the risk factors evidence review because it is concerned with risk of pelvic organ prolapse rather than for the constellation of pelvic floor dysfunction symptoms as a whole. Handa 2019 was included in the risk factors evidence review.

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Frimley	Guideline	044	014	Diet- noadded sugar= sorbitol can irritate the bladder/oxalate/citrus/blackcurrsnt & dieiticians needed to aid bowel evacuation- stools too hard/lose……pt are poor at manipulating their diet	Thank you for your comment. No evidence on sorbitol, oxalate, citrus or blackcurrants was identified and the committee therefore decided that there was too much uncertainty about this to make a recommendation. With regards to stools the committee decided that a varied diet with fibre and sufficient fluids would improve stool consistency and decrease the risk of constipation. They also cross referred to recommendation 1.3.2 of the NICE guideline on faecal incontinence which gives guidance on maintaining healthy bowel habits. Due to a lack of evidence the committee decided that they could not be more specific than that.
FTWW (Fair Treatment for the Women of Wales)	Guideline	001	006	We would suggest making the list of examples of pelvic floor dysfunction more comprehensive on this first page. As it stands, the very brief list of two examples could potentially perpetuate one of the main reasons why pelvic floor dysfunction is not adequately explored with patients who have symptoms other than the two mentioned. The result is that non-surgical management, such as pelvic physiotherapy, is not offered to many who would benefit from it and / or is not sufficiently specialised to manage multifarious factors.	Thank you for your comment. We have removed the examples because the committee agreed that listing only 2 would potentially be confusing and adding all symptoms would be too detailed for this section.
FTWW (Fair Treatment for the Women of Wales)	Guideline	004	004	Include abdominal / pelvic adhesions	Thank you for your comment. The International Urogynecological Association (IUGA)/International Continence Society (ICS) Joint Report on the Terminology (Haylen 2010) refers to 'scars' as a 'sign' to look out for in examinations rather than a symptom. Therefore, it does not feature in the list of symptoms and disorders.
FTWW (Fair Treatment	Guideline	005	007	Consider including information in consent forms and post-operative information for gynaecological operations	Thank you for your comment.

for the Women of Wales)					This recommendation relates to examples of formats and settings where information to raise awareness of pelvic floor dysfunction can be provided. The committee decided that it would be preferable if this information was in leaflets which could also be post-operative rather than in consent forms because even though there is an increased risk the absolute risk could not be definitively calculated. So it would be difficult to sign up to an unknown increased quantity of risk.
FTWW (Fair Treatment for the Women of Wales)	Guideline	006	006	Whilst the guideline mentions educational settings (school), maternity, menopause, and care homes, it misses out on interventions which commonly take place during women's early and middle adult lives which are not maternity-related. These might include cervical screening appointments, coil insertion / removal, and gynaecological investigations or procedures. It is in these three settings particularly, where pelvic pain / pain during intercourse might be mentioned. As such, they lend themselves to being opportunities to discuss pelvic floor dysfunction and (non-surgical) management.	Thank you for your comment. We have added 'as part of existing programmes for example, cervical screening or NHS national or local health checks' as opportunities to raise awareness of pelvic floor dysfunction.
FTWW (Fair Treatment for the Women of Wales)	Guideline	008	001	FTWW's members would cite conditions like endometriosis and resulting adhesions, as well as other chronic conditions like Ehlers Danlos Syndrome (a connective tissue disorder which can impact on bowel and bladder function) as also being non-modifiable risk factors for developing pelvic floor dysfunction / pain.	Thank you for your comment. No evidence was identified for an association between endometriosis or Ehlers Danlos Syndrome and pelvic floor dysfunction. The committee therefore was unable to comment on this.
FTWW (Fair Treatment for the Women of Wales)	Guideline	009	005	We would ask that the guideline makes clear the need for practitioners to be aware of limitations to exercise imposed by pre-existing impairments, including chronic pain conditions and / or reduced mobility. We would suggest that guidelines make clear that conversations of this nature need to be tailored to the individual's capacity and handled sensitively. Whilst there is some reference to this later on, it is only in the context of 'older people' and 'frailty'.	Thank you for your comment. Recommendations are guidance and should not be used out of context and advice should be given according to clinical judgment. The committee thought that a positive message about physical activity would be beneficial for the majority of women. The committee anticipates that such advice would be adjusted if there are particular conditions that limit the amount of exercise that can be done. They thought however that even for people with reduced mobility or chronic pain

					some physical activity is important. In other parts of the guideline tailoring approaches to pelvic floor dysfunction prevention and management was recommended which would making adjustments for women with reduced mobility.
FTWW (Fair Treatment for the Women of Wales)	Guideline	009	014	We would ask that the guideline makes clear that for those with a history of long-term health conditions, such as endometriosis and / or invasive surgery, the presence both of disease and adhesions can impact on organ function, something that often results in patients having an extremely limited diet or fluid intake. The same would apply to a range of other conditions, most particularly connective tissue disorders, for which non-surgical management of symptoms is often necessary. The guideline should make clear that any conversation about diet should be sensitively handled and for the practitioner to have a clear understanding of patients' individual histories.	Thank you for your comment. Dietary advice related to conditions other than pelvic floor dysfunction is outside the scope of this guideline. We have also cross referred to the NICE guideline on patient experience in adult NHS services which recommends that all conversations with patients are handled sensitively.
FTWW (Fair Treatment for the Women of Wales)	Guideline	010	018	The guideline might consider using inclusive language here, ie 'all women and those assigned female at birth'.	Thank you for your comment. The guideline includes an overarching statement clarifying that 'This guideline uses the term 'women' throughout, but this should be taken to include those who do not identify as women but who have female pelvic organs'.
FTWW (Fair Treatment for the Women of Wales)	Guideline	013	023	We would advise including 'women who have chronic gynaecological conditions like endometriosis'; 'women who have long-term connective tissue disorders (like Ehlers Danlos Syndrome / EDS) and whose bowel / bladder function might be compromised', and 'women who have undergone gynaecological operations, including hysterectomy'.	Thank you for your comment. The list is giving a few examples of women at different stages of life rather than women with particular conditions. Women with chronic conditions would have these during many stages of their lives so are not relevant examples in the context of this recommendation. In other recommendations the committee has emphasised communication and information should be tailored to the individual woman which would include tailoring to women who have co-existing conditions.

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FTWW (Fair Treatment for the Women of Wales)	Guideline	014	013	We would advise including endometriosis here as it is highly prevalent amongst women / those assigned female at birth, affecting around one in ten. Symptoms most commonly include pelvic pain and organ dysfunction (bowel and bladder) so clinical examination could aid in expediting diagnosis (which currently stands at around 8 years on average in the UK) as well as helping patients to manage symptoms.	Thank you for your comment. We have added endometriosis to the list.
FTWW (Fair Treatment for the Women of Wales)	Guideline	020	013	We would suggest here some consideration for those patients who have chronic pelvic pain and hypertonic pelvic floor muscles as a result. Whilst the guideline makes a specific recommendation here for those unable to perform an effective contraction, for those with chronic pain, the reverse may be the case, with patients unable to relax their pelvic floor. This can have implications for bladder / bowel function and would likely also warrant biofeedback.	Thank you for your comment. These supplementary techniques are designed to support the woman to get feedback on her contraction rather than how much she could relax the muscles. Therefore, the committee decided that they could not add anything about relaxation to this recommendation.
FTWW (Fair Treatment for the Women of Wales)	Guideline	025	010	We are concerned that the guideline fails to make specific recommendations for those who are not pregnant or considering pregnancy but may have a chronic gynaecological or connective tissue disorder and for whom non-surgical management of pelvic floor dysfunction may be appropriate and beneficial. Similarly, we would ask for reference to those who have had (repeated) lower abdominal operations, including hysterectomy, and for whom adhesions may be playing a part in pelvic floor and organ dysfunction.	Thank you for your comment. The guideline makes recommendations based on the symptom(s) of pelvic floor dysfunction that the woman presents with. These are symptoms regardless of whether or not they are related to pregnancy or whether the woman plans a pregnancy. It was noted that gynaecological surgery (such as a hysterectomy) is a risk factor for pelvic floor dysfunction. No evidence was identified that chronic gynaecological or connective tissue disorders are risk factors for pelvic floor dysfunction and similarly no evidence was identified for preventative action following on from such gynaecological surgery. However, the committee decided that all women should be encouraged to do preventative pelvic floor dysfunction.

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					They also made a research recommendation: 'How effective is pelvic floor muscle training in preventing pelvic floor dysfunction during pregnancy in women who are in higher-risk groups?' which would include women with gynaecological surgery (see appendix L of evidence review F).
FTWW (Fair Treatment for the Women of Wales)	Guideline	031	004	For patients with chronic gynaecological / connective tissue disorders, the guideline may wish to consider expanding its recommendations for research into colonic irrigation as well as rectal irrigation. Patients with these conditions often report bowel strictures / impaction / dysfunction higher up the large bowel which would not be remedied by rectal irrigation.	Thank you for your comment. The committee was interested in faecal incontinence as a symptom of pelvic floor dysfunction whereas impaction and constipation is a risk factor rather than a symptom. They therefore prioritised rectal irrigation rather than colonic irrigation.
FTWW (Fair Treatment for the Women of Wales)	Guideline	031	008	We notice that there is no specific recommendation for research on non-surgical management of symptoms which commonly occur alongside and are linked to pelvic floor dysfunction. We would expect to see some reference to management of pelvic pain and abdominal adhesions which might include pelvic physiotherapy and associated techniques such as myofascial release and visceral manipulation. With the aim of reducing costs to health services, making this type of holistic approach available would likely reduce repeated ineffective interventions.	Thank you for your comment. The committee recognised that there was little evidence for many of the symptoms associated with pelvic floor dysfunction so in the details of the research recommendations in each related evidence review it is made clear that when referring to 'pelvic floor dysfunction' it should relate to all symptoms associated with this including pelvic pain when it is chronic. Techniques such as myofascial release and visceral manipulation were outside the scope of the guideline and were therefore not covered by a research recommendation.
FTWW (Fair Treatment for the Women of Wales)	Guideline	034	007	Whilst we appreciate the guideline not being able to list every type of condition which may incur additional risk of pelvic floor dysfunction, we would argue that something as prevalent as endometriosis and with which pelvic pain and organ dysfunction are commonly associated, should be mentioned. This is not least because non-surgical management of symptoms (such as pelvic physiotherapy) is recommended in the NICE Guideline for Diagnosis & Management of Endometriosis. Its omission also presents a missed opportunity for diagnosis and onward referral,	Thank you for your comment. Endometriosis was not identified as a risk factor in evidence review B or as a co-existing condition in evidence review C. The committee therefore did not comment on it but added it to the list of conditions to exclude when carrying out a focussed history depending on the symptoms the woman describes (see recommendation 1.5.2).

				which would have considerable cost implications for services and outcomes for patients.	
FTWW (Fair Treatment for the Women of Wales)	Guideline	040	019	We would suggest that recommendations around primary care-related practice be widened to include sexual health and contraceptive services so that symptoms of pelvic floor dysfunction can be noted and discussed when patients present for cervical screening and insertion or removal of IUDs. It is important to be aware of the numbers affected who may not be pregnant / considering pregnancy and for whom symptoms may be 'normalised', reducing likelihood of self-initiated help-seeking.	Thank you for your comment. We have added a bullet to recommendation 1.1.2 stating that awareness could be raised 'as part of existing programmes for example, cervical screening or NHS national or local health checks' and also when in 'contact with a healthcare practitioner with pelvic floor dysfunction knowledge' this could also be an opener for women with symptoms to discuss them with a practitioner. The guideline focuses on symptoms rather than whether or not women are pregnant. However, pregnancy is mentioned because various risk factors directly relate to pregnancy and giving birth. As part of raising awareness there will be information on when to seek help (see recommendation 1.1.1) which is aimed to empower women to come forward when they have symptoms and not to 'normalise' them.
FTWW (Fair Treatment for the Women of Wales)	Guideline	041	018	We would suggest that recommendations around community-based multi-disciplinary teams make some reference to pelvic pain management and pelvic physiotherapy which is focused on pain reduction not just incontinence. We see a role for abdominal massage in this kind of holistic offer, particularly as service-providers look to develop non-surgical interventions as opposed to repeated operations which can exacerbate pain and dysfunction, incur additional costs, and impact on patient outcomes. For those for whom surgery is required, in the light of extended waiting lists due to Covid-19, a community-based multi-disciplinary approach can help patients self-manage symptoms in the interim period, improve psychological wellbeing, and provide some degree of preventative support post-operatively.	Thank you for your comment. The competencies mentioned in the community-based multidisciplinary team section are consistent with the recommendations that were made about the non-surgical management in this guideline. The majority of evidence that was identified for this guideline related to the most common symptoms: urinary incontinence, faecal incontinence and pelvic organ prolapse. However, when recommendations refer to 'pelvic floor dysfunction' the committee meant this to apply to all symptoms of pelvic floor dysfunction even if evidence was not found for all of them. Effectiveness of abdominal massage was outside the scope of the guideline. The committee agreed that for those women

					who are on surgical waiting lists non-surgical options should be explored by the community-based multidisciplinary team to help women manage their symptoms and improve wellbeing. Preventative support for women who have had a surgical intervention for their symptoms is outside the scope of this guideline.
FTWW (Fair Treatment for the Women of Wales)	Guideline	047	024	We would also add that a benefit of biofeedback is the role it can play in supporting patients' adherence to exercises in their own homes. As service-providers look to develop innovative digital approaches to care, we wonder if further research might be conducted to see how biofeedback might be used to help clinician and patient share information digitally and tailor exercise programmes remotely.	Thank you for your comment. There was no evidence identified showing that biofeedback increases adherence to exercise in women's own homes. However, the committee made a research recommendation on 'effectiveness of virtual contact with a trainer, compared with in-person contact', for pelvic floor muscle training. Potentially this could incorporate biofeedback for women unable to perform an effective pelvic floor muscle contraction which could link in with potentially innovative digital approaches. The details of this research recommendation are broad (see appendix L of evidence review M) so that it allows flexibility in the details of proposed studies.
Institute of Health Visiting	Comments Form Questions	Q1 – Q5	General	We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.	Thank you for your comment. The committee decided that the additional time to talk about pelvic floor dysfunction would be very important because of the impact on physical and psychosocial wellbeing on women affected by the condition. To support such activities the committee made recommendations in section 1.1 of the guideline about 'Raising awareness of pelvic floor dysfunction for all women' and in section 1.4 'Communicating and providing information to women with pelvic floor dysfunction' containing various suggested formats that could be used as resources. This would help health visitors to save time and could save costs. Therefore, your comments related to resources and training material will be considered by NICE where relevant support activity is being planned.

				- The iHV welcomes the guideline for pelvic floor dysfunction: prevention and non-surgical management. It aligns with the 'Making Every Contact Count' (MECC) agenda. The guidelines highlight the importance of education at all stages of life, enabling the discussion about pelvic floor exercises to be raised more frequently. Health visitors can build this topic into conversations at key antenatal and postnatal contacts. This will add more time to the contacts and time is something that health visitors are very short of due to large caseloads and their role managing increasing complexity with vulnerable families. Easy access to online resources will help support implementation for health visitors. 2. Would implementation of any of the draft recommendations have significant cost implications? - Time comes with an associated cost, especially for health visitors who have very limited time available to spend with new parents and their babies. Health visiting time has been impacted due to significant budget cuts to the public health grant since 2015, and the Covid-19 pandemic has further exacerbated clinical capacity due to redeployment of staff, which has left a backlog of unmet need, as well as increasing service demand. Health visitors also manage several competing priorities of health promotion and health prevention topics at each mandated HCP contact. Therefore, for effective implementation of these practice recommendations,	We have amended the guideline to give greater emphasis to teaching healthcare and other professionals about the topic of pelvic floor dysfunction by making one of the sub-bullets in recommendation 1.1.2 into a separate recommendation. This highlights that pelvic floor dysfunction ought to be covered in the syllabus for healthcare and other professionals, such as trainee nurses, physiotherapists, doctors, midwives and teachers. It is the aim that greater focus on this will also encourage development of resources that could be used for teaching the topic. NICE routinely produce baseline assessment and resource impact tools. Your comments related to other resources will be considered by NICE where relevant support activity is being planned. Thank you also for highlighting the impact of COVID-19 on services and the postcode lottery that this has resulted in. NICE has an obligation to advance equality and the aim of this guideline is to provide access to services for more woman in the prevention and non-surgical management of pelvic floor dysfunction than there currently is. We have added the concern about geographical inequalities to the Equality Impact Assessment form to highlight that this point was raised.

				further investment is needed to increase the number of health visitors to ensure that all health visitors have the capacity to discuss this topic and share key messages, information and advice with all women. 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) - Training for health visitors on pelvic floor dysfunction and pelvic floor exercises, - Health visitors value short, accessible, evidence-based learning materials and resources to support their practice (the iHV Good Practice Points have been produced on a range of topics to improve health visitor capability) – the development of a bespoke resource on pelvic floor exercises and dysfunction would support the dissemination of best practice in this topic. - Easy access to online reliable, evidence-based, national resources to share with mothers on how to perform pelvic floor exercises and the risk factors for pelvic floor dysfunction. 4. Development of this guideline began before the COVID-19 pandemic. We have aimed to ensure that the recommendations take into account COVID-19 where possible but please tell us if there are any particular issues relating to COVID-19 that we should consider when finalising the guideline for publication. The Covid-19 pandemic has impacted on service provision resulting in a postcode lottery of support. As	

				the health service recovers from the pandemic, it will be important that all women that need support/ supervision for pelvic floor muscle training receive this from physiotherapists regardless of where they live. 5. NICE is aware that there are existing NICE guidelines regarding symptoms associated with pelvic floor dysfunction such as NG123 Urinary incontinence and pelvic organ prolapse in women: management; CG49 Faecal incontinence in adults: management; and CG148 Urinary incontinence in neurological disease: assessment and management. The draft guideline on pelvic floor dysfunction cross refers to these existing NICE guidelines where necessary. However, after this consultation NICE will assess whether some or all of these guideline recommendations should be amalgamated. If you have any views on this potential amalgamation of guideline recommendations, please let us know.	
Institute of Health Visiting	Guideline	General	General	[This text was identified as confidential and has been removed]. The importance of language What is the difference between Physical Activity, Exercise, and Sport? By definition, physical activity represents any form of bodily movement produced by skeletal muscles that results in energy expenditure. This could be everyday activities such as walking the dog, active transport, gardening, playing with the kids, etc., but could also include exercise and sporting activities.	Thank you for your comment. We have reflected on the wording and considered the definitions provided. We looked for evidence for physical activity so we have changed exercise to physical activity in most instances because exercise is also a physical activity. Even though there are a number of risk factors for pelvic floor dysfunction that are related to pregnancy, the guideline is not a pregnancy or obstetric guideline. Therefore returning to exercise after pregnancy was outside the scope of the guideline because is not directly related to pelvic floor dysfunction.

				Exercise is a more structured form of physical activity that is usually planned and repetitive, with the objective of improving or maintaining physical fitness or body condition (e.g. attending an exercise class such as Pilates or Yoga; doing a prescribed training program involving strength and conditioning, pre- or rehabilitation, etc.). Sport is an organised form of physical activity, bound by rules, defined by skill, and typically associated with competition (e.g. netball, rugby, tennis, etc.). It is important not to exclude individuals or deny them the benefits of physical activity through the language we use, as saying exercise when we mean physical activity maybe off-putting. Returning to physical activity after childbirth The national physical activity guidance for returning to physical activity after childbirth, state that following childbirth, women should aim to gradually build back up to accumulating 150 minutes of moderate intensity physical activity throughout the week and build up to doing muscle strengthening activities twice a week. It is, however, important to recognize that every birth is different and advice should be individual and tailored accordingly. If a woman has had a straightforward birth, activities such as walking, gentle stretches, and pelvic floor exercises can resume as soon as she feels up to it. In case of surgical intervention or other complications, recovery may be longer. After the 6-8 week postnatal check, advice should be tailored to whether a woman was previously active.	

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				If active before… Encourage a gradual reintroduction of physical activities. However, emphasise that activities may need to change or be adapted initially. If not active… Encourage a gradual introduction of activities and building up activity levels over time. Only after having built up moderate intensity physical activities over a minimum period of three months and in the absence of any signs or symptoms of pelvic floor or abdominal wall dysfunction, can more intense activities, such as running, gradually resume. I hope this is helpful in explaining our comments, please let us know if you have any questions or would like further details/information.	
Institute of Health Visiting	Guideline	006	010	Agree, but should it read: “Health visitors, midwives and GPs should discuss pelvic floor dysfunction with women at ALL postnatal contacts.”	Thank you for your comment. The committee decided that 'each postnatal contact' would mean 'all' postnatal contacts.
Institute of Health Visiting	Guideline	006	General	As section 1 is about raising awareness, suggest that health visitors and GPs discuss pelvic floor dysfunction during the inter-pregnancy/pre-conception period as part of routine health enquiries	Thank you for your comment. The list of settings and formats in recommendation 1.1.2 is not exhaustive but includes a bullet 'contact with a healthcare practitioner with pelvic floor dysfunction knowledge'. This could be a GP or a health visitor or any other appropriate healthcare practitioner. Therefore, the committee decided that this was already covered. Most other 'pregnancy related' matters would be covered in maternity settings, for example with information provided by midwifes (see recommendation 1.1.6).

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Institute of Health Visiting	Guideline	011	006	It is not until further into the document that it is easily identifiable that this is a physio service, suggest signposting to the section starting at line 21 or wording as: “Offer a 3-month programme of physiotherapy supervised pelvic floor muscle training”	Thank you for your comment. The committee stated in recommendation 1.3.14 that pelvic floor muscle training should be supervised by ' a physiotherapist or other healthcare professional with the appropriate expertise in pelvic floor muscle training'. It is therefore not restricted to physiotherapists and therefore recommendation 1.3.13 cannot be amended as suggested. Also the section on 'supervising pelvic floor muscle training' provides further details on what supervision should involve and the committee decided that a dedicated section for this is preferable to trying to build it into other recommendations. A hyperlink has been added and once the guideline is digitally published it will be easy to navigate from one section to the other.
Institute of Health Visiting	Guideline	011	014	Suggest adding in that once discharged from midwifery services, health visitors will continue to enquire about pelvic floor function and advise women about the importance of pelvic floor exercises, this will enable women to be reminded at regular intervals and that it is not just for the first few months in the postnatal period.	Thank you for your comment. Recommendation 1.3.12 which recommends to 'encourage women to do pelvic floor muscle training during routine postnatal care' as well as recommendation 1.1.6 stating that 'health visitors, midwives and GPs should discuss pelvic floor dysfunction with women at each postnatal contact' and also recommendation 1.5.3 which emphasises that women who have recently given birth should be asked about symptoms of pelvic floor dysfunction during routine postnatal care, in hospital and in the community' would cover all of these during postnatal care.
Institute of Health Visiting	Guideline	019	001 - 007	There are some restrictions in the first 3mths postnatally, women should avoid physical activity that place strain on pelvic floor, stomach, back muscles and include rapid twisting or lifting and high intensity physical activity. https://gpcpd.heiw.wales/clinical/motivate-2-move/chapter-11-exercise-during-pregnancy	Thank you for your comment. When and how to restart exercising after pregnancy is outside the scope of this guideline. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date

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Institute of Health Visiting	Guideline	019	001 - 007	The term exercise should be replaced with physical activity. The most recent evidence recommends that we should now be talking to people about being physically active or their physical activity, therefore the term 'exercise' should only be used in specific profiles, ie pelvic floor exercises, strength building exercises	Thank you for your comment. We have amended 'exercise' to 'physical activity' as suggested.
Lancashire and South Cumbria LMS PPHS	Guideline	General	General	There is no mention of the other bowel dysfunction presentations e.g. obstructive defaecation, either in terms of presentation or treatment, other than in the primary care screening section – seems exclusively about urinary issues when bowel dysfunction is part of PFD too.	Thank you for your comment. When recommendations in the guideline refer to 'pelvic floor dysfunction' then this would encompass all pelvic floor dysfunction symptoms that are listed at the beginning of the guideline including those related to bowel functions. This applies also to recommendations where the committee generalised or extrapolated from evidence on a limited number of symptoms. When specific symptoms are listed in the recommendation then the evidence was limited to only the symptoms that are mentioned in the recommendation and the committee decided that these could not be generalised to all symptoms (reasons are described in the rationale sections of the guideline). There was very limited evidence identified on the prevention and non-surgical management of bowel symptoms apart from some studies relating to 'faecal or anal incontinence' in the non-surgical management section (for instance there was evidence related to pelvic floor muscle training to manage symptoms of faecal incontinence and co-existing pelvic organ prolapse). The committee recognised that evidence was sparse for a number of symptoms so they made research recommendations to encourage researchers to address this gap (one research recommendation specifically related to bowel symptoms – details of which can be found in appendix L of evidence review F and where other research recommendations refer to pelvic floor dysfunction they are

					intended to look at the constellation of symptoms including bowel symptoms).
Lancashire and South Cumbria LMS PPHS	Guideline	General	General	Aligns well with aims of NHSE/I Perinatal Pelvic Health system and the PPHS may also feed into the recommended areas of research in the longer term as this is part of plan for PPHS	Thank you for your comment.
Lancashire and South Cumbria LMS PPHS	Guideline	004	018 - 019	Using visual aids/anatomical models for education is ideal but anatomical pelvic models are about £1000 each!	Thank you for your comment. The guideline does not specify that visual aids have to be anatomical models. If they were available that would be good, but if not they could be any visual means by which possible causes of symptoms can be shown to the woman.
Lancashire and South Cumbria LMS PPHS	Guideline	006	012 - 014	**1.1.7**: • All students aged 12 –17 should be informed re pelvic health/PFMT as men have pelvic floor dysfunction (PFD) too and also raises awareness of PFD and reduces taboo around this. • The Association for Continence Advice (ACA) have produced leaflets for PFMT for 12-17 year olds (winner of Nursing Times Award) as well as a you-tube video in for this • Who will train/educate/support school staff to teach PFMT correctly – funding impact to develop and deliver this type of support. There is very limited provision of specialist paediatric continence services across the UK. Where will 12-17 year olds access help/treatment as when we raise awareness it will highlight issues (needs investment/development)? The role was moved into School Nursing but this has also been reduced and is very limited too	Thank you for your response. With regards to Association for Continence Advice (ACA)'s leaflets for PFMT for 12-17 year olds your comment related will be considered by NICE where relevant support activity is being planned. In relation to continence services specifically for 12 to 17 year olds we have added to recommendation 1.6.2 (list of competencies in a community-based multidisciplinary team) that one of the competencies should be '• identifying which women need referral to specialist care or other services (including in young women aged 12 to 17 years this may include referral to paediatric services, or adolescent gynaecology services where available).'
Lancashire and South Cumbria	Guideline	006	015	**1.1.8:**	Thank you for your comment.

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LMS PPHS				• Bladder and Bowel services (Continence Nurse Specialists) are one of the specialisms involved and important in the assessment and treatment of PFD in the older population Hospital staff should be screening and referring on re identified PFD too ('every contact counts')- the bladder and bowel questions should be asked by all HCPs etc.	When referring to 'information about pelvic floor dysfunction' we would expect this to reflect the definition given in the guideline and therefore should include all symptoms listed at the beginning of the recommendations. This includes both bladder and bowel symptoms as well as other symptoms such as sexual dysfunction and chronic pelvic pain.
Lancashire and South Cumbria LMS PPHS	Guideline	008	001	**Box 1:** Complicated Perineal trauma (not just OASI) as a risk factor??	Thank you for your comment. There was no evidence identified for the broad category of complicated perinatal trauma and the committee thought that it was difficult from the identified risk factors to generalise to all. They therefore were unable to add this.
Lancashire and South Cumbria LMS PPHS	Guideline	011	006 - 009	**1.3.11;** Supervised PFMT by specialist physiotherapists for all women from 20 weeks of pregnancy with these identified risk factors (having 1st degree relative with PFD) will require greatly increased funding to develop more specialist physios to deliver this (the increased numbers planned within the PPHS will still not be able to meet this). If you consider 50 % of all women have POP and 1 in 3 have urinary incontinence and 1 in 9 have faecal incontinence this is a huge number of women to provide this for. Also approx. 3% of all women sustain OASI (greater in some areas) so delivering supervised assessment and treatment for these women post-natally is already challenging (but essential). If we add all women with perineal trauma onto this this will have further impact on ability to deliver this within current provision. Concern about point **1.3.11** due to the prescriptive nature stating certain groups of women should have a 3 month programme of PFMT during pregnancy. Whilst it is obviously important to raise awareness and to screen for symptoms it seems very unlikely that asymptomatic people will feel it necessary to engage with such a lengthy intervention.	Thank you for your comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is.

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Lancashire and South Cumbria LMS PPHS	Guideline	011	026	**1.3.15** says that supervision should involve an assessment of the woman's ability to contract the PFM - I feel it should say "offer to assess".	Thank you for your comment. The focus of the recommendation is a description of the elements that should be involved in the supervision of pelvic floor muscle training. Such supervision is tailored to the individual woman. However, essentially pelvic floor muscle training would usually be an exercise focusing on this muscle and therefore it would not be possible to tailor the programme to the woman's abilities and needs without being able to assess this first It is assumed that patient preference is always taken into account and if a women objects to an assessment this would not be conducted against her will.
Lancashire and South Cumbria LMS PPHS	Guideline	018	018 - 019	**1.6.10:** • Add bladder irritants not just caffeine (there are a number of other bladder irritants that can exacerbate/cause symptoms) Whilst further on in the draft guideline it explains why you didn't advise recommended fluid intake, there are daily normal recommendations in regard to person's weight and we could just add 'more if exercising/hot conditions etc. Fluid restriction or over-drinking do impact on symptoms.	Thank you for your comment. The reduction of caffeine recommendation was underpinned by evidence from a randomised controlled trial where women reduced their caffeine intake, but there was no evidence on other bladder irritants so the committee did not comment on these. Due to the wide age range and the wide variety of settings and circumstances that women with pelvic floor dysfunction could be in, the committee did not want to be prescriptive about the intake of fluids because potentially it could be too high for women older and less active whereas too low for an active pregnant woman in summer .The aim of this recommendation is to raise awareness of this in the context of pelvic floor dysfunction rather than give guidance on the topic of hydration.
Lancashire and South Cumbria LMS PPHS	Guideline	019	002 - 004	**1.6.11:** • No evidence that exercise other than specific targeted PFMT after PFD (e.g. yoga/Pilates) High impact/high intensity exercise can affect PFD detrimentally- needs to be more mention of rehab of PFM for function.	Thank you for your comment. The recommendations are based on the evidence that was identified which related to supervised physical activities. There was no evidence to suggest a particular level of impact

					or intensity and therefore the committee decided that they could not comment on this. However, they made a couple of research recommendations (one on weight lifting and the other on unsupervised exercise) which can inform future updates of this guideline. For details of these see appendix L of evidence review L.
Lancashire and South Cumbria LMS PPHS	Guideline	020	002	**1.6.16** says there should be choice of group or individual sessions when lots of places will not offer a group for PFMT.	Thank you for your comment. The committee agreed that there are pros and cons for either of these options. Individual sessions could focus on tailoring the programme to each woman's symptoms whereas groups sessions would also provide peer support and could potentially be a cheaper option. They therefore decided that both of these options would be implementable for different reasons to avoid inequalities by geographical location.
Lancashire and South Cumbria LMS PPHS	Guideline	020	008 - 010	**1.6.18** around reviews during the period of supervised PFMT - we do not see that this should be prescriptive about how many and when the reviews take place – should be based on negotiation and engagement with patient.	Thank you for your comment. This recommendation ensures that there is a minimum number of reviews of the woman's progress. If it is achievable, practical and feasible then potentially more reviews could be arranged. Nothing in the guideline prohibits this.
Lancashire and South Cumbria LMS PPHS	Guideline	020	014	**1.6.19**: • Rather than be specific – mention 'other adjuncts'? Vaginal cones are available on prescription in some areas but not all (can cause health inequalities if patients have to buy these). Also most hospital Trusts cannot fund/supply adjuncts.	Thank you for your comment. The supplementary techniques are not recommended as a routine option but can be considered for some women where appropriate and available. The aim of the recommendation is to raise awareness of this option so that it becomes available where it has not been previously and therefore supports NICE's responsibility to advance equality in access to treatments.
Lancashire and South Cumbria	Guideline	020	020	**1.6.21:**	Thank you for your comment.

LMS PPHS				Some intravaginal devices are available on prescription (e.g.: contiform, efemia) but not all and not in all areas and again Trusts often won't fund provision of these.	The aim of this recommendation is to improve the availability of these devices across different trusts.
Lancashire and South Cumbria LMS PPHS	Guideline	022	General	Psychological support has been shown to be effective in adherence to PFMT and attendance for physiotherapy (see Prof Phil Reed et al papers/work re this) Psychological support is essential for a lot of women with PFD – especially pelvic pain and improves outcomes.	Thank you for your comment. There are studies by Phil Reed's research group included in the evidence review for psychological interventions. However, the committee decided that this was not strong enough to recommend a specific psychological intervention or could justify the resource impact of making psychological services available to all women with pelvic floor dysfunction. However, they focused on advice and encouragement to motivate the woman to continue with pelvic floor muscle training if that was beneficial. Recommendation 1.6.28 also highlights the psychological impact that symptoms of pelvic floor dysfunction can have and that there should be a discussion about this.
MacGregor Healthcare	Guideline	005	005	1.1.2 Great to have such guidance in place and with some real in-depth information	Thank you for this comment in support of the guideline.
MacGregor Healthcare	Guideline	005	025	1.1.3 Tailoring aspects in this group of patients compares to other treatments with tailoring to the individual and their requirements	Thank you for your comment. The committee agreed that it was very important to adopt a person centred approach to raising awareness and therefore decided that an emphasis on tailoring is needed in a number of recommendations (recommendation 1.1.3 as well as 1.1.10, 1.1.11, 1.3.16, 1.4.2 and 1.4.6).
MacGregor Healthcare	Guideline	006	025	1.1.7 Teaching in earlier years may prevent problems in later years and bring an awareness.	Thank you for this comment in support of the guideline recommendation.

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MacGregor Healthcare	Guideline	012	012	1.4.2. Communication and terminology crucial in bringing about an understanding for all. May be worth considering with the wording around irrigation, should this be rectal irrigation or transanal irrigation	Thank you for your comment. The focus of recommendation 1.4.2 is on being aware of potential sensitivities or embarrassment when talking about symptoms. It is not about specific terminology but about the words that the woman prefers to use and best understands and is tailored to her level of knowledge of the anatomy so it does not include any mention of irrigation and the committee thought that the examples that were already included would be sufficient but noted that the they are not exhaustive.
MacGregor Healthcare	Guideline	015	015	1.5.7 Following the NICE FI Guidance will also provide treatments options for a condition inclusive of rectal irrigation irrigation	Thank you for your comment. Recommendation 1.5.7 is in the assessment section rather than management and therefore cross references directly to the baseline assessment section of the NICE faecal incontinence guideline. The committee could not comment on rectal irrigation because no evidence was identified in the context of faecal incontinence due to pelvic floor dysfunction. However, the committee made a research recommendation for this topic (see appendix L of evidence review N).
MacGregor Healthcare	Guideline	031	006 - 007	Consensus review This expert review provides a practical adjunct for careful patient selection, directly supervised training and sustained follow-up, which are key to optimising outcomes with this technique. Adopting a tailored, stepped approach to care is important in in this group of patients to whom rectal irrigation may be applied. (https://pubmed.ncbi.nlm.nih.gov/27977546/)	Thank you for your comment. The study referred to in the comment relates to a consensus view on transanal irrigation for bowel dysfunction, constipation and faecal incontinence in children (male and female). There is no reference to those symptoms being related to pelvic floor dysfunction. It would have also not have met the protocol criteria related to study design (see appendix A of evidence review N). For these reasons it was not included as evidence and future studies based on this research recommendation would need to be conducted in women with pelvic floor dysfunction (for details see appendix L in evidence review N).

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MacGregor Healthcare	Guideline	031	006 - 007	Systematic review This systematic review assessed research studies for the use of rectal irrigation in neurogenic bowel dysfunction, low anterior resection syndrome, faecal incontinence and chronic constipation. Studies assessed were of excellent or good methodological quality. Results showed an improvement in bowel function among patients in these groups, with some studies showing improvement in QoL Results from this review show that rectal irrigation improves bowel function and potentially QoL. (https://pubmed.ncbi.nlm.nih.gov/33668658/)	Thank you for your comment. The systematic review addresses a list of symptoms but they are not described as being associated with pelvic floor dysfunction. It was therefore not included as evidence.
MacGregor Healthcare	Guideline	031	006 - 007	Audit Rectal irrigation in the form of low volume can be used for those with passive faecal incontinence and/or evacuation difficulties. This audit demonstrates that two thirds of patients improved their symptoms and would wish to continue using the system. (https://www.magonlinelibrary.com/doi/abs/10.12968/gasn.2013.11.5.35)	Thank you for your comment. The symptoms covered in this article are not described as being associated with pelvic floor dysfunction. It is also a study type that would not have met the inclusion criteria of the protocols (see appendix A of evidence review N). On these grounds this was not included as evidence in the guideline.
MacGregor Healthcare	Guideline	031	006 - 007	Consensus review The number of rectal irrigation systems available are constantly growing, which can be overwhelming when choosing the optimal equipment. Therefore, this consensus review of best practice from a working party of experts was thought to represent the most appropriate means of arriving at clinically meaningful advice. This led to the production of an article as well as a decision-guide booklet to aid choice of equipment, initiation, patient education, regimen setting and follow-up. These are designed to help healthcare providers initiating rectal irrigation to make optimal decisions for each individual patient, ensuring right product for right patient. (https://www.magonlinelibrary.com/doi/abs/10.12968/gasn.2019.17.7.24)	Thank you for your comment. The committee's aim for this research recommendation is to encourage research into rectal irrigation for faecal incontinence as a symptom of pelvic floor dysfunction. The suggested article is also a study type that would not have met the inclusion criteria for the related protocol (see evidence review N: appendix L for details of the research recommendation and appendix A for details of the protocol). It was therefore not included as evidence for this guideline.

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MacGregor Healthcare	Guideline	031	006 - 007	**Paragraph 2.7** If bowel continence cannot be achieved by medication, changes to diet and physiotherapy and long-term management strategies, rectal irrigation is considered the next treatment option in the pathway. A number of different rectal irrigation systems are available. Clinicians and patients should discuss the options available and may try a number of devices before settling on a preferred system. **Paragraph 4.9** The NICE committee are aware that there are other rectal irrigation devices available in the NHS. It considered that clinicians should discuss the different options with the patient to help identify the device which is most appropriate. https://www.nice.org.uk/guidance/mtg36)	Thank you for your comment. The NICE medical technology guideline on the Peristeen transanal irrigation system for managing bowel dysfunction is not specific to bowel dysfunction associated with pelvic floor dysfunction which is what the research recommendation is trying to address (see appendix L of evidence review N).
Mumsnet	Guideline	005 - 006	005 – 030, 001 - 010	1.1.2/1.1.6 Settings: include postnatal wards in hospitals as a good contact point to signpost signs to look out for, and how to get further help if needed	Thank you for your comment. Recommendations 1.1.5 and 1.1.6 specifically refer to raising awareness in women who use maternity services so rather than adding it to 1.1.2 or 1.1.6 as suggested we added postnatal wards in hospitals to recommendation 1.1.5.
Mumsnet	Guideline	011	006 - 013	1.3.11 Really pleased to see this recommendation. Will this be at six-week check?	Thank you for your comment. The six-week check could provide an opportunity to discuss this issue and raise awareness of pelvic floor dysfunction (see recommendation 1.1.5) but the committee did not want to be too prescriptive about the details of when and how recommendation 1.3.11 would be implemented.
Mumsnet	Guideline	019	005 - 007	1.6.12 Specific guidance is needed on running – many postpartum women take up running (eg very popular Couch to 5k programme) to lose baby weight; many women's physios (anecdotally) tell women running can worsen pelvic floor dysfunction if women take it up before pelvic muscle strength is fully regained. Women need good-quality evidence and clarity on this point.	Thank you for your comment. The recommendations are based on the evidence that was identified which related to supervised physical activities. There was no evidence on postpartum running. However, they made a couple of research recommendations (one on weight lifting and the other on unsupervised exercise which could include running) which can inform future updates of this

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					guideline. For details of these see appendix L of evidence review L.
MUTU Holdings Limited	Guideline	5	2	Re: 'where to go for help (including self-referral to community-based multidisciplinary teams, where available)' – suggest add: '**refer to free online credible resources, such as those that have been DAQ approved or prior approval for NHS app, identifying those in particular which have visual aids/video included for accessibility**' *Comment - Credible online resources are crucial following COVID-19.*	Thank you for your comment. Once published the online version of the guideline will have a tab called 'information for the public' which will contain links to relevant resources. We have also added a link to the NHS Accessible Information Standard to recommendation 1.1.2 in relation to formats and settings where awareness can be raised.
NHSEI	Committee membership List	001	General	The office for the Chief Allied Health Professions (AHP) Officer for England note that the pelvic floor dysfunction committee membership includes a specialist physiotherapist as a topic advisor AND another as a core member. As AHPs who are specialist in this field we are confident these individuals will be able to provide expert detailed feedback on the consultation with an AHP lens. (CAHPO)	Thank you for your comment.
NHSEI	EIA	005	3.2 1.4.2	We do not believe the following wording fully encompasses the cultural sensitives around pelvic floor dysfunction: *"Be aware that women may feel embarrassed discussing their symptoms, and they may believe that healthcare professionals will also be embarrassed"* Our suggestion is that cultural sensitivities should be more overtly mentioned across the EIA as talking about pelvic floor can be taboo for some cultures and minority ethnic groups. This may impact the implementation of these NICE guidelines and could lead to health inequalities for this area of healthcare delivery. (CAHPO)	Thank you for your comment. The topic of 'embarrassment' was one of the themes highlighted in evidence review G where women stated that they felt embarrassed talking about their symptoms as well as that they thought that doctors felt embarrassed, too. The committee therefore decided that this should be specifically mentioned. It is also emphasised throughout other sections that options should be tailored to the woman whatever their specific circumstances may be. The committee agrees that cultural sensitivities could be emphasised explicitly and added 'be aware of cultural sensitivities' as a bullet into the communication section (to recommendation 1.4.2). The committee also amended the recommendation on clinical examination in the assessment

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					section by adding that 'the woman's preferences and circumstances' should be taken into account which could also relate to 'cultural sensitivities' as one of the preferences or circumstances impacting on intimate clinical examinations.
NHSEI	Guideline	General	General	Overall comment: there are considerations for commissioners of community services and awareness raising in the public and health profession. (PC)	Thank you for your comment.
NHSEI	Guideline	General	General	We note there is an absence of reference to the role of obstetric and intrapartum practice in maintaining pelvic floor health. We would welcome a greater focus on this now (where possible) and certainly in future as it seems clear this has a significant role, and is an area of current interest with projects like the OASI care bundle ongoing.	Thank you for your comment. Even though there are a number of risk factors for pelvic floor dysfunction that are related to pregnancy, the guideline is not a pregnancy or obstetric guideline. It is envisaged that obstetric guidelines can cross-refer to this guideline where appropriate. However, the committee have added a cross reference to the NICE Caesarean birth guideline (NG192 – last updated 2021) to make women aware of the full list of benefits and risks associated with this mode of birth.
NHSEI	Guideline	General	General	We would welcome opportunity to discuss the potential of assessment tools and self-assessment in empowering women to identify issues and also know when to seek clinical advice.	Thank you for your comment. NICE will be discussing this topic with NHSEI.
NHSEI	Guideline	011	007 - 008	Point 1.3.11: Offer a 3-month programme of supervised pelvic floor muscle training: • from week 20 of pregnancy, for pregnant women who have a first degree relative with pelvic floor dysfunction While we welcome the emphasis on a proactive, risk-based approach to PFMT as a preventative measure in the perinatal period, we have significant concerns with the resource implications of recommending 3 months PFMT to all women 'who have a first degree relative with pelvic floor dysfunction'. This is likely to apply to a very large number of the pregnant population.	Thank you for this comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some

				There is currently a shortage in the number of clinicians competent in providing this level of supervised training. NHSEI is trying to address this through the creation of additional specialist physiotherapy posts and additional training for midwives, however additional physiotherapy capacity should be prioritised first and foremost to ensuring that symptomatic women can receive best practice treatment in a timely manner. This requirement could take away resource from providing the most specialist care to symptomatic women and undermine the work of Perinatal Pelvic Health Services. We do not support this recommendation in its current form and suggest that any recommendation for proactive supervised PFMT should follow improved evidence, such as an evaluation of a formal screening/assessment methodology, and then an assessment on capacity of the specialist workforce to provide supervised training on that basis.	women in these groups. The committee's aim is to make this more available than it currently is.
NHSEI	Guideline	011	009 - 013	• during postnatal care, for women who have experienced any of the following risk factors during birth: o assisted vaginal birth (forceps or vacuum) o a vaginal birth when the baby is lying face up o injury to the anal sphincter. We are again concerned that a 'one-size-fits-all' approach based on the postnatal criteria provided may not be the most efficient use of specialist resource. As a more personalised and agile option, we would welcome a recommendation for a 'follow-up assessment' to be provided based on these criteria. The provision of follow-up assessments for high-risk women is also likely to be a KPI for Perinatal Pelvic Health Services.	Thank you for this comment. Based on their expertise and experience the committee considered that preventative pelvic floor muscle training was likely to be especially cost effective in these groups with known risk factors. However, as there was not economic evidence for these groups the committee weakened the strength of their recommendation from "offer" (routinely given to all) to "consider" (given to some women where possible).
NHSEI	Guideline	014	012	Section 1.5 on page 14 sets out Assessment in primary care. Line 12, 1.5.2 It would be helpful to make explicit that an internal and vaginal examination is recommended. (PC)	Thank you for your comment. The list includes 'neurological disease', 'urinary tract infection' and 'adverse effects from medication' which do not always

					need an internal and vaginal examination. Therefore the committee decided leaving 'clinical examination' as one of the options would be correct rather than making this mandatory in recommendation 1.5.5 because there could be many potential symptoms as well as conditions to rule out. However, in recommendation 1.5.5 the committee emphasised that other clinical examinations, such as internal and vaginal examinations should be considered depending on the symptoms and the women's preferences and circumstances.
NHSEI	Other	General	General	[This text was identified as confidential and has been removed].	Thank you for this comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is.
Pelvic Obstetric and Gynaecological Physiotherapy	EIA	General	General	Should there be explicit mention of how culturally sensitive PFD situations may be addressed e.g. FGM	Thank you for your comment. It is emphasised throughout (for example in sections on raising awareness, communication and information, preventative measures and non-surgical management) that options should be tailored to the woman whatever their specific circumstances may be.

					The committee agrees that cultural sensitivities could be emphasised explicitly and added 'be aware of cultural sensitivities' as a bullet into the communication section (recommendation 1.4.2). The committee also amended the recommendation on clinical examination in the assessment section by adding that 'woman's preferences and circumstances' should be taken into account whether or not that may be related to FGM or other circumstances that may impact on intimate clinical examinations.
Pelvic Obstetric and Gynaecological Physiotherapy	Evidence Review F	General	General	Consider adding the following systematic reviews for consideration: **Additional references of well conducted systematic reviews supporting a broader view of pelvic floor muscle function** 1. Physical Management of Scar Tissue: A Systematic Review and Meta-Analysis 2020 https://www.liebertpub.com/doi/full/10.1089/acm.2020.0109 2. Pelvic Floor Physical Therapy for Pelvic Floor Hypertonicity: A Systematic Review of Treatment Efficacy 2021 Pelvic Floor Physical Therapy for Pelvic Floor Hypertonicity: A Systematic Review of Treatment Efficacy - ScienceDirect 3. Pelvic floor hypertonicity in women with pelvic floor disorders: A case control and risk prediction study 2018 Relevant case control study on risk profiles for PFD cases with or without hypertonicity https://onlinelibrary.wiley.com/doi/full/10.1002/nau.23896	Thank you for your comment. The Deflorin 2020 systematic review on management of scar tissue was not included because it was not directly relevant to any of our evidence review protocols and was outside the scope of the guideline (for details see appendix A of all evidence reports). The van Reijn-Baggen 2021 systematic review was not identified because it was published after our literature search cut-off date of February 2021. We looked at the included studies of this review and most would have not been included because they would not have met inclusion criteria based on interventions (for example internal connective tissue manipulation), population (some studies only included men), comparison (some compared women with hypertonicity versus women without) or study type (for example prospective pilot study). Therefore the systematic review would not have met inclusion criteria regardless of when it was published. The Cameron 2018 case-control study was excluded from our review on risk factors as it compared women with PFD plus hypertonic pelvic floor versus women with PFD without

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					hypertonic pelvic floor. Our review was concerned with risk factors for PFD itself.
Pelvic Obstetric and Gynaecological Physiotherapy	Evidence review sections	General	General	Throughout the guideline reference is made to the limitations of the evidence, and the difficulty in interpreting the available evidence. Might NICE consider making a recommendation that for complex health conditions where RCTs are more difficult to conduct and evidence to date may include other study designs that a method of appraising a broader range of evidence be brought into the NICE process. e.g. establishing the weight of a body of evidence rather than grading a limited range of study designs	Thank you for your comment. We did not restrict our searches to randomised controlled trial (RCT) evidence only. For any symptom for which RCT evidence was identified we used this as the best available evidence, but for symptoms for which no RCT evidence was found we then looked for evidence from other non-randomised study designs. This means when there was no evidence for a symptom it was neither RCT nor non-randomised controlled studies or prospective cohort studies (see the protocols in appendix A of any intervention review, row 9 'types of study to be included').
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Terminology and Inclusion • The Guideline states that it encompasses the benefits and drawbacks of all non-surgical management but throughout the document there is a strong reliance on pelvic floor training (PFT) ad pelvic floor exercises (PFE) – but there is no definition of what PFT might legitimately include. Suggest that pelvic floor re-education or pelvic floor training could be used but should be defined at the start. • Re Pelvic floor dysfunction – a clear definition at the start would allow for better awareness of situations where the term could be modified to be pelvic floor problems and to acknowledge that interventions may improve pelvic floor function where a dysfunction has not been confirmed i.e. not every women consider the limitations of her pelvic floor to be a dysfunction Incontinence nurses is not an appropriate job title	Thank you for your comment. The International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction (Haylen 2010) describes this in terms of the constellation of symptoms rather than providing a short, concise definition that could be used in the guideline. This same approach was taken in the scope of the guideline and since this provides the remit of what the guidelines covers we need to be consistent with this. However, the committee added to the beginning 'Pelvic floor dysfunction is a condition where the pelvic floor muscles around the bladder, anal canal, and vagina do not work properly'. The International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction (Bo 2017) has a definition of pelvic floor muscle training which is: 'Exercise to improve pelvic floor muscle strength, endurance,

					power, relaxation or a combination of these parameters.' We have added this as a definition to the guideline. We have amended 'incontinence nurse' to 'continence adviser'.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	"in women aged 12 and over" POGP are very concerned that there is insufficient clarity in this Guideline of the differing requirements of the population group that includes children aged 12 and over, and women. Additionally, there is confusion in the document about the use of the word children, women and older women without any definitions of what the age groups are. POGP are in agreement that there is a requirement for PF education, knowledge and awareness of possible dysfunctions for the school age person, but much of the further detail in the Guideline is not suitable for that population group. POGP suggest that an appendix is added, or a separate section is included to identify the learning needs and pathways to help, advice and treatment for this population. Advising a blanket provision of pelvic floor exercises for this age group may result in the creation of pelvic floor dysfunctions due to overexercise or inappropriate PFME. The evidence does not support early PFME in this age group. Instead gathering evidence about what is required for this group could be a recommendation.	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses are from ages 12 years and above. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not specifically look for evidence for anyone younger than 12 years. We have added a statement to the beginning of the guideline explaining that: 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population'. Generally we have avoided being specific about ages because the committee decided that tailoring information to individual symptoms and circumstances is more important, for example we talk about pregnancy regardless of age and similarly with menopause. However, we have acknowledged that there is a lack of evidence in some areas for a 12 to 17 year old women and have therefore made specific research recommendations for this group (see the prioritised research recommendation 2 – details of which are in appendix L of evidence review F, as well as a research recommendation on

					information valued by this age group – details of which are in appendix L of evidence review G). There is no recommendation in the guideline 'advising a blanket provision of pelvic floor muscle training for this age group'. The evidence showed that pelvic floor muscle training was effective at preventing pelvic floor dysfunction across a number of different age group and in a number of different settings / contexts (with most participants in their 20s or 30s but some participants being 15 to 17 years old and others in their 60s or older – see appendix D of evidence report F). The committee agreed that was an important message and recommended that women of all ages should be 'encouraged' to do this. However, this is not in terms of providing supervised pelvic floor muscle training. A supervised programme of pelvic floor muscle training is only recommended as an option that can be considered for pregnant women of all ages who have a first degree relative with PFD or women who experienced risk factors during birth. This is regardless of the age of the woman.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Not much mention is made of the use of and the recording of data for women with PFD - this should be made clear in all the intervention areas that a recognised OM if available should be used as a baseline by all HCPs.	Thank you for your comment. Making recommendations about which types of data would be most effective to measure and record was not part of the scope of this guideline.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Guideline 1.2 This section is worded in such a way that if implemented could create a negative dialogue if shared with a women at the wrong time. Perhaps consider that a HCP **understanding** the risk factors might enable the appropriate information to be shared if advisable.	Thank you for your comment. To support opportunities for open discussions of pelvic floor dysfunction the committee has dedicated entire sections to raising awareness, communication and information provision including recommendations on how advice can be given.

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				Ref the risk factors box: This could have an introduction suggesting that the risk factors might be taken into account when advising women in certain healthcare situations e.g. undergoing procedures likely to affect her pelvic floor function. e.g. is there evidence to suggest that women being told that they are better to have their children before 30 is better for their pelvic floor risk level or makes a difference to their choice of when to start their family?	In section 1.2 we looked for evidence for any factor / characteristic that increases the risk of pelvic floor dysfunction. So this section is intended to be a summary of the identified factors rather than how this ought to be communicated. Advice for women with these risk factors is then provided in the section on preventing pelvic floor dysfunction so that it can be tailored to each individual women. There was evidence that being over 30 years when having a baby was a risk factor. Risk of future pelvic floor dysfunction would only be one factor when planning a family and it is therefore unclear how much it would overall affect a woman's choice to have children at an earlier age. However since it was identified as a risk factor the committee wanted to raise awareness of this so that women are fully informed about this.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Guideline 1.3. Pelvic floor muscle training This section should have an introduction clearly explaining normal PFM function and exactly what PFMT means – i.e. that it might include re-education of the PFM before strengthening and endurance exercises are indicated. This could include a small section on what might inhibit proper functioning of the PFM – pain / scarring / psychological factors and a section on PFM overactivity: For example provide an explanation such as: “For women who have a good pelvic floor function – overexercising the muscles might lead to overactive and hypertonic muscles – that may in turn become symptomatic.	Thank you for your comment. The International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction (Bo 2017) has a definition of pelvic floor muscle training which is: 'Exercise to improve pelvic floor muscle strength, endurance, power, relaxation or a combination of these parameters.' We have now added this as a definition to the guideline (except the final word 'parameters'). We have also added 'and relaxation' to recommendations 1.3.16 (in the context of assessing a woman's pelvic floor contraction) as well as recommendation 1.6.2 in the assessment section.

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				For women with already overtight PFM – the term pelvic floor muscle training includes the process of treatment and retraining to achieve 'normal' muscle activity." The ICS terminology emphasises relaxation after contraction – and this should be made clear that non- relaxation may require intervention that does not include PFME).	
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Guideline 1.3.11 Ref bullet point re forceps delivery: Given the clear evidence that forceps does increase the risk of pelvic floor damage – might NICE consider a research recommendation to look at the alternatives to forceps in the final stage of delivery e.g large episiotomy / late C/S. Women rarely choose to have a FD – but it is clear that it increases their risks post delivery with the ensuing long term costs – is this a priority area for research – to bring the UK more in line with Europe	Thank you for your comment. Research on how to best avoid a late forceps birth would be outside the scope of this guideline because the risk of pelvic floor dysfunction would only be one factor affecting this potential decision. Therefore, the committee decided that this research would fit better into an obstetric guideline rather than a pelvic floor dysfunction guideline.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Guideline 1.5 Section 1.5 Assessment in primary Care This section should have an introduction explaining who might be providing the assessment. Several of the symptoms and conditions mentioned are not likely to be dealt with in primary care at the moment. Several of the suggestions in 1.5.2 are likely to be referred into other services for the relevant tests. This should be made clear. Suggest not including 1.5.1 and 1.5.2 here but start the section from 1.5.3 General requirement of PF assessment in Primary Care.	Thank you for your comment. The committee did not want to be too prescriptive about the particular role in primary care who would provide the assessment because they noted that this would depend on the type of symptoms the women would present with, the severity and any other relevant circumstances. However, the committee has amended the 'assessment' section heading to ' Assessment in primary care or community-based services'. The have also amended recommendation 1.5.1 to: 'initial assessment in primary care or community-based services (which may include assessments by physiotherapists, bladder and bowel team members and

					continence advisors)' to highlight that this could be done by other professionals rather than being restricted to GPs. .
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Guideline 1.5 This section should also include a recommendation to use a simple / suitable outcome measure for QOL and/or PFD symptoms	Thank you for your comment. Throughout our evidence reviews we have looked for validated Quality of Life or validated pelvic floor dysfunction symptom outcome measures. This is also what is specified in all of our research recommendations. There are many such measures and it would be difficult to provide a list since it is very symptom dependent. So the committee focused on history taking. The committee decided that it should be left to clinical judgement how this would be conducted.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	General	General	Guideline Exercise P19 This section is likely to encourage women to think that only pilates and yoga is safe for PFD. This is not evidenced. Seeking advice and support about returning to or taking up a chosen activity would be more inclusive. Add: - "Help a woman to understand the impact of exercise on her symptoms to help guide exercise choices ".	Thank you for your comment. The physical activity interventions covered were yoga, pilates, weight training and aerobic exercises. All of these exercises were supervised. It was not clear from the studies what type of exercises were beneficial, because they were usually combined with some form of pelvic floor muscle training. Because of this, the committee recommended 'supervised exercise' in general, rather than specific exercises. They also limited the recommendation to women who are doing supervised pelvic floor muscle training, as this aligned with the evidence. Yoga is given as an example because it was one of the activities for which there was evidence. 'Supervised' exercise is specified because certain exercises, if done incorrectly, can weaken the pelvic floor by increasing intra-abdominal pressure. This could worsen symptoms of pelvic floor dysfunction. The reasoning for this is described in the related rationale and impact section. There was no further evidence on the impact of other types of exercise and a lack of evidence on unsupervised physical activity on symptoms so the committee decided that it was

					not possible to add the suggested recommendation. However, they made research recommendation on weight training and unsupervised physical activity to address this gap in the evidence base.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	004	007	Why is the term faecal incontinence rather than anal incontinence used, as flatus incontinence is also significant	Thank you for your comment. The committee used faecal incontinence as an umbrella term that included anal incontinence. The text at the beginning of the guideline is a broad overview of symptoms to put the guideline into context. This is also consistent with the scope of the guideline. There are several subgroups for many of these symptom categories but that would be a matter for a text book rather than a guideline. There was some specific evidence that chronic respiratory disease and cough could increase the risk of developing faecal incontinence and flatus incontinence (which is indicated in Box 1). Apart from this we did not uncover a lot of evidence related to anal incontinence or flatus incontinence which is why it is not specifically mentioned more than this. However, where the committee refer to 'pelvic floor dysfunction' they meant this to apply to all associated symptoms rather than named individual symptoms and as such would also include anal incontinence.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	004	011	Suggest use the term “pelvic pain” not chronic pelvic pain – which carries a specific definition relating to length of symptoms. Pelvic pain would allow for all pelvic pains – short term / long term / acute or chronic	Thank you for your comment. The committee used 'chronic pelvic pain' since this is referring to an enduring pain associated with pelvic floor dysfunction. Isolated individual episodes of 'pelvic pain' were not considered to be specific enough to differentiate pelvic pain originating from pelvic floor dysfunction from pelvic pain caused by other conditions.
Pelvic Obstetric and Gynaecolo	Guideline	005	004	Guideline 1.1.1 Add the following bullet points – or amend existing to include:	Thank you for your comment. The list in this recommendation is not exhaustive. Visual aids are mentioned in bullet 2 and could also be used to describe

gical Physiotherapy				• A clear and concise explanation of normal anatomy and function and, where appropriate, using visual aids to help understanding • Self-help advice whilst waiting for the appointment to get help	pelvic anatomy whilst the final bullet point includes information on risk factors, prevention and management options, such as lifestyle changes. Self-help would therefore be possible in relation to the final bullet. We have also hyperlinked to the relevant sections of the guideline so that navigation between sections is easier.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	005	012	Guideline 1.1.2 Add in Format section - leaflets in schools and HEIs - on packaging of continence products	Thank you for your comment. Teaching about pelvic floor dysfunction in educational settings is covered in a separate recommendation (1.1.8) and this could include the use of leaflets. We have added 'information given alongside over-the-counter continence products' to the list.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	005	015	Guideline 1.1.2 Suggest change to: In leaflets about having a hysterectomy or about gynaecological cancer (to be clear that they are not always connected) and any other leaflet about gynaecological or colorectal surgery	Thank you for your comment. There was evidence that directly linked gynaecological cancer and its treatment as well as gynaecological surgery (such as hysterectomy) to pelvic floor dysfunction. See Box 1 and evidence review B. We have amended the wording of this bullet to be consistent with the wording in Box 1. There was no evidence indicating rectal surgery as a specific risk factor for pelvic floor dysfunction and the committee therefore was unable to comment on this.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	005	018	Guideline 1.1.2 Change to: Liaise with relevant contacts in the community so they can provide appropriate information on pelvic floor dysfunction prevention e.g. exercise and fitness instructors, teachers	Thank you for your comment. The committee preferred the current wording, 'give advice' rather than 'liaise' because 'liaise' is vague and 'relevant' and 'appropriate' do not need to be highlighted.
Pelvic Obstetric and	Guideline	005	024	Guideline 1.1.2 Add in Settings section	Thank you for your comment. We have added 'information given alongside over-the-counter continence products' to the list.

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Gynaecological Physiotherapy				- in supermarkets as info leaflets beside relevant continence / bladder and bowel products	
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	005	024	Guideline 1.1.2 Add sports scientists	Thank you for your comment. Exercise and fitness instructors are given as examples in one of the bullets of recommendation 1.1.2 but the list is not meant to be exhaustive.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	005	025	Guideline 1.1.3 Suggest: “Tailor the information and language used for different age groups - teenagers through to the very elderly. For example pelvic floor awareness or pelvic floor health might send a more positive message than PFD and there may be a requirement for different information about pregnancy or menopause for example.	Thank you for your comment. We have added 'and communication' to this recommendation because 'language' is ambiguous.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	005	029	Guideline 1.1.4 Change to: …..when there is evidence of healthcare inequalities of provision / access or uptake.	Thank you for your comment. We have added 'provision' and 'uptake' to the example of 'access' to services that was already provided.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	006	009	Guideline 1.1.5 Add extra bullet: - in any labour, postnatal ward or discharge information	Thank you for your comment. We have added 'postnatal ward' to this recommendation.

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Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	006	010	Guideline 1.1.6 Suggest “health visitors, midwives and GPs should discuss and ask about pelvic floor dysfunction with women at each antenatal and postnatal contact”	Thank you for your comment. This section is focused on raising awareness which involves a discussion of the subject. Recommendation 1.5.3 in the assessment section emphasises that women who have recently given birth should be asked about symptoms of pelvic floor dysfunction during routine postnatal care.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	006	012	Guideline 1.1.7 Teach 12 – 17 y olds (girls and boys) in school about pelvic floor health including correct terms, anatomy, recognising problems and knowing how to access support and information to prevent pelvic floor dysfunction.	Thank you for your comment. It is anticipated that teaching anatomy would include the correct terms and that teaching about pelvic floor dysfunction would include the symptoms and how to recognise them. The committee decided not to be too prescriptive about the content of the teaching material. The guideline focuses on women and female pelvic organs therefore we did not look for evidence for the effectiveness of raising awareness in boys. Therefore the committee did not comment on teaching boys.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	006	015	Guideline 1.1.8 Define older (under or over 65yrs perhaps) and then add to the bullet points: - when attending for a smear test NB Scotland and England have different age ranges for smear programme for women	Thank you for your comment. We have included in recommendation 1.1.2 a bullet: 'as part of existing programmes for example, cervical screening or NHS national or local health checks'. However, we have not defined 'older' in recommendation 1.1.8 because age of perimenopause and menopause could be earlier than age 65 years so adding this to the preamble of the recommendation would exclude younger women in perimenopause or menopause.
Pelvic Obstetric and Gynaecological	Guideline	008	001 - 002	Box 1 Risk Factors p8 Add to non-modifiable risk factors: Neurological conditions e.g. MS. PD	Thank you for your comment. No evidence was identified for neurological conditions as risk factors for pelvic floor dysfunction. The committee therefore did not comment on this.

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Physiotherapy				And related to pregnancy: change to - Having had any pregnancies or children before the current pregnancy	In relation to pregnancy we have reworded the bullet referred to 'Having given birth before their current pregnancy.'
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	009	005	Guideline 1.3.1 Change to: regular exercise and a healthy diet	Thank you for your comment. The committee thought that the word 'regular' even commonly used in the context of 'exercise' is not providing additional clarity because it is open to interpretation. So, the committee decided not to add this.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	009	015	Guideline 1.3.3 We are concerned that the advice regarding constipation is rather generalist. Consider specifying soluble fibre, and that with regards to faecal incontinence, fibre intake needs to be tailored depending on symptoms	Thank you for your comment. There was some evidence that was identified showing that a higher intake of fibre reduced the risk of faecal incontinence and the committee therefore mentioned this. The evidence was not granular enough to be able to recommend specific types of fibre so the committee decided not to specify this.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	010	019	Guideline 1.3.8 Change to: "Encourage all women to be aware of the role of a healthy pelvic floor in preventing pelvic floor dysfunction"	Thank you for your comment. For this section we looked for evidence of pelvic floor muscle training in preventing pelvic floor dysfunction. So the committee could not comment on the role of 'a healthy pelvic floor' in preventing pelvic floor dysfunction because this was not the aim of the related evidence review. For information on the protocol and the evidence see appendix A of evidence review F.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	011	001	Guideline 1.3.9 If changed above then change this to: " where women require PFMT to improve the strength of their pelvic floor and reduce their symptoms, long term adherence and training should be encouraged"	Thank you for your comment. The focus of recommendation 1.3.9 is the prevention of pelvic floor dysfunction for women without symptoms. The evidence showed that this was effective in the prevention of pelvic floor dysfunction most likely by the mechanism of improved pelvic floor muscle strength.

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Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	011	006	1.3.11 this recommendation will be extremely challenging to implement in practice due to the increase in numbers of women who would require intervention and the limited resources available	Thank you for this comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	011	007	Guideline 1.3.11 Add additional bullet: • To women who had problems during and/or following a previous pregnancy	Thank you for your comment. Recommendation 1.2.2. focuses on this issue and cross-refers to the prevention and management section for further guidance.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	011	013	Guideline 1.3.11 Add extra bullet: – retention of urine requiring catheterisation	Thank you for your comment. This was not identified as a particular risk factor in evidence review B and the committee therefore was unable to add it to recommendation 1.3.11.
Pelvic Obstetric and Gynaecological	Guideline	011	015	Guideline 1.3.12 Add to this point “or seek further help if symptoms of PFD persist or develop”	Thank you for your comment. This section is about the prevention of pelvic floor dysfunction. Therefore, it focuses on asymptomatic women. However, in the assessment section it is emphasised that

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Physiotherapy					'women who have recently given birth should be asked about symptoms of pelvic floor dysfunction during routine postnatal care, in hospital and in the community.' (see recommendation 1.5.3). The committee therefore decided that women with symptoms of pelvic floor dysfunction after pregnancy would be picked up based on this recommendation and would therefore get this help.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	011	024	Guideline 1.3.14 Add "…and set according to the woman's identified goals"	Thank you for your comment. We have added 'training goals' to the second bullet point of recommendation 1.3.16.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	011	026	Suggest an alternative: assessing the pelvic floor muscles to ensure that they contract and relax correctly to provide functional support for the woman's lifestyle needs "	Thank you for your comment. We have added 'and relaxation' to this recommendation as suggested.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	012	005	Guideline 1.3.15 Suggest: "encouraging the woman to complete the course of pelvic floor muscle training as it may prevent problems occurring in later life"	Thank you for your comment. The committee decided that 'occurring in later life' implies that problems may be far in the future when for some women symptoms can occur early and persist. They decided therefore not to add this.
Pelvic Obstetric and Gynaecological	Guideline	012	009	1.4.1. There is experience from practice that education is required to ensure the public are supportive of all types of appointment opportunities including vide / telephone. Confidence in these methods needs to be instilled	Thank you for your comment. The recommendation states that formats should be agreed with each woman so it would depend on each woman's preference. However, the committee also highlighted that

Physiotherapy					there may be a need for an examination in which case a remote consultation format may not be appropriate.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	012	011	Guideline 1.4.1 Add to this sentence ..”and the need for there to be time for the woman to explain her symptoms”	Thank you for your comment. Recommendation 1.4.1 focuses on what format (telephone or video for example) the women would like to use to communicate with the healthcare professional. The committee decided that explaining her symptoms would be part of history taking in the assessment section (i.e. 1.5.1 rather than 1.4.1). They also thought taking time to listen to symptoms is part of any clinical practice and would not need to be specifically stated.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	012	020	Guideline 1.4.2 Add a final bullet: - be aware of language variation relating to age, culture and gender	Thank you for your comment. We have added 'be aware of potential cultural sensitivities' to recommendation 1.4.2. Age is covered specifically in recommendation 1.4.6. In regard to gender, the patient experience guideline referenced in recommendation 1.4.3 requests that all patients are recognised as individuals. It states that patients value healthcare professionals acknowledging their individuality and the unique way in which each person experiences a condition and its impact on their life. Patients' values, beliefs and circumstances all influence their expectations of, their needs for and their use of services. The committee felt that this addressed the requirements of both women and people who do not identify as women but who have female pelvic organs.
Pelvic Obstetric and Gynaecological	Guideline	013	019	Guideline 1.4.6 This paragraph should include a reference to goals	Thank you for your comment. This recommendation focuses on tailoring information to the women in different stages of their lives to help them understand their condition. The committee decided that goals

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Physiotherapy					would not feature in the description of the symptoms of pelvic floor dysfunction.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	013	025	Guideline 1.4.6 Add a bullet : - women who have never been pregnant	Thank you for your comment. This recommendation focuses on 'different stages of life' and 'women who have never been pregnant' could be at any time of a women's life.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	014	002	1.5.1 This recommendation will require a review of the patient pathway and a person-centred approach to pathway development	Thank you for your comment. This is the first recommendation of the 'assessment in primary care' section. The history taking in this recommendation in relation to the symptoms would most often be the beginning of the pathway so the committee decided that it would potentially be confusing to add the suggested wording to the recommendation.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	015	010	Guideline 1.5.5 Suggest change to: asking them to bear down sufficiently to check for visible vaginal or rectal prolapse	Thank you for your comment. The committee decided that adding 'sufficiently' may cause confusion since this would be difficult to define so they decided to leave this to clinical judgement.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	006	Guideline 1.6.2 Add to this sentence: The community -based multidisciplinary team should work within their scope of practise but ideally have competencies…..	Thank you for your comment. The committee amended this to read '1.6.2 The community-based multidisciplinary team (or teams) should have members with competencies related to assessing and managing pelvic floor dysfunction, such as'. The committee noted that to cover such a wider age range and circumstances there could be teams that may be specialised in pelvic floor dysfunction related to pregnancy or other teams more suited to have members that cover the

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					management of pelvic floor dysfunction of older women. The committee decided not to use the phrase 'work within their scope of practice' because it would not be very clear what is meant by this in the context of pelvic floor dysfunction.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	010	Guideline 1.6.2 Perhaps change to biopsychosocial	Thank you for your comment. This bullet is intended to focus on the psychological and social impact of pelvic floor dysfunction. Other bullets cover the biological aspects, so the committee decided to keep 'psychosocial' rather than 'biopsychosocial'.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	013	Guideline 1.6.2 Change to: conducting and interpreting ultrasound tests to measure post void residual volumes and/or pelvic floor muscle action	Thank you for your comment. This recommendation relates to the competencies that a community-based multidisciplinary team should have rather than how to conduct the assessment.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	015	Guideline 1.6.2 Suggest instead: “conduct a digital assessment of the pelvic floor if indicated and consented, and check pelvic floor muscle function”	Thank you for your comment. This recommendation relates to the competencies that a community-based multidisciplinary team should have rather than how to conduct the assessment. NICE guidelines should always be used in the context of laws and professional standards such as the GMC's decision making and consent guidance.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	019	Guideline 1.6.2 Add “…knowledge of interactions and side effects….	Thank you for your comment. We have added ‘and side effects’ as suggested.

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Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	024	1.6.2 This recommendation appears to imply that all competencies are interchangeable within professional roles and therefore fails to acknowledge the ethos of person-centred care in respect of “right person, right time, right place”	Thank you for your comment. The preamble of this recommendation was amended to '1.6.2 The community-based multidisciplinary team (or teams) should have members with competencies related to assessing and managing pelvic floor dysfunction…' to clarify that there would be several members to cover these competencies.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	026	Guideline 1.6.2 Identifying which women require onward referral for further management including surgery	Thank you for your comment. Referral to specialist care may not necessarily involve surgery and adding this to the recommendation may potentially be confusing.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	016	027	Guideline 1.6.3 Change to: Discuss and agree a management plan and goals with women…….”	Thank you for your comment. The committee decided that a discussion and agreement would include goals and would therefore not have to be explicitly mentioned.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	017	010	There is a discrepancy in the documentation, The recommendation on weight loss suggests that women with a BMI over 30kg/m when earlier on in the guideline (Page 8) a BMI over 25kg/m is identified as a risk factor for pelvic floor dysfunction	Thank you for your comment. In the risk factor review the evidence suggested a BMI of 25kg/m increases the risk of pelvic floor dysfunction. In the evidence review on weight management interventions the included studies had women with a BMI of 30kg/m or over as participants. So the committee used these different BMI levels to be consistent with the evidence.
Pelvic Obstetric and Gynaecolo	Guideline	018	018	Guideline 1.6.10	Thank you for your comment. The reduction of caffeine recommendation was underpinned by evidence from a randomised controlled trial where women

gical Physiotherapy				- reduce their caffeine intake including being aware of caffeine in OTC medications - The recommendation states that women should reduce their caffeine intake. We are concerned that the advice given is rather contentious as caffeine half- life is over 12 hours and that one cannot fully assess caffeine sensitivity until patients have ceased intake rather than reduced it. - , and modify their fluid intake over 24 hours (increase or decrease as clinically indicated following a bladder diary) as part of a bladder retraining programme	reduced rather than stopped their intake of caffeine. The reference to fluid intake is a general comment on fluids rather than a specific description on the timeframe for this change or that it ought to be part of a bladder retraining programme. Bladder retraining is covered in recommendation 1.6.30.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	019	012	Guideline 1.6.13 “Not extend beyond the hymen” does not align with the studies for effectiveness in Stage 2 prolapse that includes -1cm and +1cm above and below the hymen. Modifying the position for PFM retraining for a prolapse beyond the hymen would be reasonable – but this could still be stage 2 (as per the rationale provided on P46 L27.	Thank you for your comment. This was revised to align with the studies and now states symptomatic pelvic organ prolapse 'that does not extend greater than 1cm beyond the hymen upon straining' which has also been clarified in the rationale. With regards to the position for pelvic floor muscle training for a prolapse beyond the hymen the evidence did not address this and the committee therefore did not comment on this.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	019	017	Guideline 1.6.15 Explain why FI with co-existing prolapse? - not clear why	Thank you for your comment. The evidence that underpins this recommendation related to a study of women with faecal incontinence with co-existing pelvic organ prolapse. The committee made the recommendation to be consistent with this.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	020	003	Guideline 1.6.16 Add “if appropriate” to the end of this	Thank you for your comment. The committee decided that an offer would depend on the woman's choice and would only be made if this was 'appropriate' according to the healthcare professional's clinical judgement.

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Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	020	014	Guideline 1.6.19 Suggest changing this to: “For women who are unable to perform an effective pelvic floor muscle contraction, consider supplementing pelvic floor muscle training with biofeedback techniques, electrical stimulation or vaginal cones and addressing any hypertonicity, scarring or restrictions in the muscle, which could be preventing effective contraction” (Rationale: Changing to “biofeedback techniques” in this sentence would allow inclusion for treatment with other modalities for high tone/ pain) 1.6.19 As vaginal cones are not available on prescription should they be mentioned within this guideline. Due to vast anatomical differences their effective use is variable within a patient population and therefore would require an individual assessment if they are to be included.	Thank you for your comment. There was no evidence that these supplementary techniques would be effective for hypertonicity, scarring or restrictions in the muscle. The committee therefore did not comment on this. However, they did change 'biofeedback' to 'biofeedback techniques'. The aim of this recommendation is to make such options available where appropriate even if they are currently not available on prescription in all areas of the country.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	020	016	Guideline 1.6.20 If including this – then also include a section for when PFMT has not been beneficial	Thank you for your comments. Please see the other non-surgical management options included in the guideline, which can be considered if supervised pelvic floor muscle exercise is not successful, including 1.6.19 "1.6.19 For women who are unable to perform an effective pelvic floor muscle contraction, consider supplementing pelvic floor muscle training with biofeedback, electrical stimulation or vaginal cones." and 1.6.21-"1.6.21 Consider a trial of intravaginal devices for women with urinary incontinence, only if other non-surgical options have been unsuccessful"
Pelvic Obstetric and	Guideline	020	020	Guideline 1.6.21	Thank you for your comments.

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Gynaecological Physiotherapy				Suggest: Consider a trial of intravaginal devices as an adjunct to other treatments for women…….”	None of the studies identified evaluated the use of intravaginal devices as an adjunct to other therapies such as pelvic floor muscle training (PFMT) in comparison to no treatment. Only one study (Medina Lucena 2019) evaluated the use of intravaginal devices with PFMT in comparison to PFMT. The quality of the evidence was low and although there was a clinically significant improvement in the ICIQ-FLUTs score, there was no significant improvement in IQOL scores. Therefore, the committee decided not to make this recommendation. However, as it was unclear whether intravaginal device would be effective when combined with pelvic floor muscle training, so the committee made a research recommendation for this (see appendix L of evidence review N).
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	021	003	Guideline 1.6.23 Add to this “and who wish to consider symptom management with a pessary”	Thank you for your comment. The aim of this guideline is to provide advice and guide the non-surgical management of women with pelvic floor dysfunction including shared decision making with health care professionals and affected women. In keeping with 1.6.22- "1.6.22 Consider pessaries for women who have symptomatic pelvic organ prolapse", pessaries would only be provided to women who wish to have them.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	021	009	Guideline 1.6.23 Change to may come back or likely to come back	Thank you for your comment. The committee agreed that, as the pessary is a mechanical device providing external support for pelvic organ prolapse, once removed (without any other adjunctive therapy) the prolapse will return. This has now been described further in the relevant rationale and impact section (see the rationale and impact section for intravaginal devices).
Pelvic Obstetric and	Guideline	021	012	Guideline 1.6.23	Thank you for your comment.

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Gynaecological Physiotherapy				Change to " may cause new symptoms of SUI" and add "or other bothersome complications that may not indicate that the pessary should be removed but might take some adjusting to"	The committee agreed that, from their clinical experience that new onset stress urinary incontinence was a known complication following pessary insertion and the committee decided that if this would happen it is important to give the woman a choice to either treat the new stress incontinence or have the pessary removed. This is described in the 'benefits and harms' section of evidence review N.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	021	021	Guideline 1.2.25 Add: "that more guidance can be found in the UK Guideline – endorsed by RCOG and all major PF related organisations"	Thank you for your comments. NICE usually cross-refers only to other NICE guidelines or other UK public health or NICE endorsed guidance. Whilst it is potentially true that a cross reference could be made to other guidelines the UK Guideline on pessary use was published after our search cut off.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	023	003	Guideline 1.6.33 This is the first mention of high tone – this needs to have been included earlier – or as part of a more extensive introduction to PFM and their dysfunctions	Thank you for your comment. The evidence did not show any benefit of vaginal diazepam. In current practice this would only be considered if women have high muscle tone because of diazepam's properties related to muscle relaxation and the relieve of muscle spasms. Since this was not supported by the evidence in the context of pelvic floor dysfunction, the committee wanted to specifically highlight that this should not be considered even in women with high muscle tone. We have made this clearer in the related rationale section of the guideline.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	024	002	Research recommendation: Suggest "What pelvic floor related intervention for children and young women is effective in preventing pelvic floor dysfunction"	Thank you for your comment. The guideline includes research recommendations for a younger age group (see the prioritised research recommendation 2 – details of which are in appendix L of evidence review F, as well as a research recommendation on information valued by this age group – details of which are in appendix L of evidence review G). However, in NICE guidelines research recommendations are drafted for the

					topics for which an evidence review was conducted and gaps in the evidence are identified. The guideline was split up into a number of different interventions so the committee decided that the suggested questions were too broad to be answered as one topic.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	029	007 - 009	Research recommendation suggest "what strategies are effective in raising awareness and changing behaviour in school age girls about pelvic floor health?"	Thank you for your comment. The committee decided that a change in behaviour would be considered an outcome for such studies and therefore have not directly listed it in the research question.
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	030	006	Research recommendation This research recommendation is at odds with the recommendation in the guideline – try other non surgical measures first before offering a pessary. Might a better research recommendation be – and in line with the JLA top 10 research questions wanting answered by women and HCPs – what effect does a pessary have for a woman with prolapse - allowing for effectiveness in symptom control, effect on QoL, long term outcomes.	Thank you for your comment. The committee did not think that the research recommendation is at odds with the recommendation to try other non-surgical measures first before offering a pessary. This recommendation referred to intra-vaginal devices. Pessaries are recommended as an option for symptomatic pelvic organ prolapse regardless of whether or not other options have failed. The research recommendation addresses a combination of intravaginal devices together with pelvic floor muscle training. The committee decided that clarity was needed and that further research could inform future updates of the guidance (see appendix L of evidence review M).
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	035	026	Committee's experience We believe that the evidence sited contradicts P43 line 21 in relation to weight training	Thank you for your comment. This sentence is in the context of weight loss and in the committee's experience excess body weight exacerbates symptoms of urinary incontinence and overactive bladder by putting pressure on the pelvic floor muscles and organs. Weight lifting or weight training is a different distribution and timing of pressure on the body and not usually directly on the

					pelvic floor muscles and organs. There was one study in evidence review L that showed some benefits of weight training combined with pelvic floor muscle training over pelvic floor muscle training alone. However, this came only from one study with the evidence rated as very low quality and so the committee made a research recommendation to investigate this further (see appendix L of evidence review L).
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	037	008	We wish to comment on the committee's findings in relation to the French model of pelvic floor rehabilitation and note that they do not support the recommendation made within the recent Cumberlege report	Thank you for your comment. We did not identify sufficient evidence to be able to recommend supervised pelvic floor muscle training to all women postnatally (which is the French model). This would include all women, with or without symptoms of pelvic floor dysfunction (i.e. elements of prevention and rehabilitation). This would have a resource impact that is too high for the NHS and cannot be justified on grounds of limited evidence of effectiveness and cost-effectiveness. The committee therefore made a research recommendation to investigate routine pelvic floor muscle training provided postnatally as a preventative measure (see appendix L of evidence review F).
Pelvic Obstetric and Gynaecological Physiotherapy	Guideline	042	009	The rationale states "incontinence nurses" and we would request consideration of a review of this title.	Thank you for your comment. We have amended this to 'continence adviser'.
Perinatal Pelvic Health Reference Group	Guideline	General	General	Surprised there isn't reference to OASI Care Bundle. The title of the guideline includes "Prevention" but it all feels quite management orientated.	Thank you for your comment. Section 1.3 of the guideline focuses specifically on prevention of pelvic floor dysfunction. Even though there are a number of risk factors for pelvic floor dysfunction that are related to pregnancy, the guideline is not

					a pregnancy or obstetric guideline. Therefore, prevention of obstetric anal sphincter injury was not part of the scope of this guideline. It is envisaged that obstetric guidelines can cross-refer to this guideline where appropriate. However, the committee have added a cross reference to the NICE Caesarean birth guideline (NG192 – last updated 2021) to make women aware of the full list of benefits and risks associated with this mode of birth.
Perinatal Pelvic Health Reference Group	Guideline	General	General	Did I miss the info on pelvic pain and sexual dysfunction?	Thank you for your comment. When recommendations in the guideline refer to 'pelvic floor dysfunction' then this would encompass all pelvic floor dysfunction symptoms that are listed at the beginning of the guideline including sexual dysfunction. This applies also to recommendations where the committee generalised or extrapolated from evidence on a limited number of symptoms. When specific symptoms are listed in the recommendation then the evidence was limited to only the symptoms that were mentioned in the recommendation and the committee decided that these could not be generalised to all symptoms (reasons are described in the rationale sections of the guideline). There was very limited evidence identified on the prevention and non-surgical management of pelvic pain and sexual dysfunction. The committee recognised that evidence was sparse for these symptoms so they made research recommendations to encourage researchers to address this gap (when research recommendations include pelvic floor dysfunction they refer to the whole constellation of symptoms including chronic pelvic pain – see for example appendix L of evidence reports E, F, J, K, and L).
Perinatal Pelvic Health	Guideline	011 - 012	General	The word “encourage” – can we try “supporting” women to do their PFMT? I think encourage is just a bit blasé – whereas supporting is making the care/treatment plan personalised to them.	Thank you for your comment. The committee used the word 'encourage' in the section for 'all women' and in relation to continuing with the exercise to

Reference Group					emphasise the motivational aspect in this discussion with the woman. This is not in the context of supervised exercise programme. If the word would be changed to 'support' it would imply that specific support to do this would be provided. To provide specific support to do this would have a significant resource impact. So the committee decided to leave it as 'encourage'.
Perinatal Pelvic Health Reference Group	Guideline	005	004	This section is about what to include in resources. Is there scope to include self assessment in there? E.g ICIQUI Short Form?	Thank you for your comment. The guideline does not recommend self-assessment so there would not be scope to include it in this section.
Perinatal Pelvic Health Reference Group	Guideline	005	015	Could you include maternity in the 'settings' section? It talks about leaflets on Gynae conditions but nothing specifically maternity or early pregnancy. Also another suggestion is GP practice/hospital etc toilets.	Thank you for your comment. The committee thought that this is a specific setting that should be separately highlighted and made specific recommendations related to maternity settings (see recommendations 1.1.5 and 1.1.6).
Perinatal Pelvic Health Reference Group	Guideline	006	012	Talks about teaching young women. Should we be teaching everyone (boys/men) about this too? I don't mean about male incontinence but generally women's pelvic health (like periods and menopause). The only way we can turn this into a 'normal' discussion is to remove the stigma – but everyone needs to be involved.	Thank you for your comment. The guideline's population is all women over the age of 12 years so this section focuses on this group rather than boys and men.
Perinatal Pelvic Health Reference Group	Guideline	006	021	"shared decision making" – I can see why you've used this here when further up you've used "informed decision making" – but whether a decision is being shared or not it still needs to be informed. Therefore, I favour "informed" rather than "shared".	Thank you for your comment. This is a cross-reference to other guidelines that include separate sections on 'information and communication' but also 'shared decision making' so the recommendation is intended to highlight these as relevant to this section.
Perinatal Pelvic Health	Guideline	006	General	Between 1.1.7 and 1.1.8 I feel there's a whole life stage missing – could pelvic dysfunction be mentioned at smear tests or pill checks/contraception appointments?	Thank you for your comment. We have added a bullet to recommendation 1.1.2 stating that awareness could be raised 'as part of existing programmes

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Reference Group					for example, cervical screening or NHS national or local health checks' and also when in 'contact with a healthcare practitioner with pelvic floor dysfunction knowledge'. The list is not exhaustive but the committee thought that the young age group (12 to 17 year old), women receiving regular cervical screening, women in maternity services and older women covers a wide range of age groups.
Perinatal Pelvic Health Reference Group	Guideline	007	003	I haven't read the hyperlink here – but I'm just thinking, after speaking with several specialist physios, that we should be actively promoting personalised care from a healthcare professional – not an app.	Thank you for your comment. As part of tailoring information to women some women may prefer a digital approach, perhaps particularly a younger age group. However, the raising awareness section would include all women regardless of whether they are symptomatic or not. The committee agrees that once there are symptoms of pelvic floor dysfunction and an assessment has suggested that the symptoms are most likely associated with pelvic floor dysfunction that a community-based multidisciplinary team approach should be considered for the management of these symptoms (see recommendation 1.6.1).
Perinatal Pelvic Health Reference Group	Guideline	008	001	Box 1 In maternity, would you be asked about family history or incontinence? How would a midwife know this? It could be the only risk factor but midwives aren't prompted currently to ask this.	Thank you for your comment. There was evidence that highlighted this as a significant risk factor. The committee decided that listing it in the guideline would help raise awareness of this and would encourage women as well as healthcare professionals to discuss this.
Perinatal Pelvic Health Reference Group	Guideline	010	019	The word "encourage" – this is assuming that they have already been taught PFMT (which of course they may have but also may not have). Can we say teach as well?	Thank you for your comment. In this case the committee decided that 'encourage' would describe the action better than 'teach' because 'teaching' implies some kind of supervision and also implies some additional time to do this. Since it is suggested for all women at any potential contact 'teaching' would have a significant resource impact and could therefore not be recommended.

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Perinatal Pelvic Health Reference Group	Guideline	011	015	"encourage" again – remind/revisit their PFMT teaching would be better.	Thank you for your comment. The committee chose 'encouragement' to highlight the motivational aspect of this action.
Perinatal Pelvic Health Reference Group	Guideline	012	019 - 020	Could we add in about using diagrams/images/supporting the woman to mark on a picture where she means.	Thank you for your comment. The committee has included 'visual aids' when helpful in recommendation 1.4.5.
Perinatal Pelvic Health Reference Group	Guideline	015	007	1.5.5 I think something around consent for said examinations should be included.	Thank you for your comment. There are laws and professional standards that should be followed when making decisions related to NICE guidelines, for example the GMC's decision making and consent guidance. It is described at the beginning of the guideline 'Making decisions using NICE guidelines' that laws and standards should be followed when making decisions. This therefore would be applicable in situations where clinical examinations would be considered.
Perinatal Pelvic Health Reference Group	Guideline	016	003	1.6.1 What do we mean by "community-based multidisciplinary team approach"? I think a specialist women's physiotherapist should be mentioned by name. Many women report that GPs/nurses/HVs/Midwives etc aren't confident in PFMT/dysfunction – how do we ensure the training is up to date for this guideline to be implemented? This can't be implemented when community health care professionals generally aren't confident/experienced. I really do think we should be mentioning a specialist physiotherapist input here is vital. I disagree strongly with p42 re: committee's decision not to list specific roles – it's almost going against what we as a Reference group have been saying about the role of a specialist women's physiotherapist.	Thank you for your comment. One of the competencies listed in the community-based multidisciplinary team refers to '• supervising a pelvic floor muscle training programme (see the section on supervising pelvic floor muscle training)' and it mentions 'physiotherapist or other healthcare professional with the appropriate expertise in pelvic floor muscle training' in the section on supervising pelvic floor muscle training. Throughout the guideline there is an emphasis on raising awareness as well as teaching the relevant professionals about pelvic floor dysfunction in the syllabus of their training. It is hoped that this would increase expertise and knowledge who may not currently be confident in discussing this matter. Adding to

					section 1.6 that each team should include a physiotherapist would have a significant resource impact and may not be achievable. However, listing competencies would mean that there is access to people with appropriate expertise (which may include physiotherapists).
Perinatal Pelvic Health Reference Group	Guideline	016	006	1.6.2 (may be 1.5.2 as well – not sure where it would come) No mention of a clear and proper self assessment baselining at first contact, which as a Reference Group we have discussed and deemed to be very important. For me, being given the ICIQUI Short Form was like an epiphany. I didn't know what to tell the doctor (GP) and they certainly didn't ask me the right questions. You've said it's embarrassing so I think we need to include ways to overcome this.	Thank you for your comment. The committee did not recommend self-assessment. The recommendations in the assessment are aimed at women who have an initial first assessment with a healthcare professional about their symptoms. At this time it is unclear what the symptoms are and whether they are related to pelvic floor dysfunction. The committee's focus in the guideline was on raising awareness and expertise related to pelvic floor dysfunction (see particularly section 1.1) including adding pelvic floor dysfunction to the syllabus of healthcare professionals' training. This will improve the general population's knowledge as well as people who assess the symptoms of women and should enable them to ask the right questions. The committee decided to not be prescriptive about whether or not this should include the use of a validated questionnaire and left this to clinical judgement.
Perinatal Pelvic Health Reference Group	Guideline	017	007	"Encouragement" – it sounds patronising. I like "support".	Thank you for your comment. The committee decided that the wording 'encouragement' is intended to mean to motivate the woman to do it herself whereas 'support' seems to imply some kind of ongoing involvement which is not the intention of this recommendation.
Perinatal Pelvic Health	Guideline	024	012	Can you suggest research into how/if ethnicity has an impact on pelvic dysfunction?	Thank you for your comment.

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Reference Group					There was some evidence related to ethnicity in the risk factor review but it was not found to be significantly associated with pelvic floor dysfunction. The committee therefore did not list it in the guideline but also thought that there was no specific gap that was identified. They therefore did not add this as another research recommendation.
Royal College of Nursing	Guideline	General	General	Thank you for the opportunity to contribute on this guideline. We do not have any comments on this occasion.	Thank you.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	General		I did not see in this document any advice on how the assessment and treatment options for women with pelvic floor dysfunction are best applied to women who have had FGM previously. This could make assessment more difficult as well as many of the interventions with physical/societal/cultural barriers. Additional efforts would be required for an equitable approach.	Thank you for your comment. It is emphasised throughout that raising awareness, communication and information, as well as any other preventative or non-surgical management option should be tailored to the woman whatever their specific circumstances may be. The committee agrees that cultural sensitivities could be emphasised explicitly and added 'be aware of cultural sensitivities' as a bullet into the communication section (see recommendation 1.4.2). The committee also amended the recommendation on clinical examination in the assessment section by adding that 'the woman's preferences and circumstances' should be taken into account one such circumstance could be female genital mutilation. They decided against listing this in the recommendation because it would imply a direct link between female genital mutilation and pelvic floor dysfunction.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	005	005 - 024	Section 1.1.2, recommendations These recommendations for communication aids are all visual. There does not seem to be any recommendation for women who have impaired vision.	Thank you for your comment. Section 1.1 is aimed at raising awareness and highlights formats and opportunities of where this can take place (broadcasts was added to give an example that would be suitable for visually impaired people). The section on settings for instance contains many ways where people communicate with the person. The section contains cross references to

					other guidance including the NHS Accessible Information Standard. All of which cover the topic of making information accessible in great detail and are overarching recommendations for the use in any conditions including pelvic floor dysfunction.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	006	012 - 014	What is the evidence that raising awareness in 12-17 year old is of benefit. This is a stretch of the existing data and there may be reason to believe that the benefit would be less when extrapolated to this group. There are no trials in for this age group in Evidence Review A. Although the entry criteria for the trials may have included women in this age group, the numbers recruited and randomised would have to be checked. Later on the Recommendation for Research 2 it states there is no evidence for primary prevention of pelvic floor dysfunction in this age group. This is contradictory and therefore I think this statement at 1.1.7 should be considered for revision.	Thank you for your comment. Evidence was found (see Evidence Review A) that introducing a pelvic floor health curriculum within schools improved the knowledge of young women aged 13-17 years. Whilst this was low quality evidence, the committee considered it important as preventative action could be taken early in life to prevent pelvic floor dysfunction in the future. Raising awareness was a general theme that the committee agreed was a critical theme of the guideline. The committee decided that educating young women (aged 12 to 17) about pelvic floor dysfunction, whilst not entirely evidence based, would contribute to a wider discussion and increase knowledge about the topic which would serve them well at different stages in their lives (such as in relation to pregnancy). It would perhaps also provide an opener for conversations about this with older siblings or mothers. The committee did not feel that the lack of information on preventative strategies for young women was a contradiction to raising awareness of pelvic floor dysfunction in this group because a lot of the preventative options listed are about healthy active lifestyles (such as diet, physical activity and smoking) which would benefit women of any age. There is a research recommendation that was made for the raising awareness section of the guideline which can include a wide age range and may contribute to an evidence base that can inform future updates.

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Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	008	001	Box 1 A possible increase in AVB should be removed as this is non-significant according to all the studies cited.	Thank you for your comment. It is incorrect to say that this was non-significant according to all studies cited. For example Durnea et al. (2017) reported that fewer women had who had a natural vaginal birth had stress urinary incontinence compared to women having vacuum vaginal birth: OR 0.6 (0.43, 0.87) also urinary urgency was more likely with forceps birth vs vaginal birth OR 1.8 (1.15 to 2.82). This was consistent with the committee's experience of clinical practice. They therefore decided to list this as a risk factor.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	011	007	Section 1.3.11 If there is evidence that women after forceps have a higher rate of developing pelvic floor dysfunction, could the NNH here be correlated to the NNT for pelvic floor exercises post forceps. In women who had a forceps before and are without pelvic floor symptoms, and then a subsequent vaginal birth - these women could be considered higher risk but not necessarily included for the intervention. The statement about offering pelvic floor intervention to women with a first degree relative with similar, from 20 weeks gestation is not a time point in the routine antenatal care. Yes, there is usually the fetal anomaly scan but I would not expected the sonographer to ask about relatives with pelvic floor dysfunction, nor arrange the appropriate follow up if needed. I think this is going to be particularly impractical to implement and cause stress/worry for the women. If this is going to be the case then the evidence of benefit is needed, and also that it does not affect the eventual mode of birth. It is possible that higher pelvic floor tone may result in a high rate of forceps, and hence ameliorate the advantages hoped for.	Thank you for this comment. The committee decided that those at significant risk would most benefit of a preventative supervised pelvic floor muscle training programme. The resource impact of recommendation 1.3.12 was on reflection too high considering the implementation challenges related to, amongst others, the availability of specialist physiotherapists. So given the limitations of the clinical and cost-effectiveness evidence the committee decided to soften this recommendation from routine use for all women in these groups. The committee still recommended the training as an option, because it is likely to be cost effective for some women in these groups. The committee's aim is to make this more available than it currently is. With respect to women who have had an assisted birth, the guideline does recommend supervised pelvic floor muscle training in the postnatal period.20-weeks relates to the start of a course of supervised preventative PFMT which came from the evidence reviewed. It is not the point at which a discussion about first degree relatives should take place or when a referral should be made. Whilst most of the evidence reviewed on preventative pelvic floor muscle training was

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					short term, one long term study found evidence of benefit in terms of stress urinary incontinence at 3 months postpartum (Reilly 2002) and no evidence of harm at 8-years (Agur 2008).
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	017	010 - 012	Section 1.6.5 Why is the cut off here BMI Over 30, when at the start of the document it is stated women with BMI over 25 are at risk.(Box 1)	Thank you for your comment. In the risk factor review the evidence suggested a BMI of 25kg/m increases the risk of pelvic floor dysfunction. In the evidence review on weight management interventions the included studies were women with a BMI of 30kg/m or over as participants. So the committee used these different BMI levels to be consistent with the evidence.
The Pelvic Floor Society	Guideline	001	004	This is a very comprehensive guidance on the prevention and non-surgical management of Pelvic Floor Dysfunction in women over the age of 12 and we would like to congratulate the committee for producing this document. Whilst these guidelines only apply to women, The Pelvic Floor Society feel it is important to recognise that pelvic floor dysfunction also occurs in men and though less prevalent than seen in females, this group experiences the same difficulties and challenges in accessing information, assessment, prevention and non-surgical treatment as women. The title does not reflect that this guidance only applies to women. Given that men also suffer from Pelvic floor dysfunction, is NICE planning to undertake further work specific only to men?	Thank you for your comment. The scope of the guideline highlighted that men were excluded. The equality impact assessment form highlights this as an equality consideration and explains that the mechanisms and reasons why men develop pelvic floor dysfunction and the complications may differ and also that one of the reasons for the referral of this guideline is the avoidance of surgical treatment for women who had urinary incontinence or pelvic organ prolapse which are two of the main complications of pelvic floor dysfunction. There are currently no plans for a pelvic floor dysfunction guideline in men.
The Pelvic Floor Society	Guideline	004	016	1.1.1 When to get help and where to go for help (1.1.1) has been highlighted as an ongoing issue in the UK and to address this, the triage process should be performed by experienced healthcare professionals who are trained in pelvic floor dysfunction.	Thank you for your comment. Section 1.1 is about 'Raising awareness of pelvic floor dysfunction for all women' so it is aimed at all women not only women with symptoms. Therefore, the triage process is not the aim of this specific recommendation. This section does include a recommendation related to including pelvic floor

					dysfunction in the syllabus for trainee nurses, physiotherapists, doctors, midwives and teachers which would up-skill the expertise of these professionals. Sections 1.5 and recommendations 1.6.1 to 1.6.3 then outline the assessment in primary care and community-based multidisciplinary teams that would be involved in recognition and management.
The Pelvic Floor Society	Guideline	005	005	1.1.2 We agree with the recommendation (1.1.2) that education and better coverage in syllabus for training is vital across all the disciplines who assess and treat women with pelvic floor dysfunction. The information should not just be only offered at gynaecology surgery, surely every patient having pelvic surgery should be targeted, for example after rectal surgery, after which pelvic floor dysfunction is very common.	Thank you for your comment. There was evidence that directly linked gynaecological cancer and its treatment as well as gynaecological surgery (such as hysterectomy) to pelvic floor dysfunction. See Box 1 and evidence review B. We have amended the wording of the bullet in recommendation 1.1.2 to be consistent with this. There was no evidence indicating rectal surgery as a specific risk factor for pelvic floor dysfunction and the committee therefore was unable to comment on this.
The Pelvic Floor Society	Guideline	005	027	1.1.4 The inequality in healthcare provision for pelvic floor dysfunction in different communities and the geographic variation across the UK is recognised in 1.1.4 and how we address and rectify this remains a challenge and appropriate steps need to be taken.	Thank you for your comment. The committee aimed to raise awareness of the condition and make practice recommendations to help overcome these inequalities.
The Pelvic Floor Society	Guideline	006	006	1.1.5 We agree and strongly support better education and early access for help from maternity services given at the time of childbirth. This is often the initial injury in women who may later develop pelvic floor dysfunction. Midwifery may require more education on assessment and treatment of Faecal incontinence to prevent progression of this devastating condition.	Thank you for your comment. The guideline includes a recommendation that pelvic floor dysfunction should be covered in the syllabus for trainee nurses, physiotherapists, doctors, midwives and teachers. The aim of this is to educate people about all of the symptoms (including faecal incontinence) so that they feel confident to help and support women where appropriate.
The Pelvic Floor Society	Guideline	006	012	1.1.7 TPFS fully supports the recommendation to provide early education of young women (age 12-17 years) to teach the	Thank you for your comment. The committee highlighted that pelvic floor dysfunction should be covered in the syllabus for trainee nurses,

				importance of pelvic floor health at this early stage in order to try to prevent or reduce dysfunction in later life (1.1.7). It is interesting that faecal incontinence is not included in medical school's undergraduate curriculum, though UI and POP are.	physiotherapists, doctors, midwives and teachers. This is aimed at raising awareness of all symptoms associated with pelvic floor dysfunction including faecal incontinence.
The Pelvic Floor Society	Guideline	008	001	In Box 1 risk factors ALL pelvic surgery including Urology cancer and Colorectal Cancer surgery should be included in Non-Modifiable risk factors. Suggest a reference to Low Anterior Resection syndrome please. Other non-modifiable factors are oncological treatments- any chemotherapy and Pelvic Radiotherapy.	Thank you for your comment. The risk factors in Box 1 came from evidence reviews B and C which did not identify evidence related to urology cancer or colorectal cancer. Also no evidence was identified for Low Anterior Resection syndrome. If the treatment for gynaecological cancer includes pelvic radiotherapy then this would be included in bullet 3 other oncological treatments were not specifically identified in the evidence. The committee therefore was unable to comment on this.
The Pelvic Floor Society	Guideline	013	019	1.4.6 Although Faecal Incontinence (FI) is less prevalent than urinary incontinence, FI is devastating and can destroy our patients' quality of life. Early recognition and early treatment from the point of injury at childbirth is essential. In section 1.4.6 there is a gap between childbirth and menopause. Many of our women experience dysfunction in this period of their life. The guidance should also emphasise the benefit of early intervention when symptoms are mild and before dysfunction becomes severe- this early intervention may be able to prevent progression to severe dysfunction.	Thank you for your comment. The emphasis of recommendation 1.4.6 is on the preamble text: '1.4.6 Tailor information to each woman's age, level of understanding and circumstances, because pelvic floor dysfunction can affect women differently at different stages of life.' The bullets give some examples of different stages in women's lives. The list is not exhaustive.
The Pelvic Floor Society	Guideline	023	004	1.6.33 There is a need to educate non-specialists of how to recognise pelvic floor dysfunction when to refer for specialist treatment to avoid the long delays in accessing specialist conservative (and surgical) treatments that our patients often describe, in order to get the right person to the right team at the right time. It would be helpful if NICE could produce guidance to guide healthcare professionals on when to refer to secondary and tertiary care and	Thank you for your comment. This guideline focuses on assessment in primary care and non-surgical management options. However, one of the competencies listed in recommendation 1.6.2 which should be covered by the community-based multidisciplinary team is: • identifying which women need referral to specialist care or other services (including in young women aged 12 to 17

				when surgery is indicated (when to refer for surgery). For example, external rectal prolapse should be placed on a surgical pathway from the start- there is no place for non-surgical treatments.	years this may include referral to paediatric services, or adolescent gynaecology services where available). The topic of referral criteria for referral to specialist care was outside the scope of this guideline.
The Pelvic Floor Society	Guideline	023	008	TPFS agree there is a need for high quality research to address unanswered questions. The research recommendations are all relevant and we fully support this.	Thank you for this comment in support of the guideline.
The Pelvic Floor Society	Stakeholder list	General	General	In the Stakeholder list, The Pelvic Floor Society is incorrectly listed as National Pelvic Floor Society.	Thank you for your comment. This has been corrected
The Pelvic Partnership	Guideline	General	General	The Pelvic Partnership offers support and information to women with pregnancy-related pelvic girdle pain (PGP), their families and carers. PGP affects around one in five women causing pain, immobility and associated mental health impacts. PGP is a biomechanical joint problem that can be successfully treated with manual therapy during pregnancy and postnatally. Many women are unable to access manual therapy on the NHS and are therefore left no option but to seek treatment privately from physiotherapists, osteopaths or chiropractors – if they can afford it. Unfortunately many women have reported being unable to be treated on the NHS and afford private manual therapy, leaving them in severe pain and immobility. Many women experience PGP alongside problems with their pelvic floor, it being either too weak or more commonly, overactive or tight. We encourage women's health physios to consider PGP as a factor when assessing and treating pelvic floor dysfunction. Similarly, if women have had manual therapy to treat their PGP and treatment has reached a plateau, we would	Thank you for your comment. There was no evidence that pelvic girdle pain is a risk factor for pelvic floor dysfunction. The committee also agreed that pelvic girdle pain is not a symptom of pelvic floor dysfunction. Therefore the treatment of it is outside the scope of this guideline. The NICE antenatal care guideline (2021) includes a recommendation on pelvic girdle pain to consider referral to physiotherapy services for exercise advice and/or a non-rigid lumbopelvic belt. The committee were keen to raise awareness of pelvic floor dysfunction in all ages and therefore dedicated a whole section of the guideline to this as well as communication and information provision for women who have symptoms.

				encourage them to have their pelvic floor assessed for pelvic floor dysfunction. We welcome the aims and objectives of this draft guideline to raise awareness and provide clarity around pelvic floor problems. In particular, while bladder incontinence is becoming more normalised, faecal incontinence and other issues remain taboo and as such women are living with ongoing pelvic floor problems unnecessarily. We also encourage the guideline to cover awareness raising for those aged 18+ as well as teenagers, and focus on antenatal and postnatal awareness sessions focusing on issues related to the pelvic floor and PGP. The majority of our comments below seek to provide further clarity and ensure clear understanding.	
The Pelvic Partnership	Guideline	004	011	The guideline states that symptoms and disorders associated with pelvic floor dysfunction are included in this guideline. This list includes “chronic pelvic pain” but there is no clear definition about what “chronic pelvic pain” is. We consider there should be a clear definition of what syndromes “chronic pelvic pain” is referring to, i.e endometriosis, pelvic girdle pain or pelvic floor dysfunction and pain, which are all very painful conditions but present very differently and have different links with the pelvic floor. Given the high number of women who experience both pelvic floor problems and pelvic girdle pain, we consider pelvic girdle pain should be added to this list, or included in a clear definition of “chronic pelvic pain”.	Thank you for your comment. The emphasis of the chronic pelvic pain in this guideline is that it is associated with pelvic floor dysfunction (as stated at the beginning of the guideline) and the chronic aspect refers to pain over a long time period rather than individual acute episodes. Therefore, other chronic pelvic pain, such as endometriosis or pelvic girdle pain are not addressed in this guideline. NICE has published a guideline on endometriosis: diagnosis and management and there is a recommendation related to pelvic girdle pain in the NICE antenatal care guideline.

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				As the term in repeated throughout the guideline, some clarification of what it encompasses would be helpful.	
The Pelvic Partnership	Guideline	005	016 - 017	Given the high number of women who experience both pelvic floor problems and pelvic girdle pain, all healthcare practitioners in this field should have an understanding of pelvic floor dysfunction and pelvic girdle pain. Where this is not currently the case, training should be made available covering pelvic girdle pain and how it relates to pelvic floor problems in women, especially during pregnancy and postnatally. Many women tell us that they receive treatment for either PGP or PF problems, but many practitioners do not have the expertise to treat both, and so women are left with either pain or continence issues (or a combination of both unresolved).	Thank you for your comment. There was no evidence that pelvic girdle pain is a risk factor for pelvic floor dysfunction. The committee also agreed that pelvic girdle pain is not a symptom of pelvic floor dysfunction. Therefore, the treatment of it is outside the scope of this guideline. The NICE antenatal care guideline (2021) includes a recommendation on pelvic girdle pain to consider referral to physiotherapy services for exercise advice and/or a non-rigid lumbopelvic belt. The committee were keen to raise awareness of pelvic floor dysfunction in all ages and therefore dedicated a whole section of the guideline to this as well as communication and information provision for women who have symptoms. Recommendation 1.3.15 in the section on supervising pelvic floor muscle training contains the following bullet point: '• tailoring the pelvic floor muscle training programme to the woman's ability to perform a pelvic floor contraction and relaxation, any discomfort felt, and her individual needs'. This means that if there is both pelvic floor dysfunction and pelvic girdle pain, it would perhaps fall into the category of 'discomfort felt' so that the programme can be adapted to find a way of exercising the pelvic floor muscle in a way that does not cause pain.
The Pelvic Partnership	Guideline	005	026	Other examples should be given, e.g. the postnatal period, menopause etc	Thank you for your comment. The committee decided that one example is sufficient for this recommendation since maternity settings are already covered in recommendation 1.1.5 and 'menopause' is specifically highlighted in recommendation 1.1.8.

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The Pelvic Partnership	Guideline	008	001	We consider pelvic girdle pain should be added as a non-modifiable risk factor related to pregnancy.	Thank you for your comment. No evidence was identified for an association between pelvic girdle pain and pelvic floor dysfunction. The committee therefore was unable to comment on this.
The Pelvic Partnership	Guideline	008	001	It is important that women are also provided with information about pregnancy-related pelvic girdle pain, given the high number of women who experience pelvic floor problems alongside their pelvic girdle pain.	Thank you for your comment. No evidence was identified for an association between pelvic girdle pain and pelvic floor dysfunction. The committee therefore was unable to comment on this.
The Pelvic Partnership	Guideline	010	018 - 020	Greater clarity is needed around what is pelvic floor muscle training and training provided to healthcare practitioners to demonstrate clearly how to do it. Many women report that they are still being given a sheet of exercises which focus on tightening the pelvic floor, and which can exacerbate pain and incontinence for women with an overactive pelvic floor, particularly associated with episiotomy or perineal tears. Pelvic floor muscle training needs to be defined clearly and include contraction and relaxation of the pelvic floor muscles, given the risks associated with an overactive pelvic floor.	Thank you for your comment. The committee emphasised that such training would need to be tailored to the 'the woman's ability to perform a pelvic floor contraction and relaxation, any discomfort felt, and her individual needs and goals'. The committee agreed that it was not sufficiently clear that pelvic floor muscle training could include relaxation. They have therefore provided a definition for pelvic floor muscle training: 'Exercise to improve pelvic floor muscle strength, endurance, power, relaxation or a combination of these.'
The Pelvic Partnership	Guideline	011	003 – 020	Information about pelvic girdle pain should also be provided to women who are pregnant or who have recently given birth, alongside clear and accessible information about pelvic floor muscle training (including how to contract and relax the pelvic floor muscles). Given the high number of women who experience pelvic girdle pain alongside their pelvic floor problems, another recommendation should be added here offering all women an assessment for pelvic girdle pain, and ongoing manual therapy treatment as needed, during pregnancy and after they have given birth.	Thank you for your comment. There was no evidence that pelvic girdle pain is a risk factor for pelvic floor dysfunction. The committee also agreed that pelvic girdle pain is not a symptom of pelvic floor dysfunction. Therefore the treatment of it is outside the scope of this guideline. The NICE antenatal care guideline (2021) includes a recommendation on pelvic girdle pain to consider referral to physiotherapy services for exercise advice and/or a non-rigid lumbopelvic belt.

					The committee were keen to raise awareness of pelvic floor dysfunction in all ages and therefore dedicated a whole section of the guideline to this as well as communication and information provision for women who have symptoms.
The Pelvic Partnership	Guideline	011	26	As explained above, need to add “and relaxation of the pelvic floor muscles”.	Thank you for your comment. We have added 'and relaxation' to this recommendation as suggested.
The Pelvic Partnership	Guideline	013	001	Suggest “communicating with women” instead of “communicating with patients	Thank you for your comment. This cross reference refers to a particular guideline related to ‘patients’ experience’. If we were to change the word patient to ‘woman’ it would imply that there is a specific part of the guideline referring to woman only.
The Pelvic Partnership	Guideline	014	011	As explained above, need a clearer definition of “chronic pelvic pain” to include pelvic girdle pain.	Thank you for your comment. There was no evidence that pelvic girdle pain is a risk factor for pelvic floor dysfunction. The committee also agreed that pelvic girdle pain is not a symptom of pelvic floor dysfunction. Therefore the treatment of it is outside the scope of this guideline. The NICE antenatal care guideline (2021) includes a recommendation on pelvic girdle pain to consider referral to physiotherapy services for exercise advice and/or a non-rigid lumbopelvic belt.
The Pelvic Partnership	Guideline	014	013	A clinical examination should include a hands-on internal assessment of the pelvic floor muscles by the primary healthcare practitioner or by a referral to a women’s health physiotherapist if required. This should not just focus on whether the woman can tighten her pelvic floor, but also whether there are painful areas which may need trigger point release treatment.	Thank you for your comment. In recommendation 1.5.5 it is stated that depending on the symptoms other clinical examinations should be considered. This section of the guideline does not mention focusing only on whether the woman can tighten her pelvic floor but makes recommendations about history taking and clinical examinations. Since these are dependent on the types of symptoms that the woman presents with, the committee could not list all possible examinations that may need to be

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					considered (so they decided to give a few examples) and the list is not exhaustive.
The Pelvic Partnership	Guideline	016	015 - 016	Rather than “conduct routine digital assessments” need to be clearer about what this involves, i.e. a hands-on internal vaginal and possibly anal assessment of the pelvic floor muscles by the practitioner using their fingers to assess the pelvic floor muscles when contracting and relaxing. Once again, “and relaxation” of the pelvic floor muscles needs to be added here.	Thank you for your comment. The recommendation lists competencies needed in the community-based multidisciplinary team and digital assessment is one of them. So the detailed description of each of them is not listed because to be competent it is assumed that there would have been an appropriate level of training and experience involved. Therefore, each of these competencies on the list are broad rather than specific. We added to the bullet 'and relaxation' as suggested.
The Pelvic Partnership	Guideline	016	023	Who does “other care providers” refer to – is this GPs, nurses etc or does this refer to carers in a care home?	Thank you for your comment. We have revised this by including some examples ‘(for example carers or care home workers)' to add a bit more detail.
The Pelvic Partnership	Guideline	019	010	It is not clear what “supervised pelvic floor training” refers to – is this individual treatment, classes or monitoring with phone calls? What should the minimum frequency of supervision be? Many women tell us they are given exercises and told to return after a few weeks to check how they are getting on, or just given a sheet of exercises to take away. Could it be made clearer what the expectation of review frequency and quality is?	Thank you for your comment. This section includes a cross reference to the 'supervising pelvic floor muscle training section' of the guideline. This recommends that 1.3.15 Supervision should involve:• assessing the woman’s ability to perform a pelvic floor contraction and relaxation• tailoring the pelvic floor muscle training programme to the woman’s ability to perform a pelvic floor contraction and relaxation, any discomfort felt, and her individual needs and goals• encouraging the woman to complete the course, because this will help to prevent and manage symptoms.
UK Continence Society	Guideline	005	007-024	There is no mention of self-purchased products, which provide an opportunity to for raising awareness and signposting	Thank you for your comment. We have added ‘information given alongside over-the-counter continence products’ to the list.

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UK Continence Society	Guideline	006	012	Not sure that Pelvic Floor Dysfunction knowledge can be made a part of teacher education – don't see the role in primary school or for an A level mathematics teacher. Maybe made part of senior school PSHE offer, physical education or biology?	Thank you for your comment. This recommendation is about raising awareness in young women between 12 and 17 years. The committee did not want to be prescriptive about which part of education it would feature in.
UK Continence Society	Guideline	008	General	Risk factors should include the fact that vaginal delivery full stop is more of a risk for pelvic floor dysfunction than Caesarean section – lots of evidence for this so can't see why it's not there.	Thank you for your comment. There was evidence that some vaginal births were more risky than others (such as vacuum and forceps) so the committee focused on those. The committee wanted to emphasise that decisions about mode of birth are multifactorial and women should make informed choices based on benefits and risks (of which symptoms of pelvic floor dysfunction would be part of the consideration). The committee have added a new recommendation which makes a cross reference to the section on benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth so that women can make an informed decision that is not restricted to symptoms of pelvic floor dysfunction.
UK Continence Society	Guideline	013	022	I am concerned that this age group is referred to as women	Thank you for your comment. Ages are described according to NICE style in the following ways: children are up to age 12, 12 to 17 year olds are classed as 'young people' (so in the context of this guideline 'young women'), and adults are aged 18 and over. The age group the guideline addresses are from ages 12 years and above. To be consistent with NICE terminology we have removed the word 'children' from the research recommendations of the guideline because we did not

					specifically look for evidence for anyone younger than 12 years. We have added a statement to the beginning of the guideline explaining that: 'This guideline covers young women aged 12 to 17 and women aged 18 and over. When recommendations refer to 'women' without specifying an age range, that means they cover this entire population'.
UK Continence Society	Guideline	020	018	The use of intravaginal devices for SUI has been recommended on the basis of no clear evidence for efficacy and no understanding of the possible adverse effects of prolonged usage – this surely needs a proper trial or prospective evaluation before being NICE recommended. The committee note that there was no demonstrable reduction in urinary leakage!	Thank you for your comments. Although the identified studies showed no objective change (for example pad weight reduction), women reported a clinically subjective improvement in the symptoms they reported. The committee agreed that subjective measures are important as they indicate the woman's perception of success, and this can have significant benefits on quality of life. If other non-surgical options have been unsuccessful, this would provide another option for women which may prevent the need for more invasive treatment (see evidence review N for further details).
University of Exeter	Evidence review G	General	General	Had the review team considered the published synthesis: Salmon, V.E., Hay-Smith, E.J.C., Jarvie, R., Dean, S., Terry, R., Frawley, H., Oborn, E., Bayliss, S.E., Bick, D., Davenport, C., MacArthur, C., Pearson, M. and on behalf of the APPEAL study. (2020). Implementing pelvic floor muscle training in women's childbearing years: A Critical Interpretive Synthesis of individual, professional, and service issues. *Neurourology and Urodynamics* 39; 863-870. DOI: 10.1002/nau.24256. I can see it could be excluded as not providing source qualitative data but it is not even mentioned in the excluded list.	Thank you for your comment. The protocol for our evidence review specified we would include qualitative data about information valued by women with pelvic floor dysfunction or their partners, parents or carers (see appendix A of evidence review G). The Salmon 2020 synthesis concerns people's views on the challenges of implementing pelvic floor muscle training (PFMT), which is a different subject area. We looked at quantitative evidence on the effectiveness of PFMT in evidence reviews F & M but qualitative evidence about women's views on or experiences of PFMT were outside the scope of these questions.
University of Exeter	Evidence review H	013	030 - 031	The recommendation as written here assumes increased adherence 'should also lead to improved pelvic floor dysfunction	Thank you for your comment.

				symptoms' but this may not always be the case, especially if apps are used in isolation. The source of evidence for this demonstrates the problem: the Araujo 2020 trial shows moderate quality evidence in favour of an app to increase adherence but very low quality evidence (with substantial imprecision) that there was any clinical benefit. Individuals could end up adhering more to the wrong exercises. A suggested rephrasing to consider: 'increased adherence to correctly performed PFMT is likely to also lead to improved pelvic floor dysfunction symptoms' and possibly also adding 'any digital information provision still needs to tackle the challenge of ensuring the exercises are performed correctly (as with any information provision intervention)'.	The wording of the committee's discussion of the evidence in evidence review H has been amended as follows in line with what is suggested: "The committee noted that increased adherence to correctly performed pelvic floor muscle training is likely to lead to improved pelvic floor dysfunction symptoms. They noted that any digital information provision still needs to tackle the challenge of ensuring the exercises are performed correctly. "
University of Exeter	Evidence Review H	070	General	Table 5 Appendix F, page 70 Araujo 2020 There are 2 entries for this trial. The first is for adherence and assesses the study as providing moderate level evidence for improving adherence; the second entry is for clinical outcomes (change in symptoms) and the study is assessed as providing very low quality evidence. I would urge caution in interpreting the evidence from this very small study (n=26) – to make a statement in isolation (that mobile phone apps promote adherence) without mentioning that this doesn't appear to result in the desired clinical outcome may mislead people to thinking the answer is to promote the use of apps in isolation (a cheap & convenient digital intervention, albeit not necessarily with equitable access), but there will be a risk here that women will be adhering to at best an ineffective exercise programme or at worst the wrong exercises / doing the right exercises incorrectly. Will the committee consider adjusting their sentence regarding the interpretation to ensure that any recommendation regarding using apps to promote adherence needs to be aligned with also saying that there is currently very low quality / imprecise findings that this will achieve good clinical outcomes.	Thank you for your comment. Each outcome from the trial is graded separately - that is why there are 2 entries in the GRADE table. The wording of the committee's discussion of the evidence has been amended to make the points that (1) adherence does not automatically mean improved outcomes and (2) the challenges of ensuring exercises are done correctly with this type of mobile application.

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University of Exeter	General	General	General	General – response to questions 1 & 2 Thank you for conducting such a thorough evidence review; my one remaining concern is that this important document will provide further stimulation to the growing demand for women's health services (from prevention through to treatment provision and to longer term management) for these conditions. I would welcome any increased emphasis on the need to invest in training (undergraduate through to post graduate, and various professional groups) to ensure we have sufficient clinical providers and support for service delivery – if the committee are prepared to really re-inforce these messages for such investment to take place. These are my very crude estimates of the potential number of women who could decide to seek help: from 2019 data if 52 m of UK population are adults (over 20) and 51% are female = 26.5m adult women in UK, if 10% leak each week = 2.6m women, if 45% report leaking sometimes = nearly 12m women. We will need more specialist trained health professionals as well as more existing health professionals trained to provide basic advice and prevention 'information and education'.	Thank you for your comment. The cited calculations and estimates showcase what a serious public health concern this condition is. In support of this the guideline aims to improve awareness and access to prevention and non-surgical management which will positively impact the quality of life of women. Improvement in services will also potentially reduce downstream costs by reducing the number of women who would require surgery and potentially adverse events associated with this. However, due to the number of women involved we reflected on specialist trained health professionals resources needed to implement this and the associated resource impact. The committee therefore decided to not make preventative supervised pelvic floor muscle training a routine offer to a subgroup of women during and after pregnancy. The committee still recommended training as an option, because it is likely to be cost effective for some women in these groups. In relation to staff training we have amended the guideline to give greater emphasis to teaching healthcare and other professionals about the topic of pelvic floor dysfunction by making one of the sub-bullets in recommendation 1.1.2 into a separate recommendation. This highlights that pelvic floor dysfunction ought to be covered in the syllabus for healthcare and other professionals, such as trainee nurses, physiotherapists, doctors, midwives and teachers.
Viveca Biomed Ltd	Evidence review N	General	General	We were pleased to review the draft NICE guidance "Pelvic floor dysfunction: prevention and non-surgical management ", particularly the section on the use of devices which recommends the use of vaginal devices for women with SUI. We believe women	Thank you for your comment. The aim of the guideline is to promote non-surgical management. Therefore, we welcome this support. We are recommending the use of continence devices, however NICE usually does not recommend specific devices unless there is

				should consider the use of physiotherapy and devices before considering surgery. In the evidence review you quoted the randomised study published by Thyssen et al 2001 which compared the Conveen continence guard device with the Contrelle continence tampon which both significantly reduced episodes of SUI when women used the devices. **The Conveen continence guard is now marketed as the Contrelle Activgard and is now manufactured by Viveca Biomed Ltd** in Ashington Northumberland (a new ISO 13485 manufacturing environment). The product has recently been launched in the UK and is available direct to patients via the company's website and will be available from Boots by mid August 2021. Direct to consumer availability will help minimise health service costs.	strong overall evidence and strong health economic evidence from a single product. This allows people to make choices based on preference and availability. The study by Thyssen 2001 used number of pads and subjective improvement in continence as outcome measures which are not easily amenable to economic analysis as outlined in the NICE reference case, especially when compared to more objective measures. This reason was given in appendix J of evidence report N which includes a table with a rationale why other studies were not used in the economic analysis.. The committee did not make specific recommendations for over-the counter products. This will allow symptoms to be monitored appropriately during the recommended trial of device use.
Viveca Biomed Ltd	Evidence review N	General	General	We are committed to extend the evidence available to support Contrelle Activgard and further UK clinical studies are planned and protocols are to be submitted for ethics approval very soon, based on successful pilot data. We are in discussions with Southampton/Basingstoke/Poole hospital group regard running a broader clinical study with patients	Thank you for your comment. We welcome future studies which will help inform future updates of this guideline.

				suffering from all types of incontinence. We are working with a team in Newcastle in the area of exercise related incontinence and how with the combination of pelvic floor exercises and the use of Contrelle Activgard we can help women get back into exercise and the consequent health improvements / quality of life improvements.	
Viveca Biomed Ltd	Evidence review N	General	General	Contrelle Activgard is unique as a vaginal device being made of soft, body compatible foam which when positioned in the vagina will cause urethral compression and reduces bladder neck mobility[1] during rises in intra-abdominal pressure thus preventing stress urinary incontinence. A single use Contrelle Activgard device can be used continuously for up to 16 hours a day. 3 sizes of device are available to optimise clinical results and patient comfort.	Thank you for your comment. NICE usually does not recommend specific devices unless there is strong overall evidence and strong health economic evidence from a single product. This allows people to make choices based on preference and availability.
Viveca Biomed Ltd	Evidence review N	General	General	Please see below additional studies that have already been published on the Contrelle Activgard device. The device was tested microbiologically by Statens Seruminstitut. The device is not sterile although only unspecified bacteria were found in small numbers(2,3 x10 CFU/ml). After *Staphylococcus aureus* was added, they were able to grow and produce toxin on	Thank you for your comment. As this study has not been published it would not be included. We have checked the reference and studies that are cited and all apart from the study by Thyssen 2001 which has been included in the evidence review, are non-randomised trials and would therefore not have met the inclusions criteria of the protocol for this review (see appendix A of evidence review N).

				the surface of the device. Therefore daily change of the device was advocated to minimize the risk of toxic shock syndrome. Thyssen and Lose first reported the use of this device in 26 women with SUI in 1996 [2]. The women completed uroflowmetry, postvoid residual urine measurement by ultrasound, two consecutive 24 hour home pad weighing tests and a 3 day voiding diary. Vaginal pH was measured and vaginal and urine culture were performed. The number of incontinence pads used per 24 hours was recorded. The women were instructed on device placement. After one month's use all of the investigations were repeated with the device in place. Four of 26 women discontinued the treatment two because of discomfort and two had difficulty placing the device. Of the 22 women who completed the study nine (40.9%) were subjectively cured, 10 (45.5%) improved while three remained incontinent. All women had decreased leakage on the 24-hour pad test with the device and place. The decrease in urine loss was highly statistically significant. The average number of pads used by the women was reduced from 3.2 to 1.4 per day.	

				There were no significant changes in peak flow rate, voided volume or post void residual urine. During gynaecological examination there were no signs of irritation or erosion. Vaginal pH remained unchanged. The vaginal cultures showed normal vagina flora before and after one month's use of the device. Two women who had modest growth of *Staphylococcus aureus* had no symptoms and repeat culture at 3 months showed one persistent modest growth. All the 19 women who became continent or improved wished to continue treatment. In a follow up study, Thyssen and Lose assessed the same 19 women one year after treatment had commenced[3]. All 19 women completed one year follow-up. 13(68%) were subjectively dry, 5(26%) were improved and one reported unchanged incontinence. All but one had significantly decreased 24-hour pad test weights. There were two new growths of *Staphylococcus aureus* and these were asymptomatic. Examination showed no signs of irritation or erosion. They concluded that the device was effective at alleviating symptoms of stress urinary incontinence in the long-term and it was safe.	

				The same research group recruited fifty-five women with stress incontinence who participated in a 3-month study[4]. They were assessed by the Incontinence Impact Questionnaire, two incontinence-related quality-of-life questions, a generic quality-of-life questionnaire (Short Form-36), two 24-hour home pad weighing tests, a 2-day voiding diary, uroflowmetry, urine cultures, and a questionnaire about subjective effectiveness of the device. Forty-one (74.5%) women completed the study. Estimated on an intent-to-treat basis, the vaginal device was associated with subjective cure in 11 women (20%) and improvement in 27 (49%). The mean 24-hour pad test leakage and leakage episodes in the voiding diary decreased significantly. Fifty-eight percent of the 55 women enrolled wanted to continue using the device after 3 months. The quality of life measured by the Incontinence Impact Questionnaire showed highly significant improvement, and the results of the two incontinence-related quality of life questions also showed significant improvement. Hahn and Milsom published a multicentre study comprising 90 women with stress incontinence mean age 47.5 years(31-65).	

				The device was used daily for 4 weeks. Urinary leakage with and without the device was assessed using a 24-hour pad test at home. The patient's subjective opinion concerning urinary leakage and the efficacy and function of the device was assessed using a questionnaire[5]. 85 women completed the study and successfully performed the pad test on both occasions. The mean (SEM) urinary leakage fell from 41.6 (7.6) mls to 13.9 (3.2) mls and this was statistically significant. 39 (46%) were completely dry during the pad test with the device in situ and 29% reported reduction in leakage. 62% of women experienced some mild discomfort and of these 72% wished to carry on with the device. There were no reported infections. Thyssen et al in 2001 [6] compared two versions of the same type of disposable intravaginal device (the Conveen Continence Guard, CCG, and the Contrelle Continence Tampon, CCT, Coloplast a/s, Humlebaek, Denmark). Women with the predominant symptom of stress incontinence were recruited from four centres in Denmark, Australia and the UK. The women were assessed using a 24-h pad-test, uroflowmetry, postvoid residual urine volume and a voiding diary before	

				treatment, and after 5 weeks using each of the two devices. Vaginal swabs and specimens of urine were sent for culture, and a questionnaire about the subjective effect and adverse events completed at each visit. In all, 94 women were recruited, of whom 62 (66%) completed the study. Both devices reduced the amount of leakage significantly, but the CCT reduced urine loss significantly more than the CCG. Uroflowmetry values and residual urine volume were unchanged when using the two devices. Vaginal culture showed no abnormality during the study period, and only one woman was treated for a urinary tract infection. Side-effects were few and not serious. The women found both devices easy to prepare, insert and use. The new version of the device is not available. In summary the Contrelle Activgard (formerly called the Conveen continence guard) is the most researched vaginal device for stress urinary incontinence with robust safety data and minimal side effects. In addition there is one publication examining the use of the device for urgency incontinence which produced promising results. Thyssen et al [7] recruited patients with urgency incontinence with urodynamic evidence of detrusor overactivity (	

				this is the severe end of the spectrum). The used all the outcome measure they used for the SUI studies. There was a significant decrease in incontinence episodes (>50%) and pad test weights. 6.7% women reported cure and 50% improvement. 1 Mouritsen L. Effect of vaginal devices on bladder neck mobility in stress incontinent women. Acta Obstet Gynecol Scand. 2001 May;80(5):428-31. 2 Thyssen H, Lose G. New disposable vaginal device(continence guard) in the treatment of female stress incontinence. Acta Obstet Gynecol Scand. 1996 Feb;75(2):170-3. 3 Thyssen HH, Lose G. Long term efficacy and safety of a disposable vaginal device (continence guard) in the treatment of female stress incontinence. Int Urogynecol J Pelvic Floor Dysfunct. 1997;8(3):130-2 4 Sander P, Thyssen H, Lose G, Andersen JT. Effect of a vaginal device on quality of life of women with urinary stress incontinence. Obstet Gynecol. 1999 Mar;93(3):407-11. 5 Hahn I, Milsom I. Treatment of female stress urinary incontinence with a new anatomically shaped vaginal device	

				(Conveen Continence Guard). Br J Urol. **1996** May;77(5):711-5. 6 Thyssen H, Bidmead J, Lose G, Moller Bek K, Dwyer P, Cardozo L. A new intravaginal devicefor stress incontinence in women. BJU Int. 2001 Dec;88(9):889-92. 7 Thyssen H, Sander P, Lose G. A vaginal device (continence guard) in the management of urge incontinence in women. Int Urogynecol J Pelvic Floor Dysfunct. 1999;10(4):219-22.	
West Hertfordshire Hospitals NHS Trust	Guideline	General	General	We are totally in support of providing 12–17-year-old young women with accurate information about female anatomy, Pelvic Floor (PF) function, risk factors for PF dysfunction, the causes and education in prophylactic measures. Education should include normal bladder function, dietary advice, healthy fluid intake, good voiding habits and defecation techniques as well as how obesity can impact the pelvic floor function. Emphasis should be given in particular to the reasons why they should avoid withholding stools and delaying voiding. Many girls have a dislike of using school toilets, and notoriously avoid voiding, especially withholding from having their bowels open at school. This often leads to constipation; consequential straining and associated pelvic floor dysfunction. Part of that education would be to encourage the practise pelvic floor muscle exercises throughout their adult lives, as this is generally the most effective way to prevent pelvic floor dysfunction.	Thank you for your comment. Recommendation 1.1.8 related to teaching 12 to 17 year olds about pelvic floor anatomy, pelvic floor muscle exercises and how to prevent pelvic floor dysfunction. This is a topic that the committee thought was critical for this guideline. Learning this at a young age may encourage more young women to engage with the topic and may even lead to them to start and continue pelvic floor muscle training into adult age. Little evidence was identified and therefore the committee did not want to be too prescriptive about the content of the lessons or who should conduct them. They made recommendations about various possible formats in the same section. They also made one of the sub-bullets in recommendation 1.1.2 into a new recommendation to emphasise that pelvic floor dysfunction should be considered

				We would like to emphasise however, that in our opinion this information needs to be supplied under the auspices of POGP-Pelvic Obstetric and Gynaecology Physiotherapists, a recognised professional network of the CSP-Chartered Society of Physiotherapy. Perhaps it could be provided in the form of Power Point, written teaching material or video. It would be desirable to be uniform, distributed throughout schools and form part of the National Curriculum Our concern that this information may otherwise be provided by teachers who are not qualified Women's Health Physiotherapists. Additionally, we see it as vitally important to provide in depth sex education in a positive enhanced manner, inextricably linked with consensual participation and the values of relationships. Education should also be provided of the harm of accessing porn that has become so readily available since material that is viewed has gained legitimacy and seems to be considered and accepted as normal sexual behaviour. In most nulliparous young women 12-17, there exists a normal correlation between movement of the diaphragm and movement of the pelvic floor musculature linked to inhalation and exhalation. This means that there is normal support activated to the PF organs. It is reasonable to consider that young women from age 12 regularly performing PFM Training-(PFMT) may theoretically lead to muscle shortening and hence weakening of PF musculature and hypertonicity. Therefore, we feel it is important to perform these exercises alongside PF stretches and release, to avoid development of potential hypertonicity. Hypertonicity is, in itself, a risk factor for PF dysfunction long term, by leading to less effective PF support and potential for vaginismus. Additionally, female school children are often predisposed to hyperactive muscles driven by the dislike of using school toilets, withholding stools or delaying micturition, and an associated increase in PFM tone. Any girl with Overactive Bladder symptom	to be included in the syllabus for healthcare and other professionals, such as trainee nurses, physiotherapists, doctors, midwives and teachers. This would upskill teachers to be able to talk about this topic with an appropriate level of expertise. Specifying that this should only be done by a Pelvic Obstetric and Gynaecology Physiotherapists would also lead to delays in the implementation of this and a resource impact because there would not be enough Pelvic Obstetric and Gynaecology Physiotherapists to carry out all this teaching. With regards to potential teaching resources your comments will be considered by NICE where relevant support activity is being planned. Sex education was outside the scope of the guideline so the committee did not comment on this. No evidence was identified for a relationship between movement of the diaphragm and movement of the pelvic floor musculature linked to inhalation and exhalation in nulliparous young women aged 12-17 and how this may related to pelvic floor dysfunction and whether or not pelvic floor muscle training may then induce hypertonic muscles. They therefore did not comment on this. However, with regards to the potential to develop hypertonicity, the committee added generally more emphasis on the ability to relax muscles throughout the guideline and provided a definition of pelvic floor muscle training that highlights relaxation as one of the components ('Exercise to improve pelvic floor muscle strength, endurance, power, relaxation, or a combination of these.'). Due to the lack of evidence on pelvic floor muscle training in this age group the committee thought it was unclear whether a differentiation could be made between 12 to 14 year olds and 15 to 17 year olds and emphasised that teaching in

				and giggle micturition will also be trying to prevent urinary leakage with potential resultant hypertonicity. We were unable to find evidence based retrospective studies showing the impact of PFMT on young women as young as 12 in particular if it causes any hypertonicity. We therefore considered that it may be safer to delay the performance of PFMT till the young women are a little older. CONCLUSION We are grateful and delighted for this most welcomed and amazing initiative. To conclude we believe that in the younger age group (say 12-14) the emphasis could be on the education as above, and perhaps leaving regular PFMT to the older age group (say 15-17.). As noted, It is essential that training comes from a POGP group Thank you The Women's Health Physiotherapy Team West Herts Therapy Unit	general would be of benefit. However, they made a research recommendation related to pelvic floor muscle training for 12 to 17 year olds which could provide answers to this (see the prioritised research recommendation 2 – details of which are in appendix L of evidence review F).

Document processed	Organisation name – Stakeholder or respondent	Disclosure on tobacco funding / links	Number of comments extracted	Comments

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*