

Pelvic floor dysfunction: prevention and non- surgical management

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guideline is the basis of QS77.

Overview

This guideline covers the prevention, assessment and non-surgical management of pelvic floor dysfunction in women aged 12 and over. It aims to raise awareness and help women to reduce their risk of pelvic floor dysfunction. For women who have pelvic floor dysfunction, the guideline recommends interventions based on their specific symptoms.

NICE has also produced a [guideline on urinary incontinence and pelvic organ prolapse in women aged 18 and over](#).

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.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Education providers (recommendation 1.1.8)
- Women using services, and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

What is pelvic floor dysfunction?

Pelvic floor dysfunction is a condition in which the pelvic floor muscles around the bladder, anal canal, and vagina do not work properly. This guideline covers the following symptoms and disorders when they are associated with pelvic floor dysfunction:

- urinary incontinence
- emptying disorders of the bladder
- faecal incontinence
- emptying disorders of the bowel
- pelvic organ prolapse
- sexual dysfunction
- chronic pelvic pain.

The 3 most common and definable symptoms are urinary incontinence, faecal incontinence and pelvic organ prolapse.

Who does this guideline cover?

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.

1.1 Raising awareness of pelvic floor dysfunction for all women

1.1.1 When producing resources on pelvic floor dysfunction, include:

- the symptoms of pelvic floor dysfunction
- visual aids to help identify potential causes of symptoms (for example, by showing the anatomy of pelvic organs)
- when to get help
- where to go for help (including self-referral to community-based multidisciplinary teams, where available)
- an outline of risk factors, prevention and management options (including non-surgical management and lifestyle changes).

1.1.2 Consider providing information on pelvic floor dysfunction in the following formats and settings:

- Formats
 - print, broadcast and online adverts
 - information given alongside over-the-counter continence products
 - leaflets in the community (for example, at GP surgeries, family planning clinics and exercise classes)
 - videos and information on social media
 - interactive online resources (for example, the NHS app).
- Settings
 - as part of general exercise programmes

- in leaflets on gynaecological cancer treatment or gynaecological surgery (such as hysterectomies)
 - as part of existing programmes, for example, cervical screening or national or local NHS health checks
 - contact with a healthcare practitioner with pelvic floor dysfunction knowledge
 - giving advice to people with contacts in the community (such as exercise and fitness instructors and teachers), so they can provide information on pelvic floor dysfunction themselves
 - on community and health trust websites
 - information provided by healthcare charities.
- 1.1.3 Tailor information and communication about pelvic floor dysfunction for different age groups and characteristics (for example, pregnancy).
- 1.1.4 Consider covering pelvic floor dysfunction in the syllabus for healthcare and other professionals, such as trainee nurses, physiotherapists, doctors, midwives and teachers.
- 1.1.5 Local authorities should consider designing pelvic floor dysfunction information programmes for specific communities when there is evidence of healthcare inequalities (for example, in how services are provided and accessed, or rates of uptake). This can be done by:
- finding more effective ways to provide information (for example, by attending community meetings)
 - involving members of the community as champions
 - using webinars to reach women who are unable to attend meetings in person.
- 1.1.6 For women using maternity services, include information on pelvic floor dysfunction, how to prevent it, the symptoms, and how to access local services:
- in the booking information pack or patient portal

- at all midwife consultations and reviews
 - at all consultations with an obstetrician
 - in hospital postnatal wards.
- 1.1.7 Health visitors, midwives and GPs should discuss pelvic floor dysfunction with women at each postnatal contact.
- 1.1.8 Teach young women (between 12 and 17) in education settings about pelvic floor anatomy, pelvic floor muscle exercises and how to prevent pelvic floor dysfunction.
- 1.1.9 Provide information on pelvic floor dysfunction for older women within primary and intermediate care services, and within care homes and supported living communities. This could be done:
- when women ask for advice about perimenopause and menopause
 - as part of general health assessments
 - as part of comprehensive geriatric health assessments.
- 1.1.10 For guidance on tailoring communication, information and shared decision making for people using health and social care services, see the:
- [NICE guideline on shared decision making](#)
 - [NICE guideline on patient experience in adult NHS services](#)
 - [NICE guideline on babies, children and young people's experience of healthcare](#)
 - [NICE guideline on people's experience in adult social care services](#)
 - [NHS Accessible Information Standard](#) (in particular, for guidance on making information accessible).
- 1.1.11 For guidance on planning and developing digital and mobile tools to provide tailored information, see the [NICE guideline on behaviour change: digital and](#)

[mobile health interventions](#).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on raising awareness of pelvic floor dysfunction for all women](#).

Full details of the evidence and the committee's discussion are in [evidence review A: community information strategies](#).

1.2 Risk factors for pelvic floor dysfunction

- 1.2.1 When discussing the risk of pelvic floor dysfunction with women, advise them that their risk is higher with any of the characteristics in box 1.

Box 1 Risk factors for pelvic floor dysfunction

Modifiable risk factors

- A body mass index (BMI) over 25 kg/m²
- Smoking
- Lack of exercise
- Constipation
- Diabetes

Non-modifiable risk factors

- Age (risk increases with increasing age)
- Family history of urinary incontinence, overactive bladder or faecal incontinence
- Gynaecological cancer and any treatments for this
- Gynaecological surgery (such as a hysterectomy)
- Fibromyalgia
- Chronic respiratory disease and cough (chronic cough may increase the risk of faecal incontinence and flatus incontinence)

Related to pregnancy:

- Being over 30 years when having a baby
- Having given birth before their current pregnancy

Related to labour:

- Assisted vaginal birth (forceps or vacuum)
- A vaginal birth when the baby is lying face up (occipito-posterior)
- An active second stage of labour taking more than 1 hour

- Injury to the anal sphincter during birth

1.2.2 For pregnant women with pelvic floor dysfunction that started before or during their pregnancy, advise them that there is an increased risk that their symptoms will get worse during their pregnancy and that they may persist after this (for preventative and management strategies, see the [section on preventing pelvic floor dysfunction](#) and the [section on non-surgical management of pelvic floor dysfunction](#)).

1.2.3 For more detailed guidance on all the benefits and risks of vaginal and caesarean birth (including urinary incontinence, faecal incontinence and injury to the anal sphincter), see the [section on benefits and risks of caesarean and vaginal birth in the NICE guideline on caesarean birth](#).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on risk factors for pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review B: risk factors for pelvic floor dysfunction](#)
- [evidence review C: coexisting long-term conditions and pelvic floor dysfunction](#)
- [evidence review D: prediction tools for pelvic floor dysfunction](#).

1.3 Preventing pelvic floor dysfunction

Physical activity and diet

1.3.1 Advise women that physical activity and a healthy diet can help prevent pelvic floor dysfunction.

- 1.3.2 On levels of physical activity, advise women to follow the standard advice, as covered by:
- the [UK Chief Medical Officers' physical activity guidelines](#)
 - the [NICE guideline on physical activity: brief advice for adults in primary care](#)
 - the [NICE guideline on physical activity: walking and cycling](#).
- 1.3.3 On diet, advise women to:
- have a balanced diet (following [Public Health England's Eatwell Guide](#)), and in particular to eat enough fibre, because this can improve stool consistency and prevent symptoms of faecal incontinence
 - ensure they have an appropriate fluid intake, increasing or decreasing it if needed.
- 1.3.4 For guidance on training to help health and social care practitioners recognise and respond to diet, physical activity and hydration needs in older people with social care needs and multiple long-term conditions, see the [section on training health and social care practitioners in the NICE guideline on older people with social care needs and multiple long-term conditions](#).

Weight loss, stopping smoking, managing constipation and diabetes

- 1.3.5 For guidance on weight loss, see the [NICE guideline on obesity](#), and (if relevant) the [NICE guideline on weight management before, during and after pregnancy](#).
- 1.3.6 Give advice on stopping smoking, using the [NICE guideline on tobacco](#).
- 1.3.7 For guidance on managing constipation in young people, see the [NICE guideline on constipation in children and young people](#).
- 1.3.8 For guidance on managing diabetes, see the NICE guidelines on:
- [type 1 diabetes in adults](#)

- [type 2 diabetes in adults](#)
- [diabetes \(type 1 and type 2\) in children and young people](#).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on physical activity and diet and other modifiable risk factors](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review B: risk factors for pelvic floor dysfunction](#)
- [evidence review E: lifestyle factors for the prevention of pelvic floor dysfunction](#).

Pelvic floor muscle training

All women

- 1.3.9 Encourage women of all ages to do [pelvic floor muscle training](#), and explain that it helps to prevent symptoms of pelvic floor dysfunction.
- 1.3.10 Encourage women to continue pelvic floor muscle training throughout their life, because long-term training continues to help prevent symptoms.

During and after pregnancy

- 1.3.11 Encourage women who are pregnant or who have recently given birth to do pelvic floor muscle training, and explain that it helps prevent symptoms of pelvic floor dysfunction.
- 1.3.12 Consider 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

- during postnatal care, for women who have experienced any of the following risk factors during birth:
 - assisted vaginal birth (forceps or vacuum)
 - a vaginal birth when the baby is lying face up (occipito-posterior)
 - injury to the anal sphincter.
- 1.3.13 Before discharging women from maternity services, and during routine postnatal care, encourage them to do pelvic floor muscle training.
- 1.3.14 When designing a pelvic floor muscle training programme, see the NICE guideline on behaviour change for relevant recommendations:
- [recommendation 7: use proven behaviour change techniques when designing interventions](#)
 - [recommendation 8: ensure interventions meet individual needs.](#)

Supervising pelvic floor muscle training

- 1.3.15 Pelvic floor muscle training programmes should be supervised by a physiotherapist or other healthcare professional with the appropriate expertise in pelvic floor muscle training.
- 1.3.16 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 training goals
 - encouraging the woman to complete the course, because this will help to prevent and manage symptoms.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

1.4 Communicating with and providing information to women with pelvic floor dysfunction

Communication

- 1.4.1 Agree consultation formats (for example, in person, video or telephone) with each woman with pelvic floor dysfunction, taking into account the need for physical examinations.
- 1.4.2 When discussing pelvic floor dysfunction:
- be aware of potential cultural sensitivities
 - be aware that women may feel embarrassed discussing their symptoms, and they may believe that healthcare professionals will also be embarrassed
 - take particular care around terminology:
 - for example, avoid using 'faeces' if a woman better understands or prefers 'poo'
 - be aware that women may not use the precise technical terms for parts of their pelvic anatomy
 - tailor information to each woman's level of understanding of anatomy and of the causes of pelvic floor dysfunction.
- 1.4.3 For general guidance on communicating with patients, see the:
- [section on communication in the NICE guideline on patient experience in](#)

adult NHS services

- section on communication and information in the NICE guideline on babies, children and young people's experience of healthcare.

1.4.4 When providing information to women with pelvic floor dysfunction and cognitive impairment, ask them if they want their family, carers and other people to be involved, to support them (as appropriate) and to help reinforce and support management plans.

Information for women with pelvic floor dysfunction

1.4.5 Help women with pelvic floor dysfunction to understand their condition by giving clear and concise information. This should include:

- the anatomy of the pelvic floor and pelvic organs (using visual aids when helpful)
- possible causes of their symptoms
- management options and possible outcomes
- an explanation that interventions will be focused on their symptoms, rather than on pelvic floor dysfunction in general
- other medical conditions and treatments that can cause or exacerbate their symptoms (see risk factors for pelvic floor dysfunction).

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. For example:

- young women (between 12 and 17)
- women who are pregnant or who have given birth
- women in perimenopause or postmenopause
- women with comorbidities or frailty.

- 1.4.7 Consider digital information sources (for example, apps or videos) to support women with pelvic floor dysfunction (see guidance on developing digital tools in the [NICE guideline on behaviour change: digital and mobile health interventions](#)).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on communicating with and providing information to women with pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review G: information provision related to the management of pelvic floor dysfunction \(people's views and experiences\)](#)
- [evidence review H: information provision about management of pelvic floor dysfunction \(most effective ways\)](#).

1.5 Assessment in primary care

- 1.5.1 At initial assessment in primary care (which may include assessments by physiotherapists, bladder and bowel team members and continence advisors), take a general history from the woman about current and past symptoms or disorders associated with pelvic floor dysfunction, such as:
- urinary incontinence
 - emptying disorders of the bladder
 - faecal incontinence
 - emptying disorders of the bowel
 - pelvic organ prolapse
 - sexual dysfunction
 - chronic pelvic pain.

- 1.5.2 Depending on the symptoms described, carry out a focused history, clinical examination and investigations to exclude other causes, such as:
- pelvic masses
 - neurological disease
 - urinary tract infection
 - adverse effects of medication
 - diabetes
 - cancer (for further information, see the [NICE guideline on suspected cancer: recognition and referral](#))
 - fistula
 - inflammatory bowel or bladder conditions
 - endometriosis
 - mobility and cognitive impairment.
- 1.5.3 Ask women who have recently given birth about symptoms of pelvic floor dysfunction during routine postnatal care, in hospital and in the community.
- 1.5.4 For women who are taking multiple medications, conduct a medication review. For guidance on how to do this, see the [section on medication review in the NICE guideline on medicines optimisation](#).
- 1.5.5 Depending on the symptoms and the woman's preferences and circumstances, consider other clinical examinations. For example:
- inspecting the woman's vulva and vagina for atrophy
 - asking them to bear down, to check for visible vaginal or rectal prolapse
 - 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).

- 1.5.6 For more guidance on assessing urinary incontinence and pelvic organ prolapse, see the [NICE guideline on urinary incontinence and pelvic organ prolapse in women](#). (The recommendations in this guideline may also be relevant for women under 18.)
- 1.5.7 If the woman has symptoms of faecal incontinence, follow the [recommendations on baseline assessment in the NICE guideline on faecal incontinence](#). (The recommendations in this guideline may also be relevant for women under 18.)

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on assessment in primary care](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review I: assessment in non-specialist care](#)
- [evidence review G: information provision related to the management of pelvic floor dysfunction \(people's views and experiences\)](#).

1.6 Non-surgical management of pelvic floor dysfunction

Community-based multidisciplinary teams

- 1.6.1 After initial assessment in primary care, consider a community-based multidisciplinary team approach for the management of pelvic floor dysfunction.
- 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:
- carrying out initial assessments (see the [section on assessment in primary care](#))

- assessments of mobility and personal care issues related to pelvic floor dysfunction
- awareness of the psychosocial implications of pelvic floor dysfunction
- identifying risk factors
- interpreting urinalysis
- conducting and interpreting bladder scans to measure post-void residual volume
- conducting digital assessments of the pelvic floor and pelvic floor muscle contraction and relaxation
- training women and their families and carers in behavioural interventions for pelvic floor dysfunction (such as bladder retraining)
- prescribing and reviewing medications, and knowledge of interactions and side effects related to pelvic floor dysfunction
- supervising a pelvic floor muscle training programme (see the [section on supervising pelvic floor muscle training](#))
- managing the use of pessaries and intravaginal devices
- training and supporting other care providers to assess and manage pelvic floor dysfunction (for example, carers or care home workers)
- identifying which women need referral to specialist care or other services (for young women aged 12 to 17, this may include referral to paediatric services or adolescent gynaecology services).

1.6.3 Discuss and agree a management plan with women who have suspected or confirmed pelvic floor dysfunction.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on community-based multidisciplinary teams](#).

Full details of the evidence and the committee's discussion are in [evidence review R: community-based multidisciplinary teams](#).

Lifestyle changes

Encouraging women to make lifestyle changes

1.6.4 When discussing lifestyle changes with women who have pelvic floor dysfunction:

- motivate them to make changes by focusing discussions on how this will improve their symptoms
- give them regular encouragement to keep up the changes, because it may take weeks or months before they notice a benefit.

For a short explanation of why the committee made this recommendation and how it might affect practice, see the [rationale and impact section on encouraging women to make lifestyle changes](#).

Full details of the evidence and the committee's discussion are in [evidence review G: information provision related to the management of pelvic floor dysfunction \(people's views and experiences\)](#).

Weight loss

1.6.5 Advise women with a body mass index (BMI) over 30 kg/m² that weight loss can help with the following symptoms associated with pelvic floor dysfunction:

- urinary incontinence

- overactive bladder
 - pelvic organ prolapse.
- 1.6.6 For guidance on weight loss, see the [NICE guideline on obesity](#), and (if relevant) the [NICE guideline on weight management before, during and after pregnancy](#).
- 1.6.7 Refer women for weight loss support following the [NICE guideline on lifestyle services for weight management in overweight or obese adults](#) and the [NICE guideline on lifestyle services for weight management in overweight or obese children and young people](#).
- 1.6.8 Do not wait for women to lose weight before starting other pelvic floor dysfunction management options.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on weight loss](#).

Full details of the evidence and the committee's discussion are in [evidence review J: weight loss interventions](#).

Diet

- 1.6.9 For all women with pelvic floor dysfunction:
- explain how a balanced diet (following [Public Health England's Eatwell Guide](#)) and appropriate fluid intake can improve stool consistency, which can help with their symptoms
 - 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).
- 1.6.10 Advise women with overactive bladder or urinary incontinence associated with pelvic floor dysfunction to:
- reduce their caffeine intake

- modify their fluid intake (increasing if it is too low, decreasing if it is too high).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on diet](#).

Full details of the evidence and the committee's discussion are in [evidence review K: dietary factors for the management of symptoms](#).

Physical activity

- 1.6.11 For women who are doing supervised pelvic floor muscle training and want to be physically active, advise them that supervised exercise (for example, yoga) may help with their symptoms.
- 1.6.12 Advise women with pelvic floor dysfunction that there is no evidence to say that unsupervised physical activity (such as walking or swimming) will improve or worsen their symptoms.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on physical activity](#).

Full details of the evidence and the committee's discussion are in [evidence review L: physical activity for the management of symptoms](#).

Pelvic floor muscle training

For pelvic organ prolapse

- 1.6.13 Consider a programme of supervised [pelvic floor muscle training](#) for at least 4 months for women with symptomatic pelvic organ prolapse that does not extend greater than 1 cm beyond the hymen upon straining.

For stress urinary incontinence or mixed urinary incontinence

- 1.6.14 Offer a programme of supervised pelvic floor muscle training for at least 3 months to women (including pregnant women) with stress urinary incontinence or mixed urinary incontinence.

For faecal incontinence with coexisting pelvic organ prolapse

- 1.6.15 Consider a programme of supervised pelvic floor muscle training for at least 4 months for women with faecal incontinence and coexisting pelvic organ prolapse.

Group and individual training

- 1.6.16 For women who are doing a supervised pelvic floor muscle training programme, offer the choice of group or individual sessions.

Supervising pelvic floor muscle training

- 1.6.17 See the [recommendations on supervising pelvic floor muscle training in the section on preventing pelvic floor dysfunction](#).

Review

- 1.6.18 When providing a programme of pelvic floor muscle training, offer at least 1 review to assess progress during the programme, and 1 review at the end of the programme.

Supplementing pelvic floor muscle training

- 1.6.19 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.

Continuing pelvic floor muscle training

- 1.6.20 If the programme is beneficial, advise women to continue pelvic floor muscle training after the supervised programme ends.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on pelvic floor muscle training for managing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review M: pelvic floor muscle training for the management of symptoms](#).

Intravaginal devices and pessaries

Intravaginal devices for urinary incontinence

- 1.6.21 Consider a trial of intravaginal devices for women with urinary incontinence, only if other non-surgical options have been unsuccessful.

Pessaries for symptomatic pelvic organ prolapse

- 1.6.22 Consider pessaries for women who have symptomatic pelvic organ prolapse.
- 1.6.23 Before starting treatment with a pessary for women with symptomatic pelvic organ prolapse:
- discuss with the woman how a pessary could help, and explain it may not help with their urinary and bowel symptoms
 - explain that a pessary will only help with their pelvic organ prolapse symptoms while it is in place, and the symptoms will come back when it is removed

- explain that reducing the prolapse with a pessary may cause new stress urinary incontinence.

See [recommendation 1.7.8 in the NICE guideline on urinary incontinence and pelvic organ prolapse](#) for further discussions to have with women before starting treatment with a pessary.

- 1.6.24 If women using a pessary experience new stress urinary incontinence, offer them a choice of treatment for the incontinence or removal of the pessary.
- 1.6.25 For more guidance on pessaries for women with symptomatic pelvic organ prolapse, see the [section on pessaries in the NICE guideline on urinary incontinence and pelvic organ prolapse](#).

Review

- 1.6.26 For women who are self-managing their intravaginal device or pessary, explain how they can seek advice from a healthcare provider if they have problems.
- 1.6.27 For guidance on reviewing pessaries for women who are at risk of complications, for example because of a physical or cognitive impairment, see [recommendation 1.7.9 in the NICE guideline on urinary incontinence and pelvic organ prolapse](#).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on intravaginal devices and pessaries](#).

Full details of the evidence and the committee's discussion are in [evidence review N: physical devices for the management of pelvic floor dysfunction](#).

Psychological interventions

- 1.6.28 Discuss the psychological impact of their symptoms with women who have pelvic floor dysfunction. Take account of this impact when developing a management

plan.

1.6.29 For more guidance on psychological management, see the:

- [NICE guideline on antenatal and postnatal mental health](#)
- [NICE guideline on depression in adults with a chronic physical health problem](#).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on psychological interventions](#).

Full details of the evidence and the committee's discussion are in [evidence review O: psychological therapy for women with pelvic floor dysfunction](#).

Behavioural approaches

- 1.6.30 Offer supported bladder retraining (combined with other interventions, such as pelvic floor muscle training) to women with urinary frequency, urgency or mixed incontinence.
- 1.6.31 For women with faecal incontinence, see the [section on diet, bowel habit and toilet access in the NICE guideline on faecal incontinence in adults](#). (The recommendations in this guideline may also be relevant for women under 18.)
- 1.6.32 When choosing a behavioural intervention, take into account that prompted toileting and habit training may be particularly suitable for women with cognitive impairment.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on behavioural approaches](#).

Full details of the evidence and the committee's discussion are in [evidence review P: behavioural approaches to the management of symptoms](#).

Medicines

- 1.6.33 Do not offer vaginal diazepam to treat pelvic floor dysfunction, even for women with high muscle tone.
- 1.6.34 For guidance on medicines for urinary incontinence and faecal incontinence associated with pelvic floor dysfunction, see the [NICE guideline on urinary incontinence and pelvic organ prolapse in women](#) and the [section on medication in the NICE guideline on faecal incontinence in adults](#). (The recommendations on medicines in these guidelines may also be relevant for women under 18.)

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on medicines](#).

Full details of the evidence and the committee's discussion are in [evidence review Q: pharmacological management](#).

Terms used in this guideline

Pelvic floor muscle training

Exercise to improve pelvic floor muscle strength, endurance, power, relaxation, or a combination of these. For more information, see the [definition of pelvic floor muscle training in the International Continence Society and International Urogynecological Association's joint report on the terminology for the conservative and non-pharmacological management of female pelvic floor dysfunction](#).

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 How to provide pelvic floor muscle training

What is the most effective way to provide pelvic floor muscle training (covering the type of training, the timing, and who should supervise it), to improve adherence and prevent pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

2 Pelvic floor muscle training for preventing pelvic floor dysfunction in young women

Is pelvic floor muscle training for young women (between 12 and 17 years) effective in preventing pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

3 Pelvic floor muscle training for preventing pelvic floor dysfunction during pregnancy for women in higher-risk groups

How effective is pelvic floor muscle training in preventing pelvic floor dysfunction during pregnancy in women who are in higher-risk groups?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

4 Lifestyle factors to reduce the risk of pelvic floor dysfunction

What lifestyle factors reduce the risk of developing pelvic floor dysfunction (diet, reducing carbonated drink and caffeine intake)?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on physical activity and diet and other modifiable risk factors](#).

Full details of the evidence and the committee's discussion are in [evidence review E: lifestyle factors for the prevention of pelvic floor dysfunction](#).

5 Prediction tools

What is the effectiveness of prediction tools for identifying women who are at risk of pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on risk factors for pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review D: prediction tools for pelvic floor dysfunction](#).

6 Pelvic floor muscle training for preventing pelvic floor dysfunction in older women

Is pelvic floor muscle training effective in preventing pelvic floor dysfunction for older women (aged 65 and over), and women in the perimenopausal or postmenopausal phases?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

7 Coexisting long-term conditions

What coexisting long-term conditions (for example, chronic respiratory disorders) are associated with a higher risk of pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on risk factors for pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review C: coexisting long-term conditions and pelvic floor dysfunction](#).

Other recommendations for research

8 Lifestyle factors to reduce the risk of pelvic floor dysfunction

What are the long-term effects of different types, intensities and frequencies of physical activity for preventing symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on physical activity and diet and other modifiable risk factors](#).

Full details of the evidence and the committee's discussion are in [evidence review E: lifestyle factors for the prevention of pelvic floor dysfunction](#).

9 Universal postnatal pelvic floor muscle training for preventing pelvic floor dysfunction

Is universal postnatal pelvic floor muscle training effective in preventing pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

10 Pelvic floor muscle training for preventing bowel symptoms associated with pelvic floor dysfunction

How effective is pelvic floor muscle training in preventing bowel symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pelvic floor muscle training for the prevention of pelvic floor dysfunction](#).

11 Weight loss for managing pelvic floor dysfunction

Can weight loss reduce symptoms of pelvic floor dysfunction in women who are overweight or obese?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on weight loss](#).

Full details of the evidence and the committee's discussion are in [evidence review J: weight loss interventions](#).

12 Diet for managing pelvic floor dysfunction

What changes in diet can improve symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on diet](#).

Full details of the evidence and the committee's discussion are in [evidence review K: dietary factors for the management of symptoms](#).

13 Weight training to improve symptoms of pelvic floor dysfunction

How effective is weight training at improving symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on physical activity](#).

Full details of the evidence and the committee's discussion are in [evidence review L: physical activity for the management of symptoms](#).

14 Unsupervised physical activity to improve symptoms of pelvic floor dysfunction

How effective is unsupervised physical activity (such as walking or swimming) at improving symptoms associated with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on physical activity](#).

Full details of the evidence and the committee's discussion are in [evidence review L: physical activity for the management of symptoms](#).

15 Psychological interventions to manage symptoms of pelvic floor dysfunction

How effective are psychological interventions (either on their own or combined with other interventions) in the management of pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on psychological interventions](#).

Full details of the evidence and the committee's discussion are in [evidence review O: psychological therapy for women with pelvic floor dysfunction](#).

16 Raising awareness about pelvic floor dysfunction

Are community-based strategies effective in raising awareness about the prevention of

pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on raising awareness of pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review A: community information strategies](#).

17 Information valued by young women with pelvic floor dysfunction

What are the experiences and information needs of young women (between 12 and 17 years) with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on communicating with and providing information to women with pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review G: information provision related to the management of pelvic floor dysfunction \(people's views and experiences\)](#).

18 Effective ways of supporting women to start and continue interventions for pelvic floor dysfunction

What is the best way to support women to start and continue interventions for pelvic floor dysfunction (for example, apps, decision aids, or behavioural change techniques)?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on communicating with and providing information to women with pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review H: information provision about management of pelvic floor dysfunction \(most effective ways\)](#).

19 Effective ways of providing information to women with pelvic floor dysfunction

What are best ways to provide information about pelvic floor dysfunction to young women (between 12 and 17 years), and to groups defined by protected characteristics under the Equality Act?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on communicating with and providing information to women with pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review H: information provision about management of pelvic floor dysfunction \(most effective ways\)](#).

20 Medicines for pelvic floor dysfunction

Is vaginal oestrogen effective at treating the symptoms of pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on medicines](#).

Full details of the evidence and the committee's discussion are in [evidence review Q: pharmacological management](#).

21 Community-based multidisciplinary pelvic floor dysfunction teams

What roles are needed in a community-based multidisciplinary pelvic floor dysfunction team?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on community-based multidisciplinary teams](#).

Full details of the evidence and the committee's discussion are in [evidence review R: community-based multidisciplinary teams](#).

22 Intravaginal devices and pessaries combined with pelvic floor muscle training for managing pelvic floor dysfunction

How effective is a pessary or intravaginal device combined with pelvic floor muscle training for managing pelvic floor dysfunction, compared with pelvic floor muscle training alone?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for managing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review M: pelvic floor muscle training for the management of symptoms](#).

23 Virtual and in-person contact time for pelvic floor muscle training

How effective is virtual contact with a trainer, compared with in-person contact, for pelvic floor muscle training?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on pelvic floor muscle training for managing pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review M: pelvic floor muscle training for the management of symptoms](#).

24 Anal plug devices and rectal irrigation for the management of bowel symptoms in women with pelvic floor dysfunction

How effective are anal plug devices and rectal irrigation for bowel symptoms in women with pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on intravaginal devices and pessaries](#).

Full details of the evidence and the committee's discussion are in [evidence review N: physical devices for the management of pelvic floor dysfunction](#).

25 Multiple pregnancy as an independent risk factor for pelvic floor dysfunction

Is multiple pregnancy an independent risk factor for pelvic floor dysfunction?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on risk factors for pelvic floor dysfunction](#).

Full details of the evidence and the committee's discussion are in [evidence review B: risk factors for pelvic floor dysfunction](#).

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Raising awareness of pelvic floor dysfunction for all women

Recommendations 1.1.1 to 1.1.11

Why the committee made the recommendations

The evidence was limited to 1 study, so most of the recommendations were based on the committee's knowledge and experience. However, this study did show that teaching pelvic floor health in school improved young women's understanding of their pelvic floor anatomy.

Improving women's knowledge of pelvic floor health is important because this increases the chance they will take action to prevent pelvic floor dysfunction (for example, through lifestyle changes and pelvic floor muscle training). The range of communication formats and strategies recommended is broad, because pelvic floor dysfunction can happen to any woman, so different strategies will be more effective for different groups of women. The committee discussed what the content of this information should be and decided that this would need to be tailored to the individual and the situation in which it is provided (for example, they noted that information provided during school lessons would likely have a different focus to information provided at a local community group). However, to ensure information is accurate and useful, it should include the topics highlighted in recommendation 1.1.1. The committee acknowledged that there can be groups of women that experience inequalities (for example, in access to services). When there is evidence of this, 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 and fostering good relations with communities.

Healthcare professionals themselves need to understand enough about pelvic floor

dysfunction to discuss it with women. In the committee's experience, this is not consistently taught during training, so they made a recommendation that this should be added to the syllabus for relevant professionals.

The committee believed it was particularly important to raise awareness in maternity services; this is when symptoms can first occur, when risk factors can be identified and when prevention strategies can be started. 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. Normalisation is important, because embarrassment often gets in the way of discussions about pelvic floor dysfunction. The committee also noted that frequent discussions would reinforce the message and improve adherence to prevention or management, which is key to their effectiveness.

Because of the sparsity of evidence, and the potential benefits of raising awareness of pelvic floor dysfunction, the committee made a [recommendation for research on raising awareness about pelvic floor dysfunction](#).

How the recommendations might affect practice and services

Pelvic floor dysfunction is not currently covered in the school curriculum. However, sex and relationship education is already a compulsory part of the curriculum, and pelvic floor dysfunction could be covered as part of these classes.

School nurses and nurses in other education settings could also be involved in raising awareness of pelvic floor dysfunction. There are already resources available on this topic (for example, this [video on pelvic floor by NHS Highland](#)).

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Risk factors for pelvic floor dysfunction

[Recommendations 1.2.1 to 1.2.3](#)

Why the committee made the recommendations

Interpreting the evidence was difficult, because there was a lot of variation in how the studies were done, the way risk factors were defined, and which symptom each risk factor affected. However, the evidence did consistently reflect the committee's experience.

The evidence suggested a number of modifiable and non-modifiable risk factors. The committee recommended advising women of these, so that they are aware of their risks, and (for modifiable factors) they can take steps to reduce them. For example, the evidence showed that constipation is a risk factor for pelvic floor dysfunction (the committee believe that this is because of the straining involved). For women with constipation, there are recommendations on diet to help with constipation and reduce their risk of pelvic floor dysfunction (see [recommendation 1.3.3](#) and [recommendation 1.6.9](#)).

Although some risk factors are non-modifiable (such as age or familial history), the committee agreed that it is still useful for women to be told about these. This is because if women know about their risks, they may be encouraged to reduce any modifiable risk factors and use preventative interventions (such as pelvic floor muscle training). Women with some of these risk factors will also be offered supervised pelvic floor muscle training (see the [recommendations on pelvic floor muscle training](#)).

For the risk factors related to vaginal birth, the committee discussed whether more information was needed in the recommendations, because these risk factors affect the decision to have a vaginal or caesarean birth. However, women consider many other factors beyond pelvic floor dysfunction when deciding on mode of birth. The committee decided not to make further recommendations on this, because the [NICE guideline on caesarean section goes into much more detail on the benefits and risks of caesarean and vaginal birth](#).

Due to the evidence being unclear, the committee made a [recommendation for research on whether multiple pregnancy is an independent risk factor for pelvic floor dysfunction](#).

Coexisting conditions

There was evidence for a variety of physical coexisting conditions associated with pelvic floor dysfunction. There was variation in the quality of the evidence because in some studies, the inclusion criteria were not clearly described. In addition, although some conditions were shown to increase the risk of pelvic floor dysfunction, there was

uncertainty around how large this increase is. Because of this, the committee did not list every condition identified in the studies. Instead, they highlighted the conditions that have a direct impact on the pelvic floor muscles, when the risk of pelvic floor dysfunction in the evidence aligns with their own experience.

For some conditions that may increase the risk of pelvic floor dysfunction (such as hypermobility, neurological disease and mental health problems), there was little evidence on their effect. In addition, there was only limited evidence on the effect of respiratory disease and chronic cough on the full range of symptoms, and this is particularly important because of the COVID-19 pandemic. A [recommendation for research on coexisting long-term conditions](#) was made to address these evidence gaps.

Tools to predict pelvic floor dysfunction

There are groups of women who have an increased risk of developing pelvic floor dysfunction. There are also interventions that can help prevent pelvic floor dysfunction (see the [section on physical activity and diet](#) and the [section on pelvic floor muscle training](#)). Because of this, it would be useful to have an effective tool for predicting pelvic floor dysfunction so that women at higher risk can be prioritised for pelvic floor muscle training programmes. However, there was no evidence on the effectiveness of existing tools. The committee agreed this was an important area for further study, and made a [recommendation for research on prediction tools](#).

How the recommendations might affect practice

The recommendations will standardise the information and advice that is provided to women, to enable better shared decision making. There are no significant costs associated with this, because providing information is already standard practice. The costs of the time taken to give this information would be outweighed by better satisfaction with services and the potential for avoiding future pelvic floor dysfunction.

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Physical activity and diet and other modifiable risk factors

[Recommendations 1.3.1 to 1.3.8](#)

Why the committee made the recommendations

The evidence suggested that physical activity, healthy diet and appropriate fluid intake help to prevent pelvic floor dysfunction. The quality of the evidence was low because some studies did not account for other factors that could potentially explain the findings. However, it reflected the committee's experience in clinical practice and was in line with standard UK diet and physical activity guidance.

One of the risk factors for pelvic floor dysfunction is constipation, and in the committee's experience, 1 way this can be addressed is by adjusting fluid intake. Public health guidance does not clearly define ideal levels of fluid intake, and there are differences in the fluid needs of individuals (for example, people need more fluid if they are very physically active). The committee therefore decided not to give their own definition of appropriate fluid intake.

The committee recognised that there were other modifiable risk factors: body mass index (BMI) over 25 kg/m², smoking and diabetes, and they referenced relevant NICE guidance for management strategies for these, which would help prevent pelvic floor dysfunction.

There was only limited evidence on specific dietary factors, such as caffeine and carbonated drinks. To address this, the committee made a [recommendation for research on lifestyle factors to reduce the risk of pelvic floor dysfunction](#).

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, emptying disorders of the bladder or bowel, sexual dysfunction or chronic pelvic pain syndromes). However, in the committee's experience, physical activity that involves repetitive pelvic floor loading (such as weight training) can improve pelvic floor muscle strength and so prevent symptoms. The committee agreed that more research is needed to support this, particularly in relation to the intensity of physical activity needed, so they made a [recommendation for research on long-term effects of different types, intensities and frequencies of physical activity for preventing symptoms associated with pelvic floor dysfunction](#).

How the recommendations might affect practice

Currently, lifestyle advice is given to women to help with the management of symptoms of pelvic floor dysfunction. However, lifestyle advice is rarely considered as part of pelvic

floor dysfunction prevention, because these women are symptom free. Therefore, these recommendations will help standardise the advice women receive on preventing pelvic floor dysfunction.

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Pelvic floor muscle training for preventing pelvic floor dysfunction

[Recommendations 1.3.9 to 1.3.16](#)

Why the committee made the recommendations

The available evidence covered women in 3 settings: community, antenatal and postnatal. It specifically addressed pelvic floor dysfunction and associated symptoms (including urinary incontinence, pelvic organ prolapse and sexual dysfunction).

In addition to the research evidence, the committee also took account of the [Independent Medicines and Medical Devices Safety Review](#) and the [NHS Long Term Plan](#), which made recommendations on pelvic floor muscle training.

Pelvic floor muscle training was shown to prevent symptoms of pelvic floor dysfunction in all 3 settings. Evidence was not available for some symptoms (such as faecal incontinence and pelvic pain). The training was most effective in the short term. The committee noted that most studies looked at pregnant women (antenatal and postnatal). However, all healthcare professionals can provide encouragement to all women doing pelvic floor muscle training in all settings (there are already resources available on this, such as the [video on pelvic floor by NHS Highland](#)). Because there are particular obstetric risk factors associated with pelvic floor dysfunction (see the [section on risk factors](#)), pelvic floor muscle training could be particularly beneficial for pregnant women. The evidence supported this, because pelvic floor muscle training was shown to be effective in preventing pelvic floor symptoms when started during or after pregnancy.

Most of the evidence was for a narrow age range of women in their twenties or thirties. However, there was a consistent pattern of risk reduction across this group. The committee believed that this supported them in making recommendations for women of all ages.

An economic analysis showed that antenatal supervised pelvic floor muscle training is likely to be cost effective for some pregnant women:

- the evidence suggested that women who have a first-degree relative with pelvic floor dysfunction are at higher risk
- the committee identified 3 risk factors related to labour that they thought would increase risk.

However, there was some uncertainty about the conclusion generated from the economic analysis, which was based on evidence from only 1 study. Because of these limitations, and the costs of providing supervised pelvic floor muscle training to such a large group, the committee did not recommend routinely offering training to all of these women. 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 did not include 'an active second stage labour taking more than 1 hour' in the recommendation on supervised pelvic floor muscle training. This is because it is quite common (so would have a high potential cost), and the evidence on this was inconsistent (some studies showed an increased risk when labour was longer than 1 hour, but others did not show increased risk when it was longer than 20 minutes).

In all the studies, pelvic floor muscle training was supervised by a trained healthcare professional. The committee agreed that this is important for ensuring that pelvic floor muscle contraction and relaxation is done correctly. In their experience, it is also important to tailor the training for each woman, to ensure that it is manageable and will meet their training goals.

There was limited evidence on long-term effectiveness, because only 2 studies had a longer follow-up period (12 months in 1 study, and 8 years in the other). However, all the studies showed that adherence decreased over time. In the committee's experience, continuing with the training is key for continued prevention of symptoms, and they agreed that low long-term adherence is likely to explain the limited evidence for long-term effectiveness. To address adherence problems, the committee made the recommendation on encouraging women to continue pelvic floor muscle training.

The committee made recommendations for research to investigate several gaps in the evidence:

- Most effective ways to provide training: the studies did not give much detail on how training should be done.
- Younger women: there was no evidence on training for young women (between 12 and 17).
- Older women: there was only 1 study supporting training for women over 60.
- 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.
- Faecal incontinence and emptying disorders of the bowel: there was no evidence on whether pelvic floor muscle training improves these symptoms (which can be particularly distressing).

The Independent Medicines and Medical Devices Safety Review recommended 'that the NHS adopts the French model for universal postnatal pelvic floor rehabilitation', to help prevent pelvic floor dysfunction. This model includes 10 sessions of routinely prescribed perineal rehabilitation sessions (pelvic floor muscle training with manual internal techniques, biofeedback and electrical stimulation) starting at least 8 weeks after birth, regardless of symptoms. The committee did not think the evidence (in particular the cost-effectiveness evidence) was strong enough to support this for all women during or after pregnancy. Instead, they identified the risk factors that put women at the greatest risk, for which pelvic floor training was most likely to be cost effective. They also made a recommendation for research on universal postnatal pelvic floor muscle training to investigate further.

How the recommendations might affect practice

Currently, pelvic floor muscle training is rarely used for prevention, and is usually only considered and taught to women when they develop symptoms (such as urinary incontinence). There would likely be a significant resource impact if training was provided to all women with the risk factors specified in the recommendation (particularly given the size of the population who would be eligible). Some of this cost is likely to be offset by savings from preventing or delaying pelvic floor dysfunction.

Pregnant women receive information on pelvic floor muscle training. However, this is usually general advice rather than specific instructions or supervised sessions. 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.

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Communicating with and providing information to women with pelvic floor dysfunction

[Recommendations 1.4.1 to 1.4.7](#)

Why the committee made the recommendations

Qualitative evidence showed that women with pelvic floor dysfunction perceived some communication styles as unhelpful. It also indicated that some women are not given enough information to understand their symptoms, diagnosis, investigations or treatment. The quality of the evidence was mixed, because of concerns about methodological limitations in the design of the studies. The committee also made recommendations based on their own experience, in areas where there was no evidence (such as video and telephone consultations).

The recommendation on asking women if they want their family, carers or other people involved is particularly important for addressing potential barriers to support for women with cognitive impairments.

Pelvic floor dysfunction is a complex condition, with particular communication issues (such as embarrassment). Based on the evidence and on their experience, the committee highlighted key issues to take into account when discussing pelvic floor dysfunction with women.

Because of the COVID-19 pandemic, many services are being provided remotely. In the committee's experience, this has been well received by some women. A particular benefit of remote services can be reduced embarrassment (both for women and for healthcare professionals), which makes women more willing to discuss problems. However, even though this may be the case for some women, the committee acknowledged that it may be harder for the healthcare professional to identify whether symptoms may not be reported because of embarrassment during a remote consultation.

The committee made recommendations for research in areas where there was no evidence:

- effective ways of providing information to young women (between 12 and 17 years) and women with protected characteristics (such as physical or learning disabilities)
- effective ways of supporting women to start and continue interventions for pelvic floor dysfunction
- information valued by young women with symptoms of pelvic floor dysfunction.

How the recommendations might affect practice

Healthcare professionals already discuss pelvic floor dysfunction with women and provide information on this. However, the information given and how it is communicated can vary, and these recommendations will standardise the process. Because the symptoms of pelvic floor dysfunction are often distressing and embarrassing, communication and sensitivity are very important for all healthcare professionals to ensure good care is provided.

Services already use translation services as needed to overcome communication barriers. However, there may be an impact in areas where video consultation or digital information aids are not currently available.

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Assessment in primary care

[Recommendations 1.5.1 to 1.5.7](#)

Why the committee made the recommendations

There are a number of signs and symptoms associated with pelvic floor dysfunction. However, there was no evidence on which assessments are needed in non-specialist care to identify these signs and symptoms. Because of this, the committee made recommendations based on their clinical expertise, highlighting the investigations they use in their practice and the most important signs and symptoms to look out for.

There was evidence that healthcare professionals may overlook symptoms of pelvic floor

dysfunction in women who have recently given birth. The evidence also highlighted that there are common misconceptions about pelvic floor dysfunction during and after pregnancy, which can prevent women from seeking care early. To address this, the committee emphasised that women who have recently given birth should be asked about symptoms.

In the committee's experience, many medications can impact on symptoms of pelvic floor dysfunction. In addition, this impact is often larger for people who are taking multiple medicines. Because of this, a medication review is important.

A focused history is important for identifying the likely cause of any symptoms, because many of the symptoms of pelvic floor dysfunction can be caused by other conditions as well.

The committee highlighted some of the examinations that would be needed to clarify whether symptoms are likely to be associated with pelvic floor dysfunction or not. Because some of these are intimate examinations, they highlighted the importance of checking the woman's preferences and ensuring a private space is available.

Further assessments are described in the [NICE guideline on urinary incontinence and pelvic organ prolapse in women](#) and the [section on baseline assessment in the NICE guideline on faecal incontinence](#). These guidelines only cover adults, but many of the initial assessments recommended are non-specialist and the committee agreed that they could be relevant for younger women (aged 12 to 17) in primary care.

How the recommendations might affect practice

Pelvic floor dysfunction is a complex condition, and there is currently variation in how it is assessed. These recommendations will ensure consistency in the initial assessments that are done in primary care.

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Community-based multidisciplinary teams

[Recommendations 1.6.1 to 1.6.3](#)

Why the committee made the recommendations

There was limited evidence on team-based approaches for managing pelvic floor dysfunction. However, the available evidence reflected the committee's experience in practice. They decided that the range of competencies needed could not be covered by 1 healthcare professional alone, and so a multidisciplinary team approach should be considered. Because pelvic floor dysfunction can happen to any woman, multidisciplinary teams will need a wide range of skills to be able to care for all women who need support. The committee agreed that several teams could be needed (for example, a team for pregnant women and another for older women). These teams would need to be community based, to ensure that care is accessible to all women.

Adherence and satisfaction with care are important factors in effective management of pelvic floor dysfunction, and the committee agreed that these would also be improved by community-based multidisciplinary teams.

The experience and training of multidisciplinary team members is likely to vary widely in different areas. Because of this, the committee made a recommendation on competencies, based on their own experience of the key knowledge and experience that is needed in the team to implement the other recommendations in this guideline.

The committee did not recommend including specific roles (such as specialist continence advisors) in the team, because community healthcare professionals can be trained to carry out non-specialist assessment, and because including specific specialists in every team could have substantial costs. The committee made a [recommendation for research on the roles needed in community-based multidisciplinary pelvic floor dysfunction teams](#).

When agreeing a management plan, it is important to involve the woman with pelvic floor dysfunction, to ensure the plan takes account of her needs, preferences and goals.

How the recommendations might affect practice

Community-based multidisciplinary teams may represent a change to current practice, because there is variation in their availability. Pelvic floor dysfunction is a common condition, and other services (such as community-based continence services) could form the basis of these teams. The committee decided that the benefits of good pelvic floor dysfunction management would outweigh potential costs associated with setting up community-based multidisciplinary teams.

There is currently variation in the competencies that community-based multidisciplinary teams have on assessing and managing pelvic floor dysfunction. There would be upfront costs for training healthcare professionals in the competencies recommended in this guideline, but these costs would be outweighed by better long-term outcomes (improved identification of symptoms and better management as a result).

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Lifestyle changes

Encouraging women to make lifestyle changes

[Recommendation 1.6.4](#)

Why the committee made the recommendation

The evidence showed that positive communication improves patient motivation and adherence to lifestyle changes. This was also consistent with the committee's experience. It can take time for women to see a benefit from lifestyle changes, so the committee believed it was important to emphasise encouraging and motivating women in the recommendation.

How the recommendation might affect practice

All healthcare professionals communicate with women and this recommendation will raise awareness that this communication should not be framed only in a negative way but provide positive messages when appropriate.

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Weight loss

[Recommendations 1.6.5 to 1.6.8](#)

Why the committee made the recommendations

The evidence showed that in women with a BMI over 30 kg/m², weight loss helped with

urinary incontinence and overactive bladder. In the committee's experience, excess body weight exacerbates these symptoms by putting pressure on the pelvic floor muscles and organs, so weight loss will be particularly beneficial. The evidence did not show any effect from weight loss on symptoms of pelvic organ prolapse. However, the committee still believe that weight loss may be beneficial in the early stages of pelvic organ prolapse, because less weight would press on the pelvic organs and this could improve symptoms.

The committee recommended against delaying other management options until women have lost weight because:

- there was no evidence on the impact of weight loss for many symptoms of pelvic floor dysfunction **and**
- there are other interventions that could benefit women with pelvic floor dysfunction.

Because other NICE guidelines cover helping people to lose weight, the committee referred to these guidelines rather than making new recommendations on weight loss interventions.

The committee made a [recommendation for research to address the lack of evidence on whether weight loss can reduce symptoms of pelvic floor dysfunction](#).

How the recommendations might affect practice

Weight loss referral related to pelvic floor dysfunction differs across the country. The recommendations would reduce variation and promote consistency in care.

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Diet

[Recommendations 1.6.9 and 1.6.10](#)

Why the committee made the recommendations

There was some evidence suggesting that reducing caffeine intake helps with urinary incontinence and overactive bladder, and this was supported by the committee's experience in practice.

No evidence was found on other symptoms associated with pelvic floor dysfunction. However, the committee agreed that in their experience, addressing fluid intake can help with symptoms by promoting an ideal stool consistency. Public health guidance does not clearly define ideal levels of fluid intake, and there are differences in the fluid needs of individuals (for example, people need more fluid if they are very physically active). The committee therefore decided not to give their own definition of appropriate fluid intake.

A balanced diet also reduces the risk of constipation and so would indirectly reduce the risk of pelvic floor dysfunction. This is particularly important for women with pelvic organ prolapse, faecal incontinence, emptying disorders of the bowel and chronic pelvic pain syndromes.

The committee believed that more research specific to pelvic floor dysfunction related to food rather than fluid intake is needed, and therefore made a [recommendation for research on diet](#) to address this.

How the recommendations might affect practice

These recommendations are in line with current clinical practice. Clinicians will already be familiar with the practical details of lifestyle changes that can be made to promote pelvic floor health, and lifestyle changes are a common aspect of management for symptoms of pelvic floor dysfunction.

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Physical activity

[Recommendations 1.6.11 and 1.6.12](#)

Why the committee made the recommendations

There was some evidence on urinary incontinence, overactive bladder and pelvic organ prolapse. The evidence showed that physical activity could improve these symptoms, but the physical activity programmes in these studies were supervised and included pelvic floor muscle training as part of the interventions.

The physical activity interventions covered were yoga, pilates, weight training and aerobic exercises. However, 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 did not recommend specific activities. The committee know from their own experience that women often ask whether physical activity could improve or worsen their symptoms. Because of the evidence that showed some improvement, they made a recommendation in favour of supervised exercise. '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.

There is no evidence that unsupervised physical activity improved or worsened symptoms of pelvic floor dysfunction. The committee acknowledged that there are general health benefits associated with having an active lifestyle. Therefore, they also made a [recommendation for research on unsupervised activities](#) (in particular, common activities such as walking and swimming).

Heavy lifting has been considered a risk factor for damaging the pelvic floor by increasing intra-abdominal pressure. The [NICE guideline on urinary incontinence and pelvic organ prolapse in women](#) recommends minimising heavy lifting. However, a more recent study showed that weight training combined with pelvic floor muscle training could improve symptoms of urinary incontinence. Because there was uncertainty around the evidence and it was not entirely consistent with the committee's experience, they made a [recommendation for research on weight training](#) to investigate this further.

How the recommendations might affect practice

The recommendations cover providing information, which is part of current practice, so there should be no cost to services. These recommendations will ensure women are educated on exercises they can do to improve their symptoms and exercises that are not harmful. In addition, they will help standardise the information being provided.

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Pelvic floor muscle training for managing pelvic floor dysfunction

[Recommendations 1.6.13 to 1.6.20](#)

Why the committee made the recommendations

The evidence showed that pelvic floor muscle training improves several symptoms of pelvic floor dysfunction (pelvic organ prolapse, stress and mixed urinary incontinence, and faecal incontinence with coexisting pelvic organ prolapse). There was greater uncertainty around the findings on faecal incontinence with coexisting pelvic organ prolapse, because there was much less evidence in this area.

For pelvic organ prolapse, the evidence showed a benefit from pelvic floor muscle training for prolapse that does not extend more than 1 cm beyond the hymen. This matched the committee's experience, because they agreed that more extensive pelvic organ prolapse would be managed in specialist care.

The recommended lengths of time for the training programmes are based on the most common time points used in the studies for assessing the benefit of training. This was 16 weeks for pelvic organ prolapse and faecal incontinence, and 3 months for urinary incontinence. The committee noted that this would give enough time to assess whether the training improved symptoms. This is also consistent with the recommendations on pelvic floor muscle training in the [NICE guideline on urinary incontinence and pelvic organ prolapse in women](#).

In addition to the research evidence, the committee also took account of the [Independent Medicines and Medical Devices Safety Review](#) and the [NHS Long Term Plan](#), which made recommendations on pelvic floor muscle training.

See the rationale section on pelvic floor muscle training for preventing pelvic floor dysfunction, for an explanation of the recommendations on supervising pelvic floor muscle training.

For additional therapies, such as weighted vaginal cones, biofeedback and electrical stimulation, the evidence was inconsistent. Some studies showed benefits, and others showed no effect. Some of the evidence suggested that these interventions could help women with pelvic floor muscle training by improving their ability to contract their pelvic floor muscles. In the committee's experience, effective pelvic floor contractions and relaxations are important for improving pelvic floor dysfunction symptoms and most women are able to do this as part of a supervised pelvic floor muscle training programme. However, the committee believed that supplementing a pelvic floor muscle training programme with biofeedback, electrical stimulation or vaginal cones could be cost

effective in the subgroup who make little progress during supervised pelvic floor muscle training. These additional therapies are particularly likely to be cost effective if using them allows women to avoid the need for surgical intervention.

Based on their experience, the committee thought it would be important that women are advised to continue doing pelvic floor muscle training and that they have the opportunity to discuss progress in regular reviews during the initial training programme. The committee believed that reviews with a healthcare professional improve adherence, which is important for the long-term effectiveness of pelvic floor muscle training.

There was some evidence suggesting that training in a group improved adherence and symptoms, but it was not consistently found to be more effective than individual training. This was supported by the committee's experience, because some women benefit from peer support whereas others feel more motivated with one-to-one supervision. To take account of this, the committee recommended giving women a choice of group or individual training. One-to-one supervision is more expensive than group training, but the difference in cost is relatively small and so the approach favoured by each woman is likely to be cost effective.

It was unclear whether using a pessary or intravaginal device would be effective when combined with pelvic floor muscle training, so the committee made a [recommendation for research on intravaginal devices and pessaries](#). The development of remote clinical practice during the COVID-19 pandemic also made the committee curious about the effectiveness of virtual pelvic floor muscle training, so they [recommended research into the effectiveness of virtual and in-person contact time for pelvic floor muscle training](#).

How the recommendations might affect practice

The recommendations will standardise practice. Pelvic floor muscle training is a key intervention for managing the symptoms of pelvic floor dysfunction and is already widely used in the NHS. However, access to group pelvic floor muscle training classes differs across the country. Although some healthcare services may need to change practice, group pelvic floor muscle training classes are less expensive, so the committee did not anticipate a significant resource impact.

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Intravaginal devices and pessaries

Recommendations 1.6.21 to 1.6.27

Why the committee made the recommendations

The evidence on intravaginal devices was unclear, with variance across outcomes. For example, there was no measurable reduction in urinary leakage, but women reported that their symptoms improved. However, the committee noted that a subjective improvement in symptoms was still important, because it is an indication of the woman's perception of the device's success. The committee were also aware from their experience that these devices can help to prevent urinary leakage in certain circumstances (for example, during exercise). Based on the limitations of the evidence and the potential complications, the committee recommended trialling intravaginal devices if other non-surgical options have been tried and have been unsuccessful, so that women could decide whether they were beneficial before using them long term.

This differs from recommendation 1.4.23 in the NICE guideline on urinary incontinence and pelvic organ prolapse, which recommends against the use of intravaginal devices.

However, the committee noted that recommendation 1.4.23 had not been updated since 2006. Most of the evidence they reviewed for this guideline has been published since 2006. Even though the findings from the evidence were not entirely certain, they decided that these devices should not be ruled out if other non-surgical options were unsuccessful. This would provide another option that may prevent the need for more invasive treatment.

The evidence on pessaries indicated that they help with symptoms of pelvic organ prolapse while they are in position, and this is in keeping with the committee's clinical experience. However, there was a lack of long-term evidence on the effectiveness and potential complications of pessary use. Because of the uncertainty around pessaries, the committee specified particular benefits and harms to discuss with women, based on the evidence that was available and their clinical experience. This will help women to make an informed decision on whether a pessary is right for them.

In the committee's experience, women with physical or cognitive impairments may have difficulty in managing an intravaginal device or pessary and are at higher risk of complications. Because of this, these women should have regular appointments to check for complications. The committee also recommended telling women how to self-refer if

they are managing the device themselves, so that they know how to get help if they are having problems or if their intravaginal device or pessary does not help.

There was a lack of evidence on the physical devices available for managing faecal incontinence (which is a particularly distressing symptom). The existing evidence consists of studies in mixed populations of men and women, so it could not be used to make recommendations for the population of this guideline. To address this, the committee made a [recommendation for research on anal plug devices and rectal irrigation for managing bowel symptoms in women with pelvic floor dysfunction](#).

How the recommendations might affect practice

These recommendations are in line with current practice on pessaries. There is variation in the use of intravaginal devices, but the recommendations would not involve major changes to practice because it would be an option only if other options had not been successful. Even though this may increase the general use of intravaginal devices, they are already used in some areas. They may also prevent more invasive options (such as surgery) which are more costly.

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Psychological interventions

[Recommendations 1.6.28 and 1.6.29](#)

Why the committee made the recommendations

The evidence showed a psychological impact from the symptoms of pelvic floor dysfunction. However, the committee noted that there was a lot of uncertainty about this evidence and made recommendations based on their experience and expertise. They made a recommendation emphasising this because women with pelvic floor dysfunction often do not seek help with the psychological impact of their symptoms, and healthcare professionals do not always ask them about it.

Some therapies were shown to improve distress associated with pelvic floor dysfunction, but the studies were very small. There was also evidence that psychological therapy could help with vaginismus, but it was not clear from the studies whether the participants'

symptoms were related to pelvic floor dysfunction. The committee decided that they could not recommend therapies based on this evidence.

Because other NICE guidelines cover identifying and managing mental health problems for people with a chronic health condition, the committee referenced these guidelines instead of making new recommendations on specific psychological interventions.

There was some evidence showing that psychological interventions improved attendance and adherence to pelvic floor muscle training. However, there were several limitations to this evidence:

- it did not show whether the improvement in attendance and adherence was sustained in the long term
- although some of the interventions improved the mental health of participants, it was not clear whether the interventions also had an impact on symptoms (which could mean that the improvement in mental health may not be sustained in the long term)
- the studies were small.

These limitations meant that the committee could not make a practice recommendation. However, they do believe that better attendance and adherence to training improves the benefit of pelvic floor muscle training. Because of this, they made a [recommendation for research on ways to improve adherence for women who are having this training.](#)

How the recommendations might affect practice

The committee agreed that there is variation in practice in how well psychological factors related to pelvic floor dysfunction are considered when planning treatment. The recommendations would not involve major changes to practice, but would standardise current good practice.

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Behavioural approaches

[Recommendations 1.6.30 to 1.6.32](#)

Why the committee made the recommendations

There was evidence about behavioural techniques including bladder retraining and lifestyle education, provided under direct supervision by a trained healthcare professional. The studies usually included pelvic floor muscle training as part of the interventions. The symptoms covered in the studies included urinary incontinence, urinary urgency and frequency, and faecal incontinence. Evidence was not available for some symptoms (such as emptying disorders of the bladder and bowel).

The evidence was difficult to interpret because there was variation in the quality of the research and a mixture of different interventions and comparators, which made it difficult to combine results. This meant that it was not clear which aspects of interventions were directly improving the symptoms of pelvic floor dysfunction.

The evidence showed that behavioural techniques in combination with pelvic floor muscle training improved these symptoms, which was in keeping with the committee's experience in clinical practice. The committee noted that bladder retraining consists of advice about when or how frequently to go to the toilet to encourage a routine that can help prevent incontinence episodes.

There was some limited evidence suggesting that a combination of behavioural techniques and pelvic floor muscle training was associated with improved adherence and satisfaction. The committee agreed that motivation and adherence were key to long-term benefit. The committee were conscious that behavioural techniques should be tailored to the individual, because ability may differ based on other coexisting conditions (such as cognitive impairment).

How the recommendations might affect practice

Behavioural techniques involve a wide range of techniques that can be used to change behaviour and teach women skills to reduce symptoms of pelvic floor dysfunction. These techniques are already used by most services, so the recommendations will reinforce current practice.

Bladder training can easily be provided in conjunction with a pelvic floor muscle training programme and would not add significant costs.

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Medicines

Recommendations 1.6.33 and 1.6.34

Why the committee made the recommendations

There was limited evidence on medicines for general pelvic floor dysfunction. However, the evidence available did show that intravaginal diazepam was not effective at improving symptoms. Although this evidence was based on a small population, the committee were also concerned about the risk of dependency from diazepam use. Because of this risk and the lack of evidence for any benefit, the committee recommended against intravaginal diazepam.

Women with high muscle tone are specifically mentioned in this recommendation because this is the only group diazepam would be considered for in current practice (because diazepam relaxes muscles and relieves muscle spasms). Because the evidence showed that diazepam was not effective, the committee wanted to make sure it was not used even in this group.

The NICE guidelines on urinary incontinence and pelvic organ prolapse in women, and faecal incontinence in adults, make recommendations on medicines for symptoms that can be associated with pelvic floor dysfunction. The committee recommended following these recommendations for women with pelvic floor dysfunction, because the medicines recommended are likely to be effective even if the underlying cause of symptoms is different in the other guidelines. They also thought that some of the recommendations in this guideline may also be relevant for women under 18.

Topical intravaginal oestrogen is currently used in clinical practice for managing pelvic floor dysfunction. However, no evidence was identified for this, so the committee made a recommendation for research on vaginal oestrogen.

How the recommendations might affect practice

The recommendation on intravaginal diazepam will not change current practice, because this is not currently used in the NHS. Because the other recommendation cross refers to other NICE guidance, it will reinforce current guidance and will not have any significant resource impact.

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Context

Pelvic floor dysfunction covers a variety of symptoms. In this guideline, the following symptoms are addressed as long as they are associated with pelvic floor dysfunction: urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes. The 3 most common and definable conditions are urinary incontinence, faecal incontinence and pelvic organ prolapse.

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 be physically active.

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.

When pelvic floor dysfunction is diagnosed, there is variation in the availability of non-surgical management options, such as pelvic floor muscle training. Women have no clear and effective strategies available to prevent worsening of the condition. This guideline provides a more community-based pathway to address these problems and to reduce the number of women who develop complex symptoms that need specialist care (including surgery).

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE webpages on gynaecological conditions](#) and [uterine prolapse](#).

For full details of the evidence and the guideline committee's discussions, see the [evidence reviews](#). You can also find information about [how the guideline was developed](#), including [details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

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