



Postpartum urinary incontinence: asking the right questions

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The connection of urinary incontinence (UI) to pregnancy and delivery is a known unknown. These conditions are linked, but exact causality is still being defined. Further, immediately postpartum women are an understudied population. Quiboeuf et al. (*BJOG* 2016;123:1222–8) report on symptomatic UI in women between 4 and 24 months postpartum assessed via mailed questionnaire. The prevalence of UI remained at about 20% at the two time points, although 50% of women experienced remission at some time. The persistence of UI was more frequent in older, more parous women who were breastfeeding or pregnant again at the time of follow-up. Women who delivered via caesarean section were more likely to have UI resolution, whereas women who became pregnant again were more likely to experience the onset of new UI.

Studies on postpartum UI should include reliable, detailed pregnancy and delivery information with discrete symptom questionnaires and long-term follow-up at multiple time points, including clinical examinations, to truly understand symptom progression and causation. One such cohort at 5–10 years after first delivery using validated questionnaires for different types

of UI and prolapse symptoms has proven the association of spontaneous vaginal delivery with stress UI [odds ratio (OR), 2.9; 95% confidence interval (CI), 1.5–5.5] and with clinically significant prolapse (OR, 5.6; 95% CI, 2.2–14.7). The association for operative vaginal delivery was even stronger (Handa et al. *Obstet Gynecol* 2011;118:777–84).

Stress UI causally stems from peripartum trauma impacting the urethral closure mechanism and urethral mobility (Thomason et al. *Int Urogynecol J Pelvic Floor Dysfunct* 2007;18:147–51). Causality for urgency UI is far less strong, if present at all. Colloquially, women refer to any of this UI as ‘leakage’ and, understandably, find it distasteful. However, as researchers and clinicians, we must separate stress and urgency UI for treatment and mechanistic reasons. Quiboeuf et al. asked women a yes/no question about UI rather than a more thorough symptom analysis. Understanding UI remission is challenging without the context of what type of UI women are experiencing. Urgency incontinence might persist before, during and after pregnancy related to a multitude of factors. If this is persistently present in the background, stress incontinence truly linked to pregnancy could occur and resolve undetected by a

simple yes/no question assessing for ‘any urine leakage’.

Although broad, population-based questionnaire studies, such as this, can access more women, subjectivity of memory and social pressure may have an impact on responses. Answers given during telephone interviews concerning UI seem to underestimate the true prevalence when women later present for clinic visits, underlining the importance of pursuing future work using objective, quantified measures reflective of symptom type and severity, clinical examinations and testing to deepen our understanding (Thomas et al. *Neurourol Urodyn* 2010;29:734–40). We have a dual goal of wanting to treat incontinence now in women experiencing this condition, and to understand the aetiology, progression and connection to symptoms later in life. As this study attempts, charting the symptoms is a step towards an understanding of causality, a step towards intervention and treatment, and then, ultimately, a step towards prevention.

Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information. ■