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Letter to the Editor

Rehabilitation combined with dietary intervention improve urinary incontinence in women with obesity: A proof-of-principle study

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We read the article titled "Rehabilitation Combined with Dietary Intervention Improve Urinary Incontinence in Women with Obesity: A Proof-of-Principle Study" by Capodaglio et al.[1] The authors studied the efficacy of a comprehensive rehabilitation treatment, including pelvic floor rehabilitation (PFR), compared to a standard rehabilitation program (consisting of combined aerobic and resistance exercise sessions) and weight loss program on urinary symptoms and quality of life in women with obesity and urinary incontinence (UI). Although the study was well designed, we would like to address a few points.

Initially, the title of the article suggested a comparison of classical PFR and dietary intervention in obese patients with UI. However, the Patients and Methods section revealed that pelvic floor exercises were added to the intervention group. The Agency for Health Care Policy and Research's Clinical Practice Guidelines recommend that the least invasive and least dangerous method should be the first choice for patients with incontinence. Therefore, lifestyle changes, bladder training, PFR, Kegel exercises, biofeedback, electrical stimulation, and electromagnetic waves are the first-line treatments for managing UI in women.[2] It is widely known that pelvic floor exercises are recommended as the first-line treatment for UI.

As expected, it was shown that the group in which PFR was added showed improvement in all the parameters examined. On the contrary, the results worsened in the control group, which was attributed to the rehabilitation program that increased intra-abdominal pressure. It is a known fact that obesity is an independent risk factor for UI. The positive results of weight loss for UI have also been shown and proven.[3] However, it would be inappropriate to conclude that dietary intervention is ineffective, as the study did not include a group receiving dietary intervention alone.

The results reveal that the patients in the control group were older and lost one-third of their weight at the end of the program compared to the other group, although not statistically different. We believe that there is a statistical error in these findings. In addition, the rate of compliance with rehabilitation is provided, but the rate of compliance with PFR and diet is not reported.

It was stated that weight loss may not be effective in three weeks, and a long-term evaluation may be necessary. However, in the PFR group, very positive results were obtained in three weeks. As physiatrists, we recognize that strengthening any muscle group requires at least six to eight weeks of exercise. The pelvic floor muscle group also gains strength slowly, and positive results are not expected in a short time. After four weeks of regular exercise, strengthening of the muscles, evidenced by a decrease in the frequency of urinary and bladder incontinence, may be observed, and significant improvement can be expected at the end of eight weeks.

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Finally, we would like to mention a few inconsistencies in the text. While the article states that 93 patients were evaluated and 33 patients were excluded, the flowchart shows that 73 patients were evaluated. This discrepancy raises concerns regarding the reliability of the data. Additionally, in the Results section, the table describing the 1-h pad test should be corrected to Table 2.

Nonetheless, the concept and structuring of the article are good and make for a compelling read. We commend the authors for this detailed study and acknowledge the difficulty of conducting and transcribing prospective randomized controlled trials.

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