Optimising Management of Urinary Incontinence

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AT THE European Association of Urology (EAU) Annual Congress 2026, held in London, UK, from 13th–16th March 2026, the session 'Incontinence Uncovered: Managing Urgency Without Stress' brought together leading clinicians to explore contemporary challenges and evolving strategies in the management of overactive bladder (OAB) and urinary incontinence. Expertly chaired by Benoit Peyronnet, University of Rennes, France; and Enrico Finazzi Agrò, University of Rome Tor Vergata, Italy, the session opened with a state-of-the-art overview spanning policy, digital health, physiotherapy, pharmacotherapy, diagnostics, and shared decision-making.

REFRAMING CONTINENCE HEALTH: THE URGE TO ACT CAMPAIGN

Michael R. Van Balken, Rijnstate Hospital, Arnhem, the Netherlands, opened by emphasising continence health as both a clinical and societal priority.

He presented an update on the EAU 'Urge to Act' campaign, launched following the 2023 EU Continence Health Summit, where stakeholders signed a joint statement calling for greater prioritisation of continence care across Europe.

A key achievement has been quantifying the burden of incontinence, which affects an estimated 55–60 million Europeans, with an economic cost approaching 70 billion EUR annually. This includes not only healthcare expenditure, but also productivity loss and environmental impact.

Van Balken stressed that clinical need alone does not drive policy change. Integrating socioeconomic and sustainability data has proven essential in engaging policymakers. A major milestone was the formation of a European Parliament Member interest group in 2025, helping elevate continence health on the political agenda. Early outcomes include practical initiatives such as petitions for appropriate disposal facilities for continence products.

Urinary incontinence is increasingly recognised as a non-communicable disease, closely linked to conditions such as cardiovascular disease, diabetes, and stroke. With growing political engagement, Van Balken concluded optimistically: "There is a lot more to come."

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Digital Solutions: Can App-Based Management Close the Care Gap?

Laura Wiemer, Charité – Universitätsmedizin Berlin, Germany, highlighted time constraints as a major barrier to optimal OAB care. In many European settings, consultations must cover both diagnosis and education within minutes.

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Wiemer elaborated that the gap between guideline recommendations and real-world practice contributes to poor adherence and outcomes, explaining that patients often find it difficult to retain complex treatment information delivered in a limited time, adding additional barriers to treatment.

App-based management offers a potential solution. Digital platforms can deliver guideline-recommended interventions, including bladder training, pelvic floor exercises, and lifestyle modification, in a structured and accessible format. They improve time efficiency, support long-term follow-up, and enable multimodal care without replacing clinicians.

Evidence that supports this is increasingly robust. The DINKS trial[1] saw a 59% reduction in incontinence episodes per 24 hours with app-supported care in women with stress urinary incontinence, urgency urinary incontinence, or mixed urinary incontinence, with 92% of patients reporting improved quality of life. Similarly, the BEST study[2] showed a 7-point improvement in International Prostate Symptom Score (IPSS) in men with lower urinary tract symptoms from benign prostatic hyperplasia, or OAB alone.

Benefits were consistent across severity levels and prior treatment exposure, with minimal adverse effects. While challenges remain, including patients' digital literacy and integration into workflows, Wiemer concluded: "We might already have a contender for best first-line OAB therapy, and it's probably already in your pocket."

PHYSIOTHERAPY: THE FOUNDATION OF CONSERVATIVE CARE

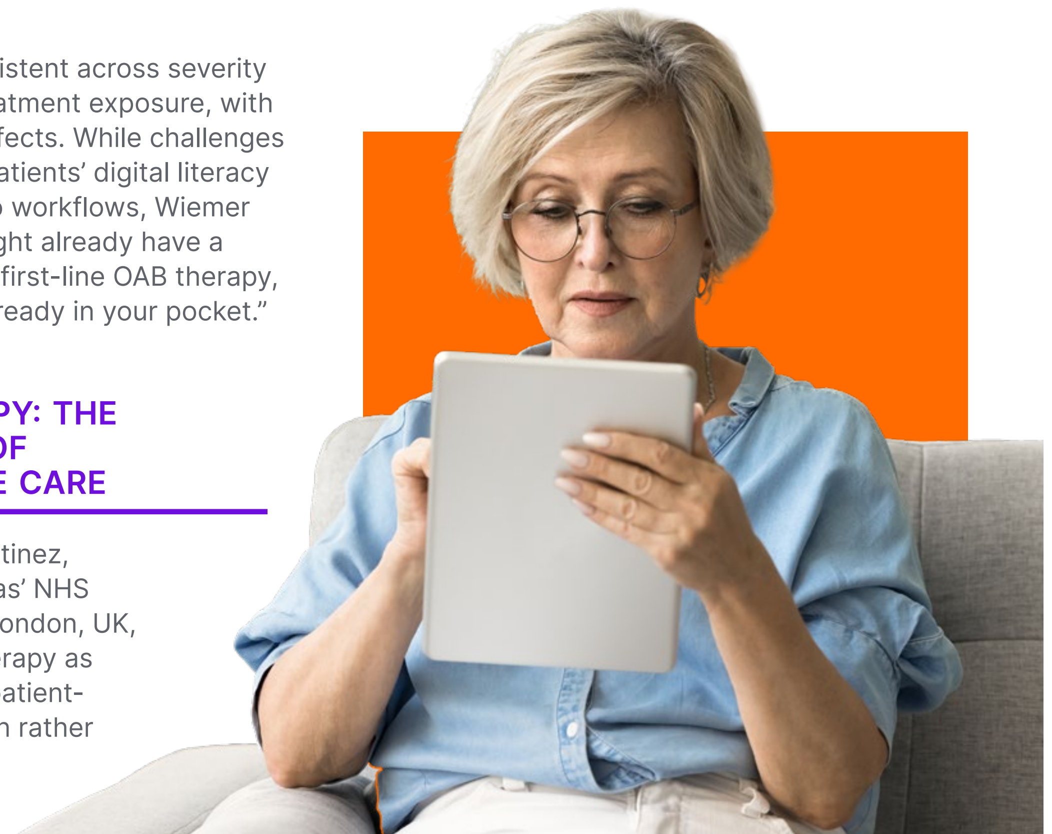
Paula Igualada-Martinez, Guy's and St Thomas' NHS Foundation Trust, London, UK, reframed physiotherapy as a comprehensive, patient-centred intervention rather than simply pelvic floor exercises.

While guidelines recommend conservative management as first-line therapy, Igualada-Martinez emphasised that real-world care requires individualised approaches. Physiotherapy includes bladder training, lifestyle interventions, weight management, and behavioural strategies, tailored to each patient.

Patient education is central. Many patients lack understanding of normal bladder function or fluid intake, and tools such as bladder diaries enable personalised treatment planning.

Assessment is equally important. Igualada-Martinez posed the question: "How many of you actually assess pelvic floor function before prescribing any medication?" Supervised, intensive training requires appropriate evaluation, particularly in urgency-dominant cases.

Physiotherapy can reduce symptoms across urgency, frequency, and incontinence, while empowering patients with long-term self-management strategies. It also helps identify those requiring escalation to pharmacological or surgical treatment.



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Although access may be limited and not all patients respond, Igualada-Martinez concluded: "Physiotherapy is not competing with other treatments. It is the foundation that makes all of your treatments better."

PHARMACOTHERAPY IN FOCUS: ANTIMUSCARINICS AND β3 AGONISTS

Marie Carmela Lapitan, University of the Philippines Manila, Philippines, positioned antimuscarinics as occupying an "optimal therapeutic window" between behavioural and surgical approaches. By inhibiting muscarinic receptors, they directly target detrusor overactivity, producing reductions in urgency, frequency, and incontinence within days to weeks. They are widely accessible, scalable, and can be prescribed in primary care, with generally mild and reversible adverse effects.

Patient preference also supports their use, even when accounting for side effects, reinforcing their role alongside conservative therapy in first-line management.

Sung Yong Cho, Seoul National University Hospital, South Korea, complemented this with evidence on β3-adrenoceptor agonists. Trials such as SCORPIO,[3] TAURUS,[4] and BESIDE[5] demonstrated significant symptom improvements, sustained efficacy over 12 months, and favourable tolerability.

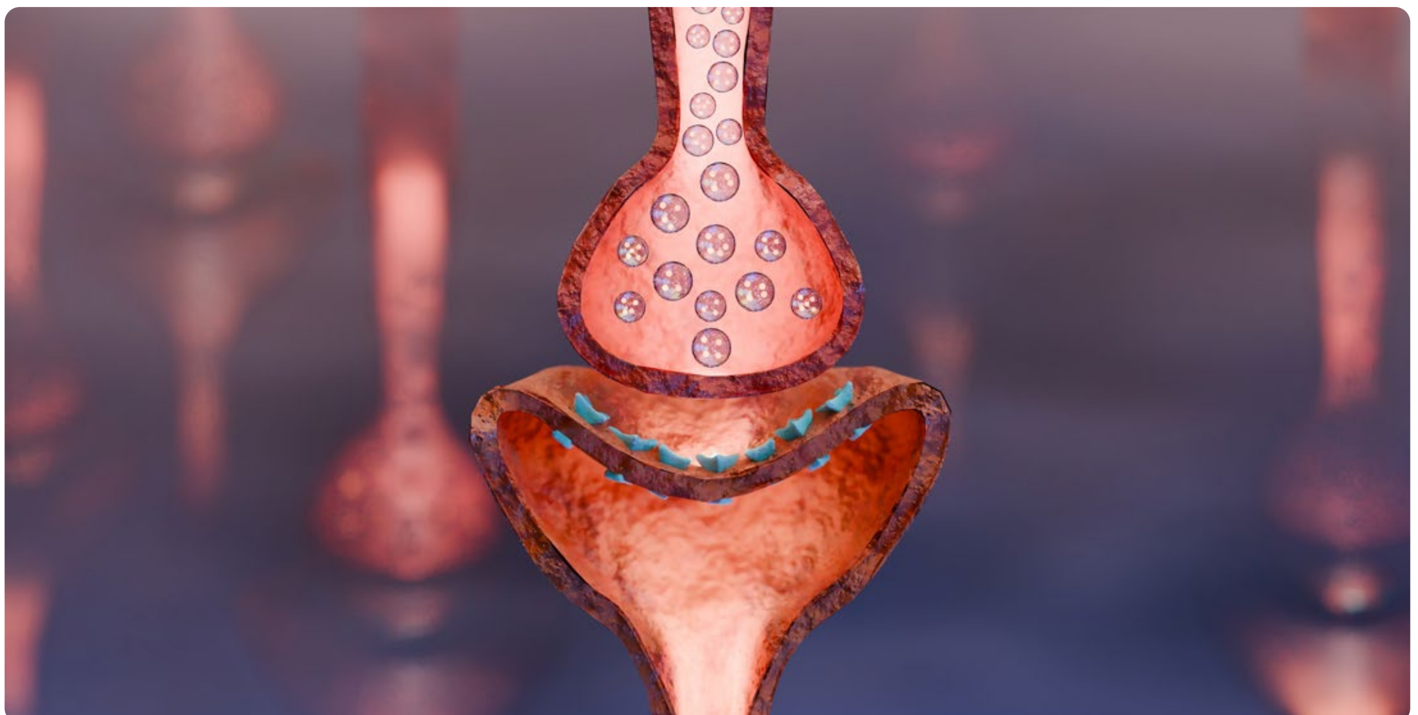
Mirabegron reduced incontinence and frequency compared with placebo, maintained long-term safety, and improved outcomes when added to antimuscarinics, with nearly half of patients achieving continence in combination therapy.

With fewer anticholinergic side effects and suitability for long-term use, Cho asked: "Is there really any reason not to use β3 agonists as a first option?"

MOVING BEYOND ALGORITHMS: A TAILORED 'NON-STEP' APPROACH

George Bou Kheir, Ghent University Hospital, Belgium, challenged the traditional stepwise model of OAB treatment. "OAB is not a disease, it is a symptom syndrome," he stated, arising from diverse pathophysiological mechanisms.

He proposed that OAB represents a fluctuating homeostatic state, explaining why treatment responses vary within the same patient over time. Examples included neurogenic-myogenic mechanisms, urethral dysfunction, and hormonal influences. In some cases, treating



one component may worsen another, highlighting the limitations of rigid algorithms.

Evidence supporting alternative approaches included improvements in both stress and urgency symptoms following midurethral sling (MUS) placement, as well as the impact of testosterone replacement on lower urinary tract symptoms.

> **OAB represents a fluctuating homeostatic state, explaining why treatment responses vary within the same patient over time**

These findings support mechanism-based, individualised care. Bou Kheir concluded: "The real question may not be which step comes next, but which mechanism we are actually treating."

THE ROLE OF URODYNAMICS: STILL PARAMOUNT?

Tufan Tarcan, Koç University, Istanbul, Türkiye, defended the continued importance of urodynamics in OAB assessment. He argued that while randomised trials are appropriate for therapies, they are not suited to evaluating diagnostics. Critiquing the FUTURE study,[6] he highlighted that urodynamic findings were underutilised, limiting the validity of its conclusions.

Urodynamics reclassified a proportion of patients initially diagnosed with OAB, identifying alternative or mixed pathologies. It also enabled comparable outcomes with less invasive treatment, suggesting a role in avoiding overtreatment.

"The bladder is an unreliable witness," Tarcan stated, emphasising that symptoms do not reliably reflect underlying mechanisms. He concluded that personalised management informed by urodynamics remains essential, particularly in complex cases.

SHARED DECISION-MAKING: REDEFINING THE CARE PATHWAY

Mohammed Belal, Queen Elizabeth Hospital, Birmingham, UK, emphasised shared decision-making as a central part of modern OAB care.

Shared decision-making integrates clinical evidence with patient preferences, which is particularly important in OAB, where multiple reasonable treatment options exist and trade-offs between efficacy, side effects, and convenience are common.

Current stepwise approaches often result in trial-and-error prescribing, leading to poor adherence and disengagement. Persistence rates remain low across therapies, reflecting differences between clinician priorities and patient values.

Belal stressed that shared decision-making goes beyond providing information. Instead, it requires structured discussion, clear recommendations, and understanding patient preferences.

He noted that decision aids can support the process, allowing patients time to consider options, and concluded that, ultimately, shared decision-making represents a redesign of care pathways, improving adherence and outcomes.

SYNTHETIC MIDURETHRAL SLINGS: A CONTROVERSIAL DEBATE

The session concluded with a debate on synthetic MUSs for stress urinary incontinence.

Elisabetta Costantini, University of Perugia, Italy, argued that MUSs remain highly effective, with long-term cure rates of 80–90% and durable outcomes beyond 15 years. Supported by extensive evidence, they offer minimally invasive treatment with rapid recovery and low re-operation rates.

While complications exist, she emphasised their relatively low incidence and the importance of appropriate training and regulation, stating: "The question is not

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whether complications exist, but whether alternatives perform better."

In contrast, Tamsin Greenwell, University College London Hospitals, UK, highlighted significant risks, including chronic pain and serious complications. She noted that complication management can lead to further morbidity, and that effective mesh-free alternatives, such as autologous fascial slings and colposuspension, are available.

Advocating caution, she concluded that treatment decisions should prioritise safety and adhere to the principle of "do no harm."

CONCLUSION

A clear theme emerged across the session: OAB and urinary incontinence are complex, multifactorial conditions requiring individualised management. From policy initiatives and digital tools to physiotherapy, pharmacotherapy, and diagnostics, no single approach is sufficient.

The future lies in integrating mechanistic understanding with patient-centred care. Tailored treatment strategies, supported by tools such as urodynamics and digital platforms, and guided by shared decision-making, offer the greatest potential to improve outcomes.

For healthcare professionals, the challenge is not only to adopt new therapies, but to deliver care that is personalised, evidence-based, and aligned with patient priorities.

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