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Title Page

Trends in urinary incontinence in women between 4 and 24 months postpartum in the EDEN cohort

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Shortened running title

Urinary incontinence between 4 and 24 months postpartum

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Trends in urinary incontinence in women between 4 and 24 months postpartum in the EDEN cohort

Abstract

Objective: Our aim was to study risk factors associated with the prevalence, incidence and remission of urinary incontinence (UI) between 4 and 24 months postpartum.

Design: Longitudinal study (EDEN cohort).

Setting: Two French university hospitals.

Population: 1643 women completed the questionnaire at 4 months and 1409 at 24 months, including 1354 who completed it both times.

Methods: Multivariate analyses identified risk factors for UI prevalence at 24 months postpartum, persistent UI versus remission, de novo UI versus continence, de novo UI versus persistent UI, and changes in IU severity between 4 and 24 months postpartum.

Main Outcome Measures: Postnatal UI and Sandvik UI severity score.

Results: UI prevalence was 20.7% (340/1643) at 4 months and 19.9% (280/1409) at 24. Significant factors associated with UI at 24 months were older age (OR = 1.07/year [95% CI: 1.04-1.11]), BMI (2.35 [1.44-3.85] ≥ 30 versus < 25 kg/m²), higher parity (1.77 [1.14-2.76] ≥ 3 versus 1), breast feeding (1.54 [1.08-2.19] ≥ 3 versus < 3 months), pregnant at follow-up (3.44 [2.25-5.26]), and caesarean delivery (0.62 [0.40-0.97] versus vaginal). The likelihood of UI remission at 24 months was 51.9% (149/287). Caesarean delivery was associated with increased likelihood of UI remission (0.43 [0.19-0.97]). The risk of de novo UI at 24 months was 12.5% (135/1067) and was associated with a new pregnancy (3.63 [2.13-6.20]).

Conclusions: Between 4 and 24 months postpartum UI, remission occurred in half of the cases. These postnatal UI changes were essentially related to mode of delivery and subsequent

46 pregnancy.

47

48 Abstract word count: 248.

49 **Keywords:** female urinary incontinence, postpartum, remission, incidence, pregnancy, cohort

INTRODUCTION

Urinary incontinence (UI) is defined by complaints of involuntary urinary leakage. This frequent symptom is reported by 10 to 40% of women.¹ It is especially disabling, has an unfavourable effect on women's social and working lives, and is costly from both individual (cost of hygiene products and treatment) and societal (health insurance costs and lost work days) perspectives.

The natural history of UI remains poorly understood.² Parity, ageing and obesity are the predominant risk factors for women. The prevalence of urinary leakage increases substantially during pregnancy as term approaches.² Different studies report prevalence rates of postpartum UI ranging from 3% to 73%.² The trauma associated with vaginal delivery appears to be the principal risk factor for postnatal UI. The prevalence of UI diminishes in the months after delivery.² However, we still do not know what factors are associated with this postnatal remission of symptoms. Longitudinal data after 12 months postpartum remain sparse,²⁻¹⁰ but those few studies report that the prevalence of UI increases progressively as women age.^{6,8} Similarly, we do not know what determinants promote the return of UI long after delivery, and few studies have focused on the remission and incidence of UI in the postpartum period. They can be examined, however, through data from the EDEN mother-child cohort, which describe UI at 4 and 24 months postpartum. The objective of this study was to describe the trends in symptoms between 4 and 24 months postpartum, to estimate remission and incidence rates,

69 and to analyse the determinants of these trends.

METHODS

The population comes from the EDEN cohort, composed of women recruited during pregnancy between 2003 and 2006 in two French maternity units, Nancy and Poitiers university hospitals (<https://eden.vjf.inserm.fr/index.php?lang=en>). The inclusion criteria required women to be pregnant with a single fetus, have health insurance, speak and write French, and have no prepregnancy history of diabetes. Women expecting to move away from the region in the 3 years to come were excluded. Among the 3758 women invited to participate, 2002 (53%) agreed (1034 women from Nancy and 968 from Poitiers). Women were included at a mean of 15 weeks of pregnancy (range: 8-26). Their mean age was 29 years (range: 18-44) and 30% of them were pregnant for the first time.

Postpartum UI was assessed at baseline (4 months postpartum) and at follow-up (24 months postpartum) by self-administered postal questionnaires that asked, among other things, about urinary symptoms during the preceding 4 weeks. Women were classified with UI if they answered yes to the question: "Have you had involuntary urinary leakages?" The UI type was determined with the BFLUTS (British Female Low Urinary Track Symptoms) questionnaire.¹¹ The question about frequency of leakage had four answer levels (less than once a month, once or several times a month, once or several times a week, every day and/or night), and the question about the amount of leakage three levels (drops, a little amount, more). The severity of UI at 4 and 24 months postpartum was estimated by Sandvik's score,

89 which has been validated with pad-weighing tests.¹²

90 The explanatory variables selected were chosen to reflect different hypotheses of

91 pathophysiologic mechanisms: traumatic factors (parity, characteristics of the index

92 pregnancy and delivery: episiotomy, long second stage of labour, child's gender, child's

93 weight, severe sphincter injury, anal incontinence 4 months postpartum, additional delivery

94 during follow-up); factors affecting tissue modification (pregnant at 24 months postpartum,

95 breast feeding, maternal age), factors affecting pelvic pressure (new pregnancy, body mass

96 index assessed before index pregnancy), constitutional factors (UI history before, during or

97 after the index delivery) and potential protective factors (postpartum pelvic floor muscle

98 training (PFMT)).² Education level and centre were considered as adjustment variables.

99 Education level may affect women's willingness to report urinary leakage and can thus modify

100 the results.¹³ We have previously observed that a low education level is associated with both a

101 lower response rate and a lower UI incidence.^{14,15}

102 The women who responded at 24 months and those who did not were compared with

103 Student's t test for the quantitative variables and a Chi-2 test for the qualitative variables.

104 The analyses of incidence and remission considered four groups of women, defined (Figure

105 S2) according to the presence or absence of postpartum UI at 4 months (baseline) and 24

106 months (follow-up): Group A comprised women who reported no urinary leakage at baseline

107 or at follow-up; group B, women with urinary leakage at baseline and at follow-up; group C
108 the women who reported no leakage at baseline but reported de novo leakage at follow-up;
109 and group D the women with leakage at baseline but not at follow-up.

110 Several multivariate logistic regressions were performed. One was an analysis of UI
111 prevalence at 24 months postpartum, and another an analysis comparing group B (persistent
112 UI) and group D (UI remission) to answer the question: what factors explain UI remission at
113 some period after delivery? An analysis comparing group A (persistent continence) and group
114 C (de novo UI) studied the question: What factors influence the onset of UI at a period after
115 delivery? Each of these models was first studied in a bivariate analysis with each explanatory
116 variable mentioned above; the variables with a P value ≤ 0.20 were included in the
117 multivariate analyses. The variables retained for the final multivariate analyses had P values $\leq$
118 0.05 and were considered significant. The analyses were adjusted for centre and education
119 level.

120 Finally we applied the same principle to the variation of the UI severity score between 4 and
121 24 months postpartum by a linear regression of the overall population.

122 All statistical analyses were performed with SAS software (version 9.2).

123 The relevant ethics committee (for the protection of people participating in biomedical
124 research at Kremlin-Bicêtre) approved the EDEN cohort study on December 12, 2002. Each

125 participating mother provided written consent at inclusion. The required declarations to the

126 French data protection authority have been made.

127

RESULTS

In all, 1643 women (87.0%) responded to the questionnaire at 4 months postpartum, 1409 (74.5%) at 24 months; these included 1354 (71.7%) who responded at both 4 and 24 months (Figure S1). The population responding at 24 months differed significantly from the women lost to follow-up; the latter were younger and more often multiparous, and they had lower incomes and less education.

The prevalence of UI in our population was 20.7% (340/1643) at 4 months and 19.9% (280/1409) at 24 months postpartum (Figure S2). The prevalence of UI at 24 months was 14.0% among women who had only caesarean deliveries, versus 20.6% for women with vaginal deliveries. UI at 24 months was significantly associated with older maternal age, parity ≥ 3 , vaginal compared with caesarean delivery, breast feeding for longer than 3 months, overweight or obesity, and being pregnant again at 2 years postpartum (Table 1). The other variables tested were not significantly associated with UI at 24 months postpartum.

Among the 287 women who reported postpartum UI at 4 months (baseline) and also completed the questionnaire at 24 months (Groups B and D, Table S1), 149 (51.9%) were continent at 24 months. UI remission between 4 and 24 months postpartum was more frequent for women whose UI first appeared during pregnancy compared with those with UI before the index pregnancy, and those whose UI was mild. Remission was less frequent for women who had had at least one vaginal delivery and for those who were pregnant when they completed

147 the 24-month questionnaire (Table 2).

148 Of the 1067 women who were continent at 4 months and completed the questionnaire at 24

149 months (groups A and C, Table S1), 135 (12.7%) reported UI at 24 months. The factors

150 significantly associated with the onset of de novo UI at 24 months were older maternal age,

151 anal incontinence reported at 4 months, being pregnant at 24 months, and obesity (Table 3).

152 Among the 273 women incontinent at 24 months who also completed the 4-month

153 questionnaire (Groups B and C, Table S1), 138 (50.5%) had persistent UI, that is, reported on

154 both questionnaires, while 135 (49.5%) had developed de novo UI at 24 months. The group of

155 women with persistent UI, compared with those with de novo UI at 24 months, more

156 frequently reported moderate or severe UI (49.3% vs. 34.1%) and mixed UI (63.0% vs.

157 48.9%) at 24 months. Moreover, their parity at inclusion was more often 3 or higher (29.7 vs.

158 21.5%, Table S1).

159 PFMT between 4 and 24 months postpartum was not associated with UI remission (group D

160 compared with group B, $P=0.26$, bivariate analysis). Only one woman, in group B (persistent

161 UI), had surgery for this problem.

162 Trends in UI severity between 4 and 24 months were associated only with new obstetric

163 events: an additional delivery during that interval ($P=0.043$) and pregnancy at 24 months

164 postpartum ($P<0.0001$). The other variables were not significantly associated with increased

165 UI severity. Delivery in the follow-up period was associated with a mean increase of 1.3
166 points in the Sandvik score, and a pregnancy at 24 months with an increase of 1.9. When no
167 obstetric event occurred during this interval, the mean Sandvik score fell by 0.14 points
168 between 4 and 24 months (Figure 1).
169

DISCUSSION

Main findings

The prevalence of UI in our population was similar at 4 and 24 months postpartum. The prevalence at 24 months was higher among women with vaginal deliveries and those who breastfed. The remission rate between 4 and 24 months was higher in women with caesarean deliveries, and the onset of de novo UI at 24 months more frequent in women who became pregnant again after the index birth.

Strengths and limitations

The strengths of our study are its longitudinal follow-up and the large number of women included, which enabled us to analyse the risk factors for UI remission and for de novo UI. The women lost to follow-up were more often socioeconomically disadvantaged. This bias could have resulted in an overestimation of UI prevalence because well-off patients report urinary leakages more easily.^{13,15} Nonetheless, our analysis were adjusted for education level, and we do not think that this point could have modified the associations observed. Our study of UI changes without considering the UI type (stress, mixed, or urge) may limit the interpretation of the changes we observed. UI may persist but change its nature (e.g., by the disappearance of the stress component and onset of an urge component). The impact of this limitation is nonetheless likely to be low. In clinical practice, changes in the nature of UI during follow-up are rare in the absence of surgery. UI type was not linked to its remission in

our analysis. The lack of medical visits (neither clinical assessments nor diagnoses) in our survey prevented any objective confirmation of urinary incontinence or its type.

Interpretation

At each observation point in our study, some women were no longer incontinent, while others had become so. This dynamic phenomenon has already been examined in some longitudinal studies.^{4,6,10,16} In our study, the chance of remission at 24 months was 51.9% among women incontinent at 4 months. Although this remission might have been due to treatment, no significant association was found between postpartum UI remission and PFMT. On the contrary, the women with persistent UI underwent PFMT more often than those whose UI disappeared. We hypothesise that a process of spontaneous recovery of continence during the postnatal period explains our results. Similarly, the longitudinal study by Viktrup⁶ did not find that remission was associated with the different treatments undertaken (physical therapy, surgery) and Hilde's¹⁷ randomised trial reported that postnatal PFMT was not associated with a higher probability of urinary continence.

In our study, the only factor associated with UI remission was caesarean delivery of the index birth. In other words, vaginal delivery was associated with persistence of UI at 24 months postpartum. Gartland et al. found a similar result in a cohort of 1507 Australian nulliparas and observed that persistent UI between 4 and 18 months postpartum was less frequent among

207 women with caesarean deliveries.¹⁸ DeLancey hypothesised that vaginal delivery affects the
208 pelvic floor in three phases: the first, traumatic phase of delivery, a second phase of repair,
209 and finally a maintenance phase, when other factors influence urinary continence.¹⁹⁻²¹

210 Continence appears to be restored more often in women with caesarean deliveries, while
211 vaginal delivery appears to expose women to a relapse or a longer recovery.

212 A caesarean delivery alone does not prevent UI in all women. In our study, 14% of the women
213 with only caesarean deliveries reported UI at 24 months postpartum. Gartland et al noted that
214 the nulliparous women with caesareans who had postpartum UI had had their first symptoms
215 during the pregnancy.¹⁸ Postnatal UI of women with caesareans may therefore result from an
216 effect of the pregnancy itself, rather than the delivery, on continence. This effect of pregnancy
217 on urinary continence may persist after delivery but it is like to be spontaneously reversible
218 more often or more rapidly after a caesarean than a vaginal delivery.

219 In our study, a new pregnancy at 24 months postpartum was associated with the onset of de
220 novo leakage. This association is consistent with Francis's observations.²² He noted that
221 incontinent women most often reported that their UI began during a pregnancy, not
222 necessarily the first, and that it resolved in the postpartum period, and then recurred at each
223 subsequent pregnancy with increasing severity until it became permanent.

224 Women with de novo UI in the late postnatal period differed from the women whose UI began

225 in the early postpartum and persisted in two ways: parity of the former was lower at inclusion
226 and they were more likely to have had another baby in the interval. The risk of UI persistence
227 at 24 months postpartum is increased among women with UI before the index pregnancy. It is
228 as if on the occasion of this new delivery the women whose UI is recent caught up to the risk
229 level of women with UI that began a longer time ago. McArthur et al. reported that the rate of
230 persistent UI increased with the number of deliveries.⁴ We hypothesise that women newly
231 incontinent at 24 months postpartum developed the disease later, corresponding to the time
232 required to accumulate the same risk factors (especially obstetric) as the women already
233 incontinent at 4 months.

234 In our study, the Sandvik score deteriorated from 4 to 24 months among the women who had
235 given birth during that interval and those newly pregnant at 24 months, while it fell slightly
236 through 24 months for those with no new obstetric event in the interval. This finding further
237 illustrates the favourable course of continence during the late postnatal period except in cases
238 of new obstetric events and suggests that the repair of obstetric injuries continues during this
239 period unless blocked by a new obstetric event.

240 New obstetrics events, pregnancy and delivery, appear to be central to the development of
241 postpartum UI in mothers. In this population, the natural history of UI is a dynamic and
242 individual phenomenon, combining progressive repair with an accumulation of supplementary
243 risk factors, principally pregnancy and delivery.

244

245

CONCLUSION

246

Our longitudinal study shows that the prevalence and course of UI in the postpartum period is

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essentially associated with pregnancies and deliveries. Although the prevalence of UI at 4 and

248

24 months indicates that symptoms are stable over this period, our longitudinal follow-up

249

shows a dynamic process that is a function of intercurrent obstetric events.

250

The remission rate observed in the postpartum period is higher among women with caesarean

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deliveries. This remission is not complete at 4 months and can continue, absent an intercurrent

252

obstetric event, up to at least 24 months postpartum. Other studies may be necessary over a

253

longer term to know just how long this remission continues and if caesarean delivery remains

254

associated with postnatal remission of UI over a longer period. Among young mothers, the

255

onset of new urinary symptoms at some point after a delivery is principally linked to yet

256

another pregnancy or delivery.

257

258 **Disclosure of interest**

259 None to declare.

260 **Contributions to authorship**

261 EQ and XF performed literature searches, and wrote and edited the article. MJSC and XF
262 initiated the project, EQ and MJSC performed data collection and analysis.

263 **Details of ethical approval**

264 The study was approved by the CCPPRB (Comité Consultatif de Protection des Personnes
265 dans la Recherche Biomédicale) of Kremlin-Bicêtre, December 12, 2002.

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Table 1. Factors associated with prevalence of urinary incontinence 24 months postpartum in the EDEN cohort. Multivariate analysis, logistic regression adjusted for centre and education level (N = 1409).

24 months postpartum urinary continence status:		Continent N= 1129	Incontinent N= 280		
Risk factors		n (%), or mean (std)		OR	95 % CI
Maternal age	(mean, years)	31.4 (4.7)	33.3 (4.6)	1.07	1.04-1.11
Parity	1	557 (49.3)	110 (39.3)	1	-
	2	404 (35.8)	97 (34.6)	1.07	0.75-1.52
	≥ 3	167 (14.8)	72 (25.7)	1.77	1.14-2.76
Mode of index delivery	natural	815 (72.2)	218 (77.9)	1	-
	instrumental	125 (11.1)	27 (9.6)	0.96	0.58-1.57
	caesarean	185 (16.4)	35 (12.5)	0.62	0.40-0.97
Duration of breast feeding	none	319 (28.3)	61 (21.8)	1.04	0.69-1.57
	< 3 months	352 (31.2)	68 (24.3)	1	-
	+ 3 months	454 (40.2)	146 (52.1)	1.54	1.08-2.19
Body mass index	< 25 kg/m ²	855 (75.7)	187 (66.8)	1	-
	25-29 kg/m ²	192 (17.0)	55 (19.6)	1.59	1.09-2.33
	≥ 30 kg/m ²	78 (6.9)	33 (11.8)	2.35	1.44-3.85
Pregnant at 24 months postpartum	no	1036 (91.8)	231 (82.5)	1	-
	yes	89 (7.9)	49 (17.5)	3.44	2.25-5.26

Factor not found to be significant and excluded from the multivariate analysis: Monthly household income, additional information about index delivery (episiotomy, long second stage of labour, child's gender, child's weight, severe sphincter injury), postpartum pelvic floor muscle training, anal incontinence 4 months postpartum, additional delivery during the follow-up, UI history.

Table 2. Factors associated with persistent urinary incontinence between 4 and 24 months postpartum in the EDEN cohort. Multivariate analysis, logistic regression for remission (Group D) versus persistence (Group B) of urinary incontinence between 4 and 24 months after delivery index, adjusted for centre and education level (N = 287).

Women incontinent at 4 months, continence status at 24 months		Remission Group D N=149	Persistent incontinence Group B N=138		
Risk factors		n (%)	n (%)	OR	(95% CI)
UI history (4 months postpartum)	before index pregnancy	40 (26.9)	80 (58.0)	3.94	1.91-8.11
	during index pregnancy	64 (42.0)	32 (23.2)	1	-
	after index delivery	34 (22.8)	20 (14.5)	1.03	0.49-2.18
UI severity (4 months postpartum)	mild	91 (61.1)	68 (49.3)	1	-
	moderate to very severe	52 (34.9)	69 (50.0)	2.13	1.20-3.79
Mode of index delivery	vaginal birth	107 (71.8)	108 (78.2)	1	-
	instrumental delivery	17 (11.4)	15 (10.9)	1.04	0.41-2.60
	caesarean section	25 (16.8)	15 (10.9)	0.43	0.19-0.97
Pregnant at 24 months postpartum	no	127 (85.2)	111 (80.4)	1	-
	yes	7 (4.7)	23 (16.7)	3.87	1.39-10.78

Factor not found to be significant and excluded from the multivariate analysis: Monthly household income, additional information about index delivery (episiotomy, long second stage of labour, child's gender, child's weight, severe sphincter injury), postpartum pelvic floor muscle training, duration of breast feeding, anal incontinence 4 months postpartum, additional delivery during the follow-up, maternal age, parity, body mass index, UI Type.

Table 3. Factors associated with de novo urinary incontinence at 24 months postpartum in the EDEN cohort. Multivariate analysis, logistic regression for persistent continence at 4 and 24 months postpartum (Group A) versus de novo urinary incontinence at 24 months postpartum (Group C) adjusted for centre and education level (N = 1067).

Women continent at 4 months, continence status at 24 months		Persistent continence Group A N= 932	De novo incontinence Group C N= 135		
Risk factors		n (%), or mean (std)	n (%), or mean (std)	OR	95% CI
Maternal age	(mean, years)	31.9 (4.6)	33.5 (4.6)	1.09	1.04-1.13
Anal incontinence (4 months postpartum)	no	808 (86.7)	100 (74.1)	1	-
	yes	120 (13.1)	32 (24.2)	1.94	1.20-3.14
Pregnant at 24 months postpartum	no	830 (89.1)	103 (76.3)	1	-
	yes	73 (8.3)	26 (19.3)	3.63	2.13-6.20
Body mass index	<25 kg/m ²	571 (61.2)	69 (51.1)	1	-
	25-29 kg/m ²	180 (19.3)	35 (25.9)	1.49	0.89-2.49
	≥30 kg/m ²	91 (9.8)	20 (14.8)	2.56	1.37-4.77

Factor not found to be significant and excluded from the multivariate analysis: Monthly household income, additional information about index delivery (mode of delivery, episiotomy, long second stage of labour, child's gender, child's weight, severe sphincter injury), postpartum pelvic floor muscle training, duration of breast feeding, additional delivery during the follow-up, parity, UI history.

Figures

Figure 1. Trends of the mean Sandvik score between 4 and 24 months postpartum according to intercurrent obstetric events (pregnant at 24 months, delivery between 4 and <24 months; N= 1354).

Figure S1. Flow chart

Figure S2. Continence status 4-24 months postpartum (N= 1354)