Invited Commentary

WOMEN'S HEALTH

Urinary Incontinence—If We Would Only Ask

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Urinary incontinence (UI) is a common condition affecting 1 in 3 adult women worldwide. Women with UI experience a lower quality of life, poorer sexual function, and are at higher risk for depression and anxiety. The condition is dramatically underreported and undertreated,[1] despite the availability of effective conservative treatments.[2] The major take-home message of the study of Collins et al,[3] published in this issue of *JAMA Internal Medicine*, is that asking a single question about UI to all women before a visit can change this.

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Women were invited for automated online screening 3 days before a routine primary care visit to 43 practices (family medicine, internal medicine, and geriatrics).[3] The single question was "Do you have bothersome leakage of urine?" More than 70 000 patients (71% of those invited) responded to the UI screening question. Prevalence of UI reached 11 383 patients (16.5% of respondents). Patients who expressed interest in information and treatment received education that included distinguishing the type of UI (stress, urgency, or mixed), and clinicians were provided with electronic health record order sets for medications, pelvic physical therapy, or a subspecialist referral. The interrupted time-series analysis showed that after implementation of the screening program, rates of UI diagnosis and physical therapy and subspecialty referrals increased. Drug treatment did not change throughout the study period. This may reflect the limited effectiveness of available drugs[4] or clinicians' reluctance to prescribe older anticholinergic drugs with significant adverse effects or newer β_3-agonist drugs without broad experience with their use. A key strength of the study is the diversity of health practices, coupled with the automated screening strategy, which reduces shame or taboo and led to a high rate of screening. Another strength was the easy access to educational materials and consultation with clinicians within 3 days, allowing women to act promptly rather than postpone seeking help. In summary, Collins et al[3] present an elegant example of how physicians can improve care for UI through a single-question screening.

The prevalence of UI in the study by Collins et al[3] (16.5%) was lower than figures commonly reported in the literature (30%-70%). The authors attributed this to the setting of their study (primary care vs community),[3] but the definition the investigators used likely had a larger impact. The internationally accepted definition includes UI irrespective of bother to the patient. Although the present study deviates from this definition, screening based on "bothersome leakage" in this study may enhance clinical relevance for patients and clinicians by focusing on symptom burden rather than mere prevalence.[3] After all, if patients are not bothered by their symptoms, clinicians do not need to offer treatment.

The significance of UI is often undervalued in health care. The authors attribute the low participation rate (43 of 74 invited practices [58.0%]) to the difficulty of adapting to new workflows.[3] We would argue that the impact on workflow of this intervention was minimal, as most of the process was automated. We hypothesize that the low rate of participation could also be an indication of lower prioritization and lack of belief in the efficacy of treatment for UI by primary care clinicians. Given the underdiagnosis and undertreatment of UI, the European Association of Urology has launched the Urge to Act campaign,[5] which aims to improve recognition of the burden of UI, improve diagnosis, and optimize outcomes through improving prevention, care, and access to treatment.

Patients often face barriers to obtaining help for UI, and health care professionals can play an important role in overcoming these. Shame and stigmatization are well-known barriers, in addition to a lack of knowledge by both patients and clinicians, as well as limited access to appropriate physical therapy. On the contrary, patient education and supportive, well-trained clinicians are facilitators.[6] As reported by Collins et al,[3] systematic screening was also found to facilitate seeking care for UI, which proved to be cost-effective in older women in primary care settings in the Netherlands.[7] In the study by Collins et al,[3] not all groups were reached equally by their approach, illustrated by the lower response rates among younger patients and those without commercial insurance.[3] This highlights the importance of efforts aimed at reaching all patients, and knowledgeable and involved clinicians who ask about UI symptoms in all patients.

Women with UI can also take advantage of evidence-based electronic health (e-health) solutions, lowering the threshold for seeking therapy. Education and treatment provided by an app (eg, URinControl[8]) or website can significantly improve UI symptoms, especially through increased treatment adherence.[9] The URinControl app is a free self-managed training program for women with urgency or stress incontinence. It provides a personalized exercise program to strengthen the pelvic floor and bladder control, along with tips and information. Currently, the app is available only in Europe. E-health can also be an easy tool for health care professionals to provide accessible and affordable UI care. This approach is even more important in remote areas and in health care systems without access to or lack of reimbursement for physical therapy. An overview of apps for bladder control and pelvic floor muscle exercises is available through Princeton Urogynecology.[10]

Decisions regarding UI treatment are preference sensitive. Once the care needs have been defined by the patient and recognized by the clinician, there is a wide range of treatment options available. Treatment options differ between predominantly stress or urgency UI (often present in combination). It is easy to distinguish the main type of UI

by asking simple questions, as was done in the study by Collins et al,[3] guiding women to the appropriate treatment options. Although it is not detailed in the study of Collins et al,[3] we expect that the advice provided was tailored to the type of UI. When primary care treatment (including e-health, pelvic floor therapy, or medication) is deemed insufficient, patients should be referred to urologists and urogynecologists who can provide more invasive treatment options. The decision for surgical treatment for UI is a textbook example of a decision that requires shared decision-making. There is not a single best treatment for all patients with UI, and patient preferences must play a major role in decision-making. However, before deciding on any treatment approach, the first step for all patients is to be diagnosed with UI and to obtain access to help.

We call on all health care professionals worldwide to prioritize UI, as the condition has a profound impact on patients' lives. Most women with UI go unnoticed by their clinicians, as UI is typically not the primary reason for a visit. For example, patients with diabetes are at higher risk for UI, as are those with chronic cough and advanced age. Asking one question can start the chain of events that results in improved continence and quality of life. We endorse the recommendation to integrate the screening question in routine health assessments. By simply asking a single question, physicians can make a substantial difference.

ARTICLE INFORMATION

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Published Online: February 9, 2026. doi:10.1001/jamainternmed.2025.7832

Conflict of Interest Disclosures: Drs Blanker and Loohuis reported a patent for the URinControl app licensed to University Medical Center Groningen. The authors have no financial interests in the app but received funding for the development, testing, cost-effectiveness study, and nationwide implementation of this app in earlier and ongoing studies. No other disclosures were reported.

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