



Proposal of a protocol for pelvic floor muscle evaluation and training to provide care to women with urinary incontinence

Proposta de protocolo de avaliação e treinamento da musculatura do assoalho pélvico para atendimento à mulher com incontinência urinária

Propuesta de un protocolo de evaluación y entrenamiento de la musculatura del suelo pélvico para atender a mujeres con incontinencia urinaria

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ABSTRACT

Objective: To present a proposal of a protocol for pelvic floor muscle evaluation and training to provide care to women with urinary incontinence. **Method:** Professional experience report, conducted in an outpatient facility for voiding dysfunctions in the Brazilian Unified Health System, conducted by an enterostomal therapist nurse. **Results:** Elaboration of a proposal of care protocol in nursing consultations based on a directed physical examination, nursing diagnoses of the International Classification for Nursing Practice, and the adaptation of a muscle training protocol as prescription. Steps: static observation, dynamic observation, and palpation to verify the tension and evaluation of strength, sustentation, relaxation, and muscle coordination, followed by prescriptions for relaxation, proprioception, training for strength, sustentation, abdominal and pelvic coordination, and maintenance, as per diagnosis. **Conclusion:** This protocol proposal intends to support the evaluation of the pelvic muscles of women with urinary incontinence or at risk for developing this condition by nurses of all levels of healthcare, especially as part of nursing consultations in primary care.

DESCRIPTORS

Urinary Incontinence; Women's Health; Pelvic Floor; Nursing Process.

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INTRODUCTION

Urinary incontinence (UI) is defined as any complaint or observation of involuntary loss of urine⁽¹⁾. According to the International Continence Society (ICS), this can be classified as: Stress, Urgency, Mixed Urinary Incontinence, Urinary Incontinence due to Retention, Nocturnal Enuresis, Continuous, Insensible Urinary Incontinence, during coitus, and Urinary Incontinence due to Neurological Disorder⁽¹⁾.

Populational studies obtaining estimates of incidence and prevalence of UI are not uniform regarding the diagnostic criterion, which leads to inconsistent estimates. The publication of ICS, based on the review of epidemiological studies for the evaluation of UI rates gives an idea of this manifestation worldwide: when all types of incontinence are considered, the prevalence ranges from 25% to 45%, depending on the studied population⁽¹⁾.

Observing the Brazilian context, researchers suggest a worrying prevalence rate. A cross-sectional study evaluating 322 women aged 18 to 85 found a UI prevalence of 37.5% and a 57.8% prevalence for nocturia⁽²⁾. Within long-stay institutions for the elderly, the prevalence of UI is over 50%, with 37% associated to fecal incontinence⁽³⁾.

The predominance of women among people affected by UI is strongly well-documented. Females have a higher risk for developing voiding dysfunctions due to intrinsic risk factors such as pelvis anatomy, pregnancies, deliveries, and the reduction of estrogen after menopause. In addition, risk factors such as anxiety, depression, and functional constipation are more prevalent in women^(1,4).

Physically, UI may lead to Incontinence-Associated Dermatitis (IAD), due to frequent contact between urine and skin⁽⁵⁾. Voiding dysfunctions related to emptying symptoms tend to result in recurrent conditions of Urinary Tract Infection (UTI), with a risk for vesicoureteral reflux, bladder wall thickening, and compromised kidney function⁽⁶⁾.

In addition to physical compromise, the impact of urinary incontinence on quality of life is broadly documented. Voiding dysfunctions are frequently associated to psycho-emotional changes and social isolation in patients of all ages⁽⁷⁻⁹⁾.

Despite considering the magnitude and impact of the problem in the manual for basic care of women in the climacteric period, the Ministry of Health does not present the possibility of UI treatment in Primary Care, which leads women with these complaints to be referred to waiting lines for specialized appointments and surgical procedures in tertiary care⁽¹⁰⁾.

The conservative treatment is first-line treatment for all types of UI. A document jointly published by the International Urogynecological Association (IUGA) and ICS describes the application of each measure, including lifestyle changes, scheduled voiding, controlling techniques, muscle training, electrotherapy, thermal therapy, and manual therapies⁽¹¹⁾.

Muscle training is related to the rehabilitation of the pelvic floor muscles (PFM) for strength, resistance, relaxation, stretching, and coordination⁽¹¹⁾. This is a first-choice treatment when the UI is due to PFM dysfunctions. In these cases, it is frequently associated with changes in intestine

and sexual functions, given that these muscles are common to all three systems^(1,4,11).

There are different protocols for PFM evaluation in the literature⁽¹²⁻¹³⁾, as well as different muscle training protocols⁽¹⁴⁻¹⁶⁾, which are mostly international, developed by pelvis physiotherapy professionals, and require regular appointment attendance and a preserved cognitive level. This report aims to present a proposal of protocol for evaluation and pelvic floor muscle training (PFMT) to provide care to women with urinary incontinence in primary healthcare. This protocol results from adaptations conducted throughout years of care experience, based on the impossibility of evaluating patients in short intervals between appointments and on the patients' incomprehension of some of the commands for PFMT.

Therefore, this is a professional experience report conducted by an enterostomal therapist nurse in an outpatient ward for voiding dysfunctions in the Brazilian Unified Health System (SUS). Also, this protocol proposal provides a systematic and simplified manner of evaluation and PFMT, which is feasible to be conducted by nurses, with a possibility of dissemination for this protocol for evaluation and first-line treatment of UI in all contexts of healthcare in Brazil.

METHOD

DESIGN OF STUDY

This is an experience report which presents a proposal of protocol of evaluation and PFMT to provide care to women with urinary incontinence. The experience report may be seen as a narrative that fundamentals experience as a scientific phenomenon⁽¹⁷⁾. The experience was chosen to be reported through the adaptation of a PFMT protocol previously used by one of the authors⁽¹⁸⁻¹⁹⁾, whose original sequence of phases and adaptation are described in the results and the application of a sequence of functional pelvic evaluation which directs PFMT according to the changed muscle function, e.g., relaxation measures in case of altered relaxation, strength training for weak contractions (Oxford 01 or 02), endurance training for endurance <10 seconds, as well as presenting the nursing diagnoses adopted for each finding, so as to facilitate its systematization and application to the clinical practice of nurses working in primary healthcare.

LOCAL

This protocol proposal is based on the professional experience of conducting nursing consultations with women with stress UI, urgency UI, and mixed UI, in an outpatient facility for voiding dysfunctions in the public federal network, conducted by an enterostomal therapist nurse. This outpatient facility has been active since 2014 and provides care to patients with voiding dysfunctions. In all appointments, patients are received by an enterostomal therapist nurse or qualified nurses, undergoes anamnesis and physical examination, including the functional evaluation of PFM, and receives orientation for muscle training in accordance with pelvic evaluation and for behavioral measures, in accordance with her urinary symptoms and voiding diary. Appointments

last a mean of 40 minutes and returns are twice a month, monthly, or bimonthly. The outpatient facility has a demand of around 160 patients per month. Admitted patients are over 18, of both sexes, referred by gynecology or urology specialists due to complaints of urinary, evacuation, or sexual symptoms. Females are predominant, as are patients older than 60 and with a record of multiparity.

APPLICATION AND ADAPTATION OF PROTOCOLS

This proposal of protocol was structured to be used during the nursing appointment, based on the nursing process applied in outpatient environments and offices, as in this report⁽²⁰⁾.

The nursing process consists of five ordered steps: Data collection, composed by anamnesis and physical examination; Nursing diagnoses, performed solely by the nurse and listed after collection; Nursing planning, which includes prescription of care and expected results; Implementation, which may be performed by the nursing team or patients themselves; and Evaluation, which corresponds to the verification of changes after the implementation of prescriptions; in nursing consultations, this step is performed in follow-up appointments⁽²⁰⁾.

Thus, for structuring this protocol proposal, the steps of anamnesis, focused physical examination, nursing diagnoses, and prescriptions for each diagnosis were followed. Anamnesis is not detailed in this material. Only suggestions of items to be introduced into clinical investigation are covered. The proposed focused physical examination recommends the strength and endurance evaluation proposed in the PERFECT scheme, in addition to evaluation of tension and quality of relaxation, with the objective of identifying altered muscle functions and directing the best phase of PFMT⁽²¹⁾. The specific nursing diagnoses departed from the International Classification for Nursing Practice (ICNP)⁽²²⁾. Finally, prescriptions for care and pelvic rehabilitation are an adaptation from the protocol of Miller and Sampselle⁽¹⁸⁻¹⁹⁾.

Given the PFMT protocol proposal and the muscle functions it covers, the evaluation adopted includes tension, contraction (strength), relaxation, endurance, and coordination of pelvic floor contractions. A goal was defined for each evaluated criterion, to guide the choice of muscle training series.

The evaluation of contraction (strength) and endurance are conducted in accordance with steps P (power) and E (endurance) of the PERFECT schema⁽²¹⁾, which consists in the evaluation of contraction, endurance, quick contractions, and repetition of PFM contractions. Understanding the need for an effective relaxation for a higher amplitude of contractions and that the spastic muscles require a focus on relaxation before a work for gaining strength, endurance, or coordination⁽²³⁻²⁴⁾, inserting tension evaluation and relaxation into the steps of the functional evaluation was opted for. The description of the evaluation of each function is detailed on the results of this report.

For specific nursing diagnoses, the browser of the International Nursing Council (ICN) was used⁽²²⁾. All were created from the causes of urinary complaints, obtained by anamnesis and the evaluation of perineal muscles. An

association of the CIPE diagnoses with the terminology of International Continence Society (ICS) was attempted at, to enable the use of this protocol by other health professionals.

For muscle training of the pelvic floor, the protocol of Miller and Sampselle⁽¹⁸⁻¹⁹⁾ was adopted; this has five phases of progression and one of maintenance. The daily training is composed of five series of ten contractions. The first phase is strong contraction and quick relaxation. The second phase is contraction, endurance, and relaxation, with endurance starting in two seconds, with two extra for each new evaluation, until endurance for 10 seconds is reached. The third phase is contraction in three strength levels. The fourth phase is similar, however, with endurance of three seconds for each level. Finally, the fifth phase is that of endurance for five seconds at maximum strength, relaxation halfway, and full relaxation⁽¹⁸⁻¹⁹⁾. For a complete application of the protocol⁽¹⁸⁻¹⁹⁾, some specificities are required on behalf of the service and the population receiving care: the number of appointments should be higher than nine, for assisted progression of each series of training.

However, in the studied service, discharges are often made from the third appointment onwards, which favors patient turnover. Return must take place within a short interval, especially in phase two, where there is progression of two seconds of endurance in each evaluation, but there are no vacancies for weekly appointments in the service due to the high demand. The patients are required to have good cognitive, coordination, and muscle capability levels for the third and fourth phases. A perception and coordination that enables PFM contraction in three distinct levels is also required, a challenge rarely achieved. In addition, the phases four and five require an endurance above nine seconds, time which was often inferior for patients who were discharged with no urine loss. Given the mentioned difficulties, the protocol phases were adapted for the local context, with a focus on reducing the number of appointments, facilitating comprehension, and respecting each patient's progression limits.

Many patients were also observed to evolve perfectly in muscle training, with an expressive gain of strength and muscle endurance; however, they still had urine loss upon effort. Such data show that, although the muscle function was reestablished, to the point of avoiding urine loss, there was no coordination between pelvic floor contraction and an increase of intra-abdominal pressure. A new series of exercises was thus created, based on the endurance training, in which an increase in intra-abdominal pressure was simulated through a strong blow, recovering thus the idea of pre-contraction⁽²⁵⁾.

ETHICAL ASPECTS

Considering this is an experience report and presents no data of services or patients, the project did not require submission to the Human Research Ethics Committee.

RESULTS

The results are presented according to the steps of the nursing process, with a focus on adaptation of the evaluation schema, nursing diagnoses, and prescriptions of muscle training, reached by the process detailed on the method section.

ANAMNESIS

Before starting the physical examination of the pelvis, anamnesis must be conducted, focusing on the patient main complaint, treatments already performed against the problem and risk factors for pelvic floor dysfunctions. Subsequently, the investigation must be started to list the defining characteristics of each nursing diagnosis.

FOCUSED PHYSICAL EXAMINATION – PELVIC FLOOR EVALUATION

Place the patient in dorsal decubitus, bent legs, feet together on support, near the glutei, knees spread apart;

Static observation: Spread labia minora, verify the presence of scars, Incontinence-Associated Dermatitis, vaginal secretion and prolapses while at rest; Evaluate humidity and elasticity of the vaginal mucosa;

Dynamic observation: Request strength test through the Valsalva maneuver (strength of evacuation), observe the stability of vaginal introitus and the progression of prolapses (projection of organ through the vaginal canal); Teach pelvic floor contraction (relax the body, concentrate on the anal region and pull inward as if needing to hold in flatulence), observe movement;

Palpation: Perform vaginal examination with two fingers (one if there is atrophy with discomfort or burning upon touch) with fingers placed horizontally, so that the sides of the fingers touch the lateral vaginal walls; Notice whether there is muscle rigidity upon touch;

Evaluation of the function: During vaginal examination, reorient the contraction of pelvic floor with no abdomen, glutei or thighs contraction and with no pause in the respiratory movement; Evaluate proprioception (perception of the right muscles to be worked); Evaluate muscle strength (per Oxford scale* under maximum contraction); Oxford 0 – absence of muscle activity, Oxford 1 – flicker of a contraction, Oxford 2 – weak contraction, Oxford 3 – contraction compressing the fingers, Oxford 4 – contraction compressing and pulling the fingers towards the pubic symphysis⁽²¹⁾.

The use of a perineometer may contribute to the evaluation of the increase in intravaginal pressure produced by PFM contraction, providing more precise values. This is recommended for services which can afford it. Evaluate time of endurance in seconds (in submaximal strength), count the time of stable contraction; Evaluate relaxing capacity: the same contraction amplitude must be felt during relaxation (capacity of releasing everything that was contracted, at the same speed); Evaluate coordination: capacity of contracting and relaxing when requested or contracting in different strength levels.

NURSING DIAGNOSES

For each possible finding in the proposed pelvic evaluation, a corresponding Nursing Diagnosis was elaborated. These diagnoses are presented with the corresponding finding between parenthesis, as they are usually described, facilitating comprehension, and enabling its use by professionals of the multiprofessional team.

Six ICNP diagnoses were formulated for pelvic floor muscles disorders: Spasticity of the perineal muscle, Impaired psychomotor activity of the perineal muscle, Perineal muscle weakness, Impaired resistance of the perineal muscle, Impaired perineal muscle reflex, and Recovery of the perineal muscle.

Chart 1 provides the nursing diagnoses and their defining characteristics, i.e., their clinical findings, signs, and symptoms.

Chart 1 – Nursing diagnoses specific for pelvic floor dysfunctions – Curitiba, PR, Brazil, 2020.

Nursing diagnoses	Defining Characteristics
Spasticity of the perineal muscle (pelvic floor hyperactivity)	Symptoms: Urine loss, gases or feces loss, hesitant urine stream, weak or intermittent stream, feeling of incomplete emptying, effort for evacuation, pain during sexual relation. Signs: Muscle tension and/or inefficient relaxation, which is presented as a slow, incomplete, uncoordinated, or unnoticed relaxation.
Impaired psychomotor activity of the perineal muscle (absence of pelvic proprioception)	Symptoms: Urine loss, loss of gases or feces, pelvic organs prolapse, reduced pleasure during sexual relation. Signs: Oxford 0, associated to impaired proprioception, difficulty understanding what the right muscles to be worked are.
Perineal muscle weakness (alteration of PFM strength)	Symptoms: Urine loss, loss of gases or feces, pelvic organs prolapse, reduced pleasure during sexual relation. Signs: Muscle strength lower than Oxford 3.
Impaired resistance of the perineal muscle (changed PFM endurance)	Symptoms: Urine loss, loss of gases or feces, pelvic organs prolapse, reduced pleasure during sexual relation. Signs: Endurance of contraction lower than 10 seconds.
Impaired perineal muscle reflex (discoordination between increased intra-abdominal pressure and PFM contraction)	Symptoms: Urine loss upon effort. Findings: Good muscle function (Oxford higher than 2, endurance of 10 seconds and effective relaxation).
Recovery of the perineal muscle (good PFM function)	Symptoms: Improvement or absence of urine loss. Findings: Good muscle function (Oxford higher than 2, endurance of 10 seconds and effective relaxation) and abdominal and pelvic coordination.

Figure 1 presents the flowchart for the functional pelvic evaluation sequence and PFMT based on the evaluation, from the orientation to the improvement of proprioception until endurance gain. Evaluation of coordination is not inserted in this flowchart due to not being applicable to all patients. This is suggested when opting for prescribing strength coordination and endurance exercises, which are applied when women are progressing in the functional gain but still present urine loss. The abdominal and pelvic coordination training is applied only when the PFM has achieved the desired function, but the woman still presents loss upon effort due to difficulties in the reflex of perineal contraction.

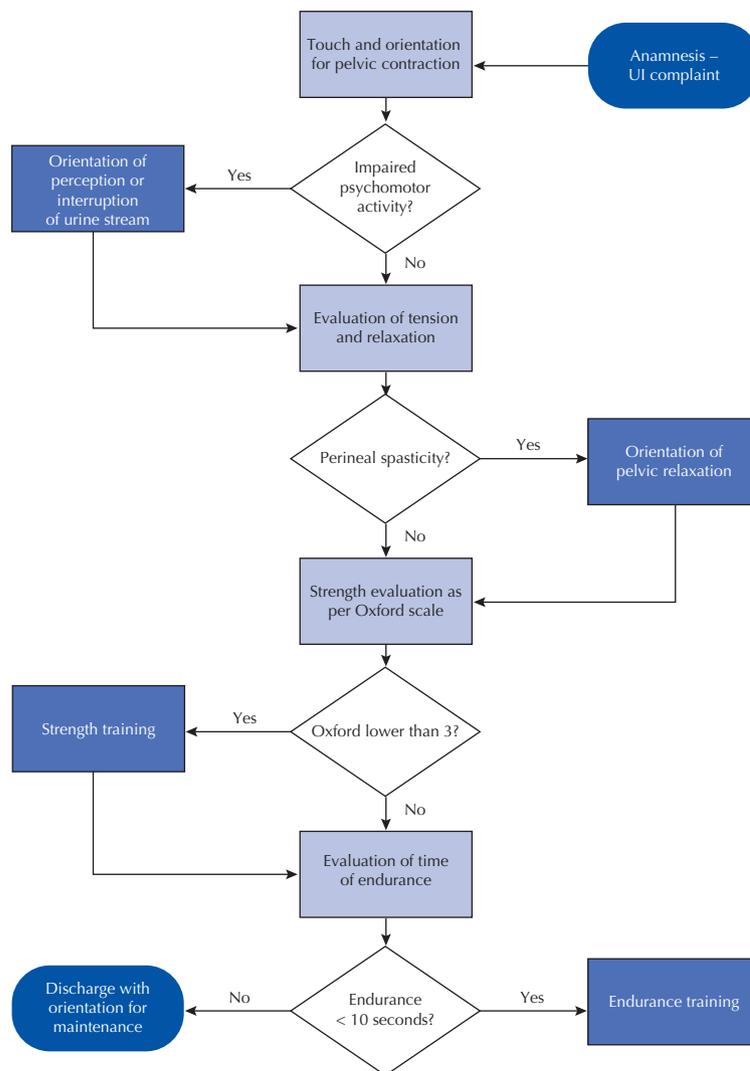


Figure 1 – Simplified evaluation flowchart and PFMT for women with urinary incontinence – Curitiba, PR, Brazil, 2020.

LIST OF PRESCRIPTIONS IN ACCORDANCE WITH EACH DIAGNOSIS

SPASTICITY OF THE PERINEAL MUSCLE (PELVIC FLOOR HYPERACTIVITY):

Initial training must focus on relaxing activities. In these cases, the patients should be oriented to perform the following measures: Intravaginal massage while showering, crouching, or standing with both feet supported in a bench or a support, or lying on the bed. Touching the left lateral vaginal wall with the right thumb, feeling the points of rigidity, and massaging in circular or linear movements until feeling a relaxation in the tension point. Repeating the movement with the left thumb in the right vaginal wall; Taking a sitz bath with warm water for 15 to 20 minutes, between once and three times a day. If there is associated pain, chamomile tea may be used for the bath; Applying dry heat with a hot water bag, gel bag, or seeds. Sitting on the bag of choice for 20 to 30 minutes, once to three times a day; Performing exercises of PFM contraction quickly and strongly and complete relaxation, with a focus on relaxation. Repeating series of 10, three times a day.

IMPAIRED PSYCHOMOTOR ACTIVITY OF THE PERINEAL MUSCLE (ABSENCE OF PELVIC PROPRIOCEPTION):

The patient must be oriented to relax the body, breathe deeply, concentrate on the anal region, and pull the anus inward (contract and pull inward) as if having to hold in flatulence. The abdominal muscles, glutei and thighs must not be contracted during the movement and breathing should not be held during contraction. The orientation of concentrating on the anus facilitates the identification of the pelvic region for a large share of women for having already contracted this region throughout life. However, in case of difficulty understanding this orientation, this could be adjusted to more easily understood language for those who are receiving care, such as “try to tighten your vagina”, “try to move the area as if you had to interrupt pee”.

The patient should know that by contracting the anus she is moving the anus lifting complex, muscles which are responsible for opening and closing the pelvic orifices (urethra, vagina, and anus) and for the endurance of pelvic organs (bladder, womb, and rectum). In case the professional must verbalize the orientation of “moving as if interrupting the

urine stream”, it should be pinpointed that the real urine stream should never be cut as a form of exercise, for this action may lead to the cessation of the detrusor contraction with a consequent high post-void residual urine.

If even with orientation the patient is not able to perform the correct movement (even if just a flicker of contraction in the fight place), she should be referred to specialized services, where she will probably have access to treatment with biofeedback and/or electrostimulation.

PERINEAL MUSCLE WEAKNESS (CHANGES IN THE PFM STRENGTH):

Start with strength training - Miller and Sampeselle Protocol: phase 01^(18,19): Contract PMF at maximal strength and relax completely; Repeat 10 contractions; Perform five series a day.

Whenever there is urine loss upon effort, the patient should be oriented to perform the Knack maneuver⁽²⁵⁾, also called pre-contraction, which consists of contracting the pelvic floor before any abdominal effort.

IMPAIRED RESISTANCE OF THE PERINEAL MUSCLE (CHANGED PFM ENDURANCE):

An endurance training must be started - Miller and Sampeselle Protocol: phase 02 adapted⁽¹⁸⁻¹⁹⁾. Contracting the PFM in submaximal contraction; Enduring contraction by the time possible with no instability; Repeating 10 contractions; Performing five series a day; Increasing one to two seconds of endurance every two weeks until sustaining for 10 seconds.

IMPAIRED PERINEAL MUSCLE REFLEX (INCOORDINATION BETWEEN INCREASE IN INTRA-ABDOMINAL PRESSURE AND PFM CONTRACTION):

Start abdominal and pelvic coordination training⁽²⁵⁾, trying to recover the reflex of perineal contraction to intra-abdominal pressure changes: Contract PFM at maximal strength, maintain contraction; Proceed to a strong blow, using the abdominal muscles; Relax the pelvic floor; Repeat 10 contractions; Perform five series a day.

RECOVERY OF THE PERINEAL MUSCLE (GOOD PFM FUNCTION):

After the patient has performed the strength and endurance training, she should proceed to the progression of exercises focusing on improving strength and endurance, associated to coordination.

Training of coordination/strength (Miller and Sampeselle: phase 3 adapted)⁽¹⁸⁻¹⁹⁾.

Contracting PFM with half the strength of contraction; Increase to maximum contraction and relax; Repeat 10 contractions; Perform five series a day.

Coordination/endurance training (Miller and Sampeselle: phase 4 adapted)⁽¹⁸⁻¹⁹⁾.

Contracting PFM with half the strength of contraction; Sustaining by half the time acquired in phase 02; Increase to maximum contraction; Sustain by time equal to mean

contraction (half the strength) and relax; Repeat 10 contractions; Perform five series a day.

Endurance/coordination training (Miller and Sampeselle: phase 5 adapted)⁽¹⁸⁻¹⁹⁾.

Contract PFM at maximum strength of contraction; Sustain by half the time acquired in phase 02; Reduce to mean contraction; Sustain by time equal to maximum contraction and relax; Repeat 10 contractions; Perform five series a day.

The patients must not necessarily perform all exercise phases. The focus is satisfaction with volume and frequency of urine loss. When the patient is satisfied, she may be discharged, with the orientation that these exercises should be performed every day for their whole life.

TRAINING AND MAINTENANCE OF THE PFM FUNCTION

For the time of maintenance after discharge, the alternation between strength and endurance training (at the maximum time achieved) can be oriented and performed three times a day. Work with Type 1 (slow contraction) and Type 2 (quick contraction) fibers, in a sufficient frequency to maintain function progression, is thus guaranteed.

DISCUSSION

Although the proposed PFMT is an adaptation from a previous protocol⁽¹⁸⁻¹⁹⁾, it meets the parameters for protocols recently published in different countries, which have presented good functional and symptomatic results⁽¹⁴⁻¹⁶⁾. A Cochrane review published in 2019 synthesizes the protocols used in the 31 included articles: the number of contractions per series varied from 05 to 100, with a predominance of 08 to 10 contractions, whereas the present protocol proposes 10 contractions; the protocols mentioned in the articles suggest an association of quick and sustained contractions, and this protocol works with the alternation of these two modalities; the endurance time applied in the studies was 02 to 59 seconds, with a predominance of 05 to 10 seconds, whereas this protocol works with an existent contraction time which is of a maximum 10 seconds; the relaxing time found in these studies was equal or double the time of endurance, which is equally suggested in this protocol; the number of series ranged from twice a week to ten times a day, and this protocol works with three to five series per day⁽¹⁴⁾.

This protocol proposal is presented at a timely moment, considering the limitations in the offering of specialist appointments in SUS⁽¹⁰⁾. It enables the patient to be reevaluated in an interval varying from 15 to 60 days, according to her comprehension of the exercise and her adherence profile.

In the Brazilian public health system, there is no protocol for management and treatment of urinary incontinence in primary care. Patients with complaints are referred to lines for appointments with a specialist physician, which by its turn, will indicate medication therapy or surgery, with some exceptions in secondary or tertiary services which have qualified professionals for applying conservative measures, which should be the first line of treatment^(10,26-27).

When the institution has a certified professional for applying behavioral measures with PFMT, this commonly follow the published protocols, which indicate the need for in-person sessions and frequent reevaluations^(19,28). There is an unquestionable gain in effectivity when the patient is frequently evaluated or undergoes sessions under professional supervision⁽²⁹⁻³⁰⁾. However, this need extrapolates the capacity of care in the public health context, since whereas a small number of patients occupies the agenda for weekly appointments, new patients are included in the lines and stay there for years, with no intervention whatsoever.

The proposal of this protocol intends to support the decision of scheduling more spaced out returns for patients with good comprehension of PFMT exercises and a good adherence profile. Thus, vacancies are opened in the agenda for caring for a higher number of patients, which acquire the right to at least one initial appointment for the orientation of simple behavioral measures capable of solving or even reducing the severity of the experienced problem, and no longer being deprived of this knowledge due to an exponential growth of the line, in addition to the lack of qualified professionals.

This protocol proposal was elaborated and adjusted in accordance with difficulties and questions of the patients cared for in the service, and it was thus simpler and more applicable to patients with different social and cognitive profiles.

The application of this protocol has been showing remarkable acceptance by patients and can be easily applied by professionals, even by those with no previous in-depth knowledge of the area. The necessity of validation with clinical trials comparing this protocol to others is acknowledged. However, this experience report has the intention of sharing

and disseminating this knowledge, enabling it to be tested in different regions and populations, not only where it was developed, including research with more robust methodological designs.

The application of this proposal of protocol for evaluation and PFMT extrapolates the expert's work, extending to the generalist nurse, even in primary care, including the evaluation of PFMT in the nursing consultation and indicating the exercises for the detection of women with complaint or risk for UI and profile for the PFMT program^(19,27).

The elaboration and adaptation of this protocol was made by an enterostomal therapist nurse. Specialist nurses have a responsibility that is beyond direct care, which is disseminating the acquired and built knowledge in their area of specialization⁽²⁷⁾. The enterostomal therapist nurse is qualified on wounds, stomas, and incontinences. There are not enough enterostomal therapists in Brazil to provide care for all the population which presents such demands. Therefore, these specialists acquire the responsibility of working in collaboration with generalist nurses to work assertively in primary care, referring to the specialist only complex or recurrent cases.

CONCLUSION

This report has presented a protocol of evaluation and PFMT for UI treatment of women receiving care in the Brazilian Unified Health System based on the nursing process. Encouragement of its use is expected, aiming at increasing the number of cared patients and the solution of symptoms in the first healthcare levels, with a consequent reduction of specialized care lines and unnecessary costs for the health system, but mainly for women suffering with UI.

RESUMO

Objetivo: Apresentar uma proposta de protocolo de avaliação e treinamento da musculatura do assoalho pélvico para atendimento à mulher com incontinência urinária. **Método:** Relato de experiência profissional realizado em ambulatório de disfunções miccionais do Sistema Único de Saúde, conduzido por enfermeira estomaterapeuta. **Resultados:** Elaboração de uma proposta de protocolo de atendimento em consulta de enfermagem baseada em exame físico direcionado, diagnósticos de enfermagem da Classificação Internacional para a Prática de Enfermagem e adaptação de um protocolo de treinamento muscular como prescrição. Etapas: inspeção estática, inspeção dinâmica e palpação para verificação de tensão, avaliação de força, sustentação, relaxamento e coordenação muscular; seguidos de prescrições para relaxamento, propriocepção, treino de força, de sustentação, de coordenação abdomino-pélvica e de manutenção, conforme o diagnóstico. **Conclusão:** Esta proposta de protocolo pretende subsidiar a avaliação, por enfermeiros de todos os níveis de atenção à saúde, da musculatura pélvica de mulheres com incontinência urinária ou em risco de desenvolvimento, especialmente como parte da consulta de enfermagem na atenção primária.

DESCRIPTORIOS

Incontinência Urinária; Saúde da Mulher; Diafragma da Pelve; Processo de Enfermagem.

RESUMEN

Objetivo: Presentar una propuesta de protocolo de evaluación y entrenamiento de la musculatura del suelo pélvico para atender a mujeres con incontinencia urinaria. **Método:** Relato de experiencia profesional realizado en un centro ambulatorio de disfunciones miccionales del Sistema Único de Salud de Brasil, conducido por enfermera estomaterapeuta. **Resultados:** Elaboración de una propuesta de protocolo de atención en consulta de enfermería basada en el examen físico dirigido, los diagnósticos de enfermería de la Clasificación Internacional de la Práctica de Enfermería y la adaptación de un protocolo de entrenamiento muscular como prescripción. Etapas: inspección estática, inspección dinámica y palpación para comprobar la tensión, evaluación de la fuerza, sustentación, relajación y coordinación muscular; seguidas de prescripciones de relajación, propiocepción, entrenamiento de fuerza, sustentación, coordinación abdomino-pélvica y mantenimiento, según el diagnóstico. **Conclusión:** Esta propuesta de protocolo pretende apoyar la evaluación de la musculatura pélvica en mujeres con incontinencia urinaria o con riesgo de desarrollarla por parte de los enfermeros de todos los niveles atención a la salud, especialmente como parte de la consulta de enfermería en atención primaria.

DESCRIPTORES

Incontinencia Urinaria; Salud de la Mujer; Diafragma Pélvico; Proceso de Enfermería.

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