



HAL
open science

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

Emeline Quiboef, Marie-Josèphe Saurel-Cubizolles, Xavier Fritel

► **To cite this version:**

Emeline Quiboef, Marie-Josèphe Saurel-Cubizolles, Xavier Fritel. Trends in urinary incontinence in women between 4 and 24 months postpartum in the EDEN cohort.. BJOG: An International Journal of Obstetrics and Gynaecology, 2015, <10.1111/1471-0528.13545>. <inserm-01185917>

HAL Id: inserm-01185917

<https://inserm.hal.science/inserm-01185917v1>

Submitted on 24 Aug 2015

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire HAL, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



HAL Authorization

1 Title Page

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

4 Authors

5 Emeline Quiboef, MD, Msc, a

6 Marie-Josèphe Saurel-Cubizolles, b

7 Xavier Fritel, MD, PhD, cde

8 and the EDEN Mother-Child Cohort Study Group

9 Institutions

10 a) CHU de Bordeaux, Université Bordeaux-2, Bordeaux, France

11 b) INSERM U1153, Obstetric, Perinatal and Pediatric Epidemiology Research Team,
12 Research Center for Epidemiology and Biostatistics Sorbonne-Paris-Cité (CRESS), Paris-
13 Descartes Université, Paris, France.

14 c) CHU de Poitiers, Université de Poitiers, CIC1402, Poitiers, France

15 d) INSERM CIC1402, Poitiers, France

16 e) INSERM U1018 CESP, Gender, sexual and reproductive health, Kremlin-Bicêtre, France

17 **Correspondence**

18 Xavier Fritel, Service de Gynécologie-Obstétrique et Médecine de la Reproduction, CHU de
19 Poitiers, 2 rue de la Milétrie, F-86000 Poitiers, France. E-mail: xavier.fritel@univ-poitiers.fr.

20 **Shortened running title**

21 Urinary incontinence between 4 and 24 months postpartum

22 **Word count:** 2646

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

25 **Abstract**

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

28 **Design:** Longitudinal study (EDEN cohort).

29 **Setting:** Two French university hospitals.

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

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

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

36 **Results:** UI prevalence was 20.7% (340/1643) at 4 months and 19.9% (280/1409) at 24.
37 Significant factors associated with UI at 24 months were older age (OR = 1.07/year [95% CI:
38 1.04-1.11]), BMI (2.35 [1.44-3.85] \geq 30 versus $<$ 25 kg/m²), higher parity (1.77 [1.14-2.76] \geq
39 3 versus 1), breast feeding (1.54 [1.08-2.19] \geq 3 versus $<$ 3 months), pregnant at follow-up
40 (3.44 [2.25-5.26]), and caesarean delivery (0.62 [0.40-0.97] versus vaginal). The likelihood of
41 UI remission at 24 months was 51.9% (149/287). Caesarean delivery was associated with
42 increased likelihood of UI remission (0.43 [0.19-0.97]). The risk of de novo UI at 24 months
43 was 12.5% (135/1067) and was associated with a new pregnancy (3.63 [2.13-6.20]).

44 **Conclusions:** Between 4 and 24 months postpartum UI, remission occurred in half of the
45 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

50

INTRODUCTION

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

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

69 and to analyse the determinants of these trends.

70

METHODS

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

80 Postpartum UI was assessed at baseline (4 months postpartum) and at follow-up (24 months
81 postpartum) by self-administered postal questionnaires that asked, among other things, about
82 urinary symptoms during the preceding 4 weeks. Women were classified with UI if they
83 answered yes to the question: "Have you had involuntary urinary leakages?" The UI type was
84 determined with the BFLUTS (British Female Low Urinary Track Symptoms)
85 questionnaire.¹¹ The question about frequency of leakage had four answer levels (less than
86 once a month, once or several times a month, once or several times a week, every day and/or
87 night), and the question about the amount of leakage three levels (drops, a little amount,
88 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

128

RESULTS

129 In all, 1643 women (87.0%) responded to the questionnaire at 4 months postpartum, 1409
130 (74.5%) at 24 months; these included 1354 (71.7%) who responded at both 4 and 24 months
131 (Figure S1). The population responding at 24 months differed significantly from the women
132 lost to follow-up; the latter were younger and more often multiparous, and they had lower
133 incomes and less education.

134 The prevalence of UI in our population was 20.7% (340/1643) at 4 months and 19.9%
135 (280/1409) at 24 months postpartum (Figure S2). The prevalence of UI at 24 months was
136 14.0% among women who had only caesarean deliveries, versus 20.6% for women with
137 vaginal deliveries. UI at 24 months was significantly associated with older maternal age,
138 parity ≥ 3 , vaginal compared with caesarean delivery, breast feeding for longer than 3 months,
139 overweight or obesity, and being pregnant again at 2 years postpartum (Table 1). The other
140 variables tested were not significantly associated with UI at 24 months postpartum.

141 Among the 287 women who reported postpartum UI at 4 months (baseline) and also
142 completed the questionnaire at 24 months (Groups B and D, Table S1), 149 (51.9%) were
143 continent at 24 months. UI remission between 4 and 24 months postpartum was more frequent
144 for women whose UI first appeared during pregnancy compared with those with UI before the
145 index pregnancy, and those whose UI was mild. Remission was less frequent for women who
146 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

170

DISCUSSION

171 Main findings

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

177 Strengths and limitations

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

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

191 Interpretation

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

203 In our study, the only factor associated with UI remission was caesarean delivery of the index
204 birth. In other words, vaginal delivery was associated with persistence of UI at 24 months
205 postpartum. Gartland et al. found a similar result in a cohort of 1507 Australian nulliparas and
206 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

247

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

251

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
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282

Disclosure of interest

None to declare.

Contributions to authorship

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

Details of ethical approval

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

Funding

We acknowledge all funding sources for the EDEN cohort: FRM (Fondation pour la Recherche Médicale), INSERM (Institut National de la Santé Et de la Recherche Médicale), Ministère de la Recherche, Université Paris-Sud, ANR (Agence Nationale de la Recherche), IRESP (Institut de Recherche en Santé Publique), AFSSET (Agence Française pour la Surveillance et la Sécurité de l'Environnement et du Travail), INPES (Institut National Pour l'Education et la Santé), INVS (Institut National de Veille Sanitaire), DGS (Direction Générale de la Santé), ALFEDIAM (Association de Langue Française pour l'Etude du Diabète et du Métabolisme), MGEN (Mutuelle Générale de l'Education Nationale), Nestlé.

Acknowledgements

Members of the EDEN mother–child cohort study group are as follows: I. Annesi-Maesano, JY. Bernard, J. Botton, M.A. Charles, P. Dargent-Molina, B. de Lauzon-Guillain, P. Ducimetière, M. de Agostini, B. Foliguet, , A. Forhan, X. Fritel, A. Germa, V. Goua, R. Hankard, B. Heude, M. Kaminski, B. Larroque†, N. Lelong, J. Lepeule, G. Magnin, L. Marchand, C. Nabet, F. Pierre, R. Slama, M.J. Saurel-Cubizolles, M. Schweitzer, and O. Thiebaugeorges.

REFERENCES

1. Hunskar S, Burgio K, Diokno A, Herzog AR, Hjälmås K, Lapitan MC. Epidemiology and natural history of urinary incontinence in women. *Urology* 2003;62:16-23.
2. Fritel X, Ringa V, Quiboef E, Fauconnier A. Female urinary incontinence, from pregnancy to menopause: a review of epidemiological and pathophysiological findings. *Acta Obstet Gynecol Scand* 2012;91:901-10.
3. Fritel X, Schaal JP, Fauconnier A, Bertrand V, Levet C, Pigné A. Pelvic floor disorders 4 years after first delivery: a comparative study of restrictive versus systematic episiotomy. *BJOG* 2008;115:247-52.
4. MacArthur C, Glazener CMA, Wilson PD, Lancashire RJ, Herbison GP, Grant AM. Persistent urinary incontinence and delivery mode history: a six-year longitudinal study. *BJOG* 2006;113:218-24.
5. Hannah ME, Whyte H, Hannah WJ, Hewson S, Amankwah K, Cheng M, et al. Maternal outcomes at 2 years after planned cesarean section versus planned vaginal birth for breech presentation at term: the international randomized Term Breech Trial. *Am J Obstet Gynecol* 2004;191:917-27.
6. Viktrup L, Lose G. Incidence and remission of lower urinary tract symptoms during 12 years after the first delivery: a cohort study. *J Urol* 2008;180:992-7.
7. Altman D, Ekström A, Gustafsson C, López A, Falconer C, Zetterström J. Risk of urinary incontinence after childbirth: a 10-year prospective cohort study. *Obstet Gynecol* 2006;108:873-8.
8. Gyhagen M, Bullarbo M, Nielsen T, Milsom I. The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery. *BJOG* 2013;120:144-51.
9. MacArthur C, Glazener C, Lancashire R, Herbison P, Wilson D. Exclusive caesarean section delivery and subsequent urinary and faecal incontinence: a 12-year longitudinal study. *BJOG* 2011;118:1001-7.
10. Pizzoferrato AC, Fauconnier A, Quiboef E, Morel K, Schaal JF, Fritel X. Urinary incontinence 4 and 12 years after first delivery: Risk factors associated with prevalence, incidence, remission, and persistence in a cohort of 236 women. *Neurourol Urodyn* 2014;181:259-66.
11. Jackson S, Donovan J, Brookes S, Eckford S, Swithinbank L, Abrams P. The Bristol Female Lower Urinary Tract Symptoms questionnaire: development and psychometric testing. *Br J Urol* 1996;77:805-12.
12. Sandvik H, Seim A, Vanvik A, Hunskar S. A severity index for epidemiological surveys of female urinary incontinence: comparison with 48-hour pad-weighing tests. *Neurourol Urodyn* 2000;19:137-45.

13. Kubik K, Blackwell L, Heit M. Does socioeconomic status explain racial differences in urinary incontinence knowledge? *Am J Obstet Gynecol* 2004;191:188-93.
14. Fritel X, Ringa V, Varnoux N, Fauconnier A, Piault S, Bréart G. Mode of delivery and severe stress incontinence. A cross-sectional study among 2625 perimenopausal women. *BJOG* 2005;112:1646-51.
15. Legendre G, Ringa V, Panjo H, Zins M, Fritel X. Incidence and remission of urinary incontinence at midlife, a cohort study. *BJOG* 2015. doi: 10.1111/1471-0528.12990.
16. Hannah ME, Hannah WJ, Hodnett ED, Chalmers B, Kung R, Willan A, et al. Outcomes at 3 months after planned cesarean vs planned vaginal delivery for breech presentation at term: the international randomized Term Breech Trial. *JAMA* 2002;287:1822-31.
17. Hilde G, Staer-Jensen J, Siafarikas F, EllstromEngh M, Bo K. Postpartum pelvic floor muscle training and urinary incontinence: a randomized controlled trial. *Obstet Gynecol* 2013;122:1231-8.
18. Gartland D, Donath S, MacArthur C, Brown SJ. The onset, recurrence and associated obstetric risk factors for urinary incontinence in the first 18 months after a first birth: an Australian nulliparous cohort study. *BJOG* 2012;119:1361-9.
19. DeLancey JO. Stress urinary incontinence: where are we now, where should we go? *Am J Obstet Gynecol* 1996;175:311-9.
20. DeLancey JO. Childbirth, continence, and the pelvic floor. *N Engl J Med* 1993;329:1956-7.
21. DeLancey JOL, Kane Low L, Miller JM, Patel DA, Tumbarello JA. Graphic integration of causal factors of pelvic floor disorders: an integrated life span model. *Am J Obstet Gynecol* 2008;199:610.e1-5.
22. Francis WJ. The onset of stress incontinence *J ObstetGynaecol Br Emp* 1960;67:899-903.

285
286
287
288

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).

Risk factors	24 months postpartum urinary continence status:	Continent N= 1129	Incontinent N= 280	OR	95 % CI
		n (%), or mean (std)			
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

289
290
291
292
293

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.

294

295
296
297
298
299

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	Persistent incontinence	OR (95% CI)	
		Group D N=149	Group B N=138		
Risk factors		n (%)	n (%)		
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

300
301
302
303
304
305

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.

306 Table 3. Factors associated with de novo urinary incontinence at 24 months postpartum in the
 307 EDEN cohort. Multivariate analysis, logistic regression for persistent continence at 4 and 24
 308 months postpartum (Group A) versus de novo urinary incontinence at 24 months postpartum
 309 (Group C) adjusted for centre and education level (N = 1067).
 310

Women continent at 4 months, continence status at 24 months		Persistent continence Group A N= 932	De novo incontinence Group C N= 135	OR	95% CI
Risk factors		n (%), or mean (std)	n (%), or mean (std)		
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

311
 312 Factor not found to be significant and excluded from the multivariate analysis: Monthly household income,
 313 additional information about index delivery (mode of delivery, episiotomy, long second stage of labour, child's
 314 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.

315

316

317

318

Figures

319

320

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

323

324

Figure S1. Flow chart

325

326

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

327

328