CHAPTER

2

Physical therapy in female urinary incontinence in times of COVID-19 pandemic: A contemporary proposal

https://doi.org/10.56238/emerrelcovid19-002

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ABSTRACT
Introduction: Urinary incontinence is defined as a multifactorial urogynecological disorder, of high incidence, and physiotherapy is one of the main treatments indicated. Group therapies, in turn, are viable to reduce the lack of care and demonstrate good cost-effectiveness, in addition to promoting autonomy and integration among subjects, resulting in good results, when correctly indicated. Objective: to verify the effect of a group follow-up for urinary incontinence on the variables; sexual satisfaction, sleep quality, and body perception. Method: This is a case series study that followed 5 participants, mean age of 50 years, urinary losses on exertion and urgency, assessed for sleep quality (Pittsburgh Sleep Quality Index), sexual performance (Female Sexual Function Index) and body perception (Body Image Scale). The intervention consisted of 10 sessions of remote, synchronous, group physiotherapeutic telecare, based on kinesiotherapy associated with fast and slow pelvic floor fiber contractions. Results: From this intervention model, a slight worsening of sexual performance was observed, general improvement of all patients in the sleep quality variable, and significant improvement in body perception were observed. Conclusion: The FSFI Sexual Satisfaction Index showed post-intervention worsening, showing improvement only in Desire. The Pittsburgh Sleep Quality Index showed an improvement in the population's sleep quality after the intervention, but it was not enough to differentiate in the final scale. There was little suffering with the image after the physical therapy intervention using the Body Image Scale, with no significant changes with the pre-intervention result.

Keywords: Urinary incontinence, Physiotherapy, Telemonitoring.

1 INTRODUCTION

Urinary incontinence (UI) is a pathology that is characterized by the inability to control urination for various reasons such as obesity, parity, smoking, menopause and gynecological surgeries. It is estimated that about a quarter of women end up developing this condition at some point in their lives (IRBER; MARTIN; FRIGO, 2016).

Fragility in the pelvic floor is a relevant factor for UI since it is a musculature composed of muscle fibers of slow contraction or type I and fast or type II, where 70% of the total is of slow contraction and responsible for the maintenance of tone, being worked with voluntary contraction; the other 30% are of rapid contraction, that is, low resistance (BERNARDS *et al.*, 2000).

When we talk about UI we can classify it into four types: stress urinary incontinence (SUI), caused by hypermobility of the urethra or some type of sphincter deficiency; urge urinary incontinence (UUI) that is associated with an uninhibited contraction of the detrusor muscle; mixed urinary

incontinence (MUI), characterized by the combination of the two types mentioned above; and overflow urinary incontinence (IUT), very common in elderly and debilitated patients who do not pay attention to voiding (IRBER; MARTIN; FRIGO, 2016).

The treatment of first choice indicated since 2005 by the International Continence Society is physiotherapy, however, few public services provide this treatment adequately, either by the cost or by the lack of knowledge of the patients about the treatment, so group care comes to cheapen public spending and promote health in an accessible way (CAIXETA NETO *et al.* , 2018).

Health promotion comes as an alternative to transform actions to improve living conditions, just as collective work arises with the idea of greater participation and interaction of patients with the same pathological complaint, so a positive and expanded view of health is necessary, making the treatment environment a place focused on lifestyle and distinct characteristics of the population to be treated (SILVA *et al.*, 2008).

Group practices allow the participation of the population in their comprehensive care according to their specific needs, agreeing with what is recommended by the SUS and its principles of universality of access, integrity of care and social control (RASERA; ROCHA, 2010).

A pelvic floor with reduced or inadequate function is a relevant etiological factor in the occurrence of UI and the physiotherapeutic treatment results in the strengthening of the muscles promoting urinary continence (BERNARDES *et al.*, 2000).

The fear of being in public and having an episode of urinary loss causes patients to have a certain tendency to social isolation, as well as sexual difficulties, sleep changes and quality of life. Thus, there is a decline in self-esteem and several symptoms and associated diseases appear as irritability, anguish and depression (CARVALHO *et al.* , 2014).

The impairment of physical, emotional, social and sexual well-being brings to patients with urinary incontinence a strong impact on their quality of life. It is estimated that, in the world, 200 million people suffer from this disease, bringing an annual cost of more than 26 billion dollars to the public coffers of different countries (SANTOS *et al.* , 2009).

The patient's fear of seeking a health service to treat UI causes the signs to worsen greatly until the arrival at the specialized health service, being necessary, in this context, a surgical intervention, increasing the expense for the Unified Health System, so the importance of health promotion and collective work with this population (IRBER; MARTIN; FRIGO, 2016).

Considering the demands of the Unified Health System (SUS) corresponding to the impairment of the female urinary system, the proposal of collective care aiming at the collective health and well-being of patients affected by urinary incontinence arises, using conservative and low-cost methods (MAGALHÃES; COAST; RODRIGUEZ, 2018).

In the past, only surgical treatment was recommended for patients suffering from urinary incontinence. Nowadays we have treatments based on behavioral therapy, pelvic floor muscle exercises, electrostimulation, vaginal cones and biofeedback (OLIVEIRA; GARCIA, 2011).

Individual care brings to the patient affected by urinary incontinence, at first, a sense of welcome and directly interferes in treatment adherence, causing the patient to react positively to the interventions made by the physiotherapist (OLIVEIRA; GARCIA, 2011).

However, group physiotherapeutic care is efficient in several diseases, because it enhances the capacities of individuals, helps to develop autonomy and copes with the suffering involved in the natural process of the disease. To minimize the gap of the existing care shortage in public health, this type of care is configured as a viable possibility, because it contemplates a greater number of patients through a better cost-benefit for the service, being performed with two or more patients who have a similar degree of functional capacity (OLIVEIRA; GARCIA, 2011).

Treatment with electrical stimulation can increase intraurethral pressure through direct stimulation of efferent nerves to the periurethral muscles, but also increases blood flow to the pelvic floor reestablishes neuromuscular connections and improves the function of the muscle fiber, hypertrophying it and modifying its pattern of action with the increase in the number of fast muscle fibers. However, due to the differences in parameters and forms of evaluation, the results of electrostimulation are conflicting with a cure rate between 30 and 50% and clinical improvement of 6 out of 10 patients. Studies indicate that for a promising result, electrostimulation must be married to other forms of treatment, also cited in this work (SANTOS et al., 2009).

Vaginal cones represent a simple and practical way to identify and strengthen the pelvic floor muscles, using the principles of biofeedback. The cones are devices of the same shape and volume, with weights ranging from 20 to 100 g, depending on the manufacturer, numbered increasingly. The evaluation consists of identifying which cone the patient can retain in the vagina for one minute, with or without voluntary contraction of the pelvic floor muscles (active cone or passive cone). Vaginal cones are particularly indicated in mild and moderate cases of stress urinary incontinence, with success rates ranging from 14 to 78% (SANTOS et al., 2009).

Biofeedback is a device that aims to measure the action potentials of pelvic floor muscle contractions, translating through visual signals which muscle group is being worked. Thus, it provides the awareness of the muscles and consequently the potentiation of perineal exercises (SILVA et al., 2014).

Regarding behavioral therapy (CT), studies emphasize that it can be introduced even if incontinence is not in its initial phase. This means that with CT it is possible to avoid a surgical

intervention. The great advantage is that CT has minimal side effects and does not preclude future surgical treatment if necessary (CALDAS et al., 2010).

Pelvic floor kinesiotherapy has determined the improvement or cure of several patients with lasting effects for more than five years. It comprises in the training of the pelvic floor muscles, which aims to work on strengthening the muscles for the treatment of hypotonia, strengthening the urethral resistance and improving the supporting elements of the pelvic organs (OLIVEIRA; GARCIA, 2011).

Another relevant point is the low cost and ease of performing kinesiotherapy of the pelvic muscles, because it does not require specific and high-cost instruments, kinesiotherapy can be performed by the patient herself at home, with intervention and prior demonstration of a professional, as well as with self-explanatory booklets and groups of patients, where the group itself is made as a form of stimulation and adherence to treatment (BIRTH; RIBEIRO, 2018).

Given all the aspects mentioned above, it is of fundamental importance to make women aware of the need for treatment, as well as to inform the benefits that it can bring to the quality of life of those who suffer from UI (CAIXETA NETO *et al.* , 2018).

Thus, the objective of the present study was to verify the effect of a group follow-up for urinary incontinence on the variables; sexual satisfaction, sleep quality and body perception.

2 METHODOLOGY

This is a case series study, which, according to the literature, is characterized by comprising 3 to 10 cases. It is a type of observational study that analyzes the objectives for further evaluation and sensitization.

The study included 5 women, aged 37 to 61 years, with symptoms of urinary loss for at least 6 months. Participants who had already had individual care, with knowledge of the perineum muscles, and had at least grade 3 strength assessed by the AFA (Pelvic Floor Functional Assessment) were included.

The project was approved by the Ethics and Research Committee of Universidade Presbiteriana Mackenzie under CAEE number 80676517.6.0000.0084 and opinion: 2.488.109, and after approval and free informed consent of the participants, we started data collection.

The evaluation and reassessment were done via *Google Forms* containing questionnaires about sexual satisfaction, sleep quality and body perception. In addition to a form containing basic information, history of the current disease, history of previous disease, behavioral habits, daily fluid intake and gynecological and obstetric history.

For the evaluation of sexual function, the Female Sexual Function Index (FSFI) was used and its main proposal is to evaluate the female sexual response in six domains: 1) sexual desire; 2) sexual

arousal; 3) vaginal lubrication; 4) orgasm; 5) sexual satisfaction; 6) pain. It consists of 19 questions that assess sexual function in the last 4 weeks, whose options receive a score from 0 to 5 in an increasing way, except for the questions about pain, where the score is defined in an inverted way. A final score is presented at the end of the application, from the sum of the scores of each domain (PACAGNELLA; MARTINEZ; VIEIRA, 2009).

To assess sleep quality, the Pittsburgh Sleep Quality Index (SPQI) was used, which consists of 19 items, grouped into seven components scored from 0 to 3. Its components are, respectively: 1) the subjective quality of sleep; 2) sleep latency; 3) sleep duration; 4) the habitual efficiency of sleep; 5) sleep alterations; 6) the use of sleep medications; and 7) daytime dysfunction. The scores of the seven components are added together to give an overall IQSP score, which ranges from 0 to 21 and the higher the patient's sleep quality, the worse (CHELLAPPA; ARAUJO, 2007).

The patient affected by UI may also suffer changes in her body image, to measure the degree of this possible body distortion we will use the Body Image Scale (BIS), composed of 10 items to measure affective, behavioral and cognitive symptoms of body image. Each item receives a score from 0 to 03 (0 "nothing" and 03 "a lot"), which together generate a final score from 0 to 30, with a higher score being a higher level of body image disorder (MELISSANT *et al.* , 2018).

The service was performed via the online platform Zoom, with all patients present, synchronous care, for 4 months, once a week, totaling 10 sessions, lasting 60 minutes each. This type of care had as its proposal the social conviviality in times of pandemic and engagement of the participants in the treatment.

As a conservative treatment protocol, kinesiotherapy was used, with exercises that promoted pelvic mobility, stretching and strengthening of the global muscles and metabolic exercises, all associated with fast and slow pelvic floor contraction, as well as functional activities.

The participants were guided at the end of the sessions about the pathology, fluid intake and consumption of foods that may affect the condition, as well as exercises that can be reproduced at home during the week and possible doubts resolved.

At the end of the 4 months of care (10 sessions), all patients were reassessed and the data were compared with each other. These data were analyzed and presented descriptively.

3 FINDINGS

Initially, 20 women with a mean age of 54±9.18 years, with complaints of urinary legs of effort and urgency, participated in this project. However, 15 patients were excluded for more than 03 absences in online care or for not completing the evaluation and/or reassessment data, which led the

study to end with 5 participants with a mean age of 50.4±8.21 years and 80.8±16.48 Kg/^{m2}, presented descriptively below.

3.1 PARTICIPANT 1

V.M.J.A, 46 years old, from home, complete elementary school, 78kg, does not undergo medical follow-up, denies smoking, elitism, hypertension and nephropathies. Multiparous with 3 pregnancies, with 2 normal deliveries and 1 cesarean section, denied the use of hormones or hormone replacement.

In the pre-intervention, the patient presented a total FSFI score of 25.8, with the best points in the variables Lubrification, Orgasm and Pain. In the post-intervention, an overall score of 24 was observed with a decrease in the variables Desire, Arousal and Lubrication (Table 1).

Table 1: Data of Participant 1 regarding the FSFI.

	I wish	Excitement	Lubrication	Orgasm	Satisfaction	Pain	Score
Pre	3,6	3,6	5,4	4,4	1,6	7,2	25,8
Post	3	3,3	4,5	4,4	1,6	7,2	24

The Pittsburgh Sleep Quality Index (PHEI) indicated in the initial evaluation of the patient's poor sleep, with an overall score of 5, with the worst score in Sleep Disorders, with a score of 2 out of 3. In the post-intervention there was a slight worsening of 1 point in the overall score, adding 6 points and classifying in poor sleep, without relevant changes (Table 2).

Table 2: Data of Participant 1 regarding the IQSP.

	Quality	Latency	Duration	Efficiency	Disorders	Medication Use	Dysfunction	Score	Classification
Pre	1	1	1	0	2	0	0	5	Poor Sleep
Post	1	1	1	1	2	0	0	6	Poor Sleep

The Body Image Scale (BIS) had an initial score of 1 point, indicating little suffering of the patient with the image. In the post-intervention, an increase presented a score of 3, indicating little suffering with the image (Table 3).

Table 3: Data of Participant 1 regarding BIS.

	1	2	3	4	5	6	7	8	9	10	General	Classification
Pre	0	0	1	0	0	0	0	0	0	0	1	Little Suffering
Post	1	0	1	0	0	0	0	0	0	1	3	Little Suffering

3.2 PARTICIPANT 2

A.C.V, 54 years old, accountant, complete higher education, 100kg, performs medical follow-up, denies smoking, elitism, hypertension and nephropathies. Primiparous of cesarean delivery, reports hormone replacement with Levothyroxine 175mg.

The patient presented a pre-intervention total FSFI score of 14.6, with the worst points in the variables Arousal, Lubrication, Orgasm and Pain.

After the intervention, an overall score of 13 was observed in the FSFI with a significant drop in variable Satisfaction (Table 4).

Table 4: Data of Participant 2 regarding the FSFI.

	I wish	Excitement	Lubrication	Orgasm	Satisfaction	Pain	Score
Pre	5,4	1,2	1,2	1,2	4,4	1,2	14,6
Post	5,4	1,2	1,2	1,2	2,8	1,2	13

The Pittsburgh Sleep Quality Index (PHEI) showed an overall score of 9, showing poor sleep of the patient, with the worst results in the variables; Sleep Latency, Sleep Disorders and Dysfunction during the Day.

The Pittsburgh Sleep Quality Index had an improvement accounting for a total of 4 points in the overall score, classifying subject 2 as good sleep (Table 5).

Table 5: Data of participant 2 regarding the IQSP.

	Quality	Latency	Duration	Efficiency	Disorders	Medication Use	Dysfunction	Score	Classification
Pre	1	3	0	0	2	1	2	9	Poor Sleep
Post	0	1	0	0	2	0	1	4	Good Sleep

The Body Image Scale (BIS) had an initial score of 18 points, indicating moderate suffering with the image. An exponential improvement was observed in the Body Image Scale, where the final overall score was 0 indicating, indicating little suffering with the image (Table 6).

Table 6: Data of Participant 2 regarding BIS.

	1	2	3	4	5	6	7	8	9	10	General	Classification
Pre	3	1	3	1	2	3	2	1	3	0	18	Moderate Suffering
Post	0	0	0	0	0	0	0	0	0	0	0	Little Suffering

3.3 PARTICIPANT 3

C.N.M, 37 years old, data operator, complete high school, 95kg, performs medical follow-up, makes use of Amitriptyline and Venalot, denies smoking, elitism, hypertension and nephropathies. Nulliparous, denies use of hormones and hormone replacement.

The patient presented a pre-intervention total FSFI score of 28.2, his best score in the variable Excitation. After the intervention, an overall score of 30 was observed with a slight improvement in the variables Desire and Orgasm (Table 7).

Table 7: Data of Participant 3 regarding the FSFI.

	I wish	Excitement	Lubrication	Orgasm	Satisfaction	Pain	Score
Pre	4,8	5,4	4,8	4,8	4,4	4	28,2
Post	5,4	5,4	4,8	6	4,4	4	30

The Pittsburgh Sleep Quality Index (SPQI) indicated a sleep disorder with a final score of 19, the patient scored maximum on all variables, except Sleep Disorders and Dysfunction during the day. Sleep quality had an improvement accounting for a total of 13 points in the overall score, where it still classifies subject 3 with sleep disorder. However, there was a significant improvement in the variables Duration and Habitual Sleep Efficiency (Table 8).

Table 8: Data of participant 3 regarding the IQSP.

	Quality	Latency	Duration	Efficiency	Disorders	Medication Use	Dysfunction	Score	Classification
Pre	3	3	3	3	2	3	2	19	Sleep Disorder
Post	3	3	0	0	2	3	2	13	Sleep Disorder

The Body Image Scale (BIS) had an initial score of 16 points, indicating moderate suffering with the image. The scale did not show a significant improvement with a final score of 15, maintaining a moderate suffering with the image (Table 9).

Table 9: Data of participant 3 regarding BIS.

	1	2	3	4	5	6	7	8	9	10	General	Classification
Pre	3	2	2	1	0	0	0	2	3	0	16	Moderate Suffering
Post	2	2	3	2	1	2	0	1	2	0	15	Moderate Suffering

3.4 PARTICIPANT 4

M.L.O.S, 54 years old, maid, incomplete elementary school, 61 kg, performs medical follow-up, reports use of Hydrochlorodiazide, denies smoking, elitism and nephropathies, reports hypertension. Multiparous of normal delivery, denies use of hormones.

It presented a total FSFI score of 29.1 pre-intervention, being its best score in the variables Lubrication and Orgasm. After the intervention, an overall score of 30.2 was observed with an improvement in the variables Arousal, Orgasm and Satisfaction (Table 10).

Table 10: Data of participant 4 regarding the FSFI.

	I wish	Excitement	Lubrication	Orgasm	Satisfaction	Pain	Score
Pre	4,8	4,5	6,6	5,2	2,4	5,6	29,1
Post	4,2	5,4	6,6	5,6	7,2	5,6	30,2

The quality of sleep qualified by the Pittsburgh Sleep Quality Index (IQSP) indicated poor sleep with a final score of 9, indicating only the variable sleep disorders with a score of 2, classifying the patient as having good sleep. Sleep quality improved with a final score of 5 points, but the patient remains in the classification of poor sleep by the Index (Table 11).

Table 11: Data of Participant 4 regarding the IQSP.

	Quality	Latency	Duration	Efficiency	Disorders	Medication Use	Dysfunction	Score	Classification
Pre	3	2	2	0	2	0	0	9	Poor Sleep
Post	1	1	1	0	2	0	0	5	Poor Sleep

The Body Image Scale (BIS) had an initial score of 0 points, indicating little suffering with the image. After the intervention, the patient presented a little expressive worsening with a final score of 1, maintaining a classification of little suffering with the image (Table 12).

Table 12: Data of participant 4 regarding BIS.

	1	2	3	4	5	6	7	8	9	10	General	Classification
Pre	0	0	0	0	0	0	0	0	0	0	0	Little Suffering
Post	1	0	0	0	0	0	0	0	0	0	1	Little Suffering

3.5 PARTICIPANT 5

W.I.F, 61 years old, the dentist, complete higher education, 70 kg, performs medical follow-up, reports use of Somalgim, denies smoking, elitism, hypertension and nephropathies. Primiparous of cesarean delivery, denies hormonal use, however, performed hormone replacement for 10 years with Totelle.

It presented a total FSFI score of 14.6 pre-intervention, being its best score in the variable Desire. After the intervention, an overall score of 24.9 was observed with an exponential improvement in the variables Arousal, Lubrication, Satisfaction and Pain (Table 13).

Table 13: Data of Participant 5 regarding the FSFI.

	I wish	Excitement	Lubrication	Orgasm	Satisfaction	Pain	Score
Pre	5,4	1,2	1,2	1,2	4,4	1,2	14,6
Post	4,8	6,9	2,4	1,2	7,2	2,4	24,9

The quality of sleep qualified by the Pittsburgh Sleep Quality Index (PHEI) presented a final score of 2, indicating only the variable sleep disorders with a score of 2, classifying the patient as having good sleep. However, it had a post-intervention worsening with a final score of 5 points, with a minimal worsening in Quality and Latency classifying the patient in poor sleep (Table 14).

Table 14: Data of participant 5 regarding the IQSP

	Quality	Latency	Duration	Efficiency	Disorders	Medication Use	Dysfunction	Score	Classification
Pre	0	0	0	0	2	0	0	2	Good Sleep
Post	1	1	1	0	2	0	0	5	Poor Sleep

The Body Image Scale (BIS) had an initial score of 4 points, indicating little suffering with the image. After the intervention, the scale did not show a significant improvement with a final score of 3, maintaining a classification of little suffering with the image (Table 15).

Table 15: Data of participant 5 regarding BIS.

	1	2	3	4	5	6	7	8	9	10	General	Classification
Pre	1	0	0	0	1	0	0	0	1	1	4	Little Suffering
Post	1	0	1	0	1	0	0	0	0	0	3	Little Suffering

When we evaluated the instruments comparing the 5 participants, the mean results regarding sexuality, evaluated by the FSFI (Table 16), found before the period of care a higher degree of average satisfaction in the variable Desire and Lubrication with an average of 4.8 out of 6 points. And the worst degree of satisfaction was observed in the variable Arousal with 3.6 out of 6 points.

The overall mean of the patients was 25.8 out of 36 points. After the 10 sessions of care, a worsening in the overall average of the patients about sexuality was observed, with an overall average score of 24.9 out of 36 points. There was a slight drop of 0.3 points in the lubrication variable and a significant drop of 1.6 points in the satisfaction variable. All the others presented the same score, only in Desire presented a score of 0.6 points.

Table 16: General data of the participants regarding the FSFI.

	I wish	Excitement	Lubrication	Orgasm	Satisfaction	Pain	Score
Pre	4,8	3,6	4,8	4,4	4,4	4	25,8
Post	5,4	4,5	4,5	4,4	2,8	4	24,9

The Pittsburgh Sleep Quality Index (PHEI) applied before the intervention indicated 60% of the population with poor sleep, 20% with good sleep and 20% with sleep disorders. Being the worst variables of Sleep Disorders and Latency. After the intervention, the Index showed the same results as

the first evaluation. However, the scores of all patients were lower, but not to the point of improving sleep quality in the evaluation of the scale (Table 17).

Table 17: General data of the participants regarding the IQSP.

	Quality	Latency	Duration	Efficiency	Disorders	Medication Use	Dysfunction	Score	Classification
Pre	1	2	1	0	2	0	0	9	Poor Sleep
Post	1	1	0	0	2	0	0	5	Poor Sleep

The Body Image Scale (BIS) applied before the intervention showed us that 60% of the patients had mild suffering with the image and the other 20% moderate suffering. After the intervention, according to the scale data, 80% of the patients presented mild suffering with the image and only 20% moderate suffering with the image itself (Table 18).

Table 18: General data of the participants regarding the BIS.

	1	2	3	4	5	6	7	8	9	10	General	Classification
Pre	1	0	1	0	0	0	0	0	1	0	4	Little Suffering
Post	1	0	1	0	0	0	0	0	0	0	3	Little Suffering

4 DISCUSSION

UI is not a condition associated with the risk of death, but it can generally have an extreme impact on the lives of affected women, and one of the fields usually little addressed is the relationship of UI with sexuality (BRASIL *et al.* , 2018) .

The existing evidence does not allow us to raise certainties that an improvement in UI is directly linked to an improvement in the sexuality of patients. Since, the theme of sexuality is much broader and more complex with an interaction of social, economic and religious factors and does not disqualify the technique used for the treatment of UI (BRASIL *et al.* , 2018).

Studies on the impact of UI on female sexual satisfaction are scarce, but it is possible to affirm that this condition impairs sexuality in several aspects, such as worsening the quality of the sexual act, lower frequency of sexual intercourse and especially in psychosocial factors (AUGE *et al.* , 2010).

However, an integrative review by (BRASIL *et al.* , 2018) showed that the FSFI when related to UI does not present an improvement in scores, only in some domains. This is due to the complexity of sexuality and the subjectivity of patients affected by UI, justifying the results found in the present study.

The body image of incontinent women can be affected due to the shame that this functional alteration causes, and because they do not find themselves more attractive (TAVARES, 2020). However, in the present study it can be observed in an improvement of 80% in body perception after the intervention and this can be due to the improvement of UI and the regular practice of physical

activities. These data can be justified because women with UI are more concerned with the functionality of their bodies, which can alter their image perception. With the improvement of functionality, there is a change in body perception since the image revolves more around functionality than appearance (TAVARES, 2020).

Some symptoms associated with urinary incontinence affect women's sleep quality, such as nocturia (getting out of bed more than once at night to urinate) and nocturnal enuresis (involuntary loss of urine during sleep) (FREITAS *et al.* , 2018). The lack of continuous sleep can bring cognitive and motor impairments to patients being incontinent patients susceptible to sleep disorders as a consequence of excessive trips to the bathroom for bladder emptying and/or the need for changes of sanitary pads, we consider of great importance the evaluation of the sleep habits of these patients (FREITAS *et al.* , 2018).

According to the Secretary General of the Brazilian Society of Urology (SBU), Alfredo Canaline, treatments for urinary incontinence fell by about 60% in 2020. The population affected by UI was afraid to seek treatment due to the COVID-19 pandemic, resulting in the worsening of symptoms and consequently worsening of quality of life (ALANA GRANDA, 2021).

With this, the Federal Council of Physical Therapy and Occupational Therapy (COFFITO) following the recommendations of the World Health Organization (WHO), authorized, through Resolution No. 516, published in the Official Gazette on March 23, 2020, the services of Teleconsultation, Teleconsulting and Telemonitoring. That allowed professionals to continue and/or begin their work with patients during the COVID-19 pandemic remotely. Interfering with less intensity in the worsening of patients affected by different pathologies (COFFITO, 2020). However, not all people are eligible for remote care, and the physical therapist is responsible for determining which people or cases can be attended to or monitored at a distance, taking into account the risks and benefits to these patients (COFFITO, 2020).

During the COVID-19 pandemic, there has been an increase in anxiety and sedentary lifestyle and we owe this to the imposition of social distancing that makes it impossible for the population to maintain the routine of work, studies and even physical activities since public and private spaces for exercising have been temporarily closed (MILEO, 2020). Concerned about the increase in sedentary lifestyle, the World Health Organization (WHO) created a program to influence physical activity at home, but we can observe in the present study how the home-office routine and the gradual reopening of cities directly and negatively impact this sudden and frequent change of routine.

Thus, the study suffered from limitations regarding evaluation and reassessment due to the lack of completion of the patients invited to participate in the project. The limitation with the use of

technology was a very important aggravating factor for us to have such a high number of excluded patients, as well as the number of absences in care.

The initial proposal was to compare online care with face-to-face care for patients with urinary incontinence, but with the onset of the COVID-19 pandemic, the project became entirely online.

We can observe that with the gradual opening of the city of São Paulo, the patients were failing to attend the appointments, which is also a justification for the number of absences observed. It is a suggestion for future research to enable the evaluation and reassessment in person so that this limitation does not occur with the collection of data and continues with the proposal of comparison of online service and face-to-face service.

Thus, the results observed in the reassessments do not corroborate the clinical improvement observed in the participating patients. We concluded that this is due to worry, lack of routine and commitments during the COVID-19 pandemic. In addition to the high levels of anxiety and depressive episodes that some of them presented during the research.

5 CONCLUSION

The Sexual Satisfaction Index (FSFI) showed a worsening in the mean of the post-intervention participants, showing only improvement in the variable Desire.

The Pittsburgh Sleep Quality Index (SPQI) showed an improvement in the population's sleep quality after the intervention, but it was not enough to change the final scale.

There was little suffering with the image in the patients after the physiotherapeutic intervention by the Body Image Scale (BIS), without significant changes with the pre-intervention result.

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