

Case Report

The HIFEM™ Treatment of Stress and Mixed Urinary Incontinence in Parous Women: A Case Series Study

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Abstract: Purpose: Urinary incontinence (UI) significantly impacts the quality of life, necessitating a range of treatments, from behavioral changes to surgical interventions. Electromagnetic muscle stimulation (HIFEM™) therapy presents an innovative, non-invasive approach to strengthening pelvic floor muscles (PFMs). Subjects and Methods: This retrospective, non-interventional case series study explores the efficacy and safety of HIFEM™ treatment in parous women experiencing stress (SUI) and mixed urinary incontinence (MUI). Nineteen women (mean age 54 ± 16) underwent six HIFEM™ sessions, with symptom progression tracked using the International Consultation on Incontinence Questionnaire-Urinary Incontinence Short Form (ICIQ-UI SF), along with comfort and satisfaction questionnaires. Results: At baseline, the mean ICIQ-UI SF score was 7.9 ± 4.2 points. By the final questionnaire administration, the average score had dropped to 4.7 ± 3.5 , reflecting a 50.6% reduction from baseline ($p < 0.001$). According to ICIQ-UI SF Item 6, 21% of subjects achieved complete continence. Additionally, the percentage of subjects experiencing urine leakage before reaching the toilet declined by 40% after the sixth treatment. Post treatment, the number of subjects who leaked urine while coughing or sneezing decreased by 50%. Conclusions: The treatment has shown high efficacy in lowering the ICIQ-SF scores across the study group, with a significant number of subjects regaining entire continence.



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1. Introduction

Pelvic floor muscles (PFMs) provide the structural and functional support of pelvic organs, including the uterus, bladder, and rectum [1]. When the pelvic floor muscles are compromised, it may lead to several pathologies under the pelvic floor dysfunction (PFD) constellation [2]. Obesity, continuous heavy lifting, vaginal childbirth, chronic constipation, hormonal changes, or simply advancing age are several of the factors contributing to pelvic floor disorders [3]. Commonly, PFD leads to urinary incontinence (UI). The three main types of UI are classified as stress urinary incontinence (SUI), urge urinary incontinence (UUI), and mixed urinary incontinence (MUI) [4]. SUI occurs predominantly when physical exertion like exercise, coughing, or sneezing causes increased intra-abdominal pressure leading to urine leakage due to urethral hypermobility or bladder sphincter weakness [5]. UUI has a more complex physiological etiology; associating the loss of urine due to urgency

results from bladder detrusor muscle overactivity (spontaneous uninhibited contractions) or poor compliance (the bladder fails to stretch to accommodate urine capacity) and bladder hypersensitivity (sensory overstimulation) [6]. MUI is a combination of both stress and urge incontinence [7].

UI has psychosocial and economic implications for the quality of life (QoL), contributing to anxiety and depression, negatively affecting sexual health, interfering with day-to-day functionality, requiring substantial financial investment in managing symptoms, and affecting productivity in the workplace [8]. The choice of treatment is an individualized multifactorial process considering the severity of symptoms, the patient's age, organs involved, medical history, the impact on the QoL, and the individual's preferences [9]. The treatment of UI often requires a combinatory case-by-case approach, as no single treatment alleviates the symptoms in all patients [10].

Various treatment options exist for managing UI, ranging from behavioral changes to surgical interventions [11]. Initially, practitioners may recommend lifestyle adjustments like weight loss, exercise, hydration, and smoking cessation. Pelvic floor muscle training (PFMT) is a non-invasive first-line approach that relies on targeted muscle activation, often aided by biofeedback devices [12,13]. Nonetheless, its efficacy depends on the patient's capability to engage designated muscles and consistently adhere to the daily training routine [14]. Pharmacological interventions, such as anticholinergics and beta-3 adrenergic receptor agonists, may be used for MUI [15], while off-label prescriptions like duloxetine can enhance urethral sphincter tone for SUI [16], but they bear the risk of bothersome side effects. Intravaginal Electrical Stimulation (IES) aims to facilitate the voluntary contraction of weakened PFM, but it can be limited by discomfort and variable success rates [17,18]. The relatively low invasiveness of injectables such as bulking agents or biocompatible polymers makes them an attractive prospect for patients unable to undergo surgery, though more data are necessary to validate the longevity of results as well as the high risk of dysuria [19]. Surgical interventions, often the final option for conservative treatment-resistant cases, involve an invasive approach, the potential loss of coital function, prolonged recovery, and limited suitability for elderly patients [20]. These diversified management options underscore the need for tailored approaches considering the condition's severity and patient suitability to optimize treatment outcomes.

Avoiding invasiveness and downtime, electromagnetic muscle stimulation (HIFEM™) technology has shown to be a viable treatment option for urinary incontinence [21,22]. HIFEM™ selectively triggers in-depth supramaximal PFM contractions by creating an oscillating magnetic field that depolarizes motoneurons, bypassing the somatic nervous system. The induced muscle contractions subsequently lead to improvement in pelvic floor musculature, achieving superior results when compared to conventional electrostimulation therapy [23]. This study thus aims to investigate the safety and efficacy of the non-invasive HIFEM™ therapy as a standalone treatment for parous women presenting with SUI and MUI. Additionally, we seek to assess its effectiveness as a standalone treatment to better understand its future potential and its role in research when combined with conservative treatments or other therapeutic modalities.

2. Methods

2.1. Case Series Study Design

This retrospective, non-interventional case series study describes standard procedures performed as part of routine clinical care. While the data were collected in a prospective manner during routine practice, the study protocol and evaluation itself were established retrospectively. All procedures were conducted with the patient's written informed consent, following the Principles for Good Practice and adhering to the Helsinki Declaration (1975).

2.2. Inclusion and Exclusion Criteria

Inclusion criteria covered women aged 30–80 years old, urinary incontinence, vaginal childbirth, and abstaining from other treatments/procedures on the abdomen and pelvic floor during the study. Subjects with electronic implants, metallic intrauterine devices, and recent surgery that might have affected muscle contraction were excluded from the study in addition to expectant or nursing mothers. After cross-referencing the database for subjects meeting all inclusion criteria and none of the exclusion criteria, 19 parous women (54.1 ± 15.5 years) were included.

2.3. Treatment Protocol

The subjects underwent treatment procedures with a device utilizing HIFEM™ technology (Emsella, BTL Industries Inc., Boston, MA, USA). The procedure consisted of 6 treatments spaced 3 to 4 days apart, each lasting 28 min. Subjects underwent treatment in a seated posture, knees at a 90° angle, whilst remaining fully clothed on the device's chair applicator. The intensity of the stimulus can be modulated based on the subject's feedback. The treatment involves the progressive stimulation of PFM with alternating phases of higher intensity for endurance and speed contractions followed by relaxation to avoid muscle overload.

2.4. ICIQ-UI SF Questionnaire

The International Consultation on Incontinence Questionnaire-Urinary Incontinence Short Form (ICIQ-UI SF) survey is a standard in evaluating UI for severity, frequency, impact on quality of life, and effects of the procedure. The higher the score, the greater the impact and severity of incontinence. The questionnaire was administered at each visit.

2.5. Comfort and Satisfaction

The subject's satisfaction, comfort, and safety with the treatment were monitored during all treatment visits and assessed via a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

2.6. Data Evaluation

The data were analyzed with descriptive statistics (average, mean, and standard deviation) and tested for normality (the Shapiro–Wilk test). The significance level was set to $\alpha = 0.05$ (5%). Friedman's test was applied to determine the statistical significance of the ICIQ-UI SF questionnaire results. A pairwise paired *t*-test was used to verify the significance of the results of each session. The data analysis for this paper was generated using the Real Statistics Resource Pack software (Release 8.9.1).

3. Results

3.1. Population

This retrospective, non-interventional case series included 19 parous women (54.1 ± 15.5 years). Among them, 13 had SUI, while 6 experienced MUI. The treatment was very well tolerated without the occurrence of adverse events.

3.2. ICIQ-UI SF

3.2.1. Subjects with SUI

At the baseline, the average ICIQ score was 7.9 ± 4.2 points. A significant difference in the ICIQ-SF score was already seen after the third treatment visit ($p < 0.05$), with a continuous and more pronounced improvement with each session. The average ICIQ-UI

SF score at the last questionnaire administration was 4.7 ± 3.5 , indicating a 50.6% decrease from the baseline ($p < 0.001$).

3.2.2. Subjects with MUI

A separate analysis of ICIQ-UI SF scores for MUI subjects showed a similar trend to the overall group improvement. At the baseline, the average ICIQ score was 7.7 ± 4.9 points. Statistical significance was achieved in the fifth session (5.2 points, $p < 0.05$). The average ICIQ-UI SF score at the last questionnaire administration was 4.2 ± 3.2 , indicating a 45.7% decrease from the baseline ($p < 0.001$).

3.3. ICIQ-UI SF Item 6 (Unscored) for All Subjects

ICIQ-SF UI Item 6 reveals that 21% of subjects gained their continence entirely (Figure 1) by scoring 0 on item 6. The proportion of patients who leaked urine before getting to the toilet decreased from 26.3% to 10.5% (a −40% relative decrease) after the sixth treatment. Of the 73.6% who leaked urine when coughing or sneezing before treatment, 36.8% (a −50% relative decrease) did not experience leakage post treatment. Before treatment, 31.6% of patients leaked urine during exercise or physical activity; this number was reduced to 21.1% (a −33.3% relative decrease) after the final treatment session.

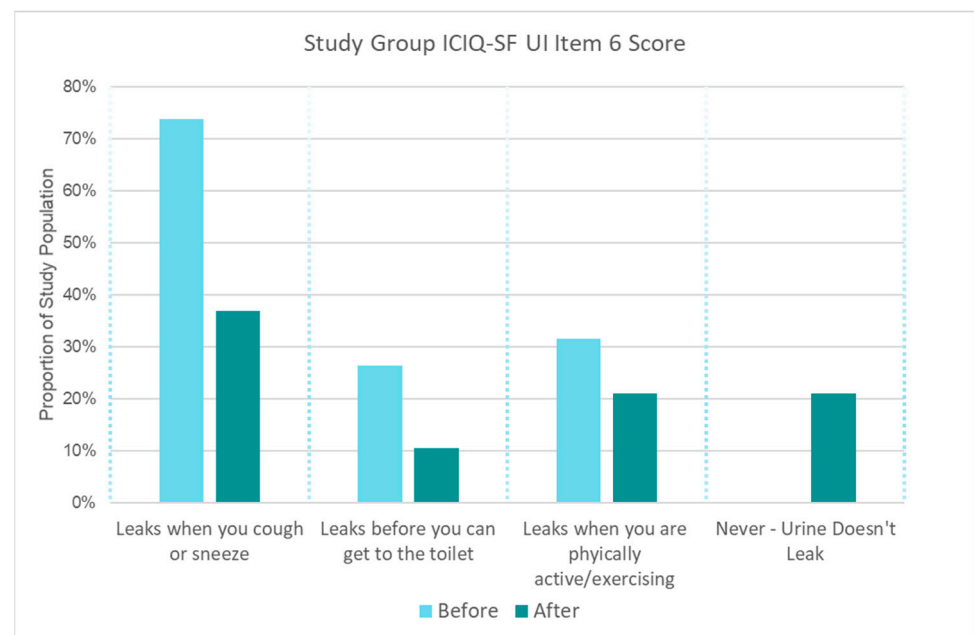


Figure 1. A graphical representation of the Unscored Item 6 results from the study population. The patients responded to the same questions before the first treatment and after the final one.

3.4. Satisfaction, Safety, and Comfort

During the treatment phase, satisfaction with treatment results increased continually between the first session (50%) and the sixth session (88%). Initially, 90% of subjects agreed that the treatment was comfortable at the first session, whereas 100% of subjects reported feeling comfortable at the last treatment.

4. Discussion

This study reported that the HIFEM™ technology significantly lowers the collective ICIQ-UI SF score as a standalone treatment in parous women with SUI and MUI. These findings align with prior research demonstrating the device's effectiveness across diverse patient populations, reinforcing its innovative impact in clinical applications. Additionally,

the use of the ICIQ-UI as a standardized tool for daily assessment provides a reliable measure for evaluating incontinence symptoms and treatment outcomes.

Similarly to the ICIQ-UI SF, the Incontinence Severity Index (ISI) is a tool used to assess the severity of urinary incontinence based on frequency, amount, and impact on daily activities. A cross-sectional analysis by Klovning et al. found a correlation between the ICIQ-UI SF and the ISI [24]. The ISI grades incontinence severity as slight, moderate, severe, and very severe. The correlation analysis overlaps the ICIQ-UF SF scores in the same categories, where an ICIQ-UF SF score of 1–5 indicates slight incontinence, 6–12 moderate, 13–18 severe, and a score of 19–21 very severe incontinence, respectively. Framing the correlation within the context of this study, the overall score of 7.9 ± 4.2 at the baseline places the group average into the moderate incontinence category. The post treatment score of 4.7 ± 3.5 reflects a 50% reduction and shifts the group average into the slight category.

Cohen's *d* offers a standardized measure of change from baseline to post treatment. Effect sizes of 0.2, 0.5, and 0.8 represent small, medium, and large effects, respectively [25]. In this study, the effect size was large ($d = 0.84$). The minimal important difference (MID), or minimal clinically important difference (MCID), offers greater clinical relevance than statistical significance. Despite varying methods to calculate MID/MCID, Norman et al. found that half the standard deviation often approximates it [26,27]. Using this approach, the MID in our study is estimated at 1.7 points, while the observed mean score reduction was 3.2 points—well above the threshold. This aligns with Lim et al., who reported a distribution-based MID of 1.7 for the ICIQ-UI SF [28].

The MUI patient analysis has shown an analogous response to the treatment to the overall group results. The baseline score of 7.7 ± 4.9 points places the MUI group into the moderate UI category according to the cross-sectional findings of Klovning et al. [24]. The post-treatment results of 4.2 ± 3.2 points place the MUI patient group into the slight UI category, corresponding to the overall group results. Furthermore, similar effect sizes (Cohen's $d = 0.86$) and MID of 1.6 were observed.

For effective PFM training, endurance and fast contractions at a high repetition rate followed by rest intervals are necessary to provide an adequate load following motor learning process principles. The superior outcomes of HIFEM therapy may be attributed to the deep penetration of high-intensity electromagnetic fields into the pelvic region, ensuring the uniform activation of the PFM and high repetition rate [29]. In contrast, the success of pelvic floor muscle exercises, with or without biofeedback devices, is limited by the patient's ability to engage in a high repetition rate to follow the motor learning principles. Electrostimulation therapy attempts to resolve the issue of conscious muscle engagement by causing involuntary contractions via electrodes. However, emotional and physical discomfort may pose limitations in use. HIFEMTM treatment overcomes these limitations by exploiting Faraday's law of induction. The coil below the seat creates oscillating magnetic fields to depolarize motoneurons, causing a muscle contraction up to a 10 cm depth.

A previous study compared the effectiveness of HIFEMTM and electrostimulation therapy in treating UI [23]. Validated by electromyography parameters such as maximal voluntary contraction, resting muscle activity, and the endurance of contractions, HIFEMTM showed superior performance. Additionally, the administered Pelvic Floor Impact Questionnaire 7 (PFIQ-7) reflected the superior effectiveness of HIFEMTM with patients, reaching a 57.16% ($p < 0.01$) relative improvement on their post-treatment questionnaire scores. The electrostimulation group reached 32.18% ($p < 0.01$) relative improvement in comparison. This is in line with the present study, where the patient group reached a 50.6% ($p < 0.01$) improvement in their ICIQ-SF UI scores. Both the PFIQ-7 and ICIQ-SF UI are standardized and validated questionnaires used in clinical settings when assessing the severity of incontinence and pelvic floor dysfunction's impact on the patient's life. Fur-

thermore, its minimal risk of adverse effects, no downtime, and suitability for the elderly make the HIFEM™ procedure an attractive option for patients as opposed to surgical or pharmacological intervention.

Future studies should include a larger sample size.

5. Conclusions

Based on the ICIQ-UI SF, HIFEM™ technology as a standalone treatment showed efficacy and safety in treating parous women presenting with SUI and MUI. The authors acknowledge the study's limitations, including its small sample size, the absence of a control group, and the lack of long-term follow-up data. As a result, the data do not generalize the findings to a broader population. However, this study establishes a foundation for future research, emphasizing the need for a further investigation of HIFEM™ technology over extended periods, across diverse populations, and in conjunction with conservative and other treatment modalities to comprehensively evaluate its efficacy.

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Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

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References

1. Raizada, V.; Mittal, R.K. Pelvic Floor Anatomy and Applied Physiology. *Gastroenterol. Clin. N. Am.* **2008**, *37*, 493–509. [[CrossRef](#)] [[PubMed](#)]
2. Peinado-Molina, R.A.; Hernández-Martínez, A.; Martínez-Vázquez, S.; Rodríguez-Almagro, J.; Martínez-Galiano, J.M. Pelvic floor dysfunction: Prevalence and associated factors. *BMC Public Health* **2023**, *23*, 2005. [[CrossRef](#)] [[PubMed](#)]
3. Bump, R.C.; Norton, P.A. EPIDEMIOLOGY AND NATURAL HISTORY OF PELVIC FLOOR DYSFUNCTION. *Obstet. Gynecol. Clin. N. Am.* **1998**, *25*, 723–746. [[CrossRef](#)] [[PubMed](#)]
4. Aoki, Y.; Brown, H.W.; Brubaker, L.; Cornu, J.N.; Daly, J.O.; Cartwright, R. Urinary incontinence in women. *Nat. Rev. Dis. Primer* **2017**, *3*, 17042. [[CrossRef](#)]
5. Falah-Hassani, K.; Reeves, J.; Shiri, R.; Hickling, D.; McLean, L. The pathophysiology of stress urinary incontinence: A systematic review and meta-analysis. *Int. Urogynecology J.* **2021**, *32*, 501–552. [[CrossRef](#)]
6. Milsom, I.; Coyne, K.S.; Nicholson, S.; Kvasz, M.; Chen, C.I.; Wein, A.J. Global Prevalence and Economic Burden of Urgency Urinary Incontinence: A Systematic Review. *Eur. Urol.* **2014**, *65*, 79–95. [[CrossRef](#)]
7. Welk, B.; Baverstock, R.J. The management of mixed urinary incontinence in women. *Can. Urol. Assoc. J.* **2017**, *11* (Suppl. 2), 121. [[CrossRef](#)]
8. Pizzol, D.; Demurtas, J.; Celotto, S.; Maggi, S.; Smith, L.; Angiolelli, G.; Trott, M.; Yang, L.; Veronese, N. Urinary incontinence and quality of life: A systematic review and meta-analysis. *Aging Clin. Exp. Res.* **2021**, *33*, 25–35. [[CrossRef](#)]
9. Corrado, B.; Giardulli, B.; Polito, F.; Aprea, S.; Lanzano, M.; Dodaro, C. The Impact of Urinary Incontinence on Quality of Life: A Cross-Sectional Study in the Metropolitan City of Naples. *Geriatrics* **2020**, *5*, 96. [[CrossRef](#)]

10. Yoo, R.; Spencer, M. Continence Promotion and Successful Aging: The Role of the Multidisciplinary Continence Clinic. *Geriatrics* **2018**, *3*, 91. [\[CrossRef\]](#)
11. O'Connor, E.; Nic An Riogh, A.; Karavitakis, M.; Monagas, S.; Nambiar, A. Diagnosis and Non-Surgical Management of Urinary Incontinence—A Literature Review with Recommendations for Practice. *Int. J. Gen. Med.* **2021**, *14*, 4555–4565. [\[CrossRef\]](#) [\[PubMed\]](#)
12. Curillo-Aguirre, C.A.; Gea-Izquierdo, E. Effectiveness of Pelvic Floor Muscle Training on Quality of Life in Women with Urinary Incontinence: A Systematic Review and Meta-Analysis. *Medicina* **2023**, *59*, 1004. [\[CrossRef\]](#) [\[PubMed\]](#)
13. Frank, D.L.; Khorshid, L.; Kiffer, J.F.; Moravec, C.S.; McKee, M.G. Biofeedback in medicine: Who, when, why and how? *Ment. Health Fam. Med.* **2010**, *7*, 85–91. [\[PubMed\]](#)
14. Sawettikamporn, W.; Sarit-apirak, S.; Manonai, J. Attitudes and barriers to pelvic floor muscle exercises of women with stress urinary incontinence. *BMC Womens Health* **2022**, *22*, 477. [\[CrossRef\]](#)
15. Gandi, C.; Sacco, E. Pharmacological Management of Urinary Incontinence: Current and Emerging Treatment. *Clin. Pharmacol. Adv. Appl.* **2021**, *13*, 209–223. [\[CrossRef\]](#)
16. Malallah, M.A.; Al-Shaiji, T.F. Pharmacological treatment of pure stress urinary incontinence: A narrative review. *Int. Urogynecology J.* **2015**, *26*, 477–485. [\[CrossRef\]](#)
17. Nightingale, G. Management of urinary incontinence. *Post. Reprod. Health* **2020**, *26*, 63–70. [\[CrossRef\]](#)
18. Antonio, F.I.; Bø, K.; Pena, C.C.; Bueno, S.M.; Mateus-Vasconcelos, E.C.; Fernandes, A.C.; Ferreira, C.H. Intravaginal electrical stimulation increases voluntarily pelvic floor muscle contractions in women who are unable to voluntarily contract their pelvic floor muscles: A randomised trial. *J. Physiother.* **2022**, *68*, 37–42. [\[CrossRef\]](#)
19. Kirchin, V.; Page, T.; Keegan, P.E.; Atiemo, K.O.; Cody, J.D.; McClinton, S.; Aluko, P. Urethral injection therapy for urinary incontinence in women. *Cochrane Database Syst. Rev.* **2017**, *2017*, CD003881. [\[CrossRef\]](#)
20. Demaagd, G.A.; Davenport, T.C. Management of urinary incontinence. *P T Peer-Rev. J. Formul. Manag.* **2012**, *37*, 345–361H.
21. Azparren, J.; Brandeis, J. HIFEM Procedure Enhances the Quality of Life in Elderly Men with PostProstatectomy Incontinence: A Pilot Study. *Med. Surg. Urol.* **2024**, *13*, 340. [\[CrossRef\]](#)
22. Guerette, N.; Molden, S.; Gopal, M.; Kohli, N. Randomized Trial of HIFEM Pelvic Floor Stimulation Device Compared with Pelvic Floor Exercises for Treatment of Urinary Incontinence. *J. Women's Health Care* **2023**, *12*, 680. [\[CrossRef\]](#)
23. Silantyeva, E.; Zarkovic, D.; Astafeva, E.; Soldatskaia, R.; Orazov, M.; Belkovskaya, M.; Kurtser, M. A Comparative Study on the Effects of High-Intensity Focused Electromagnetic Technology and Electrostimulation for the Treatment of Pelvic Floor Muscles and Urinary Incontinence in Parous Women: Analysis of Posttreatment Data. *Female Pelvic Med. Reconstr. Surg.* **2021**, *27*, 269–273. [\[CrossRef\]](#) [\[PubMed\]](#)
24. Klovning, A.; Avery, K.; Sandvik, H.; Hunskaar, S. Comparison of two questionnaires for assessing the severity of urinary incontinence: The ICIQ-UI SF versus the incontinence severity index. *Neurourol. Urodyn.* **2009**, *28*, 411–415. [\[CrossRef\]](#)
25. Sullivan, G.M.; Feinn, R. Using Effect Size-or Why the P Value Is Not Enough. *J. Grad. Med. Educ.* **2012**, *4*, 279–282. [\[CrossRef\]](#)
26. Norman, G.R.; Sloan, J.A.; Wyrwich, K.W. Interpretation of Changes in Health-related Quality of Life: The Remarkable Universality of Half a Standard Deviation. *Med. Care* **2003**, *41*, 582–592. [\[CrossRef\]](#)
27. Norman, G.R.; Sloan, J.A.; Wyrwich, K.W. The truly remarkable universality of half a standard deviation: Confirmation through another look. *Expert. Rev. Pharmacoecon Outcomes Res.* **2004**, *4*, 581–585. [\[CrossRef\]](#)
28. Lim, R.; Liong, M.L.; Lim, K.K.; Leong, W.S.; Yuen, K.H. The Minimum Clinically Important Difference of the International Consultation on Incontinence Questionnaires (ICIQ-UI SF and ICIQ-LUTSqol). *Urology* **2019**, *133*, 91–95. [\[CrossRef\]](#)
29. Barba, M.; Cola, A.; Rezzan, G.; Costa, C.; Melocchi, T.; De Vicari, D.; Terzoni, S.; Frigerio, M.; Maruccia, S. Flat Magnetic Stimulation for Stress Urinary Incontinence: A 3-Month Follow-Up Study. *Healthcare* **2023**, *11*, 1730. [\[CrossRef\]](#)

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