



Patient Decision Aids for Stress and Urgency Urinary Incontinence in Women: A Scoping Review

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Abstract

Context Stress and urgency urinary incontinence (UI) significantly impact the quality of life of women worldwide. The complexity of treatment options calls for robust decision support tools to guide informed, patient-centered care.

Aim This scoping review maps best practices in the development, implementation, use, evaluation, and reported outcomes of patient decision aids (PDAs) for adult women with stress and/or urgency urinary incontinence.

Method Complementary literature searches (2000–2024) were conducted between March 2023 and May 2024 using scientific databases and gray literature. The first focused on general PDA, the second on PDAs specific for women with stress and/or urgency UI. Selected documents were analyzed using standardized extraction grids; inter-rater agreement ensured validity.

Results Fourteen literature reviews and six studies specifically about PDAs for women with stress and/or urgency UI were selected. PDAs were reported to improve patient knowledge, reduce decisional conflict, and support shared decision-making. Key facilitators of PDA development and implementation include involving patients and healthcare professionals, adapting tools for diverse needs, clinician training, clear guidelines, regular updates, and multiformat accessibility. Barriers include time constraints, limited access, comprehension difficulties, individual preferences, media influence, and organizational challenges. Addressing these factors through tailored design, improved access, and targeted training is important for successful adoption and implementation of PDAs in this context.

Conclusion PDAs represent a valuable tool for supporting decision-making for women with stress and/or urgency UI. Future research should address long-term outcomes, cost-effectiveness, and strategies to tailor PDAs to diverse patient needs, ultimately enhancing patient-centered care and adoption in practice.

Keywords Urinary incontinence · Patient decision aids · Shared decision-making · Urogynecology · Scoping review · Patient-centered care

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Introduction

Urinary incontinence (UI) affects up to one in three women worldwide [1, 2]. It includes stress, urgency, and mixed incontinence, each with distinct mechanisms and contributing factors [1, 3]. UI poses significant medical and economic challenges, particularly as prevalence rises with an aging population [4–6]. Beyond physical symptoms, UI can severely impact quality of life, contributing to anxiety, depression, and social withdrawal [7–9]. Despite its burden, it remains under-diagnosed and under-treated, emphasizing the need for improved awareness and management [10–13].

Effective UI treatment should align with patient goals, considering adverse effects, costs, and expected benefits [3]. Concerns over the safety of surgical mesh, such as in

transvaginal mesh for prolapse and synthetic mid-urethral slings for stress UI have fueled legal actions and reinforced the necessity of informed consent, as highlighted by the 2015 Montgomery decision [14, 15]. This underscores the role of shared decision-making (SDM) and patient decision aids (PDAs) in urogynecology.

PDAs provide evidence-based information on treatment options, risks, benefits, and uncertainties, fostering discussions between patients and clinicians [16, 17]. Available in various formats (e.g., brochures, videos, online resources), PDAs enhance patient understanding and support SDM [16]. According to the International Patient Decision Aid Standards (IPDAS), an effective PDA must include at least these three essential elements: (1) define the decision context, (2) present unbiased, evidence-based options, and (3) help patients clarify their values regarding potential outcomes [18].

Studies indicate that PDAs can improve patient knowledge, risk perception, and engagement in decision-making, supporting more informed choices [16]. In urogynecology, where patients often face multiple treatment options, PDAs may be especially helpful, including for older adults managing other health conditions. However, beyond their potential impact, there is growing interest in how PDAs are specifically developed and implemented in practice.

Given the heterogeneity of PDA formats, contexts, and outcome reporting, a scoping review is appropriate to describe the landscape rather than estimate comparative effectiveness. In this context, the aim of this scoping review is to map the best practices in the development, implementation, use, evaluation, and reported outcomes of patient decision aids for adult women with stress and/or urgency urinary incontinence. To achieve this, the review examines the elements related to PDAs, as detailed in Appendix 1.

Materials and Methods

Literature Search

The literature search was conducted in two complementary phases:

- I. General literature on PDAs: This phase focused on identifying review articles on norms, standards, and best practices for PDA development and use across various decision-making contexts, without restricting to a specific population or healthcare area. Publications from 2000 to 2024 were included to capture evolving standards and ensure a comprehensive, up-to-date perspective on PDAs. Maintaining a broad scope provided a conceptual foundation, covering

current quality standards and recent developments in PDA research and implementation.

- II. Literature specific to PDAs for adult women (≥ 18 years) with stress and/or urgency UI: This phase targeted scientific articles and gray literature on PDAs specifically designed for women with stress and/or urgency UI, using the same 2000–2024 timeframe. These sources provided precise information on PDA development and implementation tailored to this population's needs.

Both searches were conducted in March 2023 and updated in May 2024 by a scientific information specialist (AM). The databases searched included EMBASE, MEDLINE, CINAHL, PSYCINFO, and COCHRANE CDSR. The search strategy combined controlled and free-text vocabulary, using “decision aids” for the general search and expanding to “urinary incontinence,” “stress incontinence,” and “urge incontinence” for the targeted search. Duplicates were removed, and results were screened for relevance. The detailed search strategy is available in Appendix 2.

To complement this search, 31 organizations and interest groups were contacted in September 2024 (SAC) to inquire whether they were aware of any documents or examples of PDAs specific to women with stress or urgency incontinence (see Appendix 3). Additionally, all references of selected documents were cross-checked, and supplementary free searches were conducted in search engines (SAC, BSA, CL, AM, SBA) to identify other relevant materials, including gray literature. The reference lists of retrieved gray literature were also screened for additional sources.

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were developed on the basis of the PICOTS framework outlined in Appendix 1. For the first general search, all populations were considered. All literature reviews were included if they focused on PDAs in general or within the urogynecology domain. If the review was specific to another medical condition or domain, it was excluded. The second research was limited to the specific topic of PDAs for adult women suffering from stress or urgency UI. While document type was not restricted, studies involving women under 18, those with UI types other than stress and/or urgency, or those addressing other health conditions were excluded. Mixed urinary incontinence was not specifically excluded. In both searches, any healthcare facility or context was included. Only French and English publications from 2000 to 2024 were included. No geographical or additional restrictions were applied. A descriptive table of the retained publications of both searches is presented in Appendix 4.

As of February 27, 2025, SBA conducted a cross-check to ensure that none of the included documents were published in journals listed as being predatory, at that time, on either www.predatoryjournals.org or www.beallslst.net.

Study Selection

Four research professionals (SAC, BSA, SBA, CL) independently screened all references in two stages: title and abstract, followed by full-text assessment. Studies that did not meet the eligibility criteria were excluded at each stage. Full-text articles of all preselected studies were retrieved to confirm compliance with the inclusion criteria. Any discrepancies during the selection process were resolved through discussion and consensus among reviewers.

Data Extraction

Data from the identified scientific publications and selected PDAs were extracted using predefined extraction grids designed for this purpose. Extracted elements included: study characteristics, objectives, main results, reported outcomes, key issues, format, and visual elements of PDAs. Data extraction and validation were conducted by three professionals (SAC, BSA, CL). Any discrepancies during the extraction process were resolved through discussion and consensus.

Data Analysis

All extracted data from the selected scientific articles were analyzed by a scientific professional (SAC) using a thematic analysis approach to identify recurring themes and patterns across the studies. Inductive coding was applied, and themes were categorized on the basis of their relevance to PDA impacts, facilitators, barriers, and key issues. This analysis was subsequently validated by another scientific professional (CL) to ensure accuracy and reliability. No formal risk-of-bias appraisal or meta-analysis was conducted because the objective was to map the breadth of evidence and practice rather than to pool effect estimates.

Ethics Approval

Not applicable. This scoping review synthesizes published, publicly available literature; no participants or identifiable data were involved.

Results

To remain concise and focused on PDAs for stress/urgency UI in women, this section briefly summarizes general PDA findings in [Section I](#); full details are in the “Supplementary Materials.” Detailed results on PDAs specific to stress/urgency UI appear in [Section II](#).

I. Results from Literature Reviews on PDAs in General

Selection Results

The general literature search identified 616 studies. After removing duplicates ($n = 131$) and excluding irrelevant studies based on title and abstract screening ($n = 471$), 14 were selected for full-text review and included in the final analysis. A PRISMA flowchart detailing this selection process is available in [Fig. 1](#) (below, left side). None of those documents were published in predatory journals; therefore, all 14 were retained for analysis.

Characteristics of Included Studies

The 14 selected studies originated from: the United States [19–22], Canada [16, 23, 24], Australia [25–27], the Netherlands [28], the United Kingdom [29], Germany [30], and South Korea [31]. All identified studies were published between 2020 and 2024, with none found between 2000 and 2019. Notably, 11 of the 14 included studies were published since 2021, highlighting a recent surge in research on this topic. Appendix 4 provides a detailed table summarizing the key study characteristics, including study objectives, methodologies, and main findings.

Summary of General Findings on PDAs

Reported outcomes PDAs improve patient knowledge [16, 22, 23, 26, 28, 31], reduce cognitive load [25], facilitate SDM [21, 26, 31], with perceived gains in SDM outcomes and treatment choices [16, 22, 23, 26, 28, 31], support evidence-based decisions [26, 28, 31], enhance decision quality [21, 23, 31], reduce decisional conflict [16, 22, 23, 26, 28, 31], and increase patient engagement [16, 22, 23, 26, 28, 31]. They were also reported to lead to better patient–clinician communication [22, 28] and overall satisfaction of both groups [16, 31].

Reported facilitators Reported facilitators include early end-user engagement [16, 21, 24, 29], integrated knowledge translation with stakeholders [29] in a fully collaborative and ongoing process [16, 19, 21, 24, 29], high readability, use of plain-language and literacy expertise [25], clear and consistent communication about risks [19], offering patient-controlled personalization with space for note-taking [19], access to multiple formats (digital, print, combined, translated, etc.) [16, 25, 26, 31], whole-team training before implementation [16, 23, 26, 29], alignment with organizational priorities and demonstrated process and outcome gains [16, 19, 23, 26, 29], iterative patient-centered improvement of PDAs [19, 21], and clear international guidelines and quality standards [16, 19, 21, 23, 26, 29].

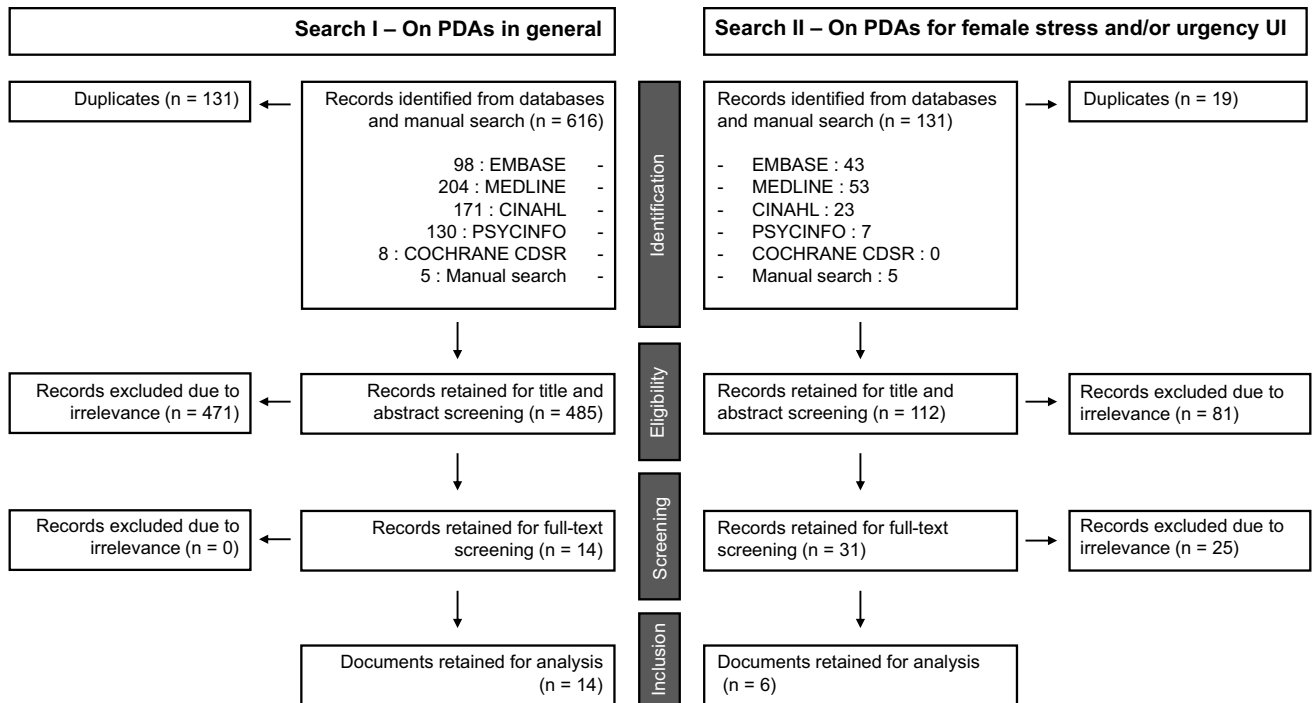


Fig. 1 PRISMA flow chart

Reported barriers Reported barriers include clinician reluctance and scepticism [16, 23, 26, 28, 31, 32], leadership discontinuity [29], limited skills integrating PDAs and confusion between SDM and informed decision-making [26, 29], insufficient funding and organizational support [16], high clinical workload [26, 29], difficulties in accessing or understanding PDAs, especially for older patients with multimorbidity, frailty, or cognitive impairment [28], and inadequate or unappealing content [16, 19, 31]. Ethical concerns reported in the literature were conflicts of interest in PDA development [27] and challenges in addressing the needs of vulnerable populations [21].

II. Specific Literature Results on PDAs for Female Stress or Urgency Urinary Incontinence

Selection Results

The initial literature search identified 131 documents. After removing duplicates ($n = 19$) and excluding irrelevant documents based on title and abstract screening ($n = 81$), 31 documents were selected for full-text review. Of these, 25 were excluded for not specifically focusing on PDAs related to women with stress and/or urgency UI, being patient education resources rather than PDAs, or being purely editorial

in nature. The remaining six documents met all inclusion criteria and were included in the analysis. The PRISMA flowchart detailing this selection process is available in Fig. 1 (above, right side). None of the identified documents were published in predatory journals; therefore, all six were retained for analysis.

Characteristics of Selected Documents

The six selected documents originate from various countries: the United Kingdom [14, 33, 34], Italy [35], the Netherlands [36], and the United States [37]. All identified documents were published between 2018 and 2022, with none found between 2000 and 2017, again highlighting a recent surge in research on this topic. Among these, four are primary research studies [14, 33, 36, 37], one is a conference abstract [35], and one is a publication in a professional journal [34]. Appendix 4 provides a detailed table summarizing key study characteristics, including objectives, methodologies, and main findings.

Reported Outcomes of PDA Use

By presenting clear, structured, and patient-centered information, PDAs were reported to boost understanding of treatment options and reinforce decision-making

confidence and sense of responsibility among women with stress and/or urgency UI [14, 33, 37]. This contributed to reduce patient uncertainty and encouraging active participation of patients in decision-making [14, 33, 37]. The transparent risk presentations of PDAs, often in a patient-centered and physical format, helped reduce confusion, particularly for older patients or those accompanied by caregivers [34, 37].

PDAs were also reported to improve satisfaction among women considering surgery for stress and/or urgency UI by reducing decision conflict, uncertainty, and by enhancing patient involvement and communication with clinicians [14, 33, 37]. Women also reported feeling more valued and engaged during medical consultations, leading to greater satisfaction with the decision-making process compared to usual care [14, 34]. They particularly appreciated the open discussions facilitated by the tool, which allowed for in-depth conversations about their concerns and strengthened dialogue with their clinician [34]. PDAs were also reported to contribute to a better understanding of patients' values and preferences, fostering a more personalized approach to therapeutic decision-making [34].

Clinicians generally accepted PDAs as they could be integrated into urogynecology workflows without significantly extending consultation times [37]. These tools streamlined decision-making by reducing the number of visits, improved patient-clinician dialogue by directly addressing concerns, and may help align patient treatment choice to patient preferences [33, 35]. PDAs were reported to influence surgical practices by prompting patients to base decisions on personal values rather than demographic factors such as age, body mass index (BMI), or number of previous childbirths [14, 33]. Most patients favored safer, less invasive procedures, such as opting for bulking agent treatments over riskier surgeries [33, 34]. Clinicians used PDAs to guide patients through treatment choices, significantly lowering decision conflict, especially when a decision conflict scale was included in the PDA [14, 34, 37].

Reported Facilitators for the Adoption and Use of PDAs

Effective PDAs were based on robust scientific guidelines, presenting objective, unbiased information through both visual and verbal explanations to help patients make well-informed decisions [36]. Standardizing treatment recommendations and educational content, with clear and consistent guidance, was also a key facilitator [36].

The literature mentioned that preparing patients before consultations allowed them time to reflect on their options, which can reduce consultation time and enhance overall effectiveness [36]. In another study, administering PDAs at the moment of UI diagnosis, prior to discussions with a

multidisciplinary team, was reported to optimize decision-making for urgency urinary incontinence [33]. Integrating a structured SDM process within PDAs empowered patients to weigh the pros and cons of each treatment in line with their personal values, thereby supporting their right to self-determination [36].

Given the progressive nature of pelvic floor disorders, developing PDAs specifically designed for older women, especially those at risk of dementia, was reported as essential [37]. Additionally, adapting interventions for patients with low health literacy was important, as such tailored approaches enhanced understanding, decision-making self-efficacy, and reduced decision conflict [36]. Finally, generally involving patient feedback during all stages of PDA development ensured that the tool was tailored to specific needs and remained relevant [36].

Educating healthcare professionals about PDAs, including how to use them and the benefits they offer, was also important for reducing disparities in treatment recommendations for stress UI in women [36]. Additionally, strong institutional support significantly promoted the adoption of PDAs by healthcare professionals [36].

Reported Barriers to the Adoption and Use of PDAs

Identifying barriers to PDA integration was reported as essential for successful implementation in the context of female stress or urgency urinary incontinence [36]. A frequently cited obstacle was consultation length: clinicians differ in their views, with some accepting a slight time increase while others see it as a major barrier [36]. Although PDA use was reported to extend median consultation duration by 2.6 min, introducing the tool before the consultation may mitigate this issue while preserving its positive impact on SDM [36]. Another barrier was physician uncertainty about the added value of PDAs, as some preferred direct discussions or view certain decisions as self-evident, thereby questioning the need for PDAs [36].

Patient health literacy also posed challenges to adoption and use of PDAs in this clinical context. Limited literacy, language difficulties, reading challenges, or lack of internet access hindered information access and PDA adoption [34, 36]. Additionally, some women preferred to rely on their physician's recommendations rather than engaging in decision-making themselves, avoiding detailed information on risks and complications related to their urinary condition [34]. Finally, media influence also complicated decision-making, as negative media coverage led patients to cite mediatic terms like "too invasive" or "risky" to reject treatments, obscuring their genuine understanding of the risks presented in the PDAs themselves [33].

Reported Issues Related to PDAs

The following issues were also drawn from literature specifically focused on female stress and urgency UI, although they also reflected broader findings previously identified in the general literature on PDAs. Some women preferred a clinician-directed approach and do not want detailed risk information [34]. Open, honest consultations that documented individual reasons for choosing a specific surgical option were important to address varying perceptions of risk and minimize dissatisfaction [34].

Patients sometimes completed PDAs to justify pre-existing surgical preferences influenced by external opinions. It was important to encourage an active, informed role in decision-making and ensure PDAs presented balanced information [34]. Concerns remained that some PDAs favored surgical options while downplaying nonsurgical approaches like pelvic floor muscle therapy [36].

Clinical team decisions sometimes diverged from patient choices, necessitating additional consultations to clarify the medical perspective and help patients reassess their options [35]. In some cases, PDA use led to significant differences between patient and clinician choices, such as patients' physical conditions that require anesthesiologist or medical consultants' input to highlight unacceptable surgical risks [35].

Adapting PDAs to vulnerable groups, such as older women or those with cognitive or functional limitations, remained important in the context of SDM for stress and urgency UI [33, 37]. For instance, cognitive decline, particularly in older women, impaired participation in SDM. When patients are at risk of or in the early stages of dementia, the ability to make a surgical decision earlier allowed them to be more actively involved in their own care and reduce surgical morbidity associated with procedures performed at an older age [37].

Finally, more research is needed to evaluate the cost-effectiveness of PDAs in the clinical setting of female stress and urgency UI, as some studies indicated they may not reduce healthcare costs and might even increase expenses [33].

Discussion

This scoping review reveals the extensive research and attention devoted to PDAs for stress and urgency UI across various regions worldwide. Our findings report several key considerations for healthcare professionals related to the development, implementation, adoption, and the accessibility of PDAs in this context.

First, PDAs are reported to increase emotional well-being, shared decision-making, patient-clinician communication, and patient engagement, possibly leading to better

treatment alignment with patient preferences, improved satisfaction, and greater adherence, ultimately supporting better long-term clinical outcomes. These results reinforce the usefulness of PDAs in supporting patient involvement in shared and informed decision-making processes.

Second, facilitators of PDAs development and adoption were reported to be involving end users (patients and healthcare professionals) in development to ensure relevance. Adapting PDAs to diverse patient profiles (e.g., older adults, low literacy levels) enhances usability, while training healthcare professionals promotes proper application and communication. Clear guidelines and continuous updates are mentioned to help maintain relevance, and multi-format accessibility supports wider adoption, particularly for those with cognitive limitations. These findings support that although PDAs were generally well received and considered valuable tools for informing treatment choices, these findings reveal that their effectiveness depends on the provision of accurate and adapted information.

Third, reported barriers to PDA implementation include time constraints, limited tool access, comprehension difficulties, patient preferences, clinician uncertainty, and external influences (e.g., media coverage). Organizational barriers, such as lack of clinician training, are well-documented in PDA use overall. Finally, ethical, clinical, and economic challenges related to PDA use, including shared decision-making difficulties, multidisciplinary coordination, and external influences on decision-making.

To support researchers, developers, and clinicians, Fig. 2 presents a concise set of practices to guide the development and implementation of patient decision aids.

Comparison with Other Literature

Our findings align with prior PDA literature showing gains in shared decision-making, communication, and patient engagement, with downstream improvements in satisfaction and treatment concordance. UI-specific reports similarly emphasize patients' desire to participate in decisions [38–41] and highlight the value of clinician involvement to operationalize PDAs in routine care. Consistent with broader PDA evidence, effective implementation in UI appears to depend on formats adapted to literacy/age and on regular content updates and multi-modal access (e.g., electronic, audio, multilingual) [42]. Divergence is mainly in the limited UI-specific outcome evaluation and inconsistent differentiation between stress versus urgency UI, underscoring the need for more targeted assessments.

Limitations

Evidence specifically on PDAs for women with stress and/or urgency UI is sparse and heterogeneous. Although we set no

DEVELOPMENT	IMPLANTATION
<input type="checkbox"/> Co-design early and iterate Include older and low-literacy patients, clinicians, and administrative staff. Observe real use and refine across cycles [21, 24].	<input type="checkbox"/> Embed in the visit (not instead of it) Use the PDA to structure dialogue/SDM while preserving clinical judgement. Introduce it briefly, then discuss key points during consult [29].
<input type="checkbox"/> Follow quality standards (e.g., IPDAS checklist) Cover content, probabilities, values, development and testing, disclosure, evidence, date [18, 21].	<input type="checkbox"/> Two-step rollout to patients 1) Introduce/explain the PDA 2) Remind before the decision point (call/portal message/handout) [26, 29].
<input type="checkbox"/> Plan for older adults Adapt both content and design for their specific needs. [28].	<input type="checkbox"/> Pre-visit access to save clinic time Provide access ahead of the appointment; allow nurse-guided preview if needed [26, 31].
<input type="checkbox"/> Design for low health literacy by default Target ~5th–8th grade, plain language, short sentences, summaries, limited on-screen text, involve literacy/communication experts [18, 25].	<input type="checkbox"/> Train the whole team and name “clinical champions” Short training for clinicians, nurses, admin; designate champions; align with clinic goals [29].
<input type="checkbox"/> Provide multi-format and translated versions Offer paper, web, video, audio; combine formats when useful [17, 26, 31].	<input type="checkbox"/> Match format to patient and context Such as print, web or audio based on literacy, access, and patient preference. Provide translations when needed [31].
<input type="checkbox"/> Communicate risks clearly Use one consistent frequency format (e.g., 3% or 3/100) with a clear and consistent time horizon. Use simple visuals and consider numeracy [25].	<input type="checkbox"/> Define workflow roles and electronic health records prompts Admin screens eligibility, hands out links; electronic health records checklist reminds clinicians to review PDA notes [29].
<input type="checkbox"/> Easily comparable options Side-by-side option table with pros/cons, followed by a quick “values check” on what matters most to the patient [18, 21, 32].	<input type="checkbox"/> Offer decision coaching when helpful Pair PDA with brief coaching/ODSF methods for patients with high decisional conflict or complex trade-offs [30, 32].
<input type="checkbox"/> Add a “Notes & Questions” box After each option section and on the summary page to capture concerns/next steps [18].	<input type="checkbox"/> Use the comparison table during consult Review side-by-side options together; invite the patient to read their “Notes & Questions” aloud [18].
<input type="checkbox"/> Use narratives/testimonials cautiously Best to avoid them to prevent persuasion bias [18, 20, 21].	<input type="checkbox"/> Address time perceptions explicitly Keep in-visit use to highlights; move education pre-visit; avoid long narratives [26, 31].
<input type="checkbox"/> Conflict-of-interest transparency Disclose nature, monetary value, and relevance. [18, 27].	<input type="checkbox"/> Equity and access checks Track reach by language/age/setting and offer alternatives (e.g. large print, audio) if needed [21, 31].
<input type="checkbox"/> Version/date the PDA Allow users to see currency of the information provided to them [18, 21].	<input type="checkbox"/> Monitor and improve Collect feedback, track document use, and update processes and content according to collected data [21, 29].
<input type="checkbox"/> Pre-plan updates Keep information up-to-date, assign an owner, set a review cadence and archive prior versions with a change log [18, 21].	

Fig. 2 How to develop and implement PDAs: reported good-practices

geographic limits, most studies come from high-income settings and English/French sources, limiting generalizability. Available data did not always distinguish stress and urgency UI, and overactive bladder (OAB) was not specifically addressed. Because this is a scoping review without meta-analysis, funnel-plot assessment of small-study/publication bias was not appropriate. Instead, mitigated dissemination bias was achieved via gray-literature searching and broad sources. Potential interpretation bias in reported positive PDA effects and possible selection bias cannot be excluded.

Strengths

Despite these limitations, this scoping review presents several strengths. It is a comprehensive overview of the

available literature on PDAs for women with stress and/or urgency UI. The systematic approach to data collection and analysis, conducted over two broad searches, and the close collaboration of multiple scientific advisors contribute to the quality of the results. By incorporating gray literature identified through a prespecified, transparent process, we aimed to reduce the risk of dissemination bias (including publication bias). Additionally, this study integrates perspectives from various stakeholders, as reported in the literature, including patients and health professionals. It also offers practical how-to guidance for professionals developing and implementing PDAs for women with stress and/or urgency UI, informed by the current state of the literature and best-known practices on the subject.

Future Research and Policy Impact

Our findings underscore the importance of continued research on PDAs for women with stress and/or urgency UI, particularly to support the development of tailored interventions that effectively combine healthcare professionals' expertise with patients' preferences, thereby promoting autonomy and informed decision-making. Additional research is needed on this topic, including to understand their impact on health outcomes and patient preferences [19, 21, 24, 26, 33, 34] for PDAs in general, as well as the influence of clinicians' preferences and limited surgical options on patient decisions [14] for PDAs specific to female UI. PDAs may also benefit caregivers and family members, helping them better understand the treatment their loved one is undergoing, but further research is still needed on this topic. These reported results highlight the need for PDAs supported by patients, healthcare providers, scientific societies, patient associations, and clinical organizations. Addressing these factors is needed for effective adoption and optimizing UI management. Systemic approaches to better integrate PDAs into healthcare systems and provider-patient interactions are recommended to enhance adoption and promote patient-centered care.

Conclusion

This scoping review highlights how PDAs are being used to support informed decision-making for women with stress and/or urgency UI. Across the included literature, PDAs were reported to enhance knowledge, reduce decisional conflict, and promote shared decision-making. Moreover, PDAs were reported to contribute to improved communication, increased patient satisfaction, and greater adherence to treatment plans. Despite these benefits, challenges remain in ensuring the effective implementation of PDAs in clinical practice. Barriers such as time constraints during consultations, variations in patient literacy, and clinician uncertainty about the value of PDAs must be addressed. Strategies to optimize PDA adoption include clinician training, institutional support, and adapting tools to the specific needs of diverse patient populations. Future research should evaluate long-term and economic outcomes with designs suited to causal inference, and test implementation strategies across settings. Ultimately, PDAs represent a valuable tool in improving patient-centered care, facilitating informed choices, and ensuring that treatment decisions align with individual patient values and preferences. Their continued development and refinement could be key to optimizing the management of stress and/or urgency UI for women and enhancing the quality of care provided.

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Declarations

Ethics Approval Not applicable. This scoping review synthesizes published, publicly available literature; no participants or identifiable data were involved.

Conflict of Interest ML has received research funding from the St. Mary's Research Centre as well as the Quebec Ageing Research Network, is a consultant for AbbVie, and is a scientific advisor for FemTherapeutics, unrelated to the content of this manuscript. GN is a consultant and speaker for Abbvie, Boston Scientific, Astellas, Searchlight Pharma and Laborie. The other authors declare that they have no conflict of interest.

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