

SUPPLEMENTARY DIGITAL MATERIAL 2

Supplementary Table II.—Therapeutic strategies and rehabilitation techniques of the current literature.

Authors, years	Therapeutic strategies
Canbaz 2017	Posterior tibial nerve stimulation was applied unilaterally with 26-gauge stainless steel needles inserted 5 cm cephalad from the medial malleolus and posterior to the edge of the tibia, placing the ground electrode on the ipsilateral extremity. Electrical stimulation was applied unilaterally by using charge-compensated 200 msec pulses with a pulse rate of 20 Hz, as used in previous studies
De Seze 2011	TPTNS was applied unilaterally with two adhesives electrodes placed above and behind the medial malleolus at the right ankle. Electrical stimulation with charge-compensated 200 $\mu$ sec with a pulse rate of 10 Hz.
Engeler 2015	The sacral neuromodulator was implanted unilateral in 88%, at sacral foramen S3 (81%), S4 (19%), with an amplitude of 0.58 Volt, impulse width 210 $\mu$ sec, stimulation frequency 14 Hz
Ferreira 2019	3 sets of 8–10 close-to-maximal contractions, in lying down, sitting up and standing positions. Each contraction should be held according to the endurance of the pelvic floor muscles with the participants aiming to hold the muscles for 10 secs. After the exercise protocol, an intravaginal electrode stimulated S2–S4 dermatomes, with a frequency of 2 Hz, positive pulse duration of 1 $\mu$ sec, intensity tolerable by the patient, and therapy time of 30 mins. During electric stimulation, participants were requested to perform 20 fast and 20 slow contractions of the pelvic floor musculature
Fjorback 2007	Electrical stimulation was applied bilaterally by using charge-compensated 200 msec pulses with a pulse rate of 20 Hz
Gobbi 2011	Electrical stimulation was applied for 30 min, once a week for 12 weeks, by unilateral insertion of a 34-gauge needle electrode at a 60-degree angle, approximately 5 cm cephalad to the medial malleolus and slightly posterior to the tibia. A PTNS surface electrode was placed on the ipsilateral calcaneus
Kabay, 2008	Electrical stimulation was applied unilaterally from the medial malleolus

	and posterior to the edge of the tibia by using charge-compensated 200 microsecond pulses with a pulse rate of 20 Hz
Kabay 2009	PTNS was applied unilaterally with 26-gauge stainless steel needles inserted 5 cm cephalad from the medial malleolus and posterior to the edge of the tibia, placing the ground electrode on the ipsilateral extremity. Electrical stimulation was applied unilaterally by using charge-compensated 200 msec pulses with a pulse rate of 20 Hz, as used in the previous studies. 1.5 times the threshold for evoking plantar flexion of the toes and/or toe fanning.
Khan 2010	Bladder re-education, behavior management, pelvic floor exercises, strategies for timed and double voiding, intermittent catheterization techniques, use of prophylactic medication (cranberry capsules); and strict bowel program. A continence nurse on the ward reviewed the bladder program daily
Lucio 2010	30 slow pelvic floor muscle contractions and 3 min of fast contractions in supine position with assistance of a perineometer and were given orientation to repeat the same 30 slow contractions and 3 min of fast contractions, learned during the intervention, three times daily at home without assistance of any device, in different positions like sitting and standing
Lucio 2011	The training focused on improving pelvic floor muscle awareness and contraction strength, and the exercises were individualized according to the degree of pelvic floor weakness, the loss of proprioception and the patient's tolerance
Lucio 2014	All participants repeat 30 slow PFM contractions and 30 fast PFM contractions as instructed during the intervention, three times daily at home without the assistance of biofeedback and were advised to practice the exercises in different position such as in sitting, in standing where applicable, and, in particular, when urgency was present. The exercises were reviewed weekly. NMES treatment consisted of placing a pair of surface electrodes over the sacrum and inducing a current with a pulse width of 50 ms administered at a frequency of 2 Hz, and a stimulation time of 2 s with 60 s rest between stimuli for a period of 30 min TTNS: width of 200 $\mu$ s at a frequency of 10 Hz for 30 min

Lucio 2016	Patients perform resting 6 seconds, until 3 min had passed. Then they repeat 30 slow PFM contractions and fast PFM contractions 3 times daily at home without biofeedback assistance.
McClurg 2006	Contraction held for 3 sec and repeated three times. The participant practice endurance at home holding for 3 sec and relaxing for 6 sec, 3 times consecutively on each occasion; relaxation time was always double the contraction time. EMG biofeedback: pulse rate 40 Hz, pulse width 250 msec, with 5 sec on and 10 sec off NMES 10 Hz, 450 msec, 10 sec on and 3 sec off, at maximum-tolerated intensity
McClurg, Ashe 2008	EMG biofeedback: frequency of 2 Hz, a pulse width of 50 msec, with 2 sec of stimulation and 60 sec of no stimulation, with a ramp of 8 sec. This was introduced at clinic and then used at home with a gradual increase to a daily maximum of 30 min
McClurg, Lowe-Stronge 2008	holding time of 3 s, with 5 s rest, repeated five times, five times a day. This would have been gradually increased according to the feedback, to holding sub-maximally for 10 s, with a 5-s rest, 5 times, five times a day
McClurg 2009	A typical program commenced with a holding time of three seconds with five seconds' rest; this was repeated five times and done five times a day. This could be gradually increased according to the feedback to holding submaximally for 10 seconds with a five-second rest, repeated five times, five times a day
Rafii 2017	The patients were instructed to stop their flow of urine midstream for three seconds (but not to repeat this exercise too often). Then they were asked to lie in a supine position with their knees bent and to squeeze the same muscles (as they did to stop urination) while they were breathing gently through the mouth and keeping all other pelvic muscles relaxed. They could gradually do the exercises in sitting and standing positions. They start by holding the squeezes for three seconds and resting for five seconds. The goal was to increase the duration of each contraction to 10 seconds and to do 90 - 100 contractions a day (depending on each patient's ability and level of fatigue). The participants had to do the exercises three times a day (the timing was determined by the patients) for 12 consecutive weeks at home.

Vahtera 1997	EMG feedback: frequency of 2000 Hz and treatment frequencies of 5-10 Hz, 10-50 Hz, and 50 Hz (7 s pulse/25 s pause). A treatment session consisted of 10 min of each frequency followed by 3 min rest.
Zecca, Digesu, Robshaw, Puccini 2014	Electrical stimulation was applied by the unilateral insertion of a 34-gauge needle electrode at a 60-degree angle, approximately 5 cm cephalad to the medial malleolus and slightly posterior to the tibia. A PTNS surface electrode was placed on the ipsilateral calcaneus. 0.5-9 mA was selected using charge compensated 200 microsecond pulses with a pulse rate of 20 Hz based on each subject's foot/plantar motor and sensory responses
Zecca, Digesu, Robshaw, Sing 2014	Electrical stimulation was applied for 30 min once a week for 12 weeks, by unilateral insertion of a thin 34-gauge needle electrode at a 60° angle approximately 4–5 cm cephalad to the medial malleolus of the ankle, between the posterior margin of the tibia and the soleus muscle

Transcutaneous posterior tibial nerve stimulation TPTNS; Neuromuscular electrical stimulation NMES.

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