

Hypopressive Exercise for Pelvic Floor Rehabilitation in Women: A Critical Narrative Review of Current Evidence

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Abstract: ***Background:** Hypopressive exercise (HE), also described as abdominal hypopressive technique (AHT), is a breathing- and posture-based exercise approach proposed for pelvic floor rehabilitation. Its clinical use has expanded despite continuing uncertainty regarding its comparative effectiveness relative to pelvic floor muscle training (PFMT). **Objective:** To critically synthesize current evidence concerning the effects of HE on pelvic floor muscle function, pelvic organ prolapse (POP), urinary incontinence (UI), postpartum pelvic floor outcomes, abdominal muscle outcomes, and patient-reported outcomes, with particular attention to comparisons with PFMT and combined programmes. **Methods:** This critical narrative review was developed from an original academic presentation and updated through targeted literature verification using PubMed and publisher-indexed records through September 2026. Priority was given to randomized controlled trials, prospective comparative studies, and systematic reviews involving adult women. Because the underlying work did not use a prospectively registered systematic-review protocol, reproducible duplicate screening, formal risk-of-bias procedures across all studies, or meta-analysis, it is presented as a narrative review rather than a systematic review. **Results:** The evidence is heterogeneous. Randomized trials in POP have generally reported greater benefit from PFMT than HE for several pelvic-floor outcomes, and adding HE to PFMT has not consistently produced additional benefit. Other trials have reported improvement with HE compared with no intervention and similar improvements to PFMT for selected outcomes. A 2024 systematic review found that HE could improve pelvic floor strength, tone and symptoms, but effects were generally less than or similar to PFMT, with no additional benefit when combined with PFMT. Recent 2025–2026 studies add evidence of improved pelvic floor contractility and selected postpartum abdominal, body-image and pelvic-floor symptom outcomes, while a 2026 observational study found levator ani activation without a significant reduction in intra-abdominal pressure. **Conclusion:** Current evidence does not establish HE as superior to PFMT for pelvic floor rehabilitation. HE may have a complementary role in selected women, particularly when abdominal, postural, breathing, functional or preference-related goals are relevant. PFMT should remain a central component of evidence-based pelvic floor rehabilitation.*

Keywords: hypopressive exercise; abdominal hypopressive technique; pelvic floor muscle training; pelvic floor dysfunction; pelvic organ prolapse; urinary incontinence; postpartum rehabilitation.

Article Highlights

- Hypopressive exercise can produce measurable pelvic floor and abdominal responses, but physiological activation should not be equated with clinical superiority.
- Across POP-focused trials and reviews, PFMT generally provides equal or greater benefit for direct pelvic-floor outcomes.
- Adding hypopressive exercise to PFMT has not consistently demonstrated additional benefit for pelvic-floor muscle outcomes.
- Recent postpartum evidence suggests possible benefits for selected abdominal, body-appreciation and pelvic-floor symptom outcomes, although anatomical outcomes such as inter-rectus distance may not improve.
- Future trials should standardize hypopressive protocols, use clinically meaningful outcomes and include longer follow-up.

1. Introduction

Pelvic floor dysfunction encompasses conditions affecting pelvic floor muscle function and pelvic organ support, including urinary incontinence, pelvic organ prolapse, fecal incontinence and pelvic floor-related symptoms. Conservative rehabilitation commonly incorporates pelvic

floor muscle training (PFMT), which has an established role in improving pelvic floor muscle function and symptoms. Hypopressive exercise (HE), also termed abdominal hypopressive technique (AHT), is a postural and breathing-based exercise approach developed by Marcel Caufriez in the 1980s. The technique combines specific postures, breathing patterns and an abdominal manoeuvre intended to produce a characteristic hypopressive response. Proposed mechanisms include coordinated postural control, respiratory manoeuvres and recruitment of abdominal and pelvic floor musculature. However, a plausible physiological mechanism does not establish clinical superiority.

The original academic presentation underlying this manuscript addressed whether HE is effective for pelvic floor muscle rehabilitation and whether it could assist recovery from pelvic floor dysfunction. Since that presentation, additional randomized trials and systematic reviews have become available. The purpose of this updated review is therefore to critically examine the contemporary evidence and clarify where HE may fit within evidence-based pelvic floor rehabilitation.

2. Review Question and Objective

Review question: What is the current evidence regarding the effectiveness of hypopressive exercise for pelvic floor

rehabilitation in women, particularly when compared with or combined with pelvic floor muscle training?

Objective: To critically evaluate evidence concerning the effects of HE on pelvic floor muscle function, POP symptoms and severity, UI, quality of life, postpartum rehabilitation outcomes, abdominal muscle function and patient-reported outcomes.

3. Methods

3.1 Review design

This manuscript is a critical narrative review. It is an updated and reorganized version of the author's original academic presentation. It is not presented as a systematic review because the underlying work did not document a prospectively registered protocol, a fully reproducible database search, independent duplicate screening, formal risk-of-bias assessment across all included studies, or quantitative synthesis. The review structure was informed by established principles for transparent narrative reviews.

3.2 Literature identification and update

The original presentation identified Google Scholar, ResearchGate, PEDro and PubMed using terms including “hypopressive exercise,” “pelvic floor muscle training” and “pelvic floor dysfunctions.” For this manuscript, key references were verified against PubMed and publisher-indexed records, and targeted searches were used to identify contemporary evidence concerning HE, pelvic floor dysfunction, POP, UI, postpartum rehabilitation and PFMT. The literature update was performed through September 2026.

3.3 Eligibility focus

Priority was given to randomized controlled trials, prospective comparative studies and systematic reviews evaluating HE in adult women. Studies examining pelvic floor muscle activation or strength, POP, UI, quality of life, postpartum rehabilitation, abdominal muscle function or related physiological outcomes were considered relevant.

3.4 Data synthesis

Study characteristics and principal findings were narratively synthesized. Particular attention was given to: (1) HE versus PFMT, (2) HE added to PFMT versus PFMT alone, and (3) consistency of findings across direct pelvic-floor, symptom, abdominal and patient-reported outcomes. Statistical findings are reported when available in the verified source records.

3.5 Methodological limitations of the review process

Because this was a targeted narrative update rather than a prospectively designed systematic review, the literature search was not exhaustive and study selection was not performed independently by two reviewers. No pooled effect estimate was calculated. Accordingly, the conclusions

should be interpreted as a critical synthesis rather than a quantitative estimate of treatment effectiveness.

4. Physiological Rationale and Proposed Mechanisms

The proposed rationale for HE is based on coordinated breathing, postural control and activation of deep abdominal and pelvic musculature. The technique has been described as involving a specific respiratory manoeuvre together with postural alignment and abdominal wall changes.

Experimental work demonstrates that HE can activate the pelvic floor. Stüpp et al. reported pelvic floor muscle activation during AHT, while isolated pelvic floor contraction produced greater pelvic floor activation; AHT produced greater transversus abdominis activation than isolated pelvic floor contraction. These findings support a neuromuscular response but do not establish that AHT provides a superior strengthening stimulus.

Importantly, a 2026 observational study examined intra-abdominal pressure and levator ani electromyographic activity during HE in 36 women naïve to the technique. Levator ani activation was observed, but there was no significant reduction in intra-abdominal pressure and no meaningful association between pressure change and levator ani activation. This finding suggests that the commonly proposed explanation that clinical effects are primarily mediated by generalized pressure reduction should be interpreted cautiously.

5. Evidence from Clinical Studies

5.1 Pelvic organ prolapse

Resende et al. conducted an assessor-blinded randomized controlled trial in women with symptomatic untreated stage II POP, comparing PFMT with a hypopressive home programme. Both groups improved; however, PFMT produced better outcomes for several POP-related symptoms, including vaginal bulge/lump, lower abdominal heaviness or dragging, and stress urinary incontinence, as well as selected Prolapse Quality of Life domains. The authors concluded that PFMT was superior for the outcomes measured.

A separate randomized trial involving 58 women with stage II POP compared PFMT, HE combined with PFMT, and a control condition. Both active treatment groups improved pelvic floor muscle contraction, but PFMT alone was superior to the combined intervention for the reported pelvic-floor muscle outcome. Thus, the addition of HE did not demonstrate an additional benefit over PFMT.

Another randomized trial assessed levator ani cross-sectional area using transperineal ultrasonography. Both PFMT and HE groups demonstrated significant increases after treatment, whereas the control group did not. For this structural outcome, the two active interventions produced similar improvements.

These findings are consistent with later evidence syntheses indicating that PFMT generally performs better than HE alone for POP-related outcomes and that adding HE to PFMT has not demonstrated a consistent additional effect.

5.2 Pelvic floor dysfunction and urinary incontinence

Navarro-Brazález et al. conducted an assessor-blinded randomized controlled trial in women with pelvic floor dysfunction, comparing PFMT, HE and a combined programme. Ninety-four women completed the intervention and follow-up. All groups demonstrated improvements in symptoms, quality of life, pelvic floor muscle strength and basal tone, without statistically significant between-group differences in the principal outcomes. The findings suggest that HE may be clinically active but do not establish superiority over individualized PFMT.

Molina-Torres et al. evaluated an 8-week supervised HE programme in women with pelvic floor dysfunction and urinary incontinence symptoms. Compared with no intervention, the HE group demonstrated improvement in pelvic floor muscle strength and reductions in pelvic-floor-disorder and urinary-incontinence symptom measures. Because the comparator was inactive rather than PFMT, the study does not establish that HE is preferable to standard pelvic floor muscle training.

Other controlled and crossover investigations have reported short-term improvements in pelvic floor tone, urinary

symptoms, body image or well-being after structured AHT programmes. These findings support potential clinical effects but leave the comparative effectiveness question unresolved.

5.3 Postpartum rehabilitation

Juez et al. conducted a prospective cohort study of 105 primiparous women participating in either a two-month PFMT or AHT programme. Outcomes included three-dimensional transperineal ultrasound, manometry, dynamometry, urinary incontinence symptoms and satisfaction. Both groups improved in urinary incontinence symptoms. AHT was associated with higher satisfaction and a greater change in levator ani muscle thickness, although the observational design limits causal inference.

More recent evidence comes from a 2026 randomized trial in 44 postpartum women with diastasis recti abdominis. Participants were 45 days to 6 months postpartum and had an inter-recti distance of at least 20 mm at one point along the linea alba. A supervised 12-week hypopressive programme did not produce a significant between-group difference in inter-recti distance. However, the hypopressive group showed better performance on selected abdominal muscle tests, greater body appreciation and fewer pelvic floor dysfunction complaints than the inactive control group. This illustrates that symptom and functional outcomes may change even when an anatomical measure does not.

Table 1: Selected clinical evidence on hypopressive exercise

Study	Population/design	Comparator	Main findings	Interpretation
Stüpp et al., 2011 [4]	Women; experimental EMG study	AHT vs isolated PF contraction	Both activated pelvic floor; isolated PF contraction produced greater pelvic-floor activation; AHT produced greater transversus abdominis activation.	Neuromuscular activation does not establish superior strengthening.
Resende et al., 2019 [1]	Stage II POP; assessor-blinded RCT	PFMT vs HE	Both improved; PFMT was better for several POP symptoms and selected QoL outcomes.	Supports PFMT as the stronger evidence-based comparator for POP.
Navarro-Brazález et al., 2020 [6]	Pelvic floor dysfunction; RCT	PFMT vs HE vs combined	All groups improved; no significant principal between-group differences.	HE may be active, but superiority over PFMT was not shown.
Molina-Torres et al., 2023 [13]	Pelvic floor dysfunction/UI; RCT	HE vs no intervention	Improved pelvic floor strength and symptom measures after 8 weeks.	Shows activity versus no treatment; does not establish superiority to PFMT.
Katz & Barbosa, 2024 [10]	Adult women; systematic review of RCTs	HE with/without PFMT	HE improved selected strength, tone and symptoms; effects were less than or similar to PFMT; no added benefit with PFMT.	Overall evidence remains preliminary and heterogeneous.
Moreira et al., 2026 [14]	Postpartum DRA; RCT, n=44	HE vs no intervention	No significant change in inter-rectus distance; better abdominal function, body appreciation and pelvic-floor symptom scores.	Potential functional/symptom benefits without anatomical reduction.
Saraiva & McLean, 2026 [15]	36 women naïve to HE; observational study	HE conditions	Levator ani activation occurred without significant IAP reduction; IAP change was not associated with activation.	Pressure-reduction mechanism should be interpreted cautiously.

6. Evidence from Systematic Reviews

Ruiz de Viñaspre Hernández (2018) concluded that available evidence did not support recommending hypopressive abdominal gymnastics for pelvic floor strengthening during or outside the postpartum period and highlighted limitations in the underlying trials.

Jacomo et al. (2020) reviewed exercise regimens other than PFMT and concluded that hypopressive and other alternative exercise approaches did not demonstrate increased pelvic muscle strength when performed alone; PFMT remained the principal method for increasing pelvic muscle strength.

Bø et al. (2023) reviewed randomized trials of hypopressive and other exercise programmes for POP and reported no

additional effect from adding HE to PFMT and greater effectiveness of PFMT compared with HE alone.

Katz and Barbosa (2024) systematically reviewed randomized clinical trials in adult women and found that HE could improve strength, tone and symptoms of pelvic floor dysfunction, but effects were less than or similar to PFMT in the available comparisons. No additional benefit was found when HE was combined with PFMT. The authors emphasized preliminary evidence and heterogeneity of intervention protocols and follow-up.

Rodrigues et al. (2024) found that the evidence for HE in healthy women was limited and methodologically problematic, with possible effects on abdominal and pelvic floor function but insufficient evidence to recommend HE routinely in healthy populations.

Mitchell et al. (2024) reported a pooled comparison of PFMT and hypopressive breathing techniques for POP, with larger effects for PFMT on pelvic floor strength measures, while one quality-of-life measure showed a larger effect with hypopressive breathing. Differences in outcomes and interventions limit simple conclusions across domains.

7. Updated Evidence: 2025–2026

A 2025 assessor-blinded randomized controlled trial evaluated an 8-week AHT programme and reported improvement in pelvic floor muscle contractility. This adds evidence that a structured AHT intervention can influence a direct pelvic-floor outcome, although the finding does not by itself demonstrate superiority to PFMT.

A 2025 pilot study also compared PFMT, AHT and AHT combined with maximal voluntary pelvic floor contraction in women with urinary incontinence, indicating continued investigation into how AHT may be integrated with voluntary pelvic floor contraction.

In 2026, Moreira et al. reported that 12 weeks of hypopressive training did not significantly reduce inter-rectus distance in postpartum women with diastasis recti, but improvements were observed in abdominal muscle function, body appreciation and pelvic floor dysfunction complaints.

Also in 2026, Saraiva and McLean directly examined intra-abdominal pressure and levator ani activation during HE. Levator ani activation was observed, but no significant reduction in intra-abdominal pressure was demonstrated and pressure change was not associated with levator ani activation. These findings refine the proposed physiological rationale and support a cautious interpretation of the pressure-reduction hypothesis.

8. Critical Interpretation

The clinically important question is not simply whether HE can produce a measurable physiological or clinical effect. Current evidence indicates that it can. The more relevant question is whether those effects are superior to, equivalent to, or meaningfully additive to PFMT.

For POP and direct pelvic-floor strength outcomes, the evidence does not establish superiority of HE over PFMT. Several trials and reviews indicate that PFMT is more effective for specific pelvic-floor or POP-related outcomes, while combining HE with PFMT has generally not produced additional benefit for principal pelvic-floor outcomes.

The evidence is nevertheless not uniformly negative. Studies comparing HE with no intervention have reported improvements, and selected trials have found similar changes to PFMT for specific outcomes. Patient satisfaction, abdominal function, body appreciation and some symptom outcomes may respond differently from direct measures of pelvic-floor strength.

Intervention heterogeneity is a major limitation. Studies differ in duration, supervision, postures, respiratory instructions, use of voluntary pelvic floor contraction, frequency and outcome measurement. Consequently, the term “hypopressive exercise” represents a family of interventions rather than a single standardized treatment dose.

Many studies are also relatively small and have short follow-up. Long-term adherence, sustainability of effects, clinically meaningful change thresholds, adverse events and cost-effectiveness remain insufficiently studied. These issues are particularly relevant to postpartum women, whose recovery, symptom burden, breastfeeding demands, physical activity and individual goals vary substantially.

Finally, muscle activation during an exercise should not automatically be interpreted as clinical effectiveness. An exercise may activate a muscle without providing the same strengthening stimulus as targeted maximal or near-maximal contractions. Physiological plausibility should therefore be interpreted alongside patient-important clinical outcomes.

9. Clinical Implications

- PFMT should remain a central component of evidence-based conservative pelvic floor rehabilitation.
- HE should not be presented as proven superior to PFMT for pelvic floor muscle strengthening or POP management.
- HE may be considered as an adjunct or alternative exercise approach in selected women after individualized assessment, particularly when abdominal, postural, breathing, functional or patient-preference goals are relevant.
- When HE is used with PFMT, clinicians should not assume that the combination will automatically provide additional pelvic-floor muscle benefits.
- Treatment should be individualized according to diagnosis, symptoms, pelvic-floor muscle function, functional goals, patient preference, tolerance and relevant contraindications or precautions.
- Clinicians should communicate the uncertainty of the evidence and avoid presenting HE as a replacement for established PFMT without clinical justification.

10. Strengths and Limitations

The strength of this review is its integration of evidence from randomized trials, prospective comparative studies and systematic reviews, with specific attention to the clinically relevant comparison between HE and PFMT. The review also distinguishes physiological activation from demonstrated clinical effectiveness and incorporates evidence published through September 2026.

The principal limitation is methodological: this is a narrative critical review and not a systematic review. The literature update was targeted rather than exhaustive, study selection was not independently duplicated, and no formal risk-of-bias synthesis or meta-analysis was performed. Therefore, the findings should not be interpreted as pooled treatment effects or as a comprehensive systematic evidence synthesis.

11. Research Priorities

- Use standardized, clearly described hypopressive protocols, including posture, breathing manoeuvre, frequency, duration and supervision.
- Compare HE directly with adequately dosed and well-described PFMT rather than relying primarily on inactive controls.
- Report validated patient-important outcomes for UI, POP symptoms, quality of life and postpartum function.
- Use objective outcomes such as pelvic floor strength, ultrasound measures and, where appropriate, electromyography alongside symptom outcomes.
- Include longer follow-up to assess adherence, persistence of benefit and clinically meaningful change.
- Report adverse events and treatment acceptability systematically.
- Investigate whether specific subgroups of women derive clinically meaningful benefit from HE as an adjunct to individualized PFMT.

12. Conclusion

Current evidence indicates that hypopressive exercise can produce measurable pelvic-floor and abdominal responses in women, but it has not been demonstrated to be superior to pelvic floor muscle training for pelvic-floor muscle strengthening or pelvic organ prolapse rehabilitation. PFMT generally provides equal or greater benefit for direct pelvic-floor outcomes, whereas HE may improve selected symptoms, urinary outcomes, abdominal function, body appreciation and patient satisfaction in some populations. Combining HE with PFMT has not consistently produced additional benefit for principal pelvic-floor muscle outcomes. The most defensible interpretation of the current evidence is that HE may have a complementary role within individualized rehabilitation, but it should not routinely replace established PFMT without clinical justification. Further high-quality randomized trials using standardized protocols, clinically meaningful outcomes and longer follow-up are needed.

Declarations

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