• A randomised controlled trial of transabdominal ultrasound biofeedback for pelvic floor muscle training in older women with urinary incontinence
  
  MP Galea, S Tisseverasinghe & M Sherburn

• Coffee consumption and male urinary incontinence

  AH Lee, F Hirayama & HC Lee
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Reference: Sluser S, Consistency is the key for treating severe perineal dermatitis due to incontinence. Poster presented at the Clinical Symposium on Advances in Skin and Wound care (ASWC), Las Vegas, NV 2005 Oct.
Editorial

From gnosis to praxis

There may be fairies at the bottom of the garden. There is no evidence for it, but you can’t prove that there aren’t any, so shouldn’t we be agnostic with respect to fairies?


As clinicians how do we decide what to do? In a paper titled “The challenge of evidence in clinical medicine”, Mark Tonelli (Professor of Medicine in the Division of Pulmonary and Critical Care Medicine at the University of Washington Medicine Centre) argues that evidence-based medicine (EBM) has become too important an influence on decision making in clinical care and has undermined the importance of other kinds of clinical knowledge that lead to clinical practice such as pathophysiologic understanding and clinical experience. He states that the strengths of EBM are that well-designed clinical trials can control bias in evaluation of the value of specific interventions, distinguish the signal of what may be a relatively small treatment effect from the noise of individual variability, be subject to scrutiny and reproducibility, and be disseminated widely to the majority of clinicians. The weakness he outlines is that as clinicians we are almost invariably dealing with an individual human being rather than an aggregate so that there is a knowledge gap between clinical research and the care of the individual. He regards clinical trial evidence as advisory rather than prescriptive. Cohen and colleagues categorise a number of limitations of EBM, including the main weakness identified by Tonelli. These include over-reliance on empiricism as a basis for clinical practice, a narrow definition of evidence, lack of evidence for the efficacy of EBM, limited usefulness for individual patients, and interference with the autonomy of the relationship between the clinician and those cared for. Over-reliance on empiricism refers to overvaluing observations, the outputs of randomised controlled trials (RCTs) and related research methods, without the background of theory, and the underlying cybernetic relationship between theory and observation, each potentially modifying the other. A narrow definition of evidence refers to three points. These are that RCTs and meta-analyses of collections of RCTs have not been demonstrated to be more reliable that other research methods; that the questions addressed by RCTs are not suitable to small patient groups, questions that require subjective evaluation, qualitative methods, or naturalistic observations; and finally that the statistical methods of RCTs may obscure clinically relevant details. Cohen and colleagues state that the hypothesis that EBM leads to better care is not supported by evidence, namely there is little or no evidence that clinicians who explicitly practise EBM provide better health care than those who do not. Cohen and colleagues also cover the issue that individual patients may not be represented in clinical trials and finally that EBM may offer a spurious patina of respectability to control and limit the treatment options that may be relevant and acceptable to individual clinicians and those they are caring for. Duggal and Menkes argue for a concept of evidence-based practice (EBP). This model advocates integration of components of EBM: publication and dissemination of RCTs, accessible evidence bases, critical appraisal, and clinical guidelines; with practice-based experience, elements of which are: patients’ experiences and preferences, clinician experience, informal networks of peer-approved practice (so-called “mindlines”), expert opinion, and peer review and support. A useful discussion of the “clinical-experience critique” of EBM is given in an accompanying commentary on Tonelli’s paper. The commentary makes the point similar to that of Cohen and colleagues namely that there is also an absence of evidence that clinicians who focus largely on clinical experience and pathophysiology achieve better outcomes for their patients. As the commentary states, this is one motivation for clinical research, the organised analysis of many clinical encounters. A further point is the comment that if studies of populations, or perhaps more correctly samples of populations, are not able to be applied in a straightforward way to an individual, how can the process of applying memories of previous patients be more straightforward? An interesting paper about clinical practice discusses reasons why physicians may decide to treat or not treat particular patients. The paper used what might be described as a semi-systematic review using...
search terms such as “physician motivation”, “practice patterns” and a number of other phrases with a similar meaning, and then an unspecified, but presumably content-based method, to list reasons why physicians chose to treat or not to treat patients. The interest in this paper is that not one of the 26 reasons for treating or not treating refers to evidence!

As clinicians dealing with continence, we deal with human beings who face challenges to their autonomy, sense of worth, and quality of life. We work in a complex environment with demands mediated by societal expectations, consumerism, economic limitations, and our professional imperatives. The evidence base that supports practice has limitations, particularly for vulnerable populations, such as those with multiple comorbid conditions, and for those disorders where our range of treatment options may be limited. The evidence base is also limited to the extent that some current treatment options are not overwhelmingly effective, carry potential risks of harm, or are expensive either for the individual or for society. This is where our journal has an important role to play in informing continence practice in Australia and New Zealand. The journal provides a venue for sharing expert opinion, for dissemination of a variety of types of evidence, and finally as a forum of providing peer support in concert with the Continence Foundation of Australia and the New Zealand Continence Association, a powerful network for improving the lived experience of our patients and encouraging the integration of knowledge with practice.

References
Peer review

A randomised controlled trial of transabdominal ultrasound biofeedback for pelvic floor muscle training in older women with urinary incontinence

Abstract

To investigate the effectiveness of transabdominal ultrasound as biofeedback for pelvic floor muscle training in older women with urinary incontinence, a randomised controlled trial was conducted in an outpatient setting in a tertiary hospital. In the trial, 22 women aged ≥60 years, with symptoms of urinary incontinence, were assigned to 10 weeks of conventional physiotherapy using either vaginal palpation or ultrasound biofeedback and followed up at three months. There were no significant differences between the groups on any outcome measures: 24-hour pad weight test; number of incontinence episodes per week; quality of life. The ultrasound group had a significant reduction in the number of incontinence episodes per week. Visual feedback using transabdominal ultrasound imaging of the pelvic floor appears to be effective in teaching pelvic floor muscle contractions to older women with urinary incontinence. Further investigation of this technique is warranted.

Keywords: Transabdominal ultrasound, pelvic floor muscle training, urinary incontinence, elderly women, randomised controlled trial.

Introduction

Urinary incontinence (UI) affects adults of all ages, with an especially high prevalence among elderly women. Pelvic floor muscle (PFM) re-education by physiotherapists is effective in reducing leakage and improving quality of life. Critical factors in training are awareness of the muscles of the pelvic floor and knowledge about correct contraction of these muscles. Feedback is an essential component of teaching any motor skill with verbal and tactile feedback during digital vaginal palpation remaining the standard clinical methods for teaching PFM contraction, together with clinical observation of an inward lift of the perineum. Since it has been reported that a large proportion of women perform PFM contractions incorrectly, there may be a place for the use of biofeedback as a means of providing more accurate feedback when teaching women how to contract the PFMs. Transabdominal ultrasound (US) is a relatively new and non-invasive technique used by physiotherapists to assess the “lift” of the pelvic floor by providing direct visualisation of a PFM contraction.

This randomised, controlled, assessor-blinded trial was an exploratory study conducted to compare the safety and effectiveness of physiotherapy intervention using transabdominal US (visual feedback) with conventional physiotherapy using initial vaginal palpation (tactile feedback) and verbal feedback for retraining of PFM in women over 60 years of age with UI.

Methods

The study was approved by the Human Research Ethics Committees at Austin Health and the University of Melbourne, and written informed consent was obtained.

Healthy women living in the community, aged between 60 and 85 years with symptoms of either stress and/or urge UI were invited to participate. All participants had a medical assessment at a continence clinic. Exclusion criteria included:
faecal loading, known neurological symptoms, or currently receiving physiotherapy intervention for UI.

Participants were randomly assigned to either pelvic floor muscle training (PFMT) with vaginal palpation, or PFMT with transabdominal US, using a computer-generated random numbers list. Allocation was controlled by an investigator (MG) independent of the recruitment process, and concealed. Figure 1 shows the flow of participants through the study.

**Intervention**

The PFMT protocol used has been previously described. All participants were examined in a crook-lying position with their head supported with pillows. The standard care treatment (SC) group underwent a vaginal examination at the first assessment to assess their PFM function and strength and to provide instruction. A correct PFM contraction was assessed as a squeeze around the pelvic opening and an inward lift. At subsequent visits, the women received no further vaginal examinations and verbal feedback about PFM contraction was provided based on clinical observation.

Participants in the visual feedback (VF) group did not have a vaginal examination at any time. The ‘lift’ aspect of the PFM contraction was assessed by observing movement of the posterior bladder wall on transabdominal US. Participants were positioned in a crook-lying position with their head supported.

<table>
<thead>
<tr>
<th>Table 1: Baseline demographic characteristics of the two groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic information</td>
</tr>
<tr>
<td>Age (years) mean (SD)</td>
</tr>
<tr>
<td>BMI (kg/m²) mean (SD)</td>
</tr>
<tr>
<td>Parity (number) [range]</td>
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<tr>
<td>Self-reported symptoms (%)</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Cystitis</td>
</tr>
<tr>
<td>Voiding dysfunction</td>
</tr>
<tr>
<td>Exercised regularly</td>
</tr>
<tr>
<td>Gynaecological surgery</td>
</tr>
</tbody>
</table>

SC=standard care; VF=visual feedback
with pillows. The US monitor was positioned so that it could be viewed by the participant for feedback during training. Visual feedback about PFM contractions was provided at each visit, 100% of the time at the first visit and reducing to 0% by the end of the fourth visit.

**Assessment**

An independent, experienced, women’s health physiotherapist, blinded to group allocation, conducted the assessments, which occurred at baseline (T1), immediately post-intervention at 10 weeks (T2) and at three months post-intervention follow-up (T3). All participants completed an initial questionnaire providing demographic information (date of birth, height, weight, parity), as well as history of constipation, cystitis, voiding dysfunction, urogynaecological surgery and amount of regular exercise undertaken.

**Primary outcome measures**

Participants wore pad(s) for their normal activities over the 24-hour period immediately prior to each assessment, changing pads when necessary\(^9\). When changed, pads were immediately placed in sealed plastic bags, stored in a cool dark place, and weighed by the blinded assessor.

Participants also recorded the number of leakage episodes they had during the seven days prior to each of the three assessments\(^11\). They recorded the amount of leakage (damp, wet, flood) and the provoking factor (laugh, sneeze, movement, exercise, urge).

**Secondary outcome measures**

The Kings Health Questionnaire is specific to bladder function and is a reliable and valid tool in the female adult population\(^12\).

**Table 2: Individual data for participants in both groups**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Pad weight (g)</th>
<th>Leakage episodes (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>Post-</td>
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<tr>
<td></td>
<td></td>
<td>intervention</td>
<td>follow-up</td>
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<tr>
<td><strong>SC participants</strong></td>
<td></td>
<td>SC participants</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>773</td>
<td>124</td>
<td>102</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>0.8</td>
<td>0.2</td>
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<tr>
<td>3</td>
<td>0.2</td>
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<tr>
<td>4</td>
<td>20.3</td>
<td>0.8</td>
<td>4.2</td>
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<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>0</td>
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<tr>
<td>8</td>
<td>11.5</td>
<td>0.6</td>
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<tr>
<td>9</td>
<td>0.3</td>
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<tr>
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<td>0.9</td>
<td>5.8</td>
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<tr>
<td><strong>VF participants</strong></td>
<td></td>
<td>VF participants</td>
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<td>0</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>0.2</td>
<td>0.9</td>
</tr>
</tbody>
</table>

SC=standard care; VF=visual feedback
This questionnaire was completed at baseline and at three months post-intervention. Participants recorded the number of PFM exercises, performed daily, in a diary from the beginning of the intervention till the three months post-intervention follow-up. At the post-intervention follow-up, three months after the start of the intervention, each participant completed a questionnaire to assess adherence with treatment advice and the intensity at which home exercises were performed. This was measured using a visual analogue scale. Participants were asked to report in the questionnaire any adverse effects, or whether they had received any other continence physiotherapy treatment during the study period.

**Sample size**

No formal sample size calculation was performed as this was an exploratory pilot study.

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**Table 3: Comparisons of groups over time**

<table>
<thead>
<tr>
<th></th>
<th>Standard Care (n=11)</th>
<th>Visual Feedback (n=11)</th>
<th>p value #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pad weight (gm): median (IQR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>2.1 (11.3)</td>
<td>6 (54)</td>
<td>0.488</td>
</tr>
<tr>
<td>Post-intervention</td>
<td>0.9 (12)</td>
<td>4.8 (47.3)</td>
<td>0.509</td>
</tr>
<tr>
<td>3-month follow-up</td>
<td>0.2 (4.2)</td>
<td>0 (4.8)</td>
<td>0.428</td>
</tr>
<tr>
<td>Leakage episodes (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>2 (5)</td>
<td>8 (8)</td>
<td>0.023</td>
</tr>
<tr>
<td>Post-intervention</td>
<td>2 (7)</td>
<td>2 (4)</td>
<td>0.664</td>
</tr>
<tr>
<td>3-month follow-up</td>
<td>2 (3)</td>
<td>3 (5)</td>
<td>0.868</td>
</tr>
</tbody>
</table>

# Between groups comparison Mann-Whitney U test

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Statistical analyses
As several of the variables were not normally distributed, pairwise comparisons between the two groups were made using the Mann Whitney U test, Wilcoxon signed rank test and Friedman's test. As this was an exploratory study, no adjustments were made for multiple comparisons. Fisher’s Exact test was used to compare descriptive data. The statistical software program used was SPSS 13 (SPSS Inc, Chicago, IL).

Results
Twenty-three participants, mean age 73.5 (6.9) years, range 61–86 years, were enrolled and all completed the study. Fifteen participants complained of urge, two of stress incontinence and six had mixed UI. Eleven were randomised to the SC group and 12 into the VF group. Only 22 participants were included in the data analyses as one participant from the VF group was extremely wet in terms of mean grams of urine loss on the 24-hour pad weigh at each assessment (extreme outlier) and was, therefore, excluded.

There were no significant differences between the two groups at baseline for age, body mass index (BMI), or parity. The groups were comparable in the number of participants who reported regular problems with constipation, cystitis, voiding dysfunction, those who exercised regularly or had previously undergone gynaecological surgery.

The two groups were not significantly different at baseline with respect to median grams of urine loss measured by the 24-hour pad weight test (p=0.488). The VF group had a significantly greater median number of leakage episodes reported in the leakage episode diary (p=0.023).

There were no significant differences within or between groups over time except for a significant reduction in leakage episodes from baseline (T1) to follow-up (T3) in the VF group (p=0.002, Wilcoxon signed rank test) (Table 3).

There were no significant differences in any domain of the King’s Health Questionnaire between the groups at baseline (T1), nor at the three-month post-intervention follow-up (T3) (Table 4).

The two groups were not significantly different with respect to adherence to the home exercise routine (SC 63.4%; VF 76.8%, p=0.28), self-reported application of home advice (mean SC 7.2; VF 8.5, p=0.50), or in-home PFM exercise intensity (mean SC 8.0; VF 9.4, p=0.10). No adverse events were reported from either group and no participant received any other continence physiotherapy treatment during the study period.

Discussion
Vaginal palpation has been recommended as the gold standard for assessing and providing feedback about PFM contraction however, in this study we have shown that transabdominal US imaging could be an effective form of feedback for PFM training.

It has been reported that 50% of women do not know how to contract the pelvic floor after brief verbal instruction. Learning how to perform a correct contraction of the PFMs is critical to the success of PFM training, and physiotherapists use various methods to give their patients the idea of PFM contraction. The initial stage of learning usually involves trial and error, with variable performance. Knowledge of Results (KR) is the feedback about the success or otherwise of a movement that can serve as a basis for rectifying incorrect contractions on future attempts so that more effective performance is achieved with practice. In standard clinical practice, KR is usually provided by the physiotherapist through verbal and/or tactile feedback.

During this initial phase, associations are formed between the sensations of movement and the voluntary motor command, and so feedback from a skilled practitioner is essential. Learning involves the establishment of an internal model representing a matching between perceived sensory and motor information. With practice and strengthening of the internal model, accuracy improves, feedback becomes less important, and movements become more automatic.

Association of visual cues with motor responses has been shown to activate a distributed cortical network, involving connections between visual association areas and the prefrontal cortex that is more strongly activated during early learning. Visuomotor skill training has been shown to be associated with changes in the corticospinal drive to spinal motor neurons. Thus, linking the visualisation of the movement of the pelvic floor with attempts at contracting the PFM may improve descending drive to the PFM, and strengthen the internal model of PFM function.

Both vaginal palpation and US imaging provide feedback as to whether the PFM is contracting correctly or incorrectly. Women with poor PFM awareness, or who are unable to contract these muscles, may have difficulty responding to tactile feedback by vaginal palpation because of possible impairment of the sensory pathways from the PFM. Moreover, this method of teaching PFM contraction is not possible in those for whom vaginal palpation is contraindicated, for example, children, older persons and women with vaginal pain.

Both groups received the same number of physiotherapy visits, and PFMT. The only difference was the relative frequency and the type of feedback given to the two groups. The VF group received visual feedback at 100% of the time at their first visit and this was reduced to 0% by the end of their last visit. The SC group received 100% tactile feedback at their first visit with the physiotherapist. Palpation was not performed at subsequent visits according to the standard clinical practice as many women preferred not to have this internal examination but had verbal feedback based on clinical observation. The non-
### Table 4: Scores on Kings Health Questionnaire

<table>
<thead>
<tr>
<th>Domain</th>
<th>SC participants baseline</th>
<th>VF participants baseline</th>
<th>SC participants follow-up</th>
<th>VF participants follow-up</th>
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<tr>
<td>Sleep/energy</td>
<td>0</td>
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<tr>
<td>Emotional</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Physical limitation</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Social limitations</td>
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<tr>
<td>Emotions</td>
<td>0</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Severity measures</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

SC=standard care; VF=visual feedback
invasive transabdominal US, on the other hand, was completely acceptable to participants during all four visits. According to “feedback as guidance” view there are two important factors in relative frequency manipulations of feedback. Low relative frequency of KR has detrimental effects in that the subjects do not have enough information to achieve a correct PFM contraction on which to base the next movement. However, reduced KR tends to prevent reliance on visual or tactile KR and forces participants to process internal feedback, leading to improved internal representation of the movement and, therefore, the ability for independent performance. In our study, the VF group had a high relative frequency of feedback compared to the SC group.

The VF group reported a significant reduction in the median number of leakage episodes from nine at baseline to four per week at the three-month post-intervention follow-up. Within the SC group, the median number of leakage episodes was two at baseline and remained at two throughout the study and follow-up period. It is possible that the increased frequency of feedback in the VF group contributed to lower number of accidents reported per week at follow-up. The SC group did not show a reduction in leakage episodes. One explanation is that the tactile feedback received only during the first visit may have provided insufficient information on how to achieve the proper movement coordination pattern, and, therefore, information to continue practising. The women in the SC group did not consent to further vaginal palpation after the first visit. On the other hand, the VF group had steadily reducing feedback on each occasion, sufficient to promote learning but gradually reducing to ensure that participants did not become too dependent on this. This group was able to learn with visual feedback by seeing the elevation/lift aspects of the PFM contraction and, with practice, were able to adapt the elevation/lift of PFM function movement pattern to demands such as coughing, and thus effectively transfer this skill into everyday life to reduce the number of leakage episodes.

A limitation of transabdominal US is the lack of a fixed bony landmark for reference for measurement the PFM displacement. However, this is not an issue when using US as biofeedback during PFMT training, as it has been shown that an anterocephal displacement of the pelvic floor fascia observed on US indicates a PFM contraction.

This study was not designed as an equivalence study, and so the findings, showing no statistically significant differences between the groups, do not imply that the two interventions are similarly effective. In view of the wide variance in the cohort on the outcome measures, the study was underpowered to detect small differences between the groups. The results from this study provide a sound basis for the design of an equivalence study investigating the use of visual feedback on the effectiveness of PFMT. The application of visual feedback using US may be most useful where a vaginal examination is considered inappropriate, such as for children, women with vaginal pain, victims of sexual abuse, women with prolapse, adolescents and older women with vaginal atrophy. Further investigation of this technique is warranted.

References

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Peer review

Coffee consumption and male urinary incontinence

Abstract

To investigate whether coffee consumption is associated with urinary incontinence in men, a total of 725 men aged 40–75 years were recruited from the community in central and southern Japan. A validated food frequency questionnaire was administered face-to-face to obtain information on dietary intake and habitual coffee consumption. Urinary incontinence status was ascertained using the International Consultation on Incontinence Questionnaire — Short Form. Among the 710 eligible participants the mean age was 62.5 years. Sixty-two men (8.7%) experienced urine leakage for a mean (SD) of 2.6 (1.8) years. The prevalence of coffee drinking was 48/59 (81.4%) in those with urinary incontinence, which was slightly higher than those without urinary incontinence 497/645 (77.1%). Relative to non-drinkers, the adjusted odds ratios (95% confidence interval) of urinary incontinence were 1.99 (0.68 to 5.87) for drinking more than 350 ml and 1.66 (0.71 to 3.91) for drinking two or more cups daily. Thus, the point estimates suggest an increased risk of urinary incontinence in relation to the quantity and frequency of coffee intake but this was not statistically significant. We found no evidence of an association between habitual coffee consumption and urinary incontinence in middle-aged and older Japanese men. Further studies are required to examine the association of coffee drinking with urinary incontinence in men and the potential to improve continence by changing coffee consumption.

Keywords: Association, coffee, older men, risk factor, urinary incontinence.

Introduction

Urinary incontinence (UI) is a common lower urinary tract symptom that affects the lifestyle of older people. The International Continence Society defines the symptom of UI as “The complaint of any involuntary leakage of urine”. Urine leakage occurs when intravesical pressure exceeds urethral closure pressure in the absence of a detrusor contraction, or due to bladder neck hyper-mobility or poor urethral closure pressure. The prevalence of UI is known to be higher for women and increases with age, obesity and tobacco smoking. The development of lower urinary tract symptoms such as UI can be affected by certain beverages. A prospective cohort study of men in the United Kingdom found significant negative association between beer intake at baseline and subsequent onset of overactive bladder, with reduced risk at all levels of intake compared with those who seldom or never drank beer. A longitudinal study from Norway observed that tea drinking could elevate the risk of female UI, whereas a cross-sectional study suggested an inverse association between UI and habitual green tea consumption in middle-aged and older women. Coffee may also play a role in the aetiology of UI but evidence of this relationship remains inconsistent. A recent population-based study in Sweden reported an overall lower risk of UI among women with a high coffee intake when compared to non-drinkers. Nevertheless, a reduction in coffee consumption is still a widely adopted treatment strategy in women with UI.

We have previously reported a study that examined total caffeine intake (mg/day) from several dietary sources (coffee, black tea, green tea, oolong tea, soda and chocolate) which found that the role of caffeine intake in UI prevention remains unclear for both men and women. Female UI has a larger evidence base than male UI. The present study aims to estimate the association between habitual coffee consumption and UI among middle-aged and older, community-dwelling Japanese men. If a positive association exists between habitual coffee consumption...
Information on habitual food and beverage consumption was obtained using a validated and reliable food frequency questionnaire developed by the Japan Epidemiological Association. The frequency of food intake was classified by nine categories ranging from “almost never” to “seven or more times per day”. Standard portion size consumed per meal was specified for each item, with amount expressed as small (50% smaller), medium (standard) and large (50% larger) and quantified in terms of grams per day. Utensils and photographs of foods were shown to clarify size and amount consumed. For each beverage type such as coffee, participants were asked to report the frequency of drinking in nine levels from “almost never” to “10 or more cups per day”. Quantity of intake was calculated by multiplying the cup size used (80 ml, 140 ml or 200 ml) by frequency of drinking per day. The reference recall for food and beverage consumption variables was set at five years before interview because estimation beyond five years would be difficult.

The final part of the structured questionnaire collected information on demographic and lifestyle characteristics such as age, weight, height, marital status, retirement status and tobacco smoking, as well as health conditions (hypertension, ischaemic stroke, diabetes mellitus, depression and cancer). On average, each interview took about 45 minutes to complete.

### Statistical analysis

For each participant, daily fluid intake (ml) was estimated by summing the amounts from all beverages including water and alcoholic drinks. Energy intake of a food or beverage item was calculated by multiplying the quantity consumed per day by its energy content obtained from the Japanese food composition tables. Daily total energy intake (kcal) was then derived by summing the energy intakes across individual items consumed.

Participants with UI were first identified on the basis of positive outcomes to the ICIQ-SF questions. After applying descriptive statistics to summarise sample characteristics by UI status, comparisons between the two groups were made using chi-square and t-tests. Unconditional logistic regression analyses were then performed to determine the association between coffee consumption and the prevalence of UI. To assess the effect of coffee exposure, separate analyses were undertaken for drinking status, quantity and frequency of intake. Both crude and adjusted odds ratios (OR) were obtained as estimates of relative risk, the latter accounted for the effects of age, body mass index (BMI), daily fluid intake, smoking status (non-smoker; smoker), alcohol drinking status (yes; no), presence of health condition (yes; no) and total energy intake. These variables were considered potential confounders from the literature. All statistical analyses were performed using the SPSS package version 18.
Results

The 710 participants had a mean (SD) age of 62.5 (7.7) years and mean (SD) BMI 23.0 (3.1) kg/m². Most of them were married (625/710, 88%) and not yet retired (464/710, 65.4%). About half of the participants (334/710, 47%) had a health condition other than UI, 189/710 (26.6%) were current smokers, and the majority (503/710, 70.8%) consumed alcohol on at least a monthly basis. According to the ICIQ-SF, the prevalence of UI was 62/710 (8.7%). Urine leakage among the 62 men who reported UI was typically “a small amount” (53, 85.5%) and occurred once a week or less often (38, 61.3%). The mean (SD) ICIQ score was 5.7 (2.9). Only a few considered the condition to greatly interfere with their daily life. They experienced urine leakage for a mean (SD) of 2.6 (1.8) years. Only three participants consulted their physician about the UI problem.

Table 1 presents the characteristics of participants by UI status. Men with UI were a mean of three years older than those without UI and were less likely to drink alcoholic beverages. The prevalence of coffee drinking and daily coffee intake were slightly higher in men with UI than those without UI. There were no statistically significant differences between those with and without UI in terms of other demographic and lifestyle characteristics.

Table 2 shows the results of logistic regression analyses for coffee consumption. There was a positive point estimate for the association of UI and coffee drinking. Relative to non-drinkers, the adjusted odds ratios (95% confidence interval) for UI were 1.99 (0.68 to 5.87) for drinking more than 350 ml per day and 1.66 (0.71 to 3.91) for drinking two or more cups daily. Thus neither of these associations were statistically significant.

Discussion

This study investigated the relationship between UI and coffee drinking in middle-aged and older Japanese men. Habitual coffee consumption, with information on both frequency and quantity of intake, was measured using a validated instrument. The prevalence of UI was 8.7%, which is comparable with previous reports for the Japanese male population16,17. Although

### Table 1: Characteristics of participants by UI status (n=710 except where indicated)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>UI</th>
<th>Without UI</th>
<th>Both</th>
<th>P a</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (%)</td>
<td>62 (8.7%)</td>
<td>648 (91.3%)</td>
<td>710 (100%)</td>
<td></td>
</tr>
<tr>
<td>Mean (SD) age (years) b</td>
<td>65.1 (7.2)</td>
<td>62.2 (7.7)</td>
<td>62.5 (7.7)</td>
<td>0.005</td>
</tr>
<tr>
<td>Mean (SD) BMI (kg/m²) b</td>
<td>23.0 (3.9)</td>
<td>23.0 (3.1)</td>
<td>23.0 (3.1)</td>
<td>0.95</td>
</tr>
<tr>
<td>Married b</td>
<td>48 (82.8%)</td>
<td>577 (89.2%)</td>
<td>625 (88.0%)</td>
<td>0.14</td>
</tr>
<tr>
<td>Retired b</td>
<td>25 (43.9%)</td>
<td>221 (34.2%)</td>
<td>246 (34.6%)</td>
<td>0.14</td>
</tr>
<tr>
<td>Current smoker b</td>
<td>18 (29.5%)</td>
<td>171 (26.4%)</td>
<td>189 (26.6%)</td>
<td>0.60</td>
</tr>
<tr>
<td>Alcohol drinker b</td>
<td>37 (59.7%)</td>
<td>466 (72.1%)</td>
<td>503 (70.8%)</td>
<td>0.041</td>
</tr>
<tr>
<td>Coffee drinker b</td>
<td>48 (81.4%)</td>
<td>497 (77.1%)</td>
<td>545 (76.8%)</td>
<td>0.45</td>
</tr>
<tr>
<td>Presence of health condition b</td>
<td>31 (50%)</td>
<td>303 (46.8%)</td>
<td>334 (47.0%)</td>
<td>0.63</td>
</tr>
<tr>
<td>Mean (SD) fluid intake (ml/day)</td>
<td>1582.0 (1151.3)</td>
<td>1448.1 (917.8)</td>
<td>1459.8 (940.3)</td>
<td>0.38</td>
</tr>
<tr>
<td>Mean (SD) energy intake (kcal/day)</td>
<td>1175.7 (424.0)</td>
<td>1196.2 (492.5)</td>
<td>1194.4 (486.8)</td>
<td>0.75</td>
</tr>
<tr>
<td>Mean (SD) coffee intake (ml/day)</td>
<td>231.8 (266.6)</td>
<td>219.3 (230.8)</td>
<td>220.4 (234.0)</td>
<td>0.69</td>
</tr>
</tbody>
</table>

a based on chi-square (for categorical variables) or t-test (for continuous variables)
b missing data present
a few participants with UI perceived the condition as interfering with daily life, the low number seeking help is of concern. It is possible that the older men were either embarrassed or unaware that the condition is treatable. Education and regular assessment for lower urinary tract symptoms may be needed as people become older.

There was a small positive association between coffee intake and UI risk, although this did not reach statistical significance. The wide confidence interval for the association means that there could still be an association of coffee intake with UI but we lacked statistical power to rule out a moderate but still potentially important association. Coffee intake may be associated with UI because of the diuretic effect of caffeine contained in coffee. Caffeine intake can lead to a rise in detrusor pressure upon bladder filling and detrusor overactivity in conjunction with a diuretic effect, especially when a large amount of caffeine is ingested. Another factor that could contribute to our failure to show an association may be the apparently low coffee consumption by the older Japanese. The mean coffee intake was less than 250 ml per day. Our previous study also found little adverse effect on male UI due to total caffeine intake, with the odds ratio exceeding one for the mid-level of intake but less than one for the high level of intake. In another study, no statistically significant association was found between coffee consumption and female UI among older Japanese women.

It is possible that some men who develop lower urinary tract symptoms may restrict their fluid intake to reduce urine leakage. To reduce reverse causation, the reference period for coffee exposure was set at five years before interview and the mean duration of UI symptoms among the 62 men with UI was 2.6 years. Similar levels of daily fluid intake were found between men with and without UI, while none of the participants reported any change in coffee drinking habit within the past five years.

Several limitations of this study should be considered. The retrospective cross-sectional study design is a major limitation because these designs are not as robust to demonstrate a causal effect as other designs, such as controlled clinical trials. However, controlled clinical trials of caffeine or coffee with an outcome of UI may be difficult to perform. Classification of UI status was based on self-report via the ICIQ-SF rather than objective measures of urine loss, and seasonal alterations were not accounted for. Nevertheless, it is now recognised that the use of psychometrically robust self-completion questionnaires is a valid approach for assessing UI. The ICIQ-SF has good measurement properties and encompasses all aspects of incontinence. Although recall bias may be present, face-to-face interviews were conducted to help the recall of food and beverage consumption and to avoid misinterpretation of the questions. Moreover, the data collection was conducted by one...
Table 2: Association of UI and coffee consumption by Japanese older men expressed as unadjusted and adjusted odds ratios (OR)

<table>
<thead>
<tr>
<th>Coffee consumption</th>
<th>N(%)</th>
<th>Odds ratio (95%CI)</th>
<th>Crude OR</th>
<th>Adjusted OR b</th>
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<tr>
<td></td>
<td>UI a</td>
<td>Without UI a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking coffee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>(18.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>148</td>
<td>(22.9)</td>
<td>1.30</td>
<td>(0.66 to 2.57)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.68</td>
<td>(0.76 to 3.70)</td>
</tr>
<tr>
<td>Yes</td>
<td>48</td>
<td>(81.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>497</td>
<td>(77.1)</td>
<td></td>
<td></td>
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<tr>
<td>Quantity of intake (ml/day)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>11</td>
<td>(18.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>148</td>
<td>(22.9)</td>
<td>1.25</td>
<td>(0.63 to 2.50)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.64</td>
<td>(0.74 to 3.65)</td>
</tr>
<tr>
<td>&gt; 0 to 350</td>
<td>40</td>
<td>(67.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>430</td>
<td>(66.7)</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>&gt; 350</td>
<td>8</td>
<td>(13.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>(10.4)</td>
<td>1.61</td>
<td>(0.62 to 4.18)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>(0.68 to 5.87)</td>
</tr>
<tr>
<td>Frequency of intake</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>11</td>
<td>(18.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>148</td>
<td>(22.9)</td>
<td>1.31</td>
<td>(0.63 to 2.76)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.69</td>
<td>(0.73 to 3.94)</td>
</tr>
<tr>
<td>1 cup/week to 1 cup/day</td>
<td>24</td>
<td>(40.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>246</td>
<td>(38.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 2–3 cups/day</td>
<td>24</td>
<td>(40.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>251</td>
<td>(38.9)</td>
<td>1.29</td>
<td>(0.61 to 2.70)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.66</td>
<td>(0.71 to 3.91)</td>
</tr>
</tbody>
</table>

* for overall effect of the three level variable

a missing data present for six men

b adjusted for age, BMI, smoking status (non-smoker, smoker), alcohol drinking (yes, no), presence of health condition (yes, no),
daily fluid intake and total energy intake.

Conclusion

The present study found no evidence of an association between UI and habitual coffee consumption in middle-aged and older Japanese men. We suggest that because of low habitual coffee consumption in our sample and a relatively low prevalence of UI that this finding is preliminary and further replications in other countries are needed. At present there is insufficient evidence to recommend a reduction in coffee consumption for older Japanese men as a preventive or treatment strategy for UI.

References


Australian news

22nd National Conference on Incontinence

The 22nd National Conference on Incontinence will be held on 23–26 October 2013 at the Crown Conference Centre in Perth, WA.

The call for abstracts for this year’s conference is now out and closes on Monday 10 June at 9 am. The registration brochure will be available in early July and we expect to have a preliminary program on the website by early June.

We remind you that accommodation in Perth can, at times, be limited and even expensive if not booked well in advance. So if you are considering attending the conference, we encourage you to book early to ensure your requirements are met. So save the dates, 23–26 October 2013, and come and join us in Perth for the 2013 conference.


National Conference on Incontinence Scholarships Program

The scholarship program is open to Continence Foundation of Australia (CFA) members working in rural and remote areas. Applications for the 2013 program are now open. The scholarship covers the full cost of attending the Perth 2013 Conference and includes registration, accommodation and travel.

To view the guidelines and apply, visit www.continence.org.au/scholarship-programs or email scholarship@continence.org.au

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The CFA is pleased to announce the winners of the eight Vocational Graduate Certificate in Continence Promotion and Management Scholarships. Developed by The Benchmarque Group in partnership with the CFA, the Vocational Graduate Certificate is designed to provide participants with the skills and knowledge to assess and manage continence care of individuals and groups in a variety of settings.

Congratulations to:
- Clair George — Tasmania
- Joanne Kamphuis — Queensland
- Amber Louison-Suwal — Victoria
- Stella Millican — Western Australia
- Robyn Mitchell-Porteous — South Australia
- Nuraini Ratnawati — Northern Territory
- Michelle Roberts — Queensland
- Catherine Scott — Victoria

New continence management service for children with a disability in WA

In WA, a new continence management service is being funded by the Disability Services Commission for children with a disability aged 3–15 years. The service will be provided by Therapy Focus, the largest private provider of allied health services for children with disabilities in WA and the Continence Advisory Service of WA. The Continence Advisory Service of WA is seeking to recruit continence health professionals for the service.

This will be a fantastic opportunity to make a difference in the lives of children with a disability and their families. For a confidential discussion or to register your interest, please contact Deborah Gordon at the Continence Advisory Service of WA on (08) 9386 9777 or email dgordon@continencewa.org.au

Every Body’s Business health professional forums

The CFA has successfully held two Every Body’s Business forums to date in 2013, visiting Bunbury, WA and Newcastle, NSW with a back to basics theme. The remaining forums for 2013 will be held in SA in September and the ACT in November. Keep an eye on the website for more information or email education@continence.org.au

Australian Continence Exchange (ACE)

“Connecting health professionals with continence resources and expertise”

Since its formal launch in June 2012, the ACE received 3,985 visits with 19,902 page views between July and December 2012, with the number of visits relatively consistent at 120 to 175 per week. The top five downloaded documents have been:
- Pelvic floor screening tool for women
- Pelvic floor screening tool for men
- Guidelines for the use of support pessaries in the management of pelvic organ prolapse
- Bladder diary
- Bladder control problems

An independent evaluation of ACE has taken place in February this year, with further improvements in the resource search, navigation and forum design being made. A new feature about to be launched on the ACE professional forum is “Ask the Expert”. Experts on different topics will be scheduled quarterly to answer the questions you post. All you have to do is register for the forum and get involved. Sign up for the ACE e-newsletter for more information.

To visit ACE go to www.continencexchange.org.au. For further information, call the ACE Team on 03 9347 2522 or email contact@continencexchange.org.au
World Continence Week 24–30 June 2013

The campaign focus for World Continence Week (WCW) this year is *Talk about incontinence: A problem in anyone's language.*

Friday 21 June will see the launch of WCW with a new initiative aimed to raise the awareness of incontinence among culturally and linguistically diverse (CALD) communities. Language specific web pages on the CFA’s website will be developed for non-English speaking communities and health professionals working with these communities. The web pages will be developed initially in the Chinese and Vietnamese languages, with a view to expanding this to another 17 languages by early 2014. The web pages will provide links to new bilingual fact sheets to be made available in 20 languages by June this year. The fact sheets will be designed to enable health professionals to know exactly what information is being provided to their clients as well as providing information to family members, friends and carers.

Also available on the site will be interpreting tools for health professionals and interpreters to use during a continence assessment. The first fact sheet will assist health professionals in how to work with interpreters within a setting where the topic is sensitive and the procedure is invasive. The second fact sheet will assist interpreters in how to work with health professionals in assessing incontinence, including a glossary of terms commonly used in this setting.

The CFA continues to rely on its members and other individuals and organisations to assist with the promotion of WCW and its theme to local communities and media networks. Every year, individuals and organisations have contributed by reaching out to local networks, including those who are, or are at risk of becoming incontinent. The WCW order form and media information kit will be made available to members in May.

Online membership renewal system

Last year the CFA introduced an online renewal system. This has been received positively, with more than 32% of members electing this option as an efficient way to renew their membership.

As the financial year draws close, it’s time once again to start thinking about renewals. We will be sending out renewal forms in the coming weeks and encourage members to renew before 30 June. Members who do renew before 30 June will go into the draw to win a free registration to the National Conference on Incontinence, held this year in Perth on 23–26 October.

We look forward to your continued support as a CFA member and hope you find our renewals process easy.

Paediatric Continence Education

The CFA is pleased to promote the next Paediatric Continence Education workshop. The theme for this workshop is *Daytime Bladder Dysfunction* and it is being held at Victoria Park in Brisbane on 31 May 2013. Attendance at this one-day workshop is free and aims to up-skill and support the paediatric continence workforce. Presentations will be delivered by specialists with expertise in the field of paediatric incontinence. Registration is essential as places are limited. To register or for further information, visit www.continence.org.au/events or call Blair Neale on (03) 9347 2522.

Carer of the Year Award

Applications are now open for the 2013 Continence Carer of the Year, this year proudly sponsored by Hartmann. The Continence Carer of the Year Award acknowledges the special way to support the important work done by at-home carers, who deal with the complex role of caring for someone with incontinence. If you are interested in making a nomination for this year’s award and for full details of the award, go to www.continence.org.au/pages/carer-of-the-year.html.

Certificate II in Continence Promotion and Care

The CFA offers fully funded positions for health professionals to complete a nationally accredited course in continence promotion and care. This one-day course is available to practice nurses, community nurses, residential aged care workers and Aboriginal and Torres Strait Islander health workers. The course aims to assist health professionals to identify, screen, manage and refer people affected by incontinence.

Separate courses are run for each specialty as course content is tailored to the specific needs of that group. The CFA hosts these courses across metropolitan, regional, rural and remote Australia. If you would like us to host a course in your area or are interested in obtaining further information, contact Blair Neale via b.neale@continence.org.au or call (03) 9347 2522.

New appointment at Victorian Continence Resource Centre

Judy Sincock, President CFA Victoria (CFA VIC) Committee of Management has announced the appointment of Lisa Wragg to the position of Executive Officer of the Victorian Continence Resource Centre (VCRC). Lisa commenced in that role on 1 May 2013.

Lisa is well known in the continence community, having been actively involved in the world of continence since 1998 and manager of the Southern Continence Service since 2002. That involvement included a period as continence nurse advisor at Southern Health Women’s and Children’s Program, and the Children with Disabilities Continence Support Scheme at the Department of Paediatrics, Monash Medical Centre. She played an active role in the development and implementation of the CFA’s National Continence Helpline.

She is a member of the CFA’s Bladder Bowel Collaborative Steering Committee and is on the clinical advisory board for the Statewide Equipment Program (SWEP).

In announcing the appointment, Ms Sincock said that Lisa’s credentials were an excellent fit for the role and the VCRC was
fortunate to have secured her services. We look forward to a bright new era for the VCRC and continence promotion and education in Victoria.

Barry Cahill, CFA CEO

New Zealand news

The New Zealand Continence Association (NZCA) is well underway with planning for World Continence Week (WCW) 2013. The theme this year is *Talk about incontinence: a problem in anyone’s language*. We have sent a letter to every Maori and Pacific Island Primary Health Organisation in New Zealand inviting them to complete a request form which offers a continence advisor to address groups to tell them what the NZCA does and how to access our free information, helpline and the availability of local free continence services. We hope to get a good response. We will then coordinate these requests with continence advisors in each area.

Physiotherapy New Zealand (NZ) will promote continence as the theme for its national awareness campaign, which will also be held during WCW. This will increase publicity. Prior to this, it was important to train physiotherapists in teaching pelvic floor exercises (PFE) as only women’s health physiotherapists have traditionally worked in this area. To train physiotherapists we are running PFE workshops in Auckland, Wellington and Christchurch. These are aimed at physiotherapists and midwives but are open to others. To see more information, go to www.continence.org.nz

Physiotherapy NZ is funding a nationwide survey to test people’s knowledge of continence. This survey will provide information that NZCA will also be able to use.

NZCA will run two advanced continence workshops for adult and child continence, both in Auckland (see website for details). The programs will be interesting and varied.

The Toilet Tactics program was introduced into schools last year, as part of WCW 2012, and this year we are have more schools requesting a copy of the program.

NZCA is investigating web-based platforms to provide our education and courses at a very reasonable cost. So far, we have education programs relating to adult and child incontinence recorded on video and it will be set up where the video presentation is viewed in tandem with the PowerPoint. At the end of each session, the registrant doing the program will answer multiple-choice questions. Once completed, the registrant would receive a completion certificate.

Jan Zander, NZCA CEO

The latest in incontinence research and practice [www.continence.org.au](http://www.continence.org.au)
In the news

Falls in older adults living in residential care or inpatients in acute care: A work in progress?

In March 2013, the Cochrane Bone, Joint and Muscle Trauma Group released an update of its 2010 review Interventions for preventing falls in older people in care facilities and hospitals1. This new review adds 20 studies to the original review. A total of 60 trials (60,345 participants) were included in the review with 43 trials (30,373 participants) in care facilities, and 17 (29,972 participants) in acute care or subacute care hospitals. The stated objective of the review was to assess interventions to reduce the risk of older people falling in residential care facilities and acute or subacute care hospitals.

Falls are very common among older people living in residential care. The background to the review cites a 2012 German study of 528 nursing homes that found a fall rate of 1.5 falls per bed per year. The majority of the falls in this study, 75% of people, were in the bedroom or bathroom, which potentially reflects falls related to toileting activities. Previously identified risk factors for falls in older adults in acute care hospitals are poor gait, agitated confusion, urinary incontinence, a history of falls, and use of psychotropic medicines.

Although urinary incontinence is noted as a risk factor for falls, it was not a focus of the review. The review noted one study in which falls were monitored as part of a multifactorial intervention among residents requiring a high level of care. The interventions included exercise, offering regular fluids and toileting, all features of a potential continence program. Although the study found a relative rate of falls of 0.62 with this intervention, the confidence intervals for this rate reduction were wide and not statistically significant.

The review found a very large number of interventions used in the identified studies. These included exercise; environmental modifications, such as sensors and changing the type of flooring, as carpet flooring may contribute to falls; medicines modification, including the addition of vitamin D supplements; the social environment; and staff education. The review is confusing at it distinguishes between rate of falls (number of falls per person per unit time) and risk of falls (number of participants with at least one fall) and often the interventions would have a positive effect on one outcome and not the other. This leads to the authors concluding for many interventions that the evidence was inconclusive. Overall, there was little evidence of a strong effect of the interventions on falls in these two settings.

Vitamin D in residential care, in five trials (2876 participants), reduced falls rates, rate ratio 0.63 (95% CI 0.46 to 0.86) but not fall risk; the proportion of participants with one or more falls. Exercise interventions in residential care did not reduce falls risk and in some individual studies, exercise intervention increased the risk of falls. In subacute wards, in hospitals, there was evidence from one or two studies that exercise or additional physiotherapy may reduce falls risk. Multifactorial interventions in hospitals, four studies with 6478 participants, reduced fall rates, rate ratio 0.69 (95% CI 0.49 to 0.96) but not falls risk. Overall, the authors conclude that apart from vitamin D administration in residential care, the evidence for falls risk reduction for any intervention is poor and make a case that this is because the trials may have design flaws regarding intervention intensity and participant selection rather than that the chosen interventions are ineffective. As always, more research is recommended and the authors make several suggestions as to the type of research intervention and the methods of the studies.

Reference

Exercise and urinary incontinence during pregnancy

This paper describes a controlled trial of exercise for pregnant women1. The background is that pregnancy and delivery are risk factors for urinary and anal incontinence. The authors comment that it is still uncertain if exercise including pelvic floor muscle training (PFMT) is truly effective. In particular, the authors wanted to see the effect of a more general exercise program in addition to PFMT.

The participants in the trial were pregnant women recruited from a routine ultrasound at two university hospitals in Trondheim in Norway. The mean age of participants was a little over 30 years
and 58% were having their first baby. About 40% of women had a previous vaginal delivery, the mean BMI was around 25 and just over 50% did regular exercise and about 60% regular PFMT. Around 10% had urinary incontinence once weekly or more.

The intervention was a combination of aerobic activity, strength training including PFMT, and balance exercises. Sessions were conducted in groups of between eight and 15 women, conducted by a physiotherapist, once a week for 12 weeks between 20 and 36 weeks’ gestation. The intervention group were also encouraged to do two home sessions a week as well. There was individual instruction in PFMT including vaginal palpation with encouragement to perform three sets of eight to 12 contractions, although it wasn’t clear from the paper if this was for three days a week as well. The control group received information only.

The primary outcome of the study was in fact the prevalence of gestational diabetes. There were multiple outcomes relating to continence-based questionnaires. The sample size calculation suggested reasonable power to detect a decline in the prevalence of urinary incontinence from 50% to 40%. Incontinence was measured at 36 weeks of pregnancy.

A total of 875 women were recruited into the trial and data was available from 762 women with more in the control group than the intervention group dropping out. For any urinary incontinence this occurred in 192/365 (53%) of the control group and 166/397 (42%) of the intervention group: absolute difference 11% (95% CI 3.7% to 18.4%), p=0.003. Urinary incontinence once a week or more happened in 68/365 (19%) of the control group and 44/397 (11%) of the intervention group.

The difference in faecal incontinence favoured the intervention group, but with only 3% of the intervention group and 5% of the control group having this it was not statistically significant.

The study is weakened by having a subjective measurement of incontinence and by the high drop-out rate, which affected one randomised group more than the other. Even the intervention group still had a relatively high prevalence of incontinence; however, it seems that a fairly labour-intensive intervention is effective at reducing the risk of urinary incontinence with a number needed to treat of about nine.

Reference

The use of a midurethral sling for vaginal prolapse repair

A controlled trial of placing a midurethral sling at the time of vaginal prolapse repair and its effect on urinary incontinence and complications of surgery is described in this paper from the *New England Journal of Medicine*1. The background is that a high proportion of women undergo surgery for pelvic organ prolapse and urinary incontinence is commonly associated with pelvic organ prolapse. Another trial showed that adding a bladder neck suspension at the time of abdominal prolapse surgery in women without preoperative stress urinary incontinence improved the rates of postoperative stress incontinence.

The participants in the trial were women having vaginal prolapse surgery who did not have the symptom of stress incontinence recruited from seven hospitals in the United States. The participants had a mean age of about 63 years; 87% were white; mean BMI was 28 and two-thirds had POP-Q stage 3.

The intervention was randomly allocated retropubic midurethral vaginal sling versus some sham cuts to mimic placement.

The primary outcome was three-month incontinence defined as a positive cough stress test, symptoms of incontinence, or treatment for incontinence.

Of the 337 women recruited into the trial, only three women were lost to follow-up for the three-month endpoint. In the sling group 39/165 (23.6%) and 85/172 (49.4%) in the sham group had incontinence, an absolute difference of 52.8% (95% CI 15.5 to 36.1). The difference was less marked at 12 months: 27.3% versus 43%. Quality of life was no difference at three months. Adverse effects were far more common in the sling group: urinary infection 31% versus 18%, as was incomplete bladder emptying at discharge (43% versus 30%) and later.

The authors conclude that urinary incontinence was reduced with some risk of increased adverse effects. It was interesting to note that overall quality of life was not improved.

Reference
Calendar of events 2013

5–6 June
3rd Annual WA Active Ageing Conference
COTA WA
Esplanade Hotel, Fremantle, WA, Australia

6–8 June
The International Children’s Continence Society meeting
Moving beyond paediatric incontinence: the challenges of transitional care
Toronto, Canada
Web http://sites.cepdtoronto.ca/bpi/

16–20 June
17th International Congress of Parkinson’s disease and movement disorders
The Movement Disorder Society
Sydney, NSW, Australia
Web www.mdscongress2013.org/

22–26 June
Wound Ostomy and Continence Nurses Society (WOCN)
45th Annual Conference
Seattle, Washington USA

24–30 June
2013 World Continence Week
Web www.continence.org.au or www.continence.org.nz

21 July
Male LUTS Meeting 2013
Urological Society of Australia and New Zealand
Westin Hotel, Sydney, NSW, Australia
Web www.usanz.org.au/usanz-calendar/

25 July
NZCA Child Continence Education Day
Auckland, New Zealand
Email zoe@continence.org.nz

26 July
NZCA Adult Continence Education Day
Auckland, New Zealand
Email zoe@continence.org.nz

21–23 August
Australian and New Zealand Spinal Cord Society (ANZSCoS)
2013 Annual Scientific Meeting
Sydney Convention Centre, Sydney, NSW, Australia

26–30 August
ICS 2013: Annual Meeting of the International Continence Society
Barcelona, Spain

3–6 September
12th Australian Palliative Care Conference
National Convention Centre, Canberra, ACT, Australia
Web www.palliativecare.org.au

24–27 September
8th Conference of the Australian College of Nurse Practitioners
Hotel Grand Chancellor, Hobart, TAS, Australia
Web www.acnp.org.au

10–13 October
International Society for Pelviperineology (ISPP) Annual Meeting,
Sydney, Australia
Web www.pelviperineology.com

23–26 October
CFA 22nd National Conference on Incontinence
Crown Conference Centre, Perth, WA, Australia
Web www.continence.org.au

17–19 October
CAG2013: Aging ... from Cells to Society
42nd Annual Scientific and Educational Meeting
Canadian Association on Gerontology
Nova Scotia, Canada
Web www.cagacg.ca/CAG2013

10–13 November
2013 ACSA National Conference
Melbourne Convention and Exhibition Centre
Web www.agedservices.asn.au

25–27 November
Grey Expectations: Ageing in the 21st Century
46th Australian Association of Gerontology National Conference
SMC Conference & Function Centre, Sydney, NSW, Australia
Web www.aag.asn.au
Nominations sought for Peer Review Panel

Experts from the disciplines involved in continence treatment, management and promotion and those who are expert in research methods and statistical analysis are invited to nominate to join the Australian and New Zealand Continence Journal Peer Review Panel.

The journal is proud to promote Australian and New Zealand scholarship.

For details regarding the Peer Review Panel, please email Jacinta Miller jacmil@bigpond.com

Electronic submission of manuscripts to the journal

The Australian and New Zealand Continence Journal now offers authors the ability to submit articles via a web-based system.

Steps to submission and publication

- Go to the publisher's web www.cambridgepublishing.com.au
- Click on Manuscript Management Login.
- Login.
- Create an account if you are using the system for the first time.
- This will be retained for future enquiries and submissions.
- Enter your personal details: all fields must be completed.
- Confirm your details.

Submitting an article

- Step 1. Type the title, type of paper and abstract. Select publication — Australian and New Zealand Continence Journal.
- Step 2. Confirm author. Add co-author details (all fields) if applicable.
- Step 3. Upload files. Please ensure your document contains the required information and is formatted according to the author guidelines. PLEASE NOTE THAT AUTHOR DETAILS SHOULD BE ON A SEPARATE COVER PAGE, DO NOT INCLUDE AUTHOR(S) NAME(S) IN THE BODY OF THE ARTICLE.
- Step 4. Add any comments for the editor.
- Step 5. Review your information then click submit.

Once submitted, the manuscript is reviewed by the Editor and, if acceptable, sent for peer review.

Peer review

Peer reviewers will be asked to review the manuscripts through the electronic process.

Author instructions are available from the website www.continence.org.au or www.continence.org.nz

National Continence Helpline

A free service staffed by continence nurses providing:

- Information for GPs, allied health and fitness professionals
- Confidential advice about bladder and bowel control problems, local referrals and product information
- Resources for consumers and clinicians

1800 33 00 66
Monday to Friday 8am-8pm

www.continence.org.au

The Helpline is funded under the Australian Government’s National Continence Program and managed by the Continence Foundation of Australia
Information for authors

The Editors and the Editorial Board of the Australian and New Zealand Continence Journal have specified guidelines for prospective authors to follow when compiling an article they wish to submit to the journal.

Terms of submission

The editors accept submissions in the form of research findings, clinical papers, case studies, reports, review articles, letters and product appraisals. Each submission is evaluated on its timeliness, relevance, accuracy, clarity and applicability to the journal. Submissions will be accepted from any country but must be written in English. Submissions to the journal must be original and unpublished. Submissions must not be under consideration elsewhere. The ANZCJ Editorial Office will check each submission using plagiarism detection software to verify content is original and not previously published. Accompanying each submission must be a competing interest statement (see form on CFA website and Cambridge Media website). Once a paper is accepted for publication, all authors must sign the author statement and copyright assignment form which will be provided by the production editor. Once it is published, the article and its illustrations become the property of the journal, unless rights are reserved before publication.

All work is sub-edited to journal style. The editors reserve the right to modify the style and length of any article submitted, so that it conforms to journal format. Major changes to an article will be referred to the author for approval prior to publication. The Australian and New Zealand Continence Journal provides assistance to first time authors and may be contacted by email.

Authorship

All listed authors should have made a substantial contribution to the manuscript and may be required to indicate their contribution. Participation solely in the acquisition of funding, the collection of data or supervision of such does not justify authorship and such contributions should be listed in acknowledgements which will be printed under the author details. All participating authors must be acknowledged as such; proof of authorship may be requested. The first-named author is responsible for ensuring that any other authors have seen and approved the manuscript and are fully conversant with its contents. It is the responsibility of the author to obtain written permission from a copyright holder to reproduce copyrighted work; a copy of that permission must be provided to the journal prior to publication and a full citation of the source must be provided.

Conflict of interest: It is the responsibility of the submitting author to disclose to the Editor any significant financial or other interests they may have pertaining to their manuscript. Conflicts of interest should be disclosed using the Australian and New Zealand Continence Journal author competing interests form. If an interest exists, publication of that interest is at the Editor’s discretion.

Ethics

Investigations in human and animal subjects must conform to accepted ethical standards. Authors must provide a statement within the text that the research protocol was approved by a suitably constituted ethics committee of the institution within which the work was carried out and that it conforms to the Statement on Human Experimentation or the Statement on Animal Experimentation by the NH&MRC.

Manuscript type

The Australian and New Zealand Continence Journal welcomes original research articles for peer review and general articles regarding the achievements of people working in the disciplines pertaining to the management of incontinence, clinical issue updates, book reviews and general project information.

Discussion: Presentation of information from more than one viewpoint (for example, for and against) and usually ending with a recommendation or opinion based on the evidence presented.

Literature review: Narrative — describes and evaluates the current knowledge of a subject, identifies gaps or inconsistencies and includes critical evaluation with recommendations for future research. Systematic — describes planned analysis and evaluation of all available research studies on a particular clinical issue, conducted in accordance with scientific principles and may include recommendations for future research.

Research report: Presentation of study results in an ordered fashion, based on common practice. Research reports are expected to follow the Uniform requirements for manuscripts submitted to biomedical journals, as published by the International Council of Science Journal Editors www.icmje.org.

Case study: Combination of recount (retelling of events as they occurred) and information report (classification and description of something). Can be presented in different ways to give a cohesive account.

Exposition (including letter to the Editor): Putting forward of a particular viewpoint, justification of a particular argument.

Narrative: An informative account of a meeting or conference, or a review of a book, journal article or relevant website.

Preparation of manuscripts

Manuscripts are to be no more than 4000 words and include an abstract of no more than 250 words. Manuscripts should be created in a Word document using minimal formatting and typed double spaced in 12 point Times Roman font. Include total word count and up to five keywords. Include title of work on the abstract page and first page of introduction. In the introduction, include key points on what is already known on the topic and what your manuscript contributes. Define abbreviations and acronyms on first mention in the text.
Tables are to be presented on separate pages, one per page. Tables should be clearly typed, showing columns and lines. Number tables consecutively using Arabic numerals in the order of their first citation in the text and supply a brief title for each. Place explanatory matter in a legend under the table, not in the heading. Explain in the legend all non-standard abbreviations used in each table.

Photographs and figures may be included in the submission and should be supplied in a graphic format such as jpeg at a resolution of 300 dpi. Illustrations and figures must be clear, well-drawn and large enough to be legible when reproduced. The title and legend for figures should be on a separate page after the references. Each figure must include its place, its number and the orientation of figure. Patients or other individual subjects should not be identifiable from photos unless they have given written consent for their identity to be disclosed; this must be supplied.

Referencing guidelines

The referencing format is based on the Vancouver style, the main feature of which is the use of numbers at the point of reference so as not to interfere with the flow of words. Each number corresponds to a single reference provided in the reference list at the end and, once assigned a number, a reference retains that number throughout the text, even if cited more than once. If more than one work is quoted in a reference, each work must be assigned a number. At any point in the text, the reference may be one or several numbers. Following are some examples of references from different sources:

Journal: A complete journal reference includes: name(s) of author(s), title of article, journal name, year of publication, volume and edition number and inclusive page numbers.


Book: A complete reference to a book includes name(s) of author(s) or editor(s), book title, edition number, name of publisher, place of publication, year of publication, specific page numbers and internet reference if applicable.


It is the author’s responsibility to ensure that all references are correct. Please double check all citations with an electronic database to ensure accuracy in the reference list. Manuscripts submitted with multiple errors will be returned for correction before being accepted for peer review.

Submission of manuscripts

Manuscripts are accepted as an electronic submission with an attachment as a Word document. The manuscript must be accompanied by a covering letter indicating that the manuscript has not been submitted elsewhere.

Manuscripts submitted via the Cambridge Manuscript Management Login:

- Go to the publisher's Web www.cambridgepublishing.com.au
- Click on Manuscript Management Login
- Login
- Create and account if first time using the system — this will be retained for future enquiries and submissions
- Enter your personal details — ANZCJ requires all fields to be completed
- Confirm your details

Follow the steps for submitting an article

- Step 1. Type the title, type of paper and abstract. ANZCJ requires an abstract for all submissions. Select publication — Australian and New Zealand Continence Journal.
- Step 2. Confirm author. Add co-author details (all fields) if applicable.
- Step 3. Upload files. Please ensure your document contains the required information and is formatted according to the author guidelines. Ensure you load a title page document separately and that there is no identifying material on the article file. Please name the file appropriate to the title of the paper.
- Step 4. Add any comments for the editor.
- Step 5. Review your information then click submit.

Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review. You will be notified by email once your manuscript has been selected for peer review.

Peer-review process

All manuscripts are initially reviewed by the Editorial committee and those deemed unsuitable (insufficient originality, serious scientific or methodological flaws, or a message that is too specialised or of limited interest to the journal readership) are returned to the author(s), usually within four weeks. If the manuscript does not conform to the submission guidelines, the author will be asked to amend it prior to peer review.

All manuscripts are reviewed by content and writing peers for relevance, construction, flow, style and grammar. This process can take eight weeks. Reviewers spend considerable time in reviewing the manuscripts and providing feedback to the authors. The length of time of the publication process may vary and depends on the quality of the work submitted. Several revisions may be required to bring the manuscript to a standard acceptable for publication. The Editorial team undertake the final review and may have different questions for the author/s to consider. Proofs of articles about to be published will be sent in PDF format to the corresponding author for review. The final decision about publication is made by the Editor.
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* PAUL. HARTMANN AG internal test method
** ABL (Absorption Before Leakage). Source: standard test method WSP 354.1 (11)
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- Uniquely formulated Menalind® professional skin care range
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