Self management for men with lower urinary tract symptoms: randomised controlled trial

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ABSTRACT

Objective To evaluate the effectiveness of self management as a first line intervention for men with lower urinary tract symptoms.

Design Randomised controlled trial.

Setting A teaching hospital and a district general hospital in London.

Participants 140 men (mean age 63 (SD 10.7) years), recruited between January 2003 and April 2004, referred by general practitioners to urological outpatient departments with uncomplicated lower urinary tract symptoms.

Interventions Self management and standard care (n=73) or standard care alone (n=67). The self management group took part in three small group sessions comprising education, lifestyle advice, and training in problem solving and goal setting skills.

Main outcome measures The primary outcome measure was treatment failure measured at 3, 6, and 12 months. Symptom severity (international prostate symptom score; higher scores represent a poorer outcome) was used as a secondary outcome.

Results At three months, treatment failure had occurred in 7 (10%) of the self management group and in 27 (42%) of the standard care group (difference=32%, 95% confidence interval 18% to 46%). Corresponding differences in the frequency of treatment failure were 42% (27% to 57%) at six months and 48% (32% to 64%) at 12 months. At three months, the mean international prostate symptom score was 10.7 in the self management group and 16.4 in the standard care group (difference=5.7, 3.7 to 7.7). Corresponding differences in score were 6.5 (4.3 to 8.7) at six months and 5.1 (2.7 to 7.6) at 12 months.

Conclusions Self management significantly reduced the frequency of treatment failure and reduced urinary symptoms. Because of the large observed benefit of self management, the results of this study support the case for a large multicentre trial to confirm whether self management could be considered as first line treatment for men with lower urinary tract symptoms.

Trial registration National Research Register N0263115137; Clinical trials NCT00270309.

INTRODUCTION

Standard care for men with lower urinary tract symptoms has developed into a “cascade” that escalates from “watchful waiting” through a variety of drugs to surgery.1 2 Healthcare professionals involved in the care of men with lower urinary tract symptoms routinely advise lifestyle modifications. However, the type of advice given varies considerably.1 A formal consensus development exercise was carried out to define the lifestyle modifications that are likely to be effective in improving lower urinary tract symptoms.4

We developed a self management intervention for men with lower urinary tract symptoms that incorporated the recommendations of the consensus panel.4 The purpose of the programme was to reduce urinary symptoms and to delay or avoid an escalation in treatment. We did a randomised controlled trial in two centres to compare men with lower urinary tract symptoms who participated in a self management programme in addition to standard care with those who received standard care alone.

METHODS

Patient population—We recruited men with uncomplicated lower urinary tract symptoms from the outpatient departments of two urological centres in London. We randomised the men either to attend a self management programme in addition to standard care or to standard care alone. All patients aged over 40 with lower urinary tract symptoms who were referred for the first time by their general practitioner were eligible for inclusion. We excluded some men on the basis of drug treatment, recent surgery, complications potentially related to their symptoms, or severe comorbidity.

Standard care—Standard care in the two participating centres began with watchful waiting. Escalation to medical treatment and surgery was left to the discretion of the clinician and patient.

Intervention—In addition to standard care, the intervention group took part in small group sessions (five to eight men), each lasting between 1.5 and 2 hours, which were scheduled one, two, and six weeks after randomisation. The aim of these sessions was to bring about modification of lifestyle (fluid management, avoidance of caffeine, and use of alcohol) and specific changes in behaviour (bladder retraining, double voiding, and urethral milking). (See appendix on bmj.com and reference 5 for a description of the information component.) We designed the sessions to enable the participants to learn techniques of problem solving
and goal setting. At 3, 6, and 12 months, clinicians who were not involved in the conduct of the trial saw participants in the urology outpatient departments.

Outcomes—The primary outcome was treatment failure (rise of 3 points or more on the international prostate symptom score, use of drugs to control lower urinary tract symptoms, acute urinary retention, or surgical intervention) during follow-up. Secondary outcomes included severity of symptoms (international prostate symptom score), troublesomeness of symptoms (benign prostatic hypertrophy impact index), and disease-specific quality of life (American Urological Association quality of life score).

Statistical analysis—We analysed outcomes at 3, 6, and 12 months separately on an intention to treat basis. We did regression to adjust comparisons for potential imbalances in the baseline characteristics of the two groups (age, severity of symptoms, duration of symptoms, level of education, and number of comorbidities).

RESULTS
Of the 186 patients who were eligible for randomisation during the recruitment period, 46 were excluded. Of the 140 men who were included, we randomised 73 to participate in the self management programme and 67 to standard care alone. Compliance with the self management programme was high; 68 (93%) patients attended all three sessions. The five patients who did not attend were included in the self management group for analysis.

Baseline characteristics
The distributions of the patient demographics in the self management group and the standard care group were broadly similar (see bmj.com). Comorbidity was slightly more frequent in the self management group. Although most patients in the two groups fell in the moderate category of symptom severity, more patients in the standard care group had either mild or severe symptoms.

Primary outcome
At 3, 6, and 12 months, treatment failure was considerably more frequent in patients who were randomised to standard care alone than in those randomised to self management (table 1). The principal reasons for failure were prescription of α blockers or a rise in international prostate symptom score (table 2). Adjustment for baseline characteristics did not change these results.

The results in table 1 represent only patients with complete information at 3, 6, and 12 months. When we imputed missing values by using results of the previous measurements, only small changes occurred in the differences between the two groups and these differences remained statistically significant.

Secondary outcomes
At 3, 6, and 12 months, patients who were randomised to self management had less severe symptoms than patients randomised to standard care alone (table 1). The differences in international prostate symptom score increased slightly when we adjusted them for baseline characteristics. Patients who were randomised to self management were also less troubled by their symptoms and had a better quality of life than patients who were randomised to standard care alone (table 1). When we imputed missing values by using results of the previous measurements, the differences in symptom severity, troublesomeness, and quality of life remained statistically significant at 3, 6, and 12 months.

DISCUSSION
Self management in addition to standard care significantly reduced the rate of treatment failure and improved urinary symptoms, compared with standard care alone. The difference in symptoms between the treatment groups is twice as large as that seen when medical treatment is compared with placebo. The benefits of self management were seen early and were sustained at six and 12 months.

Methodological considerations
The treatment of men in the standard care group may have been contaminated because of the conduct of the trial. This contamination, which would have reduced the difference between the groups, may have occurred through changes in the advice the clinicians gave to their patients or through direct communication between patients allocated to different groups. However, the crucial difference between the two treatment groups is the problem solving and goal setting skills that patients acquired as a result of attending the programme. These skills are unlikely to have been conferred during the clinical consultation or transferred from one patient to another.

Lack of blinding of patients to the treatment allocation is another source of bias. However, we asked patients not to reveal their allocation to the clinicians.
Self management was at least as effective as medical treatment for men with uncomplicated lower urinary tract symptoms. A possible explanation is that the influences of lifestyle modification for lower urinary tract symptoms are immediately apparent to patients, in contrast to the delayed effects associated with lifestyle modifications for other chronic diseases. This immediacy of effect provides positive feedback. Furthermore, patients can try out the effects of the different lifestyle modifications and adapt them according to their individual circumstances.

Severity of symptoms in the standard care group remained more or less the same compared with baseline. This apparent lack of effect of standard care in our study contributes to the large difference in symptom severity between the two treatment groups. We would have expected an improvement in symptoms with standard care either through “regression to the mean” or as a result of some of the men being offered medical or surgical treatment. However, the impact of regression to the mean is likely to be small. Symptom severity was not one of the inclusion criteria, and the time interval between referral and recruitment was long (four to six months) and variable, which will have diminished the link between severity of symptoms at the time of referral and at the time of recruitment. Furthermore, only about 20% of the men who received standard care alone were given medical or surgical treatment, and the rest remained untreated.

A multicentre pragmatic randomised controlled trial should now be carried out to determine whether our results can be replicated in everyday clinical practice.9

Conclusion

The results from this small two centre study are sufficiently impressive that a policy of self management as described in this paper has the potential to become the ideal first line treatment for men with uncomplicated lower urinary tract symptoms, provided that further studies show their generalisability. The only imaginable harm that can result from self management is that for some patients medical or surgical treatment is postponed.

We thank all the men who agreed to take part in this trial. We also acknowledge the work of Jane Coe and Daphne Colpman, urology nurse specialists, University College London Hospitals NHS Foundation Trust, for acting as facilitators to the self management groups.

WHAT IS ALREADY KNOWN ON THIS TOPIC

Standard treatment for men with lower urinary tract symptoms has developed into a “cascade” that starts with watchful waiting and moves up to drugs and surgery. Self management interventions that aim to enhance patients’ problem solving and goal setting skills have been shown to be an effective treatment for arthritis, diabetes, and asthma.

WHAT THIS STUDY ADDS

Self management was at least as effective as medical treatment for men with uncomplicated lower urinary tract symptoms.

Explanations for observed results

Our study indicates that self management may be a very effective treatment for men with lower urinary tract symptoms. A possible explanation is that the influences of lifestyle modification for lower urinary tract symptoms are immediately apparent to patients, in contrast to the delayed effects associated with lifestyle modifications for other chronic diseases. This immediacy of effect provides positive feedback. Furthermore, patients can try out the effects of the different lifestyle modifications and adapt them according to their individual circumstances.

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Provision of taped conversations with neonatalists to mothers of babies in intensive care: randomised controlled trial

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ABSTRACT

Objective To determine whether providing mothers of babies in neonatal intensive care units with audiotapes of their conversations with a neonatologist improves recall of information and psychological wellbeing.

Design Randomised, single blinded trial.

Setting Neonatal intensive care unit, north Queensland, Australia.

Participants 200 mothers of babies in a neonatal intensive care unit.

Interventions Mothers given (n=102) or not given (n=98) audiotapes of their conversations with a neonatologist.

Main outcome measures Recall of information, attitudes to and use of the tape, satisfaction with conversations, postnatal depression, anxiety, general health, and stress about parenting, at 10 days and four and 12 months.

Results 91% (n=93) of mothers in the tape group listened to the tape (once by day 10, twice by four months, and three times by 12 months; range 1-10). At 10 days and four months, mothers in the tape group recalled significantly more information about diagnosis, treatment, and outcome than mothers in the control group. At four months mothers in the tape group were 75% more likely to recall all of the information whereas other authors found no benefit.1-3 We carried out a randomised single blind trial to compare the effects of providing or not providing mothers of babies in neonatal intensive care units with an audiotape of their conversations with the neonatologist.

METHODS

Mothers were eligible for the study if their babies were admitted to the neonatal intensive care unit at the Townsville Hospital, the regional neonatal unit for north Queensland (see bmj.com). The study was a randomised controlled trial of audiotape provision, with the neonatal team blinded to allocation. Before the first conversation the mothers completed a questionnaire eliciting personal details, anxiety, satisfaction with conversations, and recall of information whereas other authors found no benefits.1,2 We carried out a randomised single blind trial to compare the effects of providing or not providing mothers of babies in neonatal intensive care units with an audiotape of their conversations with the neonatologist.

After randomisation the initial conversation and subsequent conversations of significance were taped and analysed. The mothers in the experimental arm received a tape of each of the conversations and a tape recorder. Ten days and four months after the initial conversation the researcher interviewed the mothers to document their recall of the diagnosis, tests, treatment, and outcome of their babies as conveyed by the neonatologist. Mothers also completed a questionnaire to ascertain views of the taping, use of the tapes, anxiety, general health, depression, marital satisfaction, social support, and satisfaction with conversations held with