Which treatment’s best? Consider the evidence …

Brian Buckley

Brian Buckley is the Consumer Liaison for the Cochrane Incontinence Group. Brian, a Researcher in Primary Care, is Chairman of InContact, a leading national organisation that provides information and support to people with bladder and bowel problems, their carers and health professionals that look after them.

How can doctors, nurses, continence advisors - any kind of clinician - keep abreast of the latest medical research? How can patients or carers be sure that the treatments recommended to them are the most appropriate? One man’s legacy is helping to ensure that health care decisions can be based on sound evidence.

In a prisoner of war camp in Greece in 1941 Captain Archie Cochrane of the Royal Army Medical Corps was worried by an epidemic amongst his fellow prisoners. Despite working in appalling conditions, he managed to conduct research in order to identify an effective treatment: he divided some of the sick men into groups, which he treated in different ways. In a short while the men treated with simple yeast bought on the black market began to get well and this fact was used to convince the camp authorities to provide yeast supplements to make up for the insufficient diet which had caused the epidemic(1). This example of successfully challenging authority by use of sound evidence was typical of Archie Cochrane. His enthusiasm for basing his medical practice on sound evidence continued throughout a long and distinguished career.

A problem for clinicians is the sheer amount of new research published around the world each year. It is impossible for any one person to read all of it - so how can clinicians be sure that their decisions are based on the best and most up-to-date evidence? Archie Cochrane hinted at the solution in 1979 when he wrote that the results of all research ought to be brought together and summarised in regularly updated reviews - treatment by treatment and condition by condition(2). A few years after his death in 1988 the Cochrane Collaboration was founded to do just that and today tens of thousands of researchers volunteer to prepare and maintain reviews of research evidence for this international, non-profit organisation.

Each Cochrane review weighs up all the available evidence for the effectiveness (or not) of treatments for all manner of illnesses and conditions, providing a reliable source of evidence-based answers……………………………continued on page 2

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......to problems which face clinicians and patients on a daily basis: is operation A more effective than operation B, is drug C better than drug D? The reviews are available through The Cochrane Library (www.thecochranelibrary.org) and although they are scientific documents, each has a summary in plain language because the library is intended for use by patients and carers as well as clinicians. Many countries now have free access to The Cochrane Library (see box below for further details).

The Cochrane Review Group which looks at treatments for incontinence is based at the University of Aberdeen and has a close relationship with Incontact. Dozens of reviews have been published to date considering everything from surgery for incontinence to complimentary therapies for bedwetting in children - invaluable resources for patients, carers and clinicians making decisions about treatments. The easiest way to look at the reviews is to go to: www.cochrane.org/reviews/en/topics/index.html where you can find a list of reviews on topics associated with continence problems, each accompanied by a plain language summary of what the reviewers found when they considered all the available evidence.

The Aberdeen group values the help of patients and carers in preparing Cochrane Reviews. At the start of the review process patients and carers can help to ensure that the reviews answer the questions which matter most to them. And later in the process their help is useful in ensuring that the reviews are published in a format and language which means they can be useful to patients, carers and clinicians alike - for example, checking that the plain language summaries really are written in plain language.

Largely thanks to Archie Cochrane’s vision patients, carers and clinicians can quickly access reliable information which can help in deciding which treatment to choose - a fine legacy indeed.

If you would like to become involved in helping the work of The Cochrane Library, contact June Cody (j.cody@abdn.ac.uk).


Citation: Buckley B. Consider the evidence. Incontact 2004; 4:20.

The author has given us permission to re-publish this article in our newsletter.

For more information on Incontact visit their website:

Free access to The Cochrane Library

As we go to press free access to The Cochrane Library is available in the following countries either to all residents or all health care professionals:

Australia, Canada (New Brunswick, Northwest Territories, Nunavut, Yukon, Nova Scotia, Saskatchewan) Finland, India, Ireland, Latin America and the Caribbean, Low-Income Countries (through Health InterNetwork Access to Research Initiative (HINARI), a partnership led by WHO or through International Network for the Availability of Scientific Publications (INASP). INASP’s Programme for the Enhancement of Research Information (PERI) provides access to many scientific resources, including health information), New Zealand, Norway, Poland, South African Cochrane Centre Sponsorship, Sweden, United Kingdom, England, Northern Ireland, Scotland, Wales, United States (Wyoming).
What do we do?

The Cochrane Collaboration is an international organisation that aims to help people make well-informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions. The Cochrane Incontinence Group is a Collaborative Review Group (CRG) of the Cochrane Collaboration.

We undertake systematic reviews of randomised controlled trials on different interventions designed to prevent or treat incontinence and related conditions, or aid rehabilitation. The group is concentrating on interventions where incontinence is the primary problem. The problems covered include urinary and faecal incontinence, enuresis, day-time wetting in children, encopresis, postprostatectomy incontinence, use of urinary catheters including catheter-related urinary tract infections (but not other urinary infections), enterocutaneous and enterovesical fistulae, neurogenic incontinence and retention, interstitial cystitis, postoperative urinary retention and rectal or vaginal prolapse.

Identifying priorities for incontinence research – the James Lind Alliance Working Partnership on Urinary Incontinence

Research on the effects of treatments which has been prioritised by health researchers or by industry often fails to address those questions and uncertainties which are of practical importance to patients and carers and the clinicians to whom they turn for help. Within the Cochrane Collaboration, choices of topics chosen for reviews have largely been driven by the interests of review authors.

The James Lind Alliance (JLA) was established in 2004 to encourage patients and clinicians to work together to identify treatment uncertainties and unanswered questions which are most important in any particular clinical area and to prioritise those in order to influence and inform the publicly funded research agenda. The JLA is facilitating the establishment of Working Partnerships, consisting of at least one patient organisation and at least one clinical organisation; these aim to identify and prioritise, by mutual consent, important uncertainties about treatment effects.

The process has two key components: identifying uncertainties about the effects of treatments which cannot be answered by referring to up-to-date systematic reviews of existing research evidence (such as Cochrane reviews); and prioritisation of these treatment uncertainties through discussion and agreement between patient representatives and clinicians.

The Cochrane Incontinence Group has developed increasingly strong links with 'Incontact', the principal UK patient-based support group for people with incontinence. The development of a JLA Working Partnership on incontinence started as a joint initiative between Incontact and the Cochrane Group. Relevant consumer and clinician organisations in the UK have now been approached and representative of some of these recently met at an initial 'awareness' meeting. Over the next 12 to 18 months, the Partnership participants will identify 'uncertainties' about treatment or management and then meet to prioritise them. The list of priorities

Visit the Cochrane Incontinence Review Group online at

www.incontinence.cochrane.org

Editorial team news

Peter Herbison, one of our editors, is on six months study leave, two months of which is to be spent at the Australasian Cochrane centre. As well as completing a Cochrane systematic review he will be trying to work on some ideas to do with the risk of bias in meta-analyses. Peter will look in more detail at the risk of bias due to different ways of hiding the allocation to groups in RCTs, for example, seeing whether central randomisation has less bias than envelopes. Another task is to see if it is possible to use the new risk of bias ideas to enable studies within a meta-analysis to be ranked by their risk of having a biased result, something that is not possible at the moment.
will then be disseminated to funders and research commissioners, and will prompt new Cochrane reviews. A concurrent qualitative evaluation of the Partnership is being undertaken to inform the broader debate about consumer involvement in healthcare research agenda setting.

Review Manager (RevMan) 5 software developments

Since the early days of The Cochrane Collaboration, authors of Cochrane reviews have used the Collaboration’s own software Review Manager (RevMan) for writing reviews.

RevMan 5 will be the first mandatory release in eight years meaning that all authors will have to upgrade to the new version. The development of RevMan 5 has been guided by advice from several Cochrane Groups, including the RevMan Advisory Group, the Information Management System Group and the Handbook Advisory Group, with the advice of Cochrane Methods Groups co-ordinated through the latter. The results of the Collaboration-wide software survey in 2001 have also influenced the development. One of the important findings from this survey was that RevMan should behave more like a word processing package.

RevMan 5 offers some exciting new features ensuring that the experience of what you see is what you get is strongly improved. The new text editor will allow more sections, including subheadings, tables embedded in the text, and nested lists (list within lists). Track changes functionality and a new note system will facilitate the task of multiple authors working together on a review.

There will be a new structure for the main text, support for appendices and it will be possible to select a few key forest plots or funnel plots to be displayed in the results section of a review. For intervention reviews, some of the most noticeable methodological changes across reviews are the introduction of Risk of Bias and Summary of Findings tables. For some, perhaps the most exciting new development in RevMan 5 is that it supports the preparation of two new review types: diagnostic test accuracy reviews and overviews of reviews (formerly referred to as umbrella reviews - see below).

RevMan 5 will be released to four pilot review groups (and their authors) at the end of 2007, and for the rest of the Collaboration in early 2008. However, the software is already available for testing. To find out how to get access to test releases and to read more about what the new version will offer, please visit: www.cc-ims.net/RevMan/RevMan5.

Citation:

The author has given us permission to re-publish this article in our newsletter.

Possible health warning: Please check with your Review Group (June Cody: j.cody@abdn.ac.uk) before using the new test software for writing/updating reviews that you plan to submit to your Review Group.

Overviews of reviews

A new development within The Cochrane Collaboration is ‘overview of reviews’, in which evidence from multiple Cochrane reviews is compiled into one accessible and user friendly document. The hope is that overview reviews will provide a quick overview of Cochrane reviews relevant to a particular clinical decision. The first of these appeared in a new derivative product of The Cochrane Collaboration, Evidence-based Child Health. It was gratifying that this was on childhood nocturnal enuresis (bedwetting) based on seven reviews led by one of our editors Cathryn Glazener, and published in The Cochrane Library through the Cochrane Incontinence Group. Based on these seven reviews it appears that enuresis alarms are the most effective method for securing sustained benefit. Drugs such as desmopressin are effective and may be particularly useful when children and parents want a short-term benefit such as during a ‘sleep-over’, but their effects do not seem to persist after stopping treatment.

There was little evidence about other approaches to management. This suite of reviews is widely quoted...
and was previously also the basis for an Effective Healthcare Bulletin.

For further information, contact Cathryn Glazener (E-mail: c.glazener@abdn.ac.uk Telephone: +44 1224 553732)

References

Citation: Health Services Research Unit newsletter Winter 2006/7:2.
http://www.abdn.ac.uk/hsru/newsletters/winter_2006.pdf

Profile of one of our editors
James N’Dow

I moved to Aberdeen from the Gambia in 1985 to study medicine. I met my wife in medical school and we have three wonderful children. The Gambia is a beautiful tiny country on the West Coast of Africa with wonderful unspoilt beaches and never-ending sun. I graduated from University of Aberdeen in 1990. After completing my basic surgical training in Aberdeen Royal Infirmary, I moved to Newcastle in 1994 to undertake my Urology specialist training. In 2001, I moved back up to Aberdeen as Senior lecturer and Consultant Urological Surgeon in Aberdeen. When I accepted this post, my remit was to establish academic urology in Aberdeen. I was the first academic appointment in Urology in Aberdeen’s history and indeed the only university appointed academic Urologist in Scotland. Research being undertaken was at individual level and there were no formal collaborative research programmes. This limited research productivity and there was little significant external funding. I could, however, see great potential and this was one of the major reasons why I accepted the job.

I embarked on a 5 year plan to establish an Academic Urology Unit in Aberdeen, with the major focus of research being in “dry science”. With this in mind, I established what has proved to be a very successful local collaboration with the Cochrane Incontinence Group. This collaboration has seen the establishment of three major areas of interest with external funding totalling over £3.5 million in the past four years. The first is based around large multicentre trials; the second area is in large multicentre comprehensive cohort studies and the third being systematic reviews. The final facet of the five year strategic plan was put in place with the launch of a new Urology Cancer Charity (UCAN) in September 2005. UCAN hopes to raise £2 million over three years to supplement existing and future external grant income. The money from UCAN will be used to raise awareness of urological cancers and to improve the quality of life for people living with urological cancers. UCAN is on target having raised over £1 million at the time of writing (https://www.ucanhelp.org.uk). I am the Managing Director of UCAN. I was appointed as Professor of Urology in Aberdeen in 2006.

An important part of my job involves undergraduate Urology ward-based teaching. I have recently led the revamping of Phase II surgical block teaching incorporating ward-based teaching, clinical skills based teaching, a structured teaching programme to ensure uniformity in teaching material delivered by different tutors. I am also the Deputy Phase II Coordinator. I have a busy general urology clinical job sub-specialising in urethral reconstructive techniques such as buccal graft urethroplasties.

Successful finding bids for the major projects mentioned above were both based in Cochrane reviews. After authoring a number of Cochrane reviews, I became an editor in 2005.

James N’Dow, Editor
Background
Overactive bladder syndrome is a common condition with a significant negative impact on quality of life. Intravesical injection of botulinum toxin is increasingly used as an intervention for refractory overactive bladder, with a considerable body of case reports and series in the literature suggesting beneficial effects.

Objectives
The objective was to compare intravesical botulinum toxin injection with other treatments for neurogenic and idiopathic overactive bladder in adults. The hypotheses addressed were whether intravesical injection of botulinum toxin was better than placebo or no treatment, pharmacological and other non-pharmacological interventions, whether higher doses of botulinum toxin were better than lower doses, whether botulinum toxin in combination with other treatments was better than other treatments alone, whether one formulation of botulinum toxin is better than another, and whether one injection technique was better than another.

Search strategy
We searched the Cochrane Incontinence Group Specialised Trials Register (searched 22 November 2005). The register contains trials identified from MEDLINE, CINAHL, the Cochrane Central Register of Controlled Trials (CENTRAL), and handsearching of journals and conference proceedings. Additionally, all reference lists of selected trials were searched. No limitations were placed on the searches.

Selection criteria
All randomised or quasi-randomised controlled trials of treatment for overactive bladder syndrome in adults in which at least one management arm involved intravesical injection of botulinum toxin were included. Participants had either neurogenic or idiopathic overactive bladder with or without stress incontinence. Comparison interventions could include no intervention; placebo; lifestyle modification; bladder retraining; pharmacological treatments; surgery; bladder instillation techniques; neuromodulation; and different types, doses, and injection techniques of botulinum toxin.

Data collection & analysis
Binary outcomes were presented as relative risk and continuous outcomes by mean differences. No data could be synthesised across studies due to differing designs and outcome measures. Data were tabulated where possible with results taken from trial reports where this was not possible.

Where multiple publications were found, the reports were treated as a single source of data.

Main results
Eight studies met the inclusion criteria. Results varied between studies. For the most part, studies reported superiority of botulinum toxin A to placebo in such outcomes as incontinence episodes, bladder capacity, maximum detrusor pressure, and quality of life. Low doses of botulinum toxin (100U to 150U) appeared to have beneficial effects, but higher doses (300U) may have been more effective. Botulinum toxin appeared to have beneficial effects in overactive bladder that quantitatively exceeded the effects of intravesical resiniferatoxin.

Reviewers’ conclusions
Intravesical botulinum toxin shows promise as a therapy for overactive bladder symptoms, but as yet too little controlled trial data exist on benefits and safety compared with other interventions, or with placebo. Practitioners should be aware that at present there is little more than anecdotal evidence, in the form of case reports to support the efficacy of intravesical botulinum toxin; there is not much in the way of substantial, robust safety data. Furthermore, the optimal dose of botulinum toxin for efficacy and safety has not yet been demonstrated.

New reviews published in Issue 3, 2007:
1. Anticholinergic drugs versus other medications for overactive bladder syndrome in adults Roxburgh C, Cook J, Dublin N.
3. Sacral nerve stimulation for faecal incontinence and constipation in adults Mowatt G, Glazener C, Jarrett M.

Substantively updated reviews in Issue 3, 2007:
5. Electrical stimulation for faecal incontinence in adults Hosker G, Cody JD, Norton CC.
7. Surgical management of pelvic organ prolapse in women Maher C, Baessler K, Glazener CMA, Adams EJ, Hagen S.

Updated reviews (minor) published in Issue 3, 2007:
9. Alarm interventions for nocturnal enuresis in children Glazener CMA, Evans JHC, Peto RE.
10. Anterior vaginal repair for urinary incontinence in women Glazener CMA, Cooper K.
11. Antibiotic policies for short-term catheter bladder drainage in adults Niël-Weise BS, van den Broek PJ.
13. Timed voiding for the management of urinary incontinence in adults Ostaszkiewicz J, Johnston L, Roe B.
14. Urinary catheter policies for short-term bladder drainage in adults Niël-Weise BS, van den Broek PJ.

15. Absorbent products for light urinary incontinence in women Fader M, Cottenden AM, Getliffe K.
16. Anticholinergic drugs versus non-drug active therapies for overactive bladder syndrome in adults Patrick K, Alhasso AA, Stewart L.
18. Behavioural and cognitive interventions with or without other treatments for the management of faecal incontinence in children Brazzelli M, Griffiths P.
20. Bladder neck needle suspension for urinary incontinence in women Glazener CMA, Cooper K.
22. Complementary and miscellaneous interventions for nocturnal enuresis in children Glazener CMA, Evans JHC, Cheuk DKL.
23. Complex behavioural and educational interventions for nocturnal enuresis in children Glazener CMA, Evans JHC, Peto RE.
24. Conservative management of postprostectomy urinary incontinence Hunter KF, Moore KN, Cody DJ, Glazener CMA.
25. Conservative management of pelvic organ prolapse in women Hagen S, Stark D, Maher C, Adams E.
27. Drug treatment for faecal incontinence in adults Cheetham M, Brazzelli M, Norton C, Glazener CMA.
28. Drugs for nocturnal enuresis in children (other than desmopressin and tricyclics) Glazener CMA, Evans JHC, Peto RE.
29. Habit retraining for the management of urinary incontinence in adult Ostaszkiewicz J, Johnson L, Roe B.
30. Laparoscopic colposuspension for urinary incontinence in women Dean NM, Ellis G, Wilson PD, Herbison GP.
31. Management of faecal incontinence and constipation in adults with central neurological diseases Coggrave, M, Wiesel PH, Norton C.
32. Mechanical devices for pelvic organ prolapse in women
Adams E, Thomson A, Maher C, Hagen S.

33. Mechanical devices for urinary incontinence in women
Shaikh S, Ong EK, Glavind K, Cook J, N'Dow JMO.

34. Oestrogens for urinary incontinence in women
Moehrer B, Hextall A, Jackson S.

35. Open retropubic colposuspension for urinary incontinence in women
Lapitan MC, Cody DJ, Grant AM.

36. Pelvic floor muscle training for urinary incontinence in women
Hay-Smith EJC, Bo K, Berghmans LCM, Hendriks HJM, van Waalwijk, van Doorn ESC.

37. Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women
Hay-Smith EJC, Dumoulin C.

38. Physical therapies for prevention of urinary and faecal incontinence in adults
Hay-Smith J, Herbison P, Mørkved S.

39. Plugs for containing faecal incontinence
Deutekom M, Dobben A.

40. Prevention and treatment of urinary incontinence after stroke in adults

41. Prompted voiding for the management of urinary incontinence in adults
Eustice S, Roe B, Paterson J.

42. Serotonin and noradrenaline reuptake inhibitors (SNRI) for stress urinary incontinence in adults
Marriapan P, Ballantyne Z, N'Dow JMO, Alhasso AA.

43. Short term urinary catheter policies following urogenital surgery in adults
Phipps S, Lim YN, McClinton S, Barry C, Rane A, N'Dow J.

44. Simple behavioural and physical interventions for nocturnal enuresis in children
Glazener CMA, Evans JHC.

45. Strategies for the removal of short-term indwelling urethral catheters in adults
Griffiths R, Fernandez R.

46. Surgery for complete rectal prolapse in adults
Brazzelli M, Bachoo P, Grant A.

47. Surgery for faecal incontinence in adults
Bachoo P, Brazzelli M, Grant A.

48. Traditional suburethral sling operations for urinary incontinence in women
Bezerra CA, Bruschini H, Cody DJ.

49. Tricyclic and related drugs for nocturnal enuresis in children
Glazener, CMA, Evans JHC, Pete RE.

50. Urinary catheter policies for long-term bladder drainage
Niel-Weise BS, van den Broek PJ.

51. Urinary diversion and bladder reconstruction/replacement using intestinal segments for intractable incontinence or following cystectomy
Nabi G, Cody J, Dublin N, McClinton S, N'Dow JMO, Neal DE, Pickard R, Yong SM.

52. Urodynamic investigations for management of urinary incontinence in children and adults
Glazener CMA, Lapitan MC.

53. Weighted vaginal cones for urinary incontinence
Herbison P, Mantle J, Dean N.

54. Which anticholinergic drug for overactive bladder symptoms in adults
Hay-Smith J, Herbison P, Ellis G, Morris A.

New protocols published in Issue 3, 2007:
1. Alpha blockers for removal of urethral catheter after acute urinary retention in men
Zeil H, Subramonian K.

2. Electromagnetic treatment for adult urinary incontinence
Khazali S, Jackson SR, Balmforth J.

3. Medical treatments for interstitial cystitis
Jamison J, Dawson TE, Helfand M.

Other Published Cochrane Protocols

4. Acupuncture for urinary incontinence in adults without neurological disease
Sung LM, Jiaqi W.

5. Acupuncture for bladder dysfunction after spinal cord injury
Jiaqi W, Sung L, Jina Y, Zhishun L.

6. Conservative management of nocturia in adults
Reynard J, Cannon A, Abrams P.

7. Drugs for nocturia in adults
Cannon A, Abrams P, Reynard J.

8. Electrical stimulation with non-implanted electrodes for urinary incontinence in adults
Berghmans B, Bø K, Hendriks E, van Kampen M, de Bie R.

9. Intravesical treatments for painful bladder syndrome/interstitial cystitis
Dawson TE, Jamison J.

10. Lifestyle interventions for the treatment of urinary incontinence in adults
Nygaard I, Bryant C, Dowell C, Wilson PD.

11. Minimally invasive sling operations for stress urinary incontinence in women
Bezerra CCB, Plata MS.

12. Neuromodulation with implanted electrodes for urinary storage and voiding dysfunction in adults
Herbison P, Arnold E.
13. Surgical management of bladder outlet obstruction in adults with neurogenic bladder dysfunction Kalyvas K, N'Dow JMO, Swami S.

14. Surgical management of vesicovaginal and/or urethrovaginal fistulae Lapitan MC, Rienhardt G.


17. Washout policies for management of long-term voiding problems in catheterised adults Sinclair L, Cross S, Hagen S, Niël-Weise BS.

We plan to run a workshop at the International Continence Society Meeting 37th Annual Meeting in Rotterdam, The Netherlands.

The workshop is entitled ‘Producing reliable summaries of incontinence research: a ‘hands-on’ workshop on how to conduct a systematic review.’

We shall take the participants through the key stages of undertaking a systematic review of controlled trials, including demonstrating Review Manager Software and description of statistical methods.

Chairing the workshop is Adrian Grant and speakers are Cathryn Glazener, Marie Carmela Lapitan, June Cody and Sheila Wallace.

The Cochrane Incontinence Group will have a stand at the ICS 2007 in the Exhibition Hall stand number 1.72. We will demonstrate The Cochrane Library at the stand. We would be very glad to meet as many of you as possible at the stand.

Workshop to be held at the International Continence Society (ICS) 2007 Rotterdam, The Netherlands

This year’s Colloquium is to be held in São Paulo, Brazil. Our Co-ordinating Editor, Adrian Grant, will be there along with June Cody, our Review Group Co-ordinator, and Sheila Wallace, our Trials Search Co-ordinator. The Colloquium is always entertaining as well as educational and is the place to be if you want to learn more about systematic review methodology, consumer and policy maker issues, widening access to and participation in Cochrane and enhancing the use of evidence in health care decisions. If you plan to come along please let June Cody know (j.cody@abdn.ac.uk) so we can contact you with further details about Incontinence Group events during the Colloquium – it would be great to see you there.

Key Dates for the Colloquium:

- Abstract submission: 14 May
- Abstract acceptance: 18 June
- Stipend applications: 25 June
- Stipend acceptance: 30 July
- Early registration closes: 30 July
- Meeting room request: 6 August
- Cancellation refunds: 3 September
- Hotel registration: 17 September
- Colloquium: 23-27 October

Sugar Loaf Mountain, Rio de Janerio, Brazil

For more details of the Colloquium visit the website: www.colloquiumbrasil.info
EDITORIAL MEETING, in Christchurch, New Zealand, November 2006.

From left to right: Back row: Cathryn Glazener, Katherine Moore, Don Wilson, Mela Lapitan, Peter Herbison, Jean Hay-Smith. Front row: Chris Norton, Sheila Wallace, June Cody. Not present are: Adrian Grant, James N'Dow, Bronwyn Davidson.

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