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, an international Organisation dedicated to informing those who provide or receive health care on the best available evidence. We undertake systematic reviews of randomised controlled trials on different interventions designed to prevent or treat incontinence, 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, post prostatectomy incontinence, use of urinary catheters including catheter-related urinary tract infections (but not other infections), enterocutaneous and enterovesical fistulae, neurogenic incontinence and retention, post operative urinary retention and rectal or vaginal prolapse.

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Staff News

The Group would like to welcome June Younes, who has been providing secretarial support to the Cochrane Group in Aberdeen since April 2002.

Cathryn Glazener, who has been our Assistant Editor since we started, has now joined the Editors.

UPCOMING COCHRANE MEETINGS AND TRAINING OPPORTUNITIES

For an up to date listing of training available see: http://www.cochrane.org/cochrane/workshop/htm
This time last year, Adrian Grant, the Group’s coordinating editor, spent two months in New Zealand, where three of our editors live. Here is an extract of a letter he sent during his stay there.

"I am now nearly three-quarters through my time in New Zealand. As many of you know, I am in Dunedin, which is in the Southeast of the South Island. It is a very attractive small city with the sea on one side and steep hills on the other. Princes Street runs through the middle of it and the street names will all be familiar to you if you know Edinburgh. Of the 110,000 people in Dunedin, about 20% are students (most in the University of Otago), so it has a very young feel. I am based in the University department of Women and Children’s health, which is in the Public Hospital.

We have been made very welcome. It is a place one feels at home in very quickly. We have taken the opportunity to go to plays, concerts and the cinema, much more than we usually do! We have got to know Dunedin and the environs pretty well. Local attractions include the penguins, the albatross, the seals, and the glow worms! We have also spent quite a lot of time in Central Otago, west of here. It is completely different - rougher, more mountainous, drier and hotter. We have been lucky that two of the Cochrane editors based in Dunedin have second houses there, which have provided superb bases for seeing the region - and relaxing too! Queenstown and Wanaka are famous for their magnificent scenery - lakes surrounded by high snow-capped mountains.

But with local guidance, we have ranged more widely, walking, visiting disused gold mines, sampling at the wineries, enjoying the produce of the local orchards, and marvelling at the natural beauty of the place. This weekend we go back there for the annual departmental walk to Rob Roy glacier. Then we are planning to go over to the South West coast to famous Doubtful Sound, weather permitting. Incidentally, it still feels odd going into autumn. April is supposed to be Spring isn’t it? Not here - definite new chill in the air and new snow on the mountains. In general, the weather has been good, though extraordinarily changeable - four seasons in a day, as the locals say.

While I am here I am partially supported by a University of Otago ‘William Evans Visiting Fellowship’. One of the conditions is that I visit the other two clinical schools of the University: in Christchurch (middle of South Island). We chose to do this by car and see some of New Zealand on the way. We did this over the last ten days or so of April. First we went west from Central Otago, through the Southern Alps before driving up the west coast. It was a memorable drive, with breathtaking views of craggy, ‘young’ mountains, plunging gorges, and gentle streams. The weather was near perfect, and we were able to walk to the Fox glacier, one of two very large glaciers near Mount Cook. If you have seen Lord of the Rings you will have some idea of the views we saw.

The next day we had another beautiful drive this time along the north coast of South Island. We left our car behind on the South Island and took the ferry across the Cook Strait to Wellington. It was a more serious crossing than I had expected, a bit like across the English Channel, but more beautiful. It took three hours, much of the time negotiating the islands of the Marlborough Sound and then getting into Wellington harbour on the other side. Apparently, it can be a very rough ride, but luckily, the sea was calm for us, both ways. Wellington is a very attractive place. Although it is small enough to feel easily accessible to a visitor, it has the sophisticated feel that goes with a capital city. We stayed the next night on the East Coast of the South Island at a place called Kakoura, famous for whale watching. Then we made a quick visit to Christchurch before making our way back to Dunedin.

Being a member of the Cochrane Collaboration has certainly opened up amazing and unexpected opportunities for me!”

Adrian Grant
Coordinating Editor
Version 1.1 of the Cochrane Collaboration Open Learning Material for Reviewers has been issued. Several thousand copies of the CD were sent out at the end of 2002. To help explain just what this material is, here are the answers to a few questions.

What is the idea behind this material?
Most reviewers have little access to in-depth, face-to-face training. Even where there are workshops, these usually cover a fraction of the skills and knowledge needed during the review process. The Cochrane Reviewers’ Handbook is an excellent source of advice, but it can be a bit daunting to use. The Open Learning Material does not replace the Reviewers’ Handbook; instead it provides a framework to progressing through the Handbook, supplementing it with examples and activities along the way.

What does it consist of?
First a note on terminology. ‘Open learning’ is used to mean learning at a person’s own pace, largely without support. It is different from ‘distance learning’ in that it is not part of a course with a set timetable, tutorial support or exams. As with many things, these terms might be used differently in different places but we had to choose one description. Anyway, the material consists of modules, including two optional ones, which follow the steps in a review from explaining what a systematic review is through to maintaining your review. Each module describes the topic in a ‘friendly’ way, suggesting appropriate points to read sections of the Handbook and giving examples and activities.

Many similar training materials have video clips, audio clips, interactive quizzes, etc. We have deliberately kept this material fairly low tech so that those who do not have access to fast computers with fast, stable internet connections are not disadvantaged. It may be that future versions do have more interactive elements.

Who has prepared the material?
This has been a collaborative project involving the UK, Australasian and Nordic Cochrane Centres, together with members of the Statistical Methods Group. It has been approved by the Handbook Advisory Group. We plan to update it every two years, with minor changes in between.

Are there any restrictions on its use?
The material is the copyright of the Cochrane Collaboration. We have also set some principles for its use, which have been endorsed by the Collaboration Steering Group.

- This material, developed by the Cochrane Collaboration for training reviewers, should be freely available to those reviewers with a registered Cochrane review title
- Profits generated from training non-Cochrane reviewers with this material should benefit the Cochrane Collaboration
- Organisations utilising this material within their courses should acknowledge its source
- Any suggestions for the improvement and updating of this material should be sent to the editors so that these suggestions can be considered in future revisions of the material.

Phil Alderson, Associate Director (Training), UK Cochrane Centre and Co-Convenor of the Quality Advisory Group
Consumer synopsis

Open retropubic colposuspension is the most effective form of surgery for stress incontinence in women, although there are also promising new techniques. Stress urinary incontinence is losing urine when coughing, laughing, sneezing or exercising. It can be caused by changes to muscles and ligaments holding up the bladder. Muscle-strengthening exercises can help, and there are surgical techniques to improve support or correct problems. Open retropubic colposuspension involves lifting the tissues around the junction between the bladder and the urethra. The review of trials found that this is the most effective surgical technique for stress urinary incontinence in women, resulting in long-term cure for most women. New techniques, particularly sling operations (including the use of TVT - tension-free vaginal tape) and keyhole (laparoscopic) colposuspension, look promising but need further research.

Cochrane summary (abstract)

Background: Urinary incontinence is a common and potentially debilitating problem. Open retropubic colposuspension is a surgical treatment which involves lifting the tissues near the bladder neck and proximal urethra in the area behind the anterior pubic bones to correct deficient urethral closure.

Objectives: To assess the effects of open retropubic colposuspension for the treatment of urinary incontinence.

Search strategy: We searched the Cochrane Incontinence Group specialised register (to April 2002) and reference lists of relevant articles. We contacted investigators to locate extra studies. Date of the most recent search: April 2002.

Selection criteria: Randomised or quasi-randomised controlled trials in women with symptoms or urodynamic diagnoses of stress or mixed incontinence that included open retropubic colposuspension surgery in at least one trial group.

Data collection and analysis: Studies were evaluated for methodological quality and appropriateness for inclusion and data extracted by two of the reviewers. Trial data were analysed by intervention. Where appropriate, a summary statistic was calculated.

Main results: This review included 33 trials involving a total of 2403 women. Overall cure rates were 68.9% to 88.0% for open retropubic colposuspension. Two small studies suggests lower failure rates after open retropubic colposuspension than conservative treatment. Evidence from six trials showed a lower failure rate for subjective cure after open retropubic colposuspension than after anterior colporrhaphy. Such benefit was maintained over time (RR of failure 0.51; 95% CI 0.34 to 0.76 before the first year, RR 0.43; 95% CI 0.32 to 0.57 at one to five years, RR 0.49; 95% CI 0.32 to 0.75 in periods beyond 5 years). In comparison with needle suspensions there was a lower failure rate after colposuspension in the first year after surgery (RR 0.66; 95% CI 0.42 to 1.03), after the first year (RR 0.48; 95% CI 0.33 to 0.71) and beyond 5 years (RR 0.32; 95% CI 15 to 0.71). Evidence from three trials in comparison with suburethral slings found no significant difference in failure rates. Patient-reported failure rates in short-, medium- and long-term follow-ups showed no significant difference between open and laparoscopic retropubic colposuspension, but with wide confidence intervals. In two trials failure was less common after Burch (RR 0.38 95% CI 0.18 to 0.76) than the Marshall Marchetti Krantz procedure at one to five year follow-up. There were few data at any other follow-up.

In general, the evidence available does not show a higher morbidity or complication rate with open retropubic colposuspension, compared to the other surgical techniques, although pelvic organ prolapse is more common than after anterior colporrhaphy and sling procedures.

Reviewers’ conclusions: The evidence available indicates that open retropubic colposuspension is the most effective treatment modality for stress urinary incontinence especially in the long term. Within the first year of treatment, the overall continence rate is approximately 85-90%. After five years, approximately 70% patients can expect to be dry. Newer minimal access procedures like tension free vaginal tape look promising in comparison with open colposuspension but their long-term performance is not known. Laparoscopic colposuspension should allow speedier recovery but its relative safety and effectiveness is not known yet.

Improving your review: Claims of 'No Difference' or 'No Effect'

Iain Chalmers and I have done a study looking at how often the abstracts of Cochrane reviews claimed that an intervention had 'no effect', or that there was 'no difference' between two or more interventions. We found that over 20% of abstracts available by mid 2001 had such claims. We looked again at new reviews available in the first half of 2002 and found that about 13% still made such claims. Feedback on this project has been sent to each CRG.

Why is this important?
It is never correct to claim that there is 'no effect' or 'no difference'. No matter how much data we have, there will always be some uncertainty around our estimates of effect, and this is reflected in the confidence interval. For example, in a review of steroids in head injury, there were 16 trials reporting on the risk of death, with a total of about 2,000 participants. The estimate of the effect of steroids was a risk ratio (RR) of 0.96 with a 95% confidence interval from 0.85 to 1.08. This means that we can conclude with some confidence that the true effect lies somewhere between a RR of 0.85 and 1.08. Both these extremes represent an effect within a range that is probably important to patients - a 15% decrease in the risk of death to an 8% increase. We would be wrong to report this as showing no effect of steroids, or that there is no difference between steroids and control.

Can we ever claim that interventions are 'similar' or 'equivalent'?

People conducting clinical trials have developed an approach called 'equivalence trials'. They come to a decision in advance about what size of effect is important to patients. When they have an estimate of effect and its confidence interval from the trial, they compare it with the predefined important difference.

So, for example, we might want to compare the effect of two different antibiotics on pain in middle ear infection in children. After consultation with parents, we could find that it would be important if the absolute risk of pain at 5 days were 10% more with one antibiotic than another. We are then saying that a result where the confidence interval lies completely between risk difference (RD) -0.1 and 0.1 has failed to find an important difference - the antibiotics have equivalent effect, in practical terms.

The diagram below gives an idea of how we might apply this idea to the results of trials. It shows the possible relationships between the line of no effect, the equivalence limits and the confidence interval from a trial. The diagram shows that it's much more helpful to think in terms of the range of likely values, and that the point estimates are only of limited value.
Improving your review: Claims of 'No Difference' or 'No Effect' (Continued)

It's also worth remembering that we choose the width of the confidence interval, usually as 95% confidence intervals, and sometimes the truth will lie outside this range. When interpreting the result we also need to remember to take all the other important factors into account, such as the possibility that the study is biased.

Should we apply the idea of equivalence to Cochrane systematic reviews?

In the same way that we could get an idea of equivalence limits for a trial, perhaps reviewers could give their readers an idea of what they consider to be an important effect size. The trials in a review may give a power calculation that specifies the size of effect the trialists considered to be important. Consumers involved in review groups could give a useful perspective on the size of effect they would hope to see with an intervention. It would certainly add some useful information to a review as long as we follow our usual rule and are explicit about how we've come up with our ideas on an important effect size. Then readers can judge for themselves if they agree.

What should we write in Cochrane reviews where we get a result with a confidence interval spanning the line of no effect?

We should be very careful never to claim that there is 'no effect' or 'no difference', unless we qualify the statement. For example, we might write that there is no statistically significant difference, although this does not give any idea of how much uncertainty there is. It is probably better to make sure we report the actual results, and draw conclusions such as 'the average effect might lie anywhere between X and Y' where X and Y are the ends of the confidence interval. Again, we need to be careful not to forget about the factors that might make our confidence interval incorrect, such as bias.

To help you think through the wording for your review, the table below gives a few examples of the way we classified the text we found in abstracts.

| Examples of statements classified as claiming 'no effect/difference' | "had no effect"  
| "the effectiveness [of intervention A] did not differ from that [of intervention B]" |
| Examples of statements not classified as claiming 'no effect/difference', but which could be better worded | "appeared to have equivalent efficacy"  
| "may be as effective"  
| "did not appear to be effective"  
| "was found to be no more effective"  
| "[Risk of the outcome] was similar [between two groups]" |
| Examples of appropriate wording | "there was no statistically significant effect" |

Phil Alderson
In Issues 1 and 2, 2003 we have published 5 new reviews:

Adrenergic drugs for urinary incontinence in women
Ammar Alhasso, Cathryn Glazener, Rob Pickard, James N'Dow

Oestrogens for urinary incontinence in women
Birgit Moehrer, Simon Jackson, Andrew Hextall

Open retropubic colposuspension for urinary incontinence in women
Marie Carmela Lapitan, June Cody

Periurethral injection therapy for urinary incontinence in adults
Rob Pickard, Jackie Reaper, Laura Wyness, June Cody, Sam McClinton, James N'Dow

Urinary diversion & bladder reconstruction / placement using intestinal segments for intractable incon or following cystectomy
Sze Yong, N Dublin, Rob Pickard, June Cody, DE Neal, James N'Dow

In Issues 1 and 2, 2003 we have published 8 new protocols:

Surgical management of pelvic organ prolapse in women
Chris Maher, Marcus Carey, Suzanne Hagen

Mechanical devices for pelvic organ prolapse in women
Elizabeth Adams, Angus Thomson, Chris Maher, Suzanne Hagen

Neuromodulation with implanted electrodes for urinary storage and voiding dysfunction in adults
Peter Herbison, Ted Arnold

Policies for removal of urethral catheters for short-term management of voiding in adults and children
Ritin Fernandez, Rhonda Griffiths

Types of urethral catheters for management of short-term voiding problems in hospitalised patients
Jane Brosnahan, Andrew Jull, Catherine Tracy

Urinary catheter policies for management of long-term voiding problems in adults
Barbara Niell-Weise, PJ van den Broek

Urinary catheter policies for short-term management of voiding in adults
Barbara Niell-Weise, PJ van den Broek

Urinary catheter washout policies for prevention of infection for long-term voiding problems in adults
John Mooney, Suzanne Hagen, Barbara Niell-Weise

Absorbent products for containing urinary and/or faecal incontinence in adults
Miriam Brazzelli, Liz Shirran, Luke Vale

Alarm interventions for nocturnal enuresis in children
Cathryn Glazener, Jonathan Evans, Rachel Peto

Anterior vaginal repair for urinary incontinence in women
Cathryn Glazener, Kevin Cooper

Anticholinergic drugs versus placebo for urinary incontinence in adults
Jean Hay-Smith, Peter Herbison, Gaye Ellis, Katherine Moore

Behavioural and cognitive interventions with or without other treatments for defaecation disorders in children
Miriam Brazzelli, Peter Griffiths

Biofeedback and/or sphincter exercises for the treatment of faecal incontinence in adults
Christine Norton, Gordon Hosker, Miriam Brazzelli

Bladder neck needle suspension for urinary incontinence in women
Cathryn Glazener, Kevin Cooper

Bladder training for urinary incontinence in adults
Brenda Roe, Kate Williams, Mary Palmer, Sheila Wallace

Conservative management of post prostatectomy incontinence
Katherine Moore, June Cody, Charis Glazener

Desmopressin for nocturnal enuresis in children
Cathryn Glazener, Jonathan Evans

Drugs for nocturnal enuresis in children (other than desmopressin and tricyclics)
Cathryn Glazener, Jonathan Evans

Electrical stimulation for faecal incontinence in adults
Gordon Hosker, Christine Norton, Miriam Brazzelli

Laparoscopic colposuspension for urinary incontinence in women
Birgit Moehrer, Gaye Ellis, Marcus Carey, Don Wilson

Management of faecal incontinence and constipation in adults with central neurological diseases
Maureen Coggrave, Miriam Brazzelli, Christine Norton

Pelvic floor muscle training for urinary incontinence in women
Jean Hay-Smith, Bary Berghmans, Kari Bo, Erik Hendricks, Rob de Bie, Ernst van Waalwijk van Doorn

Physical therapies for prevention of urinary and faecal incontinence in adults
Jean Hay-Smith, Peter Herbison

Prompted voiding for the management of urinary incontinence in adults
Sharon Eustice, Brenda Roe, Jan Paterson
This combined a position as Senior Registrar (with a particular emphasis in urogynaecology) with a Research Fellowship where I carried out my first RCT (on oestrogens and urodynamic stress incontinence) also doing several other studies related to conservative treatment of incontinence. This I eventually submitted for my MD thesis to the University of Glasgow.

Towards the end of my time in Manchester, Professor Ted Arnold from Christchurch in New Zealand visited our unit while he was on study leave. He suggested I apply for a Senior Lecturer position in Obstetrics and Gynaecology with the University of Otago in Dunedin. As a consequence I have been working here since 1980 and have been able to continue with clinical urogynaecology combining this with my interest in research and have enjoyed and benefitted from collaboration with Peter Herbison from the Department of Preventive and Social Medicine at the same University. I corresponded with Adrian Grant regarding our plans for an RCT on conservative treatment of postnatal incontinence and eventually met up with Adrian while he was still in Oxford in the early 1990’s. Through Adrian, I became interested in the Cochrane Collaboration and became an editor of our Cochrane Urinary and Faecal Incontinence Review Group in 1995 shortly after being appointed to the Chair of Obstetrics and Gynaecology at the Dunedin School of Medicine.

I was ‘grandfathered’ as a subspecialist in urogynaecology by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in 1998 and currently chair our College Subspecialty Committee in Urogynaecology. Most of my clinical work is now in this subspecialty, though I still take my share of the acute obstetrics and gynaecology on call roster.

Our Research group in Dunedin is very active with Jean Hay-Smith and Peter Herbison as co-editors of the Cochrane Urinary and Faecal Incontinence Review Group, along with Gaye Ellis as our departmental Research Coordinator.

I have been involved with the last two WHO International Consultations on Incontinence and I look forward to Chairing the group reviewing Conservative Treatment in Adults at the third ICI next year. In particular I am committed to evidence based practice in urogynaecology and the Cochrane Urinary and Faecal Incontinence Review Group - my only regret being that I am not able to spend as much time as I would like due to my other clinical and academic commitments.
The workshop was considered very successful. More than 31 people attended the workshop - very pleasing considering the charges (40 Euros to prebook or 50 Euros on the day) and last minute change of venue. There was a mixture of attendees, both health care professionals and company representatives. A number of offers of collaboration were received.

International Continence Society (ICS) Meeting 2003, Florence, Italy

The ICS will hold its 33rd Annual Meeting in Florence, Italy from 5th to 9th October. The Incontinence Group will hold their annual editorial meeting in Florence. We hope to be able to have an exhibition stand.

The XI Cochrane Colloquium Will Be Held in Barcelona, Spain from October 26 to 31, 2003

“Evidence, Health Care and Culture” by Jordi Pardo

The format of the Colloquium will be different from that of previous years: the Colloquium will be divided in two parts. The first part (26-29 October) will offer anyone who is currently actively involved in the Collaboration or anyone who wishes to understand more about systematic review methodology, a chance to meet and reflect on issues directly related to the internal work of the Cochrane Collaboration. During these three days, meetings of the different Cochrane entities and workshops on methodological training will be prioritised. We will also devote three plenary sessions and four parallel sessions to issues relevant to the Cochrane Collaboration.

The second part of the Colloquium (29-31 October) will focus on the discussion of the experiences and challenges of applying the scientific evidence in different health, cultural and economical backgrounds, evaluating the contribution of the Cochrane Collaboration to this process. The objective of this differentiation is to assess whether this format is appropriate for achieving the dual objectives of a Cochrane Colloquium that is: to discuss internal organisational and methodological issues, and also to offer an opportunity for academic and scientific debate of issues linked to the aims of the Collaboration. In previous Colloquia, sessions aimed to meet these different objectives took place during the same period of time, with opinion differing about their compatibility. For this reason, and with the agreement of the Cochrane Colloquium Policy Advisory Group, we have decided to implement this new format in Barcelona and to evaluate its success. A large range of sensational social events will be scheduled alongside all these scientific events: you will enjoy Barcelona!

Jordi Pardo is the Administrator of the Iberoamerican Cochrane Centre

For more information about the XI Colloquium please visit the Iberoamerican Centre Web site at: http://www.cochrane.es/colloquium/
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