

Pelvic floor exercises really do work

Dumoulin C, Lemieux MC, Bourbonnais D, Gravel D, Bravo G, Morin M. *Physiotherapy for persistent postnatal stress urinary incontinence: a randomized controlled trial. Obstet Gynecol.* 2004;104:504–510.

STUDY QUESTION

Do pelvic floor muscle exercise regimens improve persistent postnatal stress urinary incontinence, compared to no treatment?

RESULTS

More than 70% of parous women in 2 treatment groups were continent on pad testing, versus 0% in the control group: Pelvic floor muscle rehabilitation, 14 of 20 continent (70%); pelvic floor plus abdominal rehabilitation, 17 of 23 (74%).

EXPERT COMMENTARY

This well-designed study had important strengths: blinded outcome assessment, randomized design, and a proper control group.

A total of 64 women were randomized to a group that underwent fairly intensive instruction and assistance in pelvic floor muscle exercise (n = 21), a group following a similar physical therapy program plus abdominal training (n = 23), or a control group that received massage but no pelvic floor muscle exercise (n = 20). All subjects had 8 weekly therapy sessions under the supervision of a physiotherapist. The primary endpoint was a 20-minute pad test.

Everybody had a coach

Several weaknesses are notable. First, the setting was highly optimized: Every woman had a personal physiotherapy coach to oversee the rehabilitation program.

The small sample size and the fact that

outcomes were reported only 1 week after treatment ended are problematic, as are the strict exclusion criteria, which make results difficult to generalize. Further, some outcomes were reported as “cure” when urine leakage persisted. Why not divide out those who were “dry” versus “improved”?

It is unclear why the authors used “postnatal” in the title, since women were several years remote from delivery. The power calculation is also unclear, as the authors failed to document the effect size they used to derive their needed sample size.

What about the long term?

Short-term results are encouraging, but the more pertinent issue is whether outcomes will persist. Still, with more than 200,000 surgeries performed each year in the United States for female stress incontinence—with their many well-recognized complications—it is encouraging to see such excellent science applied to evaluating nonsurgical care.

BOTTOM LINE

Whenever possible, attempt nonsurgical treatment of persistent stress urinary incontinence. It is less invasive and less expensive than surgery, and stands a good chance of easing a patient’s symptoms.

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FAST TRACK

Pelvic floor muscle exercise restores continence in more than 70% of parous women with chronic stress incontinence

Aromatase inhibitors and breast cancer? Don't write off tamoxifen

Morandi P, Rouzier R, Altundag K, Buzdar AU, Therlault RL, Hortobagyi G. The role of aromatase inhibitors in the adjuvant treatment of breast carcinoma. The MD Anderson Cancer Center Evidence-Based Approach. *Cancer*. 2004;101:1482-1489.

STUDY QUESTION

What are the findings of 3 large randomized, controlled trials on adjuvant use of aromatase inhibitors?

RESULTS

All 3 trials found improved disease-free survival with aromatase inhibitors in women with early-stage breast carcinoma, compared with tamoxifen.

EXPERT COMMENTARY

Each aromatase inhibitor should be offered in clinical scenarios similar to those in the studies, the investigators concluded from their analysis. Each of the 3 trials focused on a single aromatase inhibitor:

- Anastrozole: 4-year disease-free survival of 86.9%, versus 84.5% in the tamoxifen group. *Arimidex, Tamoxifen Alone or in Combination study*
- Exemestane: 3-year disease-free survival of 91.5% for women already disease-free after 2 to 3 years of tamoxifen, versus 86.8% with 3 years of additional tamoxifen. *Intergroup Exemestane Study*
- Letrozole: 4-year survival of 93% for women who had completed 5 years of tamoxifen, versus 87% for no further treatment. *MA-17 trial*

Too little long-term data

Morandi and colleagues acknowledge the immaturity of their safety data, but give short shrift to osteoporotic fractures. With more and more women diagnosed with stage I—and even stage 0—breast tumors, I believe we must consider long-term safety data, especially in terms of osteoporotic fractures, before we make a wholesale change from selective estrogen receptor modulators (ie, tamoxifen) to aromatase inhibitors.

Match the patient to the study

While aromatase inhibitors are clearly superior in women with advanced breast cancer and probably superior in women at highest risk of recurrence, I am concerned about using them in women at extremely low risk for recurrence or mortality. We must make certain, however, that the patient we are treating has the same characteristics as the patients in the study upon which we are basing our management.

Furthermore, the American Society of Clinical Oncology Technology Assessment Working Group^{1,2} found that the evidence of tamoxifen's safety and efficacy is "compelling, extensive, and long-term." When it came to anastrozole, however, they found "extensive supporting data very promising, but insufficient to change the standard of practice at this time."

BOTTOM LINE

A 5-year course of adjuvant tamoxifen remains the standard for women with hormone-receptor-positive breast cancer. ■

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REFERENCES

1. Winer EP, Hudis C, Burstein HJ, et al. American Society of Clinical Oncology technology assessment on the use of aromatase inhibitors as adjuvant therapy for women with hormone receptor-positive breast cancer: status report 2002. *J Clin Oncol*. 2002;20:3317-3327.
2. Winer EP, Hudis C, Burstein HJ, et al. American Society of Clinical Oncology technology assessment working group update: use of aromatase inhibitors in the adjuvant setting. *J Clin Oncol*. 2003;21:2597-2599.

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Don't switch from tamoxifen to aromatase inhibitors until long-term safety data are in