Author’s response to reviews

Title: Mixed feelings: General practitioners’ attitudes towards eHealth for stress urinary incontinence - a qualitative study

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Author’s response to reviews:

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Dear Dr. Akila Sridar,

We are very delighted to hear that our paper ‘Mixed feelings: General practitioners’ attitudes towards eHealth for stress urinary incontinence – a qualitative study’ is potentially acceptable for publication in the BMC Family Practice.

We would like to thank the reviewer again for the constructive comments because we believe that these improved our manuscript. We have addressed these comments in this point-to-point letter and the manuscript is amended accordingly.

We await your reply with interest and we hope for a positive decision on publication in the BMC Family Practice.

Yours sincerely, on behalf of my co-authors,
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Point-to-point letter
Comments from Janny Dekker (reviewer 1)

‘The authors have reacted very adequately on my comments. Only some minor remarks and a few questions are left:’

1. ‘In the BACKGROUND section is stated that stress incontinence is the most prevalent subtype of incontinence. I doubt if that is correct: many studies have shown that mixed incontinence is the most prevalent type (but of course: mixed incontinence is partly stress incontinence). ref. Melville, et al. Urinary incontinence in US women: a population-based study. Archives of Internal Medicine 2005; 165(5), 537-542.’

The study of Melville et al., indeed showed that mixed urinary incontinence (MUI) is more prevalent than stress urinary incontinence (SUI) in American women who are over 50 years. Prevalence rates for women under the age of 50 are equal for SUI and MUI. The studies that we refer to (Hannestad et al. 2000 and Schreiber Pedersen et al. 2017) are conducted in European countries and they both report that SUI is more prevalent than MUI. In the Norwegian study conducted by Hannestad et al. the overall prevalence of SUI and MUI was 50% and 36% respectively, although MUI is more common in women over 60 years. The study of Schreiber Pedersen, et al showed an overall prevalence of SUI and MUI of 21-24% and 13% respectively. This study was conducted in Germany and Denmark. The strength of this latter study is that they used a consistent definition and method to assess prevalence and therefore to be able to compare it between countries. Definition and methods often differ between prevalence studies which hampers comparison.
In our background section we added that the epidemiological studies were conducted in European counties. Furthermore, your comment gave us the opportunity to correct the prevalence rate of 69% that we initially wrote down, because that was the overall prevalence rate of urinary incontinence and not of SUI specifically (that was 33%).

The text in the ‘Background’, page 4, was rewritten accordingly:

‘According to two European studies the prevalence of SUI varies between 21% and 33%, with a peak prevalence between 40 and 49 years [2,3].’

2. ‘Also in the BACKGROUND section: Only 15 % of women with SUI seek help. Is that percentage not too low? As far as I know, 30 % - 50 % of the women with urinary incontinence seek help.’

The study of Shaw et al. (ref 6 in our manuscript) showed indeed a help-seeking rate of 15% for British women with SUI. However, we completely agree with the reviewer that help-seeking rates do vary between studies. For example, Schreiber Pedersen et al, Int Urogynecol J, 2018 reported that in Germany and Denmark rates are 31% and 25% among women with all types of urinary incontinence. For SUI specifically the help-seeking rates among German and Danish women were 27% and 19% respectively. In conclusion, there is a variation in help-seeking rates and we therefore changed the help-seeking rate into a number that approximates the exact rate.

We amended the background section, page 4, accordingly.

‘Among women with SUI only one in three seek professional help [6, 7].’

3. We divided the third comment of the reviewer into four subcomments:

a. ‘On page 4 lines 53-59 and page 5 line 1-7 the evidence on the effectiveness of e-Health interventions for UI is summarized. Unfortunately, the authors only give information on one trial, with an internet based program (Sjostrom). What was the result of the App based study by Asklund?’

Initially, we reported the findings of Sjöström because our study was based on that study’s intervention. In the current version of the manuscript we combined the results of the study of Asklund and Sjöström and thereafter we explain the Internet-based intervention.
The background section, page 4 and 5, was changed into:

‘Two Swedish randomised controlled trials (one with an internet-based and one with a mobile phone intervention) and one observational feasibility study (internet-based intervention) have been conducted in this area [18,19, 20]. The Swedish trials showed that symptom severity and incontinence-related quality of life improved significantly after women received an Internet-based intervention, or a mobile phone app intervention with PFMT [18,19]. During the Internet-based intervention, there was no face-to-face contact, but a urotherapist sent reminders via e-mail and was available for questions if needed. Most women appreciated this contact because it motivated them, and they felt supported without being exposed [21].’

b. ‘And the third study by Barbato was a small (n=34) observational study, with a web-based intervention (not an App as is suggested in line 4 on page 5, where the authors write about two studies using a mobile phone application).’

We made a mistake here, thank you for making this comment. We changed it in our manuscript on page 4.

‘Two randomized controlled trials (one with an internet-based and one with a mobile phone intervention) and one observational feasibility study (internet-based intervention) have been conducted in this area [18,19, 20].’

c. ‘The way of recruiting participants for these three studies differs from the way a GP would use an e-Health application for his/her patients. So, in my opinion, we do not have firm evidence on the effectiveness of e-Health for UI in general practice. And especially not on the effectiveness in elderly women.’

The reviewer correctly stated that participants in the three studies are selected from the community and not from a primary care practice. However, in our opinion the content of eHealth is very similar to the existing first-line treatment. The studies used an intervention that was based on highly recommended pelvic floor muscle training. The only and important difference with regular care being that eHealth has no face-to-face supervision. The studies have shown that this internet or mobile phone PFMT-based treatment without supervision can be successful.
Regarding the elderly women, Lindh et al (ref 37) showed that increasing age was a significant predictor of treatment success among women who participated in the RCT conducted by Sjöström et al. The mean age for the ‘success group’ was 53.45 (SD ±9.50) and for the ‘failure group’ 48.73 (SD ±10.73). However, we realize that this difference in age might not quite match with our statement that there is enough evidence about the effectiveness in elderly. Therefore we rewrote the text in the discussion on page 14.

‘Lastly, this study implicates that GPs might be prejudiced about age and treatment for women with SUI. GPs expected that young women would be more suitable for an eHealth intervention compared with older women, but a previous eHealth study for SUI showed that increasing age is a significant predictor for success [37]. Caution is needed, however, as eHealth interventions for urinary incontinence are only studied in a relatively young population [18,19].’

d. ‘That is why I do not agree with the remark in the CONCLUSION (page 15 line 29-31: These perceived shortcomings are in contrast with the literature on eHealth for SUI. The research on eHealth for SUI is not yet convincing enough. We have to be more cautious in drawing conclusions.’

We removed the sentence about the GPs’ perceived shortcomings of eHealth as no-cure all because the evidence for the effectiveness for the elderly is not yet convincing (see sub comment c).

This removal resulted in the following text in the conclusion on page 15:

‘GPs also thought that eHealth was no cure-all therapy, especially not for the elderly. Training should inform GPs about these new treatment possibilities for SUI and should focus on common misunderstandings about regular care for these women.’