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Authors' reply

Men were taught to tighten both their deep and superficial muscles by imagining stopping the flow of urine, preventing wind from escaping, and observing penile and testicular lift. Pelvic-floor muscle training was not used to strengthen the external sphincter, but to compensate for its reduced function by preventing the passage of urine using the pelvic floor muscles to constrict the urethra at or below the level of the external sphincter. Our outcome of interest was whether this was successful in preventing urine leakage.

Our pragmatic trial was designed to assess the effectiveness and cost-effectiveness of routine physiotherapy services typically available in the National Health Service in the UK and other publicly funded health-care systems, in contexts where information about pelvic floor muscle training is widely available. The study was not intended to assess the efficacy of long-term and individually tailored instruction, nor the use of highly specialised physiotherapists. We did show an increase in pelvic-floor muscle strength and increased practice of contractions,[1] but whether more frequent or more specialised training might be more effective remains unclear.

We used the first two questions of the ICIQ-UI short-form questionnaire to define "any urinary incontinence", not taking into account the third question which captures the effect on quality of life. We would argue that any urine loss is meaningful to patients. We justified our choice of a subjective outcome measure as one that is relevant to men, and judged by them to be affecting their quality of life. We do not agree that "objective" measures such as the pad test are more relevant to men, and in addition these are very variable and hence unreliable.[2] We accounted for the degree of incontinence by accepting all men with urinary incontinence into the trial but analysing "more severe" urinary incontinence separately. In fact, more than 90% of our participants had "severe urinary incontinence" at baseline (defined as losing a moderate to large amount of urine at least once per day), and half of them improved to having only "mild urinary incontinence" by 12 months.

Our trial was pragmatic in that it reflected the range of prostate surgery available in a large number of typical UK centres, including high-volume and low-volume centres. There are many factors that affect outcome after radical prostatectomy including tumour factors, patient factors, surgeon factors, and centre factors. Although all surgeons attempted nerve-sparing techniques, this was not always possible. Some men had laparoscopic or perineal surgery rather than open abdominal procedures.

The panel in our paper was intended to place the MAPS trial in the context of other published studies. MAPS is the largest trial of formal one-to-one pelvic-floor muscle training for the treatment of urinary incontinence in men after radical prostatectomy and the only such study in men after transurethral resection of the prostate. A 1999 Cochrane review had highlighted the lack of reliable evidence on which treatment decisions could be based. The most recent search of the literature identified at least 16 more trials, of which only one (by Manassero and colleagues) had 12-month outcome data in the relevant population. Comments were made specifically about the Manassero trial only because it was relatively recent and therefore was not included in the last published review. We explained the effect of adding the Manassero trial to the Cochrane meta-analysis and highlighted possible reasons for these effects, one of which was the differential dropout rate, which can be regarded as a source of bias in the context of meta-analysis.

Finally, the small trial by Centemero and colleagues might be regarded as prevention rather than treatment of urinary incontinence, and hence did not address the same population of men. Nevertheless, we considered that there was a high risk of bias because outcomes were assessed by those who did the interventions.

BB has received reimbursement of expenses for attending symposia, conferences, and educational events from Pfizer, Astellas, Medtronic, Roche, and SCA Hygene, and a consultancy fee from Astellas for preparing a report on a television awareness campaign on overactive bladder. Between 2003 and 2008, JN was Director of CHaRT, the NIHR fully registered Trials Unit that supported the design, conduct, analysis, and reporting of the MAPS study. The other authors declare that they have no conflicts of interest.

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Can the Dutch Government really be abandoning smokers to their fate?

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The Government of the Netherlands has announced that it is all but closing down its tobacco control

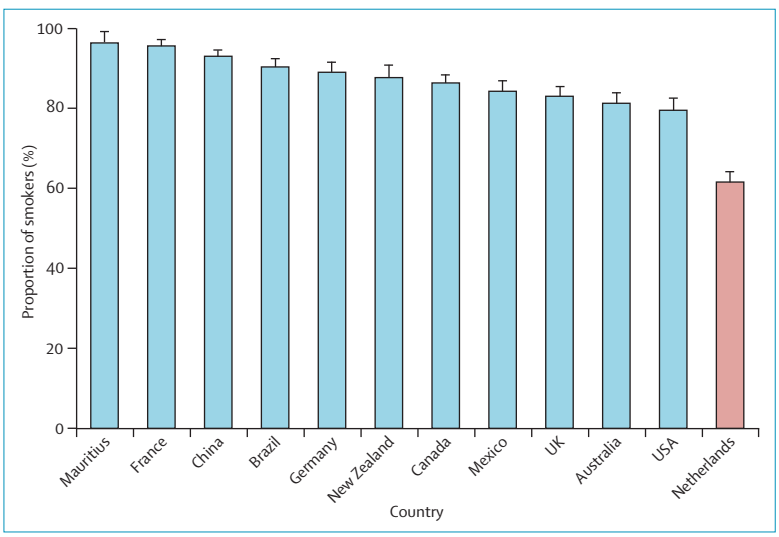

Figure: **Proportion of smokers who agree that smoking is dangerous to non-smokers**
Reproduced from reference 4 with permission.

operations. It has already weakened its existing smoke-free laws. It will reverse a previous decision to ensure that smokers who want to stop but cannot do so by themselves receive evidence-based treatment to help them.[1] And it plans to close down the world-renowned national centre on tobacco control, STIVORO. This at a time when smoking prevalence in the Netherlands is relatively high among western countries at 27%,[2] resulting in an estimated almost 20 000 premature deaths per year.[3]

Moreover, cross-country comparative findings from the International Tobacco Control Policy Evaluation Project[4] show that Dutch smokers are the least knowledgeable or concerned about the harms of smoking and second-hand smoke of all the 12 countries covered—by a substantial margin (figure). These findings indicate that the Dutch Government should not be cutting funding for tobacco control but should instead be increasing its efforts to reduce smoking in line with its commitments as a party to the WHO Framework Convention on Tobacco Control.

The contrast with the UK could not be more stark. The English Department of Health recently published an ambitious tobacco-control strategy that is both comprehensive and evidence-based.[5] It recognises that tobacco is lethal and addictive and that society as a whole has a responsibility to encourage and help smokers who want to stop and to prevent young people getting addicted.

It would be a matter of no little shame to a country that prides itself on a compassionate and inclusive ethos if its government were to abandon smokers to their fate. Every death that ensued would not just be the responsibility of the tobacco industry, which continues to promote its lethal product, but also of every politician in the Dutch Government who chose to look the other way and allow it to happen.

RW receives research funding and undertakes consultancy for companies that manufacture smoking cessation medications. MCW is a senior researcher at STIVORO. The other authors declare that they have no conflicts of interest.

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Department of Error

Mehilli J, Pache J, Abdel-Wahab M, et al, for the Is Drug-Eluting-Stenting Associated with Improved Results in Coronary Artery Bypass Grafts? (ISAR-CABG) Investigators. Drug-eluting versus bare-metal stents in saphenous vein graft lesions (ISAR-CABG): a randomised controlled superiority trial. Lancet *2011;* ***378:*** *1071–78*—In table 1 of this Article (Sept 17), the mean age of the drug-eluting stent group should have been 71·4 (9·0) years. This correction has been made to the online version as of Jan 13.