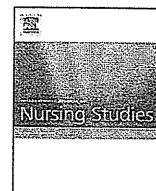


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The effects of multidimensional exercise treatment on community-dwelling elderly Japanese women with stress, urge, and mixed urinary incontinence: A randomized controlled trial

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ABSTRACT

Background: Urinary incontinence is one of the most prevalent health problems and a significant cause of disability and dependence in the elderly. Pelvic floor exercise is effective in reducing stress urinary incontinence, but few studies have investigated the effect of behavioral management on urge and mixed incontinence.

Objectives: To determine the effects of multidimensional exercise treatment on reducing urine leakage in elderly Japanese women with stress, urge, and mixed urinary incontinence.

Design: Randomized controlled, follow-up trial.

Settings: Urban community-based study.

Participants: 127 community-dwelling women aged 70 and older with stress, urge, and mixed urinary incontinence were randomly assigned to the intervention ($n = 63$) or the control group ($n = 64$).

Methods: Urine leakage and fitness data were collected at baseline, and after the intervention and follow-up. The intervention group received a multidimensional exercise treatment twice a week for 3-month. After treatment, the participants were followed for 7-month.

Results: There were significant differences in changes of functional fitness and incontinence variables between the intervention and control groups. The intervention group showed urine leakage cure rates of 44.1% after treatment and 39.3% after follow-up ($\chi^2 = 21.96$, $p < 0.001$); whereas, the control group showed no significant improvement. The multidimensional exercise treatment was significantly effective in decreasing all three types of urinary incontinence. However, the effects of the exercise treatment were greater on stress urinary incontinence than on urge or mixed urinary incontinence. At the 7-month follow-up, while cure rates of all three types of urinary incontinence were significantly maintained, a slight reversal was seen only in the urge and mixed urinary incontinence ($\chi^2 = 10.28$, $p = 0.008$). According to the logistic regression model, urine leakage volume (adjusted odds ratio OR = 0.69, 95% confidence interval CI = 0.39–0.98), compliance (OR = 1.03, 95%CI = 1.01–1.16), and BMI reduction (OR = 0.67, 95%CI = 0.48–0.89) were significantly associated with the cure of urine leakage after intervention. The cure rate of urine leakage after the follow-up was significantly associated with compliance (OR = 1.13, 95%CI = 1.02–1.29) and BMI reduction (OR = 0.78, 95%CI = 0.60–0.96).

Conclusions: The intervention group showed higher urine leakage cure rates than control group. This result suggests that multidimensional exercise strategies may be effective for all three types of urinary incontinence. BMI reduction and compliance to the intervention was the consistent predictor for the effectiveness of the exercise treatment.

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What is already known about the topic?

- Several factors such as overweightness, high body mass index, and increased abdominal fat have been associated with higher risk of urinary incontinence.
- Behavioral management is effective in the treatment of stress urinary incontinence and is therefore recommended as a first-line therapy.
- Compliance has a positive influence on the effects of the exercise treatment.

What this paper adds

- Multidimensional exercise treatment targeting pelvic floor muscles and abdominal fat and/or BMI reduction are equally effective in reducing stress, urge, and mixed urinary incontinence after the intervention and follow-up.
- BMI reduction as well as compliance to the prescribed exercise regimen was the most consistently significant predictors of the short- and long-term effectiveness to the behavioral therapy.
- Multidimensional exercise treatment should be considered for the elderly as a strategy for reducing incontinence and improving functional capacity.

1. Introduction

Urinary incontinence (UI) in elderly people is a common condition that contributes greatly to the loss of independence, decrease in quality of life, restriction of social activities, and increase in risk for hospitalization or long-term care. The estimated prevalence of UI ranged from 17 to 55% depending on the definition of UI, the population characteristics, and the methodological approach (Thom, 1998). A number of methods are used to treat or deal with UI. Pelvic floor muscle (PFM) exercise, devised by Kegel (1948), is recommended as a first line of treatment in the management of stress UI and many investigators have validated the short- and long-term effects on stress UI (Cammu and Van Nylen, 1995; Goode et al., 2003; Kim et al., 2007). PFM exercise is hypothesized to enhance urethral resistance by increasing the strength and endurance of the periurethral and perivaginal muscles and by improving the anatomic support given to the bladder neck and proximal urethra (Kegel, 1951; Bo et al., 1999). One previous study found that PFM exercise reduces urine leakage in urge and mixed UI because of inhibition of the bladder reflex associated with PFM contraction; however, this study had no control group (Nygaard et al., 1996).

Several studies have reported that obesity and high BMI are associated with UI (Bump et al., 1992; Brown et al., 1999). One study reported objective and subjective resolution of stress and urge UI after surgically inducing weight loss in morbidly obese women (Bump et al., 1992). These results suggest that weight reduction is desirable for UI treatment (Subak et al., 2005; Auwad et al., 2008; Wing et al., 2010). We hypothesized that fitness exercises focused on strengthening the abdominal muscles would reduce abdominal fat and/or BMI, and thereby reduce

abdominal wall pressure, intravesicular pressure, and the risk of UI in elderly women.

We conducted a randomized controlled trial to measure the effects of a multidimensional exercise treatment (FPM and fitness exercises) on urine leakage episodes in community-dwelling elderly Japanese women with stress, urge, and mixed UI, and to identify the factors that influence the effectiveness of the trial.

2. Methods

2.1. Subjects

The subjects in this study were randomly selected from the Basic Resident Register of 5935 women aged 70 and older that resided in the Itabashi ward (district) of Tokyo as of April 1, 2006. Information about the study was mailed to potential subjects. The baseline survey was conducted in November 2006, and 957 (16.1%) women participated. Out of the participants, 416 (43.5%) were experiencing some urinary incontinence, and 194 (46.6%) were classified as experiencing urine leakage more than once a week.

The inclusion criteria were: (1) suffering from urge, stress, or mixed UI; (2) being ≥ 70 years old; (3) having urine leakage episodes more than once a week; and (4) completing a 1-week urinary diary. The exclusion criteria included (1) an unclear UI type; (2) having urine leakage episodes less than once a week; (3) not completing the 1-week urinary diary; (4) impaired cognition (a Mini-Mental State Examination score of < 24) (Folstein et al., 1975; McDowell et al., 1999) and (5) unstable cardiac conditions such as ventricular dysrhythmias, pulmonary edema, or other musculoskeletal conditions. Sixty seven (34.5%) of the potential participants were excluded because they were classified into one or more of the exclusion criteria. The study protocol was approved by the Clinical Research Ethics Committee of Tokyo Metropolitan Institute of Gerontology (TMIG). The procedures were fully explained to all participants, and written informed consent was obtained (Fig. 1).

2.2. Randomization

Randomization was performed after the baseline assessment and completion of the 1-week urinary diary, and any variable that identified personal information was not included in the randomization process. The assigned identification numbers of 127 participants (stress = 37, urge = 47, and mixed = 43) were divided into two groups based on the computer-generated random numbers. One group was randomly assigned to the intervention group ($n = 63$), and the other to the control group ($n = 64$). There was no attempt to equalize the size of the groups based on their characteristics or to recruit subjects with specific characteristics. The randomization procedure was blinded, and the investigators that evaluated the effects of the exercise treatment were blind to the allocation of interventions.

2.3. Outcome measures

The primary outcome of this trial was the cure rate of urine leakage episodes, which was assessed by the self-

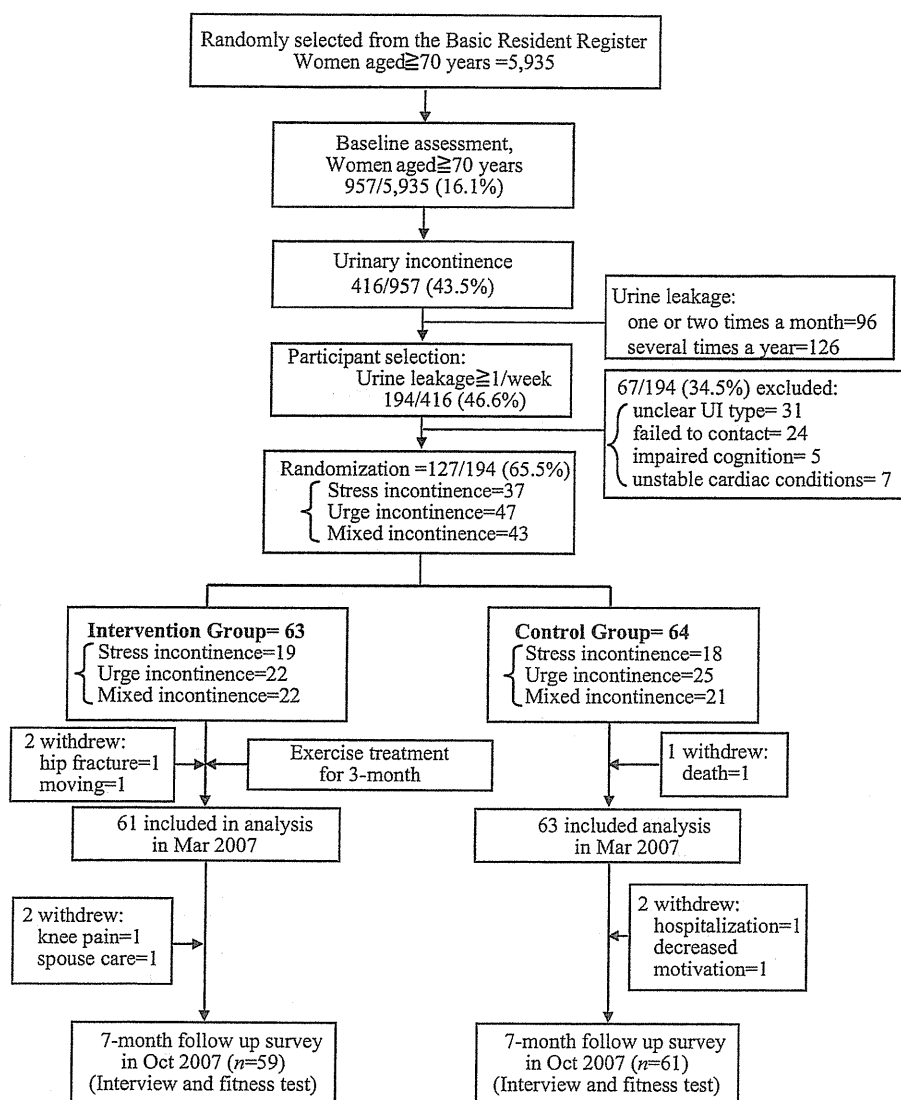


Fig. 1. Flow of the participants through the randomized controlled trial of exercise treatment and analyses.

reported urinary diary data (Wyman et al., 1988; Locher et al., 2001). The effects of the exercise treatment on urine leakage episodes were assessed based on the changes in the 5-point scale (1 = no urine leakage, 2 = less than once a week, 3 = once a week, 4 = two or three times a week, and 5 = everyday) recorded in the 1-week urinary diary, which was obtained pretreatment, after the 3-month exercise and 7-month follow-up. Complete cessation of urine leakage episodes was defined as cured.

2.3.1. Interview survey and urinary diary

A face-to face interview was conducted to assess temporary UI conditions based on the modified International Consultation on Incontinence Questionnaire (ICIQ) (Avery et al., 2004). The ICIQ was easily completed with low levels of missing data (mean 1.6%), good construct validity, and acceptable convergent validity. Reliability

was good with moderate to very good stability in test-retest analysis and a Cronbach's alpha of 0.95 (Avery et al., 2004; Gotoh et al., 2009). The first question was "Have you experienced urine leakage during the previous year?" If the person responded that urine leakage episodes occurred more than once a week, to confirm the pretreatment frequency of urine leakage episodes, potential subjects were provided with a 1-week urinary diary. The subjects documented the time of every void and urine leakage episode, as well as the amount and circumstance of each episode. To confirm the changes of frequency, the urine leakage scores were calculated based on the self-reported 1-week urinary diary as follows: 0 = no urine leakage, 1 = less than once a week, 2 = once a week, 3 = two or three times a week, and 4 = every day.

UI type was classified based on inquiries about urine leakage in relation to 8 possible antecedents (Avery et al.,

2004). Stress UI was recorded when urine leakage was associated with increased abdominal pressure such as coughing, sneezing, or participating in some other physical activity. Urge UI was recorded when urine leakage was reported to be associated with running water or an urge to void and not being able to reach the toilet in time. When the characteristics of both stress and urge UI types were present, it was defined as mixed UI.

The subjects were asked about the onset age and duration of UI, frequency of daytime and nighttime voiding, and chronic medical conditions.

2.3.2. Functional fitness test

Measurements of height and body weight were converted to body mass index (BMI, kg/m²), waist circumference, and fitness test variables including grip strength, usual and maximum walking speed, and seated hip adductor muscle strength. The procedures for the fitness tests have been described in detail in a previous report (Kim et al., 2007).

2.4. Intervention

2.4.1. Intervention group

The participants attended an exercise treatment session 2 times a week for 3-months at the TMIG health promotion classes. The protocols of the PFM and fitness exercises have been published previously (Kim et al., 2007). The following exercises were performed by the participants.

2.4.2. Stretching exercise

Before the PFM exercise and muscle strengthening training, the participants performed 5–10 min of warm-up and stretching exercises, including shoulder rotation, waist rotation, and others.

2.4.3. PFM exercises

The subjects were trained to exert force only on the PFM without excessively straining the abdomen. The exercise regimen was designed to strengthen the fast- and slow-twitch muscle fibers located on the pelvic floor. The participants were initially instructed to perform 10 fast contractions (3 s) with a 5-s relaxation and 10 sustained contractions (8–10 s) with a 10-s relaxation between the contractions. The PFM exercise was performed in the sitting, lying, and standing positions with the legs apart, while emphasizing contraction of the PFM and relaxation of the other muscles.

2.4.4. Fitness exercises

Strength training of the thigh and abdominal muscles was performed between the PFM exercises. The fitness exercise included: lifting the foot (or both feet) and pointing toes then slowly pulling toes back toward the shin, slowly lifting one knee (or both knees), tilting the pelvis backward and forward, lifting the buttocks while on the back with the knees bent, raising one leg while lying on the back, and others. The ball exercises included actions like sitting on the ball, rolling the ball and the pelvis forward and backward, and moving from side to side, squeezing the thighs, lifting the ball with the legs, and others.

2.4.5. Control group

The control group received general education classes once a month for three months, where participants were educated on cognitive function, osteoporosis, and oral hygiene.

2.5. Follow-up

During the 7-month follow-up period, the participants attended 1-h exercise classes once a month at the TMIG health promotion center. The home-based program consisted of two to three sets of the 13 exercises and the PFM exercises that they had learned during the group exercise sessions. They were encouraged to perform the home-based exercises at least three times per week for approximately 30 min per day. To accurately monitor the exercise times and the number of sets performed during the follow-up period, a pamphlet illustrating the PFM and strengthening exercises and a recording sheet were distributed to the subjects. The subjects were asked to document the time and sets of exercises performed at home each day, the urine leakage episodes, and the amount and circumstances of each episode. The record sheets were collected once a month at the group exercise class and analyzed to calculate the mean exercise frequency per week and the mean exercise time per day. When a participant was absent from an exercise class, we mailed the record sheet to the individual.

2.6. Data analysis

The sample size was calculated to allow detection of a 20.0% reduction in urine leakage episodes between groups with 80% power and a significance level of 0.05 (Burgio et al., 2002).

The mean differences between groups were analyzed using the *t*-test for continuous variables and the chi-square test for categorical variables. To evaluate the differences between the groups in the effects of the intervention on selected continuous variables and urine leakage score at the baseline, after the 3-month exercise, and at the 7-month follow-up, a repeated-measures two-way analysis of variance (ANOVA) was performed. Significant interactions were analyzed to determine whether the effects were greater in the intervention or control group. A repeated-measures one-way ANOVA was also performed to evaluate the within group. A *post hoc* analysis was performed using the Scheffe method. The generalized estimating equation was used to compare the effects between the groups after 3-month exercise and at the 7-month follow-up on the cure rate of UI. The Kruskal–Wallis test was used to evaluate the differences of UI type in the effect of the exercise treatment on urine leakage episodes. The Cochran Q-test was used to evaluate the within-group differences in the effect of the exercise program on urine leakage episodes for baseline, 3-month exercise, and follow-up data.

Multiple logistic regressions were performed to identify variables that were associated with cured urine leakage after 3-month of exercise and at the 7-month follow-up after intervention. All analyses were performed using SPSS software, Windows version 15.0 (SPSS, Inc., Tokyo, Japan).

Table 1
Selected variables characteristics of participants at baseline by study group.

Variables ^a	Intervention group (n = 63)	Control group (n = 64)	p Value ^b
Age (yr)	76.1 ± 4.3	75.7 ± 4.4	0.625
Height (cm)	148.4 ± 5.8	148.9 ± 6.2	0.639
Body weight (kg)	51.8 ± 8.7	54.0 ± 7.9	0.202
BMI (kg/m ²)	23.4 ± 3.3	24.3 ± 3.0	0.195
Waist circumference (cm)	78.9 ± 10.2	78.5 ± 9.9	0.853
Grip strength (kg)	19.2 ± 4.6	18.6 ± 4.7	0.561
Adductor muscle strength (kg)	20.6 ± 6.9	21.5 ± 4.8	0.502
Usual walking speed (m/s)	1.2 ± 0.3	1.1 ± 0.3	0.282
Maximal walking speed (m/s)	1.7 ± 0.4	1.7 ± 0.4	0.423
Onset age of incontinence (yr)	71.3 ± 7.6	71.0 ± 7.1	0.865
Period of incontinence (year)	4.8 ± 6.4	4.6 ± 6.0	0.890
Frequency of toilet in daytime (times)	7.7 ± 3.1	7.4 ± 2.3	0.525
Frequency of toilet in night (times)	1.9 ± 1.2	1.8 ± 1.3	0.581
Frequency of urine leakage (%)			
Everyday	46.0	50.0	0.714
1 every two days	11.1	7.8	
More than once a week	42.9	42.2	
Amount of urine leakage, large (%)	23.8	32.8	0.210
Chronic medical conditions, yes (%)			
Hypertension	57.1	57.8	0.918
Hyperlipemia	36.5	40.6	0.712
Diabetes	17.5	15.6	0.780

^a Data are presented as M (mean) and SD (standard deviation) for continuous variables, and percentage for categorical variables. BMI = body mass index.

^b Two group *t*-tests for continuous variables and chi-square test for categorical variables.

3. Results

3.1. Subjects characteristics and compliance

The baseline demographic, fitness, and interview variables of the participants in the two groups are

summarized in Table 1. Most of the baseline characteristics were similar between the groups.

The attendance rate during the 3-month exercise treatment ranged from 63.5% to 81.1%, with a mean of 70.3%. Seven participants (intervention group = 4, control group = 3) were unable to complete the study after

Table 2
Comparison of functional fitness and incontinence variables between intervention (n = 59) and control (n = 61) after 3-months of exercises and the 7-month follow-up.

Variables ^a	G ^b	Baseline	3-month exercise	7-month follow-up	ANOVA ^c G × T	p Value
Body Weight (kg)	I	52.0 ± 8.9	51.9 ± 8.8	50.9 ± 8.9	F = 5.78	0.018
	C	53.9 ± 8.2	53.9 ± 8.2	53.9 ± 8.1		
BMI (kg/m ²)	I	23.7 ± 3.4	23.5 ± 3.0	23.2 ± 3.1	F = 11.49	0.001
	C	24.1 ± 2.9	24.0 ± 2.7	24.4 ± 3.4		
WC (cm)	I	78.8 ± 10.3	77.8 ± 9.7	77.7 ± 9.9	F = 4.06	0.041
	C	79.3 ± 10.4	79.2 ± 10.5	78.9 ± 9.6		
UWS (m/s)	I	1.2 ± 0.2	1.2 ± 0.2	1.2 ± 0.2	F = 2.79	0.099
	C	1.1 ± 0.3	1.1 ± 0.3	1.1 ± 0.2		
MWS (m/s)	I	1.7 ± 0.4	1.8 ± 0.4	1.8 ± 0.4	F = 5.10	0.027
	C	1.7 ± 0.4	1.6 ± 0.3	1.6 ± 0.4		
GS (kg)	I	19.0 ± 4.7	20.7 ± 5.0	19.8 ± 5.7	F = 0.37	0.547
	C	19.0 ± 4.2	20.2 ± 3.5	19.5 ± 3.8		
AMS (kg)	I	20.5 ± 7.1	24.1 ± 7.7	24.3 ± 7.9	F = 11.00	0.001
	C	21.2 ± 4.8	22.1 ± 4.8	21.8 ± 4.9		
ULS (point)	I	5.0 ± 1.0	3.0 ± 2.0	3.6 ± 2.2	F = 7.64	0.007
	C	5.1 ± 1.0	4.4 ± 1.6	4.8 ± 1.6		
Cure of urine leakage	I	0.0	44.1	39.3	21.96	<0.001
	C	0.0	1.6	1.6		
Cure of urine leakage in intervention group	Stress	0.0	63.2 ^d	66.7 ^e	15.77	<0.001
	Urge	0.0	35.0 ^d	26.1 ^e	7.49	0.032
	Mixed	0.0	40.1 ^d	30.0 ^e	9.56	0.016

^a Data are presented as mean and standard deviation. WC = waist circumference; UWS = usual walking speed; MWS = maximum walking speed; GS = Grip strength; AMS = adductor muscle strength; ULS = urine leakage score.

^b G = group, I = intervention group, C = control group.

^c ANOVA = analysis of variance, T = time. Chi-square and *p* values are from generalized estimating equation. Conhnan's Q-value.

^d Kruskal–Wallis test: chi-square = 1.99, *p* = 0.391.

^e Kruskal–Wallis test: chi-square = 10.28, *p* = 0.008. (Scheffe's *post hoc* = stress > urge, mixed urinary incontinence).

randomization due to hip fracture ($n=1$), moving ($n=1$), knee pain ($n=1$), spouse care ($n=1$), death ($n=1$), hospitalization ($n=1$), and decreased motivation ($n=1$) (Fig. 1). The exercise frequency during the 7-month follow-up period was reported to be every day in 35.7% of the subjects, two to three times a week in 42.9%, and once or less per week in 21.4%. The mean exercise time was 29.3 min, and the mean number of contractions of the PFM was 52 times a day during the 7-month follow-up period.

3.2. Functional fitness and urinary incontinence

The comparison of the effects of the treatment on selected variables between the intervention and control group are summarized in Table 2. A repeated measures ANOVA and generalized estimating equation revealed significant increases in adductor muscle strength ($F=11.00$, $p=0.001$) and maximum walking speed ($F=5.10$, $p=0.027$) after the 3-month exercise and at the 7-month follow-up in the intervention group compared with the control group. Body weight ($F=5.80$, $p=0.018$), BMI ($F=11.49$, $p=0.001$), waist circumference ($F=4.06$, $p=0.041$), and the urine leakage score ($F=7.64$, $p=0.007$) decreased significantly in the intervention group, whereas no significant changes were seen in the control group. The women who reported no urine leakage episodes in their 1-week urinary diaries accounted for 44.1% of the intervention group and 1.6% of the control group after the 3-month exercise treatment, and 39.3% of the intervention group and 1.6% of the control group at the 7-month follow-up ($\chi^2=21.96$, $p<0.001$). After the 3-month exercise, the cure rates of urine leakage increased significantly across the three subgroups of UI. At the 7-month follow-up, although slight decreases were observed in the cure rates of urine leakage related to urge and mixed UI, the cure rates of all three subtypes; stress (Q-value = 15.77, $p<0.001$), urge (Q-value = 7.49, $p=0.032$), and mixed (Q-value = 9.56, $p=0.016$) UI were significantly maintained. However, the efficacy of the exercise treatment on stress UI was greater than the effects on urge or mixed UI after 7-month follow-up ($\chi^2=10.28$, $p=0.008$; *post hoc* = stress > urge, mixed UI).

Before treatment, the urine leakage score was similar between the groups (Fig. 2). However, the urine leakage score significantly decreased after the 3-month exercise treatment and at the 7-month follow-up in the intervention group compared with the control group ($F=7.22$, $p=0.009$) (A). The effect of the treatment across the intervention period was assessed for each subgroup of UI (B). At baseline, the urine leakage scores were similar across the three subgroups, although the mixed UI subgroup had a slightly higher score. A repeated measures ANOVA also showed significant subgroup by time interaction ($F=5.13$, $p=0.008$). The stress subgroup showed a significant decline in urine leakage score after the 3-month exercise treatment and the 7-month follow-up ($F=8.23$, $p<0.001$). The urge ($F=3.46$, $p=0.034$) and mixed ($F=4.10$, $p=0.019$) subgroups each also showed significant declines in urine leakage scores after the 3-month exercise, although slight reverse patterns of increase were observed at the 7-month follow-up, these changes were not significant.

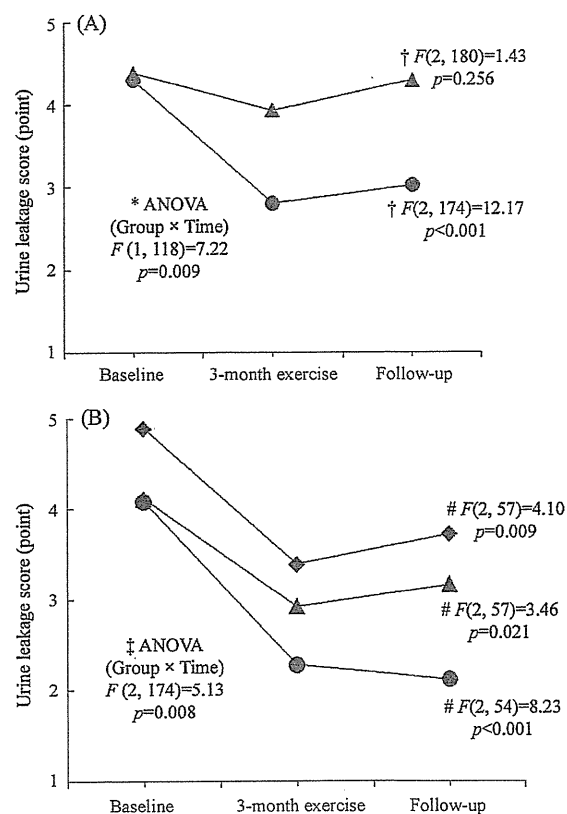


Fig. 2. Changes in the mean urine leakage score on a 5-point scale based on self-reported urinary diaries at the baseline, after 3-months exercise, and at the 7-month follow-up. (A) (●) intervention group; (▲) control group. (*) A comparison of urine leakage scores between the intervention and control groups ($F=7.22$, $p=0.009$). (†) A comparison of urine leakage scores at the baseline (b), after 3-months exercise (p), and at the 7-month follow-up (f) within group: intervention group ($F=12.17$, $p<0.001$; Scheffe's *post hoc* = b > p, f); control group ($F=1.43$, $p=0.256$). (B) (●) Stress incontinence; (▲) urge incontinence; (◆) mixed incontinence. (‡) A comparison of urine leakage scores among stress, urge, and mixed urinary incontinence in the intervention group. # A comparison of urine leakage scores at the baseline (b), after 3-months exercise (p), and at the 7-month follow-up (f) within group: stress incontinence ($F=8.23$, $p<0.001$; Scheffe's *post hoc* = b > p, f); urge incontinence ($F=3.46$, $p=0.021$; Scheffe's *post hoc* = b > p, f); mixed incontinence ($F=4.10$, $p=0.009$; Scheffe's *post hoc* = b > p, f).

3.3. Predictor variables

As shown in Table 3, the amount of urine leakage (OR = 0.69, 95%CI = 0.39–0.98), compliance to the exercise treatment (OR = 1.03, 95%CI = 1.01–1.16), and BMI reduction (OR = 0.67, 95%CI = 0.48–0.89) were significantly associated with being cured of urine leakage after the 3-month exercise. The cure of urine leakage at the 7-month follow-up was significantly associated with compliance (OR = 1.13, 95%CI = 1.02–1.29) and BMI reduction (OR = 0.78, 95%CI = 0.60–0.96).

4. Discussion

While the ratio of participation by the random population was very low, a baseline of 957 people is an

Table 3
Adjusted OR for cure of urine leakage after intervention and the 7-month follow-up.

Variable	After 3-month exercise			After 7-month follow-up		
	Adjusted OR ^a	95%CI	p Value	Adjusted OR ^a	95%CI	p Value
Amount of urine leakage	0.69	0.39–0.98	0.049	0.78	0.26–1.88	0.600
Frequency of urine leakage	1.16	0.24–5.79	0.856	1.63	0.73–4.01	0.248
Compliance to exercise	1.03	1.01–1.16	0.048	1.13	1.02–1.29	0.031
Decreased of BMI	0.67	0.48–0.89	0.011	0.78	0.60–0.96	0.028
Increased of walking speed	0.97	0.91–1.04	0.414	0.99	0.94–1.06	0.913
Period of urine leakage	1.01	0.91–1.13	0.919	1.01	0.91–1.14	0.913

^a Dependent variable; cure of urinary incontinence: 1 = cured, 0 = urine leakage. Independent variables: (a) Amount of urine leakage: large amount, 1 = requiring change of undergarments or soaked outerwear, small amount, 0 = wet undergarments. (b) Frequency of urine leakage: high frequency 1 = every day, low frequency, 0 = less than once every two days. (c) Compliance to exercise: full compliance, 1 = more than 60.0% attendance, partial compliance, 0 = less than 59.9% attendance. OR = odds ratio; CI = confidence interval.

acceptable sample size for analysis of UI in the community-dwelling elderly. Analysis of the efficacy of a 3-month exercise treatment for UI, demonstrated that exercise treatment was equally effective in reducing stress, urge, and mixed UI; although the cure rates of urine leakage were maintained until the 7-month follow-up for all the three types of UI, the efficacy of the treatment was greater for stress UI than urge or mixed UI in the intervention group. However, the changes of UI cure rate were not significant in the control group. These results suggest that improvements in primary outcomes may be observed in an intervention group but such improvements may not be expected in a control group.

PFM exercise is known to be an effective treatment for stress UI (Bo et al., 1990; McDowell et al., 1999; Kim et al., 2007). However, a previous study reported that the mean number of incontinent episodes per day decreased not only stress but also urge and mixed UI, so PFM exercises are equally effective against all three urodynamic conditions, and no urodynamic test is necessary before behavioral treatment (Nygaard et al., 1996). Another study showed that behavioral training achieved comparable improvements in urge UI (Burgio et al., 2002). These previous studies had no control or follow-up data. Recently, one study suggested that decrease in BMI and increase in walking speed may contribute to the decline in stress UI episodes, but they did not examine urge or mixed UI (Kim et al., 2007). In this study no significant relationship between hand grip strength and cure of urinary incontinence was shown. A significant relationship was seen between adductor muscle strength, maximum walking speed and cure of urinary incontinence.

After the 3-month intervention and 7-month follow-up, UI was defined as cured if no urine loss episodes were present in the 1-week urinary diary. Our trial confirmed that exercise treatment involving PFM training and fitness exercises can achieve a 63.2% cure rate in stress UI, a 35.0% in urge UI, and a 40.0% in mixed UI within the intervention group after 3-months of exercise. This exercise treatment had immediate effects in women with UI regardless of their urodynamic diagnosis, and the effects are comparable to those of the previous study. The efficacy of the exercise treatment was greater for stress UI than urge or mixed UI, and although the cure rates of urge and mixed UI showed slight decreasing trends after the 7-month follow up, the decreases were statistically not significant. Our data

suggests that exercise treatment is more effective for stress UI than urge or mixed UI, and also raises the possibility that for both urge and mixed UI, a combined behavioral and drug therapy (Burgio et al., 2000) may be more effective than exercise treatment alone. However, this study does not provide an explanation for the slight reversal in the effectiveness of the treatment on urge and mixed UI after the follow up.

Many studies have indicated that BMI (Bump et al., 1992; Brown et al., 1999; Richter et al., 2010) and waist circumference (Krause et al., 2010) are a risk factor for UI, and decrease in BMI may contribute to the decline in stress UI episodes (Kim et al., 2007). Presumably, a decrease in BMI causes a decrease in abdominal-wall weight, decreasing intra-abdominal pressure and intra-vesicular pressure, which may have led to the improvement of stress UI. In this analysis, BMI reduction was significantly associated with the total cure rates of urge, mixed as well as stress UI, but the data does not explore the mechanism of how decreases in BMI improves urge and mixed UI. Also, previous studies have emphasized that compliance to exercise is the key factor to long-term success (Lagro-Janssen, 1998; McDowell et al., 1999). In this study, compliance to the multidimensional exercise treatment was the most significant and consistent predictor of efficacy post-intervention and follow-up. Our findings also support the idea that high compliance and BMI reduction have positive influences on urge, mixed and stress UI treatment. However, the current results were obtained based on a small sample size. The relationships need to be further researched in a population study which would contain a larger number of subjects and for a longer follow-up period.

This study has several limitations. First, the assessments of UI type and urine leakage episodes were self-reported. This could have led to a reporting bias, as subjects with UI may have underreported their symptoms, but a urinary diary is a reliable method for assessing episodes of urine leakage (Wyman et al., 1988; Locher et al., 2001). Thus, this study provided data that was reliable for objective assessment of the behavioral treatment on urinary incontinence. Second, PFM strength, which is likely to have increased through the PFM exercises, was not measured. Therefore, whether the cure rate of urine leakage is correlated with the increase in PFM strength or functional fitness, or the decrease in BMI or abdominal fat could not be explored.

The results suggest that a multidimensional exercise intervention may be equally effective for treatment of stress, urge, and mixed UI. BMI reduction as well as compliance to the prescribed exercise regimen was a significant and consistent predictor of the effectiveness of the behavioral therapy. Thus, multidimensional exercise treatments should be considered for elderly women as part of a strategy for improving functional capacity and UI. Health care for UI patients should undertake a team approach where physical therapists, doctors and nurses work together. Nurses should not only objectively assess the urinary diaries collected, they will play a very important role for the prevention of UI and maintenance of cured UI cases by instructing changes in daily lifestyle among the elderly.

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ORIGINAL ARTICLE: EPIDEMIOLOGY,
CLINICAL PRACTICE AND HEALTH

Effects of exercise treatment with or without heat and steam generating sheet on urine loss in community-dwelling Japanese elderly women with urinary incontinence

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Aim: To determine the effects of exercise treatment with or without heat and steam generating sheet (HSGS) on reducing urine loss in community-dwelling elderly women with urinary incontinence (UI).

Methods: One hundred and forty-seven community-dwelling women aged 70 years and older with stress, urge and mixed UI were randomly assigned to exercise + HSGS ($n = 37$), exercise only ($n = 37$), HSGS only ($n = 37$) or an education group ($n = 36$). Exercise + HSGS, and exercise groups received exercise training twice a week for 3 months. When the HSGS was placed on the lower back, the temperature of the skin surface rose to 38–40°C and it continued to generate heat and steam for over 5 h. The HSGS group used one sheet per day continuously for 3 months. Urine loss and fitness data were collected at baseline and after intervention.

Results: The intervention groups showed significant improvements in muscle strength and walking speed compared to the education group. Exercise and HSGS showed urine loss cure rates of 54.1%, exercise 34.3% and HSGS 21.6% after treatment; whereas, the education group (2.9%) showed no significant improvement ($\chi^2=21.89$, $P < 0.001$). Combining the HSGS to the exercise intervention showed a 61.5% cure rate for stress UI, 50.0% urge UI and 40.0% mixed UI.

Conclusion: This data suggests that exercise treatment with HSGS is more effective for treating urine loss regardless of UI type. The HSGS can be used as a supplementary treatment method to enhance the effects of exercise on women with urge, mixed and stress UI. *Geriatr Gerontol Int* 2011; 11: 452–459.

Keywords: elderly women, fitness exercise, heat and steam generating sheet, pelvic floor muscle exercises, urinary incontinence.

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Introduction

Urinary incontinence (UI) is one of the most prevalent health problems among the elderly population. Several studies have assessed the association of UI with multiple factors, such as smoking, obesity, cognitive impairment,

nocturia and poor mobility.¹⁻³ Currently, a number of methods are used to treat or deal with UI including medication, surgery and behavior management. Behavioral therapy for UI is not a new topic, and several randomized control trials and systematic reviews have confirmed that pelvic floor muscle (PFM) training is an effective treatment for stress UI.^{4,5} Even though many studies have validated the effectiveness of these behavioral therapies, reporting improvement rates from 17–84%,⁶ such previous studies have focused exclusively on stress UI, and investigations on the effects of behavioral therapies on urge and mixed UI have been relatively limited.⁷ Furthermore, several studies have suggested that abdominal and lower back heating may have positive effects on renal function such as renal sympathetic nerve activity suppression, promotion of bladder voiding and increasing frequency of urination.⁸⁻¹⁰ Therefore, it can be speculated that heating methods will positively affect renal function.

The purpose of the current study was to investigate the effects of a 3-month exercise and/or heat and steam generating sheet (HSGS) intervention aimed to treat urine loss in community-dwelling women with UI.

Methods

The study population was randomly selected from the Basic Resident Register of 5935 women aged 70 years

and older that resided in the Itabashi ward of Tokyo as of 1 April 2006. Information about the comprehensive health check-up was mailed to selected subjects. The recruitment survey was conducted in November 2006, where 957 women participated in baseline testing and 416 of them reported experience of urine loss over several times a year.

The inclusion criteria were: (i) suffering from urge, stress or mixed UI; (ii) being 70 years or older; and (iii) having urine loss episodes more than once a month. The exclusion criteria included: (i) an unclear UI type; (ii) having urine loss episodes less than once a month; (iii) impaired mental health (a Mini-Mental State Examination score of <24);^{11,12} and (iv) unstable cardiac conditions such as ventricular dysrhythmias, pulmonary edema or other musculoskeletal conditions. One hundred and twenty-six (30.3%) potential subjects were excluded because they were classified into one or more of the exclusion criteria. The study protocol was approved by the Clinical Research Ethics Committee of Tokyo Metropolitan Institute of Gerontology (TMIG). The procedures were fully explained to all subjects and written informed consent was obtained (Fig. 1).

Randomization

After the baseline assessment, 147 participants (stress = 50, urge = 59 and mixed = 38) were randomly

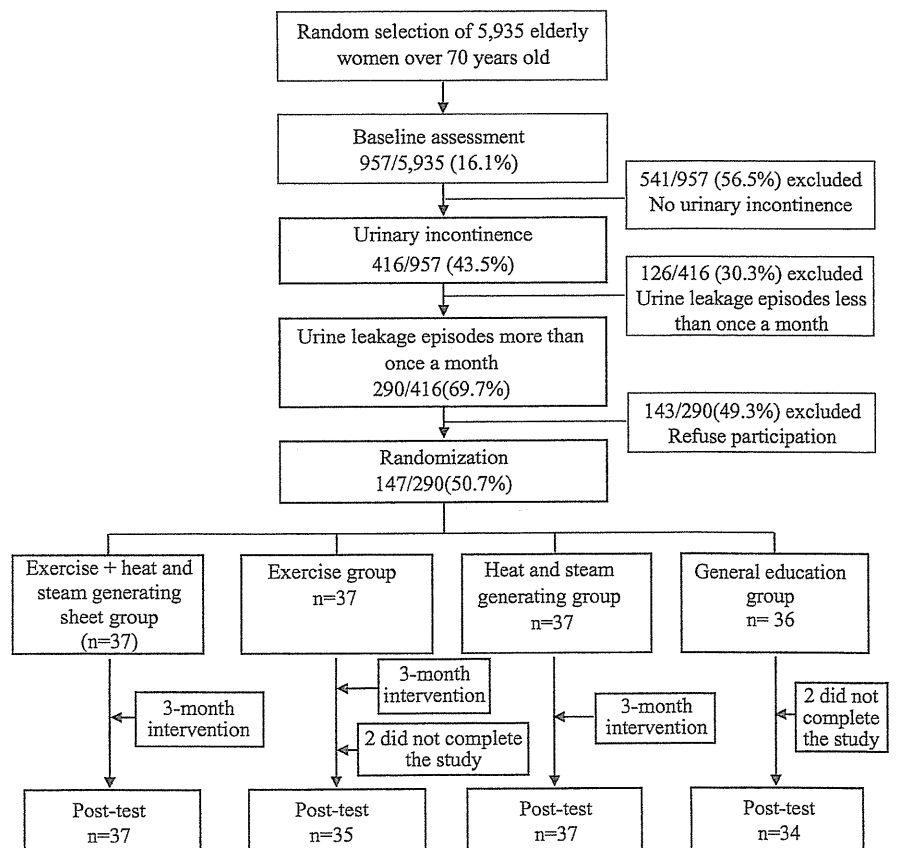


Figure 1 Flow chart of participant recruitment through the randomized controlled trial of exercise and/or heat and steam generating sheet trial.

assigned to the general education ($n = 36$), HSGS ($n = 37$), exercise ($n = 37$) or exercise + HSGS ($n = 37$) groups with an allocation ratio of 1:1 according to computer-generated random numbers. There was no attempt to equalize the size of the groups based on their characteristics or to recruit subjects with specific characteristics. The investigators were blind to the allocation of interventions.

Outcome measures

The primary outcome variable of this study was the cure of urine loss episodes, which was assessed by interview.¹³ Complete cessation of urine loss episodes was defined as cured. The secondary outcomes were functional fitness and changes in frequency of urine loss episodes, which was assessed based on changes in a 5-point scale obtained in the interviews conducted pre-treatment and after the 3-month intervention.

Interview survey

A face-to-face interview was conducted to assess temporary UI conditions based on the modified International Consultation on Incontinence Questionnaire (ICIQ).¹⁴ The first question was "Have you experienced urine loss during the previous year?". If the participant responded "yes", we then asked the frequency, volume and circumstance of urine loss. The frequency of UI was assessed based on a 5-point scale by interview (1, every day; 2, once every 2 days; 3, once or twice per week; 4, once or more per month; 5, several times per year). Those whose response ranged 1–4 were classified as potential subjects. The same 5-point scale was presented to the participants after the 3-month intervention. The changes in the 5-point scale were converted to the following 6-point scale in order to assess improvements observed in urine loss frequency from baseline to after the 3-month intervention: 0 for no urine loss, 1 for several times per 3 months; 2 for one to three times per month, 3 for one to two times per week, 4 for once every 2 days, and 5 for every day.

Urinary incontinence type was assessed based on all answers to the following question: "When do you experience urine loss? 1, before reaching the toilet; 2, while coughing, sneezing or laughing; 3, while sleeping at night; 4, while physically active or exercising; 5, upon re-dressing after urinating; 6, for no apparent reason; 7, all the time; 8, while working with water, touching water or drinking cold water."¹⁴ Participants were classified as having stress UI when urine loss was associated with increased abdominal pressure, as in responses 2 and/or 4. Participants were classified as having urge UI if they responded with 1 and/or 8. When characteristics of both stress and urge UI types were present, it was defined as mixed UI. Urine loss volume was assessed based on the

answer to the question: "How much urine is leaked each time? 1, wets or dampens undergarment; 2, requires a change in undergarment; 3, soaks through to outer clothing; 4, runs down the leg(s) and onto the floor."

The subjects were asked about the onset age and duration of UI, frequency of daytime and nighttime voiding, and chronic medical conditions such as heart disease, diabetes, hypertension and osteoporosis.

Functional fitness test

Measurements of height and body weight were converted to body mass index (BMI, kg/m^2), and fitness test variables including grip strength, one-leg standing time with eyes open, usual and maximum walking speed, and seated adductor muscle strength were taken. The procedures for the fitness tests have been described in detail in a previous report.¹⁵

Intervention

Exercise group

The exercise group participants attended an exercise training session 2 times a week for 3 months at the TMIG health promotion classes. The following exercises were performed by the participants.

Stretching exercise

The participants performed 5–10 min of warm-up and stretching exercises, including shoulder rotation, waist rotation and others.

PFM exercises

The participants were informed that straining the abdomen increases abdominal pressure and exerts pressure on the PFM. The subjects were trained to exert force only on the PFM without excessively straining the abdomen. The exercise regimen was designed to strengthen the fast- and slow-twitch muscle fibers located on the pelvic floor. The participants were initially instructed to perform 10 fast contractions (3 s) with a 5-s rest and 10 sustained contractions (8–10 s) with a 10-s rest between the contractions. The PFM exercise was performed in the sitting, lying and standing positions with the legs apart, while emphasizing contraction of the PFM and relaxation of the other muscles.

Fitness exercises

Strength training of the thigh and abdominal muscles were performed between the PFM exercises. The exercises included chair exercises, weight-bearing exercises, ball exercises, and others.

HSGS group

The HSGS is a thin, flexible filmed sheet (120 mm × 204 mm; Kao, Tokyo, Japan), that generates heat and steam immediately after unsealing. When the sheet is placed on the body, the temperature of the skin surface rises to 38–40°C and it continues to generate heat and steam for over 5 h.¹⁶ The participants gathered at TMIG classes every 2 weeks, where HSGS were provided for 2 weeks and the urinary diaries were collected. The participants in the HSGS group were asked to place the HSGS on their lower back once a day immediately after waking up. The participants recorded the time of day that they placed and removed the sheet in their urinary diary.

Exercise + HSGS group

The participants were instructed to perform a combination of the same intervention as the exercise group as well as the HSGS group.

General education group

General education classes were held (topics including cognitive function, osteoporosis and oral hygiene) once a month, a total of three times.

Urinary diary

A urinary diary was distributed to the participants in the exercise, HSGS and exercise + HSGS groups where they recorded times of urination (number of times during the day [waking up in the morning to sleeping at night] and number of times during the night [sleeping at night to waking up in the morning]), time of defecation, presence or absence of UI, time of loss, volume of loss and actions taken at the time of loss.¹⁷ The urinary diaries were collected every 2 weeks and were monitored for any changes in UI for 3 months.

Data analysis

Means and standard deviations were calculated for continuous variables, and a one-way ANOVA was performed to measure significant differences in baseline values and urine loss score post-treatment between the intervention groups, and the χ^2 -test was used for categorical variables. Scheffé's post-hoc method was performed when significance was found. A repeated-measures ANOVA (4 × 2) was performed to find differences in pre- and post-intervention functional fitness and urine loss score between groups, and paired student's *t*-tests were done on pre- and post-intervention measures to find changes within groups. A Kruskal–Wallis test was used to measure the difference in cure rates between the

intervention groups. All analyses were performed using SPSS ver. 15.0 for Windows and $P < 0.05$ was considered statistically significant.

Results

Table 1 shows the baseline comparisons in anthropometric values, physical fitness measures and interview survey results among the exercise + HSGS, exercise, HSGS and general education groups. There were no significant differences between the groups in all variables including age, walking speed, adductor muscle strength, duration and onset age of urine loss, frequency of urine loss episodes, and chronic medical conditions.

In comparing the pre- and post-intervention changes in physical fitness between groups (Table 2), there was a significant group × time interaction in adductor muscle strength and usual walking speed, where the exercise + HSGS group was significantly greater than the other groups.

The within group analysis showed that grip strength ($P = 0.001$), one-leg standing time with eyes open ($P = 0.033$), adductor muscle strength ($P < 0.001$) and usual walking speed ($P = 0.020$) changed significantly in the exercise + HSGS group; grip strength and adductor muscle strength significantly improved and BMI decreased in the exercise group; and grip strength and adductor muscle strength significantly improved in the HSGS group (Table 2).

The cure rates of UI after the 3-month intervention were 51.4% in the exercise + HSGS group, 34.3% in the exercise group, 21.6% in the HSGS group and 2.9% in the general education group ($\chi^2 = 21.89$, $P < 0.001$). Analysis of stress UI cure rates revealed 61.5% in the exercise + HSGS group, 53.8% in the exercise group, 25.0% in the HSGS group and 9.1% in the general education group ($\chi^2 = 8.94$, $P = 0.030$). Urge UI had a 50.0% cure rate in the exercise + HSGS group, 16.7% in the exercise group, 13.3% in the HSGS group and 0.0% in the general education group ($\chi^2 = 12.88$, $P = 0.005$). No significant differences were observed in mixed UI cure rates (Table 3).

In comparing the pre- and post-intervention urine loss scores between the groups (Fig. 2), there was a significant group × time interaction in stress and urge UI, and the exercise + HSGS group showed a significantly larger decrease in urine loss score compared with the other three groups. At baseline, there were no significant differences in urine loss scores (based on the converted 6-point scale) between the stress, urge or mixed UI groups. However, there was a significant improvement in stress and urge urine loss scores (urine loss scores of participants who had stress and urge UI) after the 3-month intervention. The stress urine loss score post-intervention was significantly lower in the

Table 1 Selected variable characteristics at baseline by study group

Variable	Ex + HSGS (<i>n</i> = 37) M ± SD	Ex (<i>n</i> = 37) M ± SD	HSGS (<i>n</i> = 37) M ± SD	GE (<i>n</i> = 36) M ± SD	<i>P</i> -value [†]
Age (years)	75.7 ± 4.6	76.7 ± 3.6	75.8 ± 4.4	75.8 ± 3.6	0.688
Height (cm)	148.4 ± 4.9	149.0 ± 6.1	148.3 ± 5.4	149.8 ± 5.8	0.638
Weight (kg)	50.3 ± 8.2	53.5 ± 8.0	54.8 ± 9.1	52.4 ± 7.1	0.113
GS (kg)	18.3 ± 4.0	19.9 ± 4.9	19.1 ± 3.7	18.2 ± 5.0	0.368
UWS (m/s)	1.2 ± 0.3	1.2 ± 0.3	1.1 ± 0.2	1.2 ± 0.3	0.774
MWS (m/s)	1.7 ± 0.4	1.8 ± 0.4	1.7 ± 0.3	1.7 ± 0.4	0.820
AMS (kg)	20.3 ± 6.1	21.6 ± 5.4	20.9 ± 4.9	22.0 ± 4.3	0.598
OLS (s)	30.5 ± 22.5	35.6 ± 25.3	29.2 ± 22.6	41.1 ± 22.6	0.121
DUS (years)	3.5 ± 5.6	5.2 ± 5.5	4.0 ± 5.8	5.9 ± 8.3	0.376
OAUS (years)	72.1 ± 6.7	71.4 ± 6.9	71.8 ± 7.4	69.9 ± 9.3	0.608
FSUL (points)	4.2 ± 1.3	4.4 ± 1.2	4.5 ± 1.2	4.1 ± 1.3	0.436
FTDT (times)	7.6 ± 2.9	7.2 ± 2.8	6.9 ± 2.5	7.3 ± 1.9	0.729
FTNT (times)	1.5 ± 0.9	1.9 ± 1.3	1.7 ± 1.2	1.6 ± 1.1	0.440
Frequency of urine loss episodes (%)					
Daily	29.7	29.7	37.8	30.6	0.493
1 every 2 days	5.4	8.1	2.7	5.6	
1–2 per week	21.6	32.4	37.8	19.4	
1–3 per month	43.2	29.7	21.6	44.4	
Chronic medical conditions (yes, %)					
Heart disease	11.8	29.4	26.5	32.4	0.131
Diabetes	26.3	21.1	15.8	36.8	0.465
Hypertension	19.4	29.2	29.2	22.2	0.659
Osteoporosis	20.6	17.6	23.5	38.2	0.177

GS, grip strength; UWS, usual walking speed; MWS, maximum walking speed; AMS, adductor muscle strength; OLS, one-leg standing time with eyes open; DUS, duration of urine loss; OAUS, onset age of urine loss; FSUL, frequency score of urine loss; FTDT, frequency of toilet in the daytime; FTNT, frequency of toilet in the night time; Ex, exercise group; HSGS, heat and steam generating sheet group; GE, general education group; M, mean; SD, standard deviation. [†]One way ANOVA for continuous variables and χ^2 -test for categorical variables.

exercise + HSGS group compared with the HSGS and general education groups; and the urge urine loss score was significantly lower in the exercise + HSGS group compared with the general education group.

Discussion

This study demonstrated that although the 3-month exercise or HSGS interventions alone were effective in improving functional fitness and reducing urine loss, the combination of exercise and HSGS was more effective not only in the treatment of UI, but also in the improvement of functional fitness in urban community-dwelling elderly women with stress, urge and mixed UI. It can be suggested that adding HSGS to exercise therapies (PFM exercises as well as muscle strength training) may increase the likelihood of curing UI.

Exercise therapies aimed to treat UI, especially PFM exercises, have been used as an effective treatment for stress UI since Kegel's first validation of an 84% cure rate,¹⁸ which has since been broadened to 17%–84% by Bo *et al.*,¹⁹ Burns *et al.*²⁰ and Cammau *et al.*²¹

It has also been reported in recent investigations that PFM exercises and muscle strength training targeting abdominal fat reduction can increase cure rates of stress UI as well. Many studies have focused only on the treatment of stress UI.^{5,15,18–20} However, one study demonstrated that 44.8% of community-dwelling Japanese elderly women are categorized into stress UI, 34.8% are urge UI and 20.4% are mixed UI, which means urge and mixed UI account for more than half of the UI cases in Japanese elderly women.²² Even though people with urge and mixed UI experience greater frequency and volume of incontinence episodes, efforts focusing on treatment of urge and stress UI are currently very limited.

Many recent studies have indicated that heating different parts of the body can cause changes in the autonomic nervous system. It has been reported that mild heat stimulation to the lower back and abdominal region suppresses the sympathetic nervous system and accelerates the parasympathetic nervous system while increasing blood flow to the muscles.^{8–10,16,23} It has also been proposed that muscular hypertrophy due to an

Table 2 Comparison of selected variable between groups after the 3-month interventions

Variable	G	Baseline	3-month intervention	ANOVA (time × group)	P-value
BMI (kg/m ²)	Ex + HSGS	22.8 ± 3.3	22.9 ± 3.1	<i>F</i> (3,129) =1.526	0.211
	Ex	24.0 ± 3.3	23.1 ± 2.8#		
	HSGS	24.8 ± 3.6	24.6 ± 3.4		
	GE	23.2 ± 2.7	23.2 ± 2.7		
Grip strength (kg)	Ex + HSGS	18.4 ± 4.2	19.8 ± 4.3#	<i>F</i> (3,110) =0.581	0.629
	Ex	19.6 ± 4.9	20.9 ± 4.7#		
	HSGS	19.2 ± 3.5	20.3 ± 3.0#		
	GE	17.5 ± 4.9	18.1 ± 4.2		
One-leg standing time (s)	Ex + HSGS	31.6 ± 22.2	37.5 ± 24.4#	<i>F</i> (3,124) =1.779	0.155
	Ex	32.7 ± 25.8	35.7 ± 24.7		
	HSGS	29.9 ± 22.9	26.3 ± 24.5		
	Co	39.9 ± 22.4	41.0 ± 21.4		
Adductor muscle strength (kg)	Ex + HSGS	20.3 ± 6.3	24.7 ± 6.1#	<i>F</i> (3,115) =5.108	0.002
	Ex	21.1 ± 6.3	24.9 ± 8.1#		
	HSGS	20.6 ± 4.9	22.7 ± 5.4#		
	GE	21.4 ± 4.7	22.5 ± 5.5		
Usual walking speed (m/s)	Ex + HSGS	1.2 ± 0.3	1.4 ± 0.2#	<i>F</i> (3,129) =4.798	0.030
	Ex	1.2 ± 0.3	1.3 ± 0.2		
	HSGS	1.1 ± 0.2	1.2 ± 0.3		
	GE	1.2 ± 0.3	1.2 ± 0.2		
Maximum walking speed (m/s)	Ex + HSGS	1.7 ± 0.4	1.8 ± 0.3	<i>F</i> (3,114) =2.661	0.051
	Ex	1.7 ± 0.4	1.8 ± 0.4		
	HSGS	1.6 ± 0.3	1.7 ± 0.4		
	GE	1.7 ± 0.4	1.7 ± 0.4		

#Paired Student's *t*-test of the baseline and 3-month intervention within-group difference, *P* < 0.05. G, group; Ex, exercise group; HSGS, heat and steam generating sheet group; GE, general education group.

Table 3 Cure rate of urinary incontinence according to urinary incontinence (UI) type and intervention group

Type of UI	Ex + HSGS (<i>n</i> = 37)	Ex (<i>n</i> = 35)	HSGS (<i>n</i> = 37)	GE (<i>n</i> = 34)	χ ² value	P-value [‡]
Stress UI	61.5 (8)	53.8 (7)	25.0 (3)	9.1 (1)	8.94	0.030
Urge UI	50.0 (7)	16.7 (2)	13.3 (2)	0.0 (0)	12.88	0.005
Mixed UI	40.0 (4)	30.0 (3)	30.0 (3)	0.0 (0)	3.02	0.389
Total cure rate	51.4 (19)	34.3 (12)	21.6 (8)	2.9 (1)	21.89	<0.001

[‡]Kruskal-Wallis test. UI, urinary incontinence; Ex, exercise group; HSGS, heat and steam generating sheet group; GE, general education group.

increase in skeletal muscle protein content from thermal loading may occur.

In this study, we demonstrated the efficacy of the exercise + HSGS intervention across UI types. As a result, it can be suggested that therapies combining HSGS with exercise can increase the cure rate of UI, regardless of UI type. The fact that exercise is an effective treatment for stress UI has been discussed extensively. The mechanism explaining the increased effectiveness in treating UI by placing a HSGS on the lower back needs further discussion, but heating the lower back does seem to have physiological effects on

the nervous and muscular systems. In this study, we confirmed the synergistic effect of UI treatment, regardless of UI type, by adding a sheet that heats the lower back to a frequently used behavioral therapy for UI. The use of the HSGS may slightly increase the cost of treatment. However, thermal therapy with the HSGS is cost-efficient because it is inexpensive and accessible for use.

Therefore, the HSGS method can be an effective supplementary UI treatment method. This study has several limitations. First, changes in urine loss were assessed based on subjective self-reported data, and they were not confirmed by objective and clinical

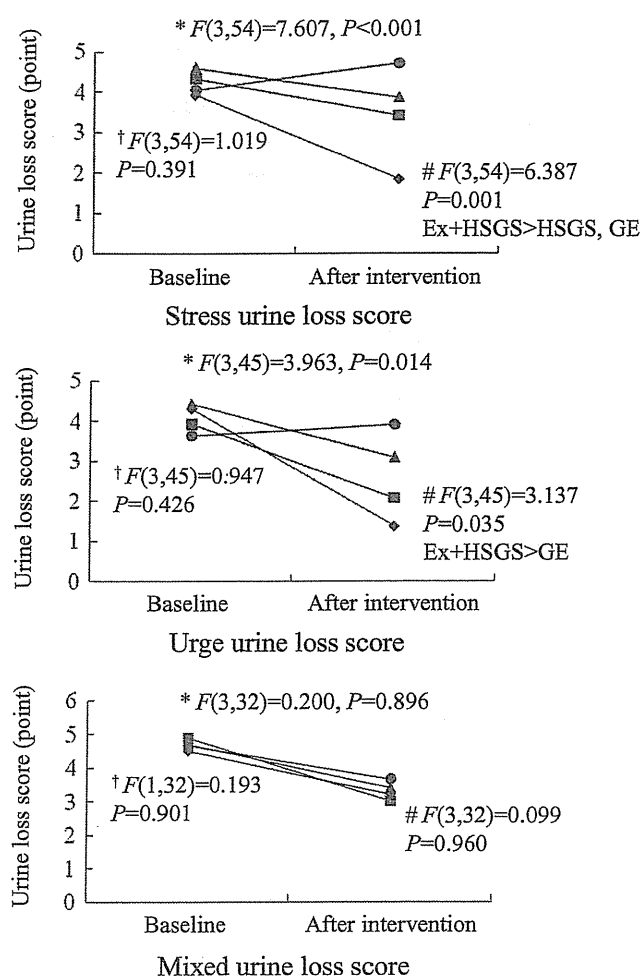


Figure 2 Changes in the mean urine loss score on the 6-point scale based on interview response at baseline and after 3-month intervention. (◆) Exercise + heat and steam generating sheet group; (■) exercise group; (▲) heat and steam generating sheet group; (●) general education group. *Comparison of urine loss scores between groups at baseline and after 3-month intervention (time \times group). †Comparison of urine loss scores between groups at baseline. #A comparison of urine loss scores between groups after 3-month intervention. Ex, exercise group; GE, general education group; HSGS, heat and steam generating sheet group.

methods. However, previous studies have reported the validity of self-reported information in older adults.²⁴ The use of data collected from interviews has little influence on the interpretation of the result of this study. Second, as indicated that measurement of PFM strength was difficult, hip adductor muscle strength was used to assess physical fitness instead of measuring PFM strength directly. Hence, whether the cure of UI was due to an increase in PFM strength, a decrease in abdominal fat, or an increase in muscle strength or walking ability could not be determined. Third, the mechanism of the physiological changes that occurred with placement of a HSGS on the lower back could not

be explained. Further investigation is necessary on a large population for more accurate results.

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温泉施設を用いた複合的介入プログラムの有効性に関する研究 —無作為化比較試験による検討—

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要約 目的：温泉は古くから治療目的などにも用いられてきたが，温泉施設を高齢者に対する健康増進を目的とした介入事業の拠点として用いる有効性について検討した研究は極めて少ない。そこで我々は，運動・栄養指導，温泉入浴からなる複合介入プログラム“すぷりんぐ”を開発し，その効果は無作為化比較試験によって検討した。方法：65歳以上の特定健診該当者を対象に公募により本プログラムへの参加者を募集した。68名が事前調査に参加し，60名（72.7歳±6.0）がプログラムへの参加に同意した。参加者を無作為に介入群31名と対照群29名の2群に割付け，交差法により前期に介入群，後期に対照群に対して複合介入プログラムを3カ月間（週2回，90分）実施した。介入群プログラム終了時（3カ月後：第2回調査）と対照群プログラム終了時（6カ月後：第3回調査）に調査を実施し，プログラムの短期・長期的効果の検討を行った。結果：介入に起因した傷害，事故の発生はなく，介入群の平均プログラム出席率は76%であった。性・年齢・BMIを調整した一般線型モデルの結果，第2回調査時には対照群に比べ，介入群の握力と開眼片足立ちに有意な改善が認められた（各々 $p=0.028$ ， $p=0.003$ ）。また，第3回調査において，介入直後に確認された握力と開眼片足立ちの有意な改善の維持が認められ（各々 $p=0.001$ ， $p=0.024$ ），改善傾向が見られたWHO-5の有意な維持・改善が示された（ $p=0.027$ ）。交差後の対照群の介入プログラム出席率も平均81%と比較的高く，対照群への介入時においても傷害，事故の発生は確認されなかった。結論：温泉施設を活用した複合的介入プログラムである“すぷりんぐ”は身体機能を中心とした高齢者の健康増進に寄与するプログラムであることが示された。また，その継続的效果とプログラムの出席率・安全性が確保されていることから，温泉施設を高齢者に対する健康増進を目的とした介入事業の拠点とする意義は高いものと考えられる。

Key words：高齢者，温泉，運動介入，栄養介入

（日老医誌 2011；48：352-360）

緒 言

我が国の天然資源である温泉は，湯治に代表されるように古くから治療的に用いられており，現在ではクアハウスやスーパー銭湯に代表されるように身近な，レジャー目的としても地域住民の憩いの場となっている。温泉入浴の効能は，循環，代謝，神経・免疫・内分泌機

能の分野から検討されているが^{1)~3)}，温泉施設を高齢者に対する健康増進を目的とした介入事業の拠点として用いる有効性について検討した研究はほとんど見られない。

上岡ら⁴⁾は中高年女性を対象として，週1回，12週間の温泉入浴と生活・運動指導からなるプログラムの有効性を無作為化比較試験（randomized control study，以下，RCTと略す）によって検証している。その結果，介入群では運動機能の改善は認められないものの，尿酸値の有意な改善や緊張状態といった心理指標の改善傾向を報告している。またKamiokaら⁵⁾は中高年女性を対象に，週1回，3カ月から6カ月の生活・運動指導に温泉入浴を組み合わせた介入プログラムの効果をRCTによって検討している。その結果，6カ月介入群ではHbA1cの有意な低下や心理指標などの有意な改善が確

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認められ、その効果が6カ月後の追跡調査においても認められたことを報告している。その一方で3カ月間の介入では、介入直後に改善が見られた項目においても、1年後の追跡調査では介入前と同じ程度に戻っていたことを報告しており、3カ月間の介入では長期的効果が乏しいことを示唆している。

以上の温泉入浴を取り入れた介入研究を概括すると、高齢者に対する健康増進効果や適切な介入方法については一致した見解が得られていないといえる。地域資源である温泉施設を利用することにより、介入への動機付けを高め、ひいては介入効果が高まる可能性も考えられる。加えて、運動および栄養介入と温泉入浴による相乗効果があるのかもしれない。そこで本研究では温泉利用型健康増進施設(以下、温泉施設と略す)を用いた運動教室・栄養教室・温泉入浴からなる複合プログラム、通称“すぷりんぐ”を開発し、地域在住高齢者に与える効果をRCTにより検証すること、および健康増進を目的とした介入事業を温泉施設で行う意義について検討することを目的とした。

方 法

群馬県草津町在住の65歳以上特定健診該当者全2,167名を対象に公募により本プログラムへの参加者を募集した。68名が事前調査に参加し、医師から運動教室への参加が禁忌と判定された8名を除く60名(平均年齢±標準偏差:72.7±6.0歳,65~93歳)がプログラムへの参加に同意した。事前調査後、乱数表を用いて参加者を介入群31名、対照群29名に無作為に割り付けた(図1)。町内にある温泉施設を主会場として介入群には3カ月間(2009年10月~12月:前期介入,週2回,1回90分)の複合プログラムを実施した。プログラムの構成は運動教室、栄養教室、温泉入浴とした。運動教室は計11回実施し、健康運動指導士3名が指導を担当した。運動内容は自重やゴムチューブを用いた筋力トレーニングであり、対象者の体力に合わせて立位、座位を適宜選択できるように配慮し(2名の健康運動指導士が運動状況を観察し、運動強度が強すぎると判断した場合に座位を勧めた)、運動強度は主観的運動強度尺度であるBorg Scale⁹⁾で12~14(ややきつい)に対応する内容を間欠的に実施した。栄養教室は、管理栄養士により適正体重を目指したグループワーク形式の講義と自己の食習慣チェックおよび調理実習を計6回行った。毎運動及び栄養教室の終了前には、6~7名の小グループ単位で約15分間、日常の運動や食習慣について各自の目標、状況、工夫についての情報交換を行い、保健師がファシリテーターとな

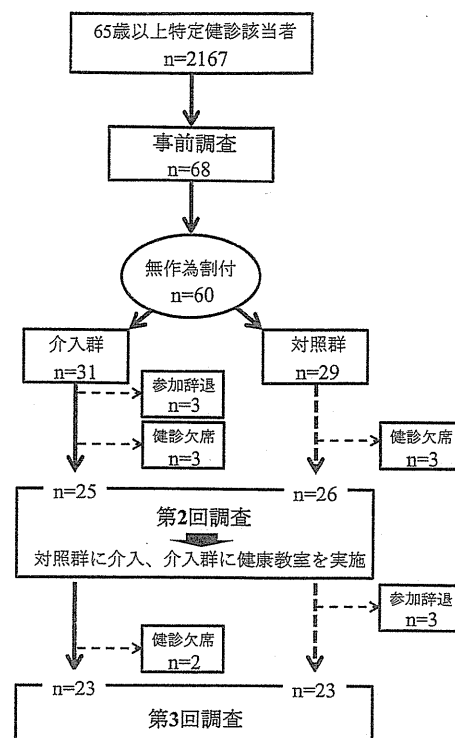


図1 本研究の流れと解析対象者の推移

り行動変容や健康行動の自主化を試みた。基本的には目標設定とセルフモニタリングを繰り返し、対象者の行動変容に対する自己効力感を高めるよう支援した。目標は実行可能な範囲で設定することにより、各人の達成感を高めるものとした。また毎運動教室終了時には30分程度の温泉入浴を課した。本研究で利用した温泉施設の泉質は酸性塩化物硫酸塩泉であり、泉温94.6℃(浴槽内水温は42℃~46℃に調整)、pH1.7であった。他方、対照群に対しては月一回の座学中心の健康教室を行った。同教室の内容は直接、本プログラムとは関連がないよう認知症や老年病の概論についての講演会とした。

介入期間終了後に介入後調査(以下、第2回調査と略す)として事前調査と同様の調査を行い、その後介入群と対照群を入れ替え、上記と同様の介入を行った(2010年1月~3月:後期介入)。後期介入終了後にも追跡調査(以下、第3回調査と略す)を行い、本プログラムの3カ月間の短期的効果と、その後3カ月間の持続効果を検討した。評価項目は体組成⁹⁾について体重、筋肉量、脂肪量、運動機能⁹⁾¹⁰⁾について握力、開眼片足立ち、通常・最大歩行速度、Timed Up & Go Test(以下、TUGと略す)、健康関連QOLについてSF-8¹¹⁾、WHO-5¹²⁾および血液検査とした。

体組成に関しては、多周波数(1 kHz, 5 kHz, 50 kHz,