the study, there were no occurrences of urinary retention, and there were no cystometric differences in women before or after device use. Fewer than 1% of the women reported any vulvar irritation.

Recommendations for clinical practice **Is this barrier device more effective than other nonsurgical treatments of urinary stress incontinence? All of the women in this study had mild or moderate stress incontinence, and the Kegel's exercises recommended by the Agency for Health Care Policy and Research's guidelines are known to be 80% to 90% effective for women with this condition.[1] Although this device may be a safe and relatively effective alternative, I am not convinced that it is preferable to doing simple exercises.**

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REFERENCE

1. Urinary Incontinence Guideline Panel. Urinary incontinence in adults: clinical practice guideline. Agency for Health Care Policy and Research publication no. 92-0038. Rockville, Md: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services; 1992.

Treatments for Atopic Eczema

Charman C. Clinical evidence: atopic eczema. BMJ 1999; 318:1600-4.

Clinical question **Which interventions are effective for the treatment and prevention of atopic eczema?**

Background Atopic eczema is an increasingly common skin disease with inflammatory erythematous pruritic eruptions usually found in the skin creases. In the United Kingdom, where this study was done, 15% to 20% of school children and 2% to 3% of adults are affected. The etiology of atopic eczema is multifactorial—genetics, environmental exposures, and infections all play a part. The author of this paper conducted a systematic review of the literature for the following treatment and prevention options: topical steroids, combination of topical steroids and topical antimicrobials, control of house dust mites, dietary manipulation, and prolonged breastfeeding.

Population studied The author searched for systematic reviews and controlled clinical trials using *The Cochrane Library* (1998), *Best Evidence* (1998), MEDLINE (1966-1998), and EMBASE (1988-1998). He included randomized controlled trials that met the criteria for quality of the "Clinical Evidence" series of systematic reviews. These criteria were not described in the article. The author did state that some studies with methodologic shortcomings were included in review.

Study design and validity This is a clinical review, not a meta-analysis. The author searched specific databases looking for systematic reviews and randomized controlled trials. The quality assessment of the articles is not clearly described, and since there is only one author, it is unlikely that the quality assessment was checked for reproducibility. The author presents each intervention option and then states whether randomized controlled trials and systematic reviews were found. No aggregation of the data from the studies was performed.

Outcomes measured The outcomes reported in this review included symptom scores and skin-related quality of life. The scoring systems used were SCORAD (scoring atopic dermatitis), SASSAD (six-sign atopic dermatitis), the Rajka and Langeland scoring system, and the dermatology life quality index.

Results No systematic reviews were identified in the literature search. The most beneficial intervention was topical steroids. Nine randomized controlled trials compared steroids with placebo. In the 3 best, 75% to 87% of patients in the treatment groups responded, compared with 8% to 29% in the control groups. No serious or systemic side effects were noted in these studies. The combination of topical steroids and antimicrobials was no better than topical steroids alone. This conclusion was made using the results of 2 randomized controlled trials comparing hydrocortisone and fusidic acid with hydrocortisone alone (186 participants for 2 weeks) and betamethasone and fusidic acid with betamethasone alone (60 participants for 1 week). Control of house dust mites may reduce the eczema severity score, according to 1 of 3 controlled trials that showed mixed results. Dietary manipulation did not have an effect on atopic eczema according to the results of 4 randomized controlled trials (1 in infants, 2 in children, and 1 in adults). Prolonged breastfeeding and restricting the mother's diet during lactation did not seem to prevent atopic eczema, although no randomized controlled trials addressed these questions.

Recommendations for clinical practice **The author of this article did a nice job of reviewing the literature on atopic eczema. He demonstrates how there may be only 1 or 2 studies on which we base our recommendations, even for common clinical problems. It is reasonable to continue to recommend topical steroids and house dust mite control measures for our patients with atopic eczema. Antimicrobials do not improve outcomes when added to topical steroids, and the different types of topical steroids all had effects similar to one another. Even if breastfeeding does not decrease the inci-**

dence of atopic eczema, it should still be recommended for other reasons.

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Telephone Treatment for Urinary Tract Infection

Saint S, Scholes D, Fihn SD, Farrell RG, Stamm WE. The effectiveness of a clinical practice guideline for the management of presumed uncomplicated urinary tract infection in women. Am J Med 1999; 106:636-41.

Clinical question **Is a policy of over-the-telephone treatment appropriate for the management of uncomplicated urinary tract infections (UTIs)?**

Background If the treatment of UTIs by telephone was shown to be safe and effective, it would be a convenient cost-effective option for patients. One health system tested this type of policy using a guideline developed by physicians, nurses, pharmacists, and support personnel.

Population studied The patients were members of Group Health Cooperative, a health maintenance organization in Washington. All women aged 18 to 55 years with symptoms of an uncomplicated UTI were eligible. Women who might be pregnant, or had symptoms of pyelonephritis (eg, fever), sexually transmitted disease (eg, vaginal discharge), or other complications (eg, diabetes, chronic catheter) were excluded. Patients of 24 primary care or family medical centers were included in the analysis. The patients of 2 other practices in the same system served as concurrent controls.

Study design and validity This evaluation of a clinical practice guideline used both a historical control and a nonrandomized concurrent control group. At intervention sites, telephone nurses offered empiric treatment for low-risk patients instead of an office visit. Treatment consisted of a 3-day course of selected antibiotics. Outcomes were measured before and after implementation of the triage policy. At 6-month intervals, data were gathered using an automated encounter and pharmacy database. Because of the limitations of these data sources, no attempt was made to measure or adjust for potential confounding variables, such as age and sexual activity. One hundred patients treated in accordance with the guideline were surveyed by telephone to assess their satisfaction with the care received. This survey could have been strengthened by also surveying patients in the control practices.

Outcomes measured The authors measured resource utilization in the following ways: the proportion of patients who had a urinalysis or urine culture performed, the proportion of patients who received a guideline-recommended antibiotic, and the proportion of patients who had an office visit rather than treatment by telephone. Potential adverse effects included the proportion of patients who developed pyelonephritis within 60 days and the number of return visits for sexually transmitted diseases or recurrent UTI. No routine follow-up was performed.

Results Approximately 40% of the 1883 women calling for an appointment for a UTI accepted treatment by telephone. Overall, patients treated after implementation of the guideline had significant decreases in the rates of urinalysis, urine culture, and office visits when compared with patients treated before implementation. These outcome measures were not statistically different when compared with the concurrent control group. The proportion of patients who received a guideline-recommended antibiotic increased from 18% before guideline implementation to 53% after implementation. This rate was also significantly higher when compared with the concurrent controls, a difference that would have been larger, except for a secular trend of increased use of appropriate antibiotics at the control clinics. The proportion of patients with pyelonephritis, recurrent UTI, or sexually transmitted diseases did not change. The telephone survey revealed that 95% of patients were satisfied with their care, and 85% would use the nurse triage system again in the future.

Recommendations for clinical practice **The authors describe the health-system–wide evaluation of a policy of telephone treatment for UTI. Although they mention significant decreases in resource use after implementation of the guideline, the comparison with concurrent control practices was not as striking. This study has significant limitations in its nonrandomized design; most important was the possibility of selection bias and confounding. There is also the potential for infrequent adverse outcomes. However, there was no evidence of worse outcomes with the policy, and it is reassuring that such high numbers of patients were satisfied with the care given in accordance with the guideline. This study suggests that it may be reasonable to have a telephone protocol to treat low-risk women with typical UTI symptoms.**

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