The 3IQ test is an accurate and simple way to classify incontinence

International guidelines for the classification of incontinence recommend detailed evaluation of patients, which can be time-consuming and impractical in a primary-care setting. Brown *et al.* modified an existing questionnaire (proven to assess incontinence symptoms accurately when administered by a trained interviewer) to derive the '3 incontinence questions' (3IQ). As patients with mixed incontinence are treated for both urge and stress incontinence, the authors tested the ability of the 3IQ to distinguish between women with urge or mixed incontinence and those with any other type, and between those with stress or mixed incontinence and those with any other type.

This prospective study, undertaken in five academic centers, recruited 301 otherwise healthy women aged >40 years with incontinence (mostly via newspaper advertisements or flyers). Exclusion criteria included incontinence treatment in the 3 months before study start, and 'complex' incontinence (including that caused by neurologic problems or diseases of the urogenital tract). Participants completed the self-administered 3IQ twice—once during the study visit and once at home 7–10 days later; all also underwent conventional detailed evaluation to classify their incontinence.

The 3IQ shows modest, but acceptable, accuracy (sensitivity 0.75, specificity 0.77) and obviates the need for a time-consuming evaluation. Although possible misclassification of the type of incontinence might inconvenience patients, it should not cause them harm—first-line treatments for stress and urge incontinence are rarely associated with serious adverse effects. In addition, any subsequent surgery for incontinence would only be performed after a detailed evaluation.

Original article Brown JS *et al.* (2006) The sensitivity and specificity of a simple test to distinguish between urge and stress incontinence. *Ann Intern Med* **144:** 715–723

Peyronie's disease is unlikely to resolve spontaneously

Since a study in the 1970s suggested that half of all cases of Peyronie's disease resolve spontaneously, treatment of this disorder has, typically, been conservative. Later studies, however, found that spontaneous resolution occurred in as few as 13% of cases, and that Peyronie's disease commonly progresses. Mulhall and colleagues used an objective measure of penile abnormality (assessment during erectogenic, intracavernous injection) in their prospective study, which investigated the natural history of Peyronie's disease.

They recruited 246 men (mean age at presentation 52 ± 22 years) with untreated, recent-onset Peyronie's disease (duration <6 months). Penile curvature was the primary abnormality in 217 men; the curvature was located dorsally (72% of cases), ventrally (17%), or laterally (11%). Participants were allowed to continue vitamin E treatment, but starting this treatment during the study was discouraged.

At follow-up (mean 14.5 months), mean curvature was significantly more pronounced than at baseline (45 ± 22° vs 62 ± 37°; $P<0.001$). Curvature had worsened in 48% of men, and improved in 12%. Objective and subjective measures of penile length were decreased, and 25% more men reported difficulty in penetration at follow-up than at study start. All men with penile pain at baseline reported an improvement; in most men, pain completely resolved during follow-up.

As the mean duration of Peyronie's disease was 18 ± 7 months at follow-up, the authors conclude that participants had moved from the acute phase to stable disease; however, fibrosis seemed to have stabilized, rather than regressed. These findings should help physicians give patients a more realistic idea of the course of Peyronie's disease.

Original article Mulhall JP *et al.* (2006) An analysis of the natural history of Peyronie's disease. *J Urol* **175:** 2115–2118

Multiple DVIU attempts are not cost-effective for treating short urethral strictures

Urethroplasty is indicated in long, densely fibrotic urethral strictures, but the best option for treatment of short (1–2 cm) strictures of the bulbar urethra remains controversial.

Wright *et al.* calculated the cost (including medical costs and lost wages from patient convalescence) and incremental cost-effectiveness ratios of four strategies for the treatment of short bulbar urethral strictures—urethroplasty