**Non-invasive techniques for stimulating urine production in non-toilet trained children: a systematic review**

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**ABSTRACT**

**Background**

Urinary tract infection requires collection of a sterile urine specimen for diagnosis, which is difficult and time consuming in pre-continent children. This systematic review summarises evidence of the effectiveness of bladder stimulation techniques on urine collection in pre-continent children, compared with standard techniques.

**Methods**

MEDLINE, PubMed, EMBASE and CINAHL were searched to May 2019. Selection, data extraction, risk of bias and quality assessment were undertaken by two independent reviewers. Inclusion: (i) all study designs (ii) pre-continent; age < 3 years receiving bladder stimulation techniques (iii) outcomes including time to urine collection or contamination rates (iv) English language articles. Exclusion: (i) co-existing neurological disorders.

**Results**

Three RCTs were identified using three techniques in 568 participants aged 1 day to 35 months. Two RCTs demonstrated an increased success in voiding within 5 minutes, one utilising a finger tapping and lumbar paravertebral massage technique and the other cold saline-soaked gauze rubbed over the suprapubic region, compared with no active intervention. A third RCT utilising a mechanical vibration device demonstrated no difference in time to voiding from advice alone. Non-randomised studies compared different temperatures for the gauze intervention and tapping alone versus urine bags. Six uncontrolled studies tested the finger tapping and massage technique. Risk of bias was low for 1 RCT and unclear for 2 RCTs with the other studies rated poor to fair quality. Overall, the evidence on success rates was graded low for tapping plus massage and moderate for the gauze rubbing intervention. Adverse effects included crying and mild distress.

**Discussion**

The results suggest a positive effect of stimulation techniques but lack of replication in rigorous RCTs and heterogeneity of techniques and outcomes assessed prevent conclusive recommendations being made. Further RCTs are required comparing non-invasive stimulation methods and assessing time to successful collection, contamination rates, adverse effects, caregiver and clinical staff acceptability.

**What this paper adds**

What is already known on this subject

* A number of trials have been published assessing the effectiveness of non-invasive techniques to stimulate urine production in non-toilet trained children.
* There have been no systematic reviews summarising or assessing the quality of this evidence.

What this study adds

* This review provides preliminary evidence that bladder stimulation techniques may be effective in stimulating urination in non-toilet trained children.
* It was not possible, based on this review, to provide recommendations on which technique was the most effective.
* Further randomised controlled trials are required to provide evidence on the most effective technique and in which population of patients they will be most beneficial.

**INTRODUCTION**

Urinary tract infection (UTI) in pre-continent children remains a challenging diagnostic dilemma. Prompt treatment of a UTI is required to reduce the risk of complications such as renal failure and scarring and it is an important diagnosis to exclude in any child with a fever.1 Prevalence of UTI amongst infants between birth and 24 months of age presenting with a fever is estimated at 7%.2 Following NICE guidance, “infants and children presenting with unexplained fever of 38°C or higher should have a urine sample tested within 24 hours”.3

Within the UK, clean catch methods are regarded as the gold standard for urine collection in children.3 These methods reduce the risk of contamination of samples and involve cleaning of the genital area and then waiting for spontaneous voiding into a sterile container. The American Academy of Pediatrics recommends collection by supra-pubic aspiration (SPA) or catheterisation to establish a diagnosis of UTI in children between 2 – 24 months of age;4 but highlights that, if a mid-stream clean catch sample is negative for both leucocytes and nitrites, further immediate invasive sampling can be avoided whilst the clinical course is monitored. Other methods (urine collection pads and bags) carry significant risks of contamination and invasive methods (catheter and SPA) carry a risk of pain or iatrogenic harm.5 Current UK national guidance concludes that ‘Limited available evidence showed that the urine collection methods that produce a most diagnostically accurate sample for testing are clean catch and SPA.’.3 The results of a systematic review on the effectiveness of pre-analytic practices on contamination and diagnostic accuracy indicates that, for non-invasive approaches, midstream collection with cleansing of the genitals prior to voiding should be used in place of collection in sterile urine bags.6

Clean catch methods can be difficult to carry out and are time-consuming in pre-continent children.7 This is a particular problem in the emergency department when obtaining a rapid diagnosis is essential for guiding management. There are published studies exploring non-invasive methods of stimulating urine production but no published comprehensive, systematic assessment of the evidence on these techniques.

This systematic review evaluates the published evidence for non-invasive bladder stimulation techniques compared with standard techniques on urine sample collection, contamination and adverse effects for children who are not yet toilet trained.

**METHODS**

A systematic review was undertaken according to the prospectively published protocol on the international register of prospective systematic reviews (PROSPERO 2017 CRD42017056224).8 This review is reported according to the criteria set out in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist for systematic reviews.9

***Literature search and selection***

The search strategy was developed by MC, KP and AD with assistance from a research librarian. The strategy for MEDLINE is presented in Appendix i.

MEDLINE; PubMed; EMBASE; CINAHL databases were accessed via the NHS Athens HDAS portal and searched from inception.

Initial database searches were undertaken in June 2017. Attempts were made to contact authors of relevant articles to identify further or ongoing studies. The searches were updated on the 27 May 2019; no further studies were found.

Searches were also undertaken using the: COCHRANE Library (including the Cochrane Central Register of Controlled Trials (CENTRAL); Cochrane Database of Systematic Reviews; Database of Abstracts of Reviews of Effects (DARE)); TRIP database (www.tripdatabase.com) and BestBETS (www.bestbets.com)

Clinical trials registries (clinicaltrials.gov and controlled-trials.com); websites of professional bodies (Royal College of Paediatrics and Child Health and Royal College of Emergency Medicine) were reviewed for unpublished or ongoing trials. Reference lists for included studies were checked for additional publications and relevant journals were hand searched for the past 5 years.

Search results were combined using Endnote software and duplicates removed. The records were imported into Abstrackr for review (Brown University, USA). Titles and abstracts were screened independently by two researchers (KP and MC) and records identified as relevant, maybe or irrelevant. Full texts were obtained for studies marked as “relevant” or “maybe” by either reviewer and consensus on inclusion/exclusion was reached by discussion. Had agreement not been reached, a further reviewer (AD) was available to provide consensus (but was not required).

Initial scoping revealed limited randomised controlled trial (RCT) evidence on the interventions being reviewed and so eligibility criteria were designed to be broad with all study designs considered.

***Eligibility criteria***

Patients/population: Pre-continent children (< 3 years of age) who were not toilet trained and without neurological problems in whom a urine sample was required to aid diagnosis.

Interventions: Any non-invasive techniques intended or designed to stimulate urine production.

Comparison: All types of control or comparative interventions were considered.

Study Design: Any clinical study reporting at least one of the outcomes was included; thus, cohort, before and after and retrospective studies in which there was no control/comparison as well as RCTs and non-randomised trials were eligible for inclusion.

Outcomes: Primary or secondary outcomes that included at least one of the following (i) success in obtaining a urine sample within a stated period of time (ii) mean time to obtain urine sample (iii) contamination rates.

Language: Only studies published in English.

***Data extraction***

Data extraction was undertaken independently by two reviewers (KP and MC) onto standardised forms developed for this review including information on study characteristics, interventions, participant characteristics and outcomes. Extracted data were compared for accuracy and reviewers met to reach consensus.

***Quality assessment***

Quality assessment was undertaken independently by two reviewers (KP and MC). Cochrane Risk of Bias tool was used for RCTs. The Newcastle-Ottawa scale for non-randomised trials was to have been used but this was replaced with the Downs and Black assessment tool as being more appropriate to the wide range of study designs identified.10 11 The Downs and Black tool can be used to assess both RCTs and non-RCTs providing a comparative score when mixed designs are included in a systematic review as in this case. It is a validated scale assessing 27 aspects and is considered an acceptable alternative to the Newcastle-Ottawa scale based on a comprehensive analysis of a wide range of such tools.12

***Data analysis***

Given significant heterogeneity of study types, interventions and outcomes, it was considered prospectively that meta-analysis would not be feasible. A reassessment of this was undertaken by a statistician once the trials had been identified and it was concluded that there was insufficient data for meta-analysis. An assessment of the overall grade of the evidence for the primary outcome (success in obtaining a sample within 5 minutes), contamination and main adverse event (crying/distress) was carried out using an approach based on the GRADE approach. 13

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram of studies

**RESULTS**

***Literature search and inclusion***

Database searches identified 1536 records. Two further relevant studies were found on review of reference lists of included studies, and one further study found by other sources. No studies were excluded due to publication language. Following initial title and abstract screening, 24 studies were assessed as relevant or maybe relevant. Full text versions of these publications were reviewed, and 11 studies selected for inclusion. Reasons for exclusion of remaining publications are listed in Figure 1. Three abstracts of studies were excluded because they did not report enough information to allow risk of bias and quality assessment to be performed.14-16

***Description of studies included***

Three RCTs,17-19 two non-randomised studies (a feasibility study which compared an intervention at two different temperatures and a comparison of tapping with collection in urine bags)20 21 and six uncontrolled pre-post trials were identified.22-27 (Tables 1 & 4)

***Randomised controlled trials***

***Risk of bias and quality assessments***

Whilst none of the included studies were blinded, the objective nature of the outcomes (time to voiding) mitigated the risk of bias posed. The nature of the interventions would make blinding of participants and those delivering the intervention challenging. The trial utilising gauze soaked in cold saline was judged to be at low risk of bias,19 with the overall risk of bias in the remaining trials being unclear.17 18 (Tables 2 & 3)

***Patient characteristics and settings***

The three RCTs included a total of 568 male and female patients aged from 2 days to 35 months. Two were carried out in Paediatric Emergency Departments and; one in a neonatal intensive care unit (NICU).

***Intervention and comparators***

Three types of non-invasive interventions were evaluated. One trial assessed the efficacy of rubbing the suprapubic region with saline soaked gauze.19 One trial evaluated a technique involving tapping with the fingers over the suprapubic region (at a rate of 100/min for 30 seconds) followed by lumbar paravertebral massage (for 30 seconds).18 One further RCT used a vibrating bladder stimulator held over the suprapubic region.17 The control interventions involved waiting for the child to void spontaneously, holding the child in the same position without stimulation and providing advice only.

***Personnel required to deliver intervention***

The number of personnel required varied depending on the intervention. The intervention involving saline soaked gauze required two operators; one to perform the intervention and one to collect the urine sample.19 Finger tapping over the suprapubic area and lumbar paravertebral massage required three operators; one to hold the child in the correct position, one to perform the intervention and one to collect the urine sample.18 The vibrating bladder stimulator was applied by the parent and it is inferred that they would be responsible for collection of the urine sample.17

***Outcomes measured***

Voiding within 5 minutes and voiding plus successful urine catch was assessed in one RCT;19 while time to voiding was assessed in another.17 The third RCT measured both voiding within 5 minutes and overall time to voiding.18 Contamination rates were recorded in two RCTs18 19 and one investigated parental and clinician satisfaction with the technique.19

***Effects of the interventions***

**Outcome: Voiding with a pre-specified time/time to void**

*Tapping plus massage*

This technique was assessed in one RCT in a NICU setting; the infants had a median age of 7-8 days and a significant difference was found between the intervention and holding the infant in the same position without stimulation (success in < 5 minutes in 78% in the intervention group vs. 33% in the control group (p< 0.0001)).18 Gender was not found to be an independent variable of success.

*Gauze soaked in cold saline*

Only one RCT was found which included 344 infants with a mean age of 5.4 months in a Paediatric Emergency Department setting. A significant difference was seen between the effects of the intervention and the control (waiting for spontaneous voiding) with successful voiding at 5 minutes of 31% and 12% respectively (p<0.001).19 Age and gender were not found to affect primary outcome results.

*Bladder stimulator (mechanical/battery operated)*

This method, using a vibrating bladder stimulator, was evaluated in one RCT in a Paediatric Emergency Department with 97 patients ranging in age from 0.5 to 35 months. No significant difference was observed between the effects of advice or a bladder stimulator on time to void (42% vs 53% waiting < 1hour; p=0.15).17 There were no significant differences in outcome found with age and gender.

***Outcome: Contamination rates***

Two of the RCTs reviewed assessed contamination rates, however they did not demonstrate a significant difference between intervention and control arms.18 19

***Outcome: Parent/carer and health professional/health care worker satisfaction***

Satisfaction amongst carers and health professionals was found to be good with statistically significant differences in Likert scores of 2 (satisfied) v 3(neutral) in favour of the intervention using gauze soaked in saline.19

***Outcome: Adverse events***

In the two RCTs that reported adverse events one commented on crying in all participants (in both the control group and those receiving tapping and massage).18 The other found 5 of 49 children in the intervention group were more upset following use of the mechanical vibrating device and 2 had a transient red mark on the skin.17 In the third RCT, crying and mild distress was not regarded as adverse events as they commonly occur with routine clean catch urine and no other adverse events were observed. 19

***Non-randomised and observational/uncontrolled pre-post studies (Tables 4 and 5)***

Eight studies other than RCTs were identified and included a total of 729 patients.20-27 Age of participants varied with means ranging from 31.5 hrs to 7.5 months (median of 10 months reported in one study). Techniques utilised in these studies included saline soaked gauze rubbed over the suprapubic region,21 a finger tapping technique,20 while the majority of studies utilised the finger tapping and lumbar paravertebral massage technique 22-27 described by Herreros-Fernandez et al.22

Quality of the non-randomised and observational studies was assessed using the Downs and Black tool and was found to be poor with scores of less than 14 in six of the eight;20-24 27 and fair in the remaining two.25 26

Six studies utilised the tapping plus lumbar paravertebral massage technique.22-27 Voiding within a pre-specified time was reported in 5 studies testing the tapping plus massage technique: 3 studies reported rates within 5 minutes of 27%, 49% and 86% respectively.25 26 22 One study reported voiding within 4 minutes and a success rate of 91%,27 and another reported voiding within 3 minutes with a success rate of 56%.24 The lowest rate was reported in a study in France in 48 infants with a median age of 10 months;25 the highest rate was found in a study of 100 neonates less than 28 days old.26 No comparison with control was reported in these studies. Rates of 35% and 25% for voiding within 5 minutes were reported in a study comparing rubbing with gauze soaked with cold and room temperature saline respectively.21 One study reported time taken to voiding rather than success rates20 and the final study did not assess voiding time.23

Three studies assessed contamination as a primary outcome.20 23 26 A non-randomised trial compared finger tapping to urine collection bags and a statistically significant reduction in contaminated samples was demonstrated in the intervention arm of the study (7.7% v. 51% p< 0.001).20 A cross-sectional study utilising the finger tapping plus massage technique paired urine samples with a subsequent sample taken by catheter within 1 hour. This demonstrated that the technique was Sensitive (97%) and Specific (89%) with low contamination rates in both groups.23 A prospective cohort study found a non-statistically significant difference in paired urine samples with a contamination rate of 16% in the tapping plus massage samples compared to 6% in paired samples collected by either catheter or suprapubic aspirate in a subgroup of the study population in the following situations ( positive urinalysis, decision to prescribe antibiotics, unsuccessful non-invasive sampling).26

Gender was not found to be an independent variable of success in any study. A number of studies demonstrated, in subgroup analysis or logistic regression, increased success in those of a younger age or lower weight.24-26 Challenges were noted in maintaining the child in the correct position in the correct position in 22 out of 48 participants (48%) in one study utilising the tapping plus massage technique.25

Satisfaction with use of the intervention was reported as 87.5% for parents and 90% for clinicians using gauze soaked in saline.21 Crying was the most common adverse event noted and incidence ranged from 77% to 100%.22 25 Local skin redness was reported in one study 25 and discomfort in another.24

**Overall grading of the evidence**

The evidence was assessed for the primary outcome measure – voiding within a pre-specified period (< 5 minutes) – for two interventions. For rubbing with saline-soaked gauze, the evidence from one RCT was not downgraded for risk of bias (low), indirectness or publication bias but was downgraded for imprecision due to sparse data (fewer than 300 events) being available. Thus, the evidence was rated as moderate. With only one RCT, consistency across RCTs could not be assessed. The non-RCT evidence (one study) reported similar success rates but was conducted by the same team and it is uncertain if similar effects would be achieved by other teams or in other settings. For the tapping plus massage technique, evidence from one RCT was not downgraded for indirectness or publication bias but was downgraded for risk of bias (unclear allocation concealment) and for imprecision due to sparse data. Thus, the evidence was rated low. Again, with only one RCT, consistency could not be assessed. More non-RCT evidence (five studies) was available for this intervention but success rates varied and, in some cases, differed from those in the RCT. Similar grades were applied to contamination as an outcome. Grading of the evidence on crying/distress was precluded by differences in reporting: crying and mild distress rates up to 100% were observed in some studies but, in at least one study, were not regarded as adverse events and not recorded. (see Appendix ii for Table containing full grading assessment).

Table 1 Summary of RCTs included

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study; country; year** | **Setting** | **Sample size** | **Participants (age/gender)** | **Intervention** | **Control or comparison** |
| Kaufman et al; Australia, 2017 19 | Tertiary Paediatric Emergency Department | 344 | Mean age months: Intervention 5.4 (SD 3.2); Control 5.4 (SD 3.0). Gender: Intervention M:F (55%:45%)Control M:F (45%:55%) | Rubbed the suprapubic region of the child in a circular pattern with gauze soaked in cold saline held with forceps.  | Wait for child to void spontaneously. Both maximum 5 mins |
| Altuntas et al; Turkey; 2015 18 | Tertiary Neonatal Intensive Care Unit | 127 | Median age days: Intervention 7 (4 - 14)Control 8 (5 - 15)Gender: Intervention M:F (52%:48%)Control M:F (53%:47%) | Fed according to weight 25 minutes before stimulation (excluded if poor feeding/dehydration). One examiner held baby under the armpits with legs dangling in males and hip flexion in females. The second examiner stimulated the bladder by tapping and lumbar paravertebral massage as per Herreros-Fernandez 201322  | Held under the armpits with legs dangling until they urinate |
| Davies et al; UK, 2008 17 | Paediatric Emergency Department | 110 (data for 97) | Mean age (range) monthsIntervention: 10.76 (1 – 31) Control: 10.72 (0.5 – 35) Gender: Intervention M:F (54%:46%)Control: M:F (42%:58%) | Queen Square bladder stimulator held on the patient for 1 min out of every 5 mins | Written advice on methods of stimulating urine flow by massage and tapping the abdomen |

 Table 2 Results and quality assessment: RCTs

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Study  | Outcomes | ResultsIntervention | ResultsControl | p value | Downs and Black score |
| Kaufman et al, 2017 19 | Voided < 5 mins | 54/174 31% (95%CI 24-39) | 20/170 12% (95%CI 7-18) | **p<0.001** | 24 |
| Voided < 5 mins & successful catch | 52/174 30% (95%CI 23-37)  | 15/170 9% (95%CI 5-14) | **p<0.001** |
| Contamination rates | 27% (95%CI 15-43) | 46% (95%CI 17-77) | **p=0.29** |
| Satisfaction | Median difference 2 (satisfied) v 3 (neutral) on a 5 point Likert scale, favouring intervention (0.6 – 1.4) |  | **p<0.001** |
| Altuntas et al, 2015 18 | Voided < 5 mins | 49/63 (78%) | 21/64 (33%) | **p<0.0001** | 15 |
| Time taken (median) seconds | 60 (IQR 64.5) | 300 (IQR 95) | **p<0.001** |
| Contaminationrates | 24% | 29% | **p=0.770** |
| Davies et al, 2008 17 | Time to void (Mean (+/- 95%CI) minutes | 53 (+/- 12) | 71 (+/- 15) | **p=0.20** | 17 |
| % waiting less than 1 hour | 53% | 42% | **P=0.15** |

Downs & Black score: Excellent/Good = 20–28; Fair = 15–19; Poor = <14; \*calculated from reported data, IQR interquartile range

Table 3 Cochrane risk of bias assessment for RCTs

|  |  |  |  |
| --- | --- | --- | --- |
|  | Kaufman et al, 2017 | Altuntas et al, 2015 | Davies et al, 2008 |
| Random sequence generation | **+** | **+** | **?** |
| Allocation concealment | **+** | **?** | **+** |
| Blinding of participants and personnel (based on primary outcome measure) | **+** | **+** | **+** |
| Blinding of outcome assessment | **+** | **+** | **+** |
| Incomplete outcome data | **+** | **+** | **?** |
| Selective reporting | **+** | **+** | **+** |
| Other sources of bias | **+** | **+** | **?** |

|  |  |
| --- | --- |
|  | Key |
| High Risk of Bias | **-** |
| Low Risk of Bias | **+** |
| Unclear Risk of Bias | **?** |

Table 4 Summary of non-RCTs included

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study; country; year** | **Setting** | **Sample size** | **Design** | **Participants (age/gender)****\*calculated from reported data** | **Downs and Black score\***  |
| Kaufman et al; Australia, 2017 21 | Tertiary Paediatric Emergency Department | 40 | Prospective feasibility study  | Mean age 7.5 mths (range 2-15) room temperature group (RT)5.7 mths (range 1-16) cold temperature group (CT)M:F 30:10 (75%:25%) | 11 |
| Nepal et al, Nepal, 2016 27 | Neonatal Intensive Care Unit and postnatal ward | 100 | Prospective feasibility study | Mean age 31.5 hoursM:F 59:41 (59%:41%) | 12 |
| Labrosse et al; Canada,2016 26 | Tertiary care Paediatric Emergency Department | 126 | Prospective cohort study | Median age55 days (IQR 37-92)M:F 64:62 (51%:49%\*) | 17 |
| Tran et al; France, 2016 24 | Paediatric Emergency Department | 142 | Cross sectional study | Mean age4.7 mths (+/- 4.0)M:F 68:74 (48%:52%) | 11 |
| Valleix-Leclerc et al; France,2016 25 | 3 Paediatric Emergency Departments | 48 | Prospective non-controlled study | Median age10 mths (IQR 3-17.25)M:F 21:27 (44%:56%\*) | 16 |
| Herreros Fernandez et al; Spain; 2015 23 | Emergency Department | 60 | Cross-sectional study | Mean age 44 daysMedian age 40 days (range 2 – 90)M:F 42:18 (70%:30%) | 11 |
| Herreros Fernandez et al; Spain; 2013 22 | Neonatal unit | 80 | Prospective feasibility and safety study | Mean age Male 6.66 daysFemale 6.23 days M:F 31:49 (39%:61%\*) | 10 |
| Taylor et al; Ireland, 1986 20(short report) | Children’s hospital | 154 samples (133 children) | Non-randomised controlled study (3 arm) | Age range1 week to 12 mthsM:F 62:71 (47%:53%\*) | 8 (based on short report |

Downs & Black score: Excellent/Good = 20–28; Fair = 15–19; Poor = <14

Table 5 Results : non-randomised trials

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Study**  | **Intervention** | **Control or comparison** | **Outcomes** | **Results** |
| Kaufman et al, 2017 21 | 10s of standard peri genital cleaning with room temperature sterile water-soaked gauze. Suprapubic area rubbed in a circular motion with saline soaked gauze at room temperature for up to 5 mins | Saline soaked gauze at 2.8 degrees  | Voided < 5 minsSatisfactionAdverse events | Room temperature saline: 5/20 25% (95%CI 9-49); Cold saline 7/20 35% (95%CI 15-59); All: 12/40 30% (95%CI 17-47)35/40 parents satisfied or very satisfied (87.5%, 95%CI 73-96)36/40 clinicians satisfied or very satisfied (90%, 95%CI 76-97)No adverse events  |
| Nepal et al, 2016 27 | Fed according to weight 25 minutes before stimulation (excluded poor feeding/dehydration). Baby held under the armpits with legs dangling. Examiner stimulated the bladder by tapping (100 taps/minute for 60 seconds) and lumbar paravertebral massage (30 seconds) repeated for two cycles | None | Voided < 4 minsTime takenAdverse events | 91/100 (91%) Mean 59.7s (SD 46.4)No adverse events |
| Labrosse et al, 2016 26 | Opportunity to feed 20 mins prior to intervention. Tapping and massage as per Herreros-Fernandez. Max 300s or successPaired catheter or supra pubic aspirate urine sample taken after if urinalysis was positive or decision to prescribe antibiotics or unsuccessful urine collection.  | None | Voided < 5 mins (all)Time takenVoided <5mins (<30 days old)Contamination  | 62/126 49% (95%CI 40-58)Median 45s (IQR 14-158)14/23 61% (p=0.01)Contamination: 16% vs 6% (invasive) |
| Tran et al, 2016 24 | Tapping and massage as per Herreros-Fernandez 2013.Up to 3mins or success | None | Voided < 3 mins (all)Time takenVoided < 3mins (>1 yr age)Adverse events | 55.6% (95%CI 47.5 – 63.8)Mean 63.6s (+/- 54.5)28.6% (p=0.0001)Discomfort: 58.5% (95% CI 50.4-66.6) |
| **Study**  | **Intervention** | **Control or comparison** | **Outcomes** | **Results** |
| Valleix-Leclerc et al 201625 | Received weight and age appropriate drink. First operator held child under the arms with legs dangling. Tapping and massage as per Herreros-Fernandez 2013. Repeated for up to 5 mins or success. | None | Voided < 5 minsTime takenAdverse events | 13/48 27% (95%CI 13-41)Mean 2 minsDifficulties in maintaining child in correct position (22/48 (46%Success rate according to weight> 9kg – 14.3%< 9kg – 37%  |
| Herreros Fernandez et al 2015 23 | Encourage oral intake based on age and weight (excluded infants with poor feeding), genital cleaning protocol and stimulation of voiding (suprapubic and lumbar paravertebral massage). Paired samples with urinary bladder catheterisation within 1 hour.  | None | Accuracy of diagnosisContamination  | Sensitivity of 97% (95% CI 82% - 100%); Specificity of 89% (95% CI 65% - 98%)Contamination: 5% (bladder stimulation) vs 8% (invasive) |
| Herreros Fernandez et al 2013 22 | Fed according to weight 25 minutes before stimulation performed (excluded poor feeding/dehydration). Tapping in the suprapubic area at 100 taps/min for 30s. Light circular massage of the lumbar paravertebral zone in the lower back for 30s, repeat until success. | None | Voided < 5 minsTime takenAdverse events | 69/80 86%Mean 57s (SD 48.6)Controlled crying 100% |
| Taylor et al, 1986 20 | Finger tapping just above the pubis with two fingers, one hours after a feed. One tap/second for one minute followed by one-minute rest until urine sample obtained. With or without genital washing prior to intervention | Urine bag (Hollister U-bag) placed over the genitalia after washing with sterile water. | Contamination Time taken | Bag with washing: 25/49 (51% contaminated)Tap with washing: 4/52 (7.7% p<0.001) Tap, no washing : 7/53 (13.2% p<0.001)Mean 5.5 mins (SD = 6.0) |

**DISCUSSION**

This systematic review aimed to evaluate the evidence for non-invasive bladder stimulation techniques in non-toilet trained children. The 11 studies identified in this review included over 1200 patients with a wide age range performed within a variety of hospital settings.

A non-invasive bladder stimulation technique was initially described in 1985,16 but only three RCTs were located in this review and each of these assessed a different intervention. The most recent and rigorous of these indicated some success in stimulating voiding in less than 5 minutes with a non-invasive technique (rubbing with saline soaked gauze), the evidence for this intervention being graded moderate. A second technique which involved tapping and massage and which has undergone the most frequent investigation in various preliminary studies and an RCT also appeared to be effective with the evidence for this intervention graded low.

Thus, this review indicates that although the evidence base is limited, bladder stimulation techniques appear to moderately improve the success of non-invasive urine collection in non-toilet trained children. This would be clinically significant if it could be replicated in clinical environments and further confirmation of findings is required. There was a lack of evidence to support the reduction in contamination rates using bladder stimulation techniques compared with other techniques. As this is a clinically important outcome, further investigation would be important to support the acceptance of these techniques within clinical settings.

Choice of technique is likely to be affected by the minimum number of personnel required in Emergency and Acute care settings. Interventions requiring more than two operators are likely to reduce the generalisability and applicability irrespective of their clinical effectiveness owing to the resource and time implications of utilising multiple members of staff. It is possible that some of these issues could be mitigated by teaching parents and caregivers to deliver the interventions utilising videos and written resources. Nevertheless, interventions requiring a child to be held suspended would be technically challenging with increasing age and weight of the child; as was demonstrated by Valleix-Leclerc.25 This would significantly limit their use in the older and heavier population.

The techniques appear to be safe but are likely to cause mild distress to children whilst being performed. Thus, further exploration of acceptability to parents and caregivers is also important, particularly if they will be actively involved in delivery of interventions. Caregiver and clinician satisfaction was high in the technique involving rubbing the suprapubic region with saline soaked gauze method but was not assessed for other methods. In the majority of studies, children were held by members of the research team and bladder stimulation was delivered by trained personnel. It is unclear whether involvement of caregivers may affect the success and acceptability of the procedure and it was not possible to ascertain caregiver or clinician preference for the different stimulation methods reviewed.

While the non-RCT evidence cannot be considered rigorous evidence, analysis of these studies has provided further information as to feasibility of these techniques. They also indicate that the proportion of infants voiding within 5 minutes is highly variable. The reasons for this are not completely clear but are likely to relate to age and weight of participants, with greater success in those of a younger age and lower weight in whom triggering of newborn voiding reflexes is more effective. Exclusion of participants with poor oral intake and co-interventions that include feeding prior to attempt stimulation method will also have increased success rates in some studies. These factors would, however, limit the generalisability in the Emergency Department setting when vomiting and decreased oral fluid intake are frequently seen. Reasons for urine specimen collection were also highly variable with exclusion of urinary tract infections being the main reason in those studies conducted in the Emergency setting and hyperbilirubinaemia being the predominant reason for those studies conducted on Neonatal Intensive Care Units. These factors significantly limit the ability to apply the findings of these studies outside of the care environments or patient groups in which they were carried out.

Based on our review, we are not able to conclude which technique was superior as a randomised superiority trial has not been undertaken. Six relevant studies were identified through the clinicaltrials.gov website. Three of these are currently recruiting, one is not yet recruiting and two have been completed but not published. Two further studies were located only as conference abstracts. The results of ongoing trials should add to the evidence base.

Further exploration of the acceptability and feasibility of the techniques available should be followed by an adequately powered, multi-centred RCT. This would focus on investigating the success of voiding (within 5 minutes to allow for standardised comparison to existing studies), contamination rates, adverse events and acceptability of the techniques compared to standard clinical practice to provide recommendations on which method is most effective and in which patient group.

**Limitations of the review**

 It is possible that, owing to the variability with which the interventions of interest are described, relevant studies may have been missed. It is therefore possible that other published data may affect the conclusions drawn from this review.

The small number of studies found and the heterogeneity in the interventions and the outcomes measured mean that it is extremely difficult to provide definitive conclusions on the evidence found.

**CONCLUSION**

The bladder stimulation techniques evaluated appear to offer some hope in the long-standing challenge of obtaining urine samples for clinical evaluation in non-toilet trained children. Based on the studies included in this review, it is not possible to offer a definitive recommendation of any of the techniques evaluated. The highest quality evidence currently is provided by the study by Kaufman et al (“Quick-Wee” method)19 but is based on a single centre study and has not been further validated making generalisability difficult to assess.

There remains the need for a multicentre, RCT to evaluate the variety of techniques available which should assess reduction in time to successful voiding, cost effectiveness and contamination rates. Planned a priori subgroup analysis should include whether gender, age of participants and personnel involved in delivering the intervention (caregivers or health care practitioners) affect success. An investigation of the acceptability of these various techniques to parents and caregivers is also crucial, a qualitative study is being undertaken by the authors to investigate this aspect.

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Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram of studies



Appendix i Search Strategy for MEDLINE (Ovid interface)

1. exp”INFANT,NEWBORN”/

2. exp INFANT

3. exp “CHILD, PRESCHOOL”/

4. exp “URINARY INCONTINENCE”/

5. (pre-continent).ti,ab

6. (precontinent).ti,ab

7. (incontinent).ti,ab

8. (toilet-trained).ti,ab

9. (non toilet trained).ti.ab

10. (1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9)

11. (bladder stimulat\*).ti,ab

12. exp “PHYSICAL STIMULATION”/

13. exp VIBRATION/

14. exp MASSAGE/

15. (clean-catch technique).ti,ab

16. (stimulation technique).ti,ab

17. (bladder percussion).ti,ab

18. (11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17)

19. exp URINATION

20. exp “URINARY BLADDER”/

21. exp “URINE SPECIMENT COLLECTION”/

22. (midstream urine).ti,ab

23. (urine sampl\*).ti,ab

24. (bladder empty\*).ti,ab

25. exp “URINE SPECIMEN COLLECTION”/

26. (micturition).ti,ab

27. exp “ URINARY TRACT INFECTINOS”/

28. (19 AND 20 AND 21 AND 22 AND 23 AND 24 AND 25 AND 26 AND 27)

29. (10 AND 18 AND 28)

|  |
| --- |
| **Appendix ii Grading of evidence based on RCTs (***with non-RCT evidence included for comparison***)** |
| **Comparison****(intervention; outcome)** | **Results (RCTs)** | ***Results (non-RCTs)*** | **Downgrade for RoB? (RCTs only)** | **Downgrade for inconsistency? (I2≥50%)** | **Downgrade for indirectness? (Review and study PICO do not match)** | **Downgrade for imprecision? (total events<300, total n<400, and/or CI includes no effect & important effect)**  | **Downgrade for other reasons? (e.g. publication bias)** | **GRADE quality of evidence**  |
| Rubbing with saline soaked gauze vs waiting**Outcome: voiding < 5mins (success)** | RD = 19%; 95% CI 11-28% (1 RCT; 344 participants; p<0.001)Success rate in intervention group: 31% (95%CI 24-39) | *1 trial comparing two saline temperatures only* *(No. of events 12; Success rate for cold saline: 35% (95%CI 15-59)* | No  | N/A for RCT*(Non-RCT success rate similar to RCT but conducted by same team)* | No | Yes (total events <300) – sparse data | No | Moderate\*\* |
| Tapping and massage vs waiting**Outcome: voiding < 5mins (success)** | RD = 45%; 95% CI 28-58%\* (1 RCT; 127 participants; p <0.0001)Success rate in intervention group: 78% (95% CI 66-86\*) | *5 uncontrolled studies only (No. of events: 314; Success rates: 27%; 49%; 56%; 86%; 91%)* | Yes (allocation concealment unclear) | N/A for RCT*(Non-RCT success rates variable and differed from RCT)* | No | Yes if only RCT considered (total events < 300) – sparse data;*(Total events >300 if non-RCTs included but wide range of rates)* | No | Low\*\*\* |
| **Comparison****(intervention; outcome)** | **Results (RCTs)** | ***Results (non-RCTs)*** | **Downgrade for RoB? (RCTs only)** | **Downgrade for inconsistency? (I2≥50%)** | **Downgrade for indirectness? (Review and study PICO do not match)** | **Downgrade for imprecision? (total events<300, total n<400, and/or CI includes no effect & important effect)**  | **Downgrade for other reasons? (e.g. publication bias)** | **GRADE quality of evidence**  |
| Rubbing with saline soaked gauze vs. waiting**Outcome: contamination** | RD = 18%; 95% CI -14% to 50% (1 RCT; 344 participants; p=0.29) | *None* | No | N/A | No | Yes (total events <300) – sparse data and CI includes no effect & important effect  | No | Moderate\*\* |
| Tapping and massage vs. waiting**Outcome: contamination** | RD = 5%; 95 CI -16% to 28%\* (1 RCT 127 participants; contamination assessed in 70) | *2 studies, rates reported in intervention group: 5%; 16%.* | Yes (allocation concealment unclear) | N/A(*Non-RCT* r*ates not all within 95%CI for RCT*) | No | Yes (total events <300) – sparse data and CI includes no effect & important effect | No | Low\*\*\* |
| Rubbing with saline soaked gauze vs. waiting**Outcome:****crying/distress (adverse event)** | 1 RCT: Crying and mild distress not reported as an adverse event; no other adverse events | *1 comparative trial: no adverse effects reported* | No | N/A | No but crying/distress not reported as an adverse event. | N/A | No | Unable to grade as differences in reporting |
| Tapping and massage vs. waiting**Outcome: crying/distress (adverse event)** | 1 RCT: No adverse effect observed except for ‘crying in all babies’. | *5 uncontrolled studies: no adverse events; discomfort 58.5%; crying 77%; crying 38%; controlled crying 100%* | Yes (allocation concealment unclear) | N/A for RCT(*Non-RCT rates and reporting varied*) | No but only reported for all babies | N/A | No | As above |