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Every now and then we come across individuals who inspire us with their extraordinary resilience in the face of unfathomable hardship. I had the honour of meeting such a person, Tony Jamieson, the subject of this edition’s personal story (p4-5).

A professional bull rider, Tony refused to let the injuries and resultant permanent incontinence sustained after a terrifying accident 23 years ago alter his life’s plans – inside and outside the arena. His story offers hope to the one in four Australians affected by incontinence, which we know can have significant impacts on their quality of life.

This is particularly so for young children, which is why we continue to target parents and teachers, who can have the greatest influence on a child’s development. We draw attention to some of the less enlightened attitudes about children’s toileting, which we continue to challenge through initiatives such as the Toilet Tactics Kit (p8).

In this edition we speak to one of the founders of the Continence Foundation of Australia (p3), hear about life as a pelvic floor physiotherapist (p10), discover how UTIs and diabetes impact continence (p6-7) and learn about some of the challenges for carers (p11).

I hope this edition informs and engages you.

Maria Whitmore
Editor

We’d love to hear your story

Maria Whitmore
Editor
Bacteria suspected in urge incontinence

An American study published in the *Journal of Microbiology* has found that bacteria present in urine could be the cause of urge urinary incontinence.

Researchers at Loyola University Chicago evaluated urine specimens taken from 90 women, with and without urge urinary incontinence, and found that bacteria present in the urine of women with urge urinary incontinence were different to the bacteria present in the urine of women without the condition.

Urge urinary incontinence occurs when a person has a sudden and compelling urge to urinate. The condition is poorly understood and thought to be due to an overactive bladder that contracts involuntarily before it is full, or to problems with the nerves controlling the bladder. It is estimated that as many as half of the patients who seek treatment from their GP for urge urinary incontinence do not respond to conventional treatments.

Researchers believe the findings could have strong implications for the prevention, diagnosis and treatment of women with this form of incontinence. Further investigation will focus on determining if and how these bacteria cause urge urinary incontinence.

If the type of bacteria associated with the urge urinary incontinence can be isolated and a new or existing antibiotic used to target them, the quality of life of the significant proportion of women (up to 25 per cent of Australian women) affected by urge incontinence could be drastically improved.

CYNTHEA WELLINGS is a registered nurse who runs nurse education and technology company Ausmed Education. She was one of the three founding members of the Continence Foundation of Australia and co-wrote a book on urinary incontinence that became a best-seller and set her on an entrepreneurial path. She was recognised as one of the 100 Women of Influence in Australia in 2014.

Why was the Continence Foundation of Australia founded?

It seems like a lifetime ago when I sat around a coffee table in 1989 with two colleagues, Rosemary Calder and Cliff Picton, who both worked at The Australian Council on the Ageing. There was a growing concern about the way in which people with incontinence were managed. Knowledge about the causes of incontinence and what could be done to alleviate the condition was not permeating through to the care providers. There were a lot of interested professionals, including nurses, physiotherapists, occupational therapists, social workers and doctors prepared to shine a light on the subject. The Australian Council on the Ageing played an enormous role in coordinating the movement that resulted in the creation of the Continence Foundation of Australia.

What was the impact of the Continence Foundation of Australia at the time?

Incontinence really came out of the closet. People who had suffered in silence were now able to acknowledge the problem and see it as a condition that had a therapeutic response rather than something to be ashamed of and hidden away. Incontinence could no longer be put in the too-hard basket or just considered a symptom of ageing, disability or childbirth. Hope was given to many people and the work performed at the time changed the lives of people forever.

It was an important and exciting time. Suddenly, there was an interest in creating positions for continence nurse specialists and advisors, and district nursing services started running excellent courses that attracted many nurses, including those from rural and remote areas. Physiotherapists started to improve women’s pelvic floor health, and people with intractable incontinence started to become socially continent for the first time.

There is no doubt the work of the Continence Foundation of Australia is very important; it is an organisation that is one of those quiet achievers making a real difference to people at a grass roots level.

How do you see the future of continence care?

We now face a growing incidence of chronic illness and an ageing population, and it is inevitable that more people will experience incontinence and require ever more sophisticated care.

I think there is a shortage of registered nurses in aged care as well as specialist and other nurses providing continence services in general, which risks care falling into the quick and easy approach of just padding up people with continence appliances. Ten years ago it was easy to find a specialist aged care nurse, but now it seems more difficult; they just don’t seem to be out there. I do believe this is likely to change with the advent of nurse practitioners, who will make a considerable difference to the delivery of health care in the future.

What is on your bucket list?

I am also very concerned about youth unemployment. I employ many young people at Ausmed Education and feel privileged to see them evolve from inexperienced individuals into confident, enquiring contributors to society. I think Australia needs an education system that will equip people for the future, and this includes more focus on emotional and social intelligence as well as instruction on how to write computer code. I think there could be great opportunities emerging for people with physical disabilities, as much work will be digitally-based, which can provide employment opportunities for people working from home. Overall, I think the future is bright for those who take the initiative to grab the many opportunities that digitisation offers.

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GRABBING LIFE BY THE HORNS

The discrimination Tony Jamieson experienced after surviving a sickening accident 23 years ago was as tough to handle, if not tougher, than the resulting incontinence, as MARIA WHITMORE discovers.

Had it not been for a young trainee ambulance officer’s last-ditch attempt to find a pulse on Tony Jamieson’s ankle on the way to the morgue, there is little doubt he would have died 23 years ago.

Had it not been for Tony’s astonishing inner strength in the face of his subsequent overwhelming physical and psychological trauma, he may well have wished the ambulance officers had continued on their way.

Tony admits to dark times in the aftermath of his horrific accident, when he says he felt like “cutting his own throat”.

“I had two choices; to lie down and die quietly or keep going. But I couldn’t settle down to any other lifestyle,” he says.

Tony’s lifestyle was one of professional bull riding. Back in 1992 at a rodeo in Longreach, a 24-year-old Tony was sitting on a bull’s back in the chute waiting for the gate to open, when the bull reared unexpectedly and flipped on top of him.

The list of injuries is sickening: four skull fractures, both eye sockets shattered, both sides of his jaw shattered, collar bones broken in four places, upper arm bones broken in two places, lower arms in three, a torn sternum, several broken ribs, badly bruised kidneys, spleen and liver, a split pelvis, both upper thigh bones broken in two places, both shin bones broken in three and both ankles shattered.

The bones have healed and the only outward sign of his injuries is a distinct limp, the legacy of his split pelvis. The trauma to his pelvis caused other permanent injuries; a ruptured bladder and irreversible damage to the bladder nerves. Tony has been incontinent ever since.

It took two years’ hospitalisation for Tony’s recovery. He discovered other things had changed around him - the medical and lay people, friends and work colleagues who, it seemed, couldn’t cope with the idea of a young, apparently able-bodied man, wetting himself.

“The medical professionals wiped me; I was just too hard. It was before CAPS (Continence Aids Payment Scheme) started, and there was not a lot of interest in helping with that problem. I lost a lot of so-called friends over it. People who had been close friends wiped me. It was mentally really hard for me to cope with. I’ve lost jobs over it,” he recalls.

“I had two choices; to lie down and die quietly or keep going. But I couldn’t settle down to any other lifestyle.”

“I walked out of hospital, and one week later - the next Saturday - I was at a rodeo, strapping down on a bull.”

Although he didn’t “make time” (staying on for a full eight seconds), Tony had his sights clearly set on picking up where he left off.

He headed to his parents’ cattle property in Maryborough and sought out one of their quiet horses, an “old plodder” that would ease him gently into his old lifestyle.

However, at the age of 27, Tony had to face an even tougher challenge; coping with the prospect of never being able to control his bladder again. Even more devastating, Tony says, were the reactions of many of those around him - the medical and lay people, friends and work colleagues who, it seemed, couldn’t cope with the idea of a young, apparently able-bodied man, wetting himself.

“The medical professionals wiped me; I was just too hard. It was before CAPS (Continence Aids Payment Scheme) started, and there was not a lot of interest in helping with that problem. I lost a lot of so-called friends over it. People who had been close friends wiped me. It was mentally really hard for me to cope with. I’ve lost jobs over it,” he recalls.

Tony believes a major reason so many shunned him was their difficulty reconciling his incontinence with his appearance. He wasn’t elderly, infirm or confined to a wheelchair, so people were at a loss to know how to behave around him.

Fortunately, Tony has retained a few “tight” friends who know of his condition and accept him as they would any other friend. He now works as a stockman on his parents’ property, but stills as a qualified tyre fitter at various workplaces after the accident didn’t amount to much.

Tony believes his tenures were cut short because his predominantly male work colleagues felt uncomfortable with his condition. These rejections, he says, triggered some of his most depressing periods, particularly as he moved from job to job in an attempt to earn enough to pay off his substantial medical debt.

“I thought maybe the government might help me with a pension, but I’m not in a wheelchair and not movement impaired. According to the government I’m able bodied and able to work. It didn’t faze me,” he says.

Through all this, Tony had to deal with the terminal illness of his former partner who died of pancreatic cancer 10 years ago, four days before they were due to marry. Tony has two children from a previous marriage; a daughter, 22, and a son, 18.

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“Had it not been for a young trainee ambulance officer’s last-ditch attempt to find a pulse on Tony Jamieson’s ankle on the way to the morgue, there is little doubt he would have died 23 years ago.”

To cope with the idea of a young, apparently able-bodied man, wetting himself.

“This man of extraordinary courage is also, clearly, a man of his word. There is little doubt, in this writer’s mind at least, that he will make the record - and then some.
Despite his permanent incontinence, Tony refused to give up his lifestyle, and now works as stockman at his parents’ Maryborough property (main), while continuing to ride bulls regularly to regain his professional bull rider status (inserts).
ALL ABOUT URINARY TRACT INFECTIONS

Urinary tract infections are common among women, the elderly and babies. They can cause a number of bladder–related issues, including incontinence.

Urinary tract infections (UTIs) can cause a number of incontinence symptoms, such as involuntary leakage, urinating more frequently, and having to urinate urgently.

A UTI is an infection in any part of the urinary system, which consists of two kidneys, a bladder, two ureters (tube from kidney to bladder) and a urethra (tube from bladder to outside).

Urine is usually sterile, so for an infection to occur a germ has to enter the urinary system from the outside via the urethra. The most common cause of infection is the bacterium Escherichia coli (E. coli), which is always present (and harmless) in the digestive tract and usually spreads to the urethra from the anus via the perineum.

Women are more susceptible to UTIs, because their urethra is just 4cm long and close to the anus - a short distance for the bacteria to travel. Diabetics and people who use urinary catheters are also more at risk. Men with an enlarged prostate are also at risk because their bladder may not empty properly. Babies are also susceptible, particularly those born with congenital abnormalities of the urinary system.

The most common symptoms of a UTI are:

• a burning sensation when urinating
• pain or pressure in your back or lower abdomen
• having to urinate urgently, or more often
• only passing a few drops when you go
• unpleasant smelling urine that may be bloody, dark or cloudy

Some evidence-based preventative measures that apply to women are:

• emptying the bladder after intercourse
• avoiding diaphragms or condoms that contain chemicals such as spermicides

Other commonly recommended preventative measures are:

• consuming adequate fluids in order to flush the urinary system
• treating vaginal infections such as thrush or chlamydia early
• avoiding or treating constipation

Although the following recommendations are yet to be backed by research, they may be worth discussing with your doctor:

• wiping from the front to the back (or dabbing thoroughly if physically restricted) after going to the toilet
• wearing cotton underwear

Treating the underlying infection is key to managing UTI-related incontinence. For many people a UTI is a one-off occurrence that responds well to treatment. However, some people have recurrent infections that are more difficult to manage. It is important to consult your doctor if you suspect a UTI to prevent the infection spreading to the kidneys.
Diabetes and incontinence

More than 1.7 million Australians have diabetes, 85 per cent of them with type 2. One of the less well understood consequences of diabetes is its potential to exacerbate bladder and bowel control problems.

**Constipation**
Constipation is the most common gastrointestinal problem for people with diabetes. Constipation increases the risk of urinary incontinence, essentially due to a space issue; an enlarged bowel compresses the bladder and reduces its holding capacity, thereby risking accidental urinary leakage. Straining on the toilet due to constipation also risks stretching and weakening the pelvic floor muscles, which are important for closing off the urinary and anal sphincters.

**High blood sugar levels**
If blood sugar levels are poorly controlled, the body will try to remove the excess blood sugars by producing more urine, which may also lead to stress incontinence (leaking when sneezing, running, laughing or coughing).

**Obesity**
Being overweight puts people at greater risk of both type 2 diabetes and incontinence. Excess weight is a major contributor to bladder and bowel control because the added strain on the pelvic floor stretches and weakens the pelvic floor muscles, compromising their ability to support the bladder and bowel and close off the sphincters.

**Nerve damage**
Poorly controlled or long-term diabetes can cause damage to nerves, which can lead to bladder and bowel control problems. This may manifest as a loss in sensation, little warning about having to go to the toilet, or lack of awareness that the bladder is filling. There may also be reduced sensation about whether or not the bladder or bowel is empty, increasing the risk of urinary tract infections (UTIs) or kidney damage.

**Reduced immunity**
Diabetes also interferes with the immune system, putting sufferers at a greater risk of infection. This combination of declining immunity and poor bladder emptying (due to nerve damage) puts people at a greater risk of urinary tract infections (UTIs). See opposite page for more information about UTIs.

**Medications**
Medications for type 2 diabetes such as metformin, acarbose and repaglinide can cause diarrhoea. Healthy sources of soluble fibre in the diet, such as oats, barley, rye, peeled fruit and vegetables, can help restore bowel motions to normal.

**Five steps for good bladder and bowel health**
For people affected by diabetes, good bladder and bowel health becomes even more critical. The Continence Foundation of Australia recommends these five steps for good bladder and bowel health.

1. **Eat healthy with plenty of fibre**
2. **Drink well**
3. **Exercise regularly**
4. **Keep your pelvic floor toned**
5. **Practise good toilet habits**

Go to continence.org.au for more details.

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Evidence shows that children who wet themselves at school can have impaired self-esteem and psychological health. MARIA WHITMORE reports.

Earlier this year, a major Melbourne newspaper published a story, Primary school punishes children for taking toilet breaks in class time. The story caused an outcry from parents and reminded us that outdated attitudes still exist among some school communities.

Follow-up media interviews served as an opportunity for the Continence Foundation of Australia to remind teachers, parents and the wider community of the critical role adults play in shaping children’s physical and psychological health.

Children can only suppress the urge to go to the toilet for so long, and eventually the urine has to come out - whether they are on the toilet or not - leading to wetting accidents.

There is ample evidence showing that children who wet themselves at school can have impaired self-esteem and psychological health, which in turn gives them a significantly higher chance of being bullied or becoming bullies themselves.

Faecal incontinence is even more devastating for a child. Soiling is often caused by constipation, and studies show that up to 30% of school children experience constipation at some point. Holding on, or not being allowed to go to the toilet when a child feels the urge to defecate, only exacerbates constipation, as moisture continues to be extracted from the stool, making it dryer and harder. If constipation isn’t treated, it may lead to impaction and subsequent distention (stretching) of the lower bowel, which can lead to soiling accidents that resemble diarrhoea but are, in fact, constipation with overflow.

Children themselves put off going to the toilet for any number of reasons; they may be engrossed in play, they may be scared of the big kids in the toilets or the toilets may be dirty, cold, smelly and lack privacy. It is not unusual for parents to observe their child make a beeline for the toilet as soon as they arrive home from school.

The physical impacts of incontinence in children can also be profound, and there is ample evidence that children who put off the need to empty their bladder or bowel predispose themselves to lifelong bladder and bowel problems, such as constipation and urinary tract infections.

Research shows that within a six-month period, as many as one in five Australian primary school-aged children will wet themselves during the day. To combat this problem, in 2012 the Continence Foundation of Australia launched the national Healthy Bladder and Bowel Habits in Schools campaign, focusing on primary school communities, parents and children.

One of the project’s major initiatives is the Toilet Tactics Kit, an interactive school resource that gives children the knowhow to adopt lifelong healthy bowel and bladder habits. Just as importantly, teachers and parents learn about the importance of encouraging and reinforcing good practices early, and the detrimental impacts of restricting children from going to the toilet when they need to.

The campaign continues to gather strength, with one in five Australian primary schools now signed up for the Toilet Tactics Kit (right). As more and more schools sign up for the Kit, fewer children will suffer the physical and psychological consequences of being denied going to the toilet when they need to, and news stories like the one that caused such an outcry earlier this year will be a thing of the past.

To learn more about Toilet Tactics or to register your school, go to continence.org.au or phone the National Continence Helpline on 1800 33 00 66.
Preventing kids’ bladder and bowel problems

Recalling early warning signs and encouraging good toileting behaviours is key to your child’s ongoing bladder and bowel health.

One of the most common bowel problems children experience is constipation, which has implications for urinary and faecal incontinence. Your child is chronically constipated if they experience at least two of the following within an eight-week period:
- fewer than three bowel motions a week
- at least one episode of faecal incontinence
- their stool blocks the toilet plumbing
- withholding behaviour
- painful defecation

Maternal child health nurse and National Continence Helpline continence nurse advisor Janine Armocida says parents can help prevent their child from becoming constipated by familiarising themselves with their child’s natural bowel patterns.

A good time to ask a child to sit on the toilet to empty their bowel is about 20 minutes after a meal. “That’s when we have the gastro-colic reflex, which is mass movement of contents through the bowel,” Ms Armocida said.

“Many people find this reflex is strongest in the morning, but most families are too busy in the morning and some children even have breakfast in the car.

“In an ideal world we would get up a bit earlier so our children have time to eat breakfast slowly, wait 20-30 minutes and then go to the toilet.”

While on the toilet, children should be encouraged to sit leaning forward with their hands or elbows on their knees, and their feet well supported. Many children require a toilet insert seat.

She said these steps, along with a balanced diet that includes fresh fruit, vegetables and wholegrains, adequate water intake and plenty of exercise, were fundamental to lifelong good bladder and bowel health.

It is equally important that children listen to their bladder’s call to go to the toilet, she said.

Resisting the urge to pass urine, or not completely emptying the bladder, can also have consequences for a child, such as wetting their pants. It can also have implications for their bladder’s health.

“If the bladder is not emptied properly and urine sits in the bladder, there’s a higher chance that bacteria could develop and start multiplying, leading to urinary tract infections,” she said.

Mrs Armocida recommended children empty their bladders before going to bed, but for the rest of the time, to only empty their bladder when they felt the urge.

“And parents should use common sense about encouraging them to go before events such as long car trips,” she said.
**A DAY IN THE LIFE OF A CONTINENCE PHYSIOTHERAPIST**

SUE CROFT is a Brisbane-based physiotherapist with a special interest in pelvic floor dysfunction including urinary incontinence, prolapse conditions, bowel management and pelvic pain. She describes a typical day at her clinic.

Getting up each day for the past 25 years has always been easy. There is great job satisfaction if you can help just one person achieve continence – and if you can help many, then work is a blast. Patients are often relieved to find someone who is comfortable talking about such private matters, and are always so grateful to have their continence improved and, many times, restored to normal.

Next to continence issues, a common scenario in my day work involves alleviating women’s fears about vaginal prolapse, and giving them alternative exercises to maintain their physical fitness. Women and men are much better informed these days about bladder, bowel and prolapse issues, thanks to the wonderful work of the Continence Foundation of Australia and, of course, the internet.

But there are some downsides to easy access of information. Increasingly, I am finding women who have been exercising heavily at the gym and overdoing their pelvic floor exercises to the extent that their pelvic floor muscles are too tight (overactive pelvic floor). This can present with dyspareunia (painful intercourse) and other pelvic pain problems. Men, too, can have muscles that are too tight, causing penile and testicular pain and even erectile dysfunction.

My days are not ordinary anymore, because recently I decided to expand and move to a bigger office. My first day in my new premises to come to work has always been easy.

My first patient, Karen* is very distressed as she has recently had surgery to remove haemorrhoids and is suffering debilitating flatus incontinence (passing wind involuntarily). Colorectal studies have identified very low pressures in both her internal and external anal sphincters. Like many patients with pelvic floor issues, she is crying throughout the consultation due to her extreme embarrassment. I explain the role of the pelvic floor muscles, the causes of faecal and flatus incontinence, and how managing her diet and stool consistency will help. We discuss the addition of local oestrogen (requiring a script from her doctor) and changing her defaecation position so she completely empties her stool.

My examination of Karen’s pelvic floor muscles reveals significant weakness due to extensive nerve and muscle damage resulting from childbirth many years ago, possibly exacerbated by the recent surgery. I arrange for a return visit in a month to see if changes to her diet have helped and to assess how her pelvic floor muscle strengthening has progressed.

Next on my list is a return visit from an anxious woman and her 10-year-old daughter Sarah, who has extreme urinary frequency and urgency. Sarah was going to the toilet up to 20 times a day, which caused her much anxiety at school and at home. Car trips were avoided, play visits with friends refused and her school marks were suffering. Again, education was key to her treatment plan, delivered in age-appropriate language so she could understand why the bladder was causing her such angst. I taught her relaxation and breath awareness techniques to assist with managing her stress hormones (cortisol and adrenaline), which were being released in response to her anxiety and making her symptoms worse. She learnt about her bladder’s normal capacity and I gave her strategies to improve her ability to control her persistent urges. (I have seen Sarah since and am happy to say she had a significant improvement in just one month. Her confidence had sky-rocketed and her mother reported that the relaxation and breath awareness practices had helped her the most.)

My next patient is Janice, a woman in her early 30s who I had seen over the course of a year. She originally presented with an anterior wall prolapse (when the bladder protrudes or bulges into the front wall of the vagina) following the birth of her first baby. She had a number of concerns; a heavy dragging feeling at the end of each day (worse when the baby was unsettled and she’d had to carry the baby in a sling for long periods) and a de-oestrogenising effect on her vaginal tissues as the result of demand feeding her baby every two to three hours.

Janice was distressed about being so young and having a prolapse. I explained that prolapse is common and onset is not necessarily age-related, but rather dependent on damage to muscles during vaginal deliveries or when straining at stool due to constipation. Evidence tells us that conservative treatment from a physiotherapist should be the first line of treatment for prolapse and the treatment plan devised a year ago had included extensive education in, what I call, the **5 Step Plan for Managing Prolapse** *(See below)*.

Janice had come to see me a year later, and even though she had been doing well, her prolapse was feeling worse whenever she exercised. I had previously suggested she try using a pessary (a firm ring or cube inserted into the vagina to support the uterus, bladder or rectum) when exercising. While she had been reluctant to use one at first, believing pessaries were only for old ladies, she had now come around to the idea. Because of her significant loss of muscle bulk, the cube pessary was the one that stayed in most effectively.

She is now ecstatic and feels empowered with a strategy that allows her to exercise, which is so important for her mental health. She also now has the option of a vaginal support while her children are little, when she is required to bend and lift repetitively.

You can see why I love going to work each day!

* All names have been changed.

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**5-STEP PLAN FOR MANAGING PROLAPSE**

1. **Find a prolapse mentor to support you on your journey**
2. **Strengthen the pelvic floor muscles**
3. **Pre-contract these muscles with pelvic floor muscle training**
4. **Manage the bowels well using the correct position and dynamics of defaecation**
5. **When returning to exercise, make sure the exercises are pelvic floor-safe so they don’t exacerbate the prolapse**

* * *
A carer focus with Stephen Marburg

National Continence Helpline coordinator Stephen Marburg responds to these typical questions from carers.

Q1. My wife has early-stage dementia and will wake me overnight for help to go to the toilet. It is an effort to wake up and then I struggle to go back to sleep. Should I put a pull-up on her overnight?

A. This is a complex and difficult problem that has no simple solution. It won’t do any harm putting a pull-up on your wife overnight if she will accept it, but whether or not it stops her waking you is another matter. If she is normally continent, you needn’t worry that she will become dependent on pull-ups during the day if they are only used overnight.

Before putting her in pull-ups, you may try offering her more fluids earlier in the day so she drinks less in the evening. You may also consider a commode next to the bed, which will keep everyone’s movements to a minimum and reduce the risk of falls.

Your wife may continue to wake up overnight regardless of any measures you take, so perhaps you might consider some respite care so you get a full night’s sleep. It’s important to look after yourself, as sleep deprivation can take a toll on your health and wellbeing if it continues indefinitely.

Q2. My partner has Parkinson’s disease and his constipation is becoming increasingly distressing. We are managing it as best we can, but he is now becoming increasingly incontinent of urine. What do you suggest?

A. The reduced dopamine production in the brain as a result of Parkinson’s disease causes the gut, as well as the rest of the body, to slow down, which is why constipation is one of the earliest and most persistent symptoms of Parkinson’s. Constipation is further exacerbated by the person’s reduced mobility.

It’s important to make every effort to treat the constipation, as it will be exacerbating the urinary incontinence. As a first step, have a continence assessment done by a continence nurse, and in the meantime, keep a bowel diary, which will help ensure the most appropriate line of treatment is offered.

While laxatives will be part of the treatment, practising good bowel habits will do much to help the constipation. The most important habits are having an adequate fluid intake and a fibre-rich diet (plenty of fruit, vegetables, legumes, whole grains and nuts), and ensuring he goes to the toilet as soon as the urge is felt to take advantage of the gastro-colic reflex (the mass movement of contents through the bowel). This can often occur about 20 minutes after a meal (often after breakfast with a hot drink), but can vary from person to person.

Q3. My partner became a partial paraplegic after an accident and now wears pull-ups. Although we enjoy a sexual relationship, his penis is often sore and inflamed. Is there anything we can do about it?

A. Ensuring your partner drinks adequate fluids is a good first step, as this will dilute the urine, which may be the cause of the soreness and inflammation. However, it’s also worth checking with his doctor that it isn’t due to something else, such as a urinary tract infection or thrush.

If it is urine causing the irritation, it may be worth looking at some incontinence-related dermatitis creams that might offer relief.

It may also be an allergic reaction to the particular pull-up material. Not all pull-ups are the same and different brands are composed of different materials, so it may be worth trying other brands. I’m unsure whether or not he has tried a urisheath and leg bag, so this may be an option worth revisiting.

Q4. Do you have any tips for reducing the odour in my mother’s home? She is incontinent of urine and occasionally faeces. She uses pull-ups.

A. This is a common question and there are quite a few measures you can take.

First, have her checked out by her doctor to rule out a urinary tract infection, which can cause urine to take on a strong odour. As well, always ensure your mother has adequate fluid intake to help dilute the urine and reduce the risk of urinary tract infections.

Dispose of all used pull-ups outside the home as soon as practicable and ensure wet or soiled clothes or bedding is washed or sealed in airtight containers until washed. The bed should have full mattress protection, as should favourite armchairs if she tends to have accidents during the day.

There are also several products that help remove or disguise odours. Supermarkets stock effective hospital-grade cleaning products and spray-on odour-absorbing products for mattresses and carpets. Scented candles, incense, aromatic oil burners and other related products can also help reduce odours.

Continence product companies sell more specialised moisture and odour-control products that come in a variety of forms such as gels, sprays and mineral rocks.

Phone the National Continence Helpline on 1800 33 00 66 for free help, information and advice.
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- Enable NSW
- Medical Aids Subsidy Scheme (MASS)
- Transport Accident Commission (TAC)
- State Wide Equipment Program (SWEP)

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