Why menopause isn’t to blame

A typical day at the children’s clinic

SPECIALIST CARE FOR MEN
From the editor

Contrary to the popular belief that incontinence affects only old ladies and new mums, bladder and bowel control issues are in fact a family affair. Incontinence affects women, men and children – regardless of their age, gender or cultural background.

All up, nearly 4.8 million Australians are living with incontinence. Yet an estimated 70 per cent of people don’t discuss the issue with anyone – not their partner, best friend or GP.

In this issue, we take an in-depth look at the issues affecting the whole family, and encourage you to talk about incontinence with your family, friends or a health professional.

Physiotherapist Pauline Chiarelli looks at why menopause itself isn’t a cause of poor bladder control (p.7), prostate cancer specialist nurse David Gray introduces the national Prostate Cancer Specialist Nursing Service (p.8), and paediatric surgeon Dr David Croaker discusses children’s bowel health (p.6).

If you are from a non-English speaking background, we look at why communication is the most important aspect of continence care (p.4). Finally, one reader shares her success story after phoning the National Continence Helpline (p.10).

Until next time,

Angela Tufvesson
Editor
Why can pregnancy and birth cause incontinence?

When you’re pregnant, hormones are released to soften the parts of your body that need to expand as your baby grows. They also allow your pelvic floor to stretch during birth. The softening effect of the hormones and the increasing weight of the baby places pressure on the pelvic floor muscles. If the muscles remain weak after pregnancy and birth, they may be unable to keep the bladder from leaking.

The risk of pelvic floor problems increases with multiple births, instrumental births, a long second stage of labour (more than one hour), severe perineal tearing or large babies (weighing more than four kilos).

Why are pelvic floor exercises so important pre and post birth?

Exercising your pelvic floor up to three times a day during and after pregnancy helps to maintain and improve pelvic floor control. A person with no pelvic floor problems will be able to hold for at least 10 seconds, relax and repeat the pelvic floor lift, and hold for 10 repetitions. If your hold time is less than 10 seconds and your muscles get tired before you do 10 reps, aim to work towards this goal.

After the birth, gentle pelvic floor exercises are advised. Find a way to make regular pelvic floor exercises a habit for at least six months after the birth, as it takes time to recover after nine months of pregnancy and birth.

How do you know if you’re performing pelvic floor exercises correctly?

Correct pelvic floor action involves lifting the muscles on the inside, holding the muscles then relaxing them fully. The absolute best way to know if you are doing this correctly is to see a continence and women’s health physiotherapist or continence nurse advisor who can check your muscle action.

If this is not possible, then one way to check if you have the right muscle action is to stop the flow of urine, which will show how well the front part of your pelvic floor is working. This is not recommended as an exercise. Another way to check your muscle action is to monitor your hold time – can you hold for 10-12 seconds without letting go?

It is extremely important to ensure that you are not holding your breath and that you feel a lifting action in your pelvic floor, otherwise you may be doing the exercises incorrectly and pelvic floor problems may result. It is fine for your lower abdominal muscles (below your belly button) to draw in as you lift your pelvic floor. Be sure to relax the muscles fully after the lift and hold.

Dianne Edmonds is a physiotherapist, Elite Personal Trainer and Pelvic Floor First Ambassador.

Women who perform high impact exercises at the gym, such as running and jumping, have a higher prevalence of urinary incontinence than women who don’t perform any high impact exercise, reports a recent study in the International Urogynecology Journal.

If you perform high impact exercises, it is important to also do pelvic floor exercises. This is because the muscles of the pelvic floor and the muscles of the lower abdomen work together to help to control the flow of urine.

In 2010, the total financial cost of incontinence in Australia was estimated to be $42.9 billion – or $66.7 billion including the cost of burden of disease.
Speaking our language

For people from non-English speaking backgrounds, there are myriad barriers to accessing continence care. We spoke to Eastern Health’s Lena Dimopoulos about the challenges facing ethnic communities.

New migrants and refugees currently arriving in Australia from non-English speaking backgrounds have the same difficulties accessing health care as the first groups of non-English speaking people to arrive in Australia. There are obviously language barriers as they don’t speak English very well. The other huge issue is health literacy, which includes cultural issues. This means the ability to understand the information that’s being delivered, as it could be totally outside the person’s usual level of understanding. People from culturally and linguistically diverse (CALD) communities may view the world differently to the way clinicians in Australia see the world in terms of health and health care.

Communication is the most important aspect of care. If you can’t communicate with someone, you don’t know what their expectations are, you don’t know about their medical history, you can’t make an appropriate diagnosis, and you can’t relay information about treatment or therapy. What’s more, it’s not just about getting an interpreter; it’s about understanding the client’s level of education and expectations.

There are several types of interpreting services. You can use face-to-face, but sometimes we have to use telephone interpreters because we can’t access an interpreter in time. There are many issues around access. For the newly arrived communities, we don’t have newly trained and qualified interpreters in all of the language groups. With the older, well-established migrant groups, interpreters are retiring and they are not being replaced because we’re no longer having huge migration from European countries such as Turkey, Greece, Italy, Macedonia and Poland.

We have more than 150 languages and dialects that we have to deal with in any one year and we can’t get interpreters for all of those language groups, so sometimes we unfortunately have to rely on relatives, which is not an ideal situation.

Ten years ago, many people who had limited English language proficiency were refusing interpreters. We decided to interview 360 people and asked them why. There were many reasons: they didn’t know if they could trust someone outside their family, they didn’t know what an interpreter was and they thought they would have to pay.

There’s a huge difference between public and private interpreting services when it comes to funding. The public system is government funded for language services, but the private isn’t. There are no health insurance companies in Australia that cover interpreter costs, so clients may be asked to pay for interpreter costs if they go into the private system. In the public system, the only time someone is asked to pay is if they are not an Australian resident and they’re not covered under Medicare.

There’s a lack of knowledge about continence issues within virtually every ethnic community in Australia. When people from non-English speaking backgrounds go to their GP, if there’s a difference in gender they might feel embarrassed talking about the issue, even if they speak the same language. A lot of migrant women have put up with incontinence for more than 40 years as they’ve been too embarrassed to bring up the topic with anyone.

Lena Dimopoulos is the manager of transcultural services at Victoria’s Eastern Health. For more information, go to easternhealth.org.au/services/interpreting

Continence awareness

The Victorian Continence Resource Centre (VCRC) report Awareness of Incontinence in Ethnic Communities explored the awareness of people from different ethnic communities in relation to the prevention, treatment and management of incontinence. Continence nurse consultant and VCRC manager Susan McCarthy discusses how the findings inform health care.

Our research confirmed the findings of other research: limited knowledge about incontinence is related to language – if you don’t speak English, your health literacy is poor because you can’t access information. To improve awareness about incontinence, our study participants asked for information in their own language via ethnic radio, TV, newspapers and brochures. There was a strong preference for both written and spoken word to be delivered in their own language.

Despite cultural differences, the issues around incontinence are pretty universal: shame, embarrassment, normalising it as part of getting old, or viewing it as not a big enough problem to bother about. An important aspect of working with different language groups is ensuring there is agreement on words used for continence and incontinence as these words do not exist in some languages. The most important issue is being able to access information in a format that you can understand, especially as most of the older migrant populations have low levels of education and some have low literacy in their own language.

For the full report, go to continencevictoria.org.au
Watch this space

The Continence Foundation is developing a series of translated online resources to assist people from non-English speaking backgrounds who are affected by incontinence. These resources will be featured in the winter issue of Bridge, and formally launched during World Continence Week, June 24-30.

Further help

Phone the National Continence Helpline through the free Telephone Interpreting Service on 131 450, state your preferred language and wait for the translator to connect you with a Helpline nurse advisor. The Continence Foundation also has fact sheets available in 21 languages, which can be accessed at continence.org.au.
A day in the life

Children’s bowel health is a tricky issue for parents and kids alike, but help is available. Paediatric surgeon Dr David Croaker shares a typical day at his Canberra-based constipation clinic.

Our Canberra-based constipation clinic comprises myself, a continence physiotherapist, two trainees and several medical students. We normally see about 12 new and follow-up patients a day.

While only a minority are real diagnostic puzzles, all patients require adequate time for assessment, sympathy and encouragement. Most will require regular follow-up – a sort of mentoring for parent and child alike.

Here’s an overview of a typical day in the clinic.

Morning patient list

The first patient of the day is 18-month-old Kayla. We first met one month ago and concluded that she likely has a cows’ milk protein allergy and recommended complete cows’ milk protein exclusion.

After some hiccups, the family have achieved this and report that Kayla’s symptoms are entirely gone. I will see them again in three months to confirm the improvement and expect that she will grow out of this condition, most likely by school entry age or earlier. The family are naturally delighted, and I see them out.

My next patient, Sonia, is also a follow-up. She is eight years old and once again she comes along with her teenage sister. I ask the sister’s boyfriend to wait outside. The girls’ mother is again unable to come to the clinic.

Sonia’s constipation presents as soiling, which is what troubles the family. In fact, it is rare to have soiling without underlying constipation in children. Previous investigation has been unrewarding and advice about laxatives and lifestyle apparently ignored.

We have attempted to help Sonia establish a rapport with our physiotherapist, as well as other usual measures.

However, we almost always need the support and cooperation of the whole family to achieve good results. The upside is that with support good results can very often be obtained. Pleasingly, patient motivation typically improves at puberty.

Busy days

The third patient of the day is Oscar, a pleasant 10-year-old who presented with an acute bowel obstruction for which he required an operation several weeks ago on the background of lifelong constipation. His condition is rare and unusual, and his parents have graciously agreed to let us study the genetics of the extended family.

The next patients, Fred and Lucinda, are two children whose constipation started at the age of toilet training and are believed to have chronic simple constipation (see box) based on stool withholding. They should improve in about a year, with regular long-term laxatives and a toileting routine.

Dan, our sixth patient, is a quiet eight-year-old boy whose mother tells me has Asperger’s syndrome. We advise Dan to have a nuclear medicine colon transit study, which provides an idea of the pumping efficiency of the colon – essentially, how quickly it pushes food through.

We use this test to rule out slow transit constipation (a condition characterised by reduced movement in the large intestine), but if the test is positive we will offer him electrical interferential treatment, which speeds up gut transit in about 80 per cent of suitable patients.

I manage to fit in six more patients, a tuna sandwich and a cappuccino before the afternoon operating list. It will be the same routine again in two weeks’ time.

*Names have been changed.

Dr David Croaker is a paediatric surgeon who has specialised in gastrointestinal conditions since he started a doctorate in Hirschsprung’s disease in 1994. He has a practice in Canberra and an episodic practice in Nepal and elsewhere. b

The bigger picture

Broadly speaking, about a quarter of our new referrals have cows’ milk protein allergy, while a further quarter have an underlying neurological or psychiatric condition associated with constipation.

Approximately 5 per cent have slow transit constipation. Another few per cent have an inherited problem such as Hirschsprung disease, which affects functioning of the large intestine.

This leaves close to 50 per cent of the children who have what we call chronic simple constipation. Generally by this, we mean that the children have fallen into a pattern of faecal withholding at some point in their life and then developed a vicious cycle of painful defecation, leading to further withholding and fear.

Of course, the longer you hold onto your stool, the larger and harder it becomes and so the more fearful you are of passing it the next time. Eventually these children become soilers as their sense of sensation and control suffers, owing to stretching of the rectum from the chronic constipation.

Typically, these children respond well to simple treatment with laxatives, regular toileting and dietary advice. Improvement is not quick and I advise parents to be prepared for their children to be on medication for about 12 months after referral to the clinic.

Toilet Tactics Kit

The Continence Foundation’s Toilet Tactics Kit contains resources for students, teachers and parents, and aims to engage the whole school community in promoting good bladder and bowel habits. To encourage your school to take up the initiative, go to continence.org.au or phone the National Continence Helpline 1800 33 00 66.
Incontinence can be blamed on the change of life, but the effects of menopause and ageing are often confused. Physiotherapist Pauline Chiarelli explains why menopause itself is not at fault.

Menopause occurs when menstruation has stopped for good and is usually confirmed when a woman hasn’t had a period for 12 months in a row. It happens between 45 and 55 years of age for most women, with an average onset age of 51.7 years in Australia – so the fairer sex live almost one third of their lives after menopause. While most women sail through menopause with very mild symptoms, for some it can be hard to cope with severe symptoms that can include hot flushes, mood swings and night sweats. However, contrary to popular belief, menopause itself is not a cause of urinary incontinence.

Later in life
While it’s easy to assume that reduced hormone levels around the time of menopause are likely to be the cause of problems with pelvic organs and their support structures, bladder symptoms don’t start around the time of menopause – they tend to appear later. Yet there is no question about the impact of ageing on the pelvic floor. An important element of pelvic floor and pelvic organ support is collagen, a type of tissue known to lose its strength with age.

While other symptoms such as vaginal dryness and bladder symptoms – including incontinence – are often said to be part of menopause, it is actually difficult to tell the difference between the effects menopause and those of ageing.

Problems with prolapse
Pelvic organ prolapse occurs when there is poor support of the pelvic organs. It’s most strongly linked with childbirth, as well as the post-menopausal drop in hormones that leads to collagen loss and ligament weakness. However, it is not actually associated with menopause itself.

While the drop in hormones that occurs with menopause underpins the changes to pelvic organ support tissues, the symptoms tend to emerge later in life and are made worse by factors such as obesity, constipation and a chronic cough. The lifetime risk of requiring surgery for pelvic organ prolapse is 11 per cent, while about 60 per cent of elderly women have some degree of prolapse.

Confuse the issue
There are two main types of urinary incontinence: stress incontinence and urge incontinence, which is also known as overactive bladder. Stress incontinence symptoms include leaking when you exercise, sneeze, cough or laugh, while symptoms of urge incontinence include a strong and sudden need to urinate and waking a number of times at night to empty the bladder (nocturia). Women who experience both sets of symptoms are said to have mixed incontinence.

There is some evidence that stress incontinence improves around the time of menopause, while the symptoms of urge incontinence may worsen. The overall prevalence of urinary incontinence increases with age, but there is no evidence that shows any increase in the prevalence of incontinence around the onset of menopause.

It is also important to note that the symptoms of incontinence reported by women change with time. Studies show stress incontinence is most common before the age of 50, while symptoms become mixed and symptoms of urge incontinence increase in women over the age of 60. And while nocturia is related to ageing, it is usually due to the decrease in hormones that control kidney function.

To further confuse the issue, there are several other factors linked to incontinence, pelvic organ prolapse and menopause. For example, obesity and osteoporosis have strong links to stress incontinence, urge incontinence and pelvic organ prolapse, as well as to the lower hormonal status that is part of menopause.

The verdict
A recent review of studies looking at the link between menopause and urinary incontinence suggests incontinence is unlikely to begin at the onset of menopause. And while menopause is often cited as a risk factor for pelvic organ prolapse, studies exploring hormonal status and prolapse have to date failed to find a strong link.

Urinary incontinence and pelvic organ prolapse in women are complex, progressive conditions with links to ageing and many other factors that can change with time. While it is not safe to assume that urinary incontinence and pelvic organ prolapse are linked to menopause, it is certainly true to say that these conditions have strong links with ageing.

Associate Professor Pauline Chiarelli (M Med Sc (H Prom), PhD) is the convenor of the Bachelor of Physiotherapy program at the University of Newcastle, NSW. She was the first Australian physiotherapist continence adviser and was a founding member of the Continence Foundation of Australia.
Prostate cancer patients are prone to incontinence, but there’s lots that can be done to better manage the problem. Prostate cancer specialist nurse David Gray outlines the benefits of a new national support program.

Tell us about your new role as a prostate cancer specialist nurse.

I assist the men by providing a consistent point of contact for the patient and their family, and reliable, accurate information about the patient’s diagnosis and treatment plan. I provide information on dealing with the effects of treatment, conduct supportive care screening, coordinate patient care, and can refer onto other services if required.

What does your role offer in addition to clinical support?

Traditionally, some patients rush into having surgery or radiotherapy without realising the side effects those treatments can bring. A patient can have “treatment decision regret” if they are not fully informed about their options.

Prostate cancer specialist nurse David Gray

What inspired you to study a Masters of Nursing in Urology and Continence?

I’ve always had an interest in urology. Many of my colleagues were going into intensive care, emergency and cardiology, but I wanted something different. I’ve always had an interest in men’s health, particularly genitourinary issues and the surgical side of nursing, and during my studies, my interest in men’s health grew.

What proportion of people with prostate cancer do you estimate to have incontinence?

A lot of the men will have varying degrees of incontinence after surgery, sometimes for about eight to 12 weeks. Their continence generally improves over time. Only a small minority of patients require radical therapy to improve their continence.

Some patients are accepting of the fact they might leak a little, and use one pad per day, whereas others are distressed and self-conscious using one pad.

What are the main forms of treatment?

The urology clinical nurse consultants and I encourage all patients undergoing radical prostatectomy or external radiation to perform pelvic floor exercises preoperatively and postoperatively. Where a patient might still experience some urinary incontinence, we refer them to our continence physiotherapist and the team of continence nurses to assist.

If problems persist, the men can meet with the urologist and depending on the patient’s incontinence and the severity of it, surgical management may be offered in the form of a male sling or artificial urinary sphincter.

Are tricky topics like incontinence becoming easier for men to discuss with a health professional or family member?

That’s a tough question. If the man has met with the urologist or nurse before, and they have already developed a rapport, the man may be more inclined to discuss sensitive or embarrassing issues.

Some men aren’t comfortable discussing incontinence with their family members, possibly for cultural reasons, or maybe they don’t want to talk about it in front of their kids. Although it is not a funny subject, sometimes humour – when used sensitively – can be a bit of an icebreaker and enable men to chat more openly.

What’s your advice to people with prostate cancer affected by incontinence?

It helps to talk about it, so don’t be shy. If you don’t talk to your health professional about your incontinence, then they can’t help you to the best of their ability. It can be tough, and things can seem overwhelming, but with good management, that inconvenience can be minimised.

David Gray works as part of the Prostate Cancer Foundation of Australia’s Prostate Cancer Specialist Nursing Service at Melbourne’s Austin Health.
The Prostate Cancer Specialist Nursing Service was launched in May last year by Prostate Cancer Foundation of Australia (PCFA). It offers the thousands of men diagnosed with prostate cancer each year accessible specialist nursing care through the entire cycle of treatment – from immediately after diagnosis through to post treatment support.

This first ever national Prostate Cancer Specialist Nursing service, funded initially by a generous contribution by the Movember Foundation, will provide a reliable central point of contact that guides men through every stage of their cancer diagnosis and treatment.

The service has delivered 13 specialist nurses to metropolitan and regional hospitals in all states and territories across Australia. It’s a free service and the nurses are available to all prostate cancer patients attending these centres for treatment.

PCFA prostate cancer specialist nurses are trained to work alongside medical teams such as oncologists, radiotherapy doctors and urologists to coordinate care plans, and give men clear and accurate information so they understand each step of the treatment process. The nurses are also an important link to other community support services.

PCFA director of nursing Julie Sykes says the service will deliver a new level of care that has been difficult for diagnosed men to access until now.

“Some men who have been diagnosed with prostate cancer have found it difficult to access a vital element of care – that is, structured contact with a healthcare professional who can guide them through every stage of their prostate cancer journey,” she says. “These nurses have been specially chosen and trained to fill that role.”

PCFA is currently undertaking a study in partnership with Queensland University of Technology Institute of Health and Biomedical Innovation and anticipate that this will demonstrate the value of this type of nursing service on a national level.

**Around the country**

Prostate Cancer Foundation of Australia has placed 13 specialist nurses in the following hospitals around Australia:

- Royal Darwin Hospital, NT
- Townsville Hospital, QLD
- Mater Adult Hospital, Brisbane, QLD
- Tamworth Hospital, NSW
- Westmead Hospital, NSW
- Canberra Hospital, ACT
- Latrobe Hospital, VIC
- Bendigo Health, VIC
- Austin Health, VIC
- Launceston General Hospital, TAS
- Royal Hobart Hospital, TAS
- Royal Adelaide Hospital, SA
- Hollywood Private Hospital, WA
Despite what you might try to tell yourself, bladder control problems won’t get better on their own. Wendy Woltmann shares her experience of seeking help from a community event.

I am a reasonably healthy and fit 59-year-old. For most of my life I’ve eaten a healthy diet and exercised regularly. I make sure I have regular health checks such as breast screening, dental visits, skin and eye checks, and a regular check-up with the GP. But recently I realised it wasn’t enough.

From little things
I don’t remember when I first noticed that my body wasn’t listening to my brain’s instructions to wait until I got to the toilet before letting go. I didn’t really take much notice as there was no harm done and no evidence to anyone else of my mishap.

So I ignored each episode and convinced myself it was a one-off and could happen to anyone. That reasoning worked up until the last 12 months when the little leaks became bigger leaks and I was unable to move to the loo fast enough.

I have worked in community support for nearly 10 years as a personal carer, and one of the problems in my line of work is that I drive from one client to the next. I know I needed to look after myself to be able to look after clients, and to avoid further decline. I realised that continued neglect of my bladder would mean I was going to have to do something about it eventually.

Creative avoidance
The training my workplace has given me over the years has been invaluable in recognising small signs of failing health in our clients, and through the reporting process, organising treatment options to prevent further decline. I realised that to be able to look after clients, I needed to look after myself.

But I am an expert in “creative avoidance”, so I came up with many innovative reasons not to seek information or help for this wee problem. However, everywhere I looked there were messages about incontinence. I picked up a magazine and opened the page to a story about incontinence; I turned on the TV and watched advertisements about incontinence.

Every time I went to the toilet, I realised I was going to have to do something about it.

I have attended more physio appointments and continue to perform simple but effective pelvic floor exercises. A detailed diagram of pictures depicting the pelvic floor is helpful in making sure I use the correct technique. These uncomplicated exercises have made a huge difference in retrieving the control I have not experienced in years and I include them in my regular gym visits.

I cannot imagine the decline in my condition had I not taken the first step in not only accepting my problem, but doing something about it.

For details about community events in your local area, go to continence.org.au/events. For more information about pelvic floor exercises, phone the National Continence Helpline (1800 33 00 66) or go to pelvicfloorfirst.org.au
Q. I had my prostate removed (radical) three weeks ago and I’m still leaking like a sieve. When will I become dry?

A. When I talk to a man after a radical prostatectomy, I first find out when the catheter was removed. To me, that is day one. Over the next few weeks, the night time control should improve to the level you had before the operation.

You can improve your bladder capacity by delaying getting out of bed for a few minutes and performing pelvic floor exercises. This helps to increase bladder volume and return the bladder to more normal function after the catheter removal. To make sure you are performing these exercises correctly, it’s important to see a continence physiotherapist.

Day time continence takes longer because the sphincter muscle (the tap) now has to do the job of two muscles, as one is taken out when the prostate is removed. This is why pelvic floor exercises are so important. Over time your continence will improve, initially in the morning. Urinary incontinence can increase later in the day as the muscles get fatigued, but over time your continence will improve through the day.

Some men believe that by drinking less, their continence will improve. Unfortunately, this concentrates the urine and might make you need to go to the toilet more often.

Another factor that complicates improving continence is if you’re prone to constipation, which could prevent the bladder from filling fully. The result is frequency of urination, and possibly incontinence.

After your operation, your specialist should have instructed you not to do any heavy lifting or straining for six weeks. This can be difficult for some men because although they feel well after the operation, their insides take a number of weeks to heal.

Q. I have this uncomfortable feeling down below. I’m 65 and have had three children. I Googled my symptoms and I think I have a prolapse. I definitely don’t want an operation – the stories I read online are horrific! Plus, I don’t like doctors. What can I do?

A. It’s unfortunate that you found the horror stories so early in your search. The symptoms you describe could be caused by many things, including prolapse, constipation and insufficient oestrogen to name a few. The internet can be helpful but you need to choose reputable sites where possible.

It would be to your advantage to have this problem investigated, as it is likely to get worse over time. Once you have a diagnosis, you can search for treatment options. If it is a prolapse, you need to know what type as there are various treatment options depending on the degree of the prolapse.

If the prolapse is at an early stage (mild), pelvic floor exercises will help. As you are reluctant to see a doctor, a continence and women’s health physiotherapist or continence nurse can help. The National Continence Helpline can provide details of a local continence service or private pelvic floor physiotherapist.

It is important to be shown the correct way to perform pelvic floor exercises because more than 30 per cent of women perform them incorrectly. You may also have to look at some lifestyle changes if they have contributed to the prolapse – for example, weight gain, heavy lifting, straining due to constipation and poor bladder habits.

If the prolapse does not respond to pelvic floor exercises, a pessary (plastic or rubber device that fits into the vagina) is an option for women who are not suitable for, or who wish to avoid, surgery. It can be a very successful alternative, but requires individual assessment by a GP or gynaecologist.
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