Playing it safe
Incontinence in elite athletes

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Incontinence; it’s not something we usually associate with elite athletes, but research tell us they are more likely to experience urinary incontinence than women with more modest sporting aspirations. Their incontinence, principally the result of the extraordinary stresses they place on their pelvic floor, is explained by two leading women’s health physiotherapists, Dr Patricia Neumann and Jill Chenoweth (page 4).

Now, while I’m well aware most of us can’t claim this level of sporting prowess, there is still much the rest of us can do to maintain pelvic floor fitness. The Pelvic Floor First campaign, launched two years ago by the Continence Foundation of Australia, has been a great success, and the pelvicfloorfirst.org.au website has proven a hit with tens of thousands of visitors. Health promotion officer Samantha Scoble provides an overview of the campaign and previews the soon-to-be-launched Pelvic Floor First smart phone app, which will enable Australians to exercise safely and effectively wherever and whenever they choose (page 9).

Adopting this new technology is just one of the Continence Foundation of Australia’s many new communications initiatives. Recently launched Facebook and Twitter accounts (see page 3) are the latest in a raft of new communication platforms that enhance and complement the existing, traditional communication channels – which include Bridge magazine.

I hope you enjoy this edition, which is full of great stories and up-to-date, practical advice from a range of health professionals.

Until next time,

Maria Whitmore
Editor
How do we get people to talk about incontinence when the issue is so stigmatised? While it is a common medical problem – affecting one in four Australians – most people never talk about it due to the embarrassment factor.

This is why the Continence Foundation decided to stamp out the stigma and join the world of social media on Facebook and Twitter – having already established the Continence Foundation on YouTube 10,000 views ago.

It will be a challenge to encourage people to engage with our social media channels, but you can help by sharing this article and starting a conversation with us on Facebook or Twitter.

The Foundation has two Facebook pages: facebook.com/AusContinence engages with the public on everyday continence issues while facebook.com/PelvicFloor1st promotes pelvic floor health to the public and fitness professionals.

Our Twitter channel at twitter.com/AusContinence hopes to engage with health professionals and the public, while at twitter.com/PelvicFloor1st, we’ll keep engaging with fitness professionals and the public.

Our YouTube channel at youtube.com/user/ContinenceFoundation has all our television ads, conference presentations, television interviews and videos about incontinence in other languages.

While it will take time to build a following, the more the Continence Foundation and you engage in an open dialogue about the problem, the more likely we are to reduce that one-in-four statistic. Follow us!

In June, the Continence Foundation of Australia launched an exciting initiative to support its national awareness campaign, Talk about Incontinence: A problem in anyone’s language, and already the results are encouraging.

Central to the campaign was the development of new language-specific web pages in 20 languages for non-English speaking communities and health professionals working with these communities. Within each web page are links to 17 bilingual fact sheets on a wide range of topics, as well as audio translations and videos (go to continence.org.au/other-languages).

These new web pages, along with the translation services available for callers to the National Continence Helpline, have been promoted widely in the ethnic community. The response has been positive, with the number of callers to the National Continence Helpline requiring assistance with translation more than tripling during the past month.

The new web pages have also proved popular, with more than 3000 page views since the launch, more than 1000 bilingual factsheets downloaded and 290 audio files accessed.

What did you enjoy most about being a continence nurse consultant?
Every client referred to the Southern Continence Service was always really grateful for the information and time they had with a continence nurse. They were able to ask questions about problems that were both personal and embarrassing in a one-on-one setting within a busy healthcare sector.

In a typical month, how many different languages did you require an interpreter for?
The Southern Continence satellite service based in Dandenong services a large and varied culturally and linguistically diverse community. Each month the service receives about 60–80 referrals and it was not unusual for me to book 15–20 interpreters for the month for up to 15 languages. For an initial continence assessment an interpreter is required for two hours, and because of the scarcity of interpreters in some languages, some bookings needed to be made six weeks in advance.

How many of the clients you assessed from non-English speaking backgrounds had ever sought prior assistance?
Very few seek assistance with incontinence issues because they are usually unaware that continence services exist. They often rely on other community services, case management or their children to seek out the service and make a referral.

Were there any recurring themes you observed when working with members of ethnic communities?
Most of the non-English speaking clients where I conducted a continence consultation in their home were very keen to feed and water me. Their kitchens often had a delicious aroma of exotic herbs and spices, and they usually had a vegetable garden that dominated their backyard. They were always hospitable and thankful for my time and assistance.

Do you have any handy hints for health professionals who may need to use an interpreter?
Prior to commencing a consultation, ensure the interpreter knows exactly what they are there to provide interpretation for. Ensure the interpreter is aware of how long the session will take. Use the telephone interpreting service (131 450) at least 48 hours prior to the consultation to ensure your client is at home or at the clinic at the designated time.
The extraordinary physical stresses endured by elite athletes can have surprising consequences when it comes to continence. Here, Maria Whitmore explores the unwanted fallout of the quest to be the best.

So you’re not an elite athlete. Nor am I. But chances are you have more control over one particular group of muscles most of the time than elite athletes; your pelvic floor muscles.

Believe it or not, elite athletes are three times more likely than other women to experience urinary incontinence.

There is a sound reason for this, and it essentially comes down to physics, according to specialist continence and women’s health physiotherapist Dr Patricia Neumann from The Pelvic Floor Clinic in Adelaide.

Urinary incontinence experienced by high-performance athletes is generally the result of a much greater downward force on the bladder (as a result of a heavy landing) than the closure force of the urethra.

“Depending on the particular sport, their pelvic floor muscles are under so much strain, they lose the ability to control unwanted leakage,” Dr Neumann said.

This was the case for Lila, an international-level hockey player, who sought help from Dr Neumann for urinary incontinence when she returned to the sport four months after the birth of her second child.

“She had had a difficult first birth with forceps, which caused an undiagnosed injury to her pelvic floor,” Dr Neumann said.

However, she had no obvious symptoms of pelvic floor dysfunction. Her incontinence issues only began after the birth of her second child.

“She also reduced her fluids to more normal amounts and stopped leaking urine. She continued to play her sport; nothing was going to stop her,” Dr Neumann said.

Jill Chenoweth, a continence and women’s health physiotherapist and lecturer at Monash School of Physiotherapy, said the problem was one rarely broached by athletes due to embarrassment and a reluctance to bother their coach about the matter.

“I’ve spoken to track, strength and conditioning coaches from the AIS and others about their athletes experiencing incontinence, and none have ever had it mentioned to them,” Ms Chenoweth said.

“There’s research that offers statistics on the embarrassment factor, which I guess is why it may not be mentioned to coaches.”

Many of Ms Chenoweth’s clients are elite athletes, and she develops pelvic floor strengthening programs that take into consideration the nature of their particular sport.

“We look at the mechanics of their sport; the pelvic floor is linked to other body parts so we integrate the pelvic floor strengthening into the function of the sport,” she said.

“For example, we train an athlete to decrease the ground landing force or to do safer strength work that doesn’t entail heavy weights or deep squats.”

Ms Chenoweth said that the issues faced by elite athletes had practical applications for regular sportswomen.

“Women who’ve had children or want to get back into an elite level of training, compete at masters level or do cross-fit, they’ll do well with treatment from a continence professional,” she said.

Her advice is echoed by Dr Neumann: “Seek out a continence and women’s health physio who can work out what the problem is and be your coach. As with any training you need to hang in there as the pelvic floor muscles don’t get strong and thick overnight.”
Happily ever after

Former Queensland Ballet Company soloist Vicky Lewis was left struggling with depression, weight gain, incontinence and a prolapse after the birth of her second child. Hers is an inspiring story of recovery.

My name is Vicky Lewis. I am a former soloist of the Queensland Ballet Company, mother of two, and now a fitness professional specialising in training women with pelvic floor dysfunction. As a ballet dancer I had a very blessed and glamorous life, with the added bonus of being a finely tuned athlete. Then I chose to become a mum.

Romantic notions of motherhood flooded my every thought. Until, I realised, I was falling apart – literally from the inside out. Both babies were born vaginally but neither without a little drama. Grace – induced a week overdue and delivered with episiotomy and forceps – calmly endured 32 hours of labour. In retrospect, maybe I should have chosen the caesarean option my obstetrician tried to persuade me to take. But no, like everything else in my life, this birth required choreography and needed to result in my “happily ever after”.

My physical recovery was surprisingly good, until two-and-a-half years later, at the age of 34, we had Caitlyn. Also induced, Caitlyn’s was a lovely birth, albeit a few weeks early. During my post-delivery check-up, my obstetrician proceeded to inform me, with much indifference, that I had a prolapse (grade 2 rectocele, I have since learned)! To me this seemed quite normal as my mother had also had a prolapse.

As time passed, the heaviness in my vagina gradually increased, along with worsening stress incontinence, rapid weight gain, immobility and constant back pain. Admittedly, I was feeling a tad depressed. Mmm ... that ballet bubble had burst abruptly. The turning point was three years later when I was invited back to Queensland Ballet to perform a mature-age role in *Romeo and Juliet*.

I started daily ballet class and began to remember what it was like to be me again. I noticed that everything that was previously heading south was beginning to feel strong and supported. Ballet at an elite level requires what is commonly known as the “core” – an ability for the pelvic floor muscle to be lifted and braced while the remainder of the body stays long, strong and agile.

So, now that I was making remarkable changes to my physicality, how was I going to maintain momentum once this artistic interlude had passed? I needed to learn more. I acquired my personal trainer certification and completed the Continence Foundation of Australia’s online Pelvic Floor First courses for fitness professionals. I also attended the Continence Foundation’s forums, and was mentored by physiotherapists Michelle Kenway and Sue Croft, while spending many hours experimenting and rehabilitating myself. My training philosophy has evolved naturally to where I now focus on safe movement patterns, and pelvic, joint and spinal stability. This training style is not exclusive to those with pelvic floor dysfunction, as all my clients have one thing in common; they require functional fitness for life.

Now, at 44, I will never look like a ballerina again and, despite my prolapse, I am empowered every day because I walk tall and move freely! In other words, I live the “happily ever after”.

Vicky Lewis with husband Tony and children Grace, left, and Caitlyn.

INCONTINENCE TAKES A TOLL ON YOUNG WOMEN

New research from the University of Adelaide shows middle-aged women are more likely to suffer depression as the result of urinary incontinence.

In a study published in *BMC Urology* in February, researcher Jodie Avery found that middle-aged women (aged 43–65) with incontinence were more likely to be depressed than older women (aged 65–89) with incontinence.

Ms Avery, a PhD student and senior research associate with the university’s School of Population Health and School of Medicine, said younger women’s self-esteem was often hit hard by urinary incontinence, while older women tended to be more resilient and accepting.

“Women with incontinence and depression scored lower in all areas of quality of life because of the impact of incontinence on their physical wellbeing,” Ms Avery said.

“Key issues for younger women ... are family, sexual relationships and sport and leisure activities.”

Urinary incontinence affects approximately 35 per cent of the female population. The main cause is pregnancy.

“Our studies show that 20 per cent of the incontinent population has depression, and this is something that we need both sufferers and GPs to better understand,” Ms Avery said.

“Ultimately, we hope our research helps raise awareness in the community about both the mental and physical issues associated with incontinence. We know it’s embarrassing, but if you discuss it with your GP, your life really can change.”
Why are continence assessments necessary?
There are many causes of incontinence and in order to identify its exact cause, a doctor or other health professional may refer a patient for a continence assessment so the correct treatment can be given.

Who performs them?
Health professionals trained in the field, such as physiotherapists, continence nurses or specialist doctors carry them out at continence clinics, in hospital or in the person’s home.

Why is a person’s general health relevant?
We take the patient’s general history to ascertain any other health problems that may be contributing to, or causing the incontinence. We ask about their medical or surgical history, the medications they are taking and if there are any other bladder or bowel symptoms. If the patient is a woman, we ask about the number of children she’s had and the type of deliveries, or if she’s menopausal.

Is knowledge of a person’s drinking and toileting habits important?
We ask about the quantity and type of the patient’s fluid intake because concentrated urine can irritate the bladder, as can alcohol and caffeine. Prior to, or as part of the assessment, patients complete a bladder chart that records their fluid intake, as well as the frequency and volume of urination for 24 hours to three days. This gives us a quick indication of what they’re drinking and what their bladder capacity is, and how often they go to the toilet through the day and night.

What is the first physical examination you perform?
We do an abdominal palpation first to check for constipation, which can exacerbate or cause bowel or bladder leakage. We also take a urine sample for a urine test to exclude urinary tract infection, which can also affect incontinence.

You sometimes conduct vaginal and/or rectal examinations. Why?
The examination checks for pelvic muscle strength, prolapses or prostate enlargements. These examinations are only completed with the patient’s consent.

A urine flow study is also completed. What does this entail?
This is where the volume, flow rate and time taken for a person’s bladder to empty are measured using a flow toilet. It’s a standard, simple test to check the voiding flow rate.

Describe a urodynamics test, which a patient may also undergo.
A small catheter is used to partially fill the bladder with water and the bladder pressure is then measured under different conditions that mimic everyday stresses such as coughing or bearing down, and we check for leaks. It’s basically to corroborate what they’ve reported.

What happens if the patient is infirm and can’t leave home?
All the tests, apart from the urodynamics test, are able to be conducted in a person’s home. The urodynamics test is a specialist diagnostic tool that has to be conducted by a continence nurse or specialist.
MYTH: We should drink less to help control urinary incontinence.

FACT: Limiting fluid intake can in fact make symptoms worse. By drinking less, the urine becomes more concentrated, further irritating the bladder lining. This will exacerbate frequency and urgency, and can contribute to an increased risk of cystitis or bladder infections, and even cause urge incontinence (leakage on the way to the toilet). If reduced fluid intake is continued, the bladder will eventually become stiff and lose its flexibility, losing its capacity to hold a normal amount of urine. This in turn will cause increased frequency, urgency and urge incontinence.

MYTH: We should empty our bowels every day.

FACT: The average frequency of emptying the bowels varies from three times a day to three times a week. Everybody’s rate of bowel motility (movement) is different, hence the variability. Many people try to force themselves to pass a stool every day, despite not having the urge to do so. This will result in habitual straining, which is a major cause of pelvic floor muscle stretch and weakening. It is always best to wait for a good urge to defecate, as the rectum will empty most efficiently when there is a good amount of stool present.

MYTH: We should drink at least two litres of water each day.

FACT: The body requires an average of 1.5 litres of fluid a day, with at least half of it being water. Adequate fluid intake will ensure the body is well hydrated and the urine appropriately diluted (clear and pale yellow in colour). Overhydrating can contribute to urinary incontinence by simply overloading the bladder. If the bladder is constantly at its maximum capacity, it is more likely to experience leakage on sudden movements (stress incontinence) or on the way to the toilet because the sphincter mechanism is overloaded. If the bladder is overfilled and overstretched regularly, it will become floppy and unable to empty effectively. This in turn can cause decreased bladder sensation, overflow incontinence and bladder infections.

MYTH: Eating more fibre always helps constipation.

FACT: Many people try to self-manage constipation by increasing the amount of fibre they consume. While in some cases this may help, it depends on the cause of the constipation and the type of fibre. If the problem stems from a slow-moving bowel (slow transit constipation), loading up on an excess of high-residue insoluble fibre can make the constipation worse. Adding too much heavy fibre such as wheat bran or lots of nuts and seeds may further slow the bowel, especially if there is inadequate fluid intake. In some cases it is actually preferable to avoid these sorts of foods in favour of moderate low-fibre foods, which digest easily and move along the gut faster.
Strengthening the Pelvic Floor First message

Since its launch in 2011, the Pelvic Floor First campaign has taken off in leaps and bounds. Now, social media is making it easier to be pelvic floor safe, even when you are on the move.

The pelvic floor health message is reaching far and wide, with more than 70,000 visits to the Pelvic Floor First website (pelvicfloorfirst.org.au), more than 150,000 resources distributed nationwide and more than 45 educational sessions held around the country since the campaign’s launch two years ago. Promotion of the Pelvic Floor First message continues to evolve, keeping pace with the ever-changing face of technology. The recent introduction of a Facebook page (facebook.com/PelvicFloorFirst) and Twitter account (twitter.com/PelvicFloor1st) enables people to engage in conversation and access information, even when they are on the move. Later this month, the Continence Foundation of Australia will launch the Pelvic Floor First app for smart phones and tablets. This free app will allow people of all levels of fitness and pelvic floor function to undertake pelvic floor-safe workouts with guided instructional videos (see opposite page).

The Continence Foundation’s health promotion officer Samantha Scoble, who helped develop the Pelvic Floor First campaign, said the new communication tools aimed to reduce the level of pelvic floor dysfunction resulting from inappropriate exercise regimes, and to encourage conversation about the topic to overcome the stigma associated with incontinence. “Pelvic Floor First primarily targets men and women who play sport or are physically active and have a high risk of pelvic floor problems,” Ms Scoble said.

These include pregnant women, women who’ve had a baby, women going through or who have been through menopause, women who have had gynaecological surgery and men who’ve had surgery for prostate cancer. “There are other people at risk too; those who are overweight, have ongoing constipation, a history of back pain, previous trauma to the pelvic region, lift heavy weights or have a chronic cough or sneeze due to conditions such as hay fever or asthma.

“Even elite athletes such as gymnasts, runners and trampolinists are at risk.” And while prevention is key, Ms Scoble said it was important people sought appropriate treatment if they experienced any leakage during exercise. “Pelvic floor safe exercises will help to control the problem while people undergo treatment. The last thing we want is people avoiding exercise due to embarrassment about leaking. “Acknowledging the problem and taking action to prevent or overcome their continence issues are key to people enjoying exercise and maintaining a healthy lifestyle,” she said.

Other important targets of the campaign are fitness professionals and health professionals, such as midwives, GPs and continence professionals.

“It’s important to reach these professionals because they’re ideally placed to raise awareness of the issue and refer clients for help and support,” Ms Scoble said.

The Continence Foundation has also appointed Pelvic Floor First ambassadors with backgrounds in physiotherapy and fitness.

“These ambassadors are important in not only promoting our health message but also in providing us with guidance and expertise in the development of our resources,” Ms Scoble said.

Anyone experiencing any symptoms suggesting a problem with their pelvic floor (see right) should consult a health professional or phone the National Continence Helpline on 1800 33 00 66. “We also recommend that anyone embarking on an exercise program should first consult a health professional,” she said.

The Pelvic Floor First app will be available for smart phones and tablets across the iOS and Android platforms. Its launch date will be announced on the Pelvic Floor First website and social media channels.

For more information go to pelvicfloorfirst.org.au or continence.org.au

Some common signs that may suggest a problem with your pelvic floor:

- Leaking urine when exercising, laughing, coughing or sneezing.
- Hurrying to the toilet or not making it in time.
- Constantly needing to go to the toilet.
- Having trouble emptying your bladder or bowel.
- Accidentally losing control of your bladder or bowel.
- A prolapse.
- Pain in the pelvic area.
- Painful sex.

One in three women

A video about pelvic floor exercises and the maintenance of good bladder and bowel health for women who’ve had a baby has just been launched by the Continence Foundation of Australia. It is narrated by world expert in the field Associate Professor Pauline Chiarelli and can be viewed at www.continence.org.au/pregnancy

For more information go to pelvicfloorfirst.org.au or continence.org.au
The onset of spring often coincides with new fitness resolutions. Now the Continence Foundation of Australia is making it easier for people to stay safe while they stay in shape with the release of its Pelvic Floor First app. The app will allow people of all levels of fitness and pelvic floor function to enjoy pelvic floor-safe workouts. Features include:

- The choice of three customised exercise programs, dependent on the user’s pelvic floor function;
- A wide range of exercises accompanied by instructional videos within each level; and
- Instructions on how to do pelvic floor muscle exercises.

The app, to be released later this month, will also feature an introduction about pelvic floor function, as well as links to the Pelvic Floor First and Continence Foundation of Australia websites. The app is available for smart phones and tablets across the iOS and Android platforms.

“Having a portable exercise app allows you to work out wherever you want to, be it in a park or a certain room in the house,” health promotion officer Samantha Scoble said.

“And because the app has detailed photographic descriptions and video instructions, you can be sure you are protecting your pelvic floor while enjoying the benefits of exercise.”

To find out when the app will be launched, like us on Facebook at facebook.com/PelvicFloorFirst, follow us on Twitter at twitter.com/PelvicFloor1st or visit our website pelvicfloorfirst.com.au

Here’s a sample of what’s included in the app:

**Lateral raise:** Sit tall on the ball with your elbows bent by your side. Engage your pelvic floor and core. Raise your elbows to shoulder height. Keep your back straight, breathe normally and avoid shrugging your shoulders.

**Wall push up:** Start with your hands on the ball at chest height. Engage your pelvic floor and deep abdominals. Keeping your shoulders down and your hips straight, bend and straighten your elbows. Do not let your back sway.
Two years after a devastating cycling accident left Martin Heng a quadriplegic, he describes the daily implications incontinence management has on his independence, health and dignity.

Two years ago I was hit by a car while riding my bicycle. I sustained a spinal cord injury (SCI), and it changed my life completely.

After almost a week in an induced coma, I awoke in intensive care paralysed from the neck down. My specialist told me I might never walk or move my limbs again.

What most people don’t appreciate about SCIs is that the body’s control over autonomic functions – body temperature regulation, sexual function and continence – is seriously compromised or lost altogether.

Although immobility is the most obvious effect of an SCI, bladder and bowel control is equally important when considering independence, inconvenience and outright danger.

There are several methods of bladder management; I have an indwelling catheter – a tube inserted through my urethra and held in place with a small balloon. The catheter is connected to a bag strapped to my leg that needs to be emptied regularly. I am lucky in that I am able to empty this myself; many with less function rely on others.

The other common method of bladder management is intermittent catheterisation, where a catheter is inserted periodically to empty the bladder. I have tried this, which has the advantage of not having to carry a bag of urine on your leg. But it has its drawbacks, needing to be done every six hours and sometimes requiring drugs to suppress voiding between catheterisations.

The alternative to drugs is to use yet another system: condom drainage, where a condom is fitted over the penis and connected to a leg bag. Clearly, these methods of bladder management are open only to those with sufficient hand function, which excludes most quadriplegics.

Bowel management is less complicated. As in bladder management, the issue is sphincter control. The majority need to use some combination of laxatives, suppositories or small liquid enemas, and sometimes manual anal stimulation to relax the sphincter.

I am lucky to have retained the use of my abdominal muscles, so am able, for the most part, to manage without manual intervention beyond insertion of a suppository every morning. Most are not so lucky.

Obviously, reliance on another person for assistance with the most private of bodily functions is difficult to come to terms with, but something that is prioritised during rehab and for most, quickly normalised.

Less easy to accept are the inconveniences and dangers of incontinence. Nobody wants to have an accident; it’s nothing short of mortifying. I have experienced them very infrequently; for many, they are common occurrences.

Then there are the dangers. One of the main dangers when unable to open the bowels is impaction and obstruction, which in extreme cases requires hospitalisation.

The main danger with indwelling catheterisation is the catheter becoming blocked. The result can be a backwash of urine into the kidneys, damaging the kidneys.

In the case of either bowel or bladder obstruction, another result can be autonomic dysreflexia, which is the body’s way of screaming that something is wrong: your blood pressure soars, you experience intense headaches, profuse sweating, stuffy nose, hot flushes and anxiety – sometimes to the extent of cognitive impairment.

Perversely, I am lucky enough to feel the pain of an over-distended bladder and this allows me to be aware when my catheter is blocked and so avoid autonomic dysreflexia.

So, while the most obvious effect of an SCI is an inability to walk, continence issues have a daily and deep effect on one’s independence, dignity and, potentially, health.

Luckily for me, things have not turned out as badly as they might: I am now able to walk for short distances using a walking frame and can do all my “transfers” – bed to chair, chair to toilet and so on without the need for a hoist.

But as a C4 quadriplegic, I still rely on a wheelchair and this lack of mobility is what is most immediately apparent to people.

It also revealed the impact on their primary carers, of which there were 72,900 during 2008–09. The majority of these were female (81 per cent), and most (73 per cent) spent more than 40 hours a week undertaking care-related duties.

“Primary carers who assist people with severe incontinence are more likely to report strained relationships with those they care for, to need more respite care, and to report lower labour force participation,” Dr Kinnear said.

The full report is available at www.aihw.gov.au/publications

AT WHAT COST?

The Australian Institute of Health and Welfare’s report Incontinence in Australia, released during World Continence Week by former Mental Health and Ageing Minister Mark Butler highlighted the social, emotional and financial cost of severe incontinence on our community.

It revealed that in 2008–2009 there were 316,500 Australians (1.5 per cent of the population) who experienced severe incontinence (always or sometimes needing help with bladder or bowel control), costing the aged and health care systems an estimated $1.6 billion.

The report also revealed that 26 per cent of those with severe incontinence aged 15 to 64 participated in the work force, compared with 56 per cent of people without incontinence problems.

“Severe incontinence can profoundly affect the quality of life of those who experience it,” AIHW spokesperson Dr Pamela Kinnear said.
Q. There are so many products on the market. How do I know what’s appropriate for my elderly mum?

A. There is no one product that is perfect for any individual and there are many factors to be taken into account. There are three styles of products:

- pads (which fit inside underwear),
- pull-ups (generally worn instead of underwear) and
- all-in-ones (products with sticky tabs on the side to improve fit and access).

Within each style there is a range of volume capacities and waist sizes, so it’s not always east to decide on the most appropriate product just by looking at it. A good idea is to obtain samples, where possible, from the supplier and decide on the most appropriate product through a process of trial and error. The product should be comfortable, discreet and able to hold the volume required. You will also have to consider whether the person will need assistance when using the product. If you’re still having trouble deciding, a continence nurse advisor can provide advice and offer suggestions, and sometimes even free samples.

Depending on your mother’s degree of incontinence she may be eligible for some financial help for the cost of these products. The Australian Government’s Continence Aids payment Scheme (CAPS) can provide up to $533.50 a year (pro-rata from July 1) to help meet the cost of continence products. Eligibility requirements apply and application forms are available from Medicare (132 011) or the National Continence Helpline (1800 33 00 66).

Q. I am about to have prostate surgery. What incontinence problems might I experience?

A. This depends on whether you are having a radical prostatectomy for prostate cancer or a trans-urethral re-section of the prostate (TURP) due to an enlarged prostate. The range of surgical options does not necessarily affect the outcome; surgery is very individual. These days there is a much greater likelihood of your urologist discussing urinary incontinence after a radical prostatectomy than there was in the past. While some men will have no urinary incontinence after the catheter is removed, the majority will have some leakage and urgency. As the bladder recovers and returns to normal, the incontinence improves. In general, about one third of men are no longer incontinent one month after surgery, and the majority are dry by three months. For those still affected, their incontinence may be as a result of previous bladder issues or complications during surgery. In these cases they should go back to their urologist to discuss further options. Remember, if you’re reluctant to go back, the urologist will assume everything is fine.

In the case of a TURP, incontinence is less common and the recovery period to full bladder control is shorter. There can be complications however, and the urologist should be contacted if there are still incontinence problems after three months. In all cases, urinary incontinence following prostate surgery needs to be assessed with an understanding of other medical conditions the person may be experiencing. For example, chronic constipation, diabetes, Parkinson’s or a stroke may all affect the outcome.
Some of the benefits offered by Independence Australia are:

• Monthly specials across a range of continence, wound care and health care products
• Prompt delivery direct to the home with discreet packaging if required
• No minimum order required *
• Free delivery for all orders over $250

*Terms and Conditions Apply

Contact us today for more information or to place an order:
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