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About us...

The Continence Foundation of Australia is the peak national body representing the interests of nearly one in four Australians affected by incontinence, their carers, families and health professionals. The Foundation, on behalf of the Australian Government, manages the National Continence Helpline (1800 33 00 66), a free service staffed by continence nurse advisors who can provide information, referrals and resources 8am – 8pm AEST weekdays. The Foundation, established in 1989, is a not-for-profit organisation.

Become a member

Become an individual, student or professional member of the Continence Foundation of Australia and receive many benefits including discounted registration to the annual National Conference on Incontinence, free publications and timely information about events and courses. Email membership@continence.org.au or phone 03 9347 2522.

References

Email bridge@continence.org.au for a list of references for any articles appearing in Bridge.
Babies and bladders keep women awake

Nocturia is not only an older gentleman’s condition, a new study has found, with about one third of women of child-bearing age affected.

The study of 1636 Turkish mothers with an average age of 34.4 years found that 35 per cent were affected with an average age of 34.4 years. The study, published in the June edition of Korean Journal of Urology, found that 35 per cent were affected by nocturia (going to the toilet more than once during the night).

The study, published in the June edition of Korean Journal of Urology, found that nocturia was more common in women who had other urinary symptoms, including urge incontinence and overactive bladder.

The researchers, led by Hasmet Sarici from Turkey’s Ankara Training and Research Hospital, found the prevalence of nocturia increased with age, BMI, number of pregnancies and the number of children delivered.

The study also revealed the high burden of nocturia among younger women as the result of its association with pregnancy and childbirth, most likely caused by a reduction in the capacity of the bladder or by a prolapse.

What prompted you to leave your position and work at Ziv Medical Centre?

A strong historical connection drew me to Israel. My family comes from the Middle East. My paternal grandparents are from Syria, my maternal grandparents from the Old City of Jerusalem and my parents are from Egypt. Our family roots lie here. I felt I wanted to contribute something to the country so I chose a remote area (Tzfat in the upper Galilee), which was poorly resourced and seemed in need of someone with my skills as a general paediatrician with an intensive care background.

What are the challenges specific to your work there?

Surprisingly few challenges relate to my work. I speak fluent Hebrew and some Arabic. The population mix of the upper Galilee is about one third each of Druze, Jews and Arabs, with extraordinary cultural diversity within each of those. Western medicine is accepted in all streams of the society. There is, however, a tendency here to want tests and intervention for almost anything, and hospital medicine has a strong undertone of protection against medico-legal issues, which leads to overtreatment and over-investigation. The Anglo-Australian way of practicing medicine based on common sense and an assumption that common things are common, is lacking.

Tell us about the continence clinic you set up at Ziv.

Child and adolescent incontinence seems equally common in all the racial, cultural and socioeconomic groups here. In the far north of Israel there is no continence service and no awareness of its importance. Incontinence is usually assumed to be a psychological/behavioural issue or else the family is fobbed off and told the child will outgrow the problem. There is little awareness about the physical basis to encopresis (faecal soiling) or about overactive bladders in children and its role in daytime wetting and urgency.

You have also worked in other countries. Are there differences in terms of prevalence and attitudes toward paediatric incontinence in different parts of the world?

I have worked in the UK and Papua New Guinea, as well as Israel. In PNG I did not see paediatric incontinence. It probably exists but it was lost as an issue in the far greater need for dealing with acute illness. I left the UK in the late 1980s when incontinence of all kinds was still neglected and fobbed off as being the child or the parents’ fault.

What do you feel is the next step in treating childhood incontinence?

Most child and adolescent continence issues are dealt with easily once the physical (rather than psychological) basis for the problem is realised and addressed. Hence, broad community-based education is needed. My attention in the future is to educate parents, psychologists and community health workers about the causes and treatment of various forms of incontinence. I have already started a series of community-focused lectures and we are soon to start a course of community-based child health for paediatricians, in which I will address childhood incontinence. I hope this will help put the topic in its true perspective and advance the treatment available in our area.

In about five years, I plan to retire from practising acute medicine to look after family, goats and a fruit and vegetable garden. Nevertheless, I hope to continue providing a continence service for many years beyond that.
In sickness and in health

Lynn Geddes’ unwavering commitment to her husband’s rehabilitation after an horrific accident six years ago has earned her the Continence Foundation of Australia’s Carer of the Year for 2014.

MARIA WHITMORE REPORTS.

Six years ago, a pallet of paper fell off the back of a semi-trailer being unloaded and onto the head of interstate truck driver Paul Geddes.

Just days after the accident, the doctors at Melbourne’s Alfred Hospital urged Lynn to turn off her husband’s life support, believing he would never recover from the horrific injuries that affected every part of his brain except the cerebellum.

Nor would Lynn send Paul, then aged 60, to a nursing home when he came out of his coma three weeks later, as was also suggested. The doctors were amazed Paul had even survived the accident and told Lynn he was, and would always remain, a vegetable.

Instead, Lynn gave up her factory job in Albury and, at the age of 52, began the daunting task of rehabilitating her husband at home in Holbrook, southern New South Wales.

Paul’s health suffered another setback six months later when surgeons operated on the worst of the brain aneurisms that had been found after the accident. During the operation Paul suffered a devastating stroke.

He came home for good after the operation and now, with the help of a carer eight hours each week day, Lynn manages Paul’s rehabilitation, which takes up nearly every waking moment of her day.

Lynn’s typical day starts before he’s even out of bed when she takes him through arm and leg stretches. After toileting, showering and dressing him – no mean feat considering he’s a strapping 100kg and she’s only 52kg – she starts the regime of exercises that go on all day, interrupted by meals, toileting and the odd half-hour break when he is strapped into his easy-stand exerciser in front of the television.

Every day he has a workout on the antiquated exercise bike, which involves shoving his wheelchair up as close as possible so he can reach the pedals, strapping his feet into the pedals, and wedging chocks into the frame so it doesn’t slide. It takes two people and it’s back-breaking work, Lynn says.

And so it goes. Throw in daily reading and writing sessions with a white board and marker pen and you have a typical day at the Geddes’.

And then there’s the cooking, cleaning, shopping and laundry for the family, which includes two adult children living at home – one with Asperger’s, the other with autism – neither of whom can care for their father on their own.

Her extraordinary attention to her husband’s toileting has paid off and Paul is now virtually accident free, even though he still wears incontinence products during the day and a uridine at night.

According to Lynn, constipation had been a significant issue since the brain injury, with early attempts to manage it causing even more problems. Lynn had to clean up bowel accidents daily for years, but since starting him on Movicol eight months ago, Paul has rarely, if ever, been faecally incontinent. These days he can even sometimes tell her when he needs to empty his bowel.

‘Anyone else would have sent him to a nursing home long ago.’ Andrea Murdoch
‘It’s taken five years to get where we are.’

Lynn Geddes

Lynn’s motivation is fuelled by his extraordinary progress, which everyone – including the experts – agrees, would not have happened without her unwavering commitment. Paul can now walk short distances and pull himself up onto the commode unassisted.

“It’s taken five years to get to where we are and everyone can notice the improvement,” Lynn said.

Lynn’s award nominator, continence nurse Andrea Murdoch, who works from the Holbrook Community Health Service, said she had never come across anyone like Lynn.

“She refused to give up on him,” Andrea said.

“Anyone else would have sent him to a nursing home long ago. Lynn’s such an amazing advocate for Paul. I told her this is about YOU. This is what YOU do. You deserve this.”

When Lynn is asked if she ever feels sorry for herself, she quickly dismisses the idea. “There’s no point in feeling sorry. You’ve just got to keep going,” she said.

Occasionally Lynn heads off to a musical in Melbourne, but the remainder of her time and energy is channelled into her husband’s rehabilitation.

In typical style, Lynn will put Paul first when it comes to spending the $1000 prize money provided by award sponsor Hartmann. She will buy Paul a new exercise bicycle.

When it’s suggested that perhaps, just once, she might do something for herself, she insists she is.

“It will help me,” she said. “And him too. That old one is really hard work!”

Luck may have deserted Paul Geddes that awful day six years ago, but luck was on his side another day about 25 years earlier when Lynn Jones agreed to marry him.

The Continence Foundation’s special project for 2015 aims to improve the lives of Australia’s many unpaid carers.

Managing incontinence places a considerable burden on primary carers, and has been found to be a key factor in deciding whether or not to place someone in residential care.

The 2009 Incontinence in Australia report from the Australian Institute of Health and Welfare found that carers of people with incontinence generally spend more time caring or supervising each week than carers of people without incontinence.

The report also found that the high-care needs of people with incontinence placed a greater load on primary carers’ mental, physical and economic wellbeing.

The special project aims to raise awareness and improve support and understanding of continence management for unpaid carers. It will focus on improving communication between carers and carer organisations, improving access to information for carers, and enlisting representation from carers in future activities and initiatives.

Carers

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Continence – Wound care – Nutrition – Respiratory
There are three main causes of food reactions in children that can impact on their bowel:

**Carbohydrates and sugars**

Carbohydrates from wheat products and complex sugars can be triggers for diarrhoea in children. In most cases this is because their small bowel doesn’t have enough of the digestive enzymes that break these large molecules into simple sugars that can then be absorbed into the bloodstream.

Instead, the carbohydrates and complex sugars travel down into the colon where they come into contact with the normal bacteria, which starts a fermentation process and the production of gas. The fermentation also draws water into the bowel, causing acidic diarrhoea.

Sugars such as fructose (from fruit) and lactose (from milk), wheat products and non-soluble sugars in sugar-free products like gum, can all trigger diarrhoea in children.

Often, simply addressing the amount of fruit and sweet drinks a child consumes can stop diarrhoea. A child’s small bowel simply doesn’t have the capacity to absorb too much fruit sugar, and children should be encouraged to eat no more than two pieces of whole fruit a day, and avoid drinking juice. Obviously, sweets, soft drink and cordial should also be limited.

Children with suspected carbohydrate or sugar intolerances can be assessed by non-invasive stool testing and breath testing.

**Lactose intolerance**

Lactose intolerance often manifests in later childhood as the body’s genetic switch turns off production of the lactose-digesting enzyme. Symptoms are triggered by lactose-containing dairy products, such as milk, cream and ice cream. Symptoms can include abdominal cramps, wind and diarrhoea one to two hours after a meal. If they are found to be lactose intolerant, foods with lactose should be substituted with calcium-rich foods with no or low lactose, such as lactose-free milk, soy milk, acidophilus yogurt and block cheese. (Even though yoghurt and cheese are made from milk, the bacteria in the cheese and yoghurt cultures consume the lactose during manufacture.)

Wheat can cause symptoms through various diseases and intolerances, ranging from poor absorption of the wheat starches (carbohydrates) in the small bowel and their subsequent fermentation in the colon (triggering symptoms in irritable bowel syndrome), to significant gut damage triggered by wheat in coeliac disease. Anyone who has gastrointestinal symptoms after consuming wheat products should see their doctor for assessment. At a minimum, they require blood testing to assess for possible coeliac disease.

**Coeliac disease**

Coeliac disease is an autoimmune disease where the body’s immune system attacks the lining of the small bowel, badly impairing its ability to absorb nutrients. It is triggered by exposure to gluten, a protein found in wheat, rye and barley.

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**WHEN FOOD AND KIDS DON’T MIX**

Food reactions in children may be the underlying cause of constipation, unpredictable diarrhoea, or for some unlucky children, both. Brisbane Royal Children’s Hospital paediatric gastroenterologist DR FRANCES CONNOR explains.

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Dr Frances Connor
A recent study found that one in 70 Australians have coeliac disease, only occurring in people with a genetic susceptibility. Classic coeliac disease presents with gastrointestinal symptoms of malabsorption, causing pain, diarrhoea and severe growth problems or weight loss. Left untreated it produces symptoms in other parts of the body as the result of such poor food absorption and damage by the immune system to healthy tissues. This can affect a person’s height, puberty onset, fertility, iron status, liver and joints, as well as skin, teeth and bones. There are also rare cases of seizures and cancers of the small bowel.

Fortunately severe coeliac disease is very rare and excellent blood tests mean more and more people are being diagnosed early. It is very important to get blood testing as soon as possible. Gluten-free diets make the testing unreliable, so patients should not take gluten out of their diet until after the coeliac testing has been done.

Coeliac disease is lifelong. The only treatment is a lifelong strict gluten-free diet, avoiding all foods, drinks and medicines derived from wheat, rye and barley. To do this safely, a dietician and a paediatrician should supervise.

**Food protein allergies**

Ten per cent of Australian infants have a food allergy and up to 15 per cent of six to seven-year-olds have a food allergy or intolerance.

The most common food allergies affecting the gut are from proteins in dairy, soy, wheat, corn, egg, rice, chicken and fish. In many cases of gastrointestinal food allergies there are no obvious external allergic symptoms such as swelling or rashes.

The problems usually start in infancy. When the allergen food proteins enter the small intestine, the body’s MAST cells (the key cell in allergic reactions) release histamines and other irritants. These chemicals cause a massive outpouring of liquid secretions into the bowel, causing diarrhoea. They also cause disturbances to the stomach’s normal rhythm, which can stop it pumping forward, and can even cause vomiting.

Sometimes protein allergies can make the anal sphincter tighten up, resulting in stools that can be quite thin - like ribbons or toothpaste. If the sphincter doesn’t relax enough to allow for defecation, it can lead to constipation.

Diagnosing food protein allergies is difficult because the symptoms are so variable and can be a combination of reflux, vomit, constipation and diarrhoea.

Basically the diagnosis comes down to elimination diets, which should be properly supervised by a dietician and a doctor to avoid compromising the child’s nutrition.
Get a Grip on BPH

Most men will be affected by an enlarged prostate at some point in their lives. It’s important to know the symptoms and when to seek help.

What is BPH?
As men get older, their prostate glands get bigger. The male hormone testosterone is responsible for this growth, roughly doubling the prostate’s size between the ages of 20 and 50 years, and doubling it again in the next 30-year stretch to 80 years.

It’s perfectly normal and nothing can be done about it.

The prostate is a donut-shaped organ that sits under the bladder. Its main role is to make the fluid that protects and feeds sperm. The urethra (urinary tract) passes through the middle of the prostate, the enlargement of which can cause the urethra to constrict, thereby affecting the urine flow out of the bladder.

This constriction of the urethra is called BPH, which refers to benign prostatic hyperplasia (an increase in number of cells) or benign prostatic hypertrophy (increase in cell size).

BPH is the most common prostate disease in men, often starting around the age of 40 years and affecting most men eventually. It’s important to note that BPH is not linked to prostate cancer.

Some of the symptoms of BPH are:
- having to wait to start urinating
- a weak stream
- straining to urinate
- dribbling after finishing
- some urine retained after finishing
- having to urinate urgently
- having to go often, including overnight

If you have any of these lower urinary tract symptoms, it’s important to see your doctor. You will need to provide a personal and family history, and may also be required to complete a voiding diary, recording your urinating and drinking patterns over the previous few days. Your doctor will also need details of your current medications and any other medical issues.

The main test when checking for prostate problems is a digital rectal examination, which involves the doctor checking the prostate’s size and shape by placing a gloved finger into the rectum.

If you have BPH, your doctor will talk you through the range of treatments, which include:

Medication
There are two main types of tablets; alpha-blockers and 5-alpha reductase inhibitors. The alpha-blockers relax the muscles of the prostate, bladder neck and urinary tract, while the 5-alpha reductase inhibitors block the effect of testosterone, causing the prostate to get smaller. Both types are effective, have few side effects and are often the first treatment option.

Surgery
This involves taking out part of the prostate gland constricting the urinary tract (a prostatectomy), either telescopically with a special instrument passed through the penis into the urinary tract, or by an open operation.

About 90 per cent of prostatectomies are done telescopically. The most common is a transurethral resection of the prostate (TURP), which involves the cutting and removal of the restricting prostate tissue (referred to colloquially as a rebore). A similar procedure, a transurethral incision of the prostate (TUIP), snips the ring of enlarged tissue near the bladder neck to make a larger opening.

Ten per cent of prostatectomies are done openly through the abdomen because the prostate gland is too large to be telescopically removed.

Pelvic floor exercises
Men who have had prostate surgery are often encouraged to do pelvic floor muscle exercises because the urinary sphincter (the muscle ring that shuts off the bladder) can be damaged by the surgery.

It is important they are done correctly, so consult a physiotherapist, continence health professional, or phone the National Continence Helpline 1800 33 00 66 to receive the correct instruction.
Men can leak too

Urinary incontinence in men is often associated with prostate disease, but there are other reasons men can be affected.

1. DRINKING TOO MUCH OR TOO LITTLE

Drinking too much – particularly alcohol – puts men at a greater risk of having accidental leakage. Apart from the body’s struggle to contain so much fluid, alcohol is particularly risky because of its diuretic properties. Conversely, not drinking enough fluids can cause leakage. Concentrated urine can irritate the bladder, which causes it to want to expel the contents, resulting in urgency and frequency. Too many caffeinated or fizzy drinks, which also irritate the bladder, can have the same effect.

Management:
Drink enough to satisfy your thirst, which equates to about six to eight glasses of fluid on a normal day – more if the weather’s hot or you’re exercising. Cut back on alcoholic, caffeinated or fizzy drinks.

2. OVERWEIGHT

Carrying extra body weight can stretch and weaken the pelvic floor muscles that hold up our pelvic organs and help close off the urinary and anal sphincters (the muscle rings that shut off the bladder and anus).

Management:
Keeping your body within the healthy weight range will significantly reduce the likelihood of urinary leakage.

3. CONSTIPATION

Regularly straining on the toilet has the same weakening effect on the pelvic floor muscles as being overweight. On top of that, a full, impacted bowel can actually take up so much space in the abdominal cavity it presses on the bladder, risking leakage.

Management:
Prevent constipation by exercising regularly, drinking sufficient fluids and ensuring your diet includes at least 30g of fibre. If you suffer from chronic constipation see your doctor or phone the National Continence Helpline, 1800 33 00 66.

Empty your bowel as soon as you get the urge, which is usually just after breakfast and a hot drink. Avoid holding on, as this will cause the stool in the colon to dry out even further. When you go to the toilet, sit with your knees higher than your hips and your elbows on your knees, as this straightens out the lower section of the bowel.

4. AGEING

As we age the muscles and nerves that control our bladder and bowel function become less compliant and responsive.

Management:
Exercise, including pelvic floor exercises, will strengthen and tone the pelvic floor muscles, which are important in preventing accidental leakage.

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Dr Ian Tucker

Women’s magazines would have you believe that drinking two litres of water a day is the elixir of youth and good health. But as MARIA WHITMORE reports, drinking too much can do more harm than good.

So, you’ve been led to believe that carrying a water bottle as a permanent fixture is a good thing? And that drinking two litres of water will improve your complexion and even help with weight loss?

Well, think again. Adelaide-based urogynaecologist Dr Ian Tucker says there is absolutely no evidence to show that drinking more water than the amount required to satisfy our thirst has any health benefits. In fact, excessive fluid intake can be dangerous if taken to extremes, he says.

Dr Tucker, like most medical professionals, is at pains to stress one simple point; that our thirst – and not some bottled water company executive or beauty editor - is the best guide as to how much we should drink.

It’s a simple case of arithmetic; we need to take in enough fluid each day to make up for the amount we lose, which is normally about two litres. Of the volume lost, about 1.5 litres is urine and the remaining 500ml is through breathing and perspiration. Therefore we need to consume about two litres of fluid each day.

However, most people overlook the fact that we get about one litre of fluid daily through our food, based on a normal diet comprising fruit, vegies, cereals, soups and casseroles.

This means we only need to drink about one litre - about six tea cups or small glasses - to make up the difference.

“Obviously this intake will need to be varied on hot days and at times of significant exercise. But even then, the urine output should be approximately 1.5 litres a day,” Dr Tucker said.

Any liquids - including tea and coffee - are suitable for hydration, with alcohol the only exception.

“That’s because alcohol is a diuretic. But there is this misconception that coffee is a diuretic too, which is incorrect. There is no diuretic effect from coffee, except from the aspect of volume – if you drink too much of it,” Dr Tucker said.

He also warned against too many fizzy or caffeine-based drinks, which can trigger urge incontinence in some people with bladder dysfunction.

Our thirst – and not some bottled water company executive - is the best guide as to how much we should drink.

Another common misconception, he said, is the belief that increasing fluid intake improves skin tone. For this to occur, a person’s fluid intake would have to be at such extreme levels as to be deemed dangerous.

“Improved skin tone will only occur if the fluid intake is sufficient to cause generalised oedema (fluid retention), and at this level, such fluid intake becomes dangerous,” Dr Tucker said.

Like most urogynaecologists, Dr Tucker has seen the dark side of excessive water consumption. In extreme cases, excess water intake can cause hyponatremia, when the body’s salt levels drop so low the brain swells, risking seizures and even death.

Excessive fluid intake can also put strain on the heart because of the increased blood volume being pumped around the body. Too much fluid can also cause peripheral oedema and worsen incontinence issues, Dr Tucker said.

He refuted the theory that drinking water helped weight loss by reducing appetite, and referred to the work of respected nephrologist Professor Stanley Goldfarb from the University of Pennsylvania. Dr Goldfarb’s 2008 review of the scientific literature about the health effects of drinking water, published in the Journal of the American Society of Nephrology, found no evidence that drinking water before meals reduced appetite.

So, next time you’re tempted to take another sip of water you don’t particularly want, don’t. Listen to your body instead.

And a quick tip. If your urine is pale lemon in colour, you can be confident you’re drinking the perfect amount.

NOTE:

1. Excessive urine output (polyuria) may be an indication of diabetes as the high blood sugar levels cause the kidneys to produce more urine. This leads to excessive thirst and is one of the early signs of diabetes. Seek medical advice if this is the case.

2. Older people may not get strong thirsty signals from the brain, putting them at risk of dehydration, and so should be reminded and encouraged to drink. However, the urine output should remain about 1.5 litres a day, which can be easily measured.
Nocturia, or waking up at night to go to the toilet to pass urine, is generally only considered a problem if it happens twice or more often a night. It’s a common condition and the chances of being affected increase with age, with about half of all men aged between 70 and 79 getting up twice or more a night.

Nocturia needs to be taken seriously because it can be disruptive to a person’s life. Waking up frequently can cause daytime fatigue, putting people, particularly older sufferers, at risk of falls and bone fractures. It can also affect work performance, concentration, memory and moods, lowering the overall quality of a person’s life.

Why does it happen?

Normally when we sleep we make only up to about 30 per cent of the urine we make during the day. This is because the anti-diuretic hormone (ADH) we make overnight causes our kidneys to produce smaller volumes of more concentrated urine so our sleep is uninterrupted. But as we age, the urine volume made at night can increase to about 50 per cent of the daytime volume. Although researchers are still not sure why this happens, one theory is that ADH levels decrease as we age, thereby increasing the volume of urine made overnight and the prevalence of nocturia with age.

There are however, many other contributory causes of nocturia, which may include one or more of the following:

- An enlarged prostate, a urinary tract infection, or neurological conditions such as stroke, multiple sclerosis or Parkinson’s Disease. (These conditions would also cause urinary urgency symptoms during the day.)
- A decline in heart and kidney function, which may lead to swollen ankles.
- Drinking too much before going to bed.
- Sleep disorders such as sleep apnoea.
- Diabetes, which causes the bladder to make a lot of urine all the time. If the blood sugars are high, the body increases its urine production to remove the excess blood glucose.
- Excessive drinking as a result of medications that cause thirstiness (such as antipsychotic medications).

What can be done about it?

Attend to and manage any underlying conditions such as diabetes, urinary tract infection, kidney and heart dysfunction, sleep apnoea, and have your prostate checked out.

Try not to drink too much after the evening meal for at least two to three hours before bedtime. It is important you drink well earlier in the day, which includes coffee, tea and the fluid contained in food) unless advised otherwise by your doctor.

If your doctor approves, try wearing compression stockings to reduce swelling in your ankles. Also try having a lie down with your feet up in the afternoon for an hour.

Make sure your bed is warm and comfortable and be aware that, if you are in bed for more than eight hours a night, you might need to get up to the toilet more than once or twice anyway.

More specialised treatments

If you have tried to manage nocturia yourself without success, there are continence professionals throughout Australia who can help.

Some of the treatments recommended after a continence assessment may include:

- Small doses of a diuretic or water tablets in the afternoon to remove fluid from the body before bedtime.
- Medication to help your bladder relax and hold more urine, and to give you more time to get to the toilet. You may also be taught techniques to retrain your bladder to hold more urine or not empty so often.
- Medication to help reduce the amount of urine produced at night. This medication is to be used with great caution as it has many side effects.

For more information about nocturia and to find your nearest continence service, contact the National Continence Helpline (1800 33 00 66) or go to continence.org.au

JANIE THOMPSON has 20 years’ experience as a continence nurse consultant. She is also the president of the Continence Nurses Society Australia and Nurses for Continence (Victoria).
Tips from the experts

• If your child wears disposable nappies it may be difficult to feel if the nappy is wet or dry. If this is the case, put a pair of underpants or a tissue inside the nappy and check at least every 90 minutes to two hours to see if they are wet.

• Children learn by imitation so it is a good idea from a young age to allow your child to watch you on the toilet. You can even get your toddler to sit on the potty when you’re on the toilet before active toilet training.

If your toddler can stay dry for a two-hour period, follow simple instructions and pull their pants up and down, they’re ready for toilet training.
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A chance call
A timely phone call to the National Continence Helpline could be a life-saver for John Duigan.

The chance sighting of a National Continence Helpline brochure during World Continence Week was a life-changing moment for John Duigan. It was World Continence Week, 2014, and John, 59, was in Sydney’s Canterbury Hospital for an unrelated matter when he picked up the brochure.

John, who had been affected by faecal incontinence and depression for four years, had been quietly managing the problem on his own, embarrassed about his condition and unaware of any services that could help.

“It’s been pretty awful coping with this. I’m sure it’s had something to do with my depression,” John said.

National Continence Helpline nurse consultant Jenni Blackman offered John a sympathetic ear and provided advice on how to best manage and minimise his incontinence.

“And there’s been continuing follow-up, which has been amazing,” John said. “The Helpline has been wonderful. They not only continue to support me, but have also sent boxes of bookmarks to put in my doctor’s practice.”

Since the Helpline call, John has made changes to his lifestyle that will also help reduce his risk of bowel cancer.

“My father, who was one of 12 children, died of bowel cancer, and many of his brothers and sisters did too,” John said. “I’ve been monitored by doctors for bowel cancer for the past 15 years, but since the Helpline call, I’ve become much more reflective about my diet and lifestyle.”

John said he is also more mindful of engaging in regular exercise, including male pelvic floor exercises.

“I’d never heard of male pelvic floor exercises, and the information sheets I’ve been sent are so clear,” he said.

John is now keen to encourage others to seek help, and has been spreading the word about the Helpline among his network of friends.

“I have mentioned to other people about how helpful you are, and they’ve mentioned it to others, and there have been four people who have contacted me to ask me about the Helpline.

“And all I did was pick up a brochure! “I say to people with bowel problems, don’t be embarrassed. It’s important to see your doctor. You can get help. You can become informed.”

Each year the National Continence Helpline handles more than 27,000 enquiries from people like John. The Helpline (1800 33 00 66) is staffed by continence nurse advisors who provide advice, referrals and resources to consumers and health professionals. The Helpline can also be accessed via the Telephone Interpreter Service on 131 450.

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Humans have been trying to deal with incontinence for millennia. The earliest writings on the subject date back to ancient Egypt around 1500 BC in the Papyrus Smith manuscript, where incontinence resulting from a spinal injury was described in detail. Other Egyptian sources around the time mention remedies ‘to remove constant running of the urine’ with devices for the collection of urine in men, and pessaries (a round device inserted into the vagina) in women.

About 1000 years later Hippocrates’ (460–377 BC) extensive writings about urinary tract diseases included a discussion about perineal lithotomy – a nasty-sounding incision into the bladder through the perineum (the section between the anus and the scrotum) – to remove bladder stones, which have been a common cause of urinary retention throughout the ages.

After 2000 years or so, Leonardo da Vinci (1452–1519) created detailed anatomical drawings of the lower urinary tract, managing to successfully identify the function of the urinary sphincter in the urination process. He didn’t, however, realise that the contraction of the detrusor (bladder muscle) was also required for urination.

This was discovered soon after by famous Renaissance surgeon Ambroise Paré (1510–1590) who realised urination required two simultaneously opposing muscle actions; the relaxation of the sphincter and the contraction of the detrusor.

Around this time, Wilhelm Fabricius Hildanus (1560–1634) created a rather crude urinal for the treatment of incontinence in men; a glass or pig bladder attached to the body by belts and straps (see above).

Lorenz Heister [1683–1758] from Germany came up with another idea: a leather-covered penile clamp (top right). While Heister saw no effective treatment for female urinary incontinence, he did write about a vaginal pessary that worked by compressing the urethra. This creative genius also designed a belt for men that produced pressure under the perineum that also closed off the urethra (above right).

His idea was revisited as recently as 1960, when S. A. Vincent used an air-inflatable cushion for the same effect, fixed to the perineum with a special belt and inflated manually with bellows.

Various conservative therapies during the 18th and 19th centuries included the introduction of antidiuretics, as well as drugs that affected nervous impulses to the area. Other therapies around this time included cold bath hydrotherapy, douches and aromatic baths.

In 1826 T. Brown designed a sophisticated, self-retaining instrument made from ivory that fitted anatomically to the female urethra, with a removable stopper for emptying.

At the end of the 19th century R. Gersuny from Vienna started injecting paraffin into the area around the urethra to restrict the urine flow. Other fillers such as cod liver oil were used later, with Teflon, collagen and silicone injections used in the late 20th century.

Robert Ulitzmann (1842–1889) was the first to use electricity for incontinence. He introduced a catheter-like electrode into the bladder (to stimulate the detrusor muscle), or into the urethra (to stimulate the sphincter). His work was the precursor for the development in 1969 of the long-term spinal root stimulator, the first of which was implanted in 1976 by Giles S. Brindley, signalling the beginning of modern neurostimulation and neuromodulation.

The introduction of antiseptics and anaesthesia in the second half of the 19th century revolutionised modern surgery, with the first transvaginal fistula repair performed in 1845 by James Marion Sims. The technique was refined in 1890 by Friedrich Trendelenburg, after whom the operating position is still named.

The 20th century saw the refinement of surgical and clinical procedures. These included the first retropubic sling for stress incontinence in women by D. Giordano in 1907. He used a muscle in the thigh and relocated it behind the pubic bone to form a sling around the urethra.

The first artificial sphincter for men with stress incontinence was created by Frederic E. B. Foley in 1947. It was an inflatable circular cuff applied surgically to the male urethra, and led to the inflatable cuffs that have become a standard clinical procedure today.

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Q & A with Dr Anna Rosamilia

Dr Anna Rosamilia, urogynaecologist and Associate Professor at Monash Medical Centre, answers some questions about treatment for prolapse and pelvic floor dysfunction.

Q I am a young mum with a prolapse, but would like to have more children. Should I have my prolapse repaired now or when I finish my family?

A It is not uncommon for prolapse to occur in younger women, although it’s more common in older women.

Mild prolapse is usually managed conservatively with pelvic floor exercises and lifestyle interventions, such as avoiding constipation and/or high impact exercises.

Moderate or severe prolapse is usually managed by the insertion of a vaginal pessary that can help support the prolapsed organs, or by surgery.

There are many types of operations to repair a prolapse, which may involve the use of mesh, sutures or the woman’s own tissue. The timing of the surgery is determined by the woman’s preference, but ideally should be performed after the completion of her family, and at a time when her recovery and rehabilitation can be optimised.

If the prolapse surgery is successful, caesarean delivery would be recommended for any further pregnancies.

Q I’m 45 years old and have recently had a prolapse. Should I have the surgery before or after menopause?

A For some women the use of vaginal oestrogen can help prolapse symptoms by improving the health of the vaginal tissues.

The timing of any surgery is dependent on the extent of discomfort or inconvenience experienced by the woman.

There are many surgical options that can be performed vaginally, abdominally (including laparoscopically) and sometimes robotically.

The type of surgery depends on the whether the bladder, bowel or uterus has prolapsed into the vagina. Surgery may include vaginal repair, with or without a hysterectomy, but if the woman’s family is not yet complete, the uterus is conserved.

Surgery for stress incontinence (leakage of urine when coughing, sneezing, running, jumping, lifting) can be performed at the same time as the prolapse surgery.

Q I had a midurethral sling 12 years ago and I’m worried that it may cause problems because it’s been there so long.

A Midurethral slings, which have been used in Australia since about 1998, have become the most performed procedure for stress urinary incontinence. The slings are made from tape or mesh, and support the urethra (the tube that carries urine from the bladder).

If the tape or mesh sling becomes exposed, symptoms may include vaginal spotting or bleeding, or a pricking sensation in the vagina at the site of the exposure. The woman or her partner may be able to feel the exposed mesh either by touching, or there may be discomfort for either partner during intercourse.

Mesh exposure is usually managed by an operation that removes the exposed mesh and repairs the vagina with dissolvable sutures. If a significant amount of mesh is removed this way, it may lead to the urethra no longer being adequately supported, and the stress urinary incontinence returning.

Q I have had a sling for several years for stress urinary incontinence, but have noticed that my urinary control is not as good as it used to be. Has the sling loosened or come undone?

A Slings have been around for about 20 years and it is uncommon for a sling to come undone. In a large series conducted in a group of patients at Mercy Hospital for Women and Monash Medical Centre in Melbourne, only 7 per cent of sling patients had to have a repeat sling.

Many women may think their sling has come undone if their urinary control deteriorates some time after successful sling surgery. This may be due to a number of causes.

If the problem is a return of stress leakage, a urodynamic assessment to test the function of the bladder and urethra may be necessary. If stress incontinence is confirmed, repeat surgery may be necessary and sometimes this is a repeat sling.

If the problem is worsening urinary urgency or urinary urge incontinence, there is a possibility of an overactive bladder or an obstruction due to the sling. A bladder diary, urine culture (a test for urinary tract infection), an ultrasound of the sling, or a cystourethroscopy (a tube with a camera inserted into the bladder) may provide further information.

If the urgency and urge incontinence is found to be due to an overactive bladder, bladder retraining and medication may help. If the assessment shows the sling is too tight, and this is thought to be the reason for the urinary urgency and urge incontinence, it can be loosened or cut.

Q How is Botox used to treat bladder problems?

A Botox bladder injection has recently been approved under the PBS for the treatment of overactive bladders that haven’t responded to other treatments. Botox injections can be performed via cystoscope (a tube, inserted into the bladder) under a general or local anaesthetic. The success rate is approximately 70 per cent and the effect can last six to nine months, with treatments able to be repeated.

Patients receiving Botox injections into the bladder need to be monitored for urine infections, difficulty passing urine and how well they respond to the Botox.

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