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Pelvic organ prolapse is no laughing matter. Well not usually — and not unless author and blogger Madeleine Hamilton decides to share her prolapse experience with the world (p.13).

Madeleine, like most women, had no idea of the causes and prevalence of prolapse, so we’ve asked Associate Professor Caroline Gargett, a leading researcher in the field, to offer some insights into the condition, which affects as many as one in four women (p.12).

We are very pleased to have secured Professor Linda Cardozo OBE as guest contributor in our regular 5 minutes with feature (p.3). Dr Cardozo, a leading London-based urogynaecologist and researcher, is one of the keynote speakers at the 23rd National Conference on Incontinence to be held later this month in Cairns.

The conference will attract many of the continence health professionals who played an important role in delivering our national campaign, Pelvic floor awareness in pregnancy, childbirth and beyond. As a result, more new and expectant mums will be better equipped to maintain good lifelong bladder and bowel habits, and midwives will be in a better position to offer support for at-risk women as the result of a new online course developed in collaboration with the Australian College of Midwives (p.7).

This edition also features some inspiring stories from a number of contributors, including Jacqueline Brown, a nurse and mother of a child affected by faecal incontinence for six years (p.9), and Perth physiotherapist Jo Milios, who provides an uplifting “nuts and bolts” account of what men and their partners can expect after a prostate cancer diagnosis (p.4).

I hope you enjoy this edition of Bridge. And keep the feedback coming at bridge@continence.org.au

Maria
Editor

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For a list of references for any of Bridge’s articles email bridge@continence.org.au

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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, established in 1989, is a not-for-profit organisation dedicated to improving the quality of life of all Australians affected by incontinence.

The Foundation manages the National Continence Helpline (1800 33 00 66) on behalf of the Australian Government, a free service staffed by continence nurse advisors who can provide information, referrals and resources. The Helpline is staffed 8am–8pm AEST Monday to Friday.

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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 for more information.

Maria Whitmore
Editor

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NOCTURIA: A WAKE-UP CALL

Nocturia, or waking at night to urinate, is often considered a trivial matter that doesn’t need treatment. However, a 2014 Danish study has revealed its considerable cost to society, incurred directly when sufferers fall and injure themselves, and indirectly when sufferers’ productivity at work drops as the result of absence or poor concentration.

According to the study, direct costs to society resulting from falls and injuries are estimated at $1.5 billion/year in the US, and €1 billion in the European Union. Indirect work-related costs are estimated to be around $61 billion/year in the US and €14 billion in the EU.

On the basis of these figures, the author of the study, Holm-Larsen, argues that nocturia places a bigger burden on the economy than that of more widely recognised conditions such as overactive bladder or urinary incontinence, and therefore warrants more public health attention than it currently receives.

Pelvic floor exercise uptake figures poor

Earlier this year the Continence Foundation of Australia commissioned a study of 1000 Australia mothers and mums-to-be. It found that 98 per cent failed to do the daily recommended level of pelvic floor exercises, despite being in a high-risk category for developing incontinence.

Other key findings of the study were:
- 72 per cent of the women said they had experienced incontinence.
- 81 per cent of those who’d experienced incontinence hadn’t sought help from a health professional.
- The prevalence of incontinence was greater for women who had had multiple births, with 80 per cent of women with three or more children experiencing unwanted leakage.
- Just 2 per cent of women performed pelvic floor exercises three times a day, the recommended level.

Find out about how we’re helping address this situation through our Pelvic Floor Awareness in pregnancy, childbirth and beyond project, on page 7.

Q: What are some examples of the type of research projects you have been involved with?

We have recently published a series of four papers regarding labiaplasty (plastic surgery to alter the labia). This was a combined project with David Veale, a psychiatrist with a special interest in body dysmorphic dysfunction. The study revealed that women suffering from body dysmorphic dysfunction in association with their perception of their labia do very well from labiaplasty and return to normal after the procedure.

Q: What are your professional interests?

I’m interested in all aspects of urogynaecology, including the influence of hormones on the lower urinary tract, the conservative and surgical treatment of stress incontinence, the management of urogenital prolapse and the pharmacological treatment of overactive bladder.

Q: Where are you based?

I am a consultant gynaecologist and Professor of Urogynaecology at London’s Kings College Hospital, a department I established nearly 30 years ago. It now comprises four consultant uрогynaecologists, three doctors in training, three specialist nurses and three dedicated women’s health physiotherapists.

Q: What demographic does your department mainly work with?

We work in a relatively socially deprived area of south-east London where the population is ethnically diverse. We treat not only our local residents but also tertiary referrals from all over the UK.

Q: Describe your department’s services.

We provide a full range of clinical services, including all methods of assessment of lower urinary tract and pelvic floor dysfunction. We offer a wide range of management strategies, encompassing conservative therapies, pharmaceutical interventions and surgical procedures, where appropriate.

Q: Describe the medical training aspect of your department.

Our urogynaecology department is recognised for providing a high level of training and we have frequent visitors from the UK and overseas. In addition we carry out ongoing clinical research projects, most of which are presented at local, national and international meetings and later published in peer-review journals.

Q: How do the various medical disciplines in your department integrate their services?

In general we are a happy, cohesive department with excellent participation in our multi-disciplinary meetings, and the vast majority of the 41 fellows who have been through our unit have ended up as urogynaecologists or special interest obstetrician and gynaecologists in good positions throughout the UK and elsewhere in Europe and beyond.

www.continence.org.au
THE NUTS AND BOLTS OF PROSTATECTOMY
When a man needs mates

Perth-based physiotherapist Jo Milios gives a nuts and bolts account of what men and their partners can expect after a diagnosis of prostate cancer.

As a physiotherapist working in men’s health, each day tosses up many brave and inspiring stories from blokes recently diagnosed with prostate cancer. No two cases are ever the same and each man brings his own briefcase of fears and anxieties.

I call it the Triple C. An otherwise healthy man (in my experience, anywhere between the ages of 34 and 84 years) has suddenly received the news that he has Cancer, will suffer Continence issues and will most certainly lose his Copulating abilities for at least a little while.

Diagnosis
I can always tell when a new patient has arrived; he’ll be upright and nervous in the waiting room.

At the first opportunity, I always shake a bloke’s hand. I can discern much from the strength of it. I also look for a partner and call him or her in too, because if there was ever a time a man was going to need a mate, this is it. I want to convey trust and hope from the outset, as I know only too well the rollercoaster ride this gent has just embarked on.

As his physiotherapist I also know there are two major physical side effects that will dominate his every waking moment for the next three to six months at least. Incontinence and erectile dysfunction hit hard and I’ve yet to meet a bloke keen to accept those two as rewards for a cancer cure. Rather than present a story of gloom, I prefer to make this an opportunity to bloom.

Australian men on average die 4.3 years earlier than women, yet men’s health receives four times less expenditure – at 35th place – just before parasites. There are 22,000 new prostate cancer cases a year compared with 15,000 new breast cancer cases. This, in addition to 78 per cent of men being overweight or obese, 58 per cent not exercising regularly and 79 per cent consuming alcohol most days of the week.

However, if prostate cancer is caught early, 94 per cent can expect to live five years and 92 per cent 10 years, so the opportunity to “make good” should not be underestimated.

Treatment
Surgery is the gold standard treatment for localised prostate cancer, and caught early, the options for improved outcomes are excellent.

Indeed, many post-prostatectomy patients I see today are neither incontinent nor impotent following treatment, despite the expectations.

In 2004, this would have been a miracle. Ten years later, it’s a daily presentation in my physiotherapy clinic. But it takes a lot of work and a team approach.

Although the jury’s still out and research hasn’t quite yet recommended a particular type of surgery over another – open, keyhole or robotic – there are some definite points to consider.

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Treat your prostate diagnosis like you would research for a new car. Look. Read. Talk. Ask questions. Seek a second opinion. An experienced surgeon should have no qualms about advising you on their number of cases, success and failure rates.

Ask too, before your surgery, if you can have pre-operative pelvic floor muscle training, as it is well established that this makes a significant difference to continence recovery.

Lift nuts to guts – pelvic floor muscle training for men
1. Find yourself a comfortable position; sitting, standing or lying. Let go of all the tension in your belly and shoulders by taking a couple of deep breaths.
2. Focus your attention on your urinary sphincter, the one that starts and stops flow when you urinate. Think of the holding-on feeling before a wee or during sex.
3. Forget about squeezing or pulling up your back passage (anal sphincter) or holding your breath. Instead feel the lifting of the scrotum and testicles and then feel a “let go” as they drop. Repeat a few times to get the feeling of letting go. Keep breathing throughout.
4. You may need some biofeedback from a physiotherapist using real-time ultrasound to confirm the correct technique. Meanwhile, stand naked in front of a mirror and you should see your penis retract and scrotum lift slightly with each lift. No six-pack, hip thrusts or breath-holding required!

Regime
A combination of fast-twitch (quick, one second) and slow-twitch (long, 2–10 second) pelvic floor muscle lifts are essential to help with everyday tasks.

To avoid leakage when coughing, sneezing or for sit-to-stand actions, try a strong, fast-twitch lift before and during the task, then let go.

Long holds are recommended to train for endurance tasks, such as holding on and walking without leakage, but there are no set formulas. Start gently with perhaps three sets a day of five fast-twitch lifts, then five slow-twitch lifts, with an equal rest time between each before gradually building up.

Why?
It is generally accepted that following a radical prostatectomy – no matter whether the surgery is open, robotic or keyhole – most men will endure between six and 12 weeks of urinary incontinence, with about 2 per cent requiring reconstructive surgery a year later.

In the initial weeks, your pelvic floor muscles are on a steep learning curve. Removal of the prostate results in a major anatomical rearrangement, and all previous automatic bladder-emptying functions are now manual. This takes time, practice, a few mishaps and some boundary-testing.

Continence recovery
No two prostates or patients are the same but in general, most men will follow the same pattern of recovery.

Achieving dryness will first occur at night, then when sitting, standing and walking, before gradually improving over a day as the pelvic floor muscle endurance increases. It should take no longer than three to six months to be completely pad-free.

Erectile function recovery
Despite recent advances in outcomes, sexual function is expected to take at least two to four years to improve, with current evidence suggesting only 30 per cent of men will regain pre-operative function. This is because the delicate neurovascular bundles that supply blood flow are either stretched, bruised or removed during surgery.

Today, however, just like early pelvic floor training for incontinence, your urologist should commence penile rehabilitation as soon as possible after surgery.

This typically involves the use of medications (such as Cialis and PDE5 inhibitors) and regular use of a vacuum compression device to stimulate blood flow.

Shortening of the penis (by up to 2cm), urinary leakage during orgasm, infertility and absence of ejaculate fluid are also common and expected side effects you may not be warned about, so ask your urologist or GP for guidance on all of the above. Remember, sex need not only be about penetration, but touch and conversation.

Talk and walk into the future
A prostate cancer diagnosis need not be an end, but a new beginning and an opportunity for the strengthening of relationships and mateship, and a time to invest in your own long-term health.

Although you may feel reluctant, a prostate cancer diagnosis is an important conversation to share with your partner, family and friends. Linking up with a “prostate mate” is also a good idea. Your local prostate support group is a great start.

A daily 30 to 45-minute walk will encourage weight loss, strengthen your pelvic floor, clear your head, improve your circulation and increase your general fitness. It will also be a measure of your progress.

But walking with your life partner is my favourite tip. You may find you have so much more to share and blood flow anywhere will help blood flow everywhere.

>> Jo Milios is a Perth-based physiotherapist who specialises in men’s health. She recently established PROST! Exercise4Prostate Cancer Inc, a not-for-profit organisation that provides exercise and peer support. For further information go to menshealthphysiotherapy.com.au
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**WORLD CONTINENCE WEEK**

**WORLD CONTINENCE WEEK WRAP**

Thousands of pregnant women and new mums will be better equipped to prevent or improve bladder and bowel control problems due to the success of a national campaign launched during World Continence Week, June 23–29.

Pelvic floor awareness in pregnancy, childbirth and beyond is a national campaign to raise awareness of the importance of prevention and better management of incontinence among mothers, who are at high risk of developing incontinence due to the demands pregnancy and birth places on their pelvic floor.

A Continence Foundation of Australia study of 1000 Australian mothers and mums-to-be found that despite falling into this high-risk category, 98 per cent failed to do the daily recommended level of pelvic floor exercises. The study found that even though almost three women out of four experience incontinence, 81 per cent had not sought help for the problem, despite research showing pelvic floor muscle exercises can prevent and effectively treat incontinence among pre and postnatal women if performed as part of a daily routine.

Continence Foundation deputy chief executive officer Rowan Cockerell said the study results were disturbing and showed young women were ignoring their pelvic floor health.

“Incontinence should not be regarded as a normal part of childbirth and women need to prioritise this pressing health issue,” Ms Cockerell said.

“For mums juggling work, kids, appointments and a social life, exercising your pelvic floor three times a day might seem a lot, but they don’t take long, can be done anywhere, and are the simplest method to either cure or better manage incontinence.”

The Foundation has developed the Pregnancy Pelvic Floor Plan smartphone app, available from iTunes and Google Play, and a booklet, The Pregnancy Guide, available free from the Continence Foundation. The guide, covering topics such as pelvic floor exercises, abdominal muscle bracing, sex, exercise and prolapse, has been distributed to 55,000 women in the Mother To Be bounty bags.

The Foundation has also joined forces with the Australian College of Midwives to develop an online course for midwives.

Australian College of Midwives executive officer Ann Kinnear said the partnership with the Continence Foundation and online resources for midwives would mean better health outcomes for women and reinforce the importance of pelvic floor health during antenatal classes.

**BACK IN CONTROL**

*Vagina Diaries* writer and director Rachael Thompson became much more familiar with her pelvic floor after the rude shock of incontinence during pregnancy and after childbirth.

As the writer and director of the ABC documentary Vagina Diaries, Rachael Thompson was no stranger to the importance of pelvic floor health. However, she was still surprised by the incontinence she experienced during pregnancy.

Worded up on the importance of strengthening the pelvic floor muscles to assist in maintaining continence by her cousin, a physiotherapist specialising in women’s health, Rachael credits pelvic floor exercises with saving her from the worst.

“When I was about four months pregnant my cousin got me doing all the pelvic floor exercises to help prevent incontinence. Once I knew how common incontinence was, I did everything I could. I took pre-natal yoga classes once a week as well,” Rachael said.

“Even though I had slight pelvic floor issues during pregnancy, without the exercises my problems would have been much more severe. Metaphorically speaking, instead of calling a plumber, I might have had to call the water board.”

Rachael had to be induced to deliver her son Flynn, who was two weeks overdue.

“It was a difficult birth and he had a pretty big head,” she said. An episiotomy and forceps delivery proved unavoidable.

After such a difficult birth, Rachael’s pelvic floor muscles were weakened and she lost control of her bladder.

“My bladder was leaking no matter what I was doing; whether I was lying down in bed, walking around or just before sitting down on the toilet. It was impossible to stop the flow,” she said.

About one week after the birth, Rachael was preparing to make a quick trip to the supermarket with her mother, but at the last minute decided to wait in the car in case she “suddenly sprung a big leak”.

It was Rachael’s midwife who saved the day.

“At a home visit I mentioned the incontinence to my midwife, who said it was very common but not normal. She got me in to a specialist physiotherapist,” Rachael said.

Rachael started her pelvic floor exercises again.

“I did my pelvic floor exercises when I remembered, and if I forgot, the one trick my yoga teacher taught me kicked in; every time you stop at a red traffic light in the car, or even on foot or on a bike, do some pelvic floor squeezes. No one can tell when you’re doing them,” she said.

In six months, Rachael has gone from losing complete control of her bladder with almost no warning, to shedding only a few drops if she sneezes multiple times in a row, or if she has a sudden bout of coughing.

“My physio tells me I’ll probably make a full recovery, but without the pelvic floor exercises I might have continued to endure bad, ongoing bladder problems,” she said.

Rachael is not embarrassed about her incontinence.

“I’m pretty open about having a leaky bladder. What really scared and upset me was feeling I’d permanently lost control of my own body,” she said.

“The stronger your muscles are to start with, the harder it is to damage them. It’s never too late to start doing the exercises that help strengthen the muscles in your pelvic floor.”
Royal Children’s Hospital Community and Child Health fellows Dr Tammy Goldwasser and Dr Kirsten Furley provide an overview of faecal incontinence in children.

Faecal incontinence is when a child who is past toilet training age poos regularly in places other than the toilet, such as their underwear, on the floor or in their bed.

It is most commonly caused by chronic constipation. Stretching of the lower bowel walls or rectum can begin when a child is constipated. When the bowel walls are constantly stretched, the child’s sensation of needing to poo can be lost. This means that poo can leak out because the child has lost control. The child usually does not know when this is happening.

About one third of children will have constipation at some time, and one in 40 will have faecal soiling. Treatment requires a team approach, comprising the child’s parents (or caregiver), a doctor and sometimes other allied health staff such as a psychologist.

A combination of laxatives and a toilet-sitting program are at the core of the treatment plan. A diary recording the child’s frequency of toileting and soiling can help support management. Resolution of symptoms normally takes somewhere between six and 12 months. To minimise the chance of relapse, it is important for the child and family to continue to promote a healthy bowel habit.

Where to go for help and advice...

Continence Foundation of Australia, your GP, a paediatrician, the Raising Children Network (raisingchildren.net.au) or the Royal Children’s Hospital (rch.org.au)

>> This information was adapted from the Centre for Community Child Health and Department of General Medicine (Royal Children’s Hospital) Training Diary. Copies of the training diary can be obtained from rch.org.au

Getting into healthy bowel habits early

- Ensure your child gets plenty of exercise, has adequate fluid intake (to satisfy their thirst) and a well-balanced diet.
- When your child is sitting on the toilet for either a poo or wee, encourage a forward-leaning position with forearms on thighs, and provide a foot stool so their knees are a little higher than their hips.
- Encourage your child to sit on the toilet for about five minutes approximately 20–30 minutes after a meal with a warm drink (preferably breakfast). This is when the gastro-colic reflex, a mass movement of contents through the bowel, is most likely to occur.

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A MOTHER’S JOURNEY

From incontinent six-year-old to continent teen

Acquiring faecal continence is a part of normal development for most children, but for some, it can be a difficult challenge. Hannah’s mother, Jacqueline Brown, tells her story.

For me, the journey started innocently enough – on one of Nelson’s balmy summer days in 2005, poolside at Mr Pattison’s swimming lessons. My daughter, Hannah, then nearly six, frantically waved me to the pool’s edge. Her face conveyed her distress clearer than any words, but when they did come she whispered urgently, “Mummy, I’ve done poos in my togs”.

With an army of parents looking on, I had her out of the pool and into the changing room so fast her feet didn’t touch the ground. Thankfully, the poo was contained in her togs – complete disaster narrowly averted.

Despite 10 years of clinical experience as a registered nurse, some of it even in paediatrics, I wrote off the event as a one-off. But the instances of soiling increased, along with day and night-time wetting, and before long we were at the GP, who correctly diagnosed faecal incontinence (encopresis) due to chronic constipation. Oral stool softening drops were prescribed, with little effect.

We were soon back at the GP, this time with a urine infection. A different stool softening laxative, Lactulose, was prescribed, the dose increasing until Hannah had a bowel motion. A toilet-sitting regime was also introduced, involving 10 minutes on the toilet with feet supported on a low stool after breakfast and dinner, complete with poo star chart.

Hannah was soon having entire bowel motions in her underpants, often while on the mat at school. When she arrived home on the bus her pants were wet and she was smelly. She was teased and stigmatised by other children.

After several particularly large motions, the laxative was reduced. In the months that followed, urinary tract infections became the norm, with bucketfuls of smelly, soiled underpants jostling for space with the bed sheets in the bath tub (our laundry at the time was a concrete tub at the front door, although we did have a washing machine). Hannah refused to take the laxative, a move I supported. We were both exhausted.

My request to the GP for a referral to a paediatrician was declined because I hadn’t followed the laxative protocol adequately, I was told! I felt powerless. I insisted on an abdominal X-ray, immature ovaries or not.

At the school’s request, Hannah saw a counsellor for play therapy to see if there were any unresolved issues due to her parents separating, moving house, starting school and my remarrying and having another child.

The counsellor referred Hannah to a paediatrician. She was also tested for learning disabilities, but much to everyone’s surprise, the diagnosis was borderline gifted. A visit to the chiropractor ruled out any spinal misalignment - no coccyx, but much to everyone’s surprise, the diagnosis was borderline gifted.

We saw the paediatrician in January 2006, almost a year to the day since the pool episode. He took one look at the then six-month-old X-ray and suggested immediate admission to hospital for a bowel wash-out. On viewing the X-ray, even my inexperienced eye could see that Hannah’s entire rectum was filled with poo.

Hannah started using a bowel stimulant with a laxative after having the bowel wash-out. However, this wasn’t enough and two months later she was symptomatic again, and had yet another urinary tract infection. The bowel stimulant dose was increased but she was still symptomatic and only having a bowel motion every three to four days. The motions wouldn’t have looked out of place in an elephant enclosure. Her underpants would mysteriously “disappear”.

Hannah underwent a rectal biopsy to rule out Hirschsprung’s Disease, and another bowel wash-out. She had ultrasounds and a further X-ray to check her lumbar spine. She started a laxative and paraffin oil protocol, and started antibiotics for the recurrent urinary tract infections.

In November 2007, a short time after Movicol was added to the pharmaceutical schedule, Hannah started one sachet daily. Within a week she was dry at night. Wetting during the day occurred only once or twice a week and she had a bowel motion five out of seven days. By the time we saw the paediatrician in May 2008, Hannah was dry day and night and her stool size was reducing. Movicol’s impact on Hannah’s life, and that of the family, was miraculous. Life no longer revolved around Hannah’s bowel and bladder function. Before long she was going to sleepovers, being invited to parties, and playing netball. Her self-esteem and behaviour improved markedly.

Three years on, the journey continued, as did the Movicol – adjusted to compensate for periods of sluggish bowel action. We were discharged from the paediatric outpatient service in 2012.

Hannah is now 15 and manages her own continence. She has a bowel motion most days and rarely needs the Movicol. She still gets one or two urinary tract infections a year.

I hope that by sharing Hannah’s story, other parents, family members and health professionals can empathise with the reality of the incontinent child and their primary caregiver, who is trying to negotiate the path of medical assessments and interventions while juggling other siblings, a relationship, the needs of the household, driving to and from appointments, washing load after load of pants and sheets every day and waiting for the inevitable call from school to come and clean up their child.

The journey to continence is not one taken overnight, but over months and years. As a parent who had travelled the journey with my child, I felt it would be wasted if I didn’t do something to help other children and their parents. With the support of the New Zealand Continence Association, I wrote A Wee Secret about bedwetting, published in 2011, and Poo Hoo about faecal soiling, published in 2012. Both contain carefully crafted stories to encourage children and inform parents. They are available from the New Zealand Continence Association website, continence.org.nz

By sharing Hannah’s story, Jacqueline hopes other parents, family members and health professionals can empathise with the reality of the incontinent child.

Jacqueline Brown

www.continenze.org.au

Spring 2014 | bridge 9
A single, childless, elderly woman has asked for help with her stress urinary incontinence (leakage when coughing, sneezing and lifting etc.). She has a long history of constipation and straining, and has been taking Metamucil and five Laxettes a day for several years.

I’ve spoken to many childless women who have stress incontinence, who sometimes admit to a long history of constipation. Disturbingly, many of these women have resorted to a frightening array of laxatives, alternative therapies and dietary regimes to try to resolve their constipation.

Constipation, or difficulty passing bowel movements, can have several underlying causes. It is indicative of something not quite right in the gastrointestinal tract, and may be due to problems with the rectum evacuating (outlet constipation), a slow or lazy bowel (slow transit of bowel content). Other causes may be medications, diet or another medical condition.

An understanding of the underlying cause(s) of the constipation is critical before taking laxatives. Clinicians see many people who have suffered from constipation for many years and have tried every known laxative available, but by the time they seek medical help, may have caused irreversible damage to their bowel.

For example, the senna in Laxettes stimulates the bowel to move, but if used for a prolonged period of time, can do damage to bowel sensation and strength. Prolonged use of Epsom salts can actually destroy bowel function, with dire consequences.

There are many laxatives available over the counter that can be of help in the short term, but with prolonged use can result in another problem that’s even more difficult to treat.

If constipation is a problem for you, speak to your doctor or pharmacist before trying all the options on the pharmacy or supermarket shelves.

If you suffer from a long history of constipation and fit the scenario here, I suggest you speak to a continence nurse advisor on the National Continence Helpline (1800 33 00 66).

A woman has contacted the forum concerned about her 89-year-old mother whose rectal prolapse has reoccurred after repair surgery some years ago. Not only is her mother’s loss of bowel control distressing, she is experiencing considerable pain whenever standing, which causes the prolapse to slip out. Her mother, who also has mild dementia, is reluctant to have surgery.

Briefly, there are no reliable non-surgical treatments for this type of prolapse. Pushing the prolapse back in is helpful initially, but as the anus loses tone the prolapse tends to come straight back out. I am not aware of any truss or pessary that will hold the prolapse in, so it is usually necessary to consider surgery in these cases.

It is unusual for even very elderly patients to be truly unfit for surgery. Operations for prolapse can be done via a perineal approach (between the anus and vagina), and this type of surgery is easily done with an epidural if the patient is unfit for a general anaesthetic. There are two perineal procedures: the Delorme and the Altmeier procedure.

A Delorme procedure is where the mucosa (rectal lining) is stripped off the protruding bowel and a series of constricting sutures are placed to pull the rectum back up inside the anal canal. This operation has a high recurrence rate over five years but is usually very effective in the short term.

If the prolapse is very large it is reasonable to do Altmeier procedure. In this operation the entire piece of protruding bowel is removed and the colon is joined to the anus. This is a more radical operation but again, is surprisingly well tolerated, even in very elderly patients.

The final option, and possibly the best, is a laparoscopic ventral rectopexy. Using laparoscopy, the rectum is pulled back into its normal position and then a short piece of mesh is used to fix the rectum to the sacrum (the large, triangular bone at the base of the spine). This operation has a low recurrence rate and often results in almost normal bowel function with a lot less incontinence and constipation. We are doing this type of surgery more often in elderly patients, providing they can be given a general anaesthetic and can tolerate their peritoneal cavity being blown up with gas for an hour or two.

In the past we have been reluctant to operate on elderly patients with early or even established dementia but rectal prolapse causes major problems for them and their carers, and the best results with surgery are achieved if the prolapse has not been present for too long, and before the anal canal loses it resting tone or pressure.

Online Incontinence Forum moderator Jenny Verbeeck and colorectal surgeon Dr James Keck respond to some complex bowel issues raised on the Continence Foundation’s online forum.

There are many laxatives available over the counter that can be of help in the short term, but with prolonged use can result in another problem that’s even more difficult to treat.

If constipation is a problem for you, speak to your doctor or pharmacist before trying all the options on the pharmacy or supermarket shelves.

If you suffer from a long history of constipation and fit the scenario here, I suggest you speak to a continence nurse advisor on the National Continence Helpline (1800 33 00 66).

A woman has contacted the forum concerned about her 89-year-old mother whose rectal prolapse has reoccurred after repair surgery some years ago. Not only is her mother’s loss of bowel control distressing, she is experiencing considerable pain whenever standing, which causes the prolapse to slip out. Her mother, who also has mild dementia, is reluctant to have surgery.

Briefly, there are no reliable non-surgical treatments for this type of prolapse. Pushing the prolapse back in is helpful initially, but as the anus loses tone the prolapse tends to come straight back out. I am not aware of any truss or pessary that will hold the prolapse in, so it is usually necessary to consider surgery in these cases.

It is unusual for even very elderly patients to be truly unfit for surgery. Operations for prolapse can be done via a perineal approach (between the anus and vagina), and this type of surgery is easily done with an epidural if the patient is unfit for a general anaesthetic. There are two perineal procedures: the Delorme and the Altmeier procedure.

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Dr James Keck is a colorectal surgeon with a special interest in pelvic floor disorders, consulting at the Mercy Hospital for Women, Eastern Health, and St Vincent’s and Royal Women’s hospitals.

> Jenny Verbeeck is a continence nurse and researcher at the Flinders University School of Nursing and Midwifery.

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> Continence Helpline (1800 33 00 66).

> People can now talk anonymously and openly about the issues of bladder and bowel health. This is an opportunity to ask your questions in a safe environment and share your story – we’d love to hear from you!

> 10 bridge | Spring 2014

> www.continence.org.au

> continence.org.au/forum
A ll people value having independent bladder and bowel control, so much so that most of us will go to extraordinary lengths to maintain continence. Therefore, losing control of bladder or bowel function is devastating for most people, as is having to depend on another person for assistance to go to the toilet or to manage incontinence.

It is equally difficult for family members who find themselves caring for a person with incontinence. Caring for a person with incontinence is distinctly different to caring for a person without incontinence. Why? Because carers often have to perform tasks that are socially difficult and typically require a renegotiation of roles and relationships. Research shows that providing intimate hands-on care that includes touching, seeing, and smelling unpleasant body products is extremely difficult for both caregivers and care recipients. Family caregivers have been found to experience a range of emotions associated with caregiving, including:

- disgust at the need to handle body products such as urine and faeces;
- embarrassment at the care recipient’s nakedness or need for help with basic bodily functions; or
- hurt from the care recipient’s frustration and anger.

Family caregivers typically attempt to conceal negative emotions about caregiving in an effort to protect care recipients’ feelings of powerlessness and helplessness. Carers often feel compelled to project a caring approach and, at the same time, conceal and manage negative emotions. However, feelings of disgust about urine and faeces are visceral and they are difficult to conceal. Thus, caregiving is sometimes laden with unspoken tension. Caring and managing incontinence is further complicated if the person has dementia. A 2008 study by Dunham and Canon claimed dementia caregiving in a family situation involved a complex relationship that paradoxically created an experience of powerlessness by the caregiver. It found that in these relationships, the ones receiving the care were not powerless, but capable of encouraging and resisting attempts at providing care. In other words, the care recipient’s resistance to care can create a situation of powerlessness for the caregiver.

Of course, not all people with dementia resist care, but if they do it could represent their attempt to exert independence. Carers have to find a way to help care recipients in ways that are sensitive to their desire to maintain optimal independence.

Because incontinence can occur at any time, carers also find they need to be on their guard. At the same time, many carers become skilled at recognising when the person in their care needs to use the toilet, or when they experience an episode of incontinence.

Similarly, carers of people with dementia learn that a flexible approach works best. Knowing when to give care and when to back off are skills that many carers develop.

Another key strategy to avoid or minimise incontinence involves prompting, encouraging, and even physically assisting the care recipient to the toilet; either at fixed and regular intervals or just prior to their predicted voiding time. It is equally important for carers to consider their own emotional and physical needs. Caring for a person with ongoing care needs such as incontinence is constant. Indeed, incontinence is a key reason for carers to relinquish the caregiving role and seek formal care for the care recipient.

There are a number of resources available to support carers at home. Similarly, there are a number of assessment and treatment services available to diagnose and treat incontinence, including services that provide home-based continence nursing advice. For further information, phone the National Continence Helpline on 1800 33 00 66.

Dr Joan Ostaszkiewicz, RN, MN, PhD, is a post-doctoral research fellow at the School of Nursing and Midwifery, Deakin University.

Funding

The Australian Government’s Continence Aids Payment Scheme (CAPS) provides an annual subsidy of up to $545.80 for someone with permanent or severe incontinence to help pay for continence aid products. Contact the National Continence Helpline (1800 33 00 66) about eligibility and applying.

Stepping out

The National Public Toilet Map provides the details and locations of more than 16,000 public and private toilets around the country. Go to toiletmap.gov.au for further information or to download the app.

The free booklet, Help for people who care for someone with bladder or bowel problems, is available from the Continence Foundation. Call the Helpline for a copy.

Practical tips for carers

NCHL co-ordinator Steven Marburg offers these practical tips for carers.

Basic bladder and bowel health

Keeping the bladder and bowel as healthy as possible is critical for avoiding accidents. The best way to do this is to consume between 1.5 and 2 litres of fluid daily (including fluids from foods), eat a balanced diet that includes plenty of fibre-rich foods, exercise daily (including pelvic floor exercises) where practical, and establish a regular bowel-emptying regime. Learning the bowel’s natural rhythm is essential for regular bowel movements and for minimising the risk of accidents. The best time to empty the bowel is when the gastro colic reflex is felt. This is a mass movement of contents through the bowel that takes place between five and 20 minutes after eating — usually breakfast. By going as soon as the urge is felt, a good bowel action is more likely to occur and the chances of becoming constipated, which can be the cause of diarrhoea-like faecal overflow, is significantly reduced.

Products

Factors such as manual dexterity, level of ability, body shape and size, and carer accessibility need consideration before choosing products, and a continence nurse or physiotherapist can provide guidance about the most appropriate products. The Helpline (1800 33 00 66) staff can also provide contact details of your closest continence health professional.
Abena Premium Range

Choose the Abena Premium range for the very best comfort and security. Genuinely breathable material ensures that the skin is protected to the highest possible standard.

For more information or to place an order call 1800 655 152 or visit www.bunzl.com.au

THE FACTS ABOUT PROLAPSE

Many women aren’t aware of the prevalence or cause of prolapses. Three common myths are dispelled by Associate Professor Caroline Gargett, a senior research fellow of the National Health and Medical Research Council of Australia.

**MYTH 1:**
**Prolapses are rare**

*Fact:* Prolapses are common. One in four Australian women have one or more symptoms of pelvic organ prolapse; the most common being urinary incontinence. Half of all women over 50 who’ve had children will suffer urinary incontinence, many due to pelvic organ prolapse.

**MYTH 2:**
**You are not at risk if you’ve had a caesarean**

*Fact:* Giving birth by caesarean section doesn’t prevent pelvic organ prolapse because pregnancy is also a contributor. While the major cause is vaginal birth, ageing, heavy lifting, chronic constipation, chronic asthma and obesity exacerbate it.

**MYTH 3:**
**Only older women have prolapses**

*Fact:* Prolapse symptoms may be experienced during pregnancy, following childbirth or may only manifest many years later, particularly after menopause.

So what is pelvic organ prolapse?

A pelvic organ prolapse occurs when the muscles and ligaments supporting a woman’s pelvic organs (her bladder, bowel and uterus) become damaged due to over-stretching during pregnancy and/or tearing during the birthing process, causing the organs to slip out of place (or prolapse) into the vagina.

There are three types of prolapse: the bladder bulges through the front wall of the vagina (a cystocele); the bowel bulges through the back vaginal wall (a rectocele); or the uterus drops down into the vagina (uterine prolapse). More than one organ may bulge into the vagina.

The main symptoms of pelvic organ prolapse are urinary and bowel incontinence, difficulty in passing bowel motions, sexual problems and an uncomfortable feeling of bulging in the vaginal area.

Prevention and treatment

Preventive measures include doing daily pelvic floor exercises to strengthen the supporting muscles and ligaments of the pelvic organs. It is important pelvic floor muscle training is checked by an expert such as a pelvic floor physiotherapist or a continence nurse advisor to ensure they are being done correctly.

Treatment

Mild prolapses in the early stages can be treated without surgery. Treatments options include:

- pelvic floor muscle training;
- lifestyle changes (diet, fluid intake, exercise, weight loss);
- adopting good bladder and bowel habits; or
- the use of a pessary (a plastic or rubber device inserted into the vagina to support the uterus).

More severe prolapses can be treated with reconstructive surgical repair operations.

If you are experiencing any of the symptoms described and think you may have a prolapse, phone the free National Continence Helpline (1800 33 00 66) to speak with a continence nurse advisor.

Dr Caroline Gargett
The ins and outs of UTERINE PROLAPSE

Madeleine Hamilton, co-author of Sh*t on my hands: A down and dirty companion to early parenthood, offers this irreverent account of her uterine prolapse.

I’m a firm believer in the mantra “knowledge is power”, so before I became a mum I happily gobbled up any information women were willing to share about birth and parenting. I was all prepared for the delivery suite, breastfeeding and baby blues.

But there was one thing I was woefully uneducated about – uterine prolapse. Understandably, mums are reticent about regaling everyone about the state of their pelvic floor because, well, it’s embarrassing (and it might put others off having babies altogether).

Unfortunately, what I know about prolapse has been gleaned after having one. It is a very sad state of affairs that I – and so, so many other women – have no idea of the damage pregnancy and childbirth can wreak on our bodies. A prolapse usually occurs when the ligaments holding up the pelvic floor stretch substantially during pregnancy and childbirth, causing the uterus to descend. This in turn pushes the bowel and/or bladder against the vaginal walls. The first indication of a prolapse for many women is a frightening outward bulge of the vagina, often occurring after a bout of heavy lifting or a bowel movement. This bulge is the vaginal wall pushing out of the vagina entrance. Sometimes the prolapse is so profound that it is actually the cervix that pops out to say hello. Eek! No wonder women don’t like to talk about this stuff.

The risk of prolapse is greater if you’re a person with generally stretchy ligaments (all that crowing about being able to do the splits might come back to haunt you), have problems with constipation, and with each subsequent pregnancy.

Aside from never getting pregnant, the best way to reduce the risk of a prolapse is to become as deeply familiar with your pelvic floor as Miley Cyrus is with unflattering unitards. Next, work that pelvic floor like you’re Rocky training for a comeback. Go to websites like pelvicfloorfirst.org.au or download a clench-reminding app like the pelvic floor safe exercises app, do Pilates.

Quit worrying about what your thighs look like and focus on keeping your inside bits inside.

Now, what about the birth? While the risk of prolapse is reduced slightly by caesarean birth, avoiding vaginal birth will not eliminate the likelihood completely.

And lastly, there are many reasons why straining on the loo is less than ideal; forcing pressure down on your pelvic floor after childbirth is one of them. If you’re prone to constipation, adjust your diet and water intake before becoming pregnant.

A prolapse is not a medical emergency, and one can just live with the symptoms. However, there is something uniquely demoralising and uncomfortable about it.

If you think regularly wearing baby vomit and never finding time to wash your hair is bad for your post-partum self-esteem, the sudden appearance of a formerly internal part of your anatomy on the outside is infinitely worse.

While the early warning signs of a prolapse are evident, don’t be shy about seeking treatment if you’re feeling heaviness or pressure in the downstairs area, having trouble clenching your pelvic floor, experiencing leakage or any other unusual sensations.

The first thing I did was ring my maternal and child health nurse. She advised me to lie on my back with my feet up in the air. While this gave me time to ponder my need for a pedicure and whether our great grandmothers who birthed eight-plus children had to roll up their vaginal walls and tie them with a ribbon, it was a very short-term solution. Running around after crazed toddlers and attending to the constant needs of a newborn generally preclude long episodes of proneness.

Next, I made an appointment with a physiotherapist specialising in various busted parts of women’s anatomy. The bad news, she told me, was that the pelvic ligaments can’t be repaired without surgery. However, a program of pelvic floor exercises could lessen the pull of gravity. She also educated me about the correct posture and even noises to make while on the loo (did you know it is better to “hiss like a snake” than “grunt like a bear”? Best not to do either in a public convenience.)

Sex, she reassured me, was not only possible, but strongly recommended! Orgasms help tone the whole area. When, exactly, mothers of little children have the time or energy for sex is, of course, a separate question.

In addition, I checked in with a gynaecologist who charged me several hundred dollars to say that, yes, I’d had a prolapse, and I should keep up the pelvic floor exercises. Not keen on being sliced open, I was glad he didn’t recommend an immediate operation to fix those maxed-out pelvic ligaments, particularly as there was a chance of a prolapse reoccurring post-surgery.

If things didn’t improve he suggested trying a pessary; they’re like a diaphragm with the middle bit cut out and look like un-crumbed calamari rings. They help keep everything up.

Any last tips from the professionals? Yes. I must commit to a life with no heavy lifting. While I don’t secretly dream of challenging the current weight-lifting champion in the next Olympics, it is confronting to be so physically restricted in my mid-thirties.

Of course now that I’ve had a prolapse, I’m staggered to learn just how many women I know have been similarly afflicted.

“Ah yes, that happened to me too”; “I had to have surgery for it”; “I was never able to pick up my children or chop wood again.”

Why didn’t any of you ladies warn me? Well, Bridge readers, consider yourselves warned. All together now, CLENCH!

This article was originally published on www.kidspot.com.au
Down Syndrome NSW provided a unique learning experience for a group of adults with Down syndrome using a $1500 Community Health Grant from the Continence Foundation of Australia.

When applications for the Continence Foundation of Australia’s $1500 Community Health Grant opened earlier this year, the staff at Down Syndrome New South Wales knew exactly how the funds could be best put to use. A weekend camp away – the Up Club Healthy Living Camp – would mean the key messages about bladder and bowel health could be delivered in the most effective and appropriate manner for the 21 adults with Down syndrome who would attend.

Down Syndrome NSW’s grants and promotion officer Kate McNamara said people with Down syndrome didn’t always take up health promotion messages the same way as other adults. “Accessing information on the web doesn’t always work for people with Down syndrome,” Ms McNamara said.

“Communication can be a barrier, to both receive information and express themselves. They’re not so proactive in seeking help with issues like these, where the rest of the population may be better equipped,” she said.

Down syndrome is also associated with physical characteristics such as low muscle tone (hypertonia) and increased weight, which can challenge bladder and bowel control. “Or it can simply be about being engrossed in an enjoyable activity and not registering the signs,” she said.

As more people with Down syndrome gain independence and enter the workforce, responsibility for their own health and wellbeing becomes increasingly important. The key messages of the weekend, which were delivered by trusted staff and volunteers, were about the importance of healthy eating and drinking, exercise, prevention and early intervention. “Repetition is important to continue the message. A weekend gives them time to hear the message a number of times – to get the message out that you don’t have to just accept accidents, but can get help or make lifestyle changes,” Ms McNamara said.

She said raising the issues in a group situation among peers made it more likely the topics would be raised again, and the camp participants more comfortable revisiting the subject matter at a later date.

Down Syndrome NSW regards the camp as an important first step in raising awareness about continence management to adults with Down syndrome.

Planning is already underway for a fun run for people of all abilities, and a Step Up walk across the Sydney Harbour Bridge for people with Down syndrome and their families.
Q: My 12-year-old daughter is a talented, sports-mad athlete and does a lot of distance running. Should I be concerned about her pelvic floor, particularly as she approaches puberty and will inevitably gain height and weight?

A: The pelvic floor is a muscle like any other in the body and thus it needs to be trained to stay strong. The only challenge is that it does not get the same training as other muscles do in activities such as running or other athletic ventures. In fact, the pelvic floor will weaken with the impact and load of the body on this muscle group, so regardless of age, it needs specific training so that incontinence is not a result of rigorous training. So the answer is yes, and mainly because your daughter is doing so much training and not just because she is moving into puberty. Specific exercises that are done separately to her sports training will be of great value to increase strength and function of the pelvic floor and her core control.

Q: I used to go to the gym before becoming pregnant, but now that I’ve had my baby, I am reluctant to go because I leak when I exert myself, sneeze or cough. How will I ever get my pre-baby body back again?

A: Pre-baby body and fitness can return, but slowly. You personally have completed one of the biggest fitness challenges that can happen in a woman’s life, so this is now recovery time. The focus needs to be on how to get strong from the inside out and the first and most important muscle to focus on is your pelvic floor. Get a pelvic floor assessment and personal training program from a women’s health physio. You will start noticing that you will stop leaking when you exert yourself, sneeze or cough, and may also feel that you are gaining strength in your lower abdominal muscles and around your lower back. Your women’s health physio will also be able to recommend some exercises that are pelvic floor-safe so that you can start returning to exercise. Match up your outer body strength with inner body strength and you will eventually find yourself being able to return to a range of exercise options that make you feel empowered and confident.

Q: My gym instructor sometimes gets us to do planks and deep lunges, which I know aren’t good for my pelvic floor. What should I do? She’s great fun and energetic and I don’t want to hurt her feelings.

A: It’s great that you have awareness of what is right for your body. You are right, planks and deep lunges are not recommended and nor is any other exercise that you feel compromises your pelvic floor. It is important to understand that instructors in the fitness industry want to keep their clients safe. They might not know everything about the body like a physiotherapist does, but they are usually very happy to allow you to do other exercises or modifications. A great instructor will accommodate your needs and even find out what modifications there are for you to do. The first step is to have a conversation with your trainer before or after your workout and explain your situation. If they do not know where to start, you can suggest they check out the Pelvic Floor First website (pelvicfloorfirst.org.au) to find out more.

Q: When I go to yoga I have to work really hard to prevent myself breaking wind. Is this a problem, and why is it happening?

A: Passing or breaking wind is a sign that your pelvic floor is weakening and it is happening because of the increased intra-abdominal pressure in certain positions. This increased pressure pushes down on the pelvic floor, and if the pelvic floor is not strong enough to withstand the load, you will pass wind. Some people will also leak urine, depending on the circumstances. The best thing to do is to start focusing on strengthening your pelvic floor, as you do with your other muscles in your body. Performing correct pelvic floor exercises every day will strengthen your pelvic floor and you will find it easier to avoid this feeling in your yoga class. It is important you are doing them correctly and it is best to be assessed by a women’s health physiotherapist or continence nurse. They will also recommend repetitions and frequency of the exercises for you.

Q: How can I “screen” any prospective gym instructors so I know they are pelvic floor aware?

A: There is growing interest among the fitness community about pelvic floor awareness, and you will need to find out if your gym instructor knows anything about pelvic floor-safe exercises. The best way to screen is the most direct; by asking your prospective gym instructor if they know anything about Pelvic Floor First. If they have done any training in pelvic floor-safe activities, they will be well aware of this government-funded initiative. If they do not know, then you safely assume that they are not pelvic floor-aware.
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