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Whenever the subject of incontinence comes up we think of older people or women who’ve had babies. Indeed, the theme for our special project this year, Pelvic floor awareness in pregnancy, childbirth and beyond, targets mums and expectant mothers.

In keeping with this theme, we are preparing to launch our national campaign, Managing the mother load, during World Continence Week later this month. This year’s project will also see the launch of newly developed educational and consumer resources that aim to reduce the number of women suffering unnecessarily from bladder and bowel problems as the result of pregnancy and childbirth.

This edition also reports on the less common but highly debilitating issue of bedwetting among healthy young adults. About 2 per cent of the population is affected by this chronic and rarely disclosed problem, which can have a profound impact on their lives. Researcher Glenice Wilson, who first became aware of the issue about 30 years ago, provides a disturbing insight into the lives of those affected and, most importantly, offers hope for sufferers.

Hope is also the theme for our story about Gerard, a retired librarian who has been caring for his elderly mother for several years. Gerard struggled for years to manage his mother’s faecal incontinence, but it was only after he contacted the National Continence Helpline that he was finally able to prevent the dozens of accidents his mother had been having each year.

Happy reading,

Maria Whitmore
Editor

From the editor
A recent US study has found that yoga may be effective in treating urinary incontinence in women. Twenty women aged 40 and older, all of whom experienced urinary incontinence on a daily basis, were recruited for the study. Half the women took a six-week yoga therapy course, and half didn’t. At the end of the six weeks, the yoga group had a 70 per cent reduction in the frequency of urine leakage – predominantly stress incontinence. The yoga program used in the trial was specifically developed to be safe for older women, including women with minor mobility issues. The researchers hope to build on this study to double the length of the trial to 12 weeks. The University of California study will be published in Female Pelvic Medicine & reconstructive Surgery, the official journal of the American Urogynecologic Society.

**Will you age well?**

Australian research has found there are different contributing factors for men and women determining whether or not they are “ageing well” in the community. The study defined ageing well as “living independently and being in good physical and psychological health”. It found that for men, the key factors were of a social nature, whereas for women, they were more physical.

For women it found three key risk factors: incontinence, low body mass index and lower physical activity. For men, the key risk factors were: perceived strain, lower levels of social activity, perceived inadequacy of social activity, low perceived social support and being a current smoker. The findings, presented at the International Centre for Scientific Debate in Barcelona in January, are based on a 2006 follow-up of a longitudinal study that has tracked 1000 community-dwelling older people since 1994.

**Depression linked to incontinence**

A new US longitudinal study that followed 4511 women for a period of 16 years has found a link between urinary incontinence and depression. The women were interviewed biennially, and the study found that the 727 (17%) women with urinary incontinence at the start of the study had an almost 50 per cent greater risk of suffering from depression than the other women. The research was published in the Journal of Obstetrics and Gynaecology in April this year.

**Will the students continue to promote continence awareness in their roles as midwives?**

Yes, most definitely. They now understand the need to focus on antenatal education and early screening, detection and management of women at risk of long-term continence issues, during the antenatal, intra-partum and postnatal period. And the topic will continue to be delivered here at FedUni, providing students with resources and information to promote a greater depth of understanding of the issues.

**Would you recommend other midwifery schools incorporate continence awareness, screening and detection into their curriculum?**

I would recommend that all midwifery curricula include a module on continence. This is an important public health issue, with many elderly people put into long-term care because they become incontinent, and far more women than men becoming incontinent as they age. This is largely due to the impact of pregnancy and childbirth, so it’s terribly important women are aware of the issues, risks and basic prevention strategies.

Midwives are most commonly the primary care providers during the antenatal, intra-partum and postnatal period, and so are ideally placed to provide this essential service.
WOMEN'S HEALTH

MANAGING THE MOTHER LOAD

Pregnancy and childbirth are two of the major life events associated with urinary incontinence, which is why the Continence Foundation of Australia is launching an awareness campaign focusing on maternity this month.

Most mothers agree; once you have a baby your life changes forever. But there are some things that don’t have to be altered quite so permanently, and one of them is your pelvic floor.

One in three women who have ever had a baby experience some form of urinary incontinence. Moreover, of the 4.2 million Australians (aged 15 years and over) affected by urinary incontinence, 80 per cent are women, with problems arising primarily after childbirth and menopause.

Unfortunately, a significant number of women ignore the problem or accept it as normal. But it’s not normal and will only get worse if left untreated.

The Continence Foundation’s project, Pelvic floor awareness in pregnancy, childbirth and beyond, aims to prevent pregnancy-related incontinence and reduce the number of women unnecessarily putting up with urinary incontinence after childbirth.

The project’s main initiatives are directed at the two key parties: midwives and expectant mothers.

1. Midwives: The Continence Foundation has been delivering a series of national educational seminars to midwives about the importance of protecting the pelvic floor before, during and after childbirth.

The Foundation, in collaboration with the Australian College of Midwives, has also developed an online course for midwives about the impact of pregnancy on pelvic floor dysfunction, to be officially launched during World Continence Week, June 23-29.
2. Expectant mothers: A range of new resources has been developed for expectant mothers, including The Pregnancy Guide booklet and the Pregnancy Pelvic Floor Plan smartphone app (available from Google Play and iTunes) – both with a focus on pelvic floor health. The Pregnancy Guide will be distributed nationally in Mother To Be bounty bags and is also available from the Continence Foundation of Australia. The Pregnancy Guide and the smartphone app will be officially launched during World Continence Week, in conjunction with the Foundation’s national awareness campaign, Managing the mother load.

The campaign aims to raise awareness among mothers of all ages, along with health professionals, about the lifelong prevention and management of urinary incontinence, which has a one in three risk of developing after pregnancy and childbirth.

The Continence Foundation’s project manager and health promotion officer, Samantha Scoble, said women needed to prioritise their pelvic floor health by incorporating pelvic floor exercises into their daily routine. She said clinical studies showed that pelvic floor muscle exercises were effective in treating incontinence among pre and postnatal women.

KEEPPING MUM ABOUT CONTINENCE

Outdated attitudes, such as accepting incontinence after childbirth as normal, are alive and well, even among the most educated in the community.

S
doary school teacher and mother of two Jessica Scurry, 37, was mortified to discover she had lost control of her bladder after introducing her eldest child, then aged three, to trampolining – one of her favourite pastimes before becoming pregnant.

Her next reaction was one of resignation. “I realised then that I wasn’t ever going to be able to go trampolining again,” Jessica said.

“I didn’t tell anyone about it or do anything because I just accepted it as a fact of life post-babies.”

Jessica said pelvic floor exercises were rarely mentioned during antenatal classes with her first child, Frank, now four-and-a-half.

“I think I probably did a few pelvic floor exercises before and after the birth, but that was all,” she said.

While pregnant with daughter Mari, now 18 months, there was no discussion she can recall about pelvic floor care during antenatal classes or after her birth.

“I was sent home three hours after she was born. A nurse visited me at home for a follow-up on day two for about an hour, and she came back one or two more times after that,” Jessica said.

Again, no mention was made of her pelvic floor or incontinence issues. Other more pressing matters, such as difficulty breast-feeding, took precedence.

“I guess it wasn’t considered to be a pressing issue,” she said.

Even her mother, a midwife herself, never broached the topic.

“My father says mum’s always rushing off to the toilet anyway, so she probably has continence issues herself. He says, ‘she’s had five kids, it’s a fact of life.’”

Jessica is typical of many young mothers who remain ignorant of the importance of maintaining a strong pelvic floor, particularly during pregnancy and after childbirth.

She believes there is still a stigma attached to urinary incontinence, even though it occurs in one in three women who have ever had a baby.

“Even in my mothers’ group, where a lot of things are talked about and laid bare, no-one talks about it. Incontinence is not discussed,” she said.

“I think the sanitary pad market is so good now that a lot of people just use pads and accept incontinence as normal.”

Five steps for a healthy pelvic floor

1. PRACTISE GOOD TOILET HABITS

Don’t get into the habit of emptying your bladder when it’s only half full; go only when you get the urge. And when you go, don’t rush. Be sure you empty your bladder fully or you may risk a bladder infection.

2. MAINTAIN GOOD BOWEL HABITS

Ensure you consume enough fibre and liquid to avoid constipation, because straining on the toilet can strain and weaken your pelvic floor muscles.

3. DRINK PLENTY OF FLUIDS

Ensure your daily fluid intake is 1.5–2 litres, unless your doctor advises otherwise. Avoid excessive alcohol and caffeinated drinks (including cola), which can irritate your bladder.

4. LOOK AFTER YOUR PELVIC FLOOR MUSCLES

Learn the correct way to do your pelvic floor exercises (go to continence.org.au or phone the National Continence Helpline (1800 33 00 66)) and do them every day. You can also be guided by your doctor, continence nurse or physiotherapist.

5. EXERCISE REGULARLY

Walking is great, but if you want to be more active, engage only in pelvic floor-safe exercises that do not put excess strain on your pelvic floor. (Go to pelvicfloorfirst.org.au for more information.)

If you experience any leaking, have to rush to the toilet often, have to go more than eight times a day (or more than two times at night), or have experienced any changes to your regular bladder habits, contact the National Continence Helpline (1800 33 00 66) or see your doctor, continence nurse or physiotherapist.
My mother has dementia and won’t stay on the toilet long enough to open her bowels. How do I get her to stay?

Most people usually have a lifelong routine time of the day when their bowel opens. Some open their bowel daily, others two to four times a week. Try recalling the pattern and time of day that your mother went to the toilet before being diagnosed with dementia. By maintaining that old routine, there may be less likelihood of accidents, and possibly better compliance with staying on the toilet.

Consider things such as comfort and temperature. Try pasting a picture of a toilet on the back of the door to help orientate her. If she was in the habit of reading on the toilet, give her something to read. (Even if they can’t read anymore, the familiarity settles them.) Try giving her a knotted pair of socks or panty hose to untie to keep her occupied, or try some music. Above all, remain calm. If all else fails, consult a continence nurse experienced with dementia clients. This is a common scenario and there is often no easy answer as each situation presents its own variations.

My husband refuses to use the toilet while we’re out, and then wets himself on the way home in the car. Do you have any suggestions?

You might try asking him to accompany you to the toilets because you need to go, and he should hopefully follow without resisting. You can then help him go as well (you may have to explain the situation to the other toilet users).

People with dementia, when confronted with an unknown situation or environment, are likely to refuse to comply. There are many steps involved in the process of toileting (21 in all), which can be terrifying if you don’t have the cognitive capacity to organise yourself.

My friend is a resident at an aged care facility as the result of a stroke. She has to be toileted using a steady frame for mobilisation, and her incontinence is getting worse by the day. How can I help her to see the need to do pelvic floor exercises more stringently?

Often when we think of bladder leakage our first response is to think of pelvic floor exercises. But strokes present their own set of problems and a proper continence assessment is critical in order to identify what’s going on. Strokes often present with urinary urgency and urge incontinence, which is troublesome enough without the stroke.

The first thing to consider is a urinary tract infection, for which the nursing staff can test quite easily. If this tests positively, a referral to the GP should follow.

Occasionally the bladder may not empty properly following a stroke and this needs to be determined by either consulting a doctor or a continence nurse with access to a bladder scanner.

The nursing staff should also consider constipation as possibly contributing to her incontinence. If the problem is still unresolved, contact the National Continence Helpline (1800 33 00 66). You can also go to the resources section on the Foundation’s website (continence.org.au) and search for the Stroke and bowel health fact sheet.

Speaking confidentially ABOUT DEMENTIA

Some of the most difficult issues raised on the Continence Foundation’s online support forum relate to dementia and age-related conditions. These edited extracts are typical of the issues being discussed, with advice provided by continence nurse, researcher and forum moderator Jenny Verbeeck.
Uncovering bedwetting in adults

Most children stop wetting the bed by about the age of six. But for a section of the population, bedwetting persists into adulthood and, as Maria Whitmore discovers, often with debilitating social and psychological consequences.

Some children never grow out of bedwetting. For between 1 and 2 per cent of the population (with males outnumbering females 3:2), the problem continues into adulthood. But you would never know. The embarrassment and shame is so extreme, the problem is rarely spoken about and virtually unheard of. This is why Glenice Wilson, a nurse with more than 50 years’ experience across a range of settings, decided to undertake a masters’ degree at Curtin University to investigate the “lived experiences” of young men with night-time bedwetting (nocturnal enuresis).

Ms Wilson said she first had an idea the condition existed while working as a school nurse in a West Australian country high school in the 1980s. She began to receive the odd note from parents asking her to excuse their 16-year-olds from school camps.

“Then a few more came in and I began to wonder if perhaps it might have been because of bedwetting. Bedwetting at 16? I didn’t think so, so I shrugged it off,” Ms Wilson said.

It was only when her daughter, then a student at the same school, told her she’d befriended a girl who had become isolated from her peers because of her smell, that she realised her suspicions might have some basis.

“My daughter, who was 14 at the time, told me about this girl no one wanted to be friends with because of her smell. And then she whispered, ‘mum, it’s wee’.”

The plight of these young adults had such a profound effect on Ms Wilson that in 1995 she began investigating the condition in a pilot study with the University of Western Australia, using the support of fifth year medical students. In the 19 years that have transpired, Ms Wilson has found it become increasingly difficult to recruit young adults suffering from nocturnal enuresis for research purposes.

“If anything, the taboo is getting worse,” she said. The lack of qualitative research on the subject was the reason Ms Wilson embarked on her current research with Curtin University.

“There is very little research about the ‘lived experience’ of persistent night-time bedwetting. When I interviewed these men it was quite shattering for them to tell me how life was for them,” she said.

Ms Wilson said the impacts on sufferers included voluntary withdrawal from normal activities that other young adults take for granted, such as socialising, forming romantic attachments and even pursuing certain lines of occupation.

One of the most despairing aspects for the majority of those interviewed, she said, was their denying themselves opportunities to pursue romantic relationships because of feelings of shame and unworthiness. Ms Wilson said it was a tragic irony that these young people were effectively denying themselves any opportunity to be treated and possibly cured because they kept the problem hidden.

“Night-time bedwetting is so easily curable. The main message is getting the problem out of hiding. How do we expose this problem to the community?” she asked.

“There also needs to be more frank discussions about the ‘lived experiences’ of young men with incontinence issues in the general community. The subject is taboo and it is time to bring it out into the open.”

Ms Wilson encouraged adults affected by nocturnal enuresis to phone the National Continence Helpline (1800 33 00 66), where they could speak confidentially with one of the continence nurse advisors.

>> She also welcomed any communication from sufferers via email at wilsong4@bigpond.net.au. Her thesis can be accessed online or by emailing her directly.

**SAM’S STORY**

On the weekends, Sam, 24, plays A-grade soccer at his local club. Monday to Friday he works as an articles clerk at one of the city law firms.

His life revolves mainly around his work and soccer, which he plays locally. Despite his passion for soccer, Sam has refused an offer to join the combined team, which travels to away games on long weekends. Very rarely will Sam go out for a social drink with the boys after the game. He says his friends wonder why he is so distant socially, pushing them away and not joining in at various functions.

Sam feels his social isolation started when he moved out of home. His mates had begged him to house-share, but he knew his family (specifically, his mother) would not be there to cover for him and his hidden problem.

Despite being told that he would grow out of the problem, Sam has not stopped wetting the bed and the odour and washing are so embarrassing he could never contemplate house-sharing.

He said bedwetting has had a huge impact on his self-esteem, mood swings, personality and has even influenced his career path.

Sam has resolved to never find a partner in view of marriage, as he does not want to pass on the condition and have his children suffer as he has.

A personal relationship was out of the question, he said, hence his refusal to join in with his friends socially.

>> For more stories about young men affected by nocturnal enuresis, email wilsong4@bigpond.net.au

**FACTS**

- Between one and two per cent of young men and women experience nocturnal enuresis.
- It is more common in males than females with a ratio of 3:2.
- If one parent wet the bed past the accepted dry stage of five to six years, the child has a 40 per cent chance of doing the same.
- If both parents wet the bed, the child has a 70 per cent chance.
- If neither parent wet the bed, the child has a 15–20 per cent chance.
- A familial gene is strongly associated with bedwetting.
- One per cent of men entering the armed services during World War II were bedwetters.
- Treatment is available from general practitioners or urology specialists and can be as simple as medication once bladder and/or kidney problems have been ruled out.

**Glenice Wilson**

**www.continence.org.au**
A GOOD CALL

Gerard* was cleaning up about 25 of his mother’s faecal incontinence accidents each year until he spoke with continence nurse Lisa Churchward from the National Continence Helpline. That was in February, 2012, and his mother has hardly had any incidents since, as Maria Whitmore discovers.

Although delighted about his mother’s improvement, Gerard is troubled by the period of time it took to get the right advice. “I often wonder why I wasn’t given this information earlier. I think there might be a trend for the stimulant treatments as a first course of action and, once started, that course of action seems to automatically continue,” he said.

Ms Churchward said it had been an extremely challenging period for Gerard and his mother. “It’s a shame when people in the community don’t have follow-up health care, so that problems can be identified early and the correct management instigated,” she said.

In the year since Gerard phoned the Helpline, his mother had only two incidents of faecal incontinence. In the following year, 2013, there was only one, and so far this year, there have been none.

“I don’t think I could overstate the gratitude I feel towards Lisa and the Helpline service,” Gerard said. “The advice received was crucial, and I certainly won’t hesitate to use the Helpline in future, nor would I hesitate to recommend the service to anyone with continence needs.”

* Surname withheld.

CARERS

Continence and Parkinson’s Disease

Parkinson’s Victoria clinical nurse consultant and health team manager, Victor McConvey, gives an overview of how Parkinson’s Disease affects bladder and bowel function.

Continent is acknowledged as one of the most confronting and difficult symptoms for people living with Parkinson’s – and their carers – to manage. Bladder and bowel function are both interrupted in Parkinson’s, but with good management these difficulties can be overcome, and the impact of the symptoms effectively reduced.

An early and persistent difficulty in Parkinson’s is constipation, which is partly caused by reduced physical activity. Further to this, the cells in the gut that produce dopamine are also affected, reducing in number and slowing down the peristalsis (or gut movement).

Problems with constipation are a frequent subject for calls to the Parkinson’s Infoline, and are the second-most common reason someone with Parkinson’s will present to a hospital emergency department.

 Constipation is best managed by ensuring you don’t become constipated in the first place! Drinking plenty of fluid, keeping active and increasing the fibre in your diet is a good place to start.

For many people, however, adding a constipation medication (aperient) to assist with maintaining normal bowel elimination is often essential. An aperient that will lubricate or soften and provide bulk to the stool is preferred over aperients that stimulate the muscles that increase gut movement and may cause abdominal cramping or bloating.
Once I was disconnected from the catheter, my control was marginal. I remember racing to the bathroom and not making it. How embar-rassing! Pads and special pants were the order of the day.

I was doing my exercises all the time and my mind was on wee ing matters most of the day. Doubts entered my mind. Would I ever be able to control myself?

I felt I was reduced to being an “old man with problems” – chair-bound with quick trips to the toilet and regular changes of pads. Progress was quick, however, and a week later my wife and I went shopping, although we had to make sure there were toilets nearby.

After three weeks I was able to resume my volunteer work and I started to feel myself again. Slowly my incontinence improved and after about three months, I thought, was back to normal – until my neighbour asked me to help shift a heavy flower pot!

I resumed jogging at about this time too and remember when I was halfway up a mountain and felt myself “go”. Luckily I was wearing a long shirt that covered my embarrassment.

At four months down the track, I felt on top of the world. I didn’t have to get up during the night. That was problem number one cured.

Problem number two? The first time I felt sexy again, I followed the physiotherapist’s advice – with good results. However, for me it’s like preparing a three-course meal and ending up with a sandwich.

We’re both in our seventies. We don’t consider ourselves past it and we’re happy with what we’ve got. On the scale of 10, my orgasm is now a two, but as long as I can give my wife her nine or 10, I’m happy, and so is she.

I don’t think an injection or any other available measures will change that, but I’m open for suggestions.

In my follow-up checks, my doctor tells me there is still a very small PSA reading. These mini PSA readings are going to haunt me, and now I’m back in treatment, having radiotherapy.

For the next six weeks, every day apart from weekends, I have to empty my bladder and bowel and drink 500ml of water before I arrive for radiotherapy.

It may sound easy but your insides are not always ready: I’ve got to stay positive and get on with it, as they say.

I’m writing a booklet dealing with my experiences, especially my thoughts, fears and joys. It helps me cope.

> Johan Luidens, a former radio officer with the Dutch Royal and merchant navies, migrated to Australia with his wife in 1971. He is now retired and can be contacted by email at helen.johan@hotkey.net.au for information about his booklet.
When the pelvic floor can take no more

The consequences of ignoring the pelvic floor when exercising can be traumatic and dramatic, as two of Katherine Modoo’s patients discovered. Maria Whitmore reports.

Katherine Modoo, a continence nurse advisor at the Sunraysia Community Health Service in Mildura, was left speechless recently after two patients presented to her clinic with disturbingly similar problems.

The women, one in her 40s and the other in her 60s, had both re-prolapsed after embarking on a vigorous fitness and exercise program. “The woman in her 40s was quite devastated; she’d had a vaginal repair after childbirth and had decided to start exercising to lose a bit of weight,” Ms Modoo said.

The older woman, who’d had a surgical sling repair done on her vaginal prolapse several years earlier, had put so much strain on the repair that it was no longer able to contain her prolapse.

According to the two women, their personal trainer had incorporated weight-bearing exercises and lunges into their fitness program, without any consideration given to their pelvic floor strength.

“It’s a bit of a worry that there are personal trainers out there who aren’t aware of the risk to the pelvic floor when exercising,” Ms Modoo said.

She said women, particularly those with a history of pelvic floor problems, should consult their doctor or health professional before embarking on any new exercise program. “It’s great to want to exercise and be healthy, but if there are any exercises that risk damaging the pelvic floor, women need medical advice from the doctor or the surgeon (who did the work) so there’s no risk of injury or a repeat of the prolapse,” she said.

Ms Modoo said there were many ways to get fit and lose weight without risking the pelvic floor. “When the younger of the two women told me she wanted to lose weight, I thought, ‘oh no! Why didn’t you go walking or swimming?’ There are so many other ways to exercise that are friendly to the pelvic floor,” she said.

Ms Modoo recommended people go to the Continence Foundation’s Pelvic Floor First website (pelvicfloorfirst.org.au) for an overview of safe exercises. “It’s a fantastic website with fact sheets and lots of other resources for personal trainers and anyone who wants to exercise without injuring their pelvic floor,” she said.

“Professional personal trainers should ask the questions. I know the Continence Foundation of Australia has worked really hard with the Australian Fitness Network to have a content component in the personal training courses.”

For consumers

• Download the free Pelvic Floor Safe app (from iTunes or Google Play) and customise your exercise routine to suit your level of fitness.

• Go to pelvicfloorfirst.org.au for a comprehensive overview and greater detail of pelvic floor-safe exercises.

• Phone the National Continence Helpline (1800 33 00 66) and talk to one of the continence nurse consultants about pelvic floor-safe exercises.

For health and fitness professionals

• The Continence Foundation, in partnership with the Australian Fitness Network, has produced an accredited online education course for health and fitness professionals. The two-part course (Part 1: Positive Practice for the Pelvic Floor, and Part 2: Proactive Programming for the Pelvic Floor) is ideal for Certificate III or IV-qualified instructors who want a thorough understanding of the importance of pelvic floor muscles. Go to pelvicfloorfirst.org.au and click on the Fitness professionals tab.

• State-based health promotion officers are available to present group information sessions for health and fitness professionals. For more information, contact the Continence Foundation on (03) 9347 2522.
**Q:** My son is two and a half and has been using the potty for about eight weeks. He is very happy to wee on the potty, but will only poo when he has a nappy on (for his day sleep or at night). Does this mean something is wrong?

**A:** This may or may not be the beginning of withholding behaviour. It certainly suggests he is not completely comfortable about pooing and is waiting for the security of his nappy.

If he is pooing regularly with soft, formed stools and without any distress, then this may be a brief transition phase. It is important to praise him for all his bowel actions and not to give mixed messages by showing disappointment that he has not used the potty. It may even help to give a reward for each poo, such as a stamp or a sticker.

At this stage it is easy for his mild apprehension to become fear and withholding, which will then lead to a vicious cycle of painful stools and further reluctance to poo. If he does develop withholding behaviours and more overt fears such as hiding when he poos, refusing to be approached, crying and posturing (legs crossed, up on toes, “dancing”), it is important to intervene quickly with stool softeners or lubricants to prevent pain and further distress.

For some children it can be helpful to offer, for a period of time, a nappy when they need to poo, and then they can be gradually transitioned to the potty or toilet when they feel comfortable.

**Q:** My six-year-old daughter has damp underwear when she comes home from school each day. She tells me she thinks that drips come out when she is walking back to class. What does this mean?

**A:** This sounds most like a condition called urethrovaginal reflux (or vaginal entrapment) of urine. This needs to be distinguished from overactive bladder, which is the other common cause of small volume urine leakage in young children.

A careful history is often all that is required to make the diagnosis. In overactive bladder, the leakage happens prior to going to the toilet, and the child will usually experience urgency, frequency and may develop posturing.

If the cause is urethrovaginal reflux, the child won’t usually have urgency or frequency, but will describe wetness occurring after they go to the toilet. This occurs because some urine has collected in the lower vagina and then drips out on standing up.

This condition is quite common, but often not recognised initially. It is more common in girls who are overweight or in children who rush to the toilet and don’t take time to pull down their underwear fully, so they’re not in the correct sitting posture.

A simple test for urethrovaginal reflux is to ask the girls to try to wee facing the cistern for a day or two at home. Ask them to sit backwards, astride the toilet. This position will ensure they separate their legs and lean forward, which directs the urinary stream downwards into the toilet and not across their perineum (the area between the vulva and the anus), where it pools in the vagina. If this stops the wetting, you have your answer and it is now a matter of re-educating the child and family about the correct posture when weeing.

Ask them to:
- Sit steadily on the toilet brim with legs fully supported and well apart.
- Lean forward as far as they can go, which makes the pelvis tilt forward and the urinary stream more vertical.
- When finished, use toilet paper to press on the perineum to empty any urine from the vagina.

**>> Professional support from the Continence Foundation about continence issues in children is available from the National Continence Helpline (1800 33 00 66) and the Continence Foundation website (continence.org.au). The website also has an online support forum (continence.org.au/forum), where parents can find support by chatting to other parents.**

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**Do you have a question?**

**Ask the experts**

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