Pushing the limits
A core issue | 10
Welcome to the summer edition of Bridge. The content of a number of articles in this edition draws on the experiences of individuals who have been affected by incontinence and have generously shared their stories.

Young women Dimity Telfer and Hannah Brown, who both suffered from faecal incontinence throughout their childhood, describe the relentless bullying they endured at school, and how they managed to survive those days relatively unscathed.

Young mothers Rachael Thompson and Vicky Lewis tell us how their awareness of their pelvic floors became an important priority after their traumatic labours, and we speak to a young man who has to live with urgency incontinence for the rest of his life, the consequence of a spinal injury resulting from poor weightlifting technique.

These personal stories are powerful because they remind us of our vulnerability. Mishaps, misfortunes and mistakes can have profound impacts, not only on our bladder and bowel health, but on every other aspect of our lives as well.

I hope these articles inform and engage you. Keep the feedback coming at bridge@continence.org.au

Maria Whitmore
Editor

About us...

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

Become a member

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

The findings of a recent Loyola University study that looked at men’s level of physical activity and compared it with the incidence of nocturia (getting up to go to the toilet more than two times a night) suggests that men who are physically active are less likely to be affected by nocturia.

The study looked at data from 28,404 men aged between 55 and 74 years who had symptoms of enlarged prostate (also known as benign prostate hyperplasia or BPH), of which nocturia is a common and bothersome one.

It found that men who engaged in physical activity for more than one hour a week were 13 per cent less likely to report nocturia, and 34 per cent less likely to report severe nocturia (getting up more than three times a night).

Nocturia can result from BPH, when the enlarged prostate squeezes the urethra (the tube that runs through it and empties the bladder), causing difficulties with bladder emptying.

BPH is benign and the most common prostate disease, often starting around the age of 40 years and affecting most men eventually. The prevalence of nocturia also increases with age, and is estimated to occur in more than half of men aged between 70 and 79 years.

The study was published in the March, 2015, edition of Medicine & Science in Sports & Exercise.

What led you to this field of work?
I did my specialist training in obstetrics and gynaecology and have always enjoyed working with children and young adults, so sub-specialising in paediatric and adolescent gynaecology was an easy choice. I was fortunate to obtain a position at the Royal Children’s Hospital (RCH) in Melbourne to do a fellowship in this area and it’s been a perfect fit for me. As part of my fellowship role, I gained exposure to the work done by the Gender Service at RCH. This piqued my interest and I began working with young people who identify as transgender or gender diverse. I also work in more traditional areas of adult obstetrics and gynaecology, but working with young people is my passion.

Tell us something about transgender health.
Caitlyn Jenner, John Jolie-Pitt, Cate McGregor and Andreja Pejic have all become household names recently, which has brought gender diversity into our national consciousness. Organisations such as Transgender Victoria have also been working for many years to steadily break down stereotypes. Approximately 1 per cent of the population identify as “trans” or gender diverse.

Trans is an umbrella term to include people who identify as transgender, gender non-binary and gender non-conforming. Many trans people report knowing they were trans at a very young age, but not all young children who express feelings of gender variance will grow to be trans. Unfortunately, trans people face marginalisation and discrimination in many areas of our society and the suicide rate in unsupported trans teenagers is astronomical.

Being trans does not define someone’s sexuality; trans people can be gay, straight, bisexual, asexual and have the same joys and problems in relationships as everyone else. Many people who identify as trans will choose a name and pronouns (such as she, he or them) that fits better with their gender expression. Trans and gender-diverse people have all of the usual medical issues of our population plus may require specialist care if hormone therapy, surgery or parenthood are desired.

Why do you have a particular interest in this area?
It’s important, interesting and I learn something new from every young person I see. It’s also wonderful working as part of a strong and broad multidisciplinary team in the RCH Gender Service. Dr Michelle Telfer and Dr Campbell Paul have created a world-leading and innovative service to support young trans people in all aspects of their health and wellbeing.

Unlike most doctors, obstetricians and gynaecologists learn to care for people in life-changing, but mostly healthy situations - such as childbirth - as well as when they are sick or injured. This translates well to working with people who identify as trans. Most trans people I see are not sick or injured, but many are going through life-changing situations. Their parents and families also need support - just like during childbirth!

Can you tell us about your work?
Most of my work is in education around hormones and fertility. My gynaecology background gives me a unique angle as I also work with young women who have inherited or acquired fertility problems. Most young trans people I see are interested in keeping their fertility options open and are relieved to talk about the various options. Menstruation can also be distressing for some young people and, as a gynaecologist, I have lots of strategies to help. I also have a good understanding of all the various contraceptive options available for young people.

What are your goals for the future?
While people identifying as trans is not new, a critical mass of interest and awareness has occurred recently and I’ve been lucky enough to enter the field while this rapid growth is happening. I hope to keep working, learning and researching with wonderful young people.

Dr Charlotte Elder, an obstetrician and gynaecologist at the Royal Children’s Hospital has a special interest in paediatric and adolescent gynaecology and transgender health. She recently presented at the 24th National Conference on Incontinence, and describes her work in this specialised, relatively unknown field.

(continent.org.au | Summer 2015 | bridge)
Trouble in the Schoolyard

Bullying can take a toll on the mental health of school children affected by incontinence. We speak to two young women and hear how they survived years of faecal incontinence and schoolyard bullying.

One in five primary school age children, average age six years, will wet themselves during the day, and one in 25 will accidentally soil themselves. While most children will eventually gain control over their bladder and bowel, some will continue to experience incontinence, with one in 60 children aged 11 and 12 years still having regular soiling accidents.

There is plenty of research telling us these children are at a greater risk of being bullied or of becoming bullies themselves, and of having mental health problems.

Dimity Telfer, 29, was affected by faecal incontinence during her primary and secondary years growing up in Broome, and had to work harder than most to develop her confidence.

“No one would let me join their group or pair voluntarily; I had to be the extra person and I was always last picked in sport teams. Very few people would invite me to their birthday party,” Dimity said.

Of the few friends she made at school, she keeps in touch with only one. “He is also an only child, like me, and also suffered from childhood incontinence (encopresis). We never mentioned it to each other. I know he was also constantly bullied,” Dimity said.

As a child Dimity loved performing, but it was only as an adult she found the confidence to tell anyone or to pursue her passion. She now is a budding actress and has featured in the 2015 US movie, A Horse for Summer, starring Dean Cain, as well as Australian movies, Bran Nue Day, Blue Dog and Walkin’ it Out.

A few years ago she joined the Sandfly Circus and is now a circus trainer and regular performer with the troupe.

She also met with Hannah’s teachers and explained her daughter’s condition. “We agreed that she could be allowed to leave the classroom to use the toilet just prior to breaks, and they often sent a safe buddy with her.

Hannah managed to find a positive through all this. “I suppose it was good in a way, having the accidents - at least I knew who my true friends were,” she said.

Hannah had two “real best friends”, who remain good friends to this day. Her mother, Jacqueline, a registered nurse, went to great lengths to ensure Hannah was equipped to deal with incidents at school, whether caused by other students or her faecal incontinence.

“From my perspective it was about making sure Hannah had the tools to fix a pooey situation on her own - clean underpants, track pants, wet wipes, a shopping bag to put the dirty stuff in,” Jacqueline said.

She also met with Hannah’s teachers and explained her daughter’s condition. “We agreed that she could be allowed to leave the classroom to use the toilet just prior to breaks, and they often sent a safe buddy with her.

I gave them written information about her condition, and made myself available to collect her at any time,” Jacqueline said.

According to Jacqueline, some teachers were better equipped than others at addressing the bullying. She even offered to speak to Hannah’s class, but Hannah wouldn’t allow it.

As a result of Hannah’s experiences, Jacqueline wrote two books, A Wee Secret and Poo Hoo, both available from the New Zealand Continence Association.

Community psychologist and KidsMatter national project manager with the Australian Psychological Society, Dr Lyn O’Grady, said schools were very aware of bullying and its negative effects.

“Schools often have social and emotional learning programs that help children learn skills to manage their own emotions, understand...
THE SCHOOLYARD

others and get along with each other,” Dr O’Grady said.

Parents and family members’ attitudes played a crucial role in helping children understand the world around them, and to tackle challenging situations, including experiences of incontinence, she said.

“Parents can send positive messages about the importance of respecting others, understanding how other children might

“I suppose it was good in a way, having the accidents - at least I knew who my true friends were” - Hannah

be feeling - for example, when a friend is experiencing incontinence - and how to resolve conflicts in peaceful and respectful ways,” Dr O’Grady said.

Some children who had been bullied in the past, or who didn’t have the social and emotional skills to deal with challenging situations, may respond by being bullies themselves, she said.

“Bullying is a very complex set of social behaviours. Often parents only find out about

their child’s bullying after being contacted by the school,” she said.

Dr O’Grady said children who bully may also be unhappy at school and feel isolated and alone, but not able to get themselves out of the situation that has developed.

“Listening to children, tuning into their body language and checking how they are feeling can also provide opportunities for children to know that they can share any concerns and will get support from parents,” she said.

Signs that your child may be being bullied are:

• A reluctance to go to school
• Being quieter or more secretive than usual
• Behavioural changes such as angry outbursts or tearfulness
• Comments that other children aren’t nice to them, or of having no friends
• School grades begin to drop

Signs that your child may be a bully are:

• Your child complains of having no friends
• Your child is not invited to after-school events
• Your child talks about other children in disrespectful ways

Dr O’Grady said parents and teachers could access information by searching “bullying” at kidsmatter.edu.au/families or by going to the National Centre Against Bullying website (The Alannah and Madeline Foundation) at ncab.org.au/forparents. Children affected by bullying can phone the National Kids Helpline on 1800 55 18 00.
WEIGHING UP THE OPTIONS

Expectant mothers may be wise to focus more of their concerns on preparing for the many unknowns of childbirth, which can result in pelvic floor dysfunction. We speak to two women whose hopes for a natural delivery ‘went south’, much like their pelvic floors.

Pelvic floor health is often the last thing on a woman’s mind when she discovers she is pregnant. More pressing matters such as weight gain, stretch marks and returning to pre-baby shape seem to occupy a large portion of many expectant mothers’ minds. However, the rude shock of incontinence or prolapse after childbirth has many wishing they’d focussed more on that unseen, vital group of muscles and connective tissue that not only holds up the uterus, bladder and bowel, but helps shut off the urethral and anal sphincters.

The facts are startling; one in three women who have ever had a baby will be affected by urinary incontinence, but when these women reach the age of 50, they have a one in two chance, most often due to prolapse.

The pelvic floor takes much more than its fair share of stress during pregnancy and childbirth, making it more vulnerable than other parts of the body during this period. This is because:

- The hormone relaxin is released throughout the body, softening the body’s tissues and ligaments so they expand to accommodate the growing baby. This softening effect, along with the increasing weight of the baby and uterus, weighs heavily on the pelvic floor, which, if not strong enough, may stretch and lose its elasticity, much like overstretched elastic, risking urinary leakage and prolapse.

- Constipation is a common problem during pregnancy, and if not managed can place further stress on the pelvic floor as the result of straining on the toilet. Added to this, a full, impacted bowel takes up much-needed space in the abdomen, restricting the bladder’s holding capacity, and risking leakage.

- The process of delivering the baby itself places enormous downward pressure on the pelvic floor, particularly if the second stage of labour (the pushing stage) is protracted.

Vicky Lewis’ story

Former principal artist with the Queensland Ballet Company, Vicky Lewis, suffered a rectocele (when the bowel bulges through the back vaginal wall) and incontinence after the birth of her second child.

Vicky was physically resilient, and her extraordinary athleticism as a dancer meant she rarely sustained injuries. However, Vicky’s capacity for endurance was to be her greatest downfall during the birth of her first baby, which occurred towards the end of her 13-year dance career.

“I felt trapped in an old person’s body; immobile, incontinent and with some sexual dysfunction” – Vicky.

Ten days overdue, Vicky was induced three times and endured a 32-hour labour, something her obstetrician and midwives believed she could handle. However, her strong abdominals and overactive pelvic floor muscles, combined with her baby’s shoulder becoming locked in the birth canal, meant she required an episiotomy and forceps delivery.

“Like everything else in my life at the time, this required choreography and the ‘happily ever after’. I was certainly unprepared for the unexpected,” Vicky said.

Vicky’s second delivery, two and a half years later was “a lovely birth”. While she recovered surprisingly well after the first baby, everything “went south” after the second, she said. Her incontinence worsened and the “heaviness in her vagina” increased.

Ironically, her exceptional joint flexibility put her at greater risk of prolapse, also possibly contributing to the spine alignment and hip stability issues she also experienced.

“I felt trapped in an old person’s body; immobile, incontinent and with some sexual dysfunction. I had really lost who I was – a lean, fit, agile athlete,” Vicky said.

Quite by chance three years later, Vicky regained her pelvic floor control when she took up an offer to return to the stage. She noticed her incontinence symptoms improve soon after she began exercising her core muscle group, which includes the pelvic floor muscles, as part of her ballet discipline.

As a result of these life-changing experiences and her subsequent rehabilitation, Vicky went on to educate herself about the pelvic floor and completed courses in personal training and pelvic floor awareness. She now works as a fitness professional, helping women with similar issues.

Rachael Thompson’s story

Unlike Vicky, Vagina Diaries writer and director Rachael Thompson was acutely aware of the importance of her pelvic floor when she first became pregnant three years ago. She did her pelvic floor exercises religiously while pregnant.

“My main concerns were to maintain my pelvic floor to avoid long-term damage, and avoid an episiotomy by doing perineal massage and stretching,” Rachael said.

“I was scared I would suddenly lose complete control of my bladder and wet myself” – Rachael.

She did all she could while pregnant to bring on a natural birth without need for induction, such as walking, expressing colostrum, acupuncture and drinking raspberry leaf tea. However, when labour hadn’t started two weeks after her due date,
Rachael was induced - twice. Her labour required an episiotomy, forceps and an epidural.

“It was a difficult birth, and he had a pretty big head,” Rachael said.

After the birth, Rachael had little control over her bladder. “For the first couple of weeks I couldn’t do things like go into the shops because I was scared I would suddenly lose complete control of my bladder and wet myself,” she said.

Her incontinence, she now realises, was further exacerbated by her excessive water intake. “Even though everyone says to drink more when breastfeeding, I overdid it!” she said.

A referral to a continence physiotherapist by her concerned midwife and the resumption of pelvic floor exercises saw a dramatic improvement in Rachael’s incontinence within six months.

Rachael attributes her relatively swift recovery to the integrity of her pelvic floor, the legacy of the strengthening work she’d done while pregnant.

“Without the pelvic floor exercises during pregnancy, my problems would have been much more severe,” Rachael said.

Lisa Westlake, physiotherapist and author of *Exercising for Two* and *Mums Shape Up*, suggests that instead of making a rigid plan about how women might like their labour to progress, they should consider the many scenarios that might present.

“Rather than making a firm plan, which sets us up for possible disappointment, I suggest women do all they can to prepare themselves mentally and physically for labour, including sensible exercise, a positive mind set, and being educated about the different possibilities by appropriate, unbiased health professionals,” Ms Westlake said.

She encouraged women to speak to their doctor prior to delivery so they could be informed during labour about their progress and options.

For Australian women giving birth for the first time:
- 27.1% have a caesarean section.
- 49.6% have a normal vaginal birth.
- 23.3% have an instrumental vaginal birth.


Lisa Westlake

She also encouraged women to seek out a women’s health and continence physiotherapist who would help them better understand their pelvic floor and ensure they were exercising it correctly.

“Inappropriate high-impact or weight training exercises can add further stress to the pelvic floor. They can be replaced with low-impact, controlled moves and lighter weights with increased reps that won’t compromise a woman’s level of fitness,” she said.

“They will help you safely and effectively regain your pelvic floor strength and function after the delivery of your beautiful baby,” she said.
SIMON IN OUR LIVES

GABRIELLE FAKHRI has been caring for her eldest son, Simon, for 42 years. She gave this touching account of life as Simon’s carer at the launch of the Carers count special project during World Continence Week.

I care for my son, Simon, who is 42 years old. Simon has autism, and 10 years ago he was diagnosed with bipolar disorder.

The bipolar disorder has been the hardest of all his conditions to deal with. Simon doesn't speak, so is unable to communicate his feelings, making it difficult for me to work out how to adjust his medication to manage his moods.

Simon has 20 days of depression, where he wants to sleep all the time, followed by 20 days of manic behaviour, where he refuses to go to bed, probably getting only three to four hours sleep a night.

When Simon was born he was one of the first children in our Lebanese community in Melbourne to have a disability. It was a shock to everyone at the time. In fact, one of my sisters-in-law kept her son away from Simon for many years, thinking his disability might be contagious.

There were a lot of superstitions around disability at that time, but we have moved on now.

We love Simon dearly; he is cared for and loved by his extended family and friends. However, for me, his main carer, it is sometimes a day-to-day struggle.

“He also likes ... playing very loud music. I suspect that is the reason I have lost many neighbours over the years.”

I had been trying to toilet train Simon since he was three. He was toilet trained at the age of 12. Since his bipolar diagnosis, Simon has reverted to being incontinent at night, and is having accidents during the day. I am resisting putting him in pads during the day because, being autistic, once I do this he will not want to use the toilet again.

I have been very lucky because, until Simon’s bipolar diagnosis, I was able to work full-time as a community development worker with migrants, refugees and asylum seekers. Simon attends day centres and I have also been blessed with a mother who has been able to care for him when I couldn’t - during school holidays, program-free days, Christmas holidays and, of course, on the many occasions when Simon was sick or in hospital and I had exhausted all my sick and holiday leave.

However, my mother is 85 and becoming frail, so I am also caring for her now, with much pleasure, because I can never make up all the help she has given me over the past 42 years.

Being a carer means you can’t just head off with a girlfriend for coffee. Any outing requires careful planning and organising. An in-house carer needs to be booked, and of course you want the same carers who are familiar with Simon and understand his behaviour.

Preparing for an overseas holiday is stressful, and requires major planning, arguing and begging for respite while you’re away. By the time you organise yourself and your son (with medication, clothing, continence products, emergency supplies, money for his day placement, taxis and the respite centre) you are so exhausted that when you head off, you immediately become sick with bronchitis. This has happened to me on each of the five holidays I have ever taken.

Simon, of course, gets bored at home and, despite the many things we have bought to try to interest him in, he is only interested in photos. He has more than 300 photo albums filled with photos I have taken, because I know they give him so much pleasure.

He also likes going for long drives and playing very loud music. I suspect that is the reason I have lost many neighbours over the years. And, of course, being non-verbal means he tends to yell and scream quite a bit.

It is difficult taking Simon on an outing if he is in one of his screaming moods. If I am feeling tired and vulnerable and people start staring, I find it hard to cope and often just return home, usually without doing the shopping.

“One of my sisters-in-law kept her son away from Simon for many years, thinking his disability might be contagious.”

Simon understands a lot of things; I recently had a knee replacement and when his father brought him to visit me in hospital, he just looked at me without yelling or screaming. When I came home he was on his best behaviour and seemed to know I was unable to care for him, but needed to be cared for myself.

There are so many positives to being Simon’s mother. When he was younger, I was worried I wasn’t spending enough time with his two younger brothers, concerned they might be feeling neglected and resentful. I sent them to a Noah’s Ark siblings group, where siblings of disabled children are counselled and helped to understand their disabled brother or sister.

When I received my sons’ assessment, the coordinator congratulated me for having two such well-adjusted boys who loved their brother and had absolutely no issues with him. To this day they offer to care for him and take him to their homes.

As a result of having Simon, I have developed qualities I might never otherwise have; patience, compassion for others, understanding and the strength to advocate for his needs.

I must admit though, that it is difficult to advocate for my own needs. When it comes to me and Simon, I feel too emotionally
Managing incontinence and MS

More than 23,000 Australians are living with multiple sclerosis (MS), with up to 90 per cent experiencing some level of bladder or bowel dysfunction. Many people with MS are reluctant to broach this sensitive topic, continuing to live with the distressing and isolating symptoms, unaware that treatment is available.

MS is a demyelinating disease and occurs when the protective covering on the nerve cells (myelin) in the brain and spinal cord are damaged. This can affect the speed and transmission of nerve impulses from the brain to the bladder and bowel and back again.

Bladder dysfunction affects about 80 per cent of people with MS, with the main problems due to the bladder’s emptying and/or storing functions. This can manifest in overactive bladder symptoms such as frequency (going often and producing small volumes) and urgency (going in a hurry). This may be accompanied by bladder leakage. This frequency and urgency often continues through the night, with some people with MS having to go to the toilet up to six times a night. This interrupted sleep can impact their daytime functioning and exacerbate other MS symptoms.

Stress incontinence can also affect many people with MS, with bladder leakage occurring in varying severity when coughing, laughing or sneezing.

The good news is that most of the urinary bladder symptoms associated with MS can be successfully managed. However, it is important that a continence assessment is performed by a doctor or continence health professional to ensure the incontinence is properly diagnosed and the appropriate treatment prescribed.

Non-medical measures such as diet and/or fluid modifications, bladder and/or bowel retraining and pelvic floor-strengthening exercises may all form part of a management plan. Anticholinergic oral medications, which act by relaxing the bladder muscles, are usually the first line medical treatment for urgency and frequency symptoms. Other options include Botox injections and intermittent self-catheterisation when the bladder doesn’t completely empty or retains urine.

While bowel issues are not as common, bowel dysfunction can also result from the compromised nerve transmission to and from the bowel. Severe constipation is one of the main symptoms, while spasticity (or spasms) of the colon or the anal sphincter, and the loss of sensation in the anus and rectum can also occur in people with MS.

As with bladder symptoms, bowel issues can be managed effectively with the appropriate treatment after a thorough assessment. Treatment often involves the establishment of a regular bowel-emptying routine in conjunction with a well-balanced diet and adequate fluid intake.

Many specialised continence products are now available to help people manage their incontinence, increasing their confidence and scope to socialise and participate in work, relationships and outdoor activities.

There is also financial assistance available through the Continence Aids Payment Scheme, the Department of Veterans’ Affairs and various state-funded schemes to help meet the cost of continence aids and products. Phone the National Continence Helpline on 1800 33 00 66 for details and eligibility criteria.

Specialist nurses at MS Connect (1800 04 21 38) can help individuals and health professionals find the best treatment options available, and continence nurses on the National Continence Helpline (1800 33 00 66) can offer advice, information and referrals on continence issues.
S
ince the age of five, Tom’s dream of joining the army never wavered. He left school at the age of 16 ½ and set aside the next 18 months to lose weight and get into shape for the army.

The five-year-old Tom could never have imagined his life at age 21; his efforts to get fit for the army caused significant damage to his spine and he now has to rush to the toilet about 20 times a day. He wears a urisheath and leg bag continuously for the many times he doesn’t get there in time. Any hopes of joining the army are dashed.

Unbeknown to Tom, the trainer was unqualified at the time. He had previously trained Tom’s older brother and, according to Tom’s mother, Irma*, the results were excellent. “We didn’t hesitate to send him along,” she said.

Tom underwent strenuous cardio and strength workouts that included “bending his knees and pushing weights above his head”, Irma said.

After just eight months, Tom noticed that the weights he’d been able to lift on previous occasions were beginning to feel heavier and heavier.

“His trainer instructed him to keep on going with heavier and heavier weights, even when he was struggling,” Irma said.

Tom also noticed that he had to rush to the toilet to pass urine more frequently, in increasingly smaller amounts.

After 18 months, Tom told his mother that “something had gone wrong”. He consulted his GP, who referred him to a urologist.

Recognising there might be neurological damage, the urologist referred him to a neurologist, who ordered an MRI that revealed a slipped, or prolapsed, disc. Tom’s diagnosis was a T11-12 severe L-spinal stenosis with urinary retention.

In layman’s terms, a disc at the bottom of his rib cage area had protruded to such an extent that it was now impacting the nerves, which meant the signals between the brain and his bladder were being affected.

“Within two weeks he was in hospital for spinal surgery. They told us the injury from the prolapsed disc was so severe that it could get to the point where he might stop urinating altogether, that he might end up in a wheelchair. He was only 19 years old,” Irma said.

The damage to Tom’s spine was much worse than the neurosurgeons had anticipated, and they were unable to repair the damage.

“They said it was just too risky. So they caged him with titanium bolts and removed some muscle to give it some space,” she said.

According to Tom, the urge to urinate comes very late or not at all. Added to this, his bladder only partially empties, which requires him to make many trips to the toilet.

“My bladder contracts and relaxes at odd times, and not all the urine comes out. At night I have to wear it (a urisheath) because I leak when I sleep,” Tom said.

Tom has been told by his specialists that his prognosis will be clearer in two and a half months to lose weight and get into shape for the army.

“Don’t ever do weights above the head. You should sit down or lie down to do them because it decreases the risk dramatically. There are lots of other ways to work these muscles.”

*Names have been changed

A CLINICAL OPINION

A Melbourne neurosurgeon says:

“Tom’s injury appears to have been caused because he bent his back when lifting heavy weights from the ground to above his head, causing a lot of strain on those vertebrae in the lower chest area. It is important to keep the back straight and bend the knees when doing any kind of lifting, and to restrict any bending or twisting activities.

The possibility that Tom may have had a weak core when he started may also have contributed to this vulnerability in his back. I always advise people to strengthen their core muscles, which include abdominal and lower back muscles, before embarking on any bodybuilding regime. The best way to get fit, strengthen your core and lose weight is mainly through low-impact exercises such as walking, swimming and a light gym program, in conjunction with diet control.

Exercise and strength training should then be built up slowly to a more intense program with increasing weight limits.”
From the Helpline
A travel focus

Our Helpline continence nurse advisors respond to travel-related questions from callers.

Q I have urgency incontinence and am worried I might have an accident during my long-haul overseas flight. How do I best prepare?
A Organise an aisle seat close to the toilet, and don’t cut down on fluids during the flight as this may make you more susceptible to urinary tract infections and deep vein thrombosis. Avoid consuming caffeine, alcohol, fizzy drinks and spicy foods, which can irritate the bladder.

If you are using continence products that are different to the ones you usually use, try them beforehand to make sure they are suitable for a long trip and have the required level of absorbency. Make sure you have packed enough products for all stages of your journey, including waiting times.

Pack wipes, a change of clothes and sealable bags in the event of accidents. Dark clothes are best at disguising accidents, and absorbent chair pads may be a good idea if you have to be seated for long periods.

Q I can’t squat to use an Asian toilet. What can I do instead?
A There are a number of practical, reusable female urinals on the market, available from the larger continence products suppliers. These are funnel-shaped devices that are placed over the vulva, and direct the stream of urine into a narrow trajectory, allowing a woman to urinate standing up.

Q I’m concerned that I won’t be able to buy my continence products overseas.
A Continence products are usually available in most pharmacies or supermarkets in developed countries. However, they may not be as readily available in less-developed countries. A good idea is to make contact with your continence product supplier well in advance of your travels to discuss your destination, requirements and quantities. Many of these companies will offer you samples beforehand to trial for suitability. You can also investigate, via the internet, possible continence product suppliers in the countries you will be visiting.

Q How do I minimise odour when travelling in confined spaces?
A Changing your continence products when needed and disposing of them in a zip-lock plastic bag will minimise odour. Products such as perfumed soil waste bags and charcoal-impregnated pads for minor faecal soiling may also help.

Q I’m travelling around Australia and have to use disabled toilets. How do I prepare?
A It may be worth purchasing a Master Locksmiths Access Key (MLAK) through the Master Locksmiths Association of Australia. MLAK is a locking system developed by Master Locksmiths and Spinal Cord Injuries Australia, and has been adopted by many organisations and councils to allow 24-hour disabled access to toilets. For more information go to masterlocksmiths.com.au/mlak.php

You can also plan your toilet stops in advance using the Australian Government’s National Toilet Map, available online (toiletmap.gov.au), as a smart phone app or on mobile phones with internet browsers. It can locate 16,000 public and private toilets around Australia and includes information such as opening hours and disability access.

Q I always seem to get constipated when travelling. What can I do to avoid it?
A Constipation is one of the biggest risk factors for urinary and faecal incontinence, so be sure you aren’t constipated before embarking on your trip. Take every measure to avoid becoming constipated when travelling such as maintaining adequate fluid intake and an appropriate diet. If you are prone to constipation it may also be worth taking medication with you in the event you do become constipated.
Enjoy the pool with SOSecure®

The SOSecure® Containment Swim Brief is designed for adults, youth and children dealing with incontinence. The hook and loop closure and four-way stretch fabric ensure a secure, snug fit regardless of body shape. This discreet garment is virtually undetectable under a swimsuit!

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