Championing Joe Roberts
Carer of the Year | 4

Sexuality and ageing 3 | A fortunate accident 6 | Prostate incontinence 11
As I was compiling articles for this edition of Bridge, I was reminded how quickly life can change in, literally, the blink of an eye. I was reminded too, of how inspired I am by the resilience, creativity and courage displayed by many of these people who are faced with seemingly insurmountable obstacles.

Martin Heng is one such person. After becoming a quadriplegic five years ago as the result of a cycling accident, the former frequent traveller and Lonely Planet editorial manager channelled much of his energy into making travel more accessible for people with disabilities and continence issues. His remarkable story is on page 8.

Jodie Roberts, the Continence Foundation’s Carer of the Year for 2015, also inspires me. Just moments after giving birth to Joe 10 years ago, her life veered off into new, unchartered territory. The story of her extraordinary devotion to Joe and her family, along with her efforts to support other carers and raise awareness of the virus that so profoundly affected her child, appears on page 6.

I hope you also find these articles inspiring and informative. I look forward to your feedback.

Maria Whitmore
Editor
Bedwetting link to frailty

A Pennsylvania University study has found night-time bedwetting in older women can be a marker for falls risk, which is associated with poorer physical function.

The research, published in the November 2015 Journal of Urology, assessed 37 community-dwelling women with urinary incontinence, average age of 74 years. They were assessed in their own homes for day and night-time urinary symptoms, physical function, falls risk, physical performance and mental function tests.

Forty-eight per cent of the women were deemed to be at a high risk of falls. However, the women who wet the bed at night were at a significantly higher risk of falls, with 61 per cent in this category. These women also scored lowest on the overall physical function scores.

The results led researchers to conclude that bedwetting in older women may be a marker for poorer physical function and an associated increased risk of falls.

Why do we need to address attitudes around older people and sexuality?

Sexuality is integral to our identity at any age. It does not disappear on a certain birthday and is not something reserved for the young. From birth to death we are sexual beings. How we express our sexuality may differ at any age and certainly illness, suffering and pain, associated with older ages, can take precedence over sexual needs.

Sexuality may be flirting, romance, fierce chemistry and physical acts such as intercourse - basically anything that gives us that sexual buzz. Older people have been complicit in the stigma surrounding older people and sex because they tend not to discuss the issue. The general view in Western society is that sex is associated with younger people and definitely NOT our parents.

This perception is reflected in health practitioner/client interactions. Older people rarely discuss their sexuality with the GP and very few health services for older people ask them about sexual needs. People in aged care facilities are the invisible sexual group. Indeed, overt acts of sexuality can result in medication, family conferences or expulsion from a facility. The issue is especially a problem where the person is living with dementia and/or unable to express themselves verbally. Happily there is an increasing number of residential aged care facilities that are more supportive. Some have even arranged liaison between residents and sex workers.

Do taboos around incontinence affect attitudes?

Incontinence is embarrassing for those who experience it. Younger people are more likely to discuss the impact incontinence is having on their sexual experiences with a health professional because they are expected to have sexual needs, so the discussion is considered normal. For older people, not only is it embarrassing to acknowledge incontinence, it is almost unthinkable that they would begin a conversation about how this is impacting their sex lives. The same stereotypes that many older people are bound by also constrain the health practitioner. It is just not something they think to enquire about. Being anything other than heterosexual magnifies the obstacles.

Is there any progress around the acceptance of sexuality in aged care facilities?

Staff of the Australian Centre for Evidence Based Aged Care (ACEBAC) have been undertaking research into this important topic since the late 1980s. The more recent work has concentrated on developing SexAT, a tool to help staff begin the conversation with older people (see the ACEBAC website for details). Incontinence is very likely to be an obstacle to people enjoying their sexuality unless they are able to discuss their concerns and receive advice and support.

In which fields do you believe more work is needed?

Further work is required in the area of sexuality, dementia and incontinence. This is triple jeopardy, without beginning to assess any other existing disorders such as pain resulting from many conditions more associated with old age. The area of consent is fraught unless we take a more common sense approach to assent. For example, what should the role of the continence advisor be when told people are incontinent and having sex? My response would be to first look at how this issue has been addressed for people with intellectual disability. My research suggests that they are streets ahead of us. Sexuality is an important part of life quality; we cannot continue to ignore it. The issues around continence provide a great opportunity for health practitioners to advance the conversation.

Disability focus during World Continence Week

The Continence Foundation’s major project this year will focus on disability and accessibility, with its main objective to increase the accessibility of the Continence Foundation’s services and information for people with a disability and/or low literacy and their carers.

One in five people has a disability, with many using assistive technology to access websites. As part of the project, the Foundation is assessing the accessibility of its website for people with a disability or low literacy, and prioritising and implementing the required changes. Selected fact sheets are also being adapted into Easy English to assist the one in four Australians with low literacy skills.

The project initiatives will be launched during World Continence Week, June 20-26.
Championing Joe Roberts

Jodie Roberts, Carer of the Year

Joe Roberts was born 10 years ago with profound disabilities as the result of a mild virus his mother, Jodie, contracted while pregnant. Her remarkable strength and leadership since his birth have earned her the 2015 Continence Foundation’s Carer of the Year award. MARIA WHITMORE reports.

Jodie Roberts’ second pregnancy 10 years ago was nothing out of the ordinary. Looking back on it, however, she does recall being particularly run down and tired at one point. But that was no big deal; she had a toddler to chase after and life was busy.

And then Joe was born at the Bowral hospital. A beautiful blond, blue-eyed boy. Jodie and her husband, Scott, barely had a moment to take in the wonder of it all when “all hell broke loose”.

He wasn’t breathing well and his tiny body, which was covered in a rash, was immediately intubated. His sight and hearing appeared to be affected, and his condition deteriorated so quickly, he was flown to the Sydney Children’s Hospital ICU after just two days.

After another agonising three days and a battery of tests, Joe was diagnosed with congenital cytomegalovirus, or CMV, a virus which, when transmitted from infected mother to foetus, can cause disabilities.

When contracted during childhood the CMV virus is relatively innocuous, but if contracted while pregnant, as Jodie did, is the most common non-genetic cause of disabilities. CMV affects one in 150 babies born in Australia each year and, while most babies have no symptoms, one quarter will develop disabilities, some of them profound, like Joe’s.

On day 10, Joe had a central line inserted and for the next three months, was infused with a highly toxic drug, ganciclovir, which would help slow down his deterioration. Jodie recalls sitting with Scott in ICU one day as they gazed into Joe’s crib, when Scott said: “If he can see us and hear us, and if he knows we’re his parents, then nothing else matters”- Scott.

Joe came home to Cootamundra after three months, and so started a round of appointments with a host of clinicians, punctuated by six-weekly trips for surgeries to the Sydney Children’s Hospital, five hours away. Jodie also tapped into all the services available in her area.

From infancy Joe screamed a lot, often in physical pain as the result of his spasticity, which still requires hours of physical therapy each week. The damage to his organs affects many parts of his body; he has scarring of the brain tissue that affects the transmission of signals, cerebral palsy, global developmental delay, visual and hearing loss, no speech or language, and is completely incontinent. Confined to a wheelchair with limited mobility, Joe is often constipated and sleeps poorly, most nights involving him waking in pain, cramping, or just crying in frustration.

In the midst of all this, Jodie had two more children; at one point she had four children aged four and under. As well as older brother Matthew, Joe has a younger brother, Oscar, and sister, Sophie.

“If he can see us and hear us, and if he knows we’re his parents, then nothing else matters” - Scott.

Jodie and Scott have been ever-mindful of the influence Joe has on the lives of their other children, and have always worked hard to make it a positive one. While Joe can’t walk, he loves to swim, so family holidays have he has infectious laugh and is much loved and treasured by his family.

Jodie believes that as a family they have acquired more empathy, awareness and understanding of difference, and are less judgemental of others. She sees this in her children, who pay no attention to other children’s differences, only noticing their commonalities.

But Jodie does admit to downsides. She has often been stretched to her limits, and says there have been times when her other children have missed out on her because of Joe. She describes particularly exhausting periods when she says she felt “lost in a maze”, and “not in this world”, even admitting, with some regret, that she can barely remember her third child, Oscar, as a toddler.

Now that Joe is at school, something he loves, Jodie has more time to organise his many appointments, attending NDIS information sessions, trial equipment or apply for funding. She also goes into school regularly to help out with Joe’s therapy sessions.

Caring for Joe also requires ongoing expense, whether for the dozens of continence products he goes through each week, his regular therapy sessions, equipment or major modifications to the house or car.

To help Jodie and Scott meet some of the funds needed to modify the family car, the local
community took part in a charity cricket match in Bowral and a ladies dinner in Cootamundra, with donations made through the Cootamundra Lions Club.

Forever championing their son, the couple are strong advocates for community awareness-raising of congenital CMV, a condition more prevalent than Down’s syndrome and foetal alcohol syndrome.

Jodie admits to periods when she has run herself dry, when she risks “going under”. The couple see the repercussions for the family if they don’t look after themselves, and make the time to “fill up their own bucket”. For Scott it’s playing cricket. For Jodie it’s time with girlfriends and helping others in positions similar to hers.

Jodie and Scott are also acutely aware that most marriages of parents of severely disabled children fail, so every Thursday Jodie and Scott have a “date night”, which might be as simple as going for a walk, while a carer looks after their children.

In Jodie’s estimation, Scott is the “best man in the world”, and she worries about women in similar positions who don’t have supportive husbands like Scott.

Jodie became a member of Carers NSW, but it wasn’t long before the organisation recognised her abilities and asked her to become a NSW Carer representative. She is now the Cootamundra Carers’ group facilitator, supporting carers in her community through monthly social activities by providing informal counselling and promoting their activities through social media and other networks.

Caring for Joe has been an intensely focussed, exhausting balancing act. However, Jodie and Scott have been a solid team throughout; they focus on what Joe can do instead of what he can’t, they don’t sweat the small stuff and have overhauled their values and priorities. She refers to Scott and the children as Team Roberts.

Jodie said she was delighted to be awarded the Continence Foundation’s Carer of the Year, accepting the accolade on behalf of Team Roberts. But she hopes the award will do more than just recognise her for her role as Joe’s carer. She hopes the award will create a greater understanding and awareness of the enormous strains and challenges carers like her experience every day.

As Jodie says, carers will always put themselves last, will be inevitably financially worse off, will put their careers aside, and will have precious little social life, if any.

But, as the Roberts’ story shows, despite the sacrifices and challenges, Joe has brought immeasurable riches to their lives.

Joe surrounded by Team Roberts with, from left: Oscar, Scott, Matthew, Jodie and Sophie.

Jodie said she was delighted to be awarded the Continence Foundation’s Carer of the Year, accepting the accolade on behalf of Team Roberts. But she hopes the award will do more than just recognise her for her role as Joe’s carer. She hopes the award will create a greater understanding and awareness of the enormous strains and challenges carers like her experience every day.

As Jodie says, carers will always put themselves last, will be inevitably financially worse off, will put their careers aside, and will have precious little social life, if any.

But, as the Roberts’ story shows, despite the sacrifices and challenges, Joe has brought immeasurable riches to their lives.

View a short video of Joe’s life. https://animoto.com/play/6JjV0dc9Ad500yTig0rxAA
Josh’s fortunate accident

Two years ago, Josh, now 14, was soiling himself regularly, until neurofeedback therapy that was meant to help manage his difficult behaviour “accidentally” resolved his faecal incontinence.

MARCIA WHITMORE reports.

Fourteen-year-old Josh Rudd from Perth was diagnosed with autism when he was four years old. According to his father, Wayne, Josh was toilet trained at the normal age, but then “didn’t seem to have the usual warning signs, and consequently wore nappies a lot longer than other children”.

At the age of 12, Josh was still soiling himself regularly.

Wayne, also Josh’s primary carer, said his son’s behaviour began to become challenging from about the age of two. Growing up, Josh was a difficult, non-compliant child and appeared to be disinterested in adopting socially appropriate behaviours. He struggled academically and at the end of grade five, at age 12, was diagnosed with a mild intellectual disability. He has always attended regular school, and now receives educational support.

According to Wayne, soiling himself didn’t appear to bother Josh, and he showed little interest in using the toilet, even when he started school. When Josh was in grade five, his father was still being regularly summoned in to school to take Josh home and return him freshly showered and changed.

Four-and-a-half years ago Wayne retired early so he could take over the role of Josh’s primary carer from his wife, who worked part-time and had become exhausted looking after Josh and their two other children.

“I had absolutely no treatment strategies. Once I retired I was on the phone constantly to see what information I could access,” Wayne said.

Josh’s doctors presumed his habitual soiling was due to his autism. “I talked to other parents of autistic children and their children did the same sort of thing; it appeared to be a common factor,” he said.

Wayne looked into a process called neurofeedback (also called EEG biofeedback), which has been shown to help children affected by ADHD. He thought it might help Josh’s general behaviour, and so approached Perth-based NeurOptimal neurofeedback practitioner and forensic psychologist, Denise Cull.

“After he’d been to about four or six sessions, I noticed I didn’t have to pick him up from school any more, and he wasn’t soiling himself at home either,” Wayne said.

Ms Cull, who was not aware of Josh’s soiling history, was taken by surprise. “He didn’t come along for his incontinence; he came because of his disruptive behaviour and his defiance,” she said.

Adelaide neuropsychologist, neurofeedback practitioner and Flinders University School of Psychology Professor Richard Clark said that neurofeedback involves operant learning, a form of learning that helps the brain change in response to positive and negative feedback to how the brain is functioning.

“I had absolutely no treatment strategies. I was on the phone constantly to see what information I could access” – Wayne.

“One way we acquire new memories involves unconscious learning through positive versus negative reinforcement,” Dr Clark said. “When we have positive outcomes during a learning process, brain dopamine and serotonin is released in those parts of the brain involved, which reinforces the networks that have been active so that learning occurs and memory is strengthened. Neurofeedback exploits that process.”

The brain activity associated with positive and negative reinforcement and related learning has been long-studied and well documented, and much is now understood about the many brain rhythms critical to such learning. Neurofeedback training monitors brain function through measurement of the EEG rhythms and patterns occurring in a person’s brain via electrodes placed on the head. It processes them mathematically in real time and can even compare them against databases of normal function, Dr Clark said.

The purpose of neurofeedback is to normalise and/or stabilise the brain rhythms underlying what we sense, feel and do. When the EEG patterns and rhythms move in the desired direction, neurofeedback provides immediate positive feedback to help strengthen the production of such rhythms; when it goes in the non-desired direction, negative feedback is provided to prevent such learning. This kind of brain learning is akin to what takes place when we acquire new skills, such as reading and writing, driving a car or playing tennis.

In neurofeedback, the learning occurs while the patient is engaged in a pleasant activity, such as watching a movie or listening to music. Negative feedback about ongoing brain activity involves modifying how the entertainment is presented – such as darkening, obscuring or stopping it. Positive feedback about ongoing brain activity ensures the entertainment continues unobscured and is clearly presented.

Dr Clark said the ongoing neurofeedback process helps the brain self-correct through this process and strengthen desired patterns of brain activity. The underlying learning processes occur subconsciously, although conscious awareness of, and interest in, the meaning of the positive and negative feedback is essential.

He speculated that the change in Josh’s toileting behaviour might have come about because the neurofeedback may have been focussing, by chance, on brain wave patterns associated with anxiety.

Josh’s neurofeedback therapist, Ms Cull, speculated that Josh’s brain had rewired itself so he could now make the connection to go to the toilet when he felt the impulse to defecate.

“Maybe it restored the developmental interruption caused by autism. Or maybe it was just laziness,” Ms Cull said.

Josh, now in his second year at high school, puts his changed behaviour down to maturity. “I probably got older,” he said.
“It’s better now. It’s easier for my mum and dad.”

Wayne said the impact on Josh’s life had been dramatic. “He’s much improved, a lot happier, a very social boy.”

So much so that Josh’ talents as an athlete and performer are only now becoming evident. Last year Josh won his school’s boy sports champion of the year, a remarkable achievement considering he hadn’t participated in sports until high school. As a result of this extraordinary turnaround, he was chosen to be ambassador of Perth’s most recent annual City to Surf, sponsored by the disability support organisation, Activ Foundation. In addition, he is one of the six finalists in Activ Foundation’s Ability Idol, and will sing Abba’s Mama Mia in the final.

“We’re very proud of Josh, so proud,” Wayne said.

“After … about four or six sessions, I noticed … he wasn’t soiling himself” - Wayne.

Dr Clark stressed that the resolving of Josh’s faecal incontinence was probably an “accidental outcome” of the neurofeedback, but that there may also have been other factors contributing to Josh’s improved behaviour.

“We don’t know what other influences there were in his life at the time; what else was going on, but it’s a good outcome for him,” Dr Clark said.

The American Academy of Paediatrics has endorsed biofeedback as a Level 1 (Best Support) treatment for ADHD. However, more research was required to determine its efficacy with autism, Dr Clark said.

He stressed that autism was a systemic problem, associated with impairments incurred during the development stages of the central nervous system and brain. “We cannot resolve autism per se, but we can alleviate many of the associated symptoms,” he said.

“What happened to Josh is not evidence that it will work for all cases. As it is a single case, it can only need to be taken as a testimonial, so parents need to be aware of that.”
Cutting a swath through the road less travelled

Inveterate traveller and former Lonely Planet editorial manager Martin Heng’s life changed in an instant five years ago when he was hit head-on by a car while cycling. He describes how his experiences as a quadriplegic led to his becoming an authority on accessible travel and the architect of an ambitious project that will make travel for people with disabilities much more possible.

I was always a very active person; as a schoolboy in Warwickshire County and Birmingham I was a table tennis champion, I played rugby and cricket and was a keen cyclist. My first overseas trip, aged 17, was to cycle 750km from my home town in Birmingham to France. I spent 10 years during my 20s and 30s travelling in Asia, and I’ve cycled the South Island of New Zealand and Hokkaido in Japan. I was also chosen to be part of the Lonely Planet relay team that completed the Cairo to Cape Town Tour d’Afrique, cycling 2200km from Nairobi to Lilongwe in just 18 days.

I also commuted to work every day; a round trip of 40km, come rain, hail or shine, until I was hit by a car and broke my neck, instantly becoming a quadriplegic.

My life changed dramatically in an instant. I am now largely sedentary and all my movements require conscious effort.

Suddenly my life came to be lived in slow motion. It’s been a huge change to come to terms with, but at least I’ve finally learned patience!

Although this change might seem catastrophic, I’m actually quite lucky. My head hit the windscreen at close to 50km/h, so I could quite easily have died or suffered brain damage. As it is, my spinal cord injury is incomplete, which means I have some degree of feeling and movement below the point of injury. Five years on, I continue to improve physically.

A few weeks after the accident, I was able to weight-bear, and a few months later, I took my first steps using a two-wheeled frame. These days I no longer have to use my power wheelchair indoors, and I am “graduating” from a four-wheeled frame to elbow crutches. Recently I managed to walk two kilometres on my four-wheeled frame, which took more than an hour!

With a spinal cord injury comes a partial or total loss of bladder and bowel control. I had an indwelling catheter for about three years and have now switched to a condom drainage system, which, apart from the occasional leak, is working really well.

My hand function is good enough for me to be able to empty my leg bag, and at work I’m even using the regular toilet instead of the accessible bathroom. I self-catheterise each night and at least once a day to make sure my bladder is empty.

“I realise how fortunate I am when it comes to bowel management.”

I’ve had to fill out many quality-of-life questionnaires for various reasons, and from these I realise how fortunate I am when it comes to bowel management. I’ve had very few bowel accidents in the past five years, whereas many people with a spinal cord injury have accidents every month or so.

My bowel routine is just that - routine - every morning without fail! Having to take laxatives and use suppositories every day is a small price to pay.

While I was still in rehab, I came into work at Lonely Planet one day a week. Until then I had never considered the issue of travelling with a disability, so I began to explore this area with a new-found interest on a part-time basis for 18 months, until the opportunity arose for me to return to my former job as editorial manager.

Sadly, when Lonely Planet was restructured two years ago, my role was made redundant, but I was fortunate to be offered a new role focusing on accessible travel. With a full-time focus I was now able to make real inroads into the field and establish broad contacts around the world.

I’m now regarded as something of an authority in the area and, at the end of 2014, was a keynote speaker at the inaugural United Nations World Travel Organisation-sponsored accessible travel summit in Montréal.

In late 2014, I published a pilot accessible guide to Melbourne as a free e-book (downloadable from lonelyplanet.com/accessible-melbourne), which already has more than 11,000 downloads - the majority from overseas. I continue to network and make new contacts and have a number of projects on the go, all of these still in the pilot phase.

A new direction my role has taken me is the use of social media, particularly Twitter (@Martin_Heng), which is invaluable as a newsfeed and networking tool.

I’ve also been asked to speak at a number of local tourism events, including Destination Melbourne and the Victorian Tourism Industry Council, and recently made my radio debut on Radio National with former Disability Discrimination Commissioner, Graeme Innes.

“Recently I managed to walk two kilometres on my four-wheeled frame, which took more than an hour!”

I think the main issue faced by people with disabilities who want to travel is a lack of reliable and detailed information on things such as access to venues, hotels, toilets, transport, travel aids, and specialised local tourist and disability organisations. To partially fill this void I recently published the world’s largest database of online resources. It is available as a free PDF from the Lonely Planet’s online shop (shop.lonelyplanet.com), covering hundreds of websites, and will be revised biannually.

Aids are also a perennial problem for travellers with a disability, particularly those who suffer from continence issues. There’s the problem of taking enough personal continence supplies with you as well as...
being able to access equipment such as commodes or shower chairs. While some accommodation has accessible rooms, very few have commodes. However, it is possible to hire such equipment overseas, and the database of online resources includes some suppliers. One of the world’s biggest and best suppliers of continence equipment is Go! Mobility Solutions, which produces a commode/shower chair that fits into a suitcase.

Personally, I hope to keep improving physically so that I can graduate fully to using walking sticks. I will always need a power wheelchair for long distances, but I’ll be happy if I can ditch it for everyday use! Professionally, I hope to keep working with Lonely Planet to help people with access issues travel more and to travel more confidently. Ultimately, my hope is to make the provision of access information and facilities the norm for the mainstream travel industry, with Lonely Planet leading the way.

1. Martin attracts curious onlookers at the Red Fort in Delhi.
2. At Humayun's Tomb in Delhi.
3. Admiring the architecture in Barcelona's Gothic Quarter.
4. At the Taj Mahal in India.
5. Negotiating his way through a crowded street in Delhi.

69% of men prefer Conveen® Optima urisheaths to traditional absorbent products

Conveen Optima is our award winning urisheath with the following key features

- Reliable and skin-friendly adhesive
- Anti-leakage features
- Stretchy and breathable silicone for perfect fit and easy removal

To find out more and order free samples contact Coloplast on 1800 653 317

A day in the life of a remote continence nurse

Anita Erlansen, who was last year awarded a clinical placement in Melbourne as part of her National Conference on Incontinence scholarship, describes a typical working day in a remote New South Wales health service.

I work at Dareton Primary Health in the far west of NSW. There is no doctor on site and the service is made up of specialist nurses, aboriginal health workers and other allied health professionals. We are on the NSW-Victoria border, about 1000km from Sydney and 550km from Melbourne. The nearest major hospital is in Mildura.

A typical day:

First up is a follow-up phone call to a client in Broken Hill, about three hours away, who I had seen the day before for help with intermittent self-catheterisation after his prostate surgery. I had earlier sent him a CD and some catheter samples and he’d done a great job; all he needed was someone to give him the confidence to do the first one. All was well.

Next I meet with primary school staff, parents, a school counsellor and a young child with faecal incontinence. He loves school, but has some learning and development issues. We spend time working out a plan so he can continue going to school without his incontinence negatively impacting on his education. By the end of the meeting we have a plan: an abdominal scan to rule out (or in) conditions such as chronic constipation and encopresis, and strategies in place for the practical side of things such as timed toileting, responsibility for changing him and responding to cues that he needs to go. We leave with a written plan and will follow-up his progress in the coming weeks.

Next is a home visit to a 90-year-old client I saw earlier in the day. The catheterisation procedure was traumatic and painful, and her Melbourne-based urologist asked me to do an at-home void trial. The catheter is removed without any problems and, after explaining what to expect and when to worry, I hand her my mobile phone number and head off.

I then head to a Fit and Strong session, a gentle exercise program for older women. Several of the nurses, including myself, are qualified community exercise leaders, and I lead a pelvic floor exercise session. We have a few regulars who attend the clinic for management of their supra-pubic catheters (SPC) and two of them come in this afternoon. The first is a gentleman in his seventies who has had his SPC for about 12 months. He manages it well, but a few months ago it became dislodged, so now we do a balloon check every few weeks. The timing today was good because I notice his urine has an unusual odour, and he tells me the catheter is more uncomfortable than usual. Sure enough, his GP later confirms a bladder infection.

Our other regular is a paraplegic woman who requires regular bladder wash-outs to avoid hospitalisation. Like many of our clients, she has a difficult home situation and, as well as keeping her bladder working, these visits to the clinic provide her with an opportunity to interact with the female staff. She is a regular fixture in the centre now, and we take pride in managing to keep her out of hospital for bladder-related problems.

The afternoon is spent preparing for a trip later in the week to Balranald, a two-hour drive from Dareton and part of our catchment. I have several referrals from the local multipurpose service for continence assessments for clients before discharge in the Balranald Hospital sub-acute ward and in respite. I make a follow-up phone call to my 90-year-old client I saw earlier in the day and, to use her words, she is “weeing beautifully”. I let her urologist know and attend to her notes.

Finally we have our clinical handover and a Primary Health meeting. Nurses and aboriginal health workers attend the handover and we discuss clients we are all involved with. Today’s new clients include a palliative patient who will require end-of-life continence care, and an elderly person with dementia who will be cared for by his wife, and will need access to continence products.

At our Primary Health meeting, it is my turn to provide an education session to my colleagues. I give them an overview of the National Conference in Melbourne I recently attended and, having spent time at the Royal Melbourne Hospital, get to tell them what a fully staffed and resourced continence clinic looks like.
About prostate function

Stuart Baptist, a Sydney-based physiotherapist and researcher specialising in men’s continence and erectile function after prostate surgery, answers these questions about prostate function.

1. I am scheduled to have prostate surgery in two weeks. Why should I start doing my pelvic floor exercises now?

A Removing the prostate is a technically complex operation and will inevitably cause trauma to the muscular sphincter complex, which has to be cut away from the prostate and stitched into place at the base of the bladder. As a result, the sphincter muscle function is compromised and urinary leakage may occur - especially under the additional abdominal pressure generated during movement.

Men are often familiar with the sensation of holding in flatulence, and so will often practise this as their pelvic floor exercises. These are indeed pelvic floor muscles, but are responsible predominantly for anal closure, not urinary control.

Recent research seems to indicate that the more important muscles to exercise are the “front end” muscles. These muscles feel like you are shortening the penis, or squeezing the last drops of urine out after weeing.

Like all training it’s important to get the right feel first and then continue to practise to develop a well-ingrained neuromotor pathway. The longer you practise, the more ingrained the pathway is, and the quicker you can re-establish neuromotor connection after surgery.

Current research is looking at using real-time ultrasound as a tool to visualise the muscles and give men the visual feedback they need to check the exercises are being performed correctly. Put simply, the better the teaching and the longer you practise, the better you will be at using the correct muscles.

2. I am nearly 60 years old. Will pelvic floor exercises improve my erectile function?

A It certainly won’t hurt, however erectile dysfunction (ED) can occur for a number of different reasons. If you have noted it and it is concerning you, then you should bite the bullet and discuss it with your GP. For some men it can be an early sign of cardiac disease, for others it may be hormonal shifts that cause reduced testosterone levels. Even an inability to deal with stress and anxiety can cause ED.

Interestingly, a 2004 study showed that pelvic floor exercise training for men with ED significantly improved their erectile function over three to six months. It might take longer to get the results than simply popping a pill, but exercise is free and available to everyone, so there really is no downside to trying.

3. I am about to have a TURP. How will this affect my bladder control or erections?

A A transurethral resection of the prostate (TURP) involves taking out part of the prostate in small pieces through the penis via the urinary tract, using a small camera and cutting device (resectoscope).

Bladder control may be affected for a period soon afterwards, with urgency incontinence reported in 30-40 per cent of patients. Due to more recent improvements in surgical techniques, permanent bladder issues are only noted in 0.5 per cent of cases.

In terms of erectile recovery, a 2010 study noted a significant decrease in erectile function for three months after TURP. However, good erectile function recovery was noted after six months.

4. I have just had my prostate removed. I am doing my pelvic floor exercises, but I leak even more when I try to do them.

A It may be you are trying too hard or doing too many. The muscles you are working have just been operated on and overloading them can cause them to be in a perpetual state of exhaustion. Slow and gentle may be a better option in the early post-op stages. I encourage my patients to do upwards of 80 contractions a day, but each one is a very short-lasting, gentle, isolated lift. I save the more intense, aggressive pelvic floor lifting exercises for more demanding exercises such as squats, lunges and push/pull activities. These, I tend to advise starting later, maybe a month or two post-op.

5. I’m 50 years old and don’t have any issues with incontinence. Do I need to do my pelvic floor exercises now, before I start to have problems?

A All muscles weaken as we age. The pelvic floor muscles are no exception. It has always intrigued me that we often spend a lot of time working out to keep our heart and body healthy, but the one muscle that is responsible for keeping us continent as we age is overlooked!

The prevalence of incontinence in nursing homes has been reported as being as high as 70 per cent of residents. It would be interesting to see if this can be changed by motivating men to incorporate pelvic floor training into their exercise programs.

6. I am scheduled to have prostate surgery in two weeks. Why should I start doing my pelvic floor exercises now?

A Removing the prostate is a technically complex operation and will inevitably cause trauma to the muscular sphincter complex, which has to be cut away from the prostate and stitched into place at the base of the bladder. As a result, the sphincter muscle function is compromised and urinary leakage may occur - especially under the additional abdominal pressure generated during movement.

Men are often familiar with the sensation of holding in flatulence, and so will often practise this as their pelvic floor exercises. These are indeed pelvic floor muscles, but are responsible predominantly for anal closure, not urinary control.

Recent research seems to indicate that the more important muscles to exercise are the “front end” muscles. These muscles feel like you are shortening the penis, or squeezing the last drops of urine out after weeing.

Like all training it’s important to get the right feel first and then continue to practise to develop a well-ingrained neuromotor pathway. The longer you practise, the more ingrained the pathway is, and the quicker you can re-establish neuromotor connection after surgery.

Current research is looking at using real-time ultrasound as a tool to visualise the muscles and give men the visual feedback they need to check the exercises are being performed correctly. Put simply, the better the teaching and the longer you practise, the better you will be at using the correct muscles.

Phone the National Continence Helpline on 1800 33 00 66 for free help, information and advice.
Enjoy the pool with

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!

Order today

1300 788 855
1300 788 811
customerservice@independenceaustralia.com
www.independenceaustralia.com