Food glorious food
For healthy bladders and bowels | 12
This year, a major focus of the Continence Foundation is helping ensure people with disabilities have better access to information about incontinence. Initiatives such as Easy English fact sheets and the development of our website to help people using assistive technology will be launched during World Continence Week, July 20 - 26. In addition, the Foundation will continue to remind all Australians to “improve their bottom line” by adopting healthy bladder and bowel habits (page 3).

Inclusive vulnerable members of the community in our health promotion initiatives is critical for organisations such as ours, but there are occasions when people slip through the cracks. Paul Fitzgerald is one such individual, and his story is a compelling mix of heartbreak and inspiration (page 4).

The NDIS will help ensure people like Paul receive all the help they need to reach their goals, and in this edition we get an insider’s clinical perspective of the NDIS in practice (page 6).

Incontinence and its impact on our lives is wide-ranging, and this edition covers topics as diverse as research, arthritis, pelvic floor exercises and food. Underpinning all of these is the message about healthy lifestyle. The food we eat is key to good health, and our cover story on page 12 looks at how our food choices can impact our health, and our bladder and bowel function.

I hope these articles engage and inform you. Please keep the feedback and suggestions for future stories coming.

Maria Whitmore
Editor

We’d love to hear your story

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.

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Email bridge@continence.org.au for a list of references for any articles appearing in Bridge.
You began your career as a special needs teacher. What steered you in the direction of relationship counselling with a special interest in people with disabilities?

I grew up with an uncle with Down syndrome and was accepting of people with a range of ability. So at the age of 23, I applied for a job in a group home. Later, I worked in a mixture of community, employment, legal and sexual health services supporting people with disability. Relationships were not high on the agenda of families or professionals working in these areas. I registered the name Relationships and Private Stuff, and gradually people became aware of my specialty.

What are some of the big challenges facing people with physical disabilities, with regard to relationships?

An additional challenge people living with a disability have is that their family, friends and professionals may assume they wouldn’t be able to have a relationship or might not be interested in sex.

What are some of the barriers that prevent people with physical disabilities, including those with obvious continence aids, such as colostomy/urostomy bags and catheters,

from seeking help about intimacy and relationships?

Most people find talking about intimate relationships and sexuality challenging. People with physical disability and/or chronic health issues can feel shame or embarrassment about incontinence. However, when people come to an appointment or realise the area in which I work, they ask many questions and all sorts of stories are shared. An 80-year-old woman I know from a past business network was excited to tell me she was dating. At a meeting a few months later she whispered, like a school girl, that they were having sex and it was great.

Why is accessing the right information about relationships and sexuality so important for people with disabilities?

Accessing the right information about relationships and sexuality is important for everyone, including people with a disability. Knowledge and awareness increases confidence and helps people explore opportunities for developing a relationship.

We know that even relatively mild cases of incontinence affect some people’s desire or confidence to pursue personal or intimate relationships. What advice do you give them?

Dating and getting to know someone you’re attracted to can be fun. We release happy hormones and endorphins and look for the positives in each other. It’s a time for sharing the things you are passionate about and gradually revealing the challenges you face.

Extending the dating process before becoming intimate can help a couple discover what they like about each other and accept the challenges they might face. When you get to the next stage, my advice would be to extend the intimacy sessions so that you become more knowledgeable of each other and what each other’s preferences, likes and dislikes are, which will help your confidence and your partner’s.

Developing relationships can be a roller-coaster of nerves and excitement. The statistics show that many relationships don’t last as long as might have been anticipated at the beginning, but taking the risk with a relationship is always worthwhile, no matter how permanent or fleeting it turns out to be. And maintaining your “best friends forever” friendships is vital.

You gave them... and your access to continence information

Healthy bladder and bowel habits: eat well, drink well, exercise regularly, practice good toilet habits, and keep your pelvic floor toned.

This year’s World Continence Week focuses on a significant portion of the population that has, until now, had limited access to information and resources about incontinence.

One in four Australians aged 15 and older is incontinent.

Certain illnesses such as Parkinson’s disease, multiple sclerosis, stroke, diabetes, spina bifida and arthritis can make people more susceptible.

During this year’s World Continence Week (June 20-26), in addition to asking Australians to “improve their bottom line” by adopting healthy bladder and bowel habits, the Continence Foundation aims to reach a significant portion of the population that has, until now, had limited access to information and resources.

This is the one in five Australians who live with disabilities; be they physical, intellectual, social, emotional or psychological. This group is the focus of the Continence Foundation’s major project for 2016: Finding the answers; improving access to continence information.

The Continence Foundation will deliver a number of initiatives during World Continence Week aimed at making their resources more accessible to people with disabilities. These include Easy English fact sheets and website modifications to allow for easier navigation for those using assistive technology.

The project recognises the significant barriers people with disabilities face every day when accessing health information, and complements the Foundation’s earlier work to improve accessibility for non-English-speaking people.

The message is the same for everyone; incontinence is, in most cases, preventable and treatable, and the key steps to maintaining good bladder and bowel health are to eat well, drink well, be as active as possible, daily pelvic floor muscle exercises and good toilet habits.

As well as the many resources and information on the website (continence.org.au), people affected by incontinence can speak to one of the continence nurse advisors on the free and confidential National Continence Helpline: 1800 33 00 66 8am to 8pm weekdays AEST.
Paul is 48, a financially independent business man, happily married with two energetic daughters, aged seven and nine.

He no longer needs to work, but chooses to do so because he loves what he does. To spend time with Paul one would never guess that as a baby, his prospects of walking, becoming a father and leading a normal life were minimal.

Born in regional Victoria with a severe form of spina bifida, Paul was born partially paralysed waist down with clubbed feet and no bladder or bowel control.

From infancy he underwent several surgeries to enclose the exposed sections of his spinal cord, to reposition muscle tissue from his lower legs to his weaker upper legs, and to try to rectify his misshapen feet. Paul spent much of his early years in plaster, walking with the aid of callipers until about the age of four.

Paul never graduated from nappies. He was, and remains, incontinent of bladder and bowel. By the time he started school, surgeons had created a urostomy, which would divert urine from his kidneys back into his bladder.保罗现在被迫自己进行导尿，但是后来开始发展慢性尿路感染。

Going to school was a defining moment, shaping the way Paul would cope with his disabilities for the rest of his life. From day one, Paul decided he wouldn’t be a victim; he would pre-empt any hostility by attacking first.

“Imagine that! Going to school with a bladder bag, no bowel control – at all!” – Paul

Paul left school at 15, practically illiterate. A realist, he knew his employment prospects were poor, so he took on a series of labouring jobs for a number of years before finally settling on two full-time jobs; a delivery driver by day and a cleaner by night. By the age of 28, he had saved enough money to buy his first home.

Fueled with fresh ambition, Paul entered into a retail franchise with a business partner at this time. While the business proved to be financially unviable, the experience became another defining moment. He had discovered his gift for selling.

At the age of 30, Paul used his remaining retail stock to establish an expo event, which he developed into a successful national business.

However, his continence issues were still plaguing him, ever since his early 20s when surgeons had closed his urostomy and diverted urine from his kidneys back into his bladder. Paul was now forced to self-catheterise every time his bladder needed emptying, but started to develop chronic urinary tract infections as a result. By his late 30s, he had become resistant to antibiotics.

“I just couldn’t shake the infections, and was often hospitalised for weeks at a time,” he said.

The chronic infections and hospitalisations were “horrendous”, he said. Desperate for relief, he switched to single-use catheters. To his relief, the infections stopped, but having to carry several catheters with him each day proved difficult. Unable to find a product that would hide several catheters on his person, Paul’s entrepreneurial attitude prevailed.

“I couldn’t find anything so I designed them myself,” he said.

After three years of testing and refining, he came up with Freedom trunks - a pair of underpants with rows of thin pockets that can hold 12 catheters and lubricant sachets at once.

A search for a manufacturer also proved fruitless, so he approached the executives at a local manufacturer who agreed to manufacture them for his own personal use - and in the event anyone else wanted them.

Paul’s ingenuity at managing his incontinence extended to social situations. He recalls an incident as a young man while having a beer with mates at his local pub. His urostomy bag suddenly gave way and drenched his lower half. He promptly
ordered another beer and “accidentally” spilt the fresh glass over himself.

Relationships were also deftly managed. Despite his disabilities, Paul never had trouble attracting girls, even managing to keep his urostomy bag hidden when one relationship became intimate. “I’ve always had a relationship; my disability hasn’t hindered me from having relationships,” he said.

Paul met his wife in his mid-30s, a few years after the franchise experience. They have been married for 11 years and, apart from clinicians, she is the only person who knows about his incontinence.

Although Paul can control his bladder using catheters, he has no control over his bowel. He “tries” to open his bowel whenever he feels it is time, with limited success. He rejects daily rituals of wash-outs and enemas, deeming them as unpleasant and invasive as the soiling itself.

Paul admits that the bowel incontinence issue has been the most problematic. He has been troubled by constipation and diarrhoea all his life, but is managing in his own way.

He remembers a pivotal moment as a child. “I was lying in bed and I remember thinking, whoever gave me this wanted to see what I could do with it.” Paul’s voice falters as he relates the story of a sportsman he admires greatly; an old school mate and life-long friend who, for many years, was a leading player in a regional football league.

“I found out that he’d had a conversation with someone, and was asked to name the toughest bloke he knew. He said it was me.” Paul takes a moment to compose himself and reflect on his largely hidden lifelong struggle with incontinence.

“My disability hasn’t hindered me from having relationships” - Paul

“It’s a bit of recognition.” He attributes his achievements in business and life to his refusal to give up. But even more important, he said, are the people in his life who continue to provide the motivation for his dogged determination.

“I don’t have enough words to explain how important they are to me, a supportive family and strong friends who won’t ever let me give up,” he said.

SPINA BIFIDA

Spina bifida is Latin for split spine, an abnormality where there is incomplete closing of the backbone and membranes around the spinal cord.

Because of this, the growing embryo doesn’t develop normally and the spinal cord and nerves are exposed on the surface of the back, instead of being protected inside a canal of bone surrounded by muscle. This means that the spinal cord and nerves can be easily damaged.

Almost always, the nerves supplying the parts of the body located below the level of the exposed area do not function properly, leading to a range of motor and sensory problems, and disturbance of bodily functions, such as bowel and bladder. (Information courtesy of Better Health Channel).

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Gearing up for the NDIS
The National Disability Insurance Scheme explained.

CATE McKINNON, project manager of the Continence Foundation’s 2016 project, Finding the answers; improving access to continence information, gives an overview of the National Disability Insurance Scheme (NDIS), and how it applies to people affected by incontinence resulting from a disability.

What is the NDIS?
The National Disability Insurance Scheme (NDIS) is a new way of providing individualised support for people with a permanent and significant disability.

The scheme is administered by the National Disability Insurance Agency (NDIA), and is designed for individual control with greater flexibility and choice. Traditionally, funding was allocated to an organisation that provided the support services, with limited choice by the person with the disability.

If you are eligible for the NDIS, the NDIA will meet with you (and your family/carer if you wish), to decide which supports you need. Together you will write an NDIS plan, and funding will be allocated depending on your needs.

On the NDIS you can choose your providers, and how, when and where your supports are provided. Supports may help you achieve goals in many aspects of your life, such as independence, involvement in the community, education and employment.

What will be funded?
The NDIS will fund “reasonable and necessary” supports. A “reasonable” support is one that is fair and represents good value for money and a “necessary” support is one that you must have to live your life independently.

The NDIS pays for different supports for different people depending on their goals. Two people with similar impairments may have very different NDIS plans because their personal goals may not be the same. Examples of the supports the NDIS will pay for include:
- transport
- support workers
- therapy
- aids and equipment
- workplace help
- home or vehicle modification

Who is eligible for the NDIS?
To be eligible for the NDIS you need to be:
- under 65 years of age
- an Australian citizen
- live in a launch site or in a launch age group
- have a permanent impairment and
  - be unable to join in activities or do things without assistive technology, equipment or home modifications or
  - usually require help from others to join in or do things.

If you are not eligible for the NDIS, you will continue to receive your existing funding.

How do you find out if you are eligible?
Go to the NDIS website’s Access Checker, which will give you an indication of eligibility. If you are eligible and currently receiving disability services through the Department of Social Services, or are on the Disability Support Register (DSR), your details will be sent to the NDIS when they are ready for your transition. You will be contacted three to six months before transition.

Keep up to date by going to information sessions run by the NDIS and disability agencies. There will be a lot of support through your local NDIS branch office when your area is due to transition.

If you are not currently receiving any disability services, you can contact the NDIS at any time to apply.

Where is the NDIS?
From July, 2016, each state will roll out the NDIS differently so you should check the NDIS website (ndis.gov.au) to find out when it is coming to your area or age group.

What is the planning process?
Planning is essential for getting the best from your funding. Preparing for a planning meeting is vital, because “if it’s not part of the goal, it’s not part of the plan”.

What do I need to think about when planning?
You need to think about considerations such as:
- your aspirations
- your goals
- your strengths and abilities

You also need to consider:
- the type of supports you need
- what and how much funding you receive now
- plans that will help you achieve your goals
- current providers you can speak to about your current services

How do you manage your plan?
Your plan can be managed by:
- yourself (with or without family/friend/carer)
- a registered plan management provider
- the NDIA
- a combination of the above

Continence and the NDIS: How are continence products/aids funded under the NDIS?
If your continence issues are due to your disability, all your continence products/aids should be supplied through your NDIS plan. These products/aids must be included in your plan.

What do I need to think about regarding incontinence in the planning process?
Ask yourself:
- Which products do I use now?
- Am I happy with my current products?
- Should I have a continence assessment to make sure I am managing my incontinence effectively?
The NDIS is being rolled out in stages, and in January this year it reached the under-18 population of the Blue Mountains, Penrith and Hawkesbury areas, all of which are in the Continence Foundation of Australia NSW branch’s catchment area.

For the past three months, NSW branch continence nurse advisor Barbara Scales has been visiting the homes of children enrolled in the NDIS to conduct continence assessments and formulate continence care plans for each child, with input from their parents and/or carers.

Although in its infancy, her impressions of the scheme’s roll-out to date are positive, with most families given adequate information and experiencing a smooth transition.

In some of the cases she has been involved with, parents who had previously been dealing with their child’s incontinence issues on their own are now receiving support through the NDIS.

“In the past, they might not have sought help. Now they’re being funded by the NDIS because the child’s incontinence is considered a result of the disability. Some children will now be wearing continence products they never wore before as a result of their continence assessments, and their parents supported and provided with strategies,” Ms Scales said.

She described how one young boy with high-functioning autism benefited from the NDIS. His sensory-related autism makes him particularly sensitive to certain sensations; he only likes to eat crunchy things and he’ll only drink water that is extremely cold. He also doesn’t like the sensation of using his bowel, and will hold on, refusing to use any toilet but the home toilet.

“In the past, his parents didn’t seek help for this, but after his assessment, we developed a plan based on his goals in relation to continence, and he and his parents are now working with the toilet training strategies with the aim of him working towards becoming continent,” Ms Scales said.

As well as conducting a continence assessment, Ms Scales provides parents and carers with information on healthy bladder and bowels, the importance of skin care, continence products, toilet timing and toilet training strategies.

“I’ll often give them a copy of the (Continence Foundation’s) Carers booklet, which is a great resource, and work through strategies with them that will achieve the goals they want for their child,” she said.

Parents are encouraged to share the care plan with any other adults involved with the child’s toileting, including teachers, grandparents, carers and foster parents.

“That means there is consistency for the child, and the encouragement of positive behaviours that will be the same at home, school or with nan and pop,” she said.

The NDIS gives participants the freedom to choose their own support services. While some parents are happy to take this on, others have found the prospect more daunting, particularly if their children have complex or profound disabilities.

“For example, another boy I saw with cerebral palsy is incontinent because he has no mobility or communication skills. He needs physios, speech pathologists and dieticians. Children with high needs with a disability like this are often already well managed, and they can just roll over to the same services if they choose,” Ms Scales said.

All NDIS participants have an allocated support officer, and Ms Scales encourages parents who are struggling with the new scheme to make contact with their officer.

“Parents of high-care needs children have a lot on their plate anyway, and because this is such a big change and an unknown, it can be a bit daunting. Often they just need reassurance there is someone who can help,” she said.

Ms Scales also recommended parents of children with disabilities and other carers access the many resources available from the Continence Foundation.

These include the Caring for someone with bladder or bowel problems booklet, videos, fact sheets and an online forum.

Phone the National Continence Helpline (1800 33 00 66) or go to continence.org.au/carers for more information.
Breaking the taboo
Let’s talk about poo...

It’s a rarely discussed subject, but one we all have in common. Having a better understanding of our bowel motions gives us a greater insight into our overall health and wellbeing.

Has your child had a poo today? How about yesterday? What does their poo look like? Does it smell particularly pungent? Is pooping easy or a drama?

Your role in your child’s toileting habits shouldn’t end with toilet training. Normalising and continuing the conversation about pooping is critical for children’s understanding of bowel health and its relationship to overall health. Much can be learnt about our bodies’ health through our bowel motions, which can provide clues about infections, digestive problems and even early signs of cancer.

Constipation accounts for up to 10 per cent of children’s visits to GPs, with an estimated 30 per cent of children affected by constipation worldwide. Problems most commonly emerge during the toilet training period, and there is a clear link between early constipation and difficulties with toilet training.

Raising parents’ awareness of healthy bowel function is critical, not only for their child’s health, but for their own. Problems often continue into childhood and adulthood, with up to one in 25 primary-age children soiling themselves accidentally at school, most often the result of chronic constipation with faecal overflow.

What is the most likely way a child can become constipated?

Medical or neurological conditions account for just 10 per cent of children affected by constipation. For the remaining 90 per cent, the most common cause of constipation is avoiding going to the toilet, or “holding on” - usually after experiencing pain when passing hard stools.

As a consequence, water continues to be absorbed from the stool inside the rectum (the last section of the large intestine), causing it to become progressively harder and more difficult to pass. This leads to a vicious circle of avoidance and holding on, where the rectum is increasingly distended, resulting in faecal incontinence, loss of sensation in the rectum and ultimately, loss of the normal urge to poo.

So what is poo made of?

When poo leaves the body, it is three-quarters water; the rest is a mixture of undigested fibre, other solids, intestinal bacteria and dietary fats. The nutrients in our food are absorbed in the small intestine, and most of the water from the leftover waste is removed as it travels through the large intestine.

How often should we go?

How often a person poos is very individual. The “normal” range is somewhere between two to three times a week, to as often as three times each day. Factors that may disrupt regularity include changes in routine, such as travel or school camps, stressful events, dietary changes or exercising less. Certain medications can also cause constipation.

What colour is normal?

Poo is generally brown because of the presence of bile, a key component in digestive juices. The colour can range from a greener to a redder brown depending on what has been eaten. For example, food such as beets, green vegetables and liquorice can affect its colour. A greener colour, often associated with diarrhoea, may be due to the bile pigment not breaking down sufficiently as a result of the food moving through the bowel too quickly.

Dramatic changes in colour should never be ignored. A maroon or black stool may be a symptom of internal bleeding, possibly due to an ulcer or cancer (iron supplements, which many women take, can also result in darker stools), and a light coloured stool may indicate a digestive disease, gall stones or hepatitis.

Why does it smell so bad?

The digestive system is swarming with bacteria that use chemical reactions to break down the waste. Some of the by-products are compounds such as hydrogen sulphide (rotten egg gas) and methane, which account for some of the smell.

However, particularly pungent poos can be a sign of infection, indicating more serious conditions such as the intestinal parasite Giardia, or inflammatory bowel disease (colitis or Crohn’s disease).

How long does it take food to pass through the body?

The time taken for food to pass through the digestive system can take anywhere between one and three days. If the food moves too quickly, not enough water will be extracted and the nutrients may not be absorbed, resulting in diarrhoea and possible dehydration, particularly in infants and young children. Stomach viruses, food intolerances and food-borne infections (food poisoning) can all cause diarrhoea.

However, if the food takes too long to move, the waste may end up dry, hard and difficult to pass, resulting in constipation.

What should its shape be?

As long as a stool is not too dry or hard, yet able to hold its shape in the water, its shape is not important. It should pass through the anus (the opening of the bowel) smoothly, with little effort. The Bristol Stool Chart (opposite) rates the appearance of a stool into seven types, with types three and four ideal.
When is the best time to go?
The best time to go is when you feel the need to. Often this feeling occurs about 10–20 minutes after a meal, most strongly felt after breakfast. You should feel empty after a poo, without the feeling that there’s some left behind.

How should I sit when emptying my bowel?
The ideal way to go is to sit on the toilet leaning forward with the feet supported on a footstool, so the knees are higher than the hips. This straightens out the last bit of colon, making it easier for the poo to leave the body.

When should I start toilet training my child?
If your child can stay dry for two hours or is dry after their afternoon nap, and can follow simple commands and pull their pants up and down, you can consider starting toilet training.

Prior to this, from about the age of 18 months, when children are instinctively mimicking their parents, you can familiarise them with the toilet by letting them climb a step-up frame and sit on the toilet with a child seat/insert. It doesn’t matter if they don’t do anything; it’s all about becoming familiar with the new sensation.

When toilet training begins, the ideal times to take them to the toilet or potty are when they get up in the morning, after meals or snacks, and after their afternoon nap. Better still, if your child has a regular time when they poo, put them on then.

Remember to stay positive. Clean ups need to be done calmly with no fuss or judgment – of yourself or your child – and it’s OK to take a break from toilet training if everything gets too stressful. If a child develops constipation and is avoiding pooing, it’s best to defer toilet training until the fear resolves.

Where to go for help.
If you have concerns about your child’s bowel habits or toilet training, phone the free National Continence Helpline (1800 33 00 66), where continence nurse advisors (including continence nurses with specialties in pediatrics) can provide advice, information and the contact details of the closest, most appropriate health service.

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The Bristol Stool Chart classifies stools into seven types, with types 3 and 4 the ideal shape.

Chart supplied by Norgine Australia.
What’s new in incontinence

These brief overviews of some of the most recent research in the treatment of incontinence reveal the importance of pelvic floor exercises.

Pelvic floor exercises before prostate surgery speeds up recovery

Men who start doing pelvic floor exercises before prostate surgery regain their continence earlier than men who start them after surgery, according to Australian researchers.

Sydney University researchers analysed the findings of 11 independent studies, which involved a total of 739 prostate cancer patients of all ages. They concluded that men who did their pelvic floor muscle exercises before surgery had a 36 per cent lower chance of urinary incontinence at the three month point after surgery, compared with men who only did them after surgery. A similar improvement was found in their quality of life assessment at three months.

However, the researchers found there was no difference in the rates of urinary incontinence between the two groups one month post-surgery, and then at six months.

The findings, published European Urology, November 2015, led study author Dr Patel to conclude that “preoperative pelvic floor muscle exercises may help early continence recovery, but may not influence long-term incontinence rates beyond six months”.

Dr Patel said this finding supported current literature, which states that more than 90 per cent of patients recover urinary incontinence after prostate surgery in the longer term.

Sit-ups not good for the pelvic floor

A recent study has found that sit-ups could be bad for the pelvic floor. The research, published last year in the International Urogynecology Journal,
Finding a long-term solution for symptom relief can be a long journey. Speak to your doctor about the treatment options and Medtronic incontinence therapy today. Visit bit.ly/snmforcontrol to learn more.

Pelvic floor exercises, not Pilates, for strengthening the pelvic floor

A new study highlights the need to regularly perform specific pelvic floor muscle exercises to ensure ongoing good pelvic floor function.

Researchers at Brazil’s Federal University of Rio Grande do Sul tested the theory that pelvic floor fitness could be improved through the practice of Pilates, a form of exercise that strengthens and improves the control of the core muscles, including the pelvic floor muscles.

Two groups of 30 women were tested, with one group doing Pilates at least twice a week and the other group not doing any exercise. The women were aged 20-40 years old, childless, in a healthy weight range and without any pelvic floor dysfunction.

Test results, published in January’s International Urogynecology Journal, found there was no significant difference in the functionality of the pelvic floor muscles in women who did the Pilates, and those who did not exercise.

The findings support the assertion by pelvic floor health specialists that regular performance of specific pelvic floor muscle exercises is the most effective way of improving pelvic floor function, which is vital for maintaining bladder and bowel control. References available on request.
A balanced diet containing a wide range of unprocessed, fibre-rich foods incorporating lots of colours will provide us with all the nutrients we need to keep our bladders and bowels – and our bodies - healthy.

Apart from protecting against constipation (a high-risk factor for urinary and faecal incontinence), a balanced, fibre-rich diet can also reduce the risk of heart disease, type 2 diabetes, stroke and hypertension.

What is fibre?
Fibre is the fibrous component that occurs in all plant-based foods. It is resistant to our digestive enzymes, so never breaks down. Fibre makes us feel fuller and softens our bowel motions so they move through the bowel easily. Fibre also feeds and increases the amount of good bacteria in our digestive tract.

Daily fibre recommendations
Men, 30g, and women, 25g. Children:
1-3 years: 14g
4-8 years: 18g
9-13 years: 20g (girls) and 24g (boys)
14-18 years: 22g (girls) and 28g (boys)

According to the Dietitians Association of Australia, few of us are achieving these recommendations. The most recent National Nutrition Survey found that on average, men consume just under 25g of fibre a day, and women just over 21g a day.

High-fibre foods
We often think of whole grain products as having the highest source of fibre, but there are many others that are just as good or even higher in fibre, weight for weight (see table above). The key is to eat a wide range of foods from the five food groups, all of which (excluding dairy) contain fibre-rich foods.

The five food groups are:
• vegetables and legumes/beans
• fruit
• grain foods and cereals
• meats, eggs, tofu, seeds, legumes/beans
• dairy products and/or alternatives

The Australian Guide to Healthy Eating chart (opposite) outlines the relative amount from each group that we should eat. There are a number of excellent online fibre calculators and charts that can provide more information about the fibre content of various foods.

Eat all colours of the spectrum
Choose foods from each of the five colour groups - red, purple, orange, green and brown – to ensure you consume the widest, most beneficial range of vitamins, minerals and phytochemicals - the compounds in fruit and vegetables that give them their colour. Not only do phytochemicals provide protection against disease in plants, they also provide us with many health benefits.

• ORANGE
Orange or yellow foods (such as carrots, rockmelon, lemons, oranges, pumpkin, apricots, mangoes) are coloured by carotenoids, an important phytochemical for eye health and healthy and mucous membranes. They have been found to help prevent eye diseases such cataracts and macular degeneration.

• GREEN
Green foods (such as spinach, avocados, green apples, capsicum, grapes, limes, broccoli, cucumber), contain a range of phytochemicals, all of which have anti-cancer properties. Leafy greens are also a good source of folate.

• BROWN
Brown or white foods (such as cauliflower, mushrooms, garlic, bananas, potatoes, dates, onions, turnips) contain a range of phytochemicals, including allicin, a viral and bacteria-fighting phytochemical found in garlic. Some of the white group foods, such as bananas
and potatoes, are good sources of potassium.

Food labels

By law, all manufactured food must have a food label on it, specifying ingredients and nutrition information. The ingredients are listed in decreasing order by weight, so if the top ingredient is fat, sugar, or salt, it is probably not the healthiest choice. The nutrition information panel shows the different amounts of nutrients. When comparing similar food products, it is useful to use the per 100g column, rather than per serve, as serve sizes vary between products and brands.

These simple label-reading tips can help you choose healthy foods and drinks:

- **Total fat**: try to choose foods with less than 10g of total fat per 100g.
- **Saturated fat**: aim for the lowest per 100g – less than 3g per 100g is best.
- **Sugars**: If there is more than 15g of sugar per 100g, check whether fruit or sugar is listed higher on the ingredient list, and avoid if it is sugar.
- **Sodium** (salt): aim for foods with less than 400mg per 100g. 120g or lower is best.
- **Fibre**: Not all food labels include fibre, but choosing breads and cereals with 3g or more per serve is best.

How much to drink?

If you are significantly increasing the amount of whole grains or other fibre-rich foods, do it gradually over time, and drink adequate fluids to ensure you don’t become constipated. Always be guided by your thirst. As a general rule you need about 6–8 glasses of fluid (1.5 – 2 litres) each day, preferably water, increasing this during hot weather or when exercising. Remember, some foods such as soups and jellies contain fluids too. Limit the amount of fizzy or caffeine-based drinks, which can irritate the bladder. Alcohol should also be limited as it is a diuretic. If you are not sure how much fluid is enough speak to your doctor. For more on healthy eating, contact an Accredited Practising Dietitian (APD) who can provide practical, tailored advice based on the latest science, and can help motivate and support you to take charge of what you eat. Go to daa.asn.au to find an APD in your area.

Boost your fibre intake

- Eat fruit whole, with the skin on rather than juicing it. (The pulp left behind in the juicer is all the fibre.)
- Don’t peel your vegies and leave the seeds in. Eat potatoes with the skin on (even when mashed) and bake pumpkin with the skin on, even the seeds in too.
- Eat a handful of nuts and seeds every day. As well as fibre, they are rich in energy, protein, packed with antioxidants, vitamins, minerals and omega-3 fatty acids.
- Add legumes/beans/lentils to your favourite meals. Use them in soups, casseroles, salads and dips. They’re a great source of fibre, protein and nutrients, and are very economical.

Eating for healthy bladders and bowels

Enjoy a wide variety of nutritious foods from these five food groups every day. Drink plenty of water.

Source: National Health and Medical Research Council to use the per 100g column, rather than per serve, as serve sizes vary between products and brands.

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Arthritis and incontinence

Some of the measures taken by people with arthritis to avoid urinary leakage may in fact be exacerbating their incontinence.

Not getting to the toilet in time

Limited mobility can result in people with arthritis not reaching the toilet in time. Some of the measures people take to avoid accidents can actually make their incontinence worse. For example, they may go to the toilet before they get the urge to urinate in order to avoid accidents later. While this may work for the short term, it can lead to the bladder losing its volume capacity over time, resulting in it having to empty more frequently in increasingly smaller amounts.

Some people will reduce their fluid intake in the hope it reduces the number of trips required to go to the toilet. While this appears logical, the reverse is true. Insufficient fluid intake causes urine to become concentrated, which can cause the bladder to become irritated, leading to it emptying its contents more often. This can result in frequency and urge incontinence.

Joint stiffness

Stiffness, particularly in the hands and wrists, can make removing underwear and outer clothing difficult. Again, going to the toilet more often or before feeling the urge, or reducing fluid intake, can all risk frequency and/or urge incontinence.

Overactive bladder

The bladder empties as a result of the bladder muscle contracting and pushing urine out through the urethra. As people get older, the bladder muscle can become overactive, resulting in more frequent contractions, along with the urge to urinate. The two main symptoms of overactive bladder - frequency and urge incontinence - can worsen over time, to the point where leakage occurs before reaching the toilet.

Correct toileting position

Knees higher than hips. Lean forward and put elbows on your knees. Bulge out your abdomen. Straighten your spine.

Constipation

People affected by arthritis frequently develop constipation, either because they are not as active as they used to be, or because they are limiting their fluid intake to manage their bladder control problems. Constipation is one of the main causes of incontinence, particularly in older people. An overfull bowel restricts the bladder’s volume and capacity to hold urine, which can lead to frequency and urge incontinence. In addition, straining on the toilet due to constipation can stretch and weaken the pelvic floor, which can lead to stress incontinence.

Preventing and managing incontinence

More than 4.8 million (one in four) Australian adults experience some form of incontinence. In the majority of cases, there is much that can be done to prevent, cure or better manage incontinence, simply by following these five steps for bladder and bowel health.

FIVE STEPS FOR BLADDER AND BOWEL HEALTH

1. **EAT WELL**
   
   Eat a balanced diet that incorporates at least 30g of fibre daily. It is important to get the balance right, because just adding fibre to the diet without increasing the fluid intake may make constipation worse. If constipation persists, consult your GP.

2. **DRINK ADEQUATE FLUIDS**
   
   Drink to satisfy your thirst, typically 1.5–2 litres of fluid a day, unless told otherwise by your doctor. Cut down on the amount of alcohol and caffeine you drink, as these can irritate your bladder. Caffeine is present in chocolate, coffee, tea, and fizzy drinks such as cola and sports drinks.

3. **EXERCISE REGULARLY**
   
   Movement is important for arthritis, so aim for about 30 minutes of exercise each day, and remember, walking is great exercise. Maintain a healthy body weight, because being overweight also increases the risk of stress incontinence.

4. **KEEP YOUR PELVIC FLOOR TONED**
   
   Toned pelvic floor muscles help control your bladder and bowel, and can help control urgency. Learn how to do pelvic floor exercises at pelvicfloorfirst.org.au.

5. **PRACTISE GOOD TOILET HABITS**
   
   Empty your bladder when you feel the urge. Don’t go “just in case” (except just before bedtime), and relax and take the time to completely empty your bladder. Similarly, empty your bowel when you get the urge, which usually occurs 20 minutes after a meal and is most strongly felt after breakfast, and avoid holding on (which risks constipation). Sit on the toilet leaning forward, elbows on knees, with your feet up on a small footstool so your knees are higher than your hips, as this straightens out the colon.

If you are affected by incontinence, speak to a continence nurse advisor on the free National Continence Helpline (1800 33 00 66).
Pelvic Floor Exercises

National Continence Helpline nurse advisor LISA CHURCHWARD answers these common questions about pelvic floor exercises.

Q: I’ve been doing my pelvic floor exercises for years, but still don’t know if I’m doing them correctly?

A: This is an all-too-common concern. We know most people don’t do pelvic floor muscles exercises regularly. We know that just under half (40 per cent) of people don’t do them correctly when following written instructions.

The most common mistake is contracting muscles other than the pelvic floor muscles, which risks exerting unwanted pressure on the pelvic floor.

When doing pelvic floor muscle exercises, the challenge is to isolate and engage only the pelvic floor muscle group, while relaxing muscles in and around the abdomen, pelvic and buttocks regions.

The Continence Foundation’s short video featuring continence physiotherapist Shira Kramer provides an excellent demonstration on how to identify and engage only those critical pelvic floor muscles (pelvicfloorfirst.org.au).

If you’re still unsure, have a continence physiotherapist assess your technique. These specialist physiotherapists can provide ultrasound feedback to show you which muscles you engage as you do your pelvic floor exercises, and teach you the correct technique.

Your nearest physiotherapist can be located on the Continence Foundation’s service directory (continence.org.au/service-providers.php) or you can ask one of the continence nurse advisors on the National Continence Helpline (1800 33 00 66).

Q: I had prostate surgery a few years ago and was told to imagine cracking a walnut between my buttocks to get the pelvic floor exercise technique right. Is this correct?

A: No, it isn’t. That method engages the wrong muscles. You want to isolate the muscles that stop urine flow and the ones that stop you breaking wind. Contracting these muscles at the front of your pelvic area feels like shortening the penis, or lifting the scrotum and testicles. Again, the nearby muscles in the abdomen, pelvis and buttocks should be perfectly relaxed. A continence physiotherapist can provide visual ultrasound feedback about the effectiveness of your technique.

Q: I am not very good at doing my pelvic floor exercises regularly. I do them for a few weeks after I’ve had some leakage, but then I stop when the leakage is not a problem anymore. I want to do them consistently, but forget for weeks at a time.

A: This is completely understandable and a very common experience. However, the trick is to make an association with daily, routine events so that pelvic floor muscle exercises almost become second nature. For example, you could try doing them in bed as soon as you wake up, then while in the shower or while brushing your teeth, and then when you have your first cup of coffee for the day. That way you are done for the day, before muscle fatigue has set in.

Q: I thought my pelvic floor muscles were strong until I started going to the gym. I’ve been put off using some exercise machines that cause me to leak, but I really want to get fitter and stronger.

A: If you are experiencing leakage while using these machines, it suggests you still have to work towards the required level of general and pelvic floor fitness. By persisting with exercises that cause leakage, you may in fact be weakening your pelvic floor.

There are many exercises you can do to increase your cardio and aerobic fitness without putting undue pressure on the pelvic floor, and these can be found on the Pelvic Floor First website (pelvicfloorfirst.org.au).

The Continence Foundation of Australia has also developed the Pelvic Floor First safe exercise app, which has three customised workouts for people of all fitness levels and pelvic floor strength, developed with physiotherapist and fitness leader Lisa Westlake. The app is downloadable from iTunes and Google Play.

In addition to doing your daily pelvic floor muscles exercises, it will also help to learn “the knack” of quickly activating the pelvic floor muscles in preparation for any activity likely to stress it and cause leakage, such as sneezing, laughing, coughing, running or lifting. Again, a pelvic floor physiotherapist can help you master “the knack”.

Phone the National Continence Helpline on 1800 33 00 66 for free help, information and advice.
At Independence Australia, we carry all the major continence brands and stock thousands of speciality products.

- Over 2,900 continence and urology products available
- Free samples for disposable continence products
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