Soon this bitter winter – well, the one experienced in the southern states, anyway - will be nothing more than a faint memory, and we will all be praying for a cool breeze.

Everyone experiences nostalgia, whether it’s rational or not. But nostalgia is not a sentiment indulged by Annie White, the subject of this edition’s feature article on page 6.

Annie contracted a serious case of diverticulitis 11 years ago, which required two major surgeries. Complications rendered her faecally incontinent, something she hid from the world, until she met Darwin-based continence nurse Kirsty Walters, whose simple intervention turned Annie’s life around.

Annie’s story demonstrates two important points: the shame and stigma around incontinence - particularly faecal incontinence - can be more debilitating than the incontinence itself; and it’s vital people affected by incontinence speak to a continence health professional for the best chance of recovery.

Nor is nostalgia a sentiment favoured by Dr Joan Ostaszkiewicz, who looks back on some misguided principals that have influenced treatment practices for incontinence until quite recently.

This edition also includes a piece by Brisbane-based GP and educator Dr Lisa Fraser, who offers advice for people who struggle to broach sensitive subjects, such as incontinence, with their doctor.

There is an insightful Q & A on urge incontinence by National Continence Helpline nurse advisor Merrill McPhee, and an interview with Professor Anthony Costello AM, the driver behind Melbourne’s progressive Prostate Cancer Centre.

Enjoy this edition and remember to keep the feedback and story ideas coming at bridge@continence.org.au

Maria
Editor

Note from the editor

We’d love to hear your story

Editor
Maria Whitmore

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About us...

The Continence Foundation of Australia is the peak national body representing the interests of nearly one in four Australians affected by incontinence, their carers, families and health professionals. The Foundation, 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.
How did the idea for the Prostate Cancer Centre come about?
About 18 months ago a private patient, Bill Guest (of Guest’s furniture), and I had a conversation about the terribly long waiting lists for men in the public system just wanting to see a urologist about prostate cancer, which is very curable if detected early, but the biggest cancer killer for men otherwise. We decided to do something about it and Bill kicked it off with a fundraiser at his home that raised $750,000.
The fit-out of the centre itself was another gesture of altruism, wasn’t it?
That’s right. We rented a building opposite the Royal Melbourne Hospital, and the entire fit-out and labour was donated by companies and businesses in the building industry. The Maben Group coordinated the project and we had the support of trade unions, such as the CFMEU and the Electrical Trades Union, which were right behind the project.
How has it impacted these public patients’ prospects?
We opened at the start of 2015, in association with the Royal Melbourne Hospital, and now see about 1000 men a month, with waiting times down to about a week. We provide holistic care with a large multidisciplinary team that includes urology, radiation and medical oncology, pelvic floor physiotherapy and exercise physiology, endocrinology, psychological services and onsite pathology.
We have a state-of-the-art tissue bank and, by the end of this year, we plan to have our own radiology clinic, an MRI and CT scanner for onsite imaging.
The centre employs more than 30 doctors and other health professionals. How is it funded?
We are attempting to become revenue-neutral and, until now have been funded entirely by philanthropy, in-kind donations, and of course, Medicare. We have no government funding yet, but are lobbying the state health minister to change that. Sustainability is important, and we are working hard toward this with initiatives, such as sponsorship.
What vision do you have for the cancer centre in the future?
This kind of thing has never been done before. Some hospital directors in other states and Victorian centres are very interested in what we’re doing, and I think ours is a great template for care in the future. My vision would be to see similar centres developed in other capital cities.
You also helped establish the Prostate Cancer Foundation of Australia in 2002.
I was involved with the Prostate Cancer Foundation’s establishment 14 years ago and was on the national board for nine years.
In 2012, I established the Australian Prostate Cancer Research Centre (APCR), which is involved with the ongoing research into the treatment, care and prevention of prostate cancer.
You also initiated the first annual Australian Prostate Cancer Conference in 2000.
Yes, I’m very proud of this. When it started in 2000, we had 25 delegates attend, but in 2014 we had more than 1000.
It’s now the Asia-Pacific Prostate Cancer Conference, and the largest multidisciplinary meeting of its kind in the world.

Incontinence in menopausal women with osteoporosis

Recent research out of Montreal University shows pelvic floor muscle exercises can dramatically improve incontinence in menopausal women with osteoporosis.

Forty-six volunteers were recruited for the study, published in the March Journal of the North American Menopausal Society. All the women were menopausal, had osteoporosis and were affected by stress or urge incontinence or both.

Half received weekly physical therapy classes incorporating pelvic floor muscle exercises for 12 weeks, while the remaining women were counselled on diet, medications and the value of physical activity that would improve their bone density. They were not given physical therapy classes.

At the end of 12 weeks, the women who received the physical therapy classes had a 75 per cent reduction in leakage episodes. There was no change in the other group.

One year later, the women in the physical therapy group had maintained or improved their leakage rates, while the other group’s incontinence stayed the same or worsened.

Study author Dr Chantal Dumolin said it was the first study that had evaluated the use of pelvic floor muscle training for women who had both osteoporosis and stress and/or urge incontinence.

Dr Dumolin said the main message for women with osteoporosis is to do pelvic floor exercises, even if they don’t have incontinence, because fractures of the lumbar spine cause their bodies to be slumped, which puts more pressure on the pelvic floor.

continence.org.au | Spring 2016 | bridge 3
It is normal for people to find it difficult to talk about incontinence (defined as any accidental or involuntary loss of urine or faeces or wind). It reminds me how the relationship between a doctor and patient is unique; where else would you have such an intimate conversation with a relative stranger?

There are many reasons a conversation about bladder and bowel health can be challenging, but there is plenty of good news. There are effective treatments for people with continence problems and your GP really wants to help. This article discusses practical tips for having the conversation.

Achieving continence in human development is one of the early milestones of independence on the journey to adulthood. Perhaps losing this, on a psychological level, symbolises the loss of a sense of significance, and that is why it is hard to accept and discuss.

People may avoid talking about incontinence because of the fear of having to detail the urinary, bowel and sexual consequences, or the extent to which they have been compensating for it. They may also be worried that the physical examination will be intrusive and uncomfortable.

Incontinence occurs across all life stages and in both sexes. It affects people’s occupations, social activities, sex life, and ability to exercise and maintain a healthy weight. Not surprisingly, it is associated with poor self-esteem, isolation, anxiety and depression. Even relatively mild cases of incontinence can require increased changes of clothing, pad use (an expense), extra toilet visits and restricted travel. Treating incontinence early can return a lifestyle to normal and prevent or delay the condition’s progression.

There are three main life stages where discussing continence with a doctor is routine: during toilet training, pregnancy and in older age. Bowel and bladder function is also often discussed when women are having a pap smear, since the structures involved in continence are also being examined. For men, it is important that doctors ask about continence after prostate cancer treatment, because it is commonly affected.

Drugs and medications associated with incontinence include caffeine, alcohol, antihypertensives and heart-failure medications, so we often ask about these as well.

When doctors talk about incontinence, they’re not just being nosy.”

Drugs and medications associated with incontinence include caffeine, alcohol, antihypertensives and heart-failure medications, so we often ask about these as well.

When doctors talk about incontinence, they’re not just being nosy; they talk about it because it is common, underreported and readily treated in most cases - often with lifestyle advice or minimal intervention.

I always allow people to tell their story. We all have stories; they convey a special meaning for us. For example, a lady’s relationship with her husband may be suffering because she is avoiding sex due to leakage during intercourse.

If you are the one raising incontinence with your GP, use whatever words feel comfortable. The conversation might sound like: “This is a bit hard for me” or “I want to talk about something personal”.

If you feel you aren’t being understood, you can emphasize your concern using phrases such as: “This is an important problem” or “Is there anything more that can be done?” or “It is really affecting me”.

Bringing some written or printed information about a problem or treatments is also helpful and directs the doctor to what you want to discuss.

Using terms such as “bladder or bowel leakage” are sufficient to indicate the nature of your problem. A GP can take it from there. “Poo” and “wee” are totally fine, too.

The quality of information doctors get from a patient relies on how good they are at making patients feel comfortable and safe. Doctors use terms such as “routine” and they ask permission, which validates the personal nature of the topic.

This might sound like: “When I assess pregnant women/women after childbirth/women for a pap smear, it is routine for me to ask some personal questions about sexual function and bowel and bladder habits. Is that OK? They will help me understand if you are at risk of common problems.”

Checklists serve to normalise all sorts of conditions, so I often use checklists. Asking questions with a yes or no answer, rather than asking for a detailed response, is a lot less confronting for patients.
Then I ask questions that further define the problem, such as whether or not they leak urine when they jog, sneeze, laugh, or are in small spaces. I ask whether they leak when they put the key in the door at home, if they leak a small amount or a lot, or if they have accidents with their bowel. I try to explore how the incontinence is impacting their lives; for example if they take pads and a change of clothes to work.

During the consultation, the GP will ask permission to do a physical examination, which is essential for understanding the cause of the incontinence. The examination will include a blood pressure test, feeling the abdomen and looking at and performing a more detailed examination of the perineum (the area between the anus and the scrotum or vulva).

A patient can decline a physical examination, request that a nurse chaperone or family member be present, and stop the examination at any time. A patient should always feel comfortable and understand what is taking place. The examination often includes some degree of internal assessment, which is usually brief and painless.

The next step in diagnosing a continence problem requires the patient to complete a diary of their drink intake and toileting habits for three days, which also helps patients understand how their body works. Further investigations are sometimes needed and may include a urine test and bladder scan, or other more specialised tests.

As GPs, we have chosen a career because we want to help people with problems just like these. We train for 11 or more years just to get here. Many GPs and other doctors do further study in this area.

We really want to talk about continence issues, and want to know the details, so don’t be afraid or uncomfortable. We’re not.

Don’t wait. Come chat to your GP about any problems you, or someone you care for, is having with incontinence.

“As GPs we have chosen a career because we want to help people with problems just like these.”

Looking for treatment options? Speak to your doctor today, or visit bit.ly/snmforcontrol.

ABOUT THE AUTHOR
Dr Lisa Fraser is the registrar liaison officer for GP Training Queensland and recently obtained her fellowship with the RACGP. She practices in outer metropolitan Brisbane and has two young children. Lisa enjoys empowering patients to take control of their health.

“I HAVE TO KNOW WHERE EVERY BATHROOM IS.”

“When I turn the water on, I usually leak.”

“I can’t travel because I have to stop so often.”

“I thought I was going to pass gas, but I had a bowel movement.”

“I have accidents without warning.”

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Incontinence: the shame of it

Annie White’s 11 years of shame and self-imposed isolation after surgery that didn’t go according to plan ended soon after she met Darwin-based continence nurse Kirsty Walters. MARIA WHITMORE reports.

Darwin-based aged care nurse Annie White* was diagnosed with a severe case of diverticulitis after becoming seriously ill at work in 2005.

Diverticulitis is the infection and inflammation of small, abnormal pockets in the wall of the large intestine or colon. Often associated with old age and diet, diverticulitis was the last thing Annie, a strict vegetarian then aged 54, or her doctors had expected.

Doctors performed a Hartmann’s procedure, a radical surgery that involved removing the infected section of the large intestine closest to the rectum, diverting the bowel contents through the wall of the abdomen to a colostomy bag, and stitching over the remaining section of bowel attached to the rectum.

Three months later, Annie’s bowel would be sufficiently repaired for the Hartmann’s procedure to be reversed, and the two sections of bowel reconnected, her doctors told her.

Annie remembers reading the specialist’s report to her GP a few months after the second surgery. It said she was “coping well – is complaining of faecal incontinence”.

“I was told by the doctors, nurses, everyone, that after everything had settled down I’d be like new again. But I was never like new again,” Annie said.

In fact, Annie only became something resembling her former self earlier this year after meeting Darwin-based continence nurse Kirsty Walters.

For the intervening 11 years, Annie had been completely and, according to her doctors, irreversibly, faecally incontinent. She had no sensation or warning that she was about to defecate, and was having to cope with up to 10 accidents a day.

“11 years is a long time to have to make up excuses not to go out” - Annie

The Hartmann’s reversal was a failure, her GP explained, the result of “complications from bowel surgery”.

During this difficult period, Annie was also dealing with a marriage breakdown, and struggling to recover physically from the trauma of the two major surgeries.

When doctors gave Annie the final prognosis, she became so despondent, she gave up her nursing career and retreated from the world. “I avoided going out and lived alone. I became a hermit,” she said.

Annie became expert at hiding her problem, keeping it secret from all but her very closest friends. She kept zip-lock bags filled with pads, baby wipes, tissues and spare underwear in every compartment of her car, in all her bags and throughout the house.

“I knew where every toilet in Darwin was. I made up excuses so I didn’t have to go out. I gave up on having any sort of romantic relationship.”

Even the nursing staff who cared for Annie during a seven-week hospital stay for an unrelated matter didn’t realise, she said.

“I just had to deal with it. I didn’t talk about it. I didn’t get depressed about it. I just dealt with it,” she said.

Although resigned to life as a recluse with just her three dogs for comfort, Annie grew desperate to talk to someone about her predicament as the years progressed.

“I wanted to talk to someone, anyone, as long as it wasn’t a doctor. I thought, surely I’m not the only person in Darwin like this,” she said.

Early this year she contacted the Palmerston Continence Clinic to enquire about a support group for people with faecal incontinence.

Kirsty Walters’ comments....

“Annie’s case highlights the shame and secrecy that surrounds faecal incontinence, but also shows that sometimes very simple conservative measures can be effective following a comprehensive continence assessment.

Faecal incontinence affects up to 20 per cent of Australian men and up to 12.9 per cent of Australian women. It is more common as you get older, but a lot of young people also have poor bowel control.

Common causes of poor bowel control include weak pelvic floor muscles, severe diarrhoea and constipation. In Annie’s case, her faecal incontinence was likely caused by losing a section of her large bowel, which led to a shortened colonic transit time and runny stools, which were difficult to control.

The idea to use loperamide came from the booklet, Improving Bowel Function After Bowel Surgery-Practical Advice, a great resource available from the Continence Foundation’s resources web page or the Department of Health’s bladderbowel.gov.au website. Other excellent resources are the fact sheet and booklet, Looking After Your Bowel – A Guide to Improving Bowel Function, also downloadable from the websites.

Healthy bowel habits include eating 25-30g of fibre daily, drinking adequately, 30 minutes of moderate-intensity exercise most days, correct posture on the toilet and pelvic floor muscle training.”
While no such group existed, she told her story to continence nurse Kirsty Walters, who referred Annie to a specialist physiotherapist who would help with pelvic floor rehabilitation and other conservative treatments.

The physiotherapist became a helpful and trusted confidant, despite Annie’s struggle with some of the exercise therapy, which, she said, “made it worse in certain positions”.

When the physiotherapist left to take up a position in Alice Springs, Annie gave up all hope of rehabilitation and, once again, retreated from the world.

A few months later, Annie met up with Kirsty, who suggested she trial loperamide, an anti-diarrhoeal drug that was being used successfully to treat faecal incontinence. Loperamide slows down the passage of faecal matter through the digestive system, allowing for more water to be absorbed, creating firmer stools, Kirsty explained. She also told Annie that her loose motions and faecal leakage were most likely due to insufficient fluids being extracted due to her shortened bowel, as opposed to damage to the anal sphincter from the Hartmann’s procedure.

Annie agreed to try the drug. The results were dramatic and immediate.

“I have never been better. I can actually feel when it’s (defecation) going to happen, and go to the toilet. I still have the occasional accident, but I can say I’m 99 per cent cured,” she said.

“And it only costs me $4.99 for a packet of 10!” she exclaimed.

“I didn’t talk about it. I didn’t get depressed about it. I just dealt with it” - Annie

Annie is delighted that her life is no longer dominated by the burden of having to hide her secret and clean up after herself constantly. “Just knowing I wake up each morning and don’t have to go straight to the toilet and haven’t had to get up three to four times overnight is a blessing,” she said.

Annie is relishing the ordinary activities that have been denied her the past 11 years. However, she is still nowhere near her “old self” again. Eleven years of forced absence from work, relationships and life in general, has taken its toll.

“I’m still a bit of a hermit; 11 years is a long time to have to make up excuses not to go out,” she said.

Added to this is the lingering shame and embarrassment she endures. For this reason, Annie requested that her surname be changed and her photograph not be published in this article.

She urged anyone suffering from a similar problem to make contact with a specialist nurse by phoning the National Continence Helpline (1800 33 00 66).

“Make the phone call. Come out of the closet. Talk about it - even to your friends.”

*Not her real name
Incontinence: a reality check

Incontinence: a smelly and embarrassing problem frequently experienced by your elderly grandmother, right? Well, no actually. You might be surprised to know the person just as likely to experience an embarrassing accident has probably just dropped the kids off at school on her way to work.

That’s right, incontinence is largely a younger women’s problem, with a 2011 Access Economics report finding that 80 per cent of Australians affected by incontinence are women, with more than half aged 50 and under.

But the age of onset for incontinence is just one of many myths about this common condition. Let’s look at some other misconceptions.

I don’t have incontinence, I just leak a little bit sometimes.

This is possibly the mother of all myths about incontinence. Incontinence is defined as any accidental or involuntary loss of urine or faeces or wind. That’s right, even “a little bit”. It’s a clever marketing term, but don’t fool yourself, light bladder leakage or “LBL” is actually incontinence.

I’ve never had a baby so I won’t have to worry about it.

While pregnancy increases a woman’s chances of being affected by incontinence, incontinence can affect as many as one in five young women who’ve never had a baby, with physically athletic women at higher risk.

My mother suffered from incontinence, so I will too.

Just because your mother was affected by incontinence, doesn’t mean you will be too. Incontinence can be prevented, often by adopting some simple lifestyle habits. In most cases, incontinence can be cured or better managed. It should not be considered normal or an “inherited” problem you have to put up with.

I’ve had a caesarean so I don’t have to worry about incontinence.

Regardless of the type of delivery you had, the pregnancy itself – primarily a combination of hormones and added weight on your pelvic floor - puts you at a higher risk of incontinence and prolapse.

Myths and misconceptions about incontinence abound. Separating fact from fiction is critical to getting the right treatment. Here are some of the most common myths.
Prolapse is rare and an older woman’s condition.

Prolapse is not rare. As many as one in four Australian women have one or more symptoms of pelvic organ prolapse (where the bladder, uterus or rectum protrude into the vagina); the most common being urinary incontinence. Ageing plays only a limited role in the causes of prolapse and symptoms may surface during pregnancy, after childbirth or many years later, particularly after menopause.

Only women have pelvic floor muscles.

Believe it or not, many men (and some women) are surprised to learn that they too have a pelvic floor muscles that require regular maintenance for good bladder and bowel health. As men age, these muscles surrounding the urethra (urine tube) can lose their tone, resulting in after-dribble. Regular pelvic floor muscle exercises help to avoid this and are useful in treating incontinence after prostate surgery.

So, do you have incontinence?

4.8 million (one in four) Australian adults aged 15 and over experience incontinence. If you have any of the following symptoms, you may have a bladder or bowel control problem.

Do you:
- sometimes feel you have not completely emptied your bladder;
- have to rush to the toilet;
- often feel anxious about losing control of your bladder or bowel;
- wake up twice or more during the night to urinate;
- sometimes leak before you get to the toilet;
- sometimes leak when you lift a heavy object, exercise, sneeze, cough or laugh;
- sometimes leak when you stand up after sitting or lying down;
- strain to empty your bowel;
- sometimes soil your underwear; or
- plan your daily routine around where the nearest toilet is?

Getting help

The good news is that incontinence can be prevented, cured or better managed in most cases, often by exercising your pelvic floor muscles and adopting some simple lifestyle changes. The Continence Foundation of Australia website (continence.org.au) has lots of information and helpful advice. The Foundation also has a free, confidential National Continence Helpline (1800 33 00 66) staffed by continence nurse advisors who can provide information, confidential advice and direct you to your nearest continence service.

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Incontinence: a question of bad behaviour?

Registered nurse and continence nurse advisor DR JOAN OSTASZKIEWICZ traces the evolution of out-dated and harsh attitudes towards people with incontinence.

Incontinence confounds social expectations and shared beliefs about bodily control and appropriate behaviour. Being incontinent, or caring for a person with incontinence, evokes difficult emotions.

These emotions are partly related to the outdated and mistaken belief that incontinence is a behavioural and psychological disorder, rather than a symptom caused by urological, gynaecological, or neurological disorders.

Early researchers emphasised an underlying psychological or social basis for incontinence, particularly in institutional settings and among individuals with challenging behaviours and attitudes.

Early medical and sociological texts even suggested incontinence was an attention-seeking act. The following transcript from a medical textbook on geriatric medicine from as recently as 1989 highlights this belief.

When elderly people feel aggrieved, there may be few ways in which they can express their anger and frustration. Such a situation may arise when elderly people are institutionalised. Many feel rejected by their relatives, find their new surroundings restrictive and feel that they have lost control of their destiny. One of the few ways in which they can express their sense of grievance is by incontinence.


Because it was generally believed that incontinence had a psychological basis, it was not uncommon for clinicians to attempt to treat incontinence using conditioning techniques to alter the person’s behaviour. A common example of this was “operant conditioning” - essentially rewarding good behaviour and punishing undesirable behaviour - which had a powerful influence on clinicians’ beliefs and practices for managing incontinence, even causing some clinicians to advocate that children be punished for wetting the bed. In the early 70s, American psychologists Azrin and Foxx devised a series of experiments whereby they successfully toilet trained children with an intellectual disability as well as children with enuresis (bedwetting) by using punishment and reward.

A publication from the 1960s demonstrates the influence of operant conditioning on the treatment of incontinence in adults. The researchers trialled several methods of training 92 individuals labelled “long-term incontinent behaviourally regressed psychotic hospitalised patients”.

The “patients” were divided into four groups: group 1 received usual care; group 2 was assisted to the toilet every two hours during waking hours; group 3 received the same intervention as group 2, but with the addition of verbal praise if they were continent and verbal disapproval if they were incontinent; and group 4 received the same intervention as group 3, with the addition of the material reward of being allowed to wear clothes of their choice if they remained continent, but hospital fatigues if they had an episode of incontinence.

The researchers found that patients who were materially rewarded (group 4) had the lowest incontinence rates, and those who received usual care (group 1) had the highest incontinence rates.

Notwithstanding the paternalism that underpinned the research, the study is noteworthy because the health professionals assumed the incontinence was behavioural, and could be modified with rewards and/or punishment.

Chastising, disciplining, shaming or humiliating a person for being incontinent stems from the belief that incontinence is an attention-seeking or behavioural act. These forms of publication have no part to play in the current management of incontinence in either adults or children.

Current best practice involves identifying underlying urological, gynaecological or neurological conditions, or factors that can cause or contribute to incontinence, many of which can be modified to improve bladder and/or bowel control.

Understanding this, the Continence Foundation of Australia has developed courses and educational opportunities to provide those working in the aged care and wider healthcare sector with the skills and knowledge to offer best practice care, details of which are available on its For Professionals web page.

Hopefully, better education and awareness will consign outdated attitudes and management practices to a bygone era.
Q I occasionally get urinary tract infections (UTIs) and the worst part is having a strong urge to urinate, but with very little urine coming out. Sometimes I get up about six times a night.

A The first step is to determine if, in fact, you do have a UTI. UTIs can be caused by micro-organisms (usually E.coli bacteria) entering the urethra (urine tube) or bladder from outside the body, and the symptoms include urgency, frequency and a strong odour. Your GP can easily test for a UTI, which should be treated early to prevent it spreading to the kidneys.

If it isn’t a UTI, other causes such as overactive bladder need to be investigated. Factors such as the amount and type of liquid you drink, whether or not you are constipated, and if you have any other medical conditions that may be contributing to the problem will provide important information for formulating a treatment plan. All of these can be investigated during a continence assessment.

Q As soon as I turn on a tap I have the urge to urinate. Why does this happen?

A The sound of the tap running is an action that “triggers” your bladder into thinking it is full and needs emptying. Other triggers such as putting the key in the front door, the sound of rain and going out into the cold weather can have the same effect. These triggers have become associated with urinating, but can be reversed with bladder training therapy, which involves techniques such as mental distraction, pelvic floor strengthening and practising holding back the sudden impulse to urinate.

Q I am menopausal and notice I need to go to the toilet frequently after sexual intercourse. Is this normal and what can I do about it?

A The loss of oestrogen often results in vaginal dryness, which contributes to the vaginal tissues becoming more easily irritated and sensitive during intercourse. The dryness can also put you at a higher risk of developing a urinary tract infection.

Oestrogen replacement in the form of a cream or a pessary can help keep the area nourished and moist, improve the skin integrity and increase the bulk of the pelvic floor muscles. Your GP will be able to prescribe this for you.

It may also help to empty your bladder before and after intercourse, as there will be less pressure on your urethra and vagina with an empty bladder, and any bacteria in your urethra can be flushed out afterwards.

Q I’m a 29-year old male and have to rush to go to the toilet quite often. I also wet the bed occasionally.

A If you wet the bed as a child after the ages of six or seven, you have a greater chance of wetting the bed as an adult. This is treatable and there are good advances in this field, which a continence health professional or urologist can advise you of.

In addition, the amount and type of fluids you drink may be an important factor in your frequency and urgency problems and, very possibly, your bedwetting. For example, it is not uncommon for men aged 30 to 40 to wet the bed after falling into a deep sleep after a bout of heavy drinking.

Factors such as constipation, underlying health conditions and some medications can also play a role in urgency and bedwetting. These factors would be investigated during a continence assessment in order for an effective treatment plan to be devised.

Q I avoid long walks because I sometimes have to rush to find a toilet to empty my bowel. Should I have this checked out?

A It may be that the walking activity triggers your bowel into action, so it’s a good idea to try to change your bowel-emptying patterns so that you open your bowel before you start your walk.

If it’s a morning walk, give yourself at least 20 minutes after breakfast to go to the toilet, because this is when the urge to go (gastrocolic reflex) is usually most strongly felt. Avoid “holding on” or putting off opening your bowel whenever you feel the urge, as this may lead to constipation.
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