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of more than your continence | 4

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Note from the editor

There are so many exciting developments here and internationally in the area of bladder and bowel health, and many of the stories in this edition touch on some of the latest. No doubt, my exposure to the research clinicians and scientists at the Continence Foundation’s recent national conference has inspired many of these articles.

For example, we look at a recent Melbourne trial where physiotherapy interventions have resulted in dramatic reductions in waiting lists and fewer invasive therapies for women at public urogynaecological clinics (page 8).

We also hear from Brisbane clinicians who use fun and novel biofeedback-based computer games to teach children with bladder and bowel dysfunction how to control their pelvic floor muscles (page 3).

The development of an extraordinary drug, derived from bottom-of-the-ocean dwelling bacteria that destroys nearby cancer cells when activated with light, is yet another inspiring story of how far research has taken us (page 10).

But most inspiring of all was getting to know Diane, a delightful 80-year-old Melbourne woman, who has reclaimed her continence and her active, stimulating life, thanks to her ever-inquiring mind and positive, can-do attitude. Her story is on page 4.

I hope you enjoy this autumn 2017 edition of Bridge. It has been a great pleasure bringing it to you, and I look forward to your feedback at bridge@continence.org.au

Maria
Maria Whitmore
Editor

We’d love to hear your story

e: bridge@continence.org.au

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.

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Email bridge@continence.org.au for a list of references for any articles appearing in Bridge.
Stephanie Hart, a senior physiotherapist at the Mars Clinic, Brisbane, is part of a team of therapists treating children with bladder and bowel dysfunction. She describes the novel use of computer game-based biofeedback therapy as a training mechanism for these children.

The Mars Clinic uses computer game-based biofeedback as one of the therapies to help children better control their toileting. How does it work?

Biofeedback refers to signals (visual and auditory) being fed back to the patient while they complete certain tasks, such as contracting or relaxing their pelvic floor. This principle is used to advantage in biofeedback computer games, which become a fun and novel teaching mechanism.

First of all, we measure the child’s pelvic floor muscle activity by placing small electronic receivers on the skin around their pelvic region. We also measure bladder volumes and urine flow rates using a urodynamic system.

This information is then sent to the main computer for analysis, and from that, we tailor specific treatments and customise a program of exercises for each child.

These exercises appear as computer games with animated characters, using biofeedback from the receivers on the child’s skin to control their participation in the game. Repetition of these tasks results in encoding the section of the brain associated with motor memory (the primary motor cortex), and eventually the tasks become automatic.

Is the biofeedback therapy suitable for all the children you see?

We provide assessment and treatment for bladder and bowel conditions such as day and night-time wetting, urinary urgency and frequency, voiding dysfunction, recurrent urinary tract infections, soiling and constipation.

Games-based biofeedback is just one of the training tools we use; other therapies include standard urotherapy, non-invasive urodynamics, ultrasound and neuromodulation.

How do children respond emotionally and clinically to this kind of therapy?

Most children respond very positively. The majority of children do not wet or soil their pants deliberately, and the fact that the clinic has the technology and clinical experience to provide a scientific explanation for their ongoing symptoms helps remove the blame, embarrassment and shame they sometimes feel.

Children also feel very encouraged when they see their improvements with the various treatments, particularly the games. When children and parents see these improvements, it reinforces that they can get better with practice, and often results in a decrease of symptoms. On the whole, we see a lot of improved confidence and enjoyment when children participate in the biofeedback games.

Is something similar available in other states, and how can parents find out more?

This technology is not found in all children’s continence clinics, but there are some private clinics and public departments outside Queensland that have access to this kind of equipment. The Continence Foundation of Australia is a good resource to direct you to those specialist centres.

More information can be found on our website marsclinic.com.au. Alternatively, follow the Mars Clinic on Facebook for tips and tricks on the treatment of children’s bladder and bowel issues.

research

Stronger and leaner - an antidote to incontinence?

The results of a recent study published in the Journal of the American Geriatrics Society show that older women may be less likely to be affected by incontinence if they lose a little weight and increase their strength slightly.

The three-year-long University of California study, which involved 1500 women in their 70s, found that a decrease in body mass index (a rough estimate of a person’s body fat based on weight and height) of just 5 percent or more resulted in a 50 per cent decrease in stress urinary incontinence.

The results also showed that a drop in the women’s hand grip strength of just 5 per cent put women at 60 per cent higher risk of experiencing stress incontinence.

The study authors suggested that losing weight - even for a woman in her 70s - would help alleviate stress urinary incontinence by reducing pressure on the bladder. Similarly, hand grip strength, which is considered an indicator of overall muscle strength, may indicate stronger pelvic floor muscles that are able to withstand more pressure from activities such as lifting, sneezing and laughing.

The study’s lead author, Dr Anne Suskind, said the results showed no improvement in the incidence of urge urinary incontinence, which was often due to neurological issues.
When perseverance pays off

One woman’s dogged determination to resolve her incontinence and restore her lifestyle.

While others might have given up decades ago, 80-year-old Diane remained steadfast in her quest to find the best treatment for her faulty bladder. After teaming up with an equally persistent urological surgeon, Diane has now reclaimed her continence and her vibrant, active lifestyle. She speaks to MARIA WHITMORE.

Eighty-year-old Diane* from the Melbourne bayside suburb of Hampton has an insatiable thirst for knowledge. If she’s not at the library researching her favourite subjects (such as archaeology, psychology, anthropology or the latest neuroscience or medical research) she’s reading books or watching documentaries on the subjects.

It is thanks to Diane’s inquiring mind that she can now live her life fully and completely dry - something she feared would never be the case 16 years ago.

Diane, a retired nurse and mother of six, began having problems in her mid-40’s, after having a hysterectomy to treat endometriosis.

Back then, her urologist’s diagnosis was stress incontinence, but Diane had her doubts. “I told them it was not necessarily only when I sneezed; it was all the time. But that’s what they said.”

Doctors performed a colposuspension, a major operation to treat stress incontinence, which lifts the bladder neck by stitching the lower part of the front of the vagina to a ligament behind the pubic bone.

Although the procedure initially improved her urinary incontinence, over time the problem reoccurred, and then “things deteriorated quickly” when she reached her early 60s.

By now, Diane was experiencing severe urinary incontinence, only able to pass small amounts of urine, with ongoing leakage between toilet visits.

“I was going through eight heavy-duty incontinence pads a day. It was just coming out all the time.” - Diane.

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“I was going through eight heavy-duty incontinence pads a day. It was just coming out all the time,” she said.

The impact on her life was significant. “I stopped going to yoga classes; I used to go swimming, but had to give it away because I didn’t want to pass urine in the pool. I used to go to the sauna but stopped that too.”

Diane was constantly excusing herself for pad changes when she was out with family and friends. “Or I’d be getting ready to go out, and would think, ‘I can’t face this’, or ‘I can’t wear light-coloured clothes’, and often I wouldn’t go,” she said.

Further compounding her problems were the frequent urinary tract infections, which were becoming increasingly resistant to all but three antibiotics.

Eventually her doctor referred her to Melbourne-based urological surgeon Dr Karen McKertich, who asked Diane to complete a bladder diary. She also conducted a fluoroscopic urodynamics test, which would take pressure readings of her bladder and urethra using computerised equipment and X-rays.

Dr McKertich diagnosed Diane as having a bladder that didn’t contract properly to empty, a condition known as an acontractile bladder causing chronic retention.

“The underlying problem is with the muscle of the bladder and/or the nerves to the bladder, which are responsible for an effective bladder contraction, which should normally empty the bladder completely during urination,” Dr McKertich said.

Diane was started on a regime of twice-daily self-catheterisations; one first thing in the morning, and the next about 12 hours later.

The results were immediate and dramatic, with Diane having little or no leakage between catheterisations.

Dr McKertich said that catheterisation works by mimicking the process of normal bladder emptying. It also prevents the bladder from becoming over-distended, which further exacerbates bladder-emptying problems.

“The more women persevere, the more they’re informed, the more they will ask the right questions” - Diane.

“Self-catheterisation also helps by reducing the number of urinary tract infections caused by a continual stagnant pool of urine sitting in the bladder, from which bacteria cannot be cleared. It also improves overflow incontinence, caused by leakage of urine (like overflow from a full dam) due to the continual high volumes of urine in the bladder,” Dr McKertich said.

After a few months of self-catheterisation, Dr McKertich was hopeful Diane’s bladder had recovered enough to fill and empty on its own.
“I can’t tell you how highly I respect Dr McKertich. She’s tenacious.”

-Diane.

Diane’s bladder function had improved and the amounts drained were minimal,” Dr McKertich said. Diane ceased self-catheterisation and managed for the next few years or so, with only occasional leakage incidents. However, her bladder-emptying function gradually deteriorated, and by the time she saw Dr McKertich again early last year, she had very little bladder control.

Again, Diane was asked to complete a bladder diary by Dr McKertich, who was surprised by what it revealed.

“She said, ‘oh dear, it’s continuous’. She couldn’t believe how much I was leaking,” Diane said.

After another fluoroscopic urodynamics test, Diane was recommenced on her twice-daily self-catheterisation regime.

Since then, Diane’s world has opened up, and she has become an active participant in life again.

An early riser, Diane gardens early every day, walks or takes public transport wherever she goes, and enjoys social and family engagements without giving her bladder a moment’s thought.

“It’s absolutely wonderful. I now have my life back. I can’t tell you how highly I respect Dr McKertich. She’s tenacious. I told her, ‘I don’t know how to thank you’.”

Dr McKertich is full of praise for Diane’s positive can-do attitude, and her willingness to undergo the challenge of self-catheterisation, which she describes as “understandably, initially, a very confronting treatment”.

“Diane has taken her health issues in her stride and has been willing to try different assessments and treatments. The pay-off for investing time and effort, and for being actively involved in her treatment, has been a very gratifying improvement in her quality of life,” Dr McKertich said.

Diane encouraged others to be persistent, open-minded and informed about their condition’s causes and treatment options.

“Women with a condition like mine could almost give up on it. I know it’s taboo to speak about personal things, but the more women persevere, the more they’re informed, the more they will ask the right questions,” Diane said.

Actively participating in her health care enabled her to be as active and self-reliant for as long as she possibly could, she said.

“And look how much extra time I’ve got being able to do all the things I do.”

*Not her real name

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STRANGE BUT TRUE: facts about bladders and bowels

Whether it’s astronauts not being able to tell if they need to pee, or chihuahuas taking just as much time as elephants to empty their bladder, there are plenty of strange but true facts in the world of bladders and bowels, as MARIA WHITMORE discovers.

Space age pit stops

Astronauts don’t feel the urge to urinate and are scheduled to go to the toilet every two hours. This is because urine doesn’t collect at the bottom of the bladder in zero or low-gravity environments, and the stretch receptor nerves lining the bladder aren’t activated in the same way they are on earth.

In fact, in space, the bladder’s stretch receptor nerves only activate when the bladder is almost totally full, instead of about one-third full, which is what normally happens. An overfull bladder risks the urethra being forced shut, making urination very difficult, sometimes requiring self-catheterisation.

Kinky business

There is a good reason a large proportion of the world’s population squats instead of sits to defecate. It’s because the last section of digestive tract through which the waste passes - the anorectal canal - straightens out when we squat. When we sit, it’s only partially straightened.

When we stand, a bend in our anorectal canal, much like a kink in the garden hose, stops waste inadvertently leaving the body. By squatting, we effectively unkink the hose and open up the tract.

Most of us don’t have a squat toilet at home, so the best way to replicate the squatting position is to bring your thighs up as close to your body as possible, using a stool or phone directories, and leaning forward.

21 seconds to pee

Most mammals, whether they’re as small as a chihuahua or as large as an elephant, will take 21 seconds – give or take a few seconds – to empty their bladder. This surprising fact was discovered by a group of physicists from the Georgia Institute of Technology who went to Zoo Atlanta in 2013 to observe and film 34 mammal species urinating.

The researchers published their findings in Proceedings of the National Academy of Sciences, and explained the phenomenon using the Law of Urination, which says that, as the urethra gets longer (and proportionately wider), the effect of gravity increases as the urine flows further down, causing the urine to come out with greater speed.

This explains why an African elephant can empty 18 litres of urine in the same time a cat can empty just a teaspoonful. The Law of Urination only works for mammals weighing more than 3 kilograms, because factors such as surface tension and the urine’s viscosity, or consistency, result in their releasing urine droplets instead of a stream.

If you’re sceptical, time yourself – and your pets!
Wake me up before you go ... and go

You shouldn’t wake up more than once overnight to urinate, and ideally, should be able to last six to eight hours.

This is because the body releases antidiuretic hormone (ADH) while we sleep, which slows down the kidney’s production of urine.

Urinating more than once overnight is a condition called nocturia and research suggests that sleep apnoea may contribute to the risk of nocturia by disrupting the production of ADH. Research also shows that when sleep apnoea is effectively treated, nocturia symptoms improve.

Other contributory causes of nocturia include drinking too much fluid close to bedtime, prostate disease, diabetes, heart conditions and some medications.

Do you smell what I smell?

Some people can wriggle their ears while others can’t. Some can wink with either eye while others can wink with only one. These traits are due to genetic differences, which scientists believe is the most likely reason most people’s (but not everybody’s) urine smells strange after eating asparagus.

Further to this, some people can’t detect a change in their urine’s odour after eating asparagus, even when others can. While these peculiarities are still the subject of research, it appears that the two abilities – to smell or to produce the smell – don’t appear to be linked.

The smell is believed to be the result of the breakdown of asparagusic acid into sulphur-containing compounds, such as methanethiol, a compound similar to methane.

Shy bladder

About 7 per cent of people have trouble going to the toilet when other people are within earshot. This condition is called paruresis, or shy bladder, and can be debilitating, particularly for people who have no option but to use toilets in public places. While the exact cause is still the subject of debate, it is considered a phobia or anxiety disorder, and can be treated.

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Physiotherapy - a stitch in time

Physiotherapy interventions for women on urogynaecology waiting lists are resulting in better patient outcomes and dramatic time and cost savings.

Waiting times of more than two years at some of Melbourne’s major public urogynaecology clinics were the motivation behind a recent trial where women were given preliminary assessments by physiotherapists.

Those women assessed as being most likely to benefit were offered physiotherapy conservative management.

The initiative, known as Advance Practice in Women’s Health and Continence Physiotherapy, was trialled over a two-year period at Monash Health, Royal Women’s Hospital, Barwon Health and Sunshine Hospital. The trial significantly reduced waiting times and the number of women requiring surgery or other invasive procedures.

Monash Health physiotherapist Robyn Brennen, one of trial’s lead physiotherapists, said the intervention also addressed the problem of women’s conditions deteriorating while waiting to see the specialist.

In addition, women with relatively moderate conditions that didn’t require a urogynaecologist’s intervention, were able to be identified, given appropriate treatment and removed from the waiting list.

“We found that some GPs were referring patients to the specialist clinics that potentially could be managed by a physiotherapist or continence service without the need for surgical intervention or opinion,” Ms Brennen said.

“The evidence-based guidelines tell us that women should have three months...
Bacterial cells in and on our bodies outnumber human cells 10 to one. Understanding the relationship between humans and bacteria is the subject of much research, and it is now widely acknowledged that a healthy, diverse bacteria population plays a key role in the prevention of illness and disease.

One particular part of the body that has, until recently, been assumed to be sterile - the bladder – is being studied by US researchers investigating the link between the bacteria present in women’s bladders (female urinary microbiota, or FUM) and their role in conditions such as overactive bladder and urinary tract infections.

Professor Elizabeth R. Mueller, a urologist and keynote speaker at the Continence Foundation’s recent national conference, is part of a US research team in the process of identifying the FUM and correlating it with certain bladder symptoms. Her recent research revealed a link between the FUM in women with overactive bladder and their response to the drug, solifenacin, often prescribed to treat it. Her research revealed that women who responded to the drug had a lower number and diversity of bacteria compared with women who didn’t respond.

Researchers also found that the presence of urinary bacteria correlated with improvements in symptoms associated with urinary tract infections, and fewer infections after the use of instruments such as catheters.

Prof Mueller’s research also revealed that the FUM may play a protective role in the bladder. For example, the most common bacteria type, lactobacillus, known to be beneficial in many other areas of the body (including the gut and vagina) may help prevent or protect from urinary symptoms, such as overactive bladder.

Another significant outcome was the increase in the number of patients receiving conservative management.

“Prior to seeing the advance practice physiotherapist, only 10 per cent of patients had been given conservative management. After their appointments, 68 per cent went on to conservative management,” Ms Brennan said.

The original trial model has now been adopted by Monash Health’s Pelvic Floor Clinic, Barwon Health and Western Health.

“It’s been a smooth transition from the trial. We’ve received ongoing funding from within Monash Health, and it’s now one of our permanent clinics,” Ms Brennan said.

The results have been so encouraging that the Mercy and Northern hospitals have since implemented similar advance practice in their urogynaecological clinics.

An important outcome for health professionals, Ms Brennan said, had been the development of a clinical competency package for advance practice skills, published by the Victorian Department of Health and Human Services.

“This is something any physiotherapist or nurse can access for their own professional development,” she said.
Tumour-blasting drug offers hope for prostate cancer sufferers

A revolutionary technique using a light-sensitive drug to destroy tumors with pin-point accuracy has the world’s urologists, and their patients, watching with great anticipation. MARIA WHITMORE reports.

A light-sensitive drug developed from ocean-dwelling bacteria could signal revolutionary advances in prostate cancer treatment and its side-effects – in particular, incontinence and erectile dysfunction.

The non-surgical treatment, developed by researchers at University College London and scientists at the Weizmann Institute of Science in Israel, involves injecting a light-sensitive drug (WST11) into the bloodstream and activating it with a laser at the site of the tumour. This triggers the drug’s release of free radicals (unstable and highly reactive atoms) that destroy surrounding cells.

The results of trials involving 413 men from 10 European countries, published late last year in The Lancet Oncology, showed that half the men who received the new vascular-targeted photodynamic therapy (VTP) went into complete remission compared with only 13.5 per cent of those who received traditional therapy.

“This is truly a huge leap forward for prostate cancer treatment”, Prof Mark Pemberton said.

stage was three times lower for patients on VTP compared to those under active surveillance, with only 6 per cent of men treated with VTP needing radical therapy compared with 30 per cent of those under active surveillance.

The removal of the prostate can cause lifelong erectile problems, with about one in five men also affected by incontinence. The study, which commenced in 2011, showed that VTP caused short-term urinary and erectile problems, which usually resolved within three months. There were no significant side-effects after two years.

“These results are excellent news for men with early localised prostate cancer, offering a treatment that can kill cancer without removing or destroying the prostate,” Prof Pemberton said.

He said there was hope that VTP could also be effective against other types of cancer.

“The treatment was developed for prostate cancer because of the urgent need for new therapies, but it should be translatable to other solid cancers including breast and liver cancer.”

Prostate Cancer Foundation of Australia chief executive Professor Anthony Lowe said the results of the trials held exciting possibilities for men in early stage, or with low-grade prostate cancer.

“We’ve had many inquiries from men with prostate cancer about the new therapy,” he said.

“They (the researchers) are moving ahead with the therapy; its use has been approved in Mexico, and the European Medical Agency has an application for its use in Europe.”

He stressed, however, that it appeared the therapy was most effective with men with low risk or early stage cancer receiving active surveillance therapy.

“We’d need to see results from further trials, and results from actual use in clinical settings to see if the treatment offers better outcomes than active surveillance for those low-risk men,” he said.

But Prof Lowe said the new therapy could offer promising advances in prostate cancer treatments.

“It appears to offer great hope for men, and it is an intriguing and exciting possibility. This could be a really important development.”

ABOUT THE DRUG

The drug, WST11, is derived from bacteria at the bottom of the ocean, which survives with very little sunshine by converting light into energy extremely efficiently. Scientists exploited this property when developing the drug WST11. When laser light hits the drug injected in the bloodstream at the site of the tumor, it releases destructive “free radical” molecules that destroy all the cells in their vicinity.

ABOUT PROSTATE CANCER

Prostate cancer is the most commonly diagnosed cancer in Australian men, with more than 3000 men dying of the disease every year. More men die of prostate cancer than women die of breast cancer.

RISK FACTORS

Age and family history are the main risk factors. Men over the age of 50, or aged 40 with a family history of prostate cancer, should talk to their doctor about testing for prostate cancer as part of their annual health check-up.

Source: Prostate Cancer Foundation of Australia
I’m a busy 35-year-old working mum and I stay healthy by eating a balanced, fibre-rich diet, drinking adequate fluids and keeping active. But I find myself going to the toilet to open my bowels up to five times a day, not passing much each time and feeling as though I’m not quite finished. Why is this happening and what more can I do about it?

**A** Being in the right place at the right time, adopting a regular toileting routine and learning effective bowel-emptying techniques are all needed for good bowel function.

The large bowel is usually most active after we wake up and after meals. Unfortunately, mornings are often the busiest time for many people and they miss the message to go. When they do have time, the urge may have weakened or gone, and won’t be very effective.

It’s best not to skip breakfast, and including a warm drink will help stimulate stronger bowel waves, which build up within half an hour until the urge to go is felt. If you have a strong urge, relaxing the abdominal, anal and pelvic floor muscles should be enough for the bowel to virtually empty itself.

If the urge is not very strong and effort is needed, the push should come from widening the side waist muscles while relaxing the anal pelvic floor muscles to allow the bowel to open.

If the urge doesn’t arrive, sit on the toilet and take five minutes (and not more than 10) to relax and “tune into the right channel”. Slow deep belly breathing can relax the abdominal and pelvic floor muscles. If unsuccessful try again 30 minutes after lunch or dinner.

While we can empty our bladder on command, we can’t do that with our bowel. Many people push, usually by pushing the abdomen in and pushing down into the bottom. This is not very effective and can lead to other problems such as haemorrhoids or prolapse.

Seek help from a pelvic floor physiotherapist to learn the right technique to empty your bowel.

My 90-year-old mother takes high doses of bowel stimulants and stool softeners every day to manage her life-long constipation. However, she often doesn’t open her bowels for a week to 10 days at a time. When she does, it’s painful and protracted. How can we help?

**A** It is likely that your mother’s rectum is gradually loading up with stool, which she is not aware of, so she doesn’t go until it is overfull.

When stools are left sitting in the rectum, it causes the bowel higher up to slow down, which makes constipation worse. The stools become drier the longer they are there and can be quite large if collected over days.

Again, establishing a good bowel routine by sitting on the toilet 30 minutes after breakfast and dinner is recommended. Her emptying technique may also need adjusting if she is straining by bearing down (see previous question).

Speak to your GP about a rectal suppository or mini-enema every 2-3 days, which would probably make things more comfortable for her. A continence nurse advisor can teach your mother, or a carer, how to use these correctly.

I am a 45-year-old business man and have ongoing diarrhoea, for which I take an anti-diarroheal tablet, but I find it is just getting worse. What can I do?

**A** First of all, you need a thorough medical assessment to rule out problems such as infection, inflammation, coeliac disease and food intolerances.

Loose bowel motions reflect rapid movement through the gut system, and anti-diarroheal tablets slow this down. They are safe to take long term, but the dose needs to be adjusted so they can do this without causing constipation.

It’s also important to reduce or stop the consumption of bowel irritants such as caffeine, artificial sweeteners and alcohol. It’s a good idea, too, to introduce a bulking agent such as psyllium husk, Metamucil, Fybogel or Normafibe each day, as these can lower the water content in the stools and reduce the need for medication.

Being stressed or anxious can also cause the bowel to be more active. Sometimes the most effective treatment is holding on and employing mind and bowel-calming techniques, rather than going every time the urge comes.

A pelvic floor physiotherapist can assist with this type of bowel retraining.

I am a 60-year old retired nurse with regular soft motions the texture of toothpaste. Sometimes my underwear becomes soiled. How can I stop this happening?

**A** To maintain bowel control we need to be able to sense when there is stool present in our rectum. However, we hear anecdotally of people in certain occupations, such as nursing, who frequently ignore the need to go, which, over time, can lead to decreased sensitivity. In addition, as we age, some of our muscles, including the pelvic floor muscles around the anus, can weaken, increasing the risk of leakage.

It is important to address the bowel texture issue, because pasty, toothpaste-like textures are not only harder to contain, they are more difficult to pass completely. Try a bulking agent and making some dietary changes to improve your stool consistency.

This, along with regular pelvic floor exercises are recommended, as is establishing a good toilet routine and an effective bowel emptying regime (as in previous questions). If the rectum is empty there is nothing to leak out.

Your local continence service and or pelvic floor physiotherapist can provide further assistance.

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**Angela Khera** answers questions about defaecation.

Alfred Health senior pelvic floor physiotherapist

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Phone the free National Continence Helpline 1800 33 00 66 for advice, resources and information about financial subsidies and local services.