Staying on top of bladder, bowel and erectile function | 7
I am always taken aback by the courage shown by ordinary Australians affected by severe bladder and/or bowel dysfunction, willing to share their story.

In this edition I speak to a quite extraordinary woman, Suzanne Twelftree, a mother of three, farmer and Paralympian. Suzanne became a paraplegic at age 15 as the result of a vascular malformation near her central nervous system. Her story is one of the most gruelling and powerful I’ve encountered (page 4).

This edition features a special focus on men’s health. We spend five minutes with physiotherapist and advocate for men’s health, Peter Dornan, and take a look at the science that suggests that the lifestyle habits recommended for bladder and bowel health can also significantly improve erectile dysfunction, including premature ejaculation (page 7).

We also look at the challenges faced by health workers in outback Australia, this year’s World Continence Week’s campaign, and we answer some of the most common questions we receive at the National Continence Helpline.

I hope you find this edition engaging and informative. And keep the feedback and story ideas coming along at bridge@continence.org.au

Maria

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.

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.
Tell me about your background in men’s health?
I started in private practice 50 years ago and developed a strong career in sports medicine, becoming the first physiotherapist for the national rugby teams, the Wallabies (union) and the Kangaroos (league), and several other national teams, including cricket. My experience led me to write a book on sports injuries. I was diagnosed with prostate cancer in 1996 at the age of 52. The surgical treatment option I chose left me seriously incontinent, impotent and depressed. With no support and little information available, I started the first support group for prostate cancer in Queensland. It became the largest group in Australia, and I became instrumental in creating the Prostate Cancer Foundation of Australia.

In 2000, still struggling with the side effects of treatment, I developed a more aggressive exercise program to treat incontinence. From here, I wrote a book on managing incontinence, erectile dysfunction and the associated psychosocial effects. I still convene the Brisbane group and sit on the Board of Cancer Council Queensland, and vigorously promote the men’s health movement.

How can a physiotherapist assist a man diagnosed with prostate cancer?
Firstly, for the pre-op consultation, I would encourage the man to bring along his partner. The partner is often more distressed than the man at this stage, a point that has to be acknowledged and addressed. At this session, the man would be taught how to do pelvic floor exercises to manage incontinence. He would also be encouraged to become as fit as possible before surgery. He should also be counselled on the impact of erectile dysfunction on his life and relationships, and be impressed of the need to learn how to do penile rehabilitation. Both partners should be instructed on the possibility of psychosocial effects, particularly depression, grief and loss. They should also be told about the positive process of post-traumatic transformational growth. And finally, the patient may need instruction after the operation for further continence and erectile dysfunction management.

Tell me how your professional focus diverted to an interest in pelvic pain.
My interest in this subject began as an accident, and now, pelvic pain makes up 80 per cent of my practice. About 14 years ago, I treated a urologist who complained of a painful lower back after executing a split squat with weights at the gym. I manipulated his sacroiliac joint (the joint between the sacrum and the right and left iliac bones) and as a result, as well as treating his back pain, it cured his scrotal pain, a symptom he had not disclosed.

This led to a decade of my researching pelvic pain and, in particular, the pudendal nerve, which supplies the scrotum and every major structure in the pelvis, including sexual, bladder and bowel functions.

The key ways to manage pelvic pain musculoskeletally, I found, included methods of treating patients through manipulation, exercise, awareness of lumbar-pelvic postural implications and managing neural hypersensitivity - a phenomenon also known as persistent pain. I published the book A Musculoskeletal approach to Pelvic Pain in 2015.

Besides men’s health, what are you passionate about?
About 40 years ago, after being exhausted from a heavy work load, I decided to look at my life as a business proposition. To get the most out of it, I devised a business plan with dynamic balance, which allowed me to reveal and nurture my creative side. I have sculptures in major Australian institutions and personal collections, and I have published four military books. I love the classics and also learn music. I am keen on travel and, after my cancer diagnosis, I found elation for life, climbing three of the world’s highest mountains (Mount Kilimanjaro in Africa, Mount Aconcagua in Argentina, and Mount Elbrus in Russia).

PFMT as effective as drugs for LUTS
About one in three older men experience lower urinary tract symptoms (LUTS). These are symptoms resulting from either bladder storage issues (such as urgency, nocturia, or frequency) or voiding issues (straining to urinate, a long time starting, a weak stream, or after-dribble).

Until now, the cause of these symptoms has been mainly attributed to an enlarged prostate hindering the flow of urine as it passes through the urethra inside the prostate. But Dutch researchers at the University of Groningen suspected pelvic muscle dysfunction might also be a contributing factor.

Their study, published in the International Journal of Urology in March this year, found that pelvic floor muscle training provided men the same benefits as the alpha-blocker drug, Flomax, a first-line treatment for LUTS. The drug works by relaxing the muscles around the prostate and relieving pressure on the urethra. However, alpha-blockers can have side-effects such as dizziness, low blood pressure and ejaculatory dysfunction.

In the study, 41 men aged 51-82 years with moderate to severe LUTS were divided into two groups; the first receiving Flomax for 90 days, and the second, pelvic floor muscle training for the same period. The second group also received counselling on nutrition and urination habits.

After 90 days, both groups had reduced their prostate symptom scores, and both had shown an improvement in a LUTS-specific quality of life index. However, the men who had received the pelvic floor muscle training had a better perception of improvement compared with those on the medication.

Study authors said that, although pelvic floor muscle training had a positive effect on symptoms comparable to that of Flomax, more studies with larger groups, and the inclusion of a control group, were needed to further confirm their results.
Suzanne Twelftree has achieved much in her 60 years. She has raised three children while running a farm with her husband, and competed in two sports at the international level. She now runs her own disability awareness consultancy, is on the national speakers’ circuit, and is active in her local community.

If that’s not enough to set Suzanne apart, then her paraplegia, acquired as a young woman, certainly is.

Suzanne has arteriovenous malformation, or AVM, a rare congenital disorder that affects one in 100,000 people. AVM is a tangled clump of blood vessels, often located in the central nervous system and vulnerable to haemorrhaging. While 88 per cent of people with AVM have no symptoms, for a small proportion, the AVM can haemorrhage and, depending on its location, cause significant damage.

At the age of 15, an AVM in Suzanne’s lower spine haemorrhaged, causing so much damage she became temporarily paralysed below the waist. Her case was so rare, the head of Adelaide Hospital’s spinal unit later said, “a tiny piece of paper with stick figures drawn on it”, handed to her as she left hospital.

This was to be the first of four major bleeds Suzanne endured during the next 30 years. But at age 15, the damage was contained and, six weeks after surgery, Suzanne was able to walk again. Her home rehabilitation physiotherapy, she says, was “a tiny piece of paper with stick figures drawn on it”, handed to her as she left hospital.

Although Suzanne was able to walk, the nerves controlling her bladder and bowel had been permanently damaged. Her bladder couldn’t contract to empty, and her defecation reflex and anal sphincter muscle were weak. She was given no instruction on managing her continence, and had “huge issues”.

“I learnt to void by making a fist and pushing down on my abdomen.” Suzanne said. “Until you have your bladder and bowel organised, you can’t do the other stuff – the sport, the travel.” She was selected to compete at the 1992 Barcelona Paralympics. Playing sport, she said, was a celebration of having finally achieved bladder and bowel control.

At age 30, after 15 years of self-management, her bladder dysfunction was finally explained and she was given instruction on self-catheterisation.

“I took to it like a duck to water,” Suzanne said. “I learnt to void by making a fist and pushing down on my abdomen. And as far as bowel motions, they just kind of happened.”

Fifteen years later, as a stay-at-home mum with three children under six, and co-managing the Yorke Peninsula farm with husband Greg, the AVM haemorrhaged again. The damage this time was much more severe, and she became a permanent paraplegic.

Suzanne spent eight weeks in rehabilitation at the Hampstead Spinal Unit in Adelaide, learning “how to live as a paraplegic”. “I had to learn how to balance, drive a car with the different controls, how to do transfers, how to get dressed – everything.”

At age 45, Suzanne suffered a catastrophic AVM haemorrhage, which her doctors feared would kill her. Three of the vertebrae in her lower spine were destroyed and her spine was now severed, her rib cage sitting on her pelvis.

For the next seven years, Suzanne played wheelchair tennis, and was selected to the 1992 Barcelona Paralympics. Suzanne’s powerlifting career also began by chance. She was handpicked by an official at a pre-Sydney Olympic Games conference in 1998, when an official asked her what she weighed. “They said they needed a 48kg powerlifter for the Sydney games, and they asked me to try out.

“I was under 48kg, and I’d loved doing weights when I was in rehab, so I did powerlifting for four years.”

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Through a process of trial and error over several years, Suzanne developed a regime of taking a laxative and eating six cashews and four dried apricots the night before she needed to empty her bowel – a regime she continues to this day.

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“They said I’d never get out of bed or be able to sit up again. I spent seven months laid-up.”
Despite spending months in bed facing the prospect of an early death, Suzanne said she never felt bitter or angry.

“I could look people in the eye and say that I couldn’t have fitted any more into my life. I’ve raised three kids, helped manage a farm, competed in the Paralympics and world championships. If this is it, well, this is it.’’

Even her parents, who had until then often offered words of comfort, reminding her “there was always someone worse off,” had no words this time.

Suzanne was fitted with a thoracic brace that would hold her torso together.

“It was difficult to feel attractive. I have a wheelchair, and a brace; I don’t need an indwelling catheter!”

Determined to avoid the prospect of an indwelling catheter, she cranked herself up a few degrees each day until she was able to sit, a position critical for her ability to self-catheterise.

The nurses were sceptical, but to their amazement, Suzanne hauled herself onto the toilet, and self-catheterised.

These days, she lives in Adelaide, away from the family farm because the “atrocious roads were too much for my permanently broken back”.

Suzanne’s days are still incredibly busy. She does the farm’s bookkeeping, runs disability awareness workshops, conducts access audits, and is involved in SA Health’s Transforming Health Project.

“I had three kids on the ground that I was responsible for. I couldn’t put them back”
– Suzanne.

Although Suzanne no longer plays sport, she is involved with local community groups, goes to the theatre and travels regularly.

She has four grandchildren, and she sees them often. “It’s lovely, but it brings back memories of what I couldn’t do as a mother.

“It is something new emotionally, which is a surprise to me. They make me laugh – that helps deal with the deficiencies I feel at times.”

Suzanne believes that, as debilitating as the AVM is, it fuels her drive to complete as much as she can in the time she has.

“I made a pact with myself that I would do all I possibly could with my life, because I knew I had AVM.”

Suzanne talks about the song, Hymn to Her, by The Pretenders, which has the repeating refrain, Some things change, some stay the same; words that convey succinctly, how the disease has impacted her life.

“Some things, like my body and my abilities, changed, but other things, like the kids and the everyday stuff I had to do, didn’t.”

It is the song she would like played at her funeral, she said.

When asked what has kept her mentally together, Suzanne is direct and without self-pity.

“You have to be resourceful, resilient. I had three kids on the ground that I was responsible for. I couldn’t put them back. And Greg still loved me. It was very much, ‘let’s get on with it.’”

Suzanne competed in wheelchair tennis and weightlifting at the international level, including the Barcelona and Sydney Paralympics and the Budapest and Los Angeles World Championships.
It’s World Continence Week June 19 -25, and Australians are being urged to take the matter of incontinence seriously, particularly in light of disturbing new data that suggests the majority of women affected simply laugh it off.

With a recent survey conducted by the Continence Foundation revealing that 85 per cent of women with incontinence simply laugh it off, it’s no surprise this year’s World Continence Week campaign, Incontinence: No laughing matter, urges Australians to take the subject more seriously.

Continence Foundation chief executive Rowan Cockerell said incontinence was never normal. “It might be common, but it’s never normal.

“Nor should it be considered a natural part of ageing or having a baby, because it isn’t,” Ms Cockerell said.

“We know that incontinence invariably worsens over time if ignored, and can significantly impact a person’s quality of life, with both men and women, at any age, at a higher risk of depression.”

Ms Cockerell said that treatment usually involved simple lifestyle changes and daily pelvic floor muscle exercises, “which everyone should be doing anyway.”

The results of the survey of 1000 women aged 30 and over, with incontinence was released ahead of World Continence Week, June 19-25. It found that 77 per cent of the women knew pelvic floor exercises would prevent or improve incontinence, but only 2 per cent performed them daily.

“Prevention is always better than cure, but early treatment is key to fixing the problem.

There is plenty of help out there.”

Ms Cockerell encouraged people affected by incontinence to phone the free National Continence Helpline (1800 33 00 66) for advice or information on local continence services, or to go to continence.org.au
Men in control... of bladder, bowel and erectile function

The probability of dying earlier than women due to preventable diseases has not been enough to convince some men to adopt healthier lifestyles. Perhaps the prospect of erectile dysfunction, along with bladder and bowel problems, might provide some motivation.

Male deaths outnumber female deaths across all age groups until men reach the age of 65, but that’s only because so many men have died by then. According to the 2008 Australian Bureau of Statistics, some of the most common causes of premature death among men are heart attack, lung, colon, rectum and prostate cancers, stroke, respiratory disease and diabetes.

Perhaps an added incentive for men taking better care of themselves might be knowing that, by adopting certain lifestyle changes (such as those recommended by the Continence Foundation – see right), they could also improve their erectile function.

Continence nurse advisor Stephen Marburg said men were often unaware of the impact lifestyle had on their bladder and bowel.

“Drinking enough fluids is a big issue; particularly for men working long hours with few breaks. If the urine is darker than pale lemon colour, they’re not drinking enough,” Marburg said.

“If their urine gets concentrated and irritates the bladder, which then tries to get rid of it, they risk frequency and urgency.”

He warned however, of drinking too many caffeine or sugar-based fizzy drinks, which also irritate the bladder. “And alcohol, which is a diuretic, drink only in moderation,” he added.

Constipation was another significant issue, particularly if men didn’t drink or exercise enough, or ate too many refined foods, he said.

“Constipation has a big impact on the bladder. A full compacted bowel can push up against the bladder, risking accidental leakage.

“And straining on the toilet when you’re constipated can stretch and weaken the pelvic floor muscles, much like overstretched elastic. These muscles are really important for continence,” Marburg said.

Marburg urged men with any bladder or bowel concerns to visit their GP or men’s health physiotherapist.

“Oh or they can speak to one of the continence nurse advisors on the free and confidential National Continence Helpline on 1800 33 00 66.”

THE FIVE STEPS TO HEALTHY BLADDERS AND BOWELS

The Continence Foundation recommends:

- Drink well
- Eat healthy
- Keep active
- Tone your pelvic floor
- Practise good toilet habits

Stephen Marburg said men were often unaware of the impact lifestyle had on their bladder and bowel.

A 2014 Rome study of 40 men aged 19-46 years who experienced premature ejaculation, found that their average ejaculation time of 32 seconds increased to nearly two-and-a-half minutes after 12 weeks of pelvic floor muscle training.

A toned pelvic floor has also been shown to improve erectile function, Marburg said, pointing to a 2005 British study of 55 men aged 20 years and over who experienced erectile dysfunction. The men who improved their lifestyle and did pelvic floor muscle exercises for three months significantly improved their erectile function compared with the group of men who only improved their lifestyles.

“And a previous study found the exercises as effective as Viagra for impotence, without the side-effects,” Marburg said.

“The pelvic floor is responsible for holding up the pelvic organs and closing off the urinary and anal sphincters. The pelvic floor muscles also play a role in gaining and maintaining erections,” Marburg said.

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Stephen Marburg said men were often unaware of the importance of their pelvic floor, a trampoline-shaped group of muscles and ligaments that extend from the tail bone to the pubic bone, and between both sitting bones.

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MARIA WHITMORE speaks with three health and fitness professionals, and continence nurse and course writer Julie Westaway, about some of the unique challenges health workers in Indigenous communities face daily.

A skilled and educated workforce is critical for improving the lives of the 4.8 million Australians affected by incontinence. Over-represented in this figure are members of the Indigenous community, who are also at greater risk of conditions such as diabetes, cardiovascular disease, kidney disease and respiratory disease, all of which put them at a higher risk of incontinence.

In addition to the prevalence of incontinence, myths, complex social structures and long-held traditions make the subject one that is rarely discussed or disclosed.

To address some of the challenges health workers in and among the Indigenous population face, the Continence Foundation of Australia developed a specialised course as an elective component of the Certificate II in Continence Care and Promotion.

Toowoomba-based continence and urogynaecology nurse, Julie Westaway, who has several years’ experience working in remote Indigenous communities, helped develop the course elective.

According to Julie, the more remote the communities, the more entrenched the attitudes, myths and traditions.

“The more remote you go, the more likely they won’t access the health services. Often English isn’t their first language, and traditionally they have family to look after them, so they won’t ask for help,” Julie said.

Taboos, too, were more likely to influence health-seeking behaviours in the more remote communities, she said.

“If there are men present at the clinics – whether they’re patients or health workers – in the more remote places, the women won’t go into the clinic because of the shame of being seen. So you have to have women’s only days, or separate waiting rooms for men and women.”

Shame and embarrassment meant that incontinence issues, which were often associated with chronic conditions such as diabetes, asthma or chronic obstructive pulmonary disease, were rarely disclosed to health workers. Julie said that by developing a rapport, using non-clinical, familiar language, and approaching the problem indirectly, patients were more likely to speak up.

“So you start with a general assessment and look at their history, and from that you can probably predict whether or not they may have continence problems, and so you approach it differently.”

Julie said the course module gave health workers insights into the complex social mores of Indigenous communities, and equipped them with strategies to help make their work more effective.

“It’s really all about being able to make that connection,” she said.

Continence Foundation chief executive Rowan Cockerell said the Certificate II was suitable for a range of health workers, including personal care attendants, pharmacy assistants, nurses, allied health professionals and Indigenous health workers.

“I encourage anyone working in remote communities, regardless of the population’s make-up, to look at the various courses that can be completed remotely, and to keep an eye out for scholarships that regularly become available,” Ms Cockerell said.

For more information about the Certificate II in Continence Care and Promotion, go to continence.org.au or email courses@benchmarque.com.au.

Robert Palmer is an Aboriginal men’s health practitioner based in Alice Springs, completing the Aboriginal and Torres Strait elective as part of the Certificate II in Continence Care Promotion.

Robert said he recognised the need to educate himself about incontinence because of the high prevalence among his patients.

He estimated one third of the men coming to his clinic had bladder leakage problems.

“They don’t bring it up themselves. They’ll tell me about other things, like their diabetes or blood pressure, or their heart. I’ll ask the questions,” he said.
INDIGENOUS HEALTH CHECK

Indigenous Australians are:

• 3.3 times more likely to have diabetes,
• 2.6 times more likely to die from kidney disease,
• 4.4 times more likely to have chronic obstructive pulmonary disease,
• 1.8 times more likely to have asthma,
• 1.8 times more likely to have upper respiratory infections,
• 2.2 more likely to have a profound/core disability,
• 1.2 times more likely to be overweight or obese, and
• 2.5 times more likely to smoke.

Source: 2015 Australian Indigenous HealthInfoNet

Part of Robert’s work is to conduct sexually transmitted infection checks, which gives him the opportunity to ask routine questions, including those about bladder leakage.

While most of the men affected tend to be in the older age group, a substantial number were under the age of 35, Robert said.

“The older guys, they just live with it. Everybody’s got used to it; it’s a part of old age. But the younger guys who are leaking, they don’t say much. They don’t know why it’s happening,” he said.

Homelessness and unhealthy practices, he said, were at the core of most of his patients’ health issues, and their needs extended beyond tackling symptomatic issues, such as incontinence.

“Often they drink excessively, most are transient. It’s a lifestyle issue - what they eat, the alcohol - which is why we have to have a holistic approach.”

Judith Henning is a community health nurse in Cunnamulla, a town of 900 inhabitants approximately 1000 km west of Brisbane.

The town’s socio-economic status is fairly consistent across its Indigenous and non-Indigenous population, each making up about one half of the population.

Judith said the community’s isolation, along with myths about incontinence, were significant contributors to the region’s health outcomes.

“There’s a lack of knowledge about incontinence and what causes it. And then there’s the embarrassment factor,” she said.

As a result of her patients’ reluctance to speak up about incontinence, Judith delivers presentations to community groups so that women with leakage problems feel more inclined to speak up.

“Generally we get a few referrals from these,” she said.

However, prevailing community attitudes are further barriers to her patients managing their incontinence, she said, with many either disinterested, or unaware that incontinence can often be prevented, treated or cured.

“Very few understand the problem; there needs to be much more awareness-raising and education so they don’t just go for a quick fix,” she said.

Isolation plays a role, too, in her own professional development. Apart from some of the larger continence product companies coming out to Charleville to promote their products, any opportunities for face-to-face education were logistically challenging, Judith said.

“It’s much harder for health workers in remote communities, particularly if you work in isolation, as I do.

“There are issues such as being able to get release to study, financial burden travelling to bigger cities; it’s a combination of factors. People don’t realise how isolated it is here in Cunnamulla,” she said.

Terri Gilbert, a fitness instructor in Bundaberg, Queensland, runs a number of classes for Indigenous women of all ages, including netball, cardio tennis, water fitness, boot camp and a walking group.

Terri said that bladder leakage during classes, particularly when the women engaged in high-impact or weight-bearing activities, was an all too common problem.

“With any activity, it’s always going to be an issue - a lot worse for some than for others. Mainly for the women who are a bit overweight, or have had children; they struggle,” Terri said.

While the women with whom she had developed a trusted relationship would speak up about their bladder leakage, most wouldn’t, she said.

Typically, the concerns were about ways to disguise or hide their incontinence, rather than prevent or mitigate it, she said.

“They ask me what they can wear, what they can do so it doesn’t show.”

Prolapse was another topic raised by women.

“They ask me what they can do to take pressure off their bladder to stop it from ‘coming down’. They tell me that some of the doctors say a tampon helps.”

Terri reinforces the importance of pelvic floor strengthening during workouts that may cause leakage.

“We focus on doing full-body workouts and strengthening their pelvic floor. It’s an ongoing issue.”

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National Continence Helpline manager SUE BLINMAN answers these common calls to the Helpline.

**Q** I’ve been buying continence pads for years and I heard from my sister-in-law that I can get funding for them?

**A** There are two types of funding, the federally-funded Continence Aids Payment Scheme (CAPS), and state-based schemes.

You can phone the National Continence Helpline (1800 33 00 66) for a CAPS application form to be posted out to you, or you can download one at bladderbowel.gov.au/caps. In addition, some pharmacists may have CAPS forms on hand, or you can ask your GP or the practice nurse for one.

Your CAPS application will need to include a report by your GP or other health professional. If you qualify you will receive a payment to help meet the cost of continence products (or part thereof if your application was made after July 1).

Each state has different funding criteria. As part of your application for state funding, you will need an assessment and prescription from your continence nurse.

For more information about the NDIS and federal and state funding schemes and eligibility, download the Continence Foundation’s *Funding schemes for continence products* fact sheet.

**Q** I saw your ad on TV, and it says bladder leakage can be treated. I’ve had bladder leakage for many years, and I didn’t realise that.

**A** We often get calls like this when the Foundation airs television campaigns, prompting many calls from people who have put up with incontinence for years.

When you phone, a continence nurse will discuss your symptoms in order to gain an understanding of the type of problems you are experiencing.

For example, are there occasions or activities that trigger the bladder
leakage? Does it happen when running, lifting or sneezing, on the way to the toilet, as you are rushing to get the key in your front door, or is it happening overnight? Or perhaps there is steady, ongoing leakage.

The continence nurse will also ask about dietary, drinking and toilet habits. As well as making recommendations or sending out helpful resources, the nurses can advise you of your nearest continence service for further assessment, and will suggest you discuss the issue with your GP.

Q: I've just had a radical prostatectomy and I was never warned about having this much leakage.

A: This is not uncommon because, when you were diagnosed with prostate cancer, you were understandably focussed on removing the cancerous prostate, and less on the side-effects post-surgery. We suggest you go back to your urologist or urology nurse to assess your progress, and to review the products and strategies you are using. We also suggest you see a pelvic floor physiotherapist specialising in men’s health to reassure you that you are doing everything you can to restore your continence, including pelvic floor muscle exercises.

Q: I’ve recently retired and am on a part-pension. As a result I need to spend less. Can you advise how I can reduce my expenditure on continence products?

A: As well as offering advice on funding schemes, which will reduce some of the financial load, the Helpline staff can advise on various products, where to get samples, and how to purchase in bulk.

We will also advise about products or aids that can help lessen the impact of incontinence, such as the most appropriate type of bed or furniture protector, commode chairs and other products such as waterproof doonas.

And more importantly, we will make sure you know where to go to get treatment to improve your continence so you don’t have to use as many products. Not only will this reduce costs, it will also improve your quality of life and open up more opportunities for social and recreational activities.

Our focus is you

No matter what your age and stage of life, Abena’s products are designed with a focus on your needs. Abena’s continence products, nappies, skin care and wound care provides solutions to everyday challenges. Visit www.abena.com.au

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