• Critique: Translating evidence into practice: pelvic floor muscle training for post-prostatectomy incontinence – or not?  
  *P Neumann, S Morrison & I Nahon*

• Abstracts: 20th National Conference on Incontinence, Melbourne, 16-19 November 2011

• Solifenacin use in older Australians – the challenge of non-government subsidised prescription for overactive bladder  
  *MMY Lai, CL Lui & CA Inderjeeth*
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Do you need topic ideas? A variety of topics are possible and include, but are not limited to: outcome studies, aged care, paediatrics, pregnancy and childbirth, novel drug therapies, reviews of devices either surgical or non-surgical, assessment articles, literature reviews of continence-related topics, home and community care issues and successes, men’s health, nursing management, physiotherapy management, support by other allied health disciplines (including occupational therapy and social workers), the psychological impact of living with incontinence, ethical issues, cultural issues and collaborative approaches to care.

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Editorial

We're in good hands

In this my farewell editorial, I think it's time to look at what the *Australian and New Zealand Continence Journal* (ANZCJ) has as its stated aims, how well these aims have been met and whether we need to revisit the vision for our journal as it moves forward. The website states “the ANZCJ is the only multidisciplinary journal dedicated to researching the diagnosis, treatment and management of incontinence, bringing together the medical, nursing and allied health specialties: continence nursing, gastroenterology, gerontology, paediatrics, physiotherapy, urogynaecology, and urology”. During my time as editor, each of these specialties has contributed, confirming the relevance of these aims, and the journal’s contribution to evidence-based clinical decision-making across the various professions.

While evidence-based practice (the science of clinical practice) is driving much of the clinical research the journal has published, it is important to remember that evidence-based practice does not do away with the need for the clinician's role within clinical decision-making (the art of clinical practice). However, clinician-centred care is standing aside to make way for patient-centred care – the emerging paradigm of clinical practice.

Evidence-based clinical practice is always tempered by the needs of each particular patient. Clinicians making decisions need to view the available evidence in regard to individual, specific patient needs. While evidence helps make clinical decisions, ultimately treatment decisions have to be made by the clinician working at all times with the best interests of individual patients in mind.

As I have previously noted, the strength of the Continence Foundation of Australia lies in its diversity. Evidence-based decision-making is common to all of our various professions and it provides an ideal platform for multidisciplinary work. The fact that the number of contributions to ANZCJ is increasing is testament to that fact, so I believe the journal’s aims have been met without a doubt.

**ANZCJ announces new editor**

As to the future of our journal – it has never looked brighter. I have every confidence in our new editor, Dr Mark Weatherall, who is yet again testament to the diversity of the membership of the CFA. Editorial professions have included urogynaecology, urology and physiotherapy. Not only does our new editor introduce a new editorial professional focus, gerontology, as he hails from New Zealand he bridges the international divide of our members, bringing us even closer together. I warmly welcome Dr Mark Weatherall to the editor’s chair – I know the journal is in good hands.

Mark Weatherall is a Consultant Geriatrician in Wellington, New Zealand, and Professor in the Department of Medicine at the University of Otago, Wellington. Mark has been a member of the executive committee of the New Zealand Continence Association (NZCA) for a number of years and President of the Association for the last six years. He has research interests in chronic diseases such as COPD and stroke, and in the combined analysis of evidence. An active member of the Australian and New Zealand Continence Journal’s Peer Review Panel and Editorial Committee for the past four years, the Journal Editorial Committee welcomes Mark as Journal Editor.

**Nominations sought for Peer Review Panel**

Experts from the disciplines involved in continence treatment, management and promotion and those who are expert in research methods and statistical analysis are invited to nominate to join the *Australian and New Zealand Continence Journal* Peer Review Panel.

Peer review was introduced to the journal in 2004 and began an exciting new era in our publication. Peer review of articles is aimed to increase the calibre of academic and research papers published and to raise the standing of the journal.

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For details regarding the Peer Review Panel, please email Jacinta Miller jacmil@bigpond.com

Assoc Prof Pauline Chiarelli

*Australian and New Zealand Continence Journal, Editor Programme Convener, Discipline of Physiotherapy, University of Newcastle, NSW*
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Critique

Translating evidence into practice: pelvic floor muscle training for post-prostatectomy incontinence – or not?

One of the pillars of evidence-based practice is high quality research. But what should clinicians do when a large, multi-centre randomised clinical trial (RCT) produces results that are seriously questioned by physiotherapy researchers and clinicians around the world? This has been the case with the study, recently published in The Lancet, by Glazener and colleagues. Men who were diagnosed with urinary incontinence following a radical prostatectomy, or TURP, were recruited into the study six weeks after surgery and randomised to treatment or control groups. The treatment group received up to four sessions of pelvic floor muscle training (PFMT) with a physiotherapist (PT) or continence nurse advisor (CNA) over the following three months. The men were then reassessed 12 months after surgery. The control group received no formal one-on-one training. The conclusions of the study were that one-to-one pelvic floor muscle (PFM) exercise taught by a continence health professional (physiotherapist or nurse) was unlikely to be effective or cost-effective.

The results of the study then hit headlines around the world. The lead author, an influential member of the Cochrane Collaboration and researcher, Professor Catherine Glazener was interviewed shortly after the paper’s publication by Norman Swan on the ABC’s Health Report. During that interview, she reported the study’s negative findings and stated that:

“What we have not been able to show is whether or not pelvic floor exercises themselves work but we have shown that it is a waste of time and a waste of resources to get a physiotherapist to teach them because the standard care, you know telling people about them and giving them leaflets, is obviously sufficiently effective without needing an extra physiotherapist as well.

The method and results of this RCT need careful scrutiny. In the study there was a surprisingly high prevalence of incontinence at 12 months follow-up among both intervention groups: 76% “any” and 38% “severe” for the prostatectomy group and 65% “any” and 25% “severe” for the TURP group. Many factors could have influenced this, not just the ineffectiveness of the intervention. For example, the results may indicate poor surgical procedures, the rate of incontinence at baseline was not clearly reported but the 12-month rates were high when compared with incontinence rates of 8–56% after surgery reported elsewhere. Another possible explanation for the high rate of incontinence may be the outcome measure used. The authors did not use any objective measure of incontinence as recommended by the International Continence Society and used only the subjective ICIQ-UI SF. Men who leaked urine “about once a week or less often” were categorised as incontinent. For example, although 76% of the men were found to have “any incontinence” at 12 months, less than half of them (32%) found their leakage bothersome enough to wear pads.

Another explanation for the poor outcomes between treatment and control groups could be that the intervention was ineffective. The intervention protocol, published in a separate paper, can be criticised on a number of counts: participants were examined four times per annum to assess and teach a PFM contraction and they were asked to contract their PFM “as if you are trying to stop wind escaping”. The authors stated that digital rectal examination (DRE) is a reliable test of PFM function. While this may be true, more important is whether DRE is a valid test of urethral sphincter function and this has not been addressed. There is a focus on anal sphincter contraction throughout the protocol, to the exclusion of any mention of the urethral sphincter or its function. This focus on the anal sphincter is also problematic. Firstly, the examination and subsequent practice possibly has the effect of providing the inappropriate sensorimotor experience of the anal sphincter. Learning the specific motor control for the bladder would have been more appropriate. Secondly, strong contraction of the anal sphincter may significantly raise intra-abdominal pressure, which could result in urine loss unless the urethral sphincter is closed. There appears to be no confirmation that subjects were checked for their ability to contract the PFM without loss of urine and there...
is no mention in the intervention protocol of the ability to stop the flow of urine at all. This is an essential skill after prostate surgery. The action of flow-stopping produces an antero-cranial movement of the urethra at the bladder base, due to activation of the pubo-perineal muscles and the external urethral sphincter. The ability to lift the urethra >2 mm with this action correlates with early recovery of urinary control. This skill also provides reassurance for the patient and increases his confidence that urine can be controlled in situations of either raised intra-abdominal pressure or with urgency.

The treatment protocol involved up to four sessions with a PT or CNA for three months, followed by no treatment for nine months. Continence status and quality of life (QoL) were assessed again at 12 months. What is striking from the graphs showing changes in the percentage of incontinent men and the impact on QoL, is that there was a marked improvement during the three months of treatment followed by no change in the nine months of no treatment. This suggests that ongoing intervention may have helped to improve continence status and QoL at final follow-up at 12 months. It may indicate a lack of motivation to continue exercising on their own or failure to fully integrate their pelvic floor skills into everyday life. By contrast, other studies have shown that men continued to improve over 12 months as long as they receive supervised PFMT with a physiotherapist.

There are other important weaknesses in the administration of the treatment and control groups that may have led to dilution of the treatment effect. A high percentage, up to 14%, of men in the treatment group did not see a healthcare professional at all and attendance dropped off after the first visit, so that by the fourth scheduled visit, 28% of men did not attend. Secondly, the ‘control’ group was doing pelvic floor exercises just about as much as the ‘treatment’ group – 50% of the control group versus 67% of the treatment group – at 12 months and both groups had very similar outcomes. Although the authors concluded that it would be cheaper, and just as effective, for all men to get their information from the internet, this was not the intervention studied. The veracity of information available on the internet may not be very helpful either. For example, information on the Australian Government Bladder and Bowel website also suggests that men should contract their pelvic floor muscles as if “holding on to wind”.

The timing of the intervention may have set up subjects to fail as they entered the study six weeks after their surgery when they were already incontinent. Positive outcomes for PFMT have been demonstrated, particularly when PFMT is started preoperatively.

The Glazener intervention was based on previous RCTs on the management of men with erectile dysfunction, women with urge incontinence and men with post-micturition dribble.
The physiological rationale for the training programme for men with urinary incontinence after prostate surgery should have been tested; for example, in a pilot study before being used in a definitive RCT.

Although the actual muscle training protocol was pragmatic, it was not based on clear principles of exercise science. It was neither a strengthening programme, nor an endurance programme, nor a functional programme, but a mix of all three. It is likely that an inadequate number of muscle contractions were recommended in the treatment programme. While other regimens, such as that described by Kegel\(^3\) who recommended 300–400 contractions per day, were considered, they were found to be "too arduous". The protocol used described an "achievable number" of contractions a day; for example, participants performed three maximum contractions in lying, sitting and standing twice a day and were concurrently practising ‘endurance’ (sustained submaximal) exercises whenever they were upright. They were also encouraged to ‘brace’ before rises in intra-abdominal pressure, ‘the Knack’\(^4\), but they were not specifically trained in ‘the Knack’. Thus, they may have failed to automate the process, or learned to apply it to new tasks as they became more physically active. The written information participants received only provided them with an “Important Tip” to contract their PFM before coughing, sneezing and so on. There was a section on advice to contract the PFM during sexual activity but 56% of men were still unable to produce an erection at 12 months, so this advice was not useful to more than half the participants as, anecdotally, we understand that sexual activity is not a high priority when men are stillcontinent of urine. So this training protocol was not essentially different from what men may have gleaned from the internet and specific individualised training over the period of incontinence was lacking in both regimens.

The protocol described urge suppression techniques using only cortical control, “staying calm” and not rushing to the toilet but did not include a contraction of the voluntary urethral sphincter and PFM, which would seem important in this population to prevent urine escaping into the proximal urethra.

This controversial study raises the question of how authors of papers should phrase their conclusions and also the role of editors and peer reviewers in ensuring that the research conclusions reflect the strengths and weaknesses of any particular study. It may have been more appropriate for the authors of this paper to have reported that their training protocol was not effective, rather than PFMT in general, and provided a more critical appraisal of its failure. This would help readers to put this study in the context of other studies that have reported positive findings\(^3,9,11,17\).

Headlines about this study have now gone out to medical practitioners throughout Australia via a GP online newsletter and to consumers through the ABC. The news that PFMT from a health professional is not effective may well undermine men’s chances of receiving appropriate and timely care. We recommend caution in the interpretation of the study’s findings and suggest that there is good evidence from other trials that PFMT may help men who are having prostate surgery.

**References**


Abstracts from the
20th National Conference on Incontinence
16–19 November 2011
Melbourne, VIC
Evidence-based guidelines for the selection and use of continence management products

Cottenden A
University College, London, United Kingdom
Invited speaker

Although in recent years we have seen great progress in treating incontinence, many individuals continue to live with the threat or reality of urinary or faecal leakage. It may be while they are awaiting treatment, or waiting for treatment to work, or in the long term if treatment is unsuccessful or they have elected not to pursue it. For all such people, the challenge is to discover how to manage their incontinence so as to minimise its impact on their quality of life, and this usually involves using some kind of continence product(s) to control or contain leakage, so achieving social continence.

However, identifying the most effective available product(s) for a given user is fraught with challenges. Although the number of fundamentally different designs is limited, the market offers a bewildering array of variants – and almost none of them the subject of published clinical evaluations. It makes no sense to run expensive trials on products that are likely to be discontinued or modified before the results are in print. The diversity of needs and priorities among users adds another dimension of complexity. Differences in gender, body shape and size, age, visual acuity, manual dexterity and mobility, for example, may result in quite different products best meeting the needs of two people with identical bladder or bowel dysfunction. Furthermore, an individual may find it best to use different products on different occasions; for example, by day versus by night, or when at home versus when out.

Nevertheless, all is not lost. There may be little published data relating to a particular product but many published studies provide insights, results and conclusions with broader application than the specific products that yielded them, so that tentative, generic guidance can be formulated. This was the approach taken by the authors of the chapter on Management using Continence Products in the book1 of the fourth International Consultation on Incontinence (IC14). They produced tables of guidelines on selecting from among product categories for various user groups (such as men with moderate to heavy UI) and for the different subcategories within a design (such as body-worn pads). The approach was to identify factors which tend to favour or discourage the use of particular products in particular contexts so as to help enquirers identify the solution(s) most likely to succeed and, therefore, worth trying first.

Such tables can be readily updated and strengthened – as is currently happening for IC15 – as further evidence accumulates, and they constitute an accessible and concise source of help to inform patient choice and support clinical practice and education. Based on this approach, web pages to help users and professionals make evidence-based choices are now being created for inclusion on the ICS website. The information there will be generic and international and will direct enquirers to the various national websites for country-specific help relating to the provision of products (and other incontinence-related help) and the specific products available for the enquirer’s country.

This lecture will present the work to date, summarise the latest guidelines and explain how the new web pages will function.

Reference


Urinary symptoms and help-seeking in a South Australian older population

Lynn P & Paterson J
School of Nursing and Midwifery, Flinders University, Adelaide, SA

Introduction: Help-seeking activities for urinary symptoms are undocumented in wider elderly populations. This study used incidental data from a large longitudinal study of ageing to identify help-seeking patterns for urinary symptoms in a cohort over 75 years old.

Materials and methods: The Australian Longitudinal Study of Aging (ALSA) is an ongoing, multidisciplinary prospective study of the older population, which commenced in 1992 in South Australia. The baseline sample of 1477 adults were aged 65 years and over, and lived in the community or residential aged care. Data, collected in two waves between 2001 and 2004 included questions about help-seeking activities for questionnaire-defined, self-reported urinary symptoms. Urinary symptoms included: accidental leakage of urine, difficulty holding urine to reach the toilet, night-time urination, painful urination and troublesome frequency of urination.

Results: Four hundred and forty-six surviving subjects reported on urinary symptoms in 2001. Both men (241) and women (254) had a mean age of 85 years (range 74–101 years), 76% of the total subjects lived in the community and 403 (90.35%) subjects reported at least one urinary symptom.

Excessive night-time urination was the most reported symptom (81.2% responders) followed by difficulty holding urine in time to reach the bathroom (49.5% responders). Logistic regression was used to identify which symptoms were more likely to be reported by males or females (X2=11.83, df=5, p<0.05). Only difficulty holding urine was a predictor for gender – associated with females with an odds ratio of 1.60.

Logistic regression was used to identify when an older person was more likely to seek help with urinary symptoms. Three independent variables were chosen: number of urinary symptoms, age and gender. The full model distinguished those who sought help with urinary symptoms (X2=182.7, df=3, p<0.0001). The only predictor for seeking help with urinary symptoms was the number of urinary symptoms reported, recording an odds ratio of 5.48. Ten subjects did not fit the model, but all had reported significant urinary symptoms in previous waves.

Of the 403 reporting symptoms, 107 people sought help for their urinary symptoms. Both men (n=51) and women (n=56)

had a mean age of 87 years (77–98 years). Fifty-five per cent lived in the community.

Subjects were more likely to receive advice or treatment rather than provision of aids when residing in the community compared to residential aged care (X^2=43.4, df=1, odds ratio=37.9), despite having no difference in the number of symptoms reported. Regarding impact on daily life, 45% of community dwelling and 30% of subjects living in residential aged care reported that the help received had no real impact on their daily lives. The type or quality of advice, treatment or aids provided was not reported. Treatment impact on daily life did not differ with the type of urinary symptom.

In the smaller 2004 wave, community help was sought from general practitioners (GPs) (20/58, 34%), tertiary health centres (13/58, 22%), continence clinics (6/58, 10%) or family and friends (3/58, 5%).

Conclusions: In this older age group, help-seeking is prevalent among those with urinary symptoms, regardless of age or gender. Having more symptoms was a predictor for seeking help, although the severity of symptoms was not investigated. Of concern is the number of older people who felt the help they had received had no impact on their daily lives. Identifying the quality of help received and the expectations and desires for treatment in this older community may identify avenues for better meeting their urinary symptom treatment needs.

A reliability study of two-dimensional transperineal ultrasound measurement of pelvic organ prolapse
Virtue D, Sherburn M, Bryant AL, Frawley H & Galea MP
The University of Melbourne, VIC

Introduction: In recent years, real-time ultrasound (RTUS) has increased in popularity within the clinical setting. However, there are few studies that have quantified the reliability of two-dimensional (2D) transperineal RTUS and no previous studies have focused specifically on women with pelvic organ prolapse (POP). Hence, the aim of this study was to evaluate the reliability of 2D RTUS in women with POP.

Materials and methods: Two raters independently measured ultrasound images of 21 women with a gynaecological diagnosis of Stage II POP on two separate occasions, four weeks apart. Variables measured were levator hiatus anteroposterior (LHAP) dimension and leading edge of the bladder, in two positions (crook-lying and standing), and under three conditions (at rest, on pelvic floor muscle contraction – MVC – and on Valsalva). Test-retest reliability for LHAP measurement was analysed using intraclass correlation coefficients (ICC) and bladder measurements were analysed with Spearman rank correlation (r).

Results: LHAP measurement was reliable in all positions and under all conditions (Tables 1 and 2). Measurement of the leading edge of the bladder was more variable in both crook-lying and standing and under all three conditions (Tables 3 and 4).

Table 1. Intra-rater reliability LHAP measurement (ICC).

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<tr>
<th></th>
<th>Rest</th>
<th>MVC</th>
<th>Valsalva</th>
</tr>
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<tbody>
<tr>
<td>Crook-lying</td>
<td>0.768–0.796</td>
<td>0.710–0.754</td>
<td>0.839–0.923</td>
</tr>
<tr>
<td>Standing</td>
<td>0.850–0.879</td>
<td>0.666–0.737</td>
<td>0.794–0.937</td>
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Table 2. Inter-rater reliability LHAP measurement (ICC).

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<th>Rest</th>
<th>MVC</th>
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<tr>
<td>Crook-lying</td>
<td>.959</td>
<td>.923</td>
<td>.961</td>
</tr>
<tr>
<td>Standing</td>
<td>.935</td>
<td>.887</td>
<td>.975</td>
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Table 3. Intra-rater correlation of leading edge of bladder measurement (r).

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<th>Rest</th>
<th>MVC</th>
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<tbody>
<tr>
<td>Crook-lying</td>
<td>0.350–0.616</td>
<td>0.004–0.616</td>
<td>0.205–0.229</td>
</tr>
<tr>
<td>Standing</td>
<td>0.189–0.243</td>
<td>0.097–0.118</td>
<td>0.570–0.526</td>
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Table 4. Inter-rater correlation of leading edge of bladder measurement (r).

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<th>Rest</th>
<th>MVC</th>
<th>Valsalva</th>
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<tbody>
<tr>
<td>Crook-lying</td>
<td>0.702</td>
<td>0.464</td>
<td>0.790</td>
</tr>
<tr>
<td>Standing</td>
<td>0.926</td>
<td>0.898</td>
<td>0.833</td>
</tr>
</tbody>
</table>

Conclusions: Two-dimensional transperineal RTUS demonstrates very good reliability in lying and standing for levator hiatus measurement but measurement of bladder descent is less reliable. Transperineal RTUS assessment could be a relatively cost-effective, accessible adjunct to clinical management to monitor the effects of treatment of POP, surgical or conservative.

Documentation of the quality of continence care in residential aged care settings: a critique of accreditation reports
Ostaszkwiezicz J, O’Connell B & Dunning T
School of Nursing & Midwifery, Deakin University, Melbourne, VIC

Introduction: Incontinence and its management in residential aged care facilities (RACF) is a significant issue that consumes one-third of the residential aged care subsidy. Urinary incontinence (UI) affects more than 50% of residents and between 10% and 30% of residents experience faecal incontinence. Despite these factors, little is known about the quality of continence care residents receive. The aim of the current study was to describe the quality of continence care in RACF.

Materials and methods: A matrix of standards for continence care in RACF was developed based on recommendations for managing incontinence in frail older adults from the International Consultation on Incontinence (ICI). The ICI recommends:

• an assessment that focuses on potentially treatable conditions and on factors that may cause or worsen UI, contribute to its burden and impact management decisions.
Introduction: The objective was to assess the medium-term effects of dimethyl sulfoxide (DMSO) therapy on overactive bladder symptoms of patients diagnosed with interstitial cystitis (IC).

Interstitial cystitis is a painful bladder condition, which is often associated with urinary urgency, frequency and nocturia. DMSO bladder installation has been used for the treatment of interstitial cystitis for years but there is limited data on its effects on overactive bladder symptoms in the medium term.

Materials and methods: Following ethics approval, 44 patients diagnosed with IC in our institution treated with DMSO between 2009 and 2011 were identified for the purpose of analysis. As treatment for IC, these patients underwent bladder installation with a mixture of 40 ml of 50% DMSO with 1.25% bupivacaine, 100 mg hydrocortisone and 5000 U heparin twice-weekly for four weeks and then weekly for another four weeks. They were also routinely surveyed with the O’Leary Sant Interstitial Cystitis Symptom and Problem Index questionnaires and bladder diaries before and after completion of the treatment<sup>1</sup>. In this study, we investigated the effect of this therapy in the short and medium term.

Results: Although most reports (65%) contained a statement about a system in place to address residents’ continence care needs, a lack of detail made it difficult to determine whether this system involved an assessment to identify potential causes and contributing factors to residents’ incontinence. Only one report contained information to indicate some form of medical involvement. Documentation about residents or representatives involvement in the assessment and care planning process was limited to 21% of reports.

Conclusions: The lack of documentation in RACF accreditation reports about the nature and outcome of care processes designed to address residents’ continence care needs is concerning, as is the lack of documentation about medical or resident involvement in care. These findings indicate the need for guidelines to assist accreditors to evaluate continence care in RACF against ICI standards.

References

Medium-term follow-up of patients with interstitial cystitis patients following treatment with a DMSO cocktail

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1. Mercy Hospital for Women, Melbourne, VIC
2. James Cook University, Townsville, QLD

**Introduction:** The objective was to assess the medium-term effects of dimethyl sulfoxide (DMSO) therapy on overactive bladder symptoms of patients diagnosed with interstitial cystitis (IC).

Interstitial cystitis is a painful bladder condition, which is often associated with urinary urgency, frequency and nocturia. DMSO bladder installation has been used for the treatment of interstitial cystitis for years but there is limited data on its effects on overactive bladder symptoms in the medium term.

**Materials and methods:** Following ethics approval, 44 patients diagnosed with IC in our institution treated with DMSO between 2009 and 2011 were identified for the purpose of analysis. As treatment for IC, these patients underwent bladder installation with a mixture of 40 ml of 50% DMSO with 1.25% bupivacaine, 100 mg hydrocortisone and 5000 U heparin twice-weekly for four weeks and then weekly for another four weeks. They were also routinely surveyed with the O’Leary Sant Interstitial Cystitis Symptom and Problem Index questionnaires and bladder diaries before and after completion of the treatment<sup>1</sup>. In this study, we investigated the effect of this therapy in the short and medium term.

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**Conclusions:** The lack of documentation in RACF accreditation reports about the nature and outcome of care processes designed to address residents’ continence care needs is concerning, as is the lack of documentation about medical or resident involvement in care. These findings indicate the need for guidelines to assist accreditors to evaluate continence care in RACF against ICI standards.

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Faecal incontinence in community-dwelling older women – associated factors and its impact on quality of life

Koloski NA, Jones M, Halland M, Byles J, Chiarelli P, Forder P & Talley NJ

Physiotherapy Program, University of Newcastle, NSW

Introduction: While it is well known that faecal incontinence (FI) is a common problem in nursing home residents, and this may be associated with anatomic, physiologic and medical conditions, there is very little data on the prevalence and other risk factors associated with FI in older women living independently in the community. We aimed to determine the prevalence and risk factors for FI during the past year in a large, population-based, cohort of older Australian women.

Materials and methods: Participants were 4889 women (aged 82–87 years) who participated in the fifth survey of the Australian Longitudinal Study on Women's Health. FI was defined as any leakage of liquid and/or solid stool over the past 12 months. Self-reported symptoms of urinary incontinence, asthma and constipation over the past 12 months were assessed. A lifetime history of prolapse repair and hysterectomy were also asked. Lifestyle factors assessed included smoking (never, current, past), alcohol intake (nil, low and high risk), body mass index (BMI) and number of live births. Eight domains of quality of life (QoL) including general and mental health, bodily pain, physical and social functioning, role physical and emotional and vitality were assessed using the valid SF-36. Demographic factors included nationality, marital status, level of education attained and socioeconomic status.

Results: The prevalence of any leakage of liquid (8.2%), solid (6.2%) or both liquid and/or solid stool was 10.4% (n=510). Univariately, urinary incontinence, constipation, asthma, constipation, a prolapse repair, lower educational level and reduced functioning on all eight domains of QoL were significantly associated with reporting FI. A multiple regression model, that included univariate significant items, was used as the dry method) in Western society. Therefore, staining is more

Significant reductions were also found in the following QoL SF-36 subscales for independently associated with reporting FI versus not reporting FI:

- General health M=6.3 vs M=5.3; OR=0.9; 95% CI 0.8-0.9, p=0.000
- Mental functioning M=8.0 vs M=7.2; OR=0.9, 95% CI 0.8-1.0, p=0.002
- Role emotional M=7.2 vs M=5.8; OR=1.0, 95% CI 0.9-1.0, p=0.014

Conclusions: FI is a common problem among older, community-dwelling women and is associated with urinary incontinence, prolapse repair, lower education and reduced aspects of QoL.

Prevalence of faecal incontinence in community-dwelling older people in Indonesia

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Introduction: The prevalence rate of faecal incontinence among older, community-dwelling Indonesians is currently undocumented, despite evidence suggesting these problems in other older populations are common health issues1-3. This study was the first in the Indonesian context aimed at determining the prevalence rate of faecal incontinence in community-dwelling older people, as well as exploring current management practices.

Materials and methods: A cross-sectional, population-based survey using validated questionnaires was adopted in this study and was administered by structured interview in participants’ homes in Bali, Indonesia. Six hundred participants were randomly selected from a population of 2,916 (age range from 60 to 102 years).

Results: Three hundred and three participants were interviewed (response rate 51%). They were mostly female (62%), mean age 68 ±7.4 (SD), ranged from 60 to 97 years. The prevalence of faecal incontinence, including staining, poor control of loose and solid stool in the past three months, was 23.1% (n=70). A Pearson Chi-square test indicated no significant association between gender and faecal incontinence, x² (1, n=303) =1.55, p=0.21, phi=0.07. More than half of older people with faecal incontinence (52.9%, n=37) did not use any measures to manage their problems. Others managed the problems by changing diet (30%, n=21), seeking help from health care professionals (14.3%, n=10), and taking traditional herbal medicines (1.4%, n=1). Twenty-three per cent (n=16) of those with faecal incontinence perceived this problem as a consequence of ageing process.

Conclusions: The prevalence rate of faecal incontinence identified in this study is higher than those reported in previous studies in Western countries4-11. This may be due to the variance of population under study, as institutionalised aged care has not been established in Indonesia. In that country, all older people live in the community; whereas, in Western countries older people with faecal incontinence may have been admitted to aged care facilities, resulting in a lower prevalence rate of faecal incontinence in the older population in the community.

Furthermore, staining is included in the definition of faecal incontinence due to a cultural issue in the method of cleaning the anal area after bowel movements. In the Indonesian context, people usually wash their anal area with water (referred to as the wet method), instead of wiping the anus with tissues (referred to as the dry method) in Western society. Therefore, staining is more
likely as a result of poor control of the bowel, rather than a hygiene issue. Poor management practice of faecal incontinence identified in this study suggests the need for developing community care services to address this problem. The evidence also suggests that knowledge about faecal incontinence could be improved.

References:

Obstetric Anal Injury (OASIS) Trial
Dilgir S, Parkin K, Gardner K, Patton V, Lubowski DZ & Karantasis E
St George Hospital, Pelvic Floor Unit, Sydney, NSW

Introduction: The perineal tear clinic was set up in 2005 to manage women with obstetric anal sphincter injury (OASIS). A pro-forma survey was developed in order to assess women who sustained OASIS. This described the events leading to and including the birth of the baby, management of anal injury and subsequent symptoms. Although there are some definite predictive factors influencing a tear, many remain debatable. These include: foetal size, maternal age, the duration of the second stage of pushing, use of epidural anaesthesia and formation of an episiotomy. At the six-weeks follow-up, presence and severity urinary and faecal incontinence were assessed using the ICIQ and St Mark’s Score.

Materials and method: A representative sample of women who did not sustain an OASIS was consented for birth events to be used in analysis and to be contacted for follow-up at six weeks post-partum. The data obtained was then compared to pre-existing data from women who sustained an OASIS and attended follow-up at the pelvic floor unit. At six weeks, both groups were assessed with regard to symptoms of anal incontinence using St Mark’s score, urinary incontinence using International Consultation on Incontinence Modular Questionnaire (ICIQ) and sexual activity.

Results: Although the study is still in continuum, a preliminary analysis was done on 222 tear patients and 49 controls. A significant difference was found in patient’s ethnic background (p=0.000) with Asian and Indian women being more likely to sustain third-degree tears. Also, instrumental deliveries (vacuum and forceps) were more likely to be associated with 3rd degree tears (p=0.009). Patients in the ‘tear’ group were less likely to have recommenced intercourse at six weeks (p=0.006) and were less likely to want children in the future (0.001). Additional variables analysed included the following: delivery details, birth position, controlled and uncontrolled pushing, guarding of the perineum, position of baby at birth, gender, birth weight, accoucheur, duration of second stage of pushing, use of epidural anaesthesia and formation of an episiotomy. At the six-weeks follow-up, presence and severity urinary and faecal incontinence were assessed using the ICIQ and St Mark’s Score.

Introduction: The Revised Urinary Incontinence Scale (RUIS) and the Revised Faecal Incontinence Scale (RFIS) are both short, five-item scales which were developed by including a number of faecal and urinary incontinence scales and items in a large Australian community survey (n=2915). These revised instruments were developed from an examination of the item psychometric properties. The community survey indicated that both instruments had excellent internal consistency reliability (RUIS=0.91; RFIS=0.85), which suggested the revised incontinence tools would be useful for evaluation and epidemiological research but further validation would be required in clinical settings. This study reports an interim validation of the RUIS and RFIS in clinical settings for incontinence treatment and also reports briefly on the validation of Short Assessment of Patient Satisfaction Scale, which was also included in this study.

Materials and method: Patients were recruited consecutively from 11 continence clinics (specialist and community) across four Australian states from 2009 to 2011. The study examined clinical and patient definitions of incontinence status, treatment outcomes and success across three treatment types (continence advice, physiotherapy and surgery). This paper reports on the analysis of 195 urinary incontinence cases with complete baseline data and 100 participants with full data (pre-post) available. It also reports on the analysis of 61 patients who reported faecal incontinence at baseline and 38 participants with full data (pre-post) available. The study protocols contain the RUIS, the RFIS, other urinary incontinence items and questionnaires; health-related quality-of-life measures, and clinician and patient satisfaction tools.

Validation of the revised incontinence and patient satisfaction tools
Sansonji J, Marosszky N, Hawthorne G, Fleming G & Owen E
Australian Health Services Research Institute, University of Wollongong, NSW

References:
global ratings of severity and improvement. The post-treatment protocols also contained the patient satisfaction items.

**Results:** At baseline for all 195 cases the mean RUIS score was 10.92 (SD=3.33, n=195). The mean RUIS score for the sample of females at pre-treatment was 10.90 (SD=3.16, n=167) and the mean RUIS score for the sample of males at pre-treatment was 11.07 (SD=4.18, n=28). There was no significant difference between these total scores when analysed by gender (F=0.07, df 1, 193; p=0.05). For most RUIS items at baseline 62–68% of the clinical sample experienced these symptoms moderately or greatly.

When examined by clinical ratings of pre-treatment severity, there was a significant difference (F=33.80, df 1, 192; p<0.000) in RUIS mean scores between those with mild incontinence (M=9.22, SD 2.97, CI 8.48–9.95, n=65) and moderate and severe incontinence (M=11.87, SD 3.02, CI 11.34–12.39; n=129). The mean RUIS scores were significantly higher for those who were receiving surgical versus conservative treatments (F Welch=7.60, df 1, 70.49; p=0.007). RUIS scores were also significantly related to pad use (F Welch=78.33, df 1, 171.06, p<0.000). These findings indicate the RUIS has good discriminant validity.

At follow-up post-treatment the mean RUIS score was 6.95 (SD=4.77, n=100). There was a significant improvement of 4.07 RUIS scores and patients improved from all types of treatment (SD=4.76, paired t-test, t=8.56, df = 99, p<0.000).

At baseline for all 61 cases the mean RFIS score was 9.66 (SD=4.66) and scores ranged from 0–20. For most RFIS items at baseline 50–68% of the sample experienced these symptoms ‘sometimes’ through to ‘always’. The mean RFIS score for the samples at pre-treatment was 9.10 for males and 9.76 for females. There was no significant difference between these total scores when analysed by gender (F=0.17, df 1, 59; p=0.05).

When examined by baseline clinician rating of the severity of faecal incontinence, there was a significant difference between RFIS scores for the more severe and less severe faecal incontinence groups (F=4.09, df 1, 57; p<0.05). The mean for those with mild incontinence was 8.05 (SD 4.47, CI 6.07–10.03, n=22) and for those with moderate or severe incontinence it was 10.51 (SD 4.57, CI 8.99–12.04, n=37). RFIS scores were also significantly (p<0.01) related to pad use and the length of time patients had experienced their symptoms.

At follow-up, the mean RFIS score was 6.68 (SD=4.82, n=38) showing a significant improvement for the patient group. There was a significant improvement of 3.11 mean RFIS scores following treatment (SD=4.92, paired t-test, t=3.89, df=37, p=0.000). The RFIS was the most sensitive instrument for detecting change.

Data analyses indicate the RUIS and the RFIS have adequate internal consistency reliability in clinical settings as well as community settings. The internal consistency alpha of the RUIS at pre-treatment was 0.73, which is considered adequate to good as contrasted with the UDI-6 where the alpha was 0.64, which is considered unacceptable. The internal consistency reliability of the RUIS for a combined sample of urinary and faecal incontinence patients was 0.84 (n=255).

At pre-treatment the RFIS alpha was 0.78, which is considered good as compared with an alpha of 0.65 for the Wexner Faecal Continence Grading Scale (Wexner) and an alpha of 0.65 for the St Mark’s Incontinence Score which are considered unacceptable. The internal consistency of the RFIS for a combined sample of urinary and faecal incontinence patients was 0.91 (n=255). This clearly shows the RUIS and the RFIS have better internal consistency reliability than other widely used incontinence instruments.

The principal components analyses undertaken indicated the internal structure of the instruments was appropriate. The RUIS appears to be a uni-dimensional measure with all RUIS items loading above 0.60 on the primary urinary incontinence factor extracted (accounting for 49% variance) which is characterised as urinary leakage. The RFIS also appears to be a uni-dimensional measure with all items loading above 0.65 on the primary faecal incontinence factor that accounted for 54% of the variance.

The RUIS correlated significantly (p<0.01) with other measures of urinary incontinence such as the Wei Urinary Symptom and Bother Indexes, the Urogenital Distress Inventory – 6, the Incontinence Severity Index, the International Consultation on Incontinence Questionnaire – Urinary Incontinence and the Incontinence Impact Questionnaire. The RFIS correlated significantly (p<0.01) with other measures of faecal incontinence such as the Wexner and the St Mark’s Incontinence Score. These correlations support construct validity.

**Conclusions:** Indications are that the RUIS and the RFIS are performing well in clinical settings demonstrating adequate to good internal consistency reliability; correlations with other measures are in the expected directions indicating construct validity, and they discriminate well between groups varying in incontinence severity. There is good evidence they are sensitive to changes in continence status. The data analyses confirm that the revised incontinence instruments have demonstrated good psychometric properties in clinical settings and this confirms the findings from the earlier community sample data.

The findings concerning the Short Assessment of Patient Satisfaction (SAPS) also indicate that it is sensitive to changes in patient status as a result of treatment, with those patients experiencing the greatest levels of improvement also reporting higher levels of satisfaction with their treatment. This suggests the scale is performing well in terms of its discriminant validity and it also has good internal consistency (alpha=0.85) reliability.

With only five items each, the RFIS and the RUIS are short and simple to use and score. Clinicians treating patients who have incontinence should be encouraged to use them both as assessment measures and as outcome evaluation measures in routine practice. The use of such measures can provide effective feedback to clinicians concerning the effectiveness of their treatments, can facilitate the systematic review and monitoring of patients, and assist in identifying ways to improve practice. Similarly, the SAPS is a short and effective measure of patient satisfaction with treatment which can readily identify patient concerns for the clinician or the practice.
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Innovation from BrightSky Australia
Awareness of incontinence in ethnic communities: knowledge and preferences for treatment and management of incontinence

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Introduction: The Continence in Ethnic Communities Project aims to raise awareness of incontinence among culturally and linguistically diverse (CALD) communities. Focus group consultation was conducted with 10 ethnic communities concerning knowledge of the causes of incontinence, prevention, treatment and management.

Materials and methods: Twenty focus group discussions were held. There were 218 participants (51 male and 167 female) who represented 10 ethnic groups. Most groups included participants aged 65 years or more, five groups included middle-aged women. The younger women were included as the prevalence of incontinence is higher among this group. The communities included those whose first language was: Arabic, Chinese, Italian, Greek, Macedonian, Spanish, Polish, Russian, Turkish or Vietnamese. The focus group discussions included a question schedule that had been translated and given to group participants along with a one-page information sheet about the project. Discussions were facilitated in the first language of the group using bilingual workers and interpreters; participant responses were interpreted into English for note-taking and audio recordings were collected and then transcribed. Five focus group note files (25%) were analysed phrase-by-phrase using NVivo computer software. Open coding was applied (using the terminology of the narratives to cluster similar views) to identify a pattern of response based on each of the 13 focus group questions. This resulted in 61 themes being identified. In a second stage, the identified sub-themes were used as an organising template to group further participant responses for each of the remaining 15 focus groups. New sub-themes were added at each stage. These results were tabulated using agreement as a stratifier (yes-applicable; no—not applicable to that ethnic group), giving a matrix of result elements by ethnic language group. A summary of common group responses was compiled. Two researchers explored the commonality of responses across groups and extracted the key findings. To add to the rigour of the study, a researcher from Monash University, School of Nursing and Midwifery, who was independent of the research team, conducted the initial qualitative analysis that relies on interpretation of data.

Results: Key findings aligned with three themes: knowledge and awareness, quality of life impacts and management of incontinence.

Knowledge of incontinence (particularly causes and treatments) was found to be low across all groups. A belief that incontinence is an inevitable part of ageing was common. Knowledge was impacted by the fact that in some languages there is not a term to describe ‘incontinence’ or otherwise the translated term often has a negative or detrimental meaning.

A common impact on people’s day-to-day lives was the limitations in participating in social activities. Among Muslim men and women, incontinence could lead to restrictions to religious practice. Cultural and religious influences were expressed in relation to preferences for information in their preferred language and preference for a doctor who spoke their language.

Gender preferences were also noted, particularly among women from some groups about speaking only to female family and friends rather than husbands, sons and even male interpreters. Some women also expressed a gender preference to see a female doctor.

Communication and language barriers were perceived to limit people’s access to information and support services. Participants expressed a desire to receive more verbal and written information in their preferred language about incontinence causes and treatments, including pelvic floor muscle exercises. A range of multimedia formats, for example, ethno-specific publications and radio programmes were also suggested.

Conclusions: Incontinence is a health issue that affects all people, regardless of cultural background. Information and education should be targeted to CALD communities in order to overcome cultural, language and knowledge barriers.

The Continence Clearinghouse Project
Downie F, Link K & Zantuck K
The Continence Foundation of Australia (CFA), Melbourne, VIC

The Continence Clearinghouse website is an online information hub that allows health professionals to access all Australian-based continence information in one place. The target audience for the project is specialist and non-specialist continence professionals. Supported by the Australian Government Department of Health and Ageing under the National Continence Program, it is the result of a joint alliance between the CFA and other key continence bodies. The clearinghouse is being developed not only to provide a central hub for all continence resources and information, but also to provide an opportunity for health professionals to connect with others, strengthen their networks and share information.

The project includes a stakeholder engagement and consultation phase, resource cataloguing and website development. Following the launch of the beta website at the 20th National Conference on Incontinence, rigorous user testing and amendments will occur. The project is guided by a project advisory group.

An initial consultation phase indicated that although a majority of people identified themselves as comfortable with navigating information-based websites, a user-friendly website that features an online forum function is desired.

The conclusions of the consultation phase will inform the development of the clearinghouse. Initial results of the consultation phase confirmed there is a real need for a continence clearinghouse and it would be regularly used by a variety of specialist and non-specialist continence professionals. The Continence Clearinghouse will be officially launched during World Continence Week 2012.
Continence care education for community pharmacy staff – evaluation of an e-learning facility compared with other modes of training

Gourlay K
The Pharmacy Guild of Australia, National Secretariat, Canberra, ACT

An e-learning facility was developed as an extension of Stage 3 of the Pharmacy Continence Care Program. The project also included an evaluation phase to compare the evaluation from this mode of training with the face-to-face training previously conducted. It was aimed to provide the project group with information in relation to pharmacist and pharmacy staff confidence in their knowledge of and ability to communicate the right messages and advice on continence care issues.

To meet the varying needs and learning styles of pharmacy staff, and introduce business development information to increase the sustainability of the provision of continence care in the context of pharmacy operation, an e-learning facility was launched in November 2010.

Evaluation revealed knowledge improved in all areas addressed by the e-learning, as did confidence in discussing continence-related issues with consumers. Further, 100% of respondents found the training informative, believed it related to their professional practice and would recommend this mode of training to others.

There were slight variations in the level of knowledge and confidence improvement across specific issues when compared to the results of the face-to-face learning evaluations conducted previously.

This is a positive investment in providing an avenue for ongoing training of community pharmacy staff to continue to contribute to positive health outcomes for consumers with continence problems and their carers.

‘Pelvic Floor First’: a case study on the effectiveness of using a dedicated brand identity to overcome the stigma associated with incontinence

Link K & Edmonds D
Continence Foundation of Australia

‘Pelvic Floor First’ is a national social marketing campaign that was established to educate exercise professionals about the link between exercise and pelvic floor dysfunction. While exercise professionals were identified as an ideal professional group to screen and refer people with, or at increased risk of, pelvic floor dysfunction, the challenges relating to the stigma associated with incontinence prevailed. This led the Continence Foundation of Australia to design, develop and implement the ‘Pelvic Floor First’ campaign, which was supported by a unique brand identity and supported by a multidisciplinary group of continence and exercise professionals.
The ‘Pelvic Floor First’ campaign is supported by a broad range of communication collateral. These materials are built on the value proposition of empowering exercise professionals to empower their clients. Using a brand embedded with a message of empowerment ensured that the materials could be distributed in a variety of settings, and assisted to overcome the embarrassment and shame that is frequently linked to accessing information relating to incontinence.

Early results indicate an overwhelmingly positive response to ‘Pelvic Floor First’ with exercise professionals proactively utilising the campaign collateral to establish relationships with local continence professionals and differentiating their business as truly health and wellbeing focussed. Uptake of the materials by the general public has been equally effective, with over 7,000 resources accessed and distributed between mid-April to mid-June 2011.

‘Pelvic Floor First’ has demonstrated the effectiveness of using a dedicated brand identity – not directly linked to continence – to promote continence. The Continence Foundation of Australia is continuing to work in collaboration with the fitness sector and hopes to promote this campaign at an international level. Thus far, the project has been adopted by the New Zealand Continence Association.

Evidence base for treatment of complex bladder dysfunction

Tucker IP
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Invited speaker

Introduction: Current treatments of bladder dysfunction include: physiotherapy techniques such as biofeedback, behaviour modification which can include hypnosis, medicines mainly anti-cholinergics alone or in combination, botulinum toxin A (Botox®), neuromodulation (for example, S3 SNS) and Percutaneous Pudendal Nerve Stimulation, posterior tibial nerve stimulation, various other forms of electrical stimulation and ablative surgery including detrusor myomectomy, clam cystoplasty, or diversion. The physiotherapy and behavioural and ablative surgery including detrusor myomectomy, clam cystoplasty, or diversion. The physiotherapy and behavioural interventions will not be discussed; focus will be on the use of medicines and other pharmacologic therapy, nerve stimulation and surgical interventions.

Pathogenesis of OAD/OAB syndromes

Before discussing treatment, some aspects need to be discussed including the pathogenesis of OAD/OAB syndromes. Professor James Gillespie has discussed the origins of bladder sensation – but is that the whole story?

Sensation and sensory nerves are curious. Sensory nerves may be stimulated by an appropriate (or an inappropriate) stimulus but what is perceived in the brain as sensation (for example, pain or urgency) is subject to many variables and influences on the way to the spinal cord, mid-brain and brain.

The spinal cord mid-brain and limbic system (including the amygdala) appear to have the ability to behave like the volume

controls in pre-amps and amplifiers – ‘winding-up’ the perceived sensation. The brain can produce sensation mimicking sensory responses. This may be seen in other situations such as auras with epilepsy and psychoses.

What happens, therefore, in the peripheral sensory receptors is extremely important but may be no more so than what can happen elsewhere in the nervous system. Hence, the origins of altered or abnormal reflex behaviour may begin anywhere in the nervous system. This is important because to develop and understand treatment methods, the pathogenesis of OAD needs to be unravelled. We have a long way to go with this.

Firstly, remember the intrinsic contractility of the bladder. To what extent this is needed in the ‘in vivo’ state is unclear but it is possible that this may be required to facilitate normal, not augmented or externally stimulated, contractions. If one looks at a nerve reflex arc, perhaps some understanding can be obtained. As Professor Gillespie pointed out, the initial stimulation of various sensory nerve endings. Nerve impulses from these sources may be normal, reduced or excessive and will be transmitted in and from the afferent nerves (Aδ fibres, capsaicin sensitive C fibres, vanilloid receptor cells and so on) to predominantly S3 section of the spinal cord but also some sympathetic stimulation to T12/L1 section.

At an early age (and before higher centre control), when the afferent impulses reach sufficient intensity, they will trigger an efferent reflex response, predominantly cholinergic motor efferents to the bladder to initiate a detrusor contraction and involuntary voiding occurs. By age 2½ years to 3 years of age, the afferent impulses travelling up the spinal cord to the pontine micturition centre are ‘processed’. Some impulses are sent to the PAG and other conscious brain centres and by both involuntary and voluntary control, impulses are sent back down the spinal cord to inhibit the voiding reflex. There is also a probable cross spinal ‘guarding’ effect to inhibit detrusor contractility.

The original sympathetic afferents achieve what the sympathetic nerves do in other situations – that is, they have an inhibitory effect on the detrusor contraction, causing a smoother ‘damped’ and coordinated contraction. Without this, the contraction would be more ‘spastic’ – this is seen in certain neurogenic situations with different responses depending on the level of the defect.

Obviously, problems may occur at point in this reflex arc and such problems can include:

- Excessive sensation, either by ‘normal’ or capsaicin sensitive bladder receptors via ‘C’ fibres, overwhelming the normal inhibitory control.
- ‘Wind-up’ in the spinal cord, as seen in some pain situations.
- Interference with nerve transmission up and down the spinal cord, as seen in conditions; for example, Multiple Sclerosis (MS) or spinal cord injury.
- Inability of either pontine or grey matter inhibitory control, as seen in frontal lobe tumours.
- Peripheral nerve injury; for example, fracture across S3, often resulting in ‘acontractile’ situations.
Underlying causes may be obvious; for example, bladder tumours, polyps, stones, infections, spinal issues such as MS, cerebral issues, Parkinson’s disease or tumours.

But what about ‘idiopathic’ OAD – where does this originate? We don’t know.

We do know that a high proportion of those who suffer ‘idiopathic OAD’ have a familial tendency. We know that childhood enuresis has a genetic basis with genes enur 1,2,3,4 involved on 8th, 12th, 13th and 22nd chromosomes and that most children with enuresis will have OAD subsequently. We need to find out how these genes are expressed at tissue level to further understand the origins of idiopathic OAD and to adequately develop new treatment methods.

It is likely that there are multiple origins of detrusor overactivity – perhaps depending on the variations of genetic inheritance; perhaps related to alterations in the urothelium as a primary or secondary problem, or to alterations in the frontal or prefrontal cortex, midbrain and spinal cord. This would certainly explain differing patterns with urodynamic testing and differing responses to the various treatments.

**Treatments**

Medication: Treatment remains empirical – for example, the use of anticholinergics to try to inhibit detrusor contractility – this is a bit like trying to ‘nuke’ the situation but remains the main treatment at this stage. There may be some future in the use of certain sympathomimetics to try to ‘dampen down the detrusor contraction – these may be more limited because they will almost certainly dampen, not prevent the contractions. The use of different agents in combination may give an improved response.

Other treatments: And when medication fails, other treatments are employed such as:

- **S3 neuromodulation**
- **Pudendal nerve neuromodulation**
- **Posterior tibial nerve neuromodulation**
- **Other electrical impulse therapy**
- **Botox®**

S3 SNS: This is empirical for refractory OAD because the actual site of origin of the problem hasn’t been confirmed. It does, however, have an effect on reducing OAD symptoms and also inhibiting detrusor contractility, which seems to be sustained in approximately 70% refractory OAD sufferers. How it achieves this remains a mystery. There may be alterations in the peripheral the innervation, effects at cross-spinal level, or even biochemical/physiological spinal cord changes responsible for the improvement in the control of OAD whether neurogenic or idiopathic. Patients with neurogenic bladders were excluded from the initial work with SNS but the use of SNS is probably more logical for neurogenic situations where one can more completely understand the point of origin of the OAD. SNS is also of value in CPPS, CBS/interstitial cystitis (IC) sufferers with an understanding that at least in a group of rats with pain from IC and which have increased spinal cord expression of NO synthase, S3 neuromodulation results in reduced spinal cord expression of NO synthase. NO synthase has the ability to send impulses backward down sensory nerves causing the release of potent inflammatory agents at the origins of those nerves.

Problems encountered using SNS may include:

- **Lead migration**
- **Lead fracture**
- **Pain from pulse generator site**
- **Infection**

Is S3 neuromodulation expensive? The answer is no, especially when one considers the life changing results for the ‘lucky ones’. Cost effectiveness has been well documented in US studies. The technique of SNS is still evolving with further improvements anticipated in relation to both lead insertion and subsequent programming.

**Pudendal nerve neuromodulation:** This is in its infancy but promises to be as effective as S3 neuromodulation. ‘Watch this space’! Controlled studies are being undertaken at present and these may well be interesting.

**Percutaneous posterior tibial nerve stimulation:** While results are varied, some effect seems likely; but realistically, the more peripheral the stimulation, the less recruitment of nerve fibres so the less result one would expect. Nevertheless, in October 2010, the National Institute for Clinical Excellence (NICE) issued NICE Interventional Procedure Guidance 362 supporting the use of percutaneous tibial nerve stimulation (PTNS) as a routine treatment for overactive bladder syndrome. Highlights of the NICE guide include: Evidence shows that PTNS is effective in reducing symptoms in the short and medium term. There are no major safety concerns. It can be offered routinely as a treatment option for people with overactive bladder provided that doctors are sure that the patient understands what is involved and agree to the treatment. The results of the procedure must be monitored. A National Institute for Health and Clinical Excellence (NICE) Guideline for Faecal Incontinence is currently under review.

**Botulinum toxin A:** Injection of botulinum toxin A (Botox®) into the bladder wall was introduced as a new treatment for intractable neurogenic detrusor overactivity, on the theoretical basis that it would temporarily block the presynaptic release of acetylcholine (Ach) from the parasympathetic innervation and produce a paralysis of the detrusor smooth muscle. Botox® certainly abolishes detrusor activity for six months but problems invariably recur. Further studies have confirmed this effect but there are probably also other complex effects in the Urothelium altering sensory receptors. Retention is a problem with the use of Botox®. Incidence of retention is variously reported but the problem of retention reduces with reduced dosage levels. Unfortunately, the duration and effect also reduce with reduced dosage levels. One would need to advise patients of 30–40% incidence of retention and arguably, teach ISC prior to the procedure. A meta-analysis reported in the *Journal of Urology*, intravesical botulinum toxin A improves the symptoms of overactive bladder (OAD), but is associated with a significant risk of urinary retention and advised that patients be taught ISC.
before use of Botox®. Long term effects after multiple Botox injections also remain in question.

Where does Botox® fit into the treatment algorithm? At recent workshops at the ICS, Glasgow 2011 and at the neuromodulation conference (INS) in London in May 2011, the suggestion was for the consideration of Botox® after failed SNS or failed Pudendal Nerve Neuromodulation. So we now have an increasing range of treatment methods to treat a range of problems, such as the OAD syndromes we so desperately need to know more about.

The playing field is shifting continuously, so the algorithm for treatment of complex bladder dysfunction requires constant review and updating.

**Transcutaneous stimulation – evidence in children**

Chase J  
Physiotherapist, Monash Medical Centre Paediatric Continence  
Clinic and the Murdoch Children’s Research Institute at the Royal Children’s Hospital, Melbourne, VIC

During the last two decades, electrical neural stimulation (ENS) has been widely used for the treatment of lower urinary tract dysfunction in children. Sacral transcutaneous ENS (TENS) in children was first described by Bower and colleagues in 2001 and Hoebeke and colleagues in 2002. Other sites of application include endoanal, ano-genital, posterior tibial nerve (PTN), infra-vesical and sacral implants. Even though the mechanism of action is still obscure, most studies have demonstrated good results with this intervention.

This presentation will present the evidence for transcutaneous ENS in children with both bladder and bowel dysfunction of non-neurogenic and neurogenic origin.

**References**


**Bowel blues after bowel procedures – the way forward**

Christine Norton  
Professor of Clinical Nursing Innovation, Imperial College Healthcare & Bucks, New University, London & Nurse Consultant (Bowel Control) St Mark’s Hospital, London, UK  
Invited speaker

Many interventions in the pelvic area have ramifications for subsequent bowel function. Colorectal procedures may result in faecal incontinence (FI) or anal incontinence (AI), for example haemorrhoidectomy (33%) and lateral sphincterotony for anal fissure (11%). Formation of an ileo-anal pouch is associated with both evacuation difficulties and FI, particularly passive soiling at night, although function is better than with a straight anastomosis.

Surgery for rectal cancer can result in the “anterior resection syndrome”, a constellation of symptoms including frequency, urgency (5–87%), FI (6–87%), evacuation difficulty and tenesmus. Radiotherapy plus surgery is associated with worse continence. A recent Cochrane review has questioned if quality of life is better for anterior resection than abdomino-perineal excision. Various surgical approaches have been tried to increase rectal capacity, such as construction of a J-pouch instead of a straight colo-anal anastomosis, transverse coloplasty or a side-to-end anastomosis. Each seems to be superior to the straight anastomosis, which has poor functional results in 50–60% of patients, with little difference between operations.

Radical prostatectomy and radiotherapy for prostate cancer each can cause unintended bowel effects in a sizeable proportion of patients, many of whom do not seek help, and who assume it is the “price to pay” for cure of the cancer. Cancer specialists likewise often do not ask, focusing on recurrence of cancer rather than symptoms. There are reports of FI in 1.6–58% of patients after radiotherapy, the variation due to different definitions and failure to use validated tools to measure FI. The mechanism is likely to be damage to the nerve plexus of the rectum. There has only ever been one intervention study reported to help these patients.

Other pelvic radiotherapy is likewise associated with a widely varying reported rate of FI (3–53%) and there are no intervention studies except formation of colostomy. The effect may decrease in the future as irradiation techniques improve and become more focused.

The remarkable aspect of nearly all the above conditions is how little attention has been paid to bothersome bowel symptoms, and how few intervention studies there have been. The first step is active case finding: if you don’t ask, many patients will not tell. This should become a routine part of follow-up after procedures with a high risk of FI. Many of the interventions used for other patients with FI, such as pelvic floor muscle training, dietary advice, prescribing loperamide, bowel retraining and biofeedback or electrical stimulation do help these patients in clinical practice, although the evidence base has yet to be developed.

**References**

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**A clinical audit of the incidence of constipation in patients presenting with lower urinary tract symptoms to a regional continence service**

Goh SC, Greenwood D & Bird MR

*Austin Health, Melbourne, VIC*

**Introduction:** Constipation is a common complaint in all ages, but especially so in the elderly. The term constipation is difficult for a patient to define. It is essentially a constellation of symptoms but there are clinical criteria such as the Rome III criteria, which can be used to define it for use in research. Lower urinary tract symptoms (LUTS), including urinary incontinence, are also common and can have a significant detrimental effect on quality of life and activities of daily living. Constipation has been recognised as an associated comorbidity and reversible precipitant of LUTS; however, there is a relative paucity of published data.

The aim of this study was to report the incidence of undiagnosed constipation in consecutive patients who presented primarily with LUTS, to a regional continence service. Secondary aims were to audit current practice at the service and the compliance of usual interventions for the treatment of constipation. Any obvious clinical associations were noted as a topic of further discussion or research.

**Materials and methods:** Consecutive patients presenting to the Austin Health Continence Service with primarily LUTS, including urinary incontinence, over a 10-week period were studied. These patients did not identify constipation as being a problem. Those who had been diagnosed with a primary bowel problem were excluded. Each patient had a detailed continence assessment, as is the clinic's usual practice. At a clinical case conference, cases were individually reviewed and a decision was made whether to treat constipation. The incidence of constipation in the study population was recorded, and the service's usual multidisciplinary approach to treatment was observed. Follow-up was at review appointment or phone call, and noted adherence to the prescribed intervention(s) and subjective improvement in constipation and LUTS.

**Results:** There was a total of 41 consecutive patients who presented with a primary urinary problem over 10 weeks. The mean age of this population was 65 years old, and the majority were female (75%). With regards to medical comorbidities present; 37% had neurological problems, 22% had cardiovascular problems and 22% had diabetes. Comorbid constipation was identified in 20 patients (49%). On statistical analysis, age of 65 years or over was found to be significantly associated with constipation.

The study was not specifically designed to statistically assess for associations or efficacy of treatment. It was designed to observe usual clinic practice and note any potential associations or outcomes. Medicines that may have been contributing to constipation, such as opioids and anti-cholinergic medicines, were identified in 16 patients. In the constipated subgroup of 20, the most common intervention was use of aperients (95%). This was used in conjunction with nurse consultation (65%), physiotherapist review (35%) and dietitian advice (30%). This multidisciplinary approach improved constipation in 17 patients (85%) and improved urinary symptoms in 14 patients (70%).

**Conclusions:** Comorbid constipation is very common in those with LUTS, although it is difficult to define and is subjective in nature. Diagnosis can be made using detailed symptom assessment. Treatment of constipation with aperients and a multidisciplinary approach appears effective at improving constipation and LUTS. It is important to raise awareness of this treatable comorbidity and it should be assessed prior to further specialised investigations or interventions. Further research is required to look at significantly associated comorbidities and to formally assess the efficacy of the interventions.

**Long term risk factors for the development of constipation in older community dwelling women**

Koloski NA, Jones M, Gill RS, Forder P, Chiarelli P & Talley NJ.

*Physiotherapy Program, University of Newcastle, NSW*

**Introduction:** Constipation is a relatively common heterogeneous condition, although its pathogenesis is still poorly understood. While concurrent diseases, medicines and some lifestyle factors such as alcohol, a diet deficient in fluid and fibre, and immobility have been implicated, there is very little prospective data on the role of these and other factors such as psychological state in the development of constipation over time, especially in older women living independently in the community. We aimed to determine risk factors for new onset constipation in a large, population-based cohort of older Australian women over a nine-year period.

**Materials and methods:** Participants were 12,762 women (aged 70–75 years) who participated in the first survey of the Australian Longitudinal Study on Women's Health in 1996. Of these women, n=3716, aged 79–84 years also completed a follow-up survey in 2005. Both the first and follow-up survey asked women: “Have you had constipation in the past 12 months?”

The following baseline variables were asked in the first survey:
- Demographic factors included: nationality, level of educational, marital status and socioeconomic status.
- Lifestyle factors assessed included: smoking, alcohol intake, Body Mass Index (BMI).
- Other factors included obstetric history such as number of live births and a history of a prolapse repair.

The number of stressful life events in the past year was assessed, as was depression using the Centre for Epidemiological Studies-
Depression scale (CES-D). Domains of quality of life were assessed using the valid SF-36.

Results: Of the 3716 women who responded to the first and follow-up survey, we found 1501 (40.3%) developed constipation over the nine-year period. Univariately, we found an increased number of live births, increased number of stressful life events, lower socio-economic status and reduced functioning in the following SF-36 domains: general health, bodily pain, mental health, physical and social functioning role emotional and physical, and vitality to be significantly associated with new onset constipation. However, in a multiple regression model that included these significant variables we found the rate of constipation in those women who had given birth versus those who had not (43% vs 34%; OR=1.1; 95%CI 1.0–1.1, P=0.003) and reduced functioning on the SF-36 subscales for vitality (M=6.4 vs M=6.8; OR=0.9; 95% CI 0.9–1.0, P=0.000) and bodily pain (M=6.8 vs M=7.4; OR=0.9; 95% CI 0.9–1.0, P=0.001) were independent risk factors for developing constipation among women who did not report constipation on the first survey.

Conclusions: Constipation is an extremely common problem among older, community-dwelling women and causes decrement in health-related quality of life. Our prospective data suggests factors related to childbirth and generally being unwell – as reflected by poor quality of life – are risk factors for developing new onset constipation among older women.

Evidence for pelvic floor muscle training during pregnancy and after childbirth: to do or not to do?

Bo K
Professor of Physiotherapy, Department of Sports Medicine, Norwegian School of Sport Sciences, Oslo, Norway Invited speaker

A Cochrane review from 2008 concluded that women without prior urinary incontinence (UI) who were randomised to intensive antenatal pelvic floor muscle training (PFMT) were 56% less likely to report UI in late pregnancy and about 30% up to six months postpartum. Postnatal women with persistent UI three months after delivery were 20% less likely than those not receiving PFMT to report UI 12 months after delivery. Women receiving PFMT after delivery were also about half as likely to report faecal incontinence. There was not enough evidence about long-term effects.

There has been a long tradition in physiotherapy to teach PFMT in prevention of faecal and urinary incontinence both during pregnancy and postpartum. However, although there seems to be a lot of practical teaching going on, to date there are no scientific studies evaluating the effect of population-based primary prevention interventions.

Most of the randomised control trials (RCTs) in the area of PFMT on UI have been conducted as secondary or tertiary prevention. To date, there are two treatment RCTs and eight

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prevention RCTs evaluating the effect of antenatal PFMT. Three of 10 studies show favourable results of physiotherapy interventions. The studies showing no effects are flawed by weak interventions (few visits and follow-up by the therapist), high drop-out, low adherence or a combination of these factors. There are four RCTs and one matched controlled study in prevention of UI postpartum, all but one show positive results. The matched controlled study demonstrated 50% less women with UI in the exercise group. The study with no effect used a very weak intervention with only three to four visits with a midwife. The three treatment studies in the postpartum period all show positive effect on UI. Dose-response issues (mode of exercise, frequency, intensity, duration of the exercise period and adherence to the exercise programme) are important factors when evaluating effect of RCTs.

There are two RCTs and one prospective cohort study evaluating a possible negative effect of PFMT during pregnancy on birth outcome and labour. No negative effects were found, with a tendency towards antenatal PFMT being protective towards less use of instrumental deliveries and reduced numbers with perineal rupture. More studies are needed to understand the mechanisms on PFMT on labour and birth.

To date there is an increasing body of evidence from MRI and ultrasound studies that vaginal childbirth can cause major muscle, nerve and connective tissue injuries. Most likely, all the published studies in the postnatal period have included participants with such injuries, and we do not know whether they are the non-responders to PFMT, or if the injuries can heal faster with training. An RCT stratifying primiparous women six-weeks postpartum based on injury or non-injury assessed by ultrasonography and then randomised to PFMT or control is presently being undertaken by our research group in Oslo, Norway.

**Urinary tract stones**

Troy A

*Urologist, Epworth Freemasons Hospital, Melbourne, VIC*

Urinary tract stone disease can be subdivided into renal or upper tract calculi and bladder calculi. This presentation will discuss both categories including any contribution they make to urinary tract symptoms including incontinence.

In addition to the classic presentation of renal colic, stones can present in other ways such as bladder pain or instability, recurrent urinary tract infections and even obstructive voiding symptoms.

The aetiology of renal and bladder stones will be discussed along with strategies for prevention and the alternative treatment options.

**Modern management of bladder cancer**

Frydenberg M

*Urologist, Melbourne VIC*

Transitional cell carcinoma is the fourth leading cause of cancer in males and constitutes a significant health issue and burden for the community. Similar to other urinary malignancies it has a varied biological activity, with some tumours demonstrating little metastatic potential (but with the risk of recurrence within the bladder) and some others behaving more aggressively with more modest five- and 10-year survivals. The biology of bladder cancer will be explained with regard to grade and stage of the disease and how that impacts on treatment choices. Common presenting symptoms will be discussed, including haematuria and the constellation of lower urinary tract symptoms. Treatment options will also be discussed, clarifying the current roles for intravesical therapies (single-dose immediate postoperatively, therapeutic six-week courses, and maintenance courses), transurethral surgery, and the role of cystectomy, and the various types of urinary diversions in the management of muscle invasive bladder cancer.

The science and technology behind the management of incontinence with products.

Cottenden A

*University College, London, UK*

*Invited speaker*

All people who report being incontinent would like to be cured, but complete cure is not always achievable. In that event, delivering the best quality of life possible through effective management is a goal just as worthy of strenuous effort and such management usually relies in some way on good science and technology. This lecture will describe the contributions of the University College, London (UCL) Continence and Skin Technology Group – in collaboration with numerous other universities, clinical groups, and companies around the world – to a better understanding of the science relating to incontinence management and the development of improved technology.

In one sense, our work is very focused – it all relates to the management of incontinence – but, in another, we are very broad, encompassing expertise and activity across the whole spectrum from clinical practice through the life sciences, the physical sciences and most branches of engineering, to mathematical modelling. A common approach for us is to identify a problem from our clinical work and take it back ‘along the chain’ till we understand it enough to return to clinical practice with a solution. For example, in the late 1980s, nurses – including Chris Norton – challenged us to devise an aesthetically better product for lightly incontinent women than the rather chunky disposable pads available at the time. We eventually came up with ordinary looking underwear with an absorbent panel sewn into the crotch – the whole thing washable – and Kylie® Pants were launched in about 1990. However, it always bothered me that we didn’t really understand how the product functioned.

In the late 1990s we ran large clinical evaluation studies of both washable and disposable absorbent products for women with light incontinence and discovered that as aesthetically attractive as the washable products were, their leakage performance was much inferior to the disposables, so we set out to improve matters. Through an industry-sponsored PhD project and the subsequent postdoctoral work of the student, we first devised laboratory test methods, which gave us insights into how the
products worked in real use, and then built mathematical models
for predicting the fluid-handling properties of products based on
measurements we could make in the laboratory. This enabled
us to write a design specification for an improved product,
which we then developed in a collaboration involving two other
universities and five companies. The design is patented and two
of the companies are currently working to commercialise it.

A similar story is unfolding with respect to our work on
incontinence-associated dermatitis. Numerous published studies
have established that skin problems in the diaper area are quite
common among pad wearers. About 10 years ago, we ran our
own careful, longitudinal observational study on nursing home
residents, which taught us a lot about the location, severity,
longevity and nature of such problems. In the process we
identified the need to develop methods for measuring how
wet ‘wet’ skin is – because wet skin is much more susceptible
to damage than dry – and also for measuring friction between
skin and pad materials, since abrasion damage seems to be quite
common. Our methods for both are now published. We are
beginning to use the skin wetness one to measure the impact
of various products and care interventions on skin wetness, and
have also begun to generate mathematical models to describe
how skin over-hydrates when occluded by wet materials. The
long-term goal is to find ways of designing pads that are
less disruptive of skin hydration. Regarding skin friction, we
have already published mathematical models describing the
interaction of skin and pad materials and begun to understand
the mechanisms involved. The long-term goal is to pave the way
for new materials that are kinder to the skin.

In more recent study we have begun an industrial collaboration
to reach a better understanding of how super-absorbent
polymers work in the core of incontinence pads as a basis for
ultimately developed improved products. Similarly, we are
helping an Australian company in their goal to develop effective
remote monitoring systems to detect urine in incontinence pads
in nursing home facilities, to support caregivers. In another
project we have been helping a consortium of companies who
wish to develop a method for measuring the absorption capacity
of incontinence pads which works better than the current
international standard, the “Rothwell” method.

Urinary incontinence in those with a psychiatric illness
Presnell I
Senior Lecturer, Monash University and Consultant PsychoGeriatrician, Southern Health, Melbourne, VIC

The acquisition of continence is an important developmental
milestone, a key achievement of the Eriksonian stage of autonomy
versus shame and doubt. Having control of one’s bodily functions
is; therefore, highly important to both childhood and adult
self-esteem and might be considered by some as a proxy for
competence.

Practical consequences of incontinence with psychiatric
implications include the use of medications that might have
psychotropic effects. Incontinence is a significant risk factor
for transition to a higher level of care, with or without
psychiatric admission in patients without dementia. For patients
with dementia, the influence of incontinence and other risk
factors on transition to residential care becomes non-significant.
Incontinence is a risk factor for incident mental illness in
patients with an intellectual disability.

Loss of continence, or the threat of this, may result in behaviour
designed to minimise or prevent embarrassment or shame, for
example, social isolation and avoidance. These may progress
to diagnosable conditions such as Agoraphobia or a Major
Depressive Disorder.

Against this background, the presentation will review psychiatric
phenomena that contribute to incontinence and focal pathology
relating to the control of micturition. Not surprisingly,
incontinence is associated with increasing cognitive decline
and with increasing physical dependency; however, dissociative
states, severity of psychotic symptoms and psychological
symptoms secondary to a medical condition are associated
with an increased risk of incontinence in psychiatric inpatients.
Frontal lobe impairment, particularly involving the anterior
cingulated gyrus, which mediates motivated behaviour, is
associated with incontinence.

These factors will then be considered in the context of the
psychodynamic meaning of incontinence, in terms of its
developmental acquisition in particular focusing on the
Eriksonian stage of autonomy verses shame and doubt. In
addition to loss of control of continence being an important
risk factor for depression and suicide, it also raises important
diagnostic considerations. Specifically, in the absence of
moderate to severe cognitive impairment (due to either dementia
or intellectual disability) and not withstanding gender-related
causes (in particular high parity), unexplained incontinence in
an otherwise mobile patient should be viewed with suspicion.
Care should be taken to exclude psychiatric illness, in particular
functional illness in a younger patient and frontal lobe pathology
in an older patient.

FDA safety communication: update on serious
complications associated with transvaginal placement
of surgical mesh for pelvic organ prolapse
Maher C
Urogynaecology, Wesley and Royal Brisbane Hospital, Brisbane, QLD

In an update published in July 2011, the FDA advised the
following: mesh used in transvaginal pelvic organ prolapse
(POP) repair introduces risks not present in traditional non-
mesh surgery for POP repair; mesh placed abdominally for POP
repair appears to result in lower rates of mesh complications
compared to transvaginal POP surgery with mesh; and there is
no evidence that transvaginal repair to support the top of the
vagina (apical repair) or the back wall of the vagina (posterior
repair) with mesh provides any added benefit compared to
traditional surgery without mesh.
While transvaginal surgical repair to correct weakened tissue between the bladder and vagina (anterior repair) with mesh augmentation may provide an anatomic benefit compared to traditional POP repair without mesh, this anatomic benefit may not result in better symptomatic results.

The FDA also recommends that health care providers recognise that, in most cases, POP can be treated successfully without mesh, thus avoiding the risk of mesh-related complications. Choose mesh surgery only after weighing the risks and benefits of surgery with mesh versus all surgical and non-surgical alternatives. Consider these factors before placing surgical mesh:

- Surgical mesh is a permanent implant that may make future surgical repair more challenging. A mesh procedure may put the patient at risk for requiring additional surgery or for the development of new complications. Removal of mesh due to mesh complications may involve multiple surgeries and significantly impair the patient’s quality of life.

- Complete removal of mesh may not be possible and may not result in complete resolution of complications, including pain. Mesh placed abdominally for POP repair may result in lower rates of mesh complications compared to transvaginal POP surgery with mesh.

- Inform the patient about the benefits and risks of non-surgical options, non-mesh surgery, surgical mesh placed abdominally and the likely success of these alternatives compared to transvaginal surgery with mesh. Notify the patient if mesh will be used in her POP surgery and provide the patient with information about the specific product used. Ensure that the patient understands the postoperative risks and complications of mesh surgery as well as limited long-term outcomes data.

The FDA held a public enquiry during September 2011 and further recommendations will be reported to the CFA annual meeting.

**The impact of prostate cancer: issues associated with incontinence and erectile dysfunction from a psychological perspective**

Siddons H

*Psychologist, Department of Urology, Royal Melbourne Hospital, Melbourne, VIC*

Prostate cancer is the most commonly diagnosed cancer in men and the second leading cause of adult male cancer deaths. Prostate cancer poses many challenges both in the short and long term. Around the time of diagnosis, distress can be understandably high and treatment decision-making can be very difficult. Treatments are often curative; however, they are frequently associated with significant side effects, including sexual problems and incontinence. This presentation will focus on the psychological impact of prostate cancer and the treatment side effects. Issues concerning masculinity, self-image, and sexual intimacy and the role of the psychologist will be explored.
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Solifenacin use in older Australians – the challenge of non-government subsidised prescription for overactive bladder

Abstract

Using an audit tool, we sought to identify the barriers to the use of solifenacin, a second-line anticholinergic drug for management of the symptoms of overactive bladder (OAB) and associated incontinence in older patients. Among 169 patients attending two geriatric continence clinics in 2008, 72 patients with urgency symptoms were identified as potential candidates for pharmacological management. Only 16 patients (mean age 81 years) proceeded to solifenacin treatment. Besides those who did not respond to conventional anticholinergic medicines, patients who were female, high functioning and those whose daily life was severely affected by OAB were more likely to receive treatment. Despite significant improvement in bladder diary at eight weeks, intolerance and affordability were identified as important factors contributing to poor compliance (28.6%) after one year in our clinics.

Keywords: Anticholinergic, aged, urinary incontinence, overactive bladder, solifenacin.
Pre- and post-solifenacin bladder diary outcomes were compared by paired t-test. Parameters were compared between solifenacin users and non-users to identify prescription pattern using unpaired t-test or Pearson’s chi-square test where appropriate. A qualitative approach was also used in examining prescription pattern and compliance to allow unanticipated issues arise. We analysed data using SPSS v16.0.

Results
Over 12 months, continence nurses identified 79 out of 169 patients as potential candidates for solifenacin use in managing urinary incontinence. Physicians prescribed solifenacin for 16 patients (20.3%) (mean age 81±10 years, 93.8% women). They included six non-responders to oxybutynin and two non-responders to amitriptyline, a tricyclic antidepressant. Baseline mini-mental state examination (MMSE) was 25 ± 2.8 out of 30.

Short-term efficacy of solifenacin
Figure 1 shows improvement of bladder diary in 16 patients prescribed solifenacin. At four weeks, solifenacin reduced frequency by 3.2 episodes per 24 hours, urgency by 2.6 episodes per 24 hours, incontinence by 2.3 episodes per 24 hours and continence product usage by seven pads per week (all p<0.05). These effects were sustained at eight weeks (all p<0.05).

Fourteen patients required 5 mg and two required 10 mg for adequate treatment response when discharged from each clinic by eight weeks after initiation. MMSE were not repeated but no patients or carers reported subjective cognitive decline on direct questioning.

Prescription pattern
Two geriatricians reported that many patients refused to commence solifenacin because it was expensive. Solifenacin was prescribed for eight participants who did not respond to conventional anticholinergics. Physicians were more likely to prescribe solifenacin for female patients, high-functioning patients and those patients more severely affected in their daily activities due to symptoms of OAB (all p<0.05).

Previous users of first-line medications
Among the eight non-responders to oxybutynin or amitriptyline, half reported dry mouth or constipation from solifenacin and two discontinued by eight weeks. It is unclear if the subjective effect of solifenacin was similar to their previous treatments.

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Compliance and cost savings at one year
Excluding two patients who died, compliance for solifenacin at one year was poor (28.6%). Among four patients who remained on solifenacin, one achieved continence and two reported tolerable dry mouth or slowness in thought. Three discontinuations were due to cost and three due to intolerance. Two patients did not remember that solifenacin was prescribed. Two provided no reason.

All analysis was presented in a pre-2010 PBS listing situation, using costs from 2009. Their average expenditure on pads and solifenacin to help with incontinence for 2009 was approximately $18.8 per week. This figure does not capture other costs such as laundry. No benefit in cost savings in overall continence management was identified (Table 1).

Discussion
We are the first to report an audit on the use of solifenacin in older Australians. Solifenacin was effective in bladder management in our patients, as reported in other studies in the current literature. However, its benefits were limited by the cost of the medicine and side effects. Patients who were prescribed solifenacin were likely to be higher functioning or more severely affected by urinary symptoms in daily activities. No overall cost saving was identified.

Cost played an important role in patient decision on initiation and compliance of solifenacin. This is an example that patients’ perspective is sometimes more important than treatment efficacy. Larger molecular size and superior M3 muscarinic receptor selectivity of solifenacin in the brain may explain the observed lower potential for central adverse effects in trials. No patients or carers reported confusion or significant cognitive decline, including two over 85 years, besides one reported slowness in thought but who chose to continue solifenacin. We cannot confirm this finding, as MMSE was not repeated after prescription. Peripheral effects of dry eyes and constipation can happen in solifenacin users because M3 receptors are present in the smooth muscles of lacrimal glands and bowels. The limitations of this study include selection bias from the recruitment of subjects attending two geriatric clinics and lack of a control arm of patients on oxybutynin. Self-measurements in bladder diary could result in random errors. Treatment allocation was based on a joint decision between clinicians and patients. The results, therefore, cannot be generalised. Reasons for non-compliance could be subjected to recall bias. Risk of side effects was not evaluated but may be higher in older people with polypharmacy and comorbidities.

Conclusion
Despite the significant short-term efficacy of solifenacin, which was evident in our patients, compliance was poor after one year of use due to intolerance and additional cost. Key points for clinicians are that prescribing for OAB in older people is difficult due to anticholinergic side effects, despite evidence that there was significant short-term efficacy of solifenacin in our older Western Australians. Additional cost played an important role in patient decision on initiation and compliance of solifenacin.

References

Table 1. Estimated direct cost in four patients who remained on solifenacin at 12 months per week (A$).

<table>
<thead>
<tr>
<th>Mean age, mean (SD)</th>
<th>Pad usage at baseline, mean (SD)</th>
<th>Pad usage at 12 months, mean (SD)</th>
<th>Solifenacin (all at 5 mg), mean (SD)</th>
<th>Total personal cost savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>87.3 (2.4)</td>
<td>13.2 (11.5)</td>
<td>7.1 (9.8)</td>
<td>11.7 (0)</td>
<td>-5.6</td>
</tr>
</tbody>
</table>
Calendar of events

2011

16–19 November
20th National Conference on Incontinence
Crown Convention Centre, Melbourne, VIC, Australia
Web www.continence.org.au

22–23 November
Directing Policy to Action: National Australian Conference on Evidence–based Clinical Leadership
Organised by The Joanna Briggs Institute, the conference will focus on the role of evidence–based clinical leadership in improving health and aged care
Adelaide, SA, Australia

27–30 November
RANZCOG 2011 Annual Scientific Meeting
Today’s Science, Tomorrow’s Practice
Melbourne, VIC, Australia
Web www.ranzcog2011asm.com.au

8–11 December
15th World Congress on Controversies in Obstetrics, Gynecology & Infertility (COGI™)
Sanya Hainan Island, China
Web www.congressmed.com/cogichina/

2012

9–10 February
2nd International Nursing Research Conference 2012
Department of Nursing Science, Faculty of Medicine, University of Malaya
Web http://umconference.um.edu.my

24–28 February
27th Annual EAU Congress
European Association of Urology
Paris, France
Web www.eauparis2012.org

7–9 March
15th Annual 2012 NICHE Conference
Improving Health Care of Older Adults: Continuing the Journey
Celebrating 20 years of NICHE
New Orleans, LA, USA
Web http://conference2012.nicheprogram.org

18–20 April
United Kingdom Continence Society
19th Annual Scientific Meeting
Liverpool, United Kingdom
Web www.ukcs.uk.net

21–24 April
Urological Society of Australia & New Zealand
Darwin Convention Centre, Darwin, Northern Territory
Web www.urologymeeting.com.au

26–28 April
The NOI Neurodynamics and the Neuromatrix Conference
Adelaide, Australia.
Web www.noii2012.com

2–4 May
Annual Scientific Meeting for the Australian and New Zealand Society of Geriatric Medicine (ANZSGM)
Hilton Hotel, Sydney, NSW, Australia
Web www.anzsgm2012sydney.org.au

7–8 May
Young Urology Meeting
A scientific urology meeting for early career researchers and clinicians
Bristol, UK
Web www.young-urology.org

14–15 May
Association for Continence Advice Annual Conference 2012
Hilton Brighton Metropole Hotel, Brighton, UK
Web www.aca.uk.com

4–8 September
IUGA 2012 Annual Meeting
Brisbane, Queensland
Web www.iuga.org

15–19 October
ICS 2012
Beijing, China
Web www.icsoffice.org
News

Australian news

CFA national office staff changes

Monday 22 August 2011, was a big day for the Continence Foundation of Australia (CFA) national office, with three staff joining the team. Rowan Cockerell has been appointed to the position of Deputy CEO, replacing Jacquie Lodewyke, who has moved to Portland, Oregon, with her husband. Some people may remember Rowan, as she has a history with the CFA, specifically in Victoria, and even had a brief moment as Acting CEO of the national office in the late 1990s. Rowan is a qualified continence nurse, and recently completed her Master of Business while working in senior management roles in aged care and subacute hospitals. Alison McClelland has been appointed as the Marketing and Communications Manager. Alison is a former journalist and brings a wealth of experience to this role due to her former role as Public Relations and Communications Manager at Crohn’s and Colitis Australia. In her new role, Alison will be responsible for media, advertising, communication materials and managing the communications unit. Nives Zerafa has been appointed to the role of Programs and Partnerships Coordinator within the communications unit. Nives has previously worked with the CFA, and will be responsible for the special projects coordinated under the Bladder Bowel Collaborative, funded by the Australian Government under the National Continence Program.

CFA strikes gold

The Continence Foundation of Australia has been named as the winner of the International Continence Society’s (ICS) gold medal for promoting continence awareness. The international award recognised the CFA’s Exercise and the Pelvic Floor programme, launched during World Continence Week (20–26 June). The CFA partnered with the Australian Government Department of Health and Ageing and the Jean Hailes Foundation of Women’s Health to promote the Exercise and the Pelvic Floor programme, estimated to have reached more than 1.4 million Australians. The ICS citation states that the award recognised the CFA’s “educational and community outreach initiatives” and demonstrated collaboration across multiple sectors of the community and industry, including patient and professional organisations, and government agencies. To maximise the campaign’s reach, the CFA also shared the programme’s resources with the New Zealand Continence Association. The ICS announced the winners of the World Continence Week Awards in August at the 41st ICS Annual Meeting in Glasgow. The gold medal was shared with the German Continence Society.

Every Body’s Business

The CFA recently held an Every Body’s Business forum in Victor Harbour, South Australia. The theme, ‘Aged Care and Incontinence’, proved very popular, attracting 105 participants from a range of disciplines. Among the topics discussed were: aged care continence care regimens, pelvic floor exercises in the elderly, continence care in a community setting, medications and incontinence, and geriatric syndromes and incontinence. Presentations from the forum are available on the CFA website, under ‘Past Events’. We appreciate the support of Dr Chris Barry and members of the South Australian CFA Branch, for their involvement in planning for this event.

ACE resource hub

The Australian Continence Exchange (ACE) has been developed as an online resource site providing access to continence resources in one central location. ACE targets both specialist and non-specialist professionals, providing online access for continence resources and an opportunity for health professionals to connect with one another, strengthen professional networks and access professional development tools. Additional information will include news and events; research tools and listings; interactive user tools, such as forums and meet-the-expert; continence community networking tools; and links to relevant peak bodies and consumer and professional groups. ACE is the result of the collaborative effort between the CFA and allied organisations that have produced continence resources, including the Department of Health and Ageing and CFA State Resource Centres. A trial version of the site will be launched at the National Conference on Incontinence in November. Users’ feedback will be incorporated to improve the site for its official launch during World Continence Week in June 2012.

If you are interested in participating in the evaluation or wish to know more, contact Kate Zantuck, email K.Zantuck@continence.org.au or Fiona Downie, email F.Downie@continence.org.au.

Health Promotion Officers

CFA is finalising the very exciting process of appointing five Health Promotion Officers (HPOs), who will operate in conjunction with the CFA state branches and resource centres.
The HPOs have begun the process of designing, implementing and evaluating bladder and bowel health promotion programmes across Australia. They are meeting consumer groups with – or at increased risk of – bladder and bowel control problems, and are securing opportunities for partnership and collaboration. The new HPOs are: Katie Miliauskas from Western Australia; Lauren Jordan from Victoria; Tracey Sparks from Queensland; and Kate Kameniar from South Australia. The NSW HPO is still to be confirmed.

Support forum
People experiencing incontinence issues are now able to share their experiences with others with the launch of the CFA’s new online support forum. The forum provides a respectful, sympathetic and anonymous environment for people to talk about their health and to connect with others who have similar experiences. Family, friends and carers who support people with incontinence are also invited to connect online and receive the support and information they need. Visit the forum at www.continence.org.au

Strategic planning forum
CFA’s Five-year Strategic Plan has been drafted and presented to the CFA Board of Directors for endorsement. The plan was developed at a strategic planning forum in May, attended by representatives from key stakeholder groups, including the Department of Health and Ageing, the Consumer Advisory Committee, Australian Nurses for Continence, the Australian Physiotherapy Association, the state resource centres and state presidents. The forum was informed by feedback from the strategic planning questionnaire circulated to all members. Thank you to Therese Tierney who facilitated the forum and to members who assisted the planning process. The plan will be made available, after it has been formally adopted by the CFA Board.

Barry Cahill, CEO CFA

New Zealand news

New Zealand is a very exciting place to be at present with the Rugby World Cup (RWC) in progress. There are parties all around the country with every city hosting matches and local events. One important event was the Evidence Based Urogynaecology Meeting (Urogynz 2011) held in Queenstown, New Zealand, 11–13 October. This meeting brought together international speakers and was held in conjunction with the 2nd Urogynaecological Society of Australasia (UGSA) meeting and the 5th Annual New Zealand Urogynaecology Meeting.

The other big event that is being overshadowed by the RWC is our national election in November. Even though it seems fairly certain that the New Zealand National Party will be in government for a second term, it is very important that we keep our politicians accountable.

We have sent a letter to the leader of every political party in New Zealand stating the facts about incontinence along with a copy of the media release from the ‘Economic Cost of Incontinence’ with a link to the full report on our website. In this letter we have asked each political leader to answer two questions:

- How will you and your party, if part of the next government after November 2011, guarantee equitable access to high-standard continence services for all District Health Board regions?
- How will you and your party, if part of the next government after November 2011, advocate for a national continence strategy that will improve awareness, promote prevention and management strategies for continence, and support the national continence helpline?

We have said that we will publish the responses on the NZCA website, newsletter and through the New Zealand Carers Alliance, a network of organisations (46 NGOs), and their regional branches.

World Continence Week
As a follow-up to National Continence Week we have an organisation that represents 2000 fitness instructors keen to work with us next year in presenting one-day PFF workshops nationwide. This organisation will promote the workshops through its network and be actively involved. This will help cement the programme as a long-term project.

Australian Continence Conference
It would be great to see as many New Zealanders as possible attend the Continence Foundation of Australia’s National Conference on Incontinence in Melbourne, 16–19 November 2011. If you are a member of the New Zealand Continence Association, remember you can apply for a grant to attend the conference. If you are attending and wish to share accommodation, please contact Zoe via email: zoe@continence.org.nz and she will indicate who else is interested to do so.

Jan Zander, CEO NZCA
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(2) Authority required; Palliative care patients where constipation is a problem

(Refer to PBS Schedule for full information)