• Urinary incontinence: severity, perceptions and population prevalence in Australian women
  Avery JC, Gill TK, Taylor AW & Stocks NP

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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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Theoria

Is the evidence from one randomised controlled trial enough to change practice?

Clinicians who provide evidence-based management for patients need to keep up with the literature in their field of interest. This can be challenging. Clinicians need access to the literature and not everyone is privileged to have library access; there needs to be time to read it, and the literature needs appraisal for its quality and rigour. The recent workshop at the CFA conference was an opportunity to learn more about evidence appraisal and this is a key skill for practising clinicians as well as researchers.

It is often tempting to base judgements about new research on the abstract or conclusion of a paper. This is based on trust. Namely the trust that researchers present an accurate summary of their findings and that reviewers of peer-reviewed papers have confirmed that such summaries are accurate. When a clinician does not have the time, or perhaps skill, to critically appraise new evidence, then there are traps for naïve and unwary readers. This is exemplified in a recent publication in the New England Journal of Medicine by Labrie and colleagues, ‘Surgery versus physiotherapy for stress urinary incontinence’.

The 5th International Consultation on Incontinence (ICI) recommends physiotherapy for first-line treatment of female stress urinary incontinence (SUI) and surgery for women who are not satisfied with the outcome of physiotherapy. Controlled trials show that both approaches are effective but they have not, before now, been compared directly in a randomised control trial (RCT).

This large scientifically robust Dutch study randomised 460 women to two treatment arms. The research participants had moderate to severe SUI, as defined by Sandvik’s 1993 criteria. The two randomised treatments were either physiotherapy or surgery, each as first-line treatment. Surgical treatment, either retropubic or transobturator midurethral slings, was provided by 49 gynaecologists and urologists, who had each performed a minimum of 20 procedures. Physiotherapy was provided by 83 pelvic physiotherapists, with specialist training, and using Dutch pelvic floor muscle training guidelines. If the participants were dissatisfied with the outcome of the randomised first-line treatment then they could cross over to the other treatment arm of the trial. The primary outcome measure was subjective improvement in symptoms on the Patient Global Impression of Improvement questionnaire. The other outcomes included a variety of other patient-reported outcomes and a cough stress test.

After 12 months, 177/195 (90.8%) of participants randomised to first-line surgery were “much better” or “very much better” compared to 112/174 (64.4%) of participants randomised to first-line physiotherapy, absolute risk difference 26.4% (95% CI 18.1 to 34.5). This corresponds to a number needed to treat of about four. Cure, based on a dry cough test, was found in 140/183 (76.5%) of the surgical treatment group compared to 94/160 (58.8%) of the physiotherapy treatment group, absolute risk difference 17.8% (95% CI 7.9 to 27.3). Both groups improved from baseline in other secondary outcome measures, such as urogenital symptoms, disease-specific quality of life and development of new symptoms. The improvements in the surgical group were greater than the physiotherapy group.

Crossover occurred in 99/202 (49%) of the physiotherapy group, while 22/196 (11.2%) of the surgical group received additional physiotherapy after surgery. The authors state that this latter group had symptoms related to pelvic-floor muscle hyperactivity, such as obstructed micturition, and underwent training to relax the pelvic-floor muscles. Adverse events were reported 65 times in 41 women. All of these occurred in the surgical group, including six episodes of re-operation for tape exposure and one to loosen the tape. New urge urinary incontinence was reported in 13/215 (6%) of the surgical group.

The conclusion in the abstract states: “For women with stress urinary incontinence, initial midurethral-sling surgery, as compared with initial physiotherapy, results in higher rates of subjective improvement and subjective and objective cure at 1 year”.

The conclusion, as stated in the abstract, suggests that the key message of this study is to operate first on women with SUI because it promises better outcomes than physiotherapy. The conclusion in the abstract is misleading. One important qualification is that the study applies to those women recruited into the study. The entry criteria were to have moderate or severe SUI. The results of the trial may, therefore, not apply to women with lesser degrees of SUI. This key point will not be apparent to clinicians, including primary health care practitioners, from a first reading of the paper, and in particular the abstract. Nowhere in the abstract or the title of the paper is this feature of the recruitment stated. The Sandvik definition

Patricia Neumann
Specialist Continence & Women’s Health Physiotherapist
International Centre for Allied Health Evidence
University of South Australia, Adelaide, South Australia
Comfort Shield
Incontinence Care Washcloth

All-in-one barrier cream cloths with 3% dimethicone for incontinent patients

- 3% dimethicone barrier seals out wetness to treat and prevent perineal dermatitis
- Breathable, transparent barrier allows easy skin assessment.
- All-in-one cloth saves time and maximises compliance.

Day 1: 72-year-old patient with severely excoriated blistered skin and extreme pain from incontinence.

Day 4: After 3 days using Shield® Barrier Cloths, patient's skin vastly improved; no discomfort.

Reference: Sluser S, Consistency is the key for treating severe perineal dermatitis due to incontinence. Poster presented at the Clinical Symposium on Advances in Skin and Wound care (ASWC), Las Vegas, NV 2005 Oct.
of moderate and severe SUI are mean 24-hour pad weights of 17 g and 63 g respectively. Slight SUI is a mean 24-hour pad weight of 4 g. An Australian study by Neumann and colleagues found that 225/274 (82%) of women seeking help for SUI had slight SUI by the Sandvik definition, as they had less than 8 ml urine loss on provocative testing. Thus it is very likely that the results of this RCT do not apply to the majority of women seeking help for SUI in Australia. In addition, about 80% of women in the Australian study were “satisfied” or “very satisfied” with the outcome of their physiotherapy treatment after one year. The failure of the authors to make absolutely clear to whom the results of this study apply may lead to a large increase in inappropriate referral for surgery ahead of non-invasive treatment. The authors themselves comment that selection bias into the study might also have led to a misleadingly high estimate of treatment effect. In particular, women with a preference for surgery may have been more likely to participate in the study. Women who had undergone physiotherapy more than six months before recruitment were also allowed to participate, although it is likely that this group would be even less likely to respond to physiotherapy, as they had moderate or worse SUI despite past physiotherapy.

Another caveat relates to the ‘dose’ of physiotherapy. In the Australian study of all-comers with SUI by Neumann and colleagues, physiotherapy was administered with an average of five episodes of treatment per patient to achieve good clinical outcomes. This compares to the planned nine episodes of treatment in the Labrie study. Clearly physiotherapy for women presenting with SUI for conservative management will be more cost-effective in Australia with fewer treatments needed.

Thus the ICI Grade A recommendation of physiotherapy as first-line treatment before surgery should not be changed as a result of this study. This study only applies to about 20% of Australian women seeking help for SUI who have moderate or severe SUI and who may do better, on average, with surgery. Even in this RCT of moderate or severe SUI, 33/75 (44%) who had only physiotherapy, in fact were objectively cured. It is surely rational to continue to offer physiotherapy as first-line therapy even in this situation and avoid the undoubtedly increased risk of operation-related complications and the increased risk of development of other urinary symptoms.

The researchers did not particularly highlight the potentially life-changing effects of the adverse events that occurred in about 10% of the surgical group or the lack of adverse events in the physiotherapy group. The risk of exposure to anaesthetics and antibiotics consequent on surgery are not discussed, even though recent research suggests that older women undergoing an anaesthetic may have an increased longer term risk of unexpected events such as dementia.

Objective cure rates depend on the particular outcome measure used. For example, Bø and colleagues described an RCT in which the pad test involved bladder filling to 200 ml and then running on the spot for 30 seconds followed by 30 seconds of jumping jacks at a rate of 132 a minute. In that study, 11/25 (44%) of participants randomised to pelvic-floor muscle training had a pad weight of less than 2 g after six months. The study by Labrie and colleagues does not specify what is meant by cough stress test. In 2005, Bø and colleagues reported on a 15-year follow-up of another group of women who had originally been randomised to intensive or home pelvic-floor muscle training. After 15 years, about half of the total group had received continence surgery and the operated women actually reported worse incontinence and quality of life measures than those who had only physiotherapy. There are potential long-term benefits of pelvic-floor muscle training to combat the effects of disuse, ageing, and the effects of increased intra-abdominal pressure, with coughing or obesity. There may also be benefits for concomitant prolapse and bowel symptoms. These potential benefits may not accrue if women are referred straight to surgery.

So, readers beware! An editorial about the Labrie study on the IUGA website headlined, ‘Sling surgery bests physiotherapy as initial treatment’, shows how quickly and easily misinformation is promulgated. Although the Labrie study is a valuable contribution to the evidence-base for incontinence, after careful appraisal of the paper it is clear that it applies to a specific subgroup of women with SUI. Clearly conservative management with pelvic-floor muscle training should remain the first-line treatment for this condition in Australia.

References

Peer-reviewed

Urinary incontinence: severity, perceptions and population prevalence in Australian women

Abstract

The objective of this study was to estimate the prevalence of urinary incontinence (UI) in women responding to the 2001 South Australian Health Omnibus Survey, a representative sample of the adult South Australian population. We examined the associations between the perception of seriousness of UI, its severity and other factors. The response rate for the survey overall was 71.3% and 1549/3037 respondents were women, UI was reported by 579/1549 (37.4%) of female respondents and severe incontinence defined by use of continence management aids by 146/1549 (9.4%). Respondents with any UI, who considered their condition to be very or moderately serious, were more likely to report severe incontinence. Women whose lifestyle was limited by incontinence were more likely to perceive their condition to be very serious. Together, severity and limitations to lifestyle were predictors of women perceiving that their incontinence was moderate to very serious. Help-seeking for incontinence may improve if education and information target women who use continence management aids, who have difficulty being involved in activities or who use other management strategies.

Keywords: Urinary incontinence, women, population study, severity, limitations, urogynaecology.

Introduction

In communities with an ageing population, the prevalence of chronic conditions, including urinary incontinence (UI), is likely to increase. It is important to overcome barriers to early diagnosis and treatment of UI to maintain individual quality of life and reduce the individual and societal costs. A recognised definition of UI from the International Continence Society is: “the complaint of any involuntary leakage of urine”, and is further described in terms of severity, frequency, social aspects, hygiene and quality of life.

However, definitions of UI in prevalence studies have been inconsistent. In 1998, “ever having urinary incontinence” was reported by 35.3% of women in South Australia, and 4.9% of women indicated severe incontinence. This reported prevalence from the South Australian Health Omnibus Survey (SAHOS), is similar to that reported in other studies, that used equivalent definitions for severity.

Perceptions about UI, its severity and the effect on an individual may influence and inhibit help-seeking behaviour. Symptoms alone are not the greatest determinant of the effects of incontinence on the individual. Help-seeking may improve if education and information target women who use continence management aids, who have difficulty being involved in activities or who use other management strategies.

Barriers that influence help-seeking can be addressed more effectively if perceptions are considered. Overall perceptions about UI and the relationship between perception and treatment seeking may be best understood if factors such as severity and the effect on the individual can be quantified.

The impetus for seeking treatment for UI is associated with severity. However, there is no current consensus as to what constitutes severity. Symptom evaluation does not strongly relate to the effect of UI on social interaction, physical activities and psychological aspects of people with this condition. In large-scale population surveys, severity has been gauged using validated questionnaires, subjective measures such as wearing pads, and asking how serous the participants thought their condition was, how bothersome the condition, the amount and
how often the problem occurred. Although not ideal, we can gauge the impact of incontinence on the population in this way.

This paper discusses the prevalence of UI in a population sample with a particular emphasis on the severity of the condition. Women with UI were considered in relation to their perceptions about how serious they believed their condition to be, and the limitations caused by the condition. These perceptions were also investigated in light of the severity of the condition, indicated by self-management practices, that is, using pads. Factors such as these may provide the framework for and understanding into treatment seeking behaviour for incontinence.

Materials and methods

Data analysed in this study was collected via the 2001 Autumn SAHOS. The methodology of the SAHOS is described elsewhere in more detail. SAHOS is a representative population survey conducted annually or twice a year, using a clustered, self-weighting, systematic, multistage area sample of metropolitan and country areas with populations of more than 1000 people. The formal analysis of this survey data uses weights in relation to age, sex and geographical location to the nearest South Australian estimated residential population. There were 3037 respondents to the survey reported here. The response rate was 71.3%.

For this study, UI was defined as a positive response to either of the first two questions shown in Box 1. For this analysis we only considered responses of women. “Severe incontinence” refers to the use of incontinence management aids, which were defined as “using aids or products to help with the problem”.

Statistical analysis

For simplicity of analysis, we assumed a simple random sample was performed. SAHOS uses a complex sampling methodology which typically increases estimates of variance and the width of confidence intervals compared to this simpler analysis. The extent of this is measured by the so-called design effect which in SAHOS was relatively small, between 1.1 and 1.2. Logistic regression was used to explore the association of the response variable, the perception of seriousness of UI, in relation to possible explanatory variables: SPSS Version 19.0 was used for analyses.

The study received ethics approval from the Women’s and Children’s Hospital Human Research Ethics Committee and the South Australian Department of Health Human Research Ethics Committee. Questions submitted for SAHOS are reviewed by a management committee.

Results

Sample characteristics

In SAHOS, as a whole, there were 1488 men (49%). This analysis focused on women, 1549 (51.0%). Of the respondents, 376 (24.3%) were under 30 years of age, 556 (35.9%) were aged between 30 and 49 years, and 617 (39.8%) were aged 50 years or older; with the complete age range of 15 to 99 years. The majority of respondents were married or living in a de facto relationship, 934 (60.3%), 144 (9.3%) separated or divorced, 168 (10.9%) widowed and 302 (19.5%) never married.

Prevalence of UI

UI affected 579/1549 (37.4%) of the women surveyed. Tabulations of responses and univariate analysis of associations are shown in Table 1. Women aged 50 years and older, reported the highest prevalence of UI (49.4%), with 97/304 (31.9%) of women experiencing incontinence in this age group reporting severe UI. Overall, 146 (9.4%) of all women surveyed reported severe UI. Women aged 50 years and over, with an education level of a trade, certificate or diploma, and those who had never married were statistically significantly more likely to experience severe incontinence (Table 1). Only 177/549 (30.6%) of the women who reported UI had seen a health professional about their condition.

Perceptions of seriousness and severity

We found 45/577 (7.7%) of women reported their condition “very serious”. Table 2 shows the tabulation of the numbers of respondents with UI, their own perception of seriousness of the incontinence, and severity as determined by incontinence management aids. The analysis showed that respondents with UI
who reported the problem was very or moderately serious were more likely to report severe incontinence. Similar relationships were found with stress and urge incontinence.

**Limitations to lifestyle**

Table 3 shows seriousness in relation to limitations. Overall 80 (14.0%) respondents indicated that incontinence limited their lifestyle in some way. Among this group, 72/80 (90%) experienced one limitation, and 8/80 (10%) two to three limitations.

Three important limitations to lifestyle were reported: an inability to leave the house for too long, 24.4% (20/80); not being able to socialise “like I used to”, 18.2% (15/80); and not being able to work “as much as I used to”, 8.5% (7/80).

**Perceived seriousness of incontinence**

There was a strong association between reporting that UI was very or moderately serious with the use of incontinence aids, and limitations to activities. A similar association was found for stress UI alone. A similar association was found between reporting that urge UI, was very or moderately serious and a positive response that they “managed their condition in other ways”.

**Discussion**

It is uncertain what aspects of measurement of UI best related to the effect of UI on quality of life. Measures of UI, such as symptom diaries, urodynamic parameters, condition-specific questionnaires and generic quality of life assessments, result in the focus of outcomes assessment being typically focused on the amount and frequency of incontinence. Can these measures predict the impact of incontinence on the individual, and their associated behaviour such as help-seeking? Health professionals and patients view the impact of incontinence on life differently. Health professionals may focus on the functional impact and the quantifiable symptom severity, while those experiencing UI may focus on emotional wellbeing and the interruption of activities of daily life.

The prevalence of UI in the SAHOS increased between 1998 and this 2001 survey, and so too did the proportion of women reporting UI who had seen a health professional regarding their condition, from 27.1% in 1998 to 30.6% in 2001. While this is encouraging, these figures highlight that the majority of women who report UI still do not seek help. This may be due to perceptions and beliefs about help-seeking and this may be modified through health promotion and targeted education. Since this survey in 2001 the proportion of women with UI and the proportion who have seen a health professional may have changed.

In this study, we found a strong association between measurements of incontinence severity, and respondent-centred perceptions of seriousness. Respondents with any UI who considered their condition to be very or moderately serious were more likely to report severe incontinence.
Table 1: Characteristics of women with UI, and Severe UI, stratified by type, SAHOS 2001

<table>
<thead>
<tr>
<th>Overall UI</th>
<th>All incontinence</th>
<th>Severe incontinence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–39 years</td>
<td>48/376</td>
<td>12.8</td>
</tr>
<tr>
<td>30–49 years</td>
<td>227/956</td>
<td>40.8</td>
</tr>
<tr>
<td>50 years-plus</td>
<td>304/617</td>
<td>49.4</td>
</tr>
<tr>
<td><strong>Area of residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metropolitan</td>
<td>396/1098</td>
<td>36.1</td>
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<tr>
<td>Country</td>
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</tr>
<tr>
<td><strong>Education</strong></td>
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<td>54/171</td>
<td>31.8</td>
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<tr>
<td>Certificate/diploma</td>
<td>142/351</td>
<td>40.4</td>
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<td>42.9</td>
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<td>No post-school education</td>
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<td>36.9</td>
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<td><strong>Marital status</strong></td>
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<td>Married/de facto</td>
<td>395/934</td>
<td>42.3</td>
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<td>Separated/divorced</td>
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<td>Widowed</td>
<td>74/168</td>
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<td>Never married</td>
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<td>Other</td>
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<td><strong>OVERALL prevalence</strong></td>
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Table 1 (continued): Characteristics of women with UI, and Severe UI, stratified by type, SAHOS 2001

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<td>37/302</td>
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<td>37.0</td>
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<tr>
<td>4.24 (2.66–6.75)</td>
</tr>
<tr>
<td>&lt;0.001</td>
</tr>
<tr>
<td>5/37</td>
</tr>
<tr>
<td>14.7</td>
</tr>
<tr>
<td>4.33 (1.53–12.29)</td>
</tr>
<tr>
<td>0.006</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household income</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than A$50,000</td>
</tr>
<tr>
<td>136/451</td>
</tr>
<tr>
<td>30.1</td>
</tr>
<tr>
<td>1.00</td>
</tr>
<tr>
<td>54/166</td>
</tr>
<tr>
<td>32.5</td>
</tr>
<tr>
<td>1.00</td>
</tr>
<tr>
<td>A$20,001 to A$50,000</td>
</tr>
<tr>
<td>171/468</td>
</tr>
<tr>
<td>36.5</td>
</tr>
<tr>
<td>1.34 (1.02–1.76)</td>
</tr>
<tr>
<td>0.039</td>
</tr>
<tr>
<td>37/171</td>
</tr>
<tr>
<td>21.8</td>
</tr>
<tr>
<td>0.58 (0.36–0.94)</td>
</tr>
<tr>
<td>0.028</td>
</tr>
<tr>
<td>Up to A$20,000</td>
</tr>
<tr>
<td>166/401</td>
</tr>
<tr>
<td>41.4</td>
</tr>
<tr>
<td>1.64 (1.24–2.18)</td>
</tr>
<tr>
<td>0.001</td>
</tr>
<tr>
<td>28/136</td>
</tr>
<tr>
<td>20.9</td>
</tr>
<tr>
<td>0.55 (0.33–0.93)</td>
</tr>
<tr>
<td>0.026</td>
</tr>
<tr>
<td>Not stated</td>
</tr>
<tr>
<td>57/228</td>
</tr>
<tr>
<td>25.0</td>
</tr>
<tr>
<td>0.77 (0.54–1.11)</td>
</tr>
<tr>
<td>0.166</td>
</tr>
<tr>
<td>20/57</td>
</tr>
<tr>
<td>3.5</td>
</tr>
<tr>
<td>1.12 (0.60–2.12)</td>
</tr>
<tr>
<td>0.721</td>
</tr>
</tbody>
</table>

OVERALL stress prevalence
529/1548 34.2 139/529 26.3

Urge UI

<table>
<thead>
<tr>
<th>Age group</th>
<th>n</th>
<th>%</th>
<th>OR</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–39 years</td>
<td>13/376</td>
<td>3.5</td>
<td>1.00</td>
<td>2/13</td>
</tr>
<tr>
<td>30–49 years</td>
<td>71/556</td>
<td>12.7</td>
<td>4.01 (2.19–7.32)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>50 years-plus</td>
<td>140/617</td>
<td>22.7</td>
<td>8.06 (4.51–14.39)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Area of residence

| Metropolitan           | 147/1098 | 13.4 | 1.00 | 53/147 | 35.9 |
| Country                | 77/451   | 17.1 | 1.33 (0.98–1.79) | 0.065 | 32/77 | 4.2 | 1.29 (0.74–2.27) | 0.373 |

Education

| Bachelor degree        | 15/171 | 8.7 | 1.00 | 59/150 | 39.6 |
| Certificate/ diploma  | 46/351 | 13.2 | 1.94 (1.11–3.40) | 0.020 | 9/13 | 70.1 | 6.96 (1.11–43.81) | 0.039 |
| Trade qualifications   | 13/71  | 18.4 | 2.36 (1.06–5.25) | 0.036 | 15/46 | 33.2 | 24.92 (2.87–216.48) | 0.004 |
| No post-school education | 150/955 | 15.7 | 1.59 (0.86–2.94) | 0.139 | 1/15 | 8.6 | 5.29 (0.78–35.76) | 0.087 |

Marital status

| Married/de facto       | 140/934 | 15.0 | 1.00 | 54/140 | 38.7 |
| Separated/divorced     | 21/144  | 14.8 | 0.98 (0.60–1.61) | 0.949 | 7/21 | 32.8 | 3.55 (0.95–13.24) | 0.059 |
| Widowed                | 45/168  | 26.5 | 2.04 (1.39–3.01) | <0.001 | 21/45 | 47.7 | 2.75 (0.58–13.11) | 0.204 |
| Never married          | 19/302  | 6.1  | 0.37 (0.23–0.62) | <0.001 | 3/19 | 15.1 | 5.14 (1.27–20.86) | 0.022 |

Country of birth

| Australia            | 164/1172 | 14.0 | 1.00 | 61/164 | 37.5 |
| UK/Ireland           | 30/184   | 16.2 | 1.19 (0.78–1.82) | 0.427 | 12/30 | 40.7 | 1.15 (0.52–2.54) | 0.739 |
| Other                | 31/192   | 15.9 | 1.17 (0.77–1.78) | 0.410 | 12/31 | 3.8 | 1.03 (0.46–2.27) | 0.951 |

Household income

| More than A$50,000  | 144/451 | 31.9 | 1.00 | 14/49 | 29.7 |
| A$20,001 to A$50,000 | 181/468 | 38.7 | 0.90 (0.59–1.38) | 0.644 | 16/46 | 35.4 | 1.30 (0.55–3.08) | 0.548 |
| Up to A$20,000      | 188/401 | 47.0 | 2.60 (1.79–3.79) | <0.001 | 42/96 | 43.5 | 1.83 (0.88–3.81) | 0.109 |
| Not stated          | 66/228  | 28.9 | 1.41 (0.88–2.26) | 0.157 | 13/33 | 37.7 | 1.44 (0.57–3.65) | 0.447 |

OVERALL urge prevalence
224/1548 14.5 85/224 38.0

Note: Rounding discrepancies may mean percentages don’t add to 100. P-values for association compared to the reference group (OR=1)

OR: Odds Ratio. CI: Confidence Interval.
### Table 2: Univariate odds ratios for the perceived seriousness of types of UI by severity (wearing incontinence protection aids) SAHOS 2001

<table>
<thead>
<tr>
<th></th>
<th>Not severe</th>
<th>Severe</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>OR</td>
</tr>
<tr>
<td><strong>Any UI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very serious</td>
<td>25</td>
<td>5.8</td>
<td>1.00</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>91</td>
<td>21.2</td>
<td>1.00</td>
</tr>
<tr>
<td>Not very serious</td>
<td>155</td>
<td>36.1</td>
<td>1.00</td>
</tr>
<tr>
<td>Not at all serious</td>
<td>159</td>
<td>36.9</td>
<td>1.00</td>
</tr>
<tr>
<td>Total overall UI</td>
<td>431</td>
<td>74.7</td>
<td>146</td>
</tr>
<tr>
<td><strong>Stress incontinence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very serious</td>
<td>22</td>
<td>5.6</td>
<td>1.00</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>82</td>
<td>21.2</td>
<td>1.00</td>
</tr>
<tr>
<td>Not very serious</td>
<td>140</td>
<td>36.1</td>
<td>1.00</td>
</tr>
<tr>
<td>Not at all serious</td>
<td>144</td>
<td>37.1</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Total stress UI</strong></td>
<td>388</td>
<td>73.6</td>
<td>139</td>
</tr>
<tr>
<td><strong>Urge incontinence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very serious</td>
<td>10</td>
<td>7.1</td>
<td>1.00</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>47</td>
<td>33.8</td>
<td>1.00</td>
</tr>
<tr>
<td>Not very serious</td>
<td>51</td>
<td>36.8</td>
<td>1.00</td>
</tr>
<tr>
<td>Not at all serious</td>
<td>31</td>
<td>22.4</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Total urge UI</strong></td>
<td>138</td>
<td>61.9</td>
<td>85</td>
</tr>
</tbody>
</table>

Note: Rounding discrepancies may mean percentages don’t add to 100. P-values for association compared to the reference group (OR=1).

### Table 3. Perceived seriousness, for respondents reporting limitations to life, SAHOS 2001

<table>
<thead>
<tr>
<th></th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td><strong>Any UI</strong></td>
<td></td>
</tr>
<tr>
<td>Not very/not at all serious</td>
<td>21/372</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>36/160</td>
</tr>
<tr>
<td>Very serious</td>
<td>24/44</td>
</tr>
<tr>
<td><strong>OVERALL</strong></td>
<td>80/577</td>
</tr>
<tr>
<td><strong>Stress urinary incontinence</strong></td>
<td></td>
</tr>
<tr>
<td>Not very/not at all serious</td>
<td>16/338</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>35/148</td>
</tr>
<tr>
<td>Very serious</td>
<td>21/41</td>
</tr>
<tr>
<td><strong>OVERALL</strong></td>
<td>73/527</td>
</tr>
<tr>
<td><strong>Urge urinary incontinence</strong></td>
<td></td>
</tr>
<tr>
<td>Not very/not at all serious</td>
<td>11/109</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>23/86</td>
</tr>
<tr>
<td>Very serious</td>
<td>18/28</td>
</tr>
<tr>
<td><strong>OVERALL</strong></td>
<td>52/223</td>
</tr>
</tbody>
</table>

Note: Rounding discrepancies may mean percentages don’t add to 100. P-values for association compared to the reference group (OR=1).

OR: Odds Ratio. CI: Confidence Interval.
to have severe incontinence. The direction of causality is not necessarily clear because respondents who used incontinence management aids, indicating a “severe” condition, may use them because they perceived their condition was “very” or “moderately serious”, or due to the severity of symptoms. Other variables related to respondent perceptions of UI to be “very” or “moderately serious” were limitations to lifestyle activities and management practices for urge UI.

These associations suggest that as severity is related to help-seeking, that it may be useful to target health promotion programs to encourage those who have the greatest perception of severity — women who use pads or other management aids, who experience interference in daily activities, and who use management strategies — to seek help.

A limitation to this study is that severity was defined as a dichotomous variable rather than one that provided a ranking of severity. In the SAHOS study, this was to simplify respondent burden but also because in such large surveys, severity may be subject to recall-bias. This is a refinement that could be included in future surveys.

Another important limitation to this study report is that multiple tests of association are reported and the results may be subject to Type I error rate inflation. For ease of analysis and understanding, survey design-based weights were not incorporated in the analysis and the P-values are likely to be small and confidence intervals for association narrower than would be the case for incorporating this aspect of analysis.

Conclusions

Population-based sample surveys can identify factors that affect perceptions about health conditions and in particular help-seeking behaviour. This is particularly so for a condition such as UI where many people who have the condition do not seek help for many reasons. This study contributes to the knowledge in this area, particularly with the association of perceptions of seriousness of UI as a barrier to seeking help. Further research using more quantifiable measure of severity when addressing perceptions of seriousness, should include quality of life measures and other psychosocial measure such as resilience and this may allow practitioners to further relieve the burden of incontinence.

References

22nd National Conference on Incontinence
23–26 October 2013, Perth, Western Australia

Keynote address abstracts
Train the mind or the muscles? Implications of a descriptive qualitative synthesis in the context of behaviour change theory

Hay-Smith EJC
Rehabilitation Teaching and Research Unit, Department of Medicine, University of Otago, Wellington, New Zealand

I would be a rich woman if I received a dollar each time a patient said something like, “I find it so hard to remember to do them” in response to my enquiry about her home pelvic floor muscle training (PFMT) programme. We know that PFMT adherence is essential if the therapy is to have any chance of effect (and continuing effect) yet adherence is problematic for many patients and appears to decrease over time.

While PFMT is commonly considered a ‘physical’ intervention, the adoption and maintenance of an exercise programme is also a behavioural change. There are many health behaviour theories and models. Most of them draw our attention to the influence of what people think, believe and feel in determining their intentions to adopt behaviours and their actual behaviours. What this suggests is that PFMT success is as much about training the mind as the muscles.

A descriptive qualitative review of qualitative studies reporting the experience of PFMT was undertaken to explore patient perceptions of influences on exercise adherence and suggest avenues for promoting adherence in clinical settings. Primary qualitative studies were located by conventional subject searching of electronic databases, reference list checking and contact with experts. To be eligible for inclusion in the review the qualitative study had to include verbatim quotes from participants about PFMT experiences. Details of study aims, methods and participants were extracted and tabulated. Data from the individual studies were thematically analysed to identify core influences on adherence.

Thirteen studies were included and all but one recruited only women. The quality of methodological reporting varied. Six themes (influences on adherence) were derived: knowledge; physical skill; feelings about PFMT; cognitive analysis, planning and attention; prioritisation; and service provision. All 13 studies contributed data to the theme about cognitive analysis, planning and attention and highlighted the strong influence of the mind (and need for training of the mind) in enhancing adherence. These data are presented and the implications for clinical practice discussed in the context of the Capability Opportunity Motivation Behavioural system (COM-B) and Behaviour Change Wheel (BCW).
Pelvic organ prolapse (POP) is a major hidden burden affecting millions of women worldwide. POP is the herniation of bladder, bowel and/or uterus into the vagina. Vaginal birth is the main risk factor but pregnancy itself, ageing and obesity all exacerbate POP. One in four women have POP. The most common presenting symptom is urinary incontinence. Incontinence profoundly impairs the quality of life and daily functioning of sufferers, comparable to stroke and dementia, and presents a significant health care burden.

Almost one in five women will undergo reconstructive gynaecological surgery for POP and up to 25% require re-operation due to recurrence of symptoms. To support pelvic tissues surgical polypropylene (PP) mesh was rapidly introduced, which improved symptomatic cure rates. However, due to mesh complications, two recent United States, Food and Drug Administration (FDA) Public Health Notifications have alerted clinicians to high rates (~10%) of adverse events associated with PP mesh for vaginal repair surgery. This has led to the withdrawal from the market of several widely used brands of vaginal mesh and looming class-action litigation. There is now a real risk that treatment options will become limited and ineffective again for many women.

To overcome these problems, we are developing a new generation of surgical constructs using tissue engineering approaches for the treatment of POP. These rely on the design and fabrication of new mesh materials, undertaken in conjunction with the Commonwealth Scientific and Industrial Research Organisation (CSIRO), Materials Science and Engineering unit, and the use of a woman’s own cells. In particular we have designed a polyamide (PA) (nylon) mesh with biomechanical properties similar to human vaginal tissues. The PA mesh has large pores (1.3 mm) and is coated in gelatin to enable the delivery of large numbers of mesenchymal stem cells for repair of para-vaginal fascia tissues damaged from childbirth injury and manifesting as POP.

Mesenchymal stem cells (MSC) were first isolated from bone marrow and are an attractive source of cells for cell-based therapies because of their capacity to undergo extensive proliferation in culture and differentiate into many soft tissue lineages (fat, bone, cartilage, stroma, tendon, muscle). Clinical trials websites indicate that there are >600 registered clinical trials using MSC and >2000 patients have received MSC of varying sorts. However, to date there have been no trials for POP. We have identified a novel source of easily accessible MSC in the highly regenerative endometrial lining of the uterus and developed methods for their purification. In ‘proof of principle’ studies using a small animal skin/fascia repair model we have shown that human endometrial MSC/PA/gelatin tissue engineering constructs decreased the rate of mesh-related complications in the long term.

In particular we showed that PA/gelatin mesh implanted with endometrial MSC increased early vascularisation around the mesh, exerted an anti-inflammatory effect that promoted wound repair with new tissue growth and minimal fibrosis compared to mesh seeded without cells. This cell-based therapy improved the mechanical properties of the tissue/mesh complex by producing a mesh with greater extensibility and diminished stiffness, increasing the biocompatibility of our novel mesh construct.

References
We are now developing a large animal vaginal surgical model using sheep, where we isolate sheep endometrial MSC as an autologous cell-based therapy for natural or induced POP in the same animals. We propose that our endometrial MSC/PGA/gelatin tissue engineering construct may provide an alternative option for the future treatment of POP.

Toilet taboos — The psychology of bathroom stigmas
Haslam N
University of Melbourne, Melbourne, VIC, Australia

Excretion is shrouded in powerful taboos. These taboos attach emotions of shame and disgust to normal bodily processes. They also create strong inhibitions against discussing these processes. As a result, people with difficulties surrounding elimination carry a stigma that is both difficult to deal with and difficult to disclose to others. As a result, people often face these difficulties alone and fail to seek appropriate help.

For discussion is the fascinating psychology of toilet taboos and their many dimensions. First, I examine the psychology of disgust and the surprising implications it has for how we think and behave in relation to excretion and its products. I then explain the ways in which disgust is linked to shame, and how that toxic emotion is fundamental to many of the inhibitions that surround excretion.

Secondly is the link between toilet taboos and an assortment of clinical conditions, including urinary inhibition (‘paruresis’), irritable bowel syndrome, urinary retention, obsessive-compulsive disorder and Tourette's syndrome.

Thirdly, focusing on incontinence, is how psychologists accounts of it have often been misguided, attaching pathological meanings to it that are generally unwarranted. Specific elements of the taboo on incontinence, emphasising the roles of disgust and shame and the associated themes of lacking self-mastery and childishness are discussed.

Finally, some suggestions about how toilet taboos and stigmas can be challenged and, ultimately, overcome are offered.

Interstitial cystitis – chronic bladder pain syndrome
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Adjunct Professor, Edith Cowan University, Australia
Visiting Consultant, Dept of Urology, Changi General & KTP
Introduction: Interstitial cystitis is a clinical syndrome characterised by daytime and night-time urinary frequency, urgency, and pelvic pain of unknown aetiology. Interstitial cystitis has no clear pathophysiology, and diagnostic criteria for the syndrome remain undefined. Despite considerable research, universally effective treatments do not exist; therapy usually consists of various supportive, behavioural and pharmacologic measures. Surgical intervention is very rarely indicated.

The International Continence Society has coined the term painful bladder syndrome\(^1\)\(^-\)\(^4\) as suprapubic pain with bladder filling associated with increased daytime and night-time frequency, in the absence of proven urinary infection or other obvious pathology and reserves the diagnosis of interstitial cystitis for patients with characteristic cystoscopic and histologic features of the condition.

An international consensus panel was able to generally agree on the following definition of bladder pain syndrome, interstitial cystitis as the: unpleasant sensation (pain, pressure, discomfort) perceived to be related to the urinary bladder and associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes\(^1\).

In 1887, Skene\(^5\) initially described a condition characterised by inflammation that destroyed the urinary bladder “mucous membrane partly or wholly and extended to the muscular parietes”. Guy Hunner\(^6\)\(^-\)\(^7\) explained the disease with the description of characteristic bladder wall ulcers. The first comprehensive epidemiologic description of interstitial cystitis is credited to Hand\(^8\), who in 1949 described the widespread, small, submucosal bladder haemorrhages and the significant variation in bladder capacity characteristic of the condition.

Despite years of intensive research, there are no specific clinical or urinary markers; no radiographic, laboratory, or serologic findings; and no biopsy patterns that are pathognomonic for interstitial cystitis. Interstitial cystitis is a diagnosis of exclusion.

Epidemiology: Reports on the prevalence of interstitial cystitis depend on the country of origin and the criteria used for diagnosis. In the United States, Curhan and colleagues reported\(^9\) a prevalence of 60–70 cases per 100,000 women. The incidence rate of interstitial cystitis is 2.6 cases per 100,000 women per year in the United States.

Reports from Europe indicate a prevalence of 18 cases per 100,000 women and in Japan the prevalence rate is three to four cases per 100,000 women. The marked differences between these countries and the United States are likely due to differences in diagnostic criteria.

Of patients with interstitial cystitis, 94% are white, and approximately 90% are female. Household size, marital status, number of male sexual partners, educational status, and parity are not statistically different between patients with interstitial cystitis and healthy controls. Interstitial cystitis appears to be slightly more common in Jewish women.

Median age at presentation is 40 years. However, Close and colleagues\(^10\) have shown that interstitial cystitis may occur in children. In their series, the median age of onset was 4.5 years, with a mean age of diagnosis of 8.2 years.

Pathophysiology: The pathophysiology of interstitial cystitis is poorly understood. Various aetiologies have been proposed, none of which adequately explains the variable presentations, clinical courses, or responses to therapies. This may indicate that interstitial cystitis represents a number of as yet undefined, disparate pathologic conditions that, over time, ultimately present as the clinical syndrome of urinary frequency, urgency, and pelvic pain.

Clinically, interstitial cystitis is often divided into two distinct subgroups based on findings at cystoscopy and bladder overdistention. These categories are the ulcerative (classic) and non-ulcerative (Messing-Stamey) types.

Ulcerative cystitis: The hallmark of classic interstitial cystitis is a diffusely reddened appearance to the bladder surface epithelium associated with one or more ulcerative patches surrounded by mucosal congestion (that is, Hunner ulcer) on the dome or lateral walls of the bladder upon cystoscopic examination. These ulcers may become apparent only after over-distension; because discrete areas of mucosal scarring rupture during the procedure. Over-distension in this type of interstitial cystitis results in fissures and cracks that bleed in the bladder epithelium.

In the United States, the ulcerative type is rare (<10% of cases), and some authors consider this type to be more resistant to therapy. Biopsy findings show that the ulcerative lesion can be transmural, associated with marked inflammatory changes, granulation tissue, mast cell infiltration, and, in some cases, fibrosis. This classic form of interstitial cystitis can be associated with progressively smaller bladder capacity over time.

Non-ulcerative: The non-ulcerative type of interstitial cystitis is characterised by similar clinical symptoms (that is, frequency, urgency, pelvic pain), but the cystoscopic findings noted for the ulcerative lesion are absent. Instead, after over-distension, this patient group demonstrate glomerulations, discrete, tiny, raspberry-like lesions appearing on the dome and lateral
walls of the bladder and tiny mucosal tears and submucosal haemorrhages. Bladder biopsy findings are often unremarkable, as compared with biopsy of patients with classic interstitial cystitis.

**Aetiology:** The aetiology of interstitial cystitis remains unknown and is likely multifactorial. Proposed aetiologies include:

- Pathogenic role of mast cells in the destructor and/or mucosal layers of the bladder.
- Deficiency in the glycosaminoglycan layer on the luminal surface of the bladder, resulting in increased permeability of the underlying submucosal tissues to toxic substances in the urine.
- Infection with a poorly characterised agent (for example, a slow-growing virus or extremely fastidious bacterium).
- Production of a toxic substance in the urine.
- Neurogenic hypersensitivity or inflammation mediated locally at the bladder or spinal cord level.
- Manifestation of pelvic floor muscle dysfunction or dysfunctional voiding.
- Autoimmune disorder.

Although interstitial cystitis has not traditionally been considered an inherited condition, in 2001 Warren and colleagues\(^1\) reported a concordance of interstitial cystitis in monozygotic and dizygotic twin pairs and pointing to the disease having a possible genetic predisposition.

Patients with interstitial cystitis are more likely to have undergone prior gynaecologic surgery and/or to have a history of urinary tract infections and are 10–12 times more likely to report childhood bladder problems. Interstitial cystitis is associated with several chronic illnesses, including inflammatory bowel disease, systemic lupus erythematosus, irritable bowel syndrome, fibromyalgia, and atopic allergy. Psychiatric conditions associated with interstitial cystitis include anxiety disorder, depression and adjustment reactions.

**Evaluation:** The diagnosis of interstitial cystitis/bladder pain syndrome (IC/BPS) is based upon a person’s symptoms and examination. A careful medical history, physical examination, and sometimes laboratory testing are needed to confirm the diagnosis and also to rule out other conditions (that is, bladder infection or kidney stone) as the cause of the patient’s symptoms. There is no one test that can definitively diagnose IC/BPS.

Therefore, the goal of the diagnostic evaluation for IC/BPS is to identify characteristic features and exclude other conditions.

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The characteristics of the bladder pain or discomfort in patients with IC/BPS are variable, but the most consistent feature is an increase in discomfort with bladder filling and a relief with voiding.

Common physical examination findings include tenderness in many areas of the abdominal wall, hip girdle, buttocks, thighs, and pelvic floor, as well as tenderness of the bladder base and/or urethra.

Urinalysis should be performed in all patients to exclude significant haematuria and infection. Urine culture can be obtained if the urinalysis results show pyuria suggestive of infection. Post-void residual urine measurement may also be useful to look for other conditions.

There are no characteristic findings for IC/BPS on imaging studies. Cystoscopy is not required to make the diagnosis, but may be used for some patients to exclude other aetiologies or identify bladder lesions associated with IC/BPS. Other tests include: hydrodistention, bladder biopsy, and potassium sensitivity testing, but these are not routinely necessary for diagnosis of IC/BPS.

**Treatment**: The most important element in treating patients with interstitial cystitis is education and emotional support. Periodic exacerbations are managed as they occur because no long-term therapy has been shown to prevent or delay recurrent episodes. Therefore, the purpose of treatment is to palliate and alleviate symptoms.

Because no discrete pathognomonic pathologic criteria exist for assessing and monitoring disease severity, indications and goals for treatment are based on the degree of patient symptoms. Assessing patient response to treatment is also complicated because of the subjective nature of symptoms and the lack of objective serologic, physical or histopathology findings. Conservative measures and oral or intravesical treatments are considered first-line treatment. Recent development of liposome instillations offers hope for those whose symptoms do not respond to current myriad range of therapies available.

A liposome (LP) is a vesicle, composed of concentric phospholipid bilayers separated by aqueous compartments. Because liposomes adsorb to cell surfaces and fuse with cells, they are being used as vehicles for drug delivery and gene therapy. In addition, they create a molecular film on cell surfaces and therefore are being tested as possible therapeutic agents to promote wound healing. LP-based drug products provide a moisture film onto the wound and promote outstanding wound healing without chronic inflammatory-reaction in the neodermal layer. Other investigators suggest that LP could interact with cells by stable absorption, endocytosis, lipid transfer and fusion.

Intravesical administration of liposomes into the wounded uroepithelium may improve the dysfunctional uroepithelium and provide an alternative treatment for IC. These concepts were proven in rat models of hypersensitive bladder, which showed that intravesical instillation of LP could reduce the bladder hypersensitivity induced by intravesical potassium chloride or acetic acid. Furthermore, researchers at Chang Gung Memorial Hospital Kaohsiung, Taiwan, have reported intravesical LP, as a bladder lotion, can ease IC symptoms without notable side effects in a phase-two study.

IC is a chronic condition with a variable course characterised by intermittent periods of exacerbations and remissions. Unfortunately, the disorder responds poorly to treatment in many cases. To date, no treatment has been shown to decrease disease progression; therefore, the purpose of treatment is to palliate and alleviate symptoms. Although rare, classic interstitial cystitis may lead to bladder wall scarring that result in a contracted, small-capacity bladder. Patients who present with classic IC often require augmentation cystoplasty or some form of urinary diversion.

Because of the chronic nature of IC and the significant impact on the patient's quality of life, the psychological impact of the condition can be enormous. Ongoing emotional support is essential.

**UPOINT strategy**: A recently devised strategy to treat chronic pelvic pain disorders is a generic programme devised for a uniform holistic approach to managing chronic prostatitis/chronic pelvic pain syndrome and its related presentations. It can be usefully applied to all patients and covers five main domains. It can be remembered easily with the mnemonic UPOINT:

- **U** = Urinary Symptoms
- **P** = Psychological
- **O** = Organ Specific, that is, Bladder or Prostate
- **I** = Infection
- **N** = Neurogenic/Systemic
- **T** = Tenderness of muscles.

This phenotypically applied directed therapy is the key to treatment success in this difficult to manage patient group and is needed in addition to addressing the specific treatment of the actual aetiology, whether or not the latter is identified and targeted or otherwise.
References


Do what you do well; what continence specialists and women say about incontinence treatment

Hay-Smith EJC
Rehabilitation Teaching and Research Unit, Department of Medicine, University of Otago, Wellington, New Zealand

For conservative treatments of incontinence to have any chance of long-term effectiveness, the woman has to be willing to change behaviour by learning new skills, refining these skills through practice, and then continue to use them to maintain any benefit. Adherence is, therefore, an important mediator of treatment effect. A possible contributor to low levels of adherence is a mismatch between patients’ and health professionals’ perceptions of rehabilitation.

We conducted a longitudinal, qualitative interview study to explore women’s and clinicians’ experiences of conservative management of urinary incontinence and what influences adherence to treatment. We recruited six continence specialists (nurses or physiotherapists), and one woman patient with stress, urge or mixed urinary incontinence symptoms from each specialist. Clinicians and women were interviewed separately at the start and end of treatment. Interviews were transcribed verbatim and analysed using principles of Interpretative Phenomenological Analysis.

Treatment adherence was variable and depended on how women ‘made sense of it all’. One influence on sense making was the influence of others. Patients perceived that the continence specialist was an ‘influential other’. Continence specialists also saw themselves as a potentially important influence on the patient’s quality of life and thought it was important to ‘seize the moment’ when a patient was referred (because the problem may have been ‘hidden’ for some time and if help-seeking was not acted on then an opportunity might be lost). Thus, for both groups, the continence specialists were seen as a credible source of information about incontinence and its treatment. However, from the patients’ perspective the information was not, in itself, motivating. More motivating was the confidence women gained from the continence specialist in how to perform a correct pelvic floor muscle contraction, and the sense of hope and support the specialist engendered; continence specialists also thought their ‘passion’ for their work was important to their patients. Unfortunately, a woman’s heightened early confidence in treatment outcomes and being able to do pelvic floor muscle training was easily and soon decreased by their experience of barriers to training.

Initial contact with the continence specialist offered women hope for a good treatment outcome, confidence in a pelvic floor muscle contraction, and support from an interested health professional. Potential areas for improvement include more ‘eliciting and offering’ rather than ‘giving’ information, and more attention to behavioural skills (for example, relapse management) that will support adherence.

References

Australian news

Pelvic Floor First App launched

The Continence Foundation has recently launched the Pelvic Floor First app for smart phones and tablets across iOS and android platforms. This free app allows people of all fitness levels and pelvic floor function to undertake pelvic floor safe workouts with guided instructional videos. Features include:

- The choice of three customised exercise programmes, dependant on the user's pelvic floor function.
- A wide range of exercises accompanied by instructional videos within each level.
- Instructions on how to do pelvic floor muscle exercises.

Download the free app from iTunes or Google Play. For more information, visit www.pelvicfloorfirst.org.au

Every Body’s Business (EBB) health professional forums

The Continence Foundation has two EBB health professional forums to be held in Melbourne in March 2014.

*Core Foundations:* This one-day practical forum for fitness professionals is presented by Marietta Mehanni (fitness leader) and Shira Kramer (continence and women’s health physiotherapist). This popular interactive workshop combines anatomy with practical demonstrations and useful imagery to encourage activation of this unique muscle, the pelvic floor, which is found in both men and women. The workshop is already fully booked, with a wait-list being taken. Five CECs are available for this forum.

Friday 14 March 2014, 9.00 am – 4.00 pm, at Rydges on Swanston, 701 Swanston St, Carlton, VIC, Australia.

*Aged care and incontinence:* The Continence Foundation invites you to attend a free one-day education forum for registered and enrolled nurses who work in aged care. This multidisciplinary forum will feature presentations from local practitioners and experts in the field of continence. Bookings are essential. Continuing professional development points will be available.

Friday 21 March 2014, 9.00 am – 4.00 pm, at Melbourne Park Function Centre, Olympic Blvd, Melbourne, VIC, Australia.

To make bookings for both forums, go to www.continence.org.au or phone 03 9347 2522.

World Continence Week: 23–29 June 2014 — Save the date

The Foundation will keep members updated on the details of World Continence Week 2014 as they become available.

23rd National Conference on Incontinence 10–13 September 2014

Join us at our national conference on incontinence, a joint meeting with the Continence Foundation of Australia, International Children's Continence Society and Urogynaecological Society of Australasia.

This conference will feature clinicians from a variety of specialities including a range of expert international speakers. The programme will include plenary sessions and workshops to showcase the latest research specific to bladder and bowel dysfunction across the lifespan.


State conferences

The CFA state branches will hold one-day conferences in the first six months of 2014. The details are as follows:

- Queensland, 14 March, Pullman Hotel, Brisbane — Registrations now open
- New South Wales, 10 April, The Menzies, Sydney
- Victoria, 30 May, Geelong Conference Centre, Geelong
- South Australia, 13 June, Adelaide Entertainment Centre, Hindmarsh, Adelaide
- Western Australia, 27 June, Mulberry on Swan, Caversham, Perth


Maternity and continence project

A special project for 2014 will focus on the maternity setting and an aim of the project is to raise awareness and improve understanding of the impact of pregnancy on continence among consumers and health professionals.

To achieve this, the project has a range of objectives and strategies including:

- Working at an advocacy level to address the amount of information included about continence and the pelvic
floor in antenatal guidelines and midwifery core competencies.

• Raising awareness of incontinence and pelvic floor muscle exercises among pre-natal and postnatal women through the development of the Pregnancy and Continence Guide resource and a smartphone application.

• Increasing knowledge and understanding of the impact of pregnancy on pelvic floor dysfunction among health professionals who work primarily with women in the pre-natal and postnatal stages through an online course and face-to-face education.

Please go to www.continence.org.au for project updates and information about the face-to-face education days. For information, please contact Samantha Scoble, Health Promotion Officer via email: s.scoble@continence.org.au

Online education
The Continence Foundation recently developed two online education initiatives: Management of Incontinence in General Practice education module; and Engaging Women via the ‘One in Three Women’ video.

Management of Incontinence in General Practice is a free online one-hour CPD education module for all Australian health professionals providing guidance on the assessment and management of urinary and faecal incontinence. It includes recommendations for patient education and self-care. To participate in the education, simply go to the website www.thinkgp.com.au and log in, or if you don’t already have a free account, register to continue.

The Continence Foundation in association with the organisation Jean Hailes for Women’s Health has developed and launched the online consumer education video, One in three women who have ever had a baby wet themselves. This eight-minute video answers the question about why a woman has an increased risk of leaking urine (urinary incontinence) after childbirth. The purpose of the video is to provide information, in a simple and easy to understand manner, about pelvic floor exercises, good bladder and bowel habits and where to go for help.

The video is located on the Continence Foundation website at www.continence.org.au/pages/pregnancy.html and there is a link to the video on the Jean Hailes consumer incontinence web page at www.healthforwomen.org.au/health-issues/30-incontinence

Both of these initiatives have been extremely well received to date by audiences and continue to attract much interest.

What's been happening on social media?
Prior to World Continence Week in June 2013, the Continence Foundation set up social media sites on Facebook and Twitter.
A strategic and successful decision was made to have two options on social media representing the different communities the Continence Foundation targets — consumers, health professionals, and with the success of Pelvic Floor First, fitness professionals.

The social media sites can be followed via the following URLs:
- www.facebook.com/AusContinence
- www.facebook.com/PelvicFloorFirst
- https://twitter.com/AusContinence
- https://twitter.com/PelvicFloor1st

The AusContinence Facebook page is designed to interact with consumers, while the AusContinence Twitter account is used for general promotion of key messages, particularly to promote educational events to health professionals.

The PelvicFloorFirst Facebook page and Twitter account promote key messages and events to fitness professionals and consumers with an interest in pelvic floor issues.

From the launch and up to 31 December 2013, the Continence Foundation's Facebook page had 400 likes and the fitness professional page had over 900 likes.

Over on Twitter, our health professional page https://twitter.com/AusContinence has almost 300 followers, which means our tweets can reach up to 6500 people and organisations. The Pelvic Floor First Twitter page https://twitter.com/PelvicFloor1st has almost 200 followers. Check out the hashtag #CFAConf14 to follow what's happening for this year's national conference in Cairns.

The Continence Foundation’s YouTube channel www.youtube.com/user/ContinenceFoundation has now received over 15,000 views across 53 videos. Top videos include 1 in 3 women who have had a baby wet themselves, and Incontinence: A problem in anyone’s language.

Continence Foundation website relaunch
Over the past few months, the Foundation’s website www.continence.org.au has undergone redesign. The new design moves the website from a static magazine to a dynamic layout that enables the user to progress through the website and take an action, for example, calling the helpline, posting to the support forum, downloading information fact sheets, becoming a member, or registering for the national conference.

Australian Continence Exchange (ACE) update
ACE has another three new Alliance Members APNA, CoNSA (Continence Nurses Society of Australia) and Palliative Care Australia, bringing the total to 16. The website also has 17 new continence resources from HACC/MASS QLD.

The Ask the Expert online forum continues to see activity with a new topic on women’s continence health at www.continenceexchange.org.au/forum. Past journal articles of the Australian and New Zealand Continence Journal are now included on ACE.

Culturally and linguistically diverse resources
The translated web pages have been heavily promoted to CALD communities via two radio campaigns, online media and mail-outs. This has been further supported by 27 information forums held in NSW, SA and QLD targeting the Chinese and Arabic communities. The Continence Foundation is now excited to launch the expanded set of translated resources in seven new languages available via the website. New written and audio translated resources can be accessed via www.continence.org.au/other-languages for Dari, Hindi, Urdu, Indonesian, Tamil, Korean and Karen language communities. If you haven’t seen the web pages in 27 different languages, go to www.continence.org.au/other-languages

Barry Cahill, CFA CEO

New Zealand News

The New Zealand Continence Association’s website www.continence.org.nz has just passed an important milestone, with 50,000 new visitors using the website during the past 12 months. Many of those returned more than once over the course of the year.

We pride ourselves on having such a highly accessible educational resource, making continence information readily available to the public.

We are now ready to launch our adult continence education module at www.continence-education.org.nz. This module is suitable for carers, health students and health professionals without prior specific continence knowledge. On completion of this course, the participant will receive a course certificate indicating completion of five education hours. A child education course will be available later in the year.

We now have 90 schools utilising the Toilet Tactics kit. We had a very slow start with these but, as word gets around about how useful they are, more requests continue to trickle in.

The NZCA is keen to support any continence education events around the country. These can be big or small. We can provide free information pamphlets, posters, helpline cards or other materials for your event. Please email zoe@continence.org.nz with the date and numbers you anticipate and we will post out these materials to you at no charge.

Jan Zander, CEO NZCA
Book review

Project Management in Health and Community Services (2nd Edn): Getting good ideas to work
Authors: Judith Dwyer, Zhanming Liang, Valerie Thiessen and Angelita Martini
Publisher: Allen and Unwin, 2013 www.allenandunwin.com
ISBN: 9781743310489
RRP: A$49.99
Reviewer: Professor Gary E Day, Deputy Head of School — Academic, School of Nursing and Midwifery, Griffith University, QLD, Australia

After having extensively used the first edition of this text as both a health executive and an academic, I was delighted to be asked to review the second edition of *Project Management in Health and Community Services*. On initial inspection, the text has undergone a significant, refreshing facelift and update. The text consists of eight easily digested chapters, taking the reader from understanding why project management is important in the first place, project management tools and methods, project initiation, project planning, budgeting and business case development, implementation and then finally project completion and evaluation.

The chapters have a useful outline and summary and are interlaced with valuable local case studies, templates, forms and practical tools to assist in understanding each component of the project management process. The text even finishes with a list of project management courses across Australia.

What is a pleasant constant with this text over its earlier edition is its ease of use. The reader can follow each step of the project management approach in the text sequentially from start to finish; equally the text is a great aide-mémoire in relation to particular aspects of a project. From a practical perspective, the text has broad appeal and can be used by a student or novice manager with little idea of a systematic approach to project management, or a great refresher for those who have been undertaking projects for some time. The authors bring a wealth of practical operational and research experience to the subject matter in this book and have converted this knowledge into an easy to read and understand reference text, even for those with little or no project management experience.

The subtitle of the book, *Getting good ideas to work*, perfectly reflects what this book is about: a practical, useful and relevant Australian text that supports good project management practices. I believe *Project Management in Health and Community Services* is a useful addition to any health manager's or practitioner's library, as well as a staple for students needing to more clearly understand approaches to managing projects in the health services.

The Australian Continence Exchange (ACE) is an online information channel designed to assist health professionals in their approach to continence management and promotion

- **RESOURCES**
  - access digital resources or submit yours
- **PROFESSIONAL FORUM**
  - network with other health professionals
- **DIRECTORIES**
  - locate service providers and product suppliers
- **PROFESSIONAL DEVELOPMENT**
  - educational opportunities and presentations in continence health
- **NEWS & EVENTS**
  - view and submit continence-related news and events

Visit the Australian Continence exchange to access continence related resources, professional development opportunities and to network with other health professionals.
Calendar of events 2014

16–19 March
Urological Society of Australia and New Zealand (USANZ) 67th Annual Scientific Meeting
Includes 19th Annual Meeting of the Australian and New Zealand Urological Nurses Society
Brisbane, QLD, Australia
Web www.usanz2014.com/about/

28–29 March
Urogynaecological Society of Australasia (UGSA) Annual Scientific and General Meeting
Hilton on the Park, Melbourne, VIC, Australia
Web www.ugsa.org.au

28–30 March
RCOG World Congress in Obstetrics and Gynaecology
Hyderabad, India
Web www.rcog2014.com/

4–6 April
Women’s Health 2014: The 22nd Annual Congress
Hosted by the Academy of Women’s Health
Grand Hyatt, Washington, DC, USA
Web http://academyofwomenshealth.org/conference/program2014/

12–14 April
15th International Meeting of the European Association of Urology Nurses (EAUN)
Stockholm, Sweden
Web www.eaustockholm2014.org/15th-eaun-meeting/

1–4 May
14th World Congress on the Menopause
International Menopause Society
Cancun Center Conventions & Exhibitions, Cancun, Mexico
Web www.imociety.org/world_congress.php

7–10 May
25th Anniversary Congress of the European Society for Paediatric Urology
Innsbruck, Austria
Web http://www.espu2014.org/

28–30 May
ANZSGM Annual Scientific Meeting 2014: Circulating the Evidence
Australian and New Zealand Society for Geriatric Medicine
Grand Hyatt Melbourne, VIC, Australia

21–26 July
American Urogynecologic Society (AUGS) and the International Urogynecology Association (IUGA) joint scientific meeting
Washington Convention Center, Washington, DC, USA
Web http://augs-iuga2014.org/

10–13 September
23rd National Conference on Incontinence
Joint meeting with the Continence Foundation of Australia (CFA), International Children’s Continence Society (ICCS) and UroGynaecological Society of Australasia (UGSA).
Cairns Convention Centre, Cairns, QLD, Australia
Web www.continence.org.au

17–20 September
11th National Conference for Rural and Remote Allied Health Professionals.
Mantra on Salt Beach, NSW, Australia

20–24 October
International Continence Society Annual Meeting ICS 2014
Rio de Janeiro, Brazil
Web www.ics.org/2014

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.

The Journal is proud to promote Australian and New Zealand scholarship in the area of continence.

For details regarding the Peer-Review Panel, please email Jacinta Miller journal@continence.org.au
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National Continence Helpline

A free service staffed by continence nurses providing:
• Information for GPs, allied health and fitness professionals
• Confidential advice about bladder and bowel control problems, local referrals and product information
• Resources for consumers and clinicians

1800 33 00 66
Monday to Friday 8am-8pm

www.continence.org.au
The Helpline is funded under the Australian Government’s National Continence Program and managed by the Continence Foundation of Australia
Submission of manuscripts to the journal

The Australian and New Zealand Continence Journal, in conjunction with Cambridge Publishing, now uses the world’s leading manuscript management system – ScholarOne. Submission of manuscripts for peer review will only be accepted via this online program. Reports and news can still be submitted to the production editor by email.

All tables, figures and photographs, as well as the main document and title page, are to be uploaded separately. Please ensure image files are uploaded as jpegs and are a MINIMUM of 500kb and no larger than 2mb in size. The manuscript may be accompanied by a Word document with tables, figures and photographs embedded so as to show the preferred positions of these. This separate file can be uploaded at step 4 as a cover letter.


To create an account when using the system for the first time, click on ‘Register here’ under ‘New User?’ in the middle right of the screen, or on ‘Create Account’ in the top right hand side of the screen. Please enter as much information as possible when creating an account.

Once in the system, the steps to submit an article are:

Step 1 – Manuscript type, title and abstract.
Step 2 – Key words – at least two are required, up to five allowed.
Step 3 – Add co-author and edit your details (if necessary).
Step 4 – Manuscript information and questions on funding, ethics, conflict of interest and copyright.
Step 5 – Upload files.
Step 6 – Review and submit.

The ANZCJ ScholarOne website has comprehensive guidelines and online tutorials to assist in using the system. Click on the orange ‘Get Help Now’ in the top right hand corner. A PDF of the Author Quick Start Guide can be downloaded after choosing ‘Author’ as your role.
# Incontinence Associated Dermatitis (IAD) Prevention Guide

## Prevention Factors

### IAD RISK ASSESSMENT
- Level and type of incontinence
- Skin condition
- Comorbidities
  - Mobility
  - Loss of sensation
  - Over/Under weight
  - Cognitive impairment

### FREQUENCY OF ASSESSMENT
- On admission
- Daily (minimum)
- Upon change in health status

### CONSIDERATIONS
- Clean, Moisturise, Protect
- Patient Education
- Regular Toileting
- Adequate Nutrition & Hydration
- Differential diagnosis of cause
  - Fungal infection
  - Pressure injury
  - Incontinence Associated Dermatitis (IAD)

## Actions

### Manage
- Continence assessment
- Determine management plan
- Implement appropriate containment & skin care program

### Clean
- Remove soil from skin with a pH balanced product
- Clean with every episode of incontinence

### Dry
- Ensure skin is kept dry at all times
- Use a pH balanced continence pad which maintains the pH of skin

### Protect
- Vulnerable skin (including light incontinence) or skin affected by moderate to severe incontinence
  - Apply a protective skin care product
  - Use a pH balanced incontinence pad

## Suggested HARTMANN Solution

- HARTMANN continence range
- Menalind professional skin care
- Moist skin care tissues
- Wash lotion
- Skin cleansing foam
- Body cleansing wipes
- HARTMANN continence range
- Transparent skin protection cream
- Skin protection foam

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