• Theoria: A NICE context for New Zealand clinical practice
  Weatherall M

• Establishing a continence nurse-led pessary clinic as a new model of care for women in rural Victoria
  Wilson M, Bellefeuille L-A, D’Amore A & Mitchell EKL

• Verbal pelvic floor muscle instructions pre-prostate surgery assessed by transperineal ultrasound: Do men get it?
  Neumann P, Fuller A & Sutherland P
For all your funding solutions... We’ve got you covered!

Independence Australia is an approved supplier under a variety of state and federal funding schemes. We stock over 2,900 continence and urology products with same day delivery available for metro areas.

- Continence Aids Payment Scheme (CAPS)
- DVA Rehabilitation Appliances Program (RAP)
- Continence Management and Support Scheme (CMASS)
- Incontinence Pad Scheme (IPS)
- Enable NSW
- Medical Aids Subsidy Scheme (MASS)
- Transport Accident Commission (TAC)
- State Wide Equipment Program (SWEP)

Independence Australia is a social enterprise that provides choices for people living with a disability or other personal need, supporting them to regain and retain their independence.

Contact us

📞 1300 788 855
📞 1300 788 811
✉️ customerservice@independenceaustralia.com
🌐 www.independenceaustralia.com
Contents

Theoria: A NICE context for New Zealand clinical practice 72

Establishing a continence nurse-led pessary clinic as a new model of care for women in rural Victoria 75

Verbal pelvic floor muscle instructions pre-prostate surgery assessed by transperineal ultrasound: Do men get it? 84

Australian news 89

New Zealand news 91

Calendar 92

Official Journal of the Continence Foundation of Australia and the New Zealand Continence Association

ACN 007 325 313
Editorial Committee — Peer Review Panel

Chair and Editor
Prof Mark Weatherall
MBChB, BA, FRACP, MAppStats
Geriatrician
President, NZCA

CFA Representative
Mr Barry Cahill, CEO

NZCA Representative
Ms Jan Zander, CEO

Committee
Dr Wendy Bower
BAppSci (Physio), PhD, PgD Epidemiology and Biostatistics
Continence Physiotherapist, Melbourne Health, Royal Park Campus,
Melbourne VIC, Australia

Assoc Prof Pauline Chiarelli
DipPhysio(SydUni), GradDipHSocSc(HthProm), MMedSci(HthProm),
PhD, FACP
Program Convener, Discipline of Physiotherapy, University of Newcastle,
NSW, Australia

Dr Jenny Kruger
BSc(Nurs & Midwif), MSc(Sport & Exercise), PhD
Royal Society of New Zealand Postdoctoral Rutherford Fellowship,
Auckland Bioengineering Institute, Auckland, New Zealand

Dr Dominic Lee
MB, BS (Hons), FRACS (Urology)
Urologist, St George Hospital, Sydney, NSW, Australia

Ms Shona McKenzie
BSc, MCHC, MN, CNA
Nurse Practitioner, Royal Brisbane and Women’s Hospital, QLD,
Australia

Dr Joan Ostaszewicz
RN, MN, PhD
Post Doctoral Research Fellow
Deakin University, Melbourne, VIC, Australia

Ms Debbie Rigby
BPharm, GradDipClinPharm, CGP, FPS, FASCP, AACPA
Consultant Clinical Pharmacist, Brisbane, QLD, Australia

Dr Margaret Sheehan
PhD, BAppSc, MWomen’s Health
Lecturer School of Physiotherapy, The University of Melbourne and Royal
Women’s Hospital, Melbourne, VIC, Australia

Assoc Prof Ka Lai (Clara) Shek
FROCG, FRANZCOG, FHKAM(O&G), PhD(Med)
Urogynaecologist
University of Western Sydney, Sydney, NSW, Australia

Dr Vincent Tie
MB, BS(Hons), MS(Syd), FRACS
Urologist, Concord Hospital, Sydney, NSW, Australia

Co-opted Members
Prof Kate Moore
MBBS, MD, FRCOG, FRANZCOG, CU
Urogynaecologist, St George Hospital, Kogarah, NSW, Australia

Managing Editor
Jacinta Miller
RN, BA, BN
PO Box 117, Wycheproof, VIC 3527, Australia
Tel (03) 5493 7755
Email journal@continence.org.au

Peer Review Panel
Mrs Donna Coates, Adelaide, SA, Australia
Prof Hans Peter Dietz, Sydney, NSW, Australia
Dr Hugh Greenland, Perth, WA, Australia
Prof Peter (Graham) Herbison, New Zealand
Dr Doreen McClurg, United Kingdom
Dr Irmina Nahon, Canberra, ACT, Australia
Assoc Prof Trygve Neveus, Sweden
Ms Vicki Patton, Sydney, NSW, Australia
Dr Wimsome St John, Gold Coast, QLD, Australia
Dr George Szonyi, Sydney, NSW, Australia
Dr Ian Tucker, Adelaide, SA, Australia
Mrs Julie Tucker, Adelaide, SA, Australia
Ms Elizabeth Watt, Melbourne, VIC, Australia

Call for papers

The Australian and New Zealand Continence Journal seeks articles and original research papers from people practising and researching the management and treatment of incontinence and continence health promotion.

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, psychotherapy 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.

Articles may be papers for peer review, clinical updates, case studies or evaluation of programs.

To discuss topics, or for assistance in the preparation of papers and articles, please email journal@continence.org.au
Introducing a reliable and discreet solution for men

When a patient can’t rely on his continence solution to prevent leakage and odour, he can easily feel uncomfortable in public. Conveen® Optima and Conveen® Active changes that, offering increased security and odour management to give your patients renewed confidence.

The reliable Conveen Optima urisheath connects to the new Conveen Active urine bag, a discreet, soft device that wraps around the inner thigh and is practically invisible under clothing.

Introduce your patients to Conveen Optima and Conveen Active, and experience their satisfaction of staying dry and feeling secure all day long.

Order FREE samples for your patients
colo plast.com.au | 1800 653 317 | au.care@coloplast.com
Theoria

A NICE context for New Zealand clinical practice

Summaries of scientific evidence relevant to personal clinical practice are increasingly available in electronic format. With my Wellington, New Zealand (NZ), University-based office laptop, I undertook a ‘Google’ search using the search text ‘evidence based guidelines urinary incontinence’ and yielded 390,000 results in 0.59sec (date and time of search was 17 June 2015 at 1355 hours). The top few ‘hits’ were the United States National Guideline Clearance House’ (which gives links to other guidelines), the National Institute for Health and Clinical Excellence (NICE) United Kingdom 2013 Clinical Guidelines Document 171, the American College of Physicians Clinical Practice Guideline, published in the Annals of Internal Medicine in 2014, the European Association of Urology Guideline, published in European Urology in 2010, and the British Medical Journal-related ‘Best Practice’, which contains links to the NICE guidelines, and the Scottish Intercollegiate Guidelines Network guidelines. The information is easy to identify and download but an important question is whether the particular guideline is relevant to a particular situation, including a particular national context.

In 1999, the NZ Guidelines Group (NZGG) — a not-for-profit organisation partially funded by the NZ Ministry of Health — was established and operated until 2012, at which time it entered voluntary liquidation. The organisation had a secretariat which coordinated guideline production and a governance structure that included a board. The guidelines that were produced were hosted on an NZGG website and were freely available. However, the NZGG also relied on other organisations to help fund the guidelines process and when this funding was not available the organisation was not viable. The guidelines that were developed are still hosted on the NZGG website and are freely available. However, the NZGG also relied on other organisations to help fund the guidelines process and when this funding was not available the organisation was not viable.

The planned process is that an ad hoc, but representative, group of interested clinicians — who would have at least two face-to-face meetings, and other forms of liaison, coordinated and supported by bpac — are to review a particular NICE guideline. In this case this is the continence guideline, NICE Guideline 171. The further tasks are to identify issues that need to be added to or addressed in the guideline to make it relevant to NZ. Once these are identified and added to the particular guideline, the draft contextualised guideline will be circulated to

Mark Weatherall
NZCA President
Editor ANZCJ
as wide a range of interested parties and stakeholders as possible to identify other issues that may need to be considered and documented. The final adapted document, with the oversight and approval of NICE, would be made publicly available by bpac. The committee has the rather grand label of the Guideline Review and Contextualisation Group (GRCG); and operates with a chair, Professor Don Wilson, a urogynaecologist with the University of Otago, with the other members including the President of the NZ Continence Association (a specialist geriatrician), an academic general practitioner, a physiotherapist with a special interest in urinary continence, a specialist nurse continence advisor and another urogynaecologist.

It is not the particular task of the GRCG to review the evidence outlined in the NICE guideline, although should they wish to do so then this must be in discussion with NICE to ensure the processes follow those that produced the guideline in the first place. It is the task of the GRCG to identify issues about recommended practice that are relevant to the national context of NZ. These can include, but are not limited to: different funding arrangements for care; availability and subsidies for medication; cultural issues; and the different legislative framework for health care providers caring for patients.

As a particular example, medications may be recommended or mentioned by NICE that are not registered products in NZ or, if they are registered, are not subsidised. NZ has a particular legislative framework about unregistered medications that means they can be prescribed but with particular reference to issues of scope of practice and consent. The NICE Guideline 171 refers to the overarching recommendations about patient-centred care but specifically references the relevant UK-related documents about this. In NZ, health care practitioners must follow a similar, but NZ-specific, set of guidance set out in the Health and Disability Code of Rights.

At its first meeting in May 2015, the GRCG identified some particular issues that were allocated to committee members to generate NZ-relevant information and at its next meeting, likely to be July 2015, will discuss how to incorporate this information into the Guideline, with a view to generating the draft Guideline for circulation and consultation with as wide a group as possible. An ambitious timeline has been set for the NZ-contextualised document to be available in late October 2015.

Although specific to NZ, at present, the ability to feed off international endeavours in clinical care may turn out to have wide applicability in health care related to incontinence and other health care areas. This may represent a highly efficient way to disseminate appropriate evidence in a manner that ultimately influences clinical practice.

References

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

Volume 21 Number 3 – Spring 2015
Experience the difference™

See the GentleCath™ Hydrophilic catheter and no-touch handling strip

GentleCath™ Hydrophilic Catheters
Help minimise the risk of infection with no-touch catheterisation

Hydrophilic catheters are coated with a hydrophilic polymer that reacts with water to create a smooth, slippery coating on the surface of the catheter. Compared to uncoated catheters, hydrophilic catheters have been shown to reduce the incidence of urinary tract infections.¹


ConvaTec (Australia) Pty Limited. ABN 79 131 232 570. PO Box 63, Mulgrave, VIC 3170. Phone: (03) 9239 2700 Fax: (03) 9238 2742. www.convatec.com.au
ConvaTec (New Zealand) Limited. PO Box 62663, Greenlane 1546 New Zealand. Phone: 0800 441 763. www.convatec.co.nz
©2014 ConvaTec Inc. AP-014361-MM CCC210
Abstract

Use of vaginal pessaries to treat vaginal prolapse and incontinence is experiencing renewed interest in Australia. The premise of this study was that a nurse-led pessary clinic would facilitate this treatment option for rural women who would otherwise have to travel long distances to metropolitan centres to access this therapy. The aim was to establish a nurse-led pessary clinic for rural women and examine patient uptake and health outcomes. Competency for assessment, fitting and ongoing management of clients using pessaries was achieved through training and expert support from experienced continence nurse advisors and gynaecologists. Women were referred to the pessary clinic, either directly by their general practitioner, or by the continence nurse advisor from the continence clinic once a continence assessment and management plan was completed, and after discussion with their doctor. Thirty-nine women were referred to the pessary clinic over the first 31 months. Three women who had a pessary already fitted were referred for management and were ineligible for this study. Seven women declined a pessary and seven were not suitable for a pessary. Twenty-two women participated in this study and of those 17 were successfully fitted with a pessary. Only four participants continued with the pessary after three months. All women completed a pre-post questionnaire to assess bladder and vaginal symptoms. The study demonstrates the practicalities of developing a new model of care in a rural setting. Expert support is a key factor in providing this treatment option.

Keywords: Incontinence, nurse, rural health, pessary, prolapse.

Introduction

Continence services include assessment and management for people with bladder and bowel incontinence and are ideally provided by interdisciplinary teams. In Victoria, Australia, multidisciplinary continence services are located in metropolitan and rural centres; however, in most rural areas these services are typically provided by a continence nurse advisor (CNA).

In Australia, the prevalence of self-reported urinary incontinence (UI) in women is 35%1. The initial phases of continence management are typically conservative, using lifestyle modifications, pelvic floor muscle exercises and bladder training2. However, if there is no satisfactory symptomatic improvement or a woman has a vaginal prolapse, then a vaginal pessary may be an additional useful management strategy, particularly for older women where medication and surgery may be contraindicated3. A recent paper using retrospective chart reviews reported that the use of pessaries, managed by a nurse-led pessary clinic, was a successful treatment for symptoms of urge, stress and mixed UI4.

A number of metropolitan tertiary continence services in Australia are developing pessary clinics. However, equitable
access to such services is not available for rural Australian communities. Fitting of vaginal pessaries must be individualised and is labour-intensive, requiring patient education and ongoing support. This practice needs convenient access for women to treating clinicians and, in the setting of rural Australian communities, options for treatment that do not involve excessive travel. Rural-based, CNA-led pessary clinics for management of incontinence and prolapse may help provide quality, cost-effective and accessible treatment for rural women.

Many studies have described the technique of assessment, fitting and management of a pessary by nurses, midwives or physician assistants and, while papers by nurses encourage others to adopt this therapy, these same papers do not provide details about how the relevant clinical skills and clinics were developed. Reports of pessary fitting cite success rates of between 41% and 86%. This range of success depends on its definition and the duration of pessary use for which success is defined.

The setting for the study reported here was Bairnsdale Regional Health Service (BRHS), located 280 kilometres east of Melbourne, the main hospital servicing the East Gippsland region. The East Gippsland Shire has a population of approximately 44,000 and covers an area of over 21,000 square kilometres. Specialist medical services are provided on a sessional basis at the hospital.

The aims of the study reported here are to report the necessary skill development for sole CNA practice and some details of the development of the pessary clinic, as well as to summarise patient uptake and outcomes for the initial phase of the clinic.

**Methods**

The data-collection phase of the study was a prospective cohort study of women presenting to a rural nurse-led pessary clinic based at the BRHS.

General practitioners (GPs) in the region and visiting medical consultants received a letter informing them about the project and a five-item questionnaire to scope current local practice of pessary use.

Referrals to the pessary clinic were from GPs or specialists, if participants required immediate treatment for prolapse, and from the CNA from the continence service, once a continence assessment and management plan was completed, and after the women had a pelvic examination and discussion with their GP. Women referred from the continence service had already completed between eight and 12 weeks of conservative therapy to treat UI. There was no local continence physiotherapist clinic at the time. Women with ‘complicated’ incontinence were referred to their doctor for further investigation.

Further criteria for inclusion in the cohort study were that participants had a commitment to comply with pessary care and follow-up, were community-dwelling, and aged 18 years or older.

A medical and surgical history was available for women referred from the continence service. Referrals from other sources meant this was completed at the first pessary clinic visit. At the first visit, a portable ultrasound bladder scan was used to measure post-void residual urine and a urinalysis was obtained. Confirmation was obtained that the patient understood the pessary fitting technique, management of their pessary and any side effects of pessary use. Vaginal assessment of shape, length and tissue health was carried out using digital and speculum examination. The participants were given a pre-intervention questionnaire on bladder and vaginal symptoms: ICIQ-FLUTS 08/04 and ICIQ-VS 10/05.

In this study, a pessary trial was offered to women, regardless of whether they were aware of prolapse symptoms, with the assumption that if the prolapse was supported then the incontinence symptoms might improve. Participants used topical oestrogen for six weeks before the first pessary fitting. If stress UI was the primary symptom a standing cough test was used to demonstrate leakage before pessary fitting. The pessary style and size was chosen according to vaginal examination and main symptom. At the initial fitting each participant was asked to walk, squat, strain and void with the pessary in place. If the pessary remained in situ, was unable to be felt, and the bladder ultrasound recorded complete bladder emptying, then the participant was reviewed after two weeks or sooner if they experienced any problems. If the fitting was unsuccessful, or not attempted, the woman was discharged with a letter to the GP for follow-up.

After two weeks the pessary was removed and speculum examination performed to check for signs of pressure. Any effect of the pessary on symptoms was noted. The GP was kept informed of progress and if a participant required investigation for suspected bacterial vaginosis. If the pessary was ineffective or uncomfortable, another size or style was trialled, if the participant was willing to keep trying a pessary. If the pessary was effective then follow-up appointments to check the pessary were made for four weeks and then three months later.

The post-intervention questionnaire on bladder and vaginal symptoms was given at three months, whether or not the pessary was in situ. Post-intervention comments were also recorded on the use of the pessary.

This study was approved by the Latrobe Regional Hospital Research Ethics Committee and informed consent was obtained from the participants.
Results

Skill development

The intervention and management guidelines for this project were based on the study by Wu and colleagues\textsuperscript{14} and current practice at the Royal Alexandra Hospital Urogynaecology Unit, Edmonton, Canada. The establishment of this study preceded the Guidelines for the use of support pessaries in the management of pelvic organ prolapse\textsuperscript{18}.

Skills in vaginal assessment and pessary selection were primarily acquired by personal tuition from an experienced CNA in Canada\textsuperscript{19}. This was documented and assessed using a specifically designed tool based on Benner's taxonomy of skills development\textsuperscript{20} (Appendix 1). CNA skills were supplemented by attendance at an Australian tertiary metropolitan pelvic floor clinic, one morning each week for five sessions. This was to further develop skills in: vaginal examination using a speculum (bivalve); use of the Pelvic Organ Prolapse Quantification (POPQ) scoring system; and in fitting a pessary according to vaginal shape, length and primary symptom. Further assistance was provided by the visiting gynaecologist to the BRHS and the on-site cervical screening (Pap test) nurses. The hospital outpatient department manager provided a clinical room for the pessary clinic. Clinic times were held concurrently with the visiting gynaecologist session once a fortnight. The gynaecologist provided mentoring and oversight for the CNA skill development. The CNA also developed protocols for fitting pessaries and pathways from the continence services to the pessary clinic, which included having the support of and access to a gynaecologist.

To fit pessaries required stocking a range of styles and sizes and the ability to sterilise equipment for reuse. Funding was obtained by a grant from the Windermere Foundation to support additional nursing hours and the purchase of a stock of silicone pessaries (ring, ring with knob, continence dish, Shaatz and Gellhorn; all in five commonly used sizes). Arrangements were made with the infection control nurse at BRHS for sterilisation.

Scoping questionnaire of medical practitioners

To determine current use of pessaries, 55 questionnaires were mailed to doctors practising in clinics throughout the East Gippsland region; however, only 10 replies were received. Eight noted that no patients used pessaries and two respondents managed patients who had been fitted with a pessary by a gynaecologist.
**Cohort study of the pessary clinic**

During the 31-month data-collection phase reported here, 39 women were referred to the pessary clinic (Figure 1). Three women who were already fitted with a pessary were referred to the clinic for ongoing management and were outside the scope of the study and 36 women referred to the pessary clinic were otherwise considered for this study.

**Participant description**

A total of 22/36 (61%) women attended the pessary clinic and participated in the cohort study. Fourteen participants were ineligible due to a variety of reasons including: vaginal dimensions, exposed vaginal mesh, an inability to apply vaginal oestrogen cream, or declined to use a pessary.

The average (range) age of the 22 eligible participants was 69 (50 to 89) years. All participants wished to avoid surgery for their incontinence or prolapse. Eleven women had symptomatic prolapse and 11 women had no symptoms of prolapse. Second-degree prolapse was present in 21 participants, and third-degree prolapse in one. Prolapse was determined according to the POPQ score. In this cohort, mixed UI was noted in 18 women, stress UI in one, one had urgency UI and one had urge UI (Figure 2) based on the questionnaires completed. Constipation was a common accompanying symptom. Twenty-one participants had one or more co-morbidities, such as urinary tract infections, back pain, heart disease, or arthritis. Each participant was multiparous. Only one participant had a past hysterectomy and none had past vaginal surgery. Five of the participants reported they were sexually active. Twenty participants used oestrogen cream and two others used a non-hormone cream due to history of breast cancer. Only one woman had incomplete bladder emptying before pessary fitting.

**Patient outcomes**

Successful pessary fitting was determined if participants left the appointment with the pessary comfortably fitted and retained, having emptied their bladder normally. Successful fitting occurred by this definition in 17/22 (77%) of participants (Figure 1). The mean (range) of pessary sizes or styles used before successful fitting was 3 (1 to 6).

After three months only four (24%) participants still wore a pessary (Figure 1). Three were wearing ring pessaries and one an continent dish pessary. Of the women with mixed incontinence, one showed improved symptoms. Four of the women with prolapse were successfully fitted with a ring pessary; however, one participant developed UI (de novo incontinence) after pessary fitting and discontinued use. One participant fitted with a ring had resolution of urge incontinence symptoms.
Post-intervention questionnaires, at three months, showed those participants still wearing a pessary had improved voiding or prolapse symptoms compared to those without. The average (range) time between pre- and post-questionnaires was 6.5 (3 to 12) months, as some women took many visits to try different pessaries over a longer time frame. Although the participants were motivated to reduce their symptoms without surgical intervention, at least four participants went on to have surgery after their involvement with the pessary clinic.

**Examples of post-intervention comments**

**Why women continued to wear a pessary**

Of the four women who continued to wear the pessary each commented that their decision was due to symptom reduction, such as the pessary “supported my prolapse”, “I am drier and have to use less pads” and I am “better able to manage”. One woman extended her comments to speak of the alternative treatment options, by saying “while it saves having an operation I will continue the use of the pessary”.

**Why women discontinued wearing a pessary**

Of the 13 participants who discontinued wearing the pessary, the reason was mainly due to poor fitting, with statements collected: the pessary “would not stay in”, “didn’t fit” or “fell out”. Other participants discussed issues relating to comfort with pessary use, such as the pessary was “uncomfortable”, the woman was...
“aware of it in place”, one participant reported the pessary “gave me stomach pains” and another stated she “couldn’t physically cope with a foreign body inside me”. Only two participants discussed incontinence symptoms as the reason for discontinued use, with one mentioning “it caused leakage” and the other noting that the pessary “did not improve my leakage”.

Comments on experience at the clinic

Regarding the experience of participants of attending a local clinic, most participants reported a positive experience, noting; “excellent treatment”, “good follow-up”, “everything possible was done”, “we tried everything and I was happy to do this”, “wonderful explanation and well informed” and “very thorough and supportive”. One participant reported an adverse experience related to “pain when being fitted and removal” of the pessary.

Discussion

An appropriately trained CNA is in the ideal position to deliver pessary services. For a CNA located in a rural health care setting, self-education and acquiring the appropriate skills is expensive and time-consuming, partly because it often requires travel to metropolitan centres. In planning other rural-based, CNA-led pessary services this cost in time and money should be carefully considered.

Pessary fitting needs to be individualised and the fitting process can be time-consuming. A CNA provided with the appropriate resources is well placed to take the time needed for this and can provide the time to educate women on the importance of topical oestrogen, as well as education on self-removal, reinsertion, and cleaning of the pessary. This is important for sexually-active women. This service can be especially valuable to allow specialist gynaecologists to provide care that cannot otherwise be provided by a CNA. However, it is still important for optimal patient care that the CNA works collaboratively with a gynaecologist, so that problems can be solved or treated as they arise during a patient appointment. Such problems can include: difficulty inserting or retrieving a pessary or confirmation that the vaginal tissue is healthy and fit to receive a pessary.

Ideally, new CNA practitioners need mentorship and on-site tuition. In this case, access to tuition and a skilled CNA mentor was by videoconferencing and face-to-face workshops at international conferences. Gynaecologists with a rural practice should consider supporting a CNA-led pessary clinic running concurrently with their clinics.

This project showed a CNA could develop independent skills to assess, fit and manage vaginal pessaries. This was achieved with ring, continence dish and ring with knob pessaries. Shaatz and Gellhorn pessaries are more challenging to fit due to the techniques required to insert and remove but are a necessary option to be offered to a woman with a large genital hiatus, who often cannot retain a ring pessary. The CNA required additional training to fit Shaatz or Gellhorn pessaries and this was completed after the conclusion of this project. The need for extra training and limited access to training may have been a factor in the later retention rates, which were relatively poor in this study.

In using pessaries in this rural hospital setting, resterilising pessaries was a practical and safe option. Financial support is required to establish a stock of styles and sizes of pessaries, which can be replenished by selling pessaries once fitted to the patient.

In contrast to previous publications, we identified relatively few women who could keep using a pessary and who also experienced reduction in symptoms. This this may be because of a learning phase in the initial establishment of the pessary clinic and extra training needed for particular pessary types. Ongoing data collection and audit may show that the treatment is more successful with patient selection and ongoing experience.

Conclusion

CNAs are in a good position to assess for and insert, or apply for a trial of pessaries, but also to educate women attending continence clinics on the wide range of pessaries now available in Australia. Gynaecologists should consider supporting a nurse-led pessary clinic that runs concurrently with their clinics to support the development of nurse specialists in pessary management.

Acknowledgements

This project was made possible with support from Judith Mays (Clinical Nurse Consultant, Continence), Louise Martin (Continence Nurse Advisor), Dianne Gibbs (Women’s Health Nurse), Dr Rob McKimm (Gynaecologist) and Dr Anne Rosamilia (Urogynaecologist, Monash Medical Centre).
This assessment tool was designed by Ms Maeve McGinley and Ms Lesley Bellefeuille in 2009, developed and modified from Benner. The clinical skills inventory will be completed by the work-based mentor in collaboration with the learner. The clinical skills inventory will facilitate the learner to identify their learning needs together with areas for further development. The learner will demonstrate commitment to meeting these needs through an agreed learning contract with their work-based mentor. Successful completion of the contract will require the learner to demonstrate proficiency in all of the identified components of the skills inventory.

The learner should note that successful completion of the module is dependent on the demonstration of proficiency in each of the skill areas identified in the skills inventory associated with this module.

The clinical skills inventory has three columns that relate to the taxonomy outlined below. The learner is required to work towards and to achieve the ‘Proficient’ level (column 3) in all of the listed skills. The work-based mentor will use the taxonomy for guidance when completing the clinical skills inventory.

Benner’s Taxonomy of Skills Acquisition

Stage/Column 1 = Advanced Beginner — Practices within guidelines

The learner has sufficient experience to recognise recurrent aspects of the situation which guides practice. The learner continues to gain experience and learning by working within broad guidelines. Increased evidence of the application of new skills; the clinician has a more confident and effective manner. The role of the work-based mentor is to provide guidance and help in prioritising work and consolidating skills. Supervision is frequent and according to need, but not under circumstances of continuous close contact. The learner is able to articulate some rationale for practice, but knowledge application restricted to specific situations; able to provide a descriptive account of practice with some range of supporting evidence from literature.

Stage/Column 2 = Competent — Practices using planning and problem solving

At this stage the learner moves from the rule following, stimulus-response actions of the novice and working within the guidelines as an advanced beginner to a more analytical level of functioning. Problems are recognised, prioritised and subjected to critical analysis. Care is planned on this basis and is delivered in a confident, effective and humanistic manner. The role of the work-based mentor is increasingly at arm’s length: acting as a facilitator, advising, critiquing, and serving as a springboard for reflection on practice. The learner is able to interpret and discuss situations. Underlying rationale is sound, drawing on a wide range of evidence. Knowledge is used to draw conclusions and explore relevant ideas relating theory to practice where appropriate.

Stage/Column 3 = Proficient — Practice by use of maxims

Here the learner has achieved an experience-based ability to recognise whole situations, to expect and anticipate certain events that recur and has an experience-developed readiness to respond in certain ways. These situational, experience-led perceptions of appropriate responses, or maxims, reflect a deep level of understanding that facilitates confident and informed practice. The role of the work-based mentor is as for competence with increased encouragement to learn from analysis of experience.
**CLINICAL SKILLS INVENTORY FOR PESSARY MANAGEMENT**

### ASSESSING

<table>
<thead>
<tr>
<th></th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demonstrates the effective use of listening skills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Demonstrates the use of sensitive questioning skills.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3 | Uses an appropriate range of assessment tools.  
   • Referral letter.  
   • Physical examination pelvic floor including: vaginal and pelvic floor strength; vaginal length/depth and width; prolapse; incontinence; atrophy; speculum exam.  
   • Frequency/volume charts.  
   • Voiding pattern and residual volumes. |

### PLANNING

<table>
<thead>
<tr>
<th></th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Structures client teaching appropriately.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Recognises clients’ strengths, needs and abilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Plans short- and medium-term objectives with client or caregiver, where possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Plans long-term objectives with the client or caregiver, where possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Demonstrates the ability to compile care plans with the client or caregiver for appropriate pessary management and care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Uses problem-solving skills at all stages of the pessary fitting process and modifies care accordingly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IMPLEMENTING

<table>
<thead>
<tr>
<th></th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Delegates work according to the skill mix.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Keeps others appropriately informed, both orally and in writing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Performs nursing activities as a reflective practitioner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Integrates pessary theory with practice when choosing appropriate size/device.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Gains informed consent to areas of work/intervention.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 6 | Demonstrates ability to explain the therapeutic value and possible negative effects/risks of:  
   • Pessary/vaginal support devices.  
   • Fitting and use.  
   • Medications or lubricants that may be used in conjunction with device use. |
| 7 | Ensures physical care is provided in a sensitive, dignified and safe manner. |
| 8 | Recognises potential hazards and takes appropriate action when implementing the following therapy:  
   • Insertion of pessary/vaginal support devices.  
   • Vaginal speculum examination.  
   • Digital vaginal examination. |
| 9 | Demonstrates “safe” practices:  
   • Pelvic floor evaluation for prolapse and incontinence.  
   • Speculum exam.  
   • Pessary insertion and removal. |

### EVALUATING

<table>
<thead>
<tr>
<th></th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Evaluates the effectiveness of pessary treatment intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is aware of standards and criteria against which to measure effectiveness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Measures outcomes against agreed goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is effective in all stages of care handover/discharge arrangements.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References


Peer review

Verbal pelvic floor muscle instructions pre-prostate surgery assessed by transperineal ultrasound: Do men get it?

Abstract
The aim of this study was to assess the effectiveness of careful verbal instruction on the ability of men to correctly contract the pelvic floor muscles. The participants were men before robotic-assisted prostate surgery for cancer. After careful verbal instruction, participants had bladder neck movement in the cranial direction assessed by two-dimensional transperineal ultrasound. All 31 participants were able to move the bladder neck in the cranial direction.

Keywords: Male, pelvic floor exercises, prostatectomy, ultrasound imaging, urinary incontinence

Background
A major potential side effect of robotic-assisted radical prostatectomy (RARP) for treatment of localised prostate cancer is urinary incontinence (UI)\(^1\). The prevalence of UI is reported between 8% and 56%\(^2\). UI in this setting could be due to a number of factors including: increased age, body mass and prostatic volume; prior lower urinary tract dysfunction and decreased membranous urethral length\(^3\). A recent study reports that a man’s ability to ‘flow stop’ after RARP indicates neuromuscular integrity of the pelvic floor, including the associated voluntary muscles, and predicts an early return of continence\(^4\). The role of the pelvic floor muscle (PFM) and exercise of PFM to minimise post-prostatectomy UI is controversial\(^5\) but, based on a number of robust studies, PFM exercises appear to improve continence outcomes if taught before surgery, rather than after it\(^6\) or\(^7\). It is uncertain if PFM exercises should be supplemented by techniques such as anal biofeedback or whether any particular exercise protocol such as strengthening or functional training is more effective. Most importantly, it is a prerequisite to further training that men learn to contact the PFMs effectively using a correct technique. The individual muscles of the male pelvic floor contract in a complex way to contribute to continence\(^8\), but it is difficult to assess whether a man can perform an effective contraction because the important muscles are deep within the pelvis.

In one recent study, one-third of young male physiotherapy students were unable to correctly contract their PFMs after verbal instruction\(^9\). However, in that study it was unclear if the research participants, who were all young men, were unable to perform a correct action or whether the particular method of evaluation of the contraction, using two-dimensional (2D) transabdominal ultrasound (TAUS), was not an effective measurement modality.

Physiotherapists use 2D TAUS to assess whether the bladder base, and by association the pelvic floor, moves in a cranial or caudal direction in women\(^10\). The method's limitations are that only the bladder base can be viewed and there is a lack of a bony landmark to gauge movement\(^11\).

Digital rectal examination (DRE) is another method used to assess a PFM contraction in men\(^12\) but it is invasive and generally disliked by men\(^13\). Also acquiring control over the anal sphincter may not be ideal for men with prostate cancer who actually need to develop control of the urethral sphincter.

Patricia Neumann *
International Centre for Allied Health Evidence
University of South Australia, SA, Australia
Email: cpneumann@ozemail.com.au

Andrew Fuller
South Terrace Urology
Adelaide, SA, Australia

Peter Sutherland
South Terrace Urology
Adelaide, SA, Australia

* Corresponding author

Competing interest statement
The authors have declared they have no relevant relationships or circumstances that present actual or potential conflicts of interest.
mechanism. Two-dimensional TAUS has a moderate correlation with DRE in assessment of PFM movement in men, with a reported correlation coefficient of 0.57\textsuperscript{13}, and with transperineal ultrasound (TPUS) in women, with a reported correlation coefficient of 0.69\textsuperscript{12}.

Two-dimensional TPUS is emerging as a widely used, valid and reproducible method of assessing PFM function in women\textsuperscript{16} and several recent studies have pioneered its use in men where its validity and reliability have been demonstrated\textsuperscript{15,18}. To date, 2D TPUS has not been used to evaluate PFM activity in men before radical prostate surgery.

The aim of this study was to investigate whether men with prostate cancer were able to contract their PFMs correctly, that is, in a cranial direction, after a pre-operative physiotherapy session, using 2D TPUS to assess the movement. This was part of a larger study investigating bladder neck displacement measures and comparing two methods of assessment with 2D TPUS. These two methods were: using an ‘office’ ultrasound system with measures taken by a specialist pelvic floor physiotherapist, or using a sophisticated ultrasound system with measures taken by a specialist pelvic sonographer. Each of these measurements was taken after the men had received visual biofeedback training.

This paper reports the part of this study that focused on men’s ability to contract the pelvic floor correctly, as measured by cranial bladder neck displacement using 2D TPUS. The measurement was taken by a specialist pelvic floor physiotherapist, before any biofeedback training. This was in the setting of routine clinic practice of teaching men with prostate cancer before their operation using an ‘office’ ultrasound system. The reliability of measures taken by each of the two methods will be reported separately.

Methods

The participants were men presenting consecutively to a dedicated urology pre-admission clinic for pre-operative physiotherapy before elective RARP for prostate cancer during a period of three months. The participants were referred by urologists who were all RARP-trained. Informed consent was obtained from each man and ethics approval was provided by Bellberry Limited, an NHMRC-approved private Human Research Ethics Committee. Exclusion criteria were: prior lower urinary tract surgery such as transurethral resection of the prostate, or planned open prostate surgery and radiotherapy.

At the study site, the routine practice for men planning to have RARP includes: routine magnetic resonance imaging, attendance at a dedicated pre-admission clinic one to four weeks before surgery for nursing advice about catheter care, pads and recording of biometry, and for pelvic floor physiotherapy.

The physiotherapy intervention included an on-site, one-hour individual session with a pelvic floor physiotherapist. The purpose of this session was to provide education about the PFM and teach men the basic technique and skills needed to enhance post-operative bladder control.

The routine physiotherapy training in detail consisted of education about the PFM using pictures and a pelvic model with palpation of the man’s own bony pelvic anatomy, verbal instruction to teach a correct PFM contraction, and subsequent TPUS scanning using a portable ultrasound system. Participants were taught in the standing position and the verbal instructions given were to: “contract the pelvic floor muscles, as if stopping urine flow, to be aware of the penis retracting, a lift of the testicles and the back passage squeezing and lifting”. Each participant was trained to be able to isolate the contraction to the PFM, with only the lower abdominal wall co-contracting, and with quiet breathing\textsuperscript{19}. The abdominal wall was observed in order to confirm appropriate coordination but direct movement of the genitals was not recorded. This latter point was because our routine practice was to then scan participants to assess their ability to contract the PFM correctly. Each man was advised to practise at home and, using a wall mirror, to observe isolated movements of his genitalia, to reinforce good motor control.

For the scan, participants were given an opportunity to disrobe below the waist in private, and to lie supine on the examination couch with head supported on two pillows, knees flexed and feet flat and apart. The participants then draped the lower part of their body with a sheet. A curved 3.5 MHZ ultrasound transducer (Mindray DP6600) was prepared with a layer of
gel, then a probe cover and a further layer of transmission gel applied. Standard infection control measures were observed. The men were asked to reach under the sheet and lift their genitals with one hand to allow the US probe to be placed sagittally in the midline between the base of the penis and the anus. Once the probe was in place, they could release their genitals, and then lie in a relaxed position. The correct placement of the probe was verified by identifying the relevant structures in the mid-sagittal plane on screen: pubic symphysis, the bladder and bladder neck, the membranous urethra and the anorectal angle.

The men were unable to view the screen. We anticipated this would eliminate any learning effect due to biofeedback as the aim of this part of the study was to assess if men were able to correctly contract the PFM as a result of verbal instruction alone. The position of the bladder neck was marked at rest and on contraction and the image saved for off-line evaluation. The ability to contract the PFM was dichotomised as correct or incorrect. Correct was considered to be any cranial movement of the bladder neck from the rest position viewed on 2D TPUS performed with normal breathing and incorrect as no cranial movement, or a caudal movement, of the bladder neck.

Statistical analysis and sample size

The sample size was limited by the number of consenting participants within the limited period of the study rather than a formal sample size calculation. Simple data descriptions were calculated including the proportion of participants who could correctly perform a PFM contraction.

Results

There were 31 participants who gave consent, from 37 potential participants who fulfilled the inclusion criteria, and who were scanned at their pre-operative appointment between July and September 2013. Of those participants, 26/31 went on to have a second scan with the sonographer for the second part of the study. The participants are described in Table 1. All 31 (100%) were able to elevate the bladder neck in a cranial direction; however, we noted considerable variability in the measured distance of the movement, the motor control shown, and the ability of the participant to maintain breathing during a PFM contraction.

Discussion

We believe that this is the first report to use of TPUS to investigate PFM activity in men with prostate cancer before RARP. The TPUS assessment found that all the men in this group were able to elevate the bladder neck in a cranial direction after verbal instruction, which suggests correct action of their PFMs. This is in contrast to previous research\textsuperscript{11}, which suggested that one-third of that study sample, male physiotherapy students, were unable to contract their PFMs correctly in a cranial direction after verbal instruction.

There are several possible explanations for the discrepancy. Firstly, the research in young physiotherapists imaged the bladder base\textsuperscript{11}, in contrast to the likely more valid transperineal bladder neck measurement used in this study. In young women a lack of agreement between TAUS and TPUS was reported in 15% of females contacting the PFM TPUS\textsuperscript{12}. It seems likely that the use of TAUS to assess PFM action in the young male population does not provide a valid measure of the movement of the bladder neck, as opposed to the assumption that the young men could not contract their PFMs correctly. Our use of TPUS should provide greater confidence that our measurements of PFM action were valid, as the method has previously been shown to be both valid and reliable\textsuperscript{16}.

Secondly, the translation of a verbal command into action depends, in part, on having an understanding of the task and the words used to elicit the movement. As the PFMs lie deep inside the pelvis, we used a picture of the pelvis, a

<table>
<thead>
<tr>
<th>Variable (mean SD)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>64.0 (5.5)</td>
</tr>
<tr>
<td>PSA (ng/ml)</td>
<td>6.3 (3.0)</td>
</tr>
<tr>
<td>Gleason score (range 2 to 10)</td>
<td>6.9 (0.5)</td>
</tr>
<tr>
<td>BMI (kg/m2) (n=24)</td>
<td>27.9 (4.4)</td>
</tr>
<tr>
<td>EPIQ Q7: Bladder dysfunction pre-operatively (n=24)</td>
<td>1.5 (0.8)</td>
</tr>
</tbody>
</table>

SD= standard deviation
PSA test = prostate-specific antigen test
Gleason score = prognostic indicator with maximum score of 10
BMI = Body mass index
Expanded Prostate Cancer Index [Question 7: “Overall, how big a problem has your bladder function been for you during the last 4 weeks?: 1 = no problem, 3 = big problem]
model pelvis with organs, self-palpation of the bony pelvis as well as verbal instruction to teach the men, in the sitting and standing positions, how to contract their PFMs. The action of the PFMs and the associated coordination of the thorax and abdominal wall in women have been described in detail\(^1\) and we have extrapolated this action to our male population. The physiotherapist visually assessed the action, looking for minimal action of the upper abdominal and respiratory muscles and correcting each participant's technique as needed. The actual words used were initially standardised but additional cues were provided as needed, with the focus being on “what you would do to stop your urine flow” This degree of instruction may not have been given in the study of young male physiotherapists.

Anal biofeedback has been commonly used to help in teaching a PFM contraction\(^5,20,21\). It may be that the failure of many of these studies to show a treatment effect is due to their training of anal sphincter awareness with anal electromyography (EMG) biofeedback or electrical stimulation rather than urethral sphincter control\(^1\). Urethral closure is a different action and involves a complex ‘double horseshoe’ action of the pubococcygeus, the external urethral sphincter and bulbocavernous muscles\(^10,21\). Recent research confirms that verbal instructions to “stop the urine flow” or “shorten the penis” will produce specific activation of the urethral sphincter, whereas “tighten around the anus” produces selective activation of the anal sphincter\(^24\). This may have great relevance for PFM training in this patient group but has yet to be tested. Thus, it may be that our detailed education and attention to appropriate use of words accounted for better execution of a contraction. Some men had difficulty isolating a contraction to their PFMs and needed additional cues to reduce their effort and breathe quietly.

We gave instructions and taught participants when standing but then scanned them in supine with knees bent to assess the displacement of the bladder neck in a cranial, that is, correct, or caudal, that is, incorrect, direction. A weakness of this study is that we did not assess PFM action with TPUS in the standing position in which the men were taught, so that there may have been some difficulty for the men transferring the skills learned when standing to a different body position. Nonetheless, each of the 31 men assessed were able to elevate the bladder neck in a cranial direction and they appeared to be typical of the men presenting for RARP at this urology practice.

The study group was of a modest size and from a single centre and so it is possible that a larger, more varied sample would recruit more men with coordination difficulties. We suggest that our results be extrapolated with caution to other men with prostate cancer being instructed verbally how to contract the PFMs. Also, not all verbal instructions will be effective as the effectiveness of instruction also relies on the skill of the therapist in providing appropriate and patient-specific cues. Feedback and patient-specific training may be very important.

A limitation of ultrasound, including TPUS, is its inability to assess PFM resting tone. Lack of movement on the screen may signify PFM weakness, poor motor control, or overactivity of the levator ani. At this clinic, men are only booked for further assessment and training before their surgery if they unable to acquire the skills adequately within the one-hour consultation. In cases where there is doubt about the patient’s ability to contract effectively with verbal instructions alone, and TPUS reveals minimal bladder neck elevation, or descent, then the tone and activity of the PFM needs to be specifically assessed per rectum. If overactivity is found, learning to relax the PFM completely is required before commencing a strengthening or functional training program. Persistent overactivity could contribute to post-operative UI or pain if not corrected.

The question of how much pelvic floor elevation is enough, or optimal, is not known. One-third of men, in one study, who were examined with TPUS after prostate surgery were “hardly or not able” to correctly contact their PFM voluntarily without visual biofeedback\(^17\). The remaining two-thirds of participants were reported to have had “good” or “excellent” contractions, but how these categories were defined is not reported. We defined a correct contraction as one with a bladder neck movement in a cranial direction but there was considerable variability in the responses. Further research should help to distinguish an effective from an ineffective pre-operative PFM contraction and the relationship of this with post-operative urinary outcomes.

Once the correct action is learned, men attending this clinic are then taught how to pre-contract their PFM when coughing and when getting up from a chair; that is, applying the technique to functional tasks, which they will need after their urinary catheter is removed post-surgery. This concept has received little attention in clinical trials to date\(^24\). Such ‘functional control’ can also be trained with TPUS feedback but was not the subject of this study.

TPUS is very practical for dynamic assessment of the PFMs in the clinical setting. It does not require any invasive insertion into the anus, it is quick to set up and can provide reassurance for both the patient and the pelvic floor physiotherapist that the action taught is correctly performed. The action of all the essential muscular components of the action, as described above, can be confirmed on screen and attention drawn to the urethral closure mechanism to enhance the training effect, as a form of biofeedback. In addition, measures of the movement can be taken, although it is unclear at this time if, and how much, movement of the bladder neck pre-operatively predicts a better recovery of continence after surgery.
Conclusion
This study suggests that men with prostate cancer can be taught how to contract their PFMs correctly after receiving specific verbal instructions focusing on the urethra. In this study careful clinical observation and feedback by a pelvic floor physiotherapist supports learning of the correct technique. Clinical assessment with TPUS is proposed as a valid method of confirming a correct PFM contraction pre-operatively in this population.

References
Australian News

24th National Conference on Incontinence
Registration is now open to attend the 24th National Conference on Incontinence to be held at the Crown Conference Centre in Melbourne 25–28 November. Online registration is available, follow the link on the Continence Foundation of Australia website, with the early bird registration closing on 2 October.

The strong scientific program is supported by the UroGynaecological Society of Australasia (UGSA) and boasts international and national speakers who are world leaders in their field. Go to continence.org.au/national-conference.php to download the conference program including workshops.

Tell someone who cares
The CFA has launched a new initiative targeting family and friend carers of people with bladder or bowel problems. Carers Count: Support for continence management aims to raise awareness and improve support and understanding of continence management.

As part of the initiative, a new web page has been developed for carers, along with videos on topical issues, practical tips and links to further information and support services. Two fact sheets and a comprehensive Caring for someone with bladder or bowel problems booklet (published by the Department of Social Services) have also been reviewed and published.

The initiative was launched as part of the World Continence Week (22–28 June) campaign, Tell someone who cares, at a breakfast held in Melbourne featuring key speakers, including Carers Australia CEO, Ara Cresswell, and a demonstration of the Foundation’s new carer resources.

Media interest in the World Continence Week awareness campaign was very positive, achieving a broad reach, with articles appearing in metropolitan, regional and local papers, as well as many popular magazines. Radio stations across the country also picked up the campaign, with several of the Foundation’s media spokespeople appearing on popular morning, afternoon and evening programs.
The Foundation wishes to thank all who made themselves available for interview, as this greatly assists in informing the public and destigmatising the issue by highlighting the need for such discussions in mainstream media. Thank you to the CFA members who ordered resources and held World Continence Week activities to promote the event and educate their peers, clients and local communities.

To download the new carer resources or for more information, visit continence.org.au/carers or call the National Continence Helpline on 1800 33 00 66.

**Australian Bladder Foundation 2015 grants round**

The Australian Bladder Foundation (ABF) annual grants round provides an opportunity for health professionals who are involved in continence management to apply for research grants. The ABF grants support the advances in knowledge which provide direct, tangible benefits in early prevention, detection and management of bladder and bowel dysfunction by funding applications endorsed by the trustees of the ABF.

Grant applications must outline a research proposal which is supported by a set of aims, methodology and budget. Applications from a single or team of investigators are invited as well as new investigators. Applications for the 2015 grants round will be accepted from 17 July 2015 and will close on 29 September 2015. To apply, go to www.continence.org.au

**Australian Continence Exchange (ACE)**

Our expert this quarter, Dr Michael Whishaw, is addressing the issue of neurogenic bladder dysfunction. Michael was a founding member of the Continence Foundation of Australia and a past National Vice-President. He works as a consultant physician in aged care medicine at Royal Melbourne Hospital (RMH) and has been a consultant continence physician for more than 30 years, currently with the RMH Royal Park Continence Service and RMH Urology Service, and with special interests in incontinence in the elderly, neurourology in adolescents and adults, and urodynamics.

Go to www.continenceexchange.org.au to watch the Neurogenic Bladder Dysfunction video. Dr Whishaw will also be available to take your questions on the topic. Send your questions to admin@continenceexchange.org.au

*BARRY CABILL*

CEO CFA
New Zealand News

We are yet to complete reports on it but we can report that at the end of another annual awareness week we ended up with one segment on Te Karere TVNZ 24 Jun 2015, with Manawa Wright interviewing a Komatua and his wife, 80-year-old Heather Ngatai, who live independently and are dealing with the issue of managing incontinence. The focus this year was on support for family carers. The interview is available on YouTube and has had 289 views.

We also had the opportunity to do radio interviews. We secured the Tuesday afternoon health and fitness slot with Claire Turnbull and Danny Watson on Newstalk ZB. Judy Hattie did each of these interviews as well as one on Pacific Radio, which is listened to by the majority of the Pacific Islander community.

As you will mostly be aware we have changed our branding to Continence NZ, although we will legally remain NZ Continence Association. We find that most organisations have changed to a more straightforward branding. We trust you like the new branding and eventually you will see this across everything we do.

We have also changed the branding on the website. There is still much work to do to get this navigating as we would like but we should be fully upgraded within the next three months.

We have some new projects in discussion and will inform you all once we have further information. We welcome any feedback from our membership.

Jan Zander

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
Calendar of events 2015

17–20 August
Prostate Cancer World Congress 2015
Presented by Australian Prostate Cancer Research
Cairns, QLD
Web: http://prostatecancercongress.org.au

31 August – 4 September
IAHSA/ACSA Joint International Global Ageing Conference
Perth, WA, Australia
Web: http://iahsa.net/11th_International_Conference_Perth_Australia.aspx

5–7 September
ISPP 16th International Pelviperineology Conference
Harbiye Military Museum, Istanbul, Turkey
Web: www.pelviperineology.com/conference_summary

4–9 October
FIGO World Congress of Gynecology and Obstetrics
International Federation of Gynecology and Obstetrics (FIGO)
Vancouver, Canada
Web: http://figo2015.org/

6–9 October
5th Annual Meeting of the International Continence Society ICS
Montreal, Canada
Web: www.ics.org/2015

14–18 October
ICCS 2015 Annual Meeting
Prague, Czech Republic
Web: http://i-c-c-s.org/

15–18 October
35th Congress of the Societe International D’Urologic (SIU)
Melbourne Convention and Exhibition Centre, VIC, Australia

19–22 October
10th LAGG Asia/Oceania Regional Congress
International Association Gerontology and Geriatrics
Chiang Mai, Thailand
Web: http://iaggchiangmai2015.com/

31 October – 6 November
10th International Society of Laparoscopic Colorectal Surgery (ISLCRS) Congress 2015
Academia, Singapore General Hospital Campus (SGH), Singapore
Web: http://www.sghcolorectal-islers-apetna.sg/

25–28 November
The 24th National Conference on Incontinence
Crown Conference Centre, Melbourne, VIC, Australia
Web: www.continence.org.au

2016

10–12 March
2016 UGSA Annual Scientific & General Meeting
The Pullman, Auckland, New Zealand

2–6 August
IUGA 41st Annual Meeting
Cape Town, South Africa
Web: www.iuga.org/
Enriching lives

As the complex world evolves, health becomes ever more important to life. That’s why we are committed to creating innovative healthcare solutions so people can manage health simply and effectively.

Find out more visit www.hartmann.com.au

Going further for health
NEW MoliCare Premium soft super plus

A revolution in continence care

The new MoliCare® Premium soft super plus now combines unique Active Skin Protection features with the new soft textile-like backsheet to ensure the skin integrity of those you care for is maintained. The product’s high absorption capacity as well as the new easy to handle, re-closable hook-and-loop fasteners, ensure that both the caregivers’ and residents’ needs, are perfectly met.

For further information on MoliCare Premium soft, please call Customer Care on 1800 805 839 or contact your local HARTMANN representative. www.hartmann.com.au