

IN FOCUS

THE OVERACTIVE BLADDER OF CHILDHOOD

Stuart B. Bauer, MD
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Introduction

The overactive bladder has been defined as involuntary contractions, or spasms, of the bladder during its filling phase with urine. Often times, these spasms cannot be controlled, no matter how much a patient would like to do so.

There are three reasons why a child may have an overactive bladder: neurologic, anatomic, and functional. The neurologic causes usually means there is a problem with the child's nervous system, such as spinal cord injuries (from birth defects, like spina bifida, or trauma, like a car accident), cerebral palsy, or other types of developmental disorders involving the lower portions of the spinal column and pelvis. These disorders can be quite serious with many patients being unable to move their legs and hips normally, as well as having internal problems controlling their bladder or bowel movements. Anatomic causes are due to the fact that an organ, or its structure, is damaged somehow. For example, the bladder could be too small in size or there could be a growth attached to the bladder's wall, which prevents the bladder from working properly. Problems like these could affect the flow or amount of urine, resulting in an overactive bladder. Functional causes occur when something is interfering with the normal workings of the bladder and the child experiences problems with urinating. An example of this type of overactive bladder could be caused by a urinary tract infection. Some urinary infections are often caused by abnormal urinating patterns or problems during toilet training, family stress at home, or behavioral issues with the child. The child may begin daytime or nighttime wetting or does the opposite by avoiding urination for long periods of time. Even constipation or stool retention problems may lead to an overactive bladder because the colon displaces the bladder.

Evaluation

The evaluation process begins with a good history from the parent. The care provider must ask all about the mother's pregnancy and if the patient had any problems during the important developmental period. The child's developmental milestones, growth patterns, current mental status, scholastic performance, events at the time of toilet training,

continued on next page . . .

from our guest editors

Mark Horowitz, MD, FAAP, FACS is the director of the Spina Bifida clinic and the pediatric voiding dysfunction center and urodynamics laboratory at The New York Hospital-Weill Cornell Medical Center. He is also the director of Pediatric Urology at the New York Hospital-Queens Medical Center and Staten Island University Hospital. He is nationally and internationally known for his clinical expertise in patients with neurogenic bladders, non-neurogenic voiding dysfunction, and obstructive uropathy. He received his MD degree from New York Medical College.

Laura E. Gamble, MSN, RN, CPNP is a certified nurse practitioner who currently works in the nurseries at East Cooper Regional Medical Center in Charleston, South Carolina. She received her undergraduate nursing degree from Texas Christian University and her MSN in Maternal-Child Health from the University of Texas. Her decades of pediatric experience derive from providing primary ambulatory care in various outpatient or community settings and home health.

Daytime and/or nighttime wetting are one of the most common problems seen in the clinical practices of pediatric urologists. Often considered a nuisance associated with the growing years, wetting can be the source of much anxiety to children, parents, teachers, and healthcare providers. Depending on the age of the child, incontinence can have a devastating impact on a child's social life, self-esteem, emotional well-being, and overall quality of life. Most children outgrow their particular disorder with maturation. A small percentage of patients will suffer from recurrent infections and kidney problems. A thorough understanding of bladder physiology and development of bladder control is critical for the proper work-up and management of patients with wetting problems. It has been reported that nearly 50 percent of children evaluated for constipation also have urinary incontinence and that relief of constipation may resolve their urinary symptoms. In this issue of Quality Care, we are very fortunate to have three experts offer their views on the three most pertinent issues with respect to incontinence in children. Bedwetting, overactive bladder, and constipation are the most challenging conditions to treat and our panel will help us to better understand these issues.

... continued

patterns of bladder and bowel emptying and frequency, timing, and severity of incontinent episodes must all be discussed. After all that information is collected, the equally important physical examination needs to take place. A careful inspection of the lower spine must be done to look for signs of possible neurologic causes, assessment of the child's hips and legs, and an examination of the external genitalia.

A urine analysis, culture, and specific gravity are needed as initial laboratory tests. There are many special types of x-rays that could be ordered to help discover abnormalities with organ formation. One type, such as a kidney and bladder ultrasound,

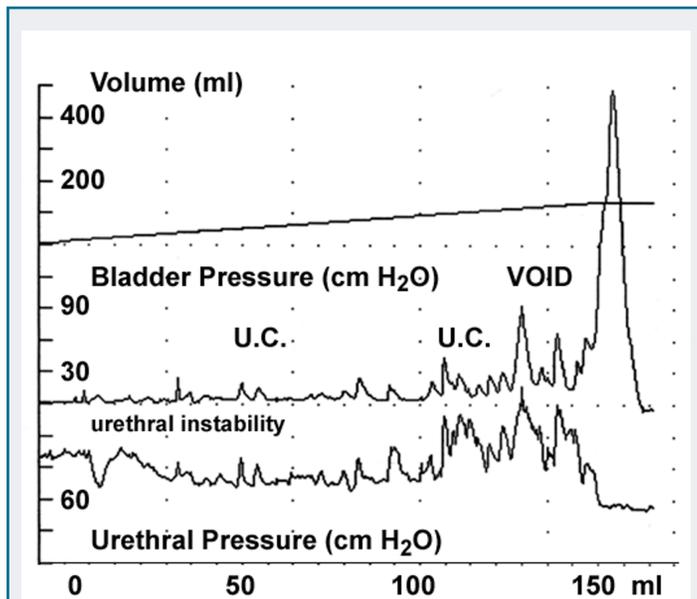


Figure 1 - A urodynamic study in a 12-year-old boy with day and nighttime wetting, simultaneously recording changes in bladder pressure and urethral resistance during filling and emptying of the bladder. UC = uninhibited (spontaneous) contractions. Note, both a decrease (early in filling) and an increase (later in filling after the child senses the uninhibited contraction with a need to void) in urethral resistance throughout the filling phase.

might be done to assess the organ's wall thickness or size and to note if there appears to be problems with your child not being able to totally empty the bladder after voiding. See Figure 1 below of a urodynamic study to map the process of urinating.

Treatment

The basis for treatment of the overactive bladder of childhood depends on the symptoms, underlying cause, condition of the kidneys and bladder, and future effects it may have on the urinary tract. Treatment must be individualized for every child. The methods used to treat patients with incontinence/overactive bladder include medications to relax the bladder (See Figure 2 - Medications), behavior modification, antibiotics, biofeedback, and in extreme cases, intermittent catheterization or surgery.

Once the bladder overactivity is controlled in children with recurrent UTIs, the risk of recurrent infection can be reduced considerably. This 3-pronged approach to treatment (antibiotics, medications to relax the bladder, and reinforcing / teaching good toileting habits) is crucial for effective management of the bladder problems.

Treating the child who only has incontinence can still be a challenging patient to tackle. Daytime and nighttime wetting (sometimes with squatting to prevent voiding), a family history of enuresis (i.e., wetting themselves after the age of 5 or 6), perinatal problems (i.e., any complications during the mother's pregnancy which might have caused problems for the child), learning disabilities, problems with fine motor coordination, hyperactivity, and/or an inability to stay focused on a given task all suggest that the child may have a hyperactive bladder. A careful exam of the nervous system may uncover signs of a subtle central nervous system dysfunction or a spinal cord abnormality. The care provider must be sure that the child is instructed on toileting well and bowel and bladder eliminations. Most children, especially those older than ten years, will respond to medications and be able to cease drug therapy within six months of starting it. If the child does not adequately respond, then urodynamic studies are recommended to correctly diagnose and treat the problem. Behavioral modification, psychiatric therapy, and biofeedback training have shown promise in reducing symptoms and improving continence on a long-term basis in most children. ❖

Figure 2 - Medications Prescribed For Overactive Bladder in Children

<i>Agent</i>	<i>Class</i>
Dicyclomine HCl (Bentyl)	antimuscarinic musculotropic
Flavoxate HCl (Urispas)	musculotropic
Glycopyrrolate (Robinul)	quaternary ammonium antimuscarinic
Hyoscyamine SO ₄ (Levsin) (Levsinex)	anticholinergic
Imipramine HCl (Tofranil)	tricyclic antidepressant alpha adrenergic agonist
Oxybutynin HCl (Ditropan)	muscarinic antagonist
Oxybutynin HCl patch (Oxytrol)	muscarinic antagonist
Propantheline Br (Probanthine)	anticholinergic
Tolterodine tartarate (Detrol)	muscarinic antagonist

Prostate Health News

An Italian research team's results (published in the August, 2003 issue of the journal *Urology*) show that an injection of Botox into the prostate can relieve urination difficulties in older men who have enlarged prostate glands. Dr. Giorgio Maria and his colleagues from the University Hospital Agostino Gemelli in Rome believe they have a safe and effective treatment to shrink the prostate.

Normally, the prostate is quite small—it is nearly the same size and shape as a chestnut. It is located in front of the rectum, just below the bladder, and wraps around the urethra, the tube that carries urine from the bladder out through the tip of the penis. The prostate is made up of approximately 30 percent muscular tissue, and the rest is glandular tissue. As a man gets older, his prostate may increase in size. This condition is called benign prostatic hyperplasia (BPH). By age 70, more than 40 percent of men will have enlargement of the prostate that can be felt during a physical examination. If the prostate grows large enough, it may press against the urethra and make the flow of urine weaker or slower. Symptoms of BPH may include: a weak urinary stream; difficulty starting urination;

frequent urination; and frequently awakening at night to urinate. Visit www.prostate.com to learn more about what the prostate is, about diseases of the prostate, and about treatment options.

An increase in the size of the prostate and a change in urine flow do not necessarily mean you have cancer; you may have BPH, an infection or another urologic condition. It is important to note that BPH is not cancer, nor has it been shown to increase the risk of prostate cancer. However, a man can have both BPH and prostate cancer. Severe cases of an enlarged prostate can require surgery.

In the study, Botox or saline solution was injected randomly into the prostates of 30 men. The men were tracked for an average of 20 months. After two months, 13 out of the 15 men who were injected with Botox reported relief from their urinary difficulties. Only three men who received the saline injection reported some relief. No side effects or complications were reported with the Botox injections. Currently Botox is approved by the US Food and Drug Administration for cosmetic applications. However, it is important to realize that Botox's use in the urinary tract is clearly investigational, and it should be strongly emphasized that more research is needed. ❖

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LINKS

The Spina Bifida Association of America

The Spina Bifida Association of America (SBAA) serves adults and children who live with the challenges of Spina Bifida. Since 1973, SBAA has been the only national voluntary health agency solely dedicated to enhancing the lives of those with Spina Bifida and those whose lives are touched by the birth defect. Its tools are education, advocacy, research and service. Through its network of chapters, SBAA has a presence in more than 125 communities nationwide and reaches thousands of people each year. Lives are changed by the programs SBAA has created, the services the organization provides, and the gains achieved through its advocacy efforts.

Understanding Through Education

Each year, as many as 10,000 people are connected with accurate information from numerous reliable resources and publications through the National Resource Center on Spina Bifida - housed in Washington, DC. Often, assistance is provided through a referral to a caring person connected with an SBAA chapter where compassionate support can be found in one's own community.

The Internet is a lifeline for many with disabilities and SBAA's website (www.sbaa.org) responds to the needs of its users by offering accurate information about this complex birth defect, as well as resources on a host of subjects. The quest for new information, the celebration of lives being lived to their fullest and the unity of a community built on caring and compassion are embodied by SBAA's Annual Conference held regularly in June.

Our Message of Hope and Prevention

Millions of people have received vital information about Spina Bifida and how it affects those who live with it and countless women know about the importance of taking folic acid prior to pregnancy to reduce the risk of Spina Bifida and other neural tube defects as a result of SBAA's efforts.

Nurturing Our Next Generation of Leaders

SBAA invests in the future by encouraging students with Spina Bifida through a series of scholarship programs. These scholarships hold an important place in SBAA's efforts to help people born with Spina Bifida achieve their full potential through higher education. ❖



www.sbaa.org
800.621.3141

A HEALTHY BALANCE

Bedwetting:

An Overview of Treatment Options

Howard J. Bennett, MD

There are 5 to 7 million children in the United States who wet the bed. Although bedwetting is rarely due to a serious medical disorder, it is difficult to live with. In most cases, a child wets the bed because of a combination of being a deep sleeper and having a small bladder. Here are some important pointers to keep in mind regarding your child's bedwetting:

- Children do not wet the bed on purpose, and punishing a child for being wet does not work.
- Since children do not talk about bedwetting outside the family, most of them think they are the only ones who have the problem. A good way to reassure children is to let them know how many kids wet the bed at school. In an elementary school of 500 children, 50 are wet at night. In a middle school of 1000 children, 31 are wet at night.
- Children are more likely to overcome their wetting if they are actively involved with the program. Therefore, be sure your child is motivated to become dry before you begin treatment.
- Before you start any bedwetting program, your child should be seen by his or her doctor to make sure a medical condition isn't causing the wetting. Constipation, difficulty with urination, and daytime wetting are a few of the medical problems that can cause bedwetting.

- The most common medication used to treat bedwetting is DDAVP. This drug helps 50 percent of the children who take it. The effects of DDAVP are not long lasting and children often relapse when the drug is stopped. For this reason, doctors usually recommend it for short-term use (i.e., sleepovers, vacations, or special occasions). If your doctor prescribes DDAVP for your child, it is very important to restrict his fluids after dinner.

- The most effective treatment for bedwetting is a device called the bedwetting alarm. The alarm is a small, battery-operated device that children wear to bed at night. One part of the alarm attaches to their undershirt or pajama top and the other part attaches to their underpants. When the child urinates, the alarm goes off, creating a loud buzzing sound. The sound is designed to wake the child up and teach him what his bladder feels like when it fills up with urine. When the alarm first starts to work, children wake up before they wet the bed. Over time, most children actually sleep through the night because their bladders have learned to hold all of their urine until morning. The most common reason that alarms don't work is because people use them incorrectly. Make sure to follow the manufacturer's instructions and be sure to use the alarm every night. In addition, because children often have difficulty waking up when they first start using the alarm, it helps if a parent sleeps in the child's room to wake him up as soon as the alarm starts to buzz.

(Dr. Bennett is currently writing a self-help book for children and parents on bedwetting.) ❖

Bowel Health in Children

Robert W. Collins, PhD, PC

Encopresis, or fecal incontinence, is a functional disorder in children characterized by soiling in inappropriate places at a developmental age of four years and older. It takes two basic forms: non-retentive encopresis and retentive encopresis.

Non-retentive encopresis is characterized by full and normal bowel movements (BMs). It is generally regarded as resulting from the simple failure to learn a toileting habit. The gastrointestinal (GI) tract and bowel generally appear to be normal in most respects. It has a lower incidence of around 5-20 percent in contrast to the much more common retentive form. Behavioral training methods have been advocated for treating this problem (see Treatment Guidelines for Primary Nonretentive Encopresis and Stool Toileting Refusal at the American Academy of Family Physicians website at www.aafp.org).

Retentive encopresis has been variously associated with chronic constipation, "megacolon", or "stool hoarding". This could be due to "slow transit" along the GI tract or "outlet obstruction" from fighting and "clamping up" against emptying urges at the end of the GI tract. A delay in transit is likely more physiological in nature, while "holding" is due to the child's fearful or conditioned sphincter contractions to his voiding urges. Whatever the cause, the large colon can become very distended (stretched or swollen) to the point of a "megacolon" because of the accumulation of foodstuff. This interferes with the GI tracts normal efficiency. The internal anal sphincter, a "purse string like" muscle at the anal canal exit, can become overwhelmed, dilated, and result in seepage causing "smears", "tire tracks", fluid leakage, or hard prune-like stool drops in the child's clothing. Finally, the child may have occasional gigantic, toilet clogging BMs from backed up stool.

All of this is clearly unhealthy and the resulting conflict perpetuates the very problem of soiling itself. Children have no conscious control or "choice" by this point in time. The usual precipitating event is a painful BM during toilet training or subsequently, which induces a cycle of fearful, reflexive withholding. This can worsen in preschool or school settings when the GI tract slows from tension during the day, but then severe voiding urges kick in as the child relaxes in anticipation of going home. Accidents may actually occur on a child's way home.

The usual pediatric approach is to prescribe oral laxatives, mineral oil, or isotonic agents to assure softer stools and more frequent voidings. This is to foster a return of the large colon to normal size and function. The physician may not be that concerned about the soiling itself! Over time, with an emphasis on having toilet sittings after meals, about 50 percent of children can become accident free.

Parents may be reluctant to employ the more aggressive behavioral conditioning approach, using sittings, suppositories, and enemas in a stepwise fashion during one period in each day to more reliably condition daily voidings. The daily assurance of adequate emptying out also ensures a much earlier end to soiling. This more intrusive approach can become an attractive option or fall back method if the usual medical approaches fail after a reasonable trial and there are severe consequences for continued soiling. ❖

(If you'd like to know more about Dr. Collins and the information he has to share, please visit www.soilingsolutions.com.)

A Family Caregiver's Guide to Hospital Discharge Planning

The National Alliance for Caregiving and the United Hospital Fund of New York have published a booklet for people with family members who are being admitted to a hospital (the information is relevant for the patient as well.) This booklet outlines discharge planning from the hospital as a process, not a single event.

The booklet covers topics such as:

- What is Discharge Planning?
- Who Does It?
- When Should It Happen?
- What Will Insurance Pay For?
- What Should I Be Doing While My Relative Is in the Hospital?
- What Are the Choices?
- Take Care of Yourself?
- The Basics of a Discharge Plan

To make the discharge process go smoothly, keep these three "Bs" in mind: be realistic, be persistent, and be prepared. Discharge from a hospital does not mean that your relative is fully recovered. It simply means that a physician has determined that the person's condition is stable and that they do not need hospital-level care.

The booklet is available online at www.caregiving.org and www.uhfnyc.org. The National Alliance for Caregiving is a nonprofit coalition of national organizations that focuses on issues of family caregiving. The booklet was funded by MetLife Foundation. ❖



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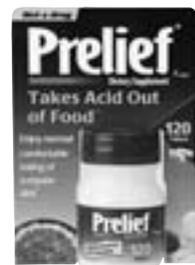
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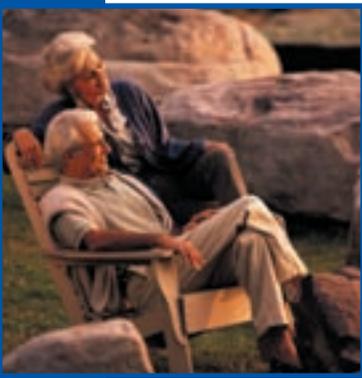
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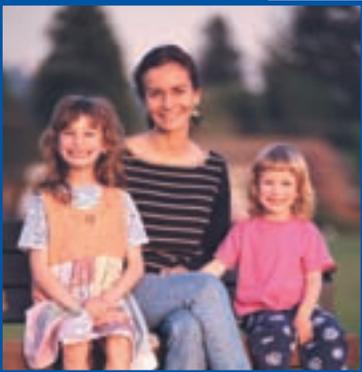
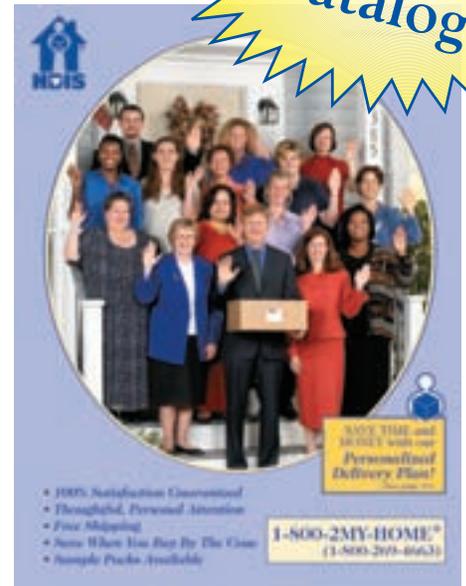
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PERSONALLY SPEAKING

A Pediatric Urologist – the Solution to My Daughter's Healthcare Problem

After more than ten years of dragging our daughter to an assortment of urologists, gastroenterologists and psychiatrists, the family therapist that we were seeing told us of promising work being done. Setting aside our own reluctance to see yet another medical professional for a problem that we were convinced was not physical – although we were keenly aware of the physical damage caused by the years of incontinence – our 14 year old daughter was even less inclined to have more doctors poking around at her and discussing her urinary and bowel habits. Yet, fresh in our minds was the hell that our home life had become. From the shame and social ostracism to the hygiene concerns for the other kids, we knew that without proper treatment, we had no hope.

To our great fortune we made the appointment to see a pediatric urologist and his physician's assistant for treatment. Honesty, sensitivity, patience and a healthy dose of good humor marked the year of sessions. Our daughter got a frank appreciation of what her problem actually was and was taught the tools by which she could achieve a healthful lifestyle. In addition, we gained the confidence that she could improve and the patience to let her do so at her pace. ❖

- Mrs. M in New York

A COLLECTIVE VOICE

The Centers for Disease Control & Prevention

The Centers for Disease Control and Prevention's (CDC) National Center on Birth Defects and Developmental Disabilities (NCBDDD) is dedicated to helping improve the lives of individuals with disabilities, while also educating the public about how to prevent the occurrence and recurrence of birth defects, such as spina bifida.

NCBDDD is excited about its many new and ongoing folic acid promotion activities. Hot off the presses is a new booklet called "Emma's Story". This booklet is designed for audiences with low to average literacy skills and stresses the importance of taking folic acid before and during early pregnancy. The booklet, available in both Spanish and English, follows a woman named Emma and her husband as she prepares for pregnancy by taking folic acid daily, eating a healthy diet, and visiting with her doctor. NCBDDD's ongoing Spanish-language folic acid campaign is in its third year. The campaign debuted in Denver and Philadelphia this year and continues in Miami and San Antonio. This campaign uses a combination of paid media on Spanish-language television and radio stations and community outreach by *promotoras*, or lay health workers. This campaign is designed to reach Spanish-speaking women with the very important folic acid message in a culturally appropriate and sensitive way. The campaign also targets healthcare providers who serve Hispanic women. In September 2003, CDC campaign

representatives traveled to Denver and Philadelphia to conduct folic acid training workshops for healthcare professionals. Participants learned more about what spina bifida is and how it affects individuals and families. Several participants had not known about the issues of bladder and bowel management and intermittent catheterization that individuals with spina bifida must face. They were encouraged to inquire more about the specific needs of their clients and to assist them in seeking resources in their communities.

The Science Ambassador Program is another exciting new program for NCBDDD. This program is designed to raise awareness about public health issues, such as birth defects prevention, among middle and high school students. Last summer, ten teachers from across Georgia came to CDC for a 3-day workshop to learn from and interact with CDC scientists. Teachers then developed and implemented lesson plans for their students based on what they had learned. The lesson plans will be published on the Internet for use by teachers everywhere. Several lesson plans are currently available at <http://www.glc.k12.ga.us/gei/NCBDDD/homepg.htm>.

All of these prevention-focused programs aim to increase awareness about the importance of folic acid for women of childbearing age, while also providing resources for those families and healthcare professionals seeking assistance for individuals already affected by spina bifida.

Visit www.cdc.gov/ncbddd/ for more information on the National Center on Birth Defects and Developmental Disabilities. ❖

FROM THE PATIENTS

Mark Horowitz, MD, FAAP, FACS
and Laura Gamble, MSN, RN, CPNP

1. At what age should I seek help for my child who is wetting the bed? I'm just not sure I can handle dealing with this for much longer.

We see children of all ages for the evaluation of primary nocturnal enuresis (PNE), which is the medical terminology for bedwetting. It represents one of the most common reasons for consultations with Pediatric Urologists. It occurs in up to 15 percent of all 5-year-old and 10 percent of 7-year old children. There is a spontaneous resolution rate of 15 percent per year with 99 percent of children becoming dry by 15 years of age. The age at which treatment is initiated varies from child to child and must be individualized. Several factors are considered in the decision making process of whom to treat and in whom treatment should be deferred.

We must realize that we are treating the patient and NOT the parents. A common scenario is one in which the patient is not bothered by his/her bedwetting but the parents are either frustrated with the persistent problem or have concerns regarding the possible causes. In this situation therapy need not be initiated, but empathy and reassurance that the child is healthy and will outgrow his/her problem is critical.

In my practice, therapy is rarely initiated in boys less than 7 years of age and girls less than 6 years. If the wetting even after these ages does not bother a child, I do not recommend treatment. We must remember that although bedwetting is a nuisance and can be costly, it is NOT deleterious to one's health. There is absolutely no danger in delaying treatment if the patient is not ready.

We must remember that children with bedwetting are doing nothing wrong, they have no control over their problem. Applying pressure will not change the situation and can cause negative emotional and psychological sequels.

2. What kind of healthcare provider can help my child with their bedwetting and incontinence problems? Who do I call and what kind of treatment are they going to provide?

A good history and physical exam is all that is necessary in the evaluation of bedwetting. If the patient has bedwetting and no other problems including daytime incontinence, urinary

tract infections, fecal problems, and/or voiding difficulties, an experience pediatrician can manage him/her. When the problem is more complicated than simple bedwetting, a Pediatric Urologist should be asked to evaluate the patient. The treatment depends on the cause and severity of the condition. There are different treatments for both daytime and nocturnal enuresis and treatment MUST be individualized. It is wrong to put every patient on the same treatment protocol. Treatment modalities include observation, medications, biofeedback, behavior modification techniques and surgery, alone or in some combination.

3. What can I do for my child with bedwetting who wants to have a sleep over or go away to camp but doesn't want to be on medications all the time?

The medications that are used for the temporary relief of bedwetting can be used on an interim basis. The medications work quickly and can be stopped and started again without a problem. If a child wants to have a Friday evening sleep over, I instruct them to take the medication starting Wednesday and continue through until Friday. There is a pretty good chance that they will remain dry for those few days.

Pull-ups also provide an invisible protection for your child. None of the other kids need to know they're being worn. If having a sleep over, suggest the kids all sleep in sleeping bags as a fun change, instead of in the beds. Then if there's an unexpected accident, no one is the wiser. Always pack extra clothes for your child if they are going to a sleep over at a friend's. And if your child wants to go to a sleep over, but is really afraid of what might happen, arrange so that they go over for the evening to enjoy being with friends. Then pick him up as the other kids get ready for bed. Take the hit for the child and just say you want your child home so they can get a good night's sleep.

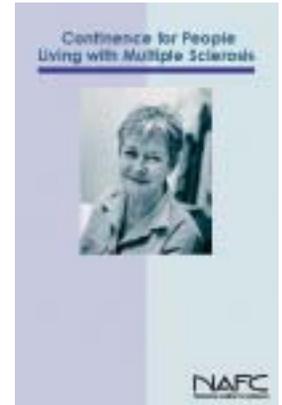
4. Is it true that bedwetting can be psychological in nature?

Yes, childhood anxiety occurring after 2 years of age can lead to bouts of incontinence with a potty-trained child or possibly delay urinary training and control. Stress factors that could influence or change a child's bladder habits might be: unhappy family life, birth of a new sibling, death of a grandparent, moving, or a new preschool/daycare. Also, the plain fact that the child knows that he/she wets the bed, can be a stressor in itself. They may worry over the helplessness, disappointment, and embarrassment that the accidents might bring. Usually incontinence caused by stressful events resolves as the anxious situations run their course and pass with time or the child learns to adapt and adjust. ❖

CONTINENCE FOR PEOPLE LIVING WITH MS

NAFC's newest publication, *Continence for People Living with MS*, marks a new chapter in NAFC's approach to public education, representing the first in a whole new family of educational materials that are disease specific and thus targeted to the intended audience. This should impart meaningful hope that is being sought out.

NAFC would like to thank the Mentor Corporation and Pfizer, Inc. for their sponsorship of this project.



There are three ways to order *Continence for People Living with MS*, call 1-800-BLADDER, visit www.nafc.org, or contact your local MS chapter.



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IN THE SPOTLIGHT

Nancy Muller Executive Director National Association For Continence

NAFC would like to take the opportunity to share recent information about products, procedures, and news related to incontinence.

NAFC is currently completing production of the new Pelvic Muscle Exercise Kit for Women. With the support of sponsors *Hollister, Laborie, SRS, and Women's Wellness Within*, we have updated and expanded our kit to include the latest thinking in the treatment of incontinence with pelvic muscle rehabilitation. The new kit includes a booklet with information on the pelvic floor and its role in the prevention and treatment of stress and urge incontinence. An audio CD will include detailed exercise instructions, updated from the previous tape. The kit will be completed with a motivational video, featuring Dr. Carolyn Sampselle, a renowned authority in the field of prevention. The kit is set for release in March 2004, and will cost \$15 (including shipping and handling.)

The Wellness Wand™ is a new pelvic floor muscle exerciser that requires vaginal insertion. The individual contracts the pelvic floor muscles and is able to create resistance to the muscle by tugging on the handle that is outside the vagina. The device is available in sizes small, medium, and large. Further details about the device and ordering information is available at www.womenswellnesswithin.com.

Loss of normal bowel control (fecal incontinence) can have a devastating effect on patients and their families. As many as one out of 13 adults suffers from this debilitating condition with approximately three percent of women reporting incontinence, primarily as a result of childbirth. The Secca® procedure offers new hope to patients who struggle with this condition. The Secca System, manufactured by Curon Medical, Inc. (Fremont, California), has been cleared by the Food and Drug Administration (FDA) for use with patients who suffer from fecal incontinence at least once a week and who have not responded to conservative treatments, such as dietary fiber therapy and/or biofeedback. This minimally invasive outpatient procedure is typically performed by a colorectal surgeon using a mild sedative, so patients can return home the same day. In clinical trials, 60 percent to 80 percent of patients experienced symptom improvement. For more information about the Secca procedure, speak with your doctor and visit Curon Medical's website at www.curonmedical.com.

On October 17th, 2003, SRS Medical Corporation announced that it had acquired all assets related to urodynamic products and certain incontinence treatment devices from Endocare, Inc. of Irvine, California. The transaction includes products related to the Timm Medical and Browne™ urodynamic products, as well as the C3™ (male) and StepFree™ (female devices) for incontinence treatments. The StepFree™ vaginal weights are the only "over the counter" item the company carries. All other products are available only by prescription.

Successful Completion of Initiative to Obtain Restroom Access for Riders of the Washington D.C. Metro System

Riders and employees of the Washington D.C. Metro will now have access to in-station restrooms at most all of the 83 Metrorail stations. In November of 2003, the Metro modified the existing Metrorail restroom procedures for the public and implemented a variety of enhancements designed to protect customers and employees. Signs will be displayed at kiosks notifying customers of public restroom availability.

Drug Cost Assistance Programs

HelpingPatients.org is an interactive web site by PhRMA and 48 of its member companies. The site was designed to help people find patient assistance programs for which they may qualify. This online service is free and completely confidential. They do not keep records of any personally identifiable information, and users just answer a few short questions. In 2003, PhRMA members provided free prescription medicines to more than 6.2 million patients in the United States.

Other web sites providing information about government-supported and private patient assistance programs include:

www.BenefitsCheckUpRX.com

(A Service of the National Council on the Aging)

www.medicare.gov

CMS Medicare Site

www.RxAssist.org

(A National Program Supported by the Robert Wood Johnson Foundation)

FROM THE HEADQUARTERS

NAFC Will Reach Out to Many Audiences with Webcast of 2004 Women's Forum

NAFC's 2004 Women's Forum on lifelong bladder health and pelvic support will touch more than just those who are able to attend the event in Charleston, South Carolina. Portions of the forum will also be accessible by webcast via NAFC's web site in the beginning of April. Anyone with access to the Internet will be able to download the forum webcast at no cost. The event is for women of all ages to create awareness about the risk factors associated with the loss of bladder control. Our speakers include professors from renowned institutions such as Mayo Clinic, Emory College of Medicine, Baylor College of Medicine, and the Medical University of South Carolina, as well as the Director of the Office of Women's Health at the Centers for Disease Control and Prevention. Topics will include an overview of bladder function and related pelvic support, how to seek treatment and what to expect, your medication and surgery options, strategies for prevention, and much more. We at NAFC hope thousands will benefit from this informative event.

- Nancy Muller
Executive Director, NAFC

Looking Forward...

NAFC places a focus on different audiences, diseases, and health matters involving incontinence for each issue of Quality Care to meet the needs of a large variety of people dealing with incontinence themselves or as caregivers or specialists. Look for these upcoming issue focuses for 2004.

2nd Quarter

- The Peri-Menopausal Woman & Incontinence

3rd Quarter

- Disabilities & Incontinence

4th Quarter

- Prostate Health & Incontinence

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- Get encouragement from others who suffer from some of the same experiences.
- Discover how treatment has enabled others to go back to doing the things they used to do and enjoying the activities they once did.
- Share your story with people who are also affected by this condition.
- Find out more information about your symptoms and what you should do if you have a bladder control problem.
- Find out what is happening on the medical front and keep informed on new information relating to bladder control issues.

Welcome

Incontinence is a very personal issue which affects as many as 25 million Americans – young and old, male and female. At the **Bladder Control Problems Discussion Forum**, you can talk to others who share your same problems and concerns. The more information you have, the better you can understand this “quality-of-life-threatening” condition and manage the impact it has on your life.

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This web tool has been provided to NAFC through the generosity of Ortho-McNeil Pharmaceutical, Inc., the distributors of DitropanXL7 for overactive bladder.

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