



# Quality Care

**NAFC just moved its  
headquarters to  
Charleston, South Carolina**

Read inside to learn about our new location...

**volume 21**  
No. 2, 2nd Quarter, 2003

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Dear Readers,

A great pulse of energy surges among us! As we are now located at the heart of the South's Medical Community in Charleston, SC, we have introduced new members to the NAFC team in the areas of public relations, education, and fund development. Teamed with these dynamic individuals, the NAFC is looking ahead at a year of unprecedented growth and mobility, bringing us closer to our mission to be the leading source for public education and advocacy about the causes, prevention, diagnosis, treatments, and management alternatives for incontinence.



Already this year, we have made several accomplishments. We have enhanced the format of our newsletter, making changes that allow for easy readability and greater in-depth coverage; improved website usage, adding a specialist search list, e-commerce capabilities, and members access pages; and begun arrangements for the 2nd Annual Lifelong Pelvic and Bladder Health for Women, an educational forum to create awareness about the risk factors associated with the loss of bladder control and ensuing incontinence.

NAFC has also set in motion plans for Discoveries, our newest publication to be released in August. Discoveries will serve as an extension of the Resource Guide, and will present new technologies and innovations in the way of incontinence. In it, you will find information on the newest incontinence products on the market. It will also offer commentary from healthcare professionals.

With all of this underway, we are looking ahead at growth and achievements. However, while ambitious in our endeavors, it is only you and your continued generosity that allows the NAFC to fulfill its mission and make enhancing the quality of life for people living with urinary incontinence (UI) a realizable goal. It is your generosity that allows the NAFC to continue to reach out to thousands of UI patients across the United States, providing a means for support and hope.

For your tax-deductible contribution, we have enclosed a self-addressed return envelope, which can be found at the center of this publication. Your contribution of \$30 will help cover the cost for one woman to attend the educational forum, Lifelong Pelvic and Bladder Health. Your donation of \$100 will allow 12 people living with incontinence to receive the Discoveries resource guide to new products and information. A donation of \$2,000 would enable us to send one NAFC representative to Washington D.C. to advocate laws promoting improved quality-of-life for the millions who have bladder and bowel control problems. Please consider the benefits we'll all enjoy, and return your check along with the enclosed form. Thank you for your generosity.



Nancy Muller  
Executive Director

# Quality Care

A Quarterly Newsletter for Members of the National Association For Continence

## INFOCUS

Richard D. Zorowitz, M.D.



## Bladder Dysfunction After Stroke

**Richard D. Zorowitz, M.D.**

Associate Professor of Rehabilitation Medicine

Medical Director, Piersol Rehabilitation Unit

Director, Stroke Rehabilitation University of Pennsylvania Health System, Philadelphia, PA

## Prevalence of Incontinence Following a Stroke

Bladder dysfunction occurs commonly after stroke. Within one week, more than half of stroke survivors have some form of bladder dysfunction. While this number may seem alarming, the number of stroke survivors with bladder dysfunction decreases significantly over time. In fact, after a year has passed, only 15% of stroke survivors require some intervention for bladder dysfunction. Post-stroke urinary incontinence has been associated with death, poor functional outcome, and institutionalization. Because some stroke survivors remain incontinent after their strokes, incontinence is a major factor when deciding to place the patient in nursing homes or extended care facilities. Incontinence after stroke is associated with severe weakness and immobility, confusion, and problems with communication.

## How does the bladder work?

The bladder receives its nerve supply from the voluntary (somatic) and involuntary (autonomic) nervous systems. The pudendal nerve causes the contraction of voluntary muscles such as the external sphincter and other pelvic muscles. The pelvic nerve supplies parasympathetic input that causes contraction of the bladder and bladder neck, and opening of the internal sphincter. It also sends signals to the brain, giving the sensation of bladder distention and the urge to urinate. The hypogastric nerve is responsible for sympathetic input that prevents

*continued next page >*

## from our guest editors

**Elizabeth Bozeman, MD**, is a private practice based urologist in Spartanburg, South Carolina. She received her undergraduate degree from Emory University and attended medical school at the Medical University of South Carolina in Charleston, South Carolina. She also completed her surgery internship and urology residency training at the Medical University of South Carolina. Dr. Elizabeth Bozeman currently serves as the director of the Continence Center of Spartanburg, and she practices at The Urology Center of Spartanburg. She serves on NAFC's Project Advisory Panel and is a frequent lecturer on incontinence and its causes and treatments. She is in practice with seven other urologists, one of whom is her husband, Gary.

**Betsy Omeis, RN, B.S.N.**, is currently the coordinator of the South Texas Pelvic Floor and Bladder Center, which is housed in the University of Texas Health Science Center San Antonio-Department of Surgery-Division of Urology. Ms. Omeis received her Bachelor of Science in Nursing from the University of Texas at Austin. She also serves as a nurse consultant for Ortho McNeil, an educator for Medtronic, Inc, and a Urodynamics Nurse with Women Partners OB/GYN. Betsy Omeis is a board member of the National Association For Continence and is a member of the Society of Urologic Nurses and Associates (SUNA) and the Wound, Ostomy, Continence Nurses Society (WOCN).

In the not too distant past, any discussion of incontinence was considered taboo. Now with increasing media attention (hasn't everyone seen the "gotta-go" commercials on TV?), people are more willing to acknowledge the problem and seek care. Unfortunately, much of the attention centers on women. When is the last time you saw an article about pelvic floor exercises or treatment options for incontinence in a male friendly magazine such as Newsweek or Sports Illustrated? Men, who commonly suffer from incontinence due to overactive bladder, benign prostatic hypertrophy, stroke, or previous prostate surgery, have been virtually ignored. All too often we see men in our offices wearing "feminine hygiene pads" because they are not aware of the multitude of other products and treatments available. The goal of NAFC is to offer both men and women a source of information to understand the cause of their problems and also encourage them to seek treatment to improve or cure their incontinence. While this issue of Quality Care, like others, strives to help all those who suffer from incontinence, we are particularly interested in making sure our male readers are aware of their options. (See "From the Patients" on page 6) Read, learn, and don't hesitate to call us at 1-800-BLADDER with your questions. ❖

- Elizabeth Bozeman, MD,  
Betsy Omeis, RN, B.S.N.

## *“Bladder Dysfunction After Stroke” continued*

urine flow by contracting the internal sphincter (alpha) and relax the bladder (beta). It also transmits pain and temperature signals to the brain.

## Bladder problems following stroke

Because the bladder and its sphincters are muscles, they can become flaccid or spastic after a stroke. A flaccid bladder can cause urinary retention and incontinence if the bladder becomes too full. A spastic bladder can cause urinary frequency, urgency, and incontinence. Spasm of the sphincters can worsen any of the symptoms, while flaccidity of the sphincters will worsen incontinence.

## Diagnosing the problem

Evaluation of bladder dysfunction should begin immediately after a stroke occurs. Goals of evaluating and treating bladder dysfunction include adequate bladder emptying at low pressures, prevention of infection, adequate urine storage without distention, adequate bladder control, social acceptability, and vocational acceptability. Usually, an indwelling catheter is inserted into the patient upon admission to the hospital so that fluid output can be monitored closely. As soon as the patient is medically stable, the catheter should be removed. Once the catheter is removed, urination patterns should be monitored. Post-void residuals should be monitored with a bladder scanner or with catheterization to determine whether the bladder is emptying properly. A urinalysis and urine culture may need to be obtained if there is a suspicion of a urinary tract infection. Bladder volumes should measure no more than the normal bladder capacity, which is 200 to 400 cc.

If a more detailed examination of bladder dysfunction is required, a urodynamic examination may be necessary. The urodynamic examination involves filling the bladder with water while bladder pressures are monitored. At the same time, an electrode can monitor the electrical activity of the sphincters to see whether they relax when the bladder contracts. If further examinations are required, cystoscopy can be performed to examine the anatomy of the bladder. Cystography can be performed to determine the presence of reflux from the bladder to the kidneys.

Once the types of bladder dysfunction are identified, management of the bladder can effectively rid symptoms of urinary frequency, urgency, and incontinence. Management of the bladder can be divided into two categories: failure to empty and failure to fill. Failure to empty the bladder occurs when the hypotonic or atonic detrusor cannot effectively contract, or when the internal or external sphincters do not relax simultaneously

when the detrusor contracts. Failure to fill the bladder occurs when the hypertonic detrusor contracts spontaneously, or when the internal or external sphincters are not contracted at rest.

## Medications

Medications are one means by which bladder dysfunction can be managed. There are medications used to treat the bladder that does not adequately fill: oxybutinin, probantheline, hyoscyamine, tolteradine, and ephedrine. And there are medications used to treat the bladder that does not adequately empty: bethanechol, prazosin, terazosin, oxazosin, baclofen, dantrolene, and tizanidine. While medications are being adjusted, post-void residuals should be monitored to insure that bladder volumes remain normal.

## Management Techniques

Physical measures may also be helpful in managing bladder dysfunction. The most common intervention used is timed voiding, in which patients are toileted on a regular schedule. The purpose of timed voiding is to empty the bladder before involuntary contractions occur. Timed voiding is a good technique for patients with cognitive deficits, but it requires someone to remind the patient to urinate periodically.

Other methods of stimulating the bladder to empty include stroking or tapping the bladder to cause the bladder to contract. The patient may bear down (Valsalva maneuver) or press on the bladder (Crede maneuver) to mechanically push out urine. Continuous intermittent catheterization (CIC) may be used to keep urine volumes less than 500 cc at regular intervals if the patient cannot spontaneously urinate. If all other interventions fail, an indwelling catheter may be placed to allow continuous bladder drainage.

## Surgical Treatment

Surgical interventions also may help to decrease outflow obstruction or prevent urethral erosions. Transurethral sphincterotomy or stenting may help to open a spastic or narrowed sphincter. Cystostomy (surgical incision into the bladder to establish a temporary opening) or suprapubic catheter (a catheter inserted above the pubic arch) may provide long-term access when an indwelling catheter is not adequate.

The diagnosis and treatment of bladder incontinence is systematic, and is easy to initiate when there is good knowledge of the anatomy and function of the bladder. With good management and family support, the majority of stroke survivors may remain continent. The maintenance of continence results in the prevention of medical complications and maximization of function and quality of life. ❖

## LINKS

### **NSA** National Stroke Association

Founded in 1984, National Stroke Association (NSA) is the nation's preeminent voice for stroke and has grown to be a leading resource on stroke for the public and professional communities. NSA is a national, non-profit health organization that dedicates 100% of its resources to stroke.

Here are some ways NSA is taking the lead in high-impact stroke education, aggressive prevention, acute care, and recovery programs.

- **Stroke Smart** magazine
- Year-round public awareness programs, including "Ask Your Doctor" and National Stroke Awareness Month in May
- Advocacy efforts to improve public health resources for stroke education and patient care programs across the country

- Collaborative efforts that will enhance acute stroke treatment
- Professional education programs/symposiums such as the North American Stroke Meeting
- Website – [www.stroke.org](http://www.stroke.org) receives nearly 4 million hits each month
- National 800 number; 1-800-STROKES
- Public service campaigns including television, radio and print
- Registry of over 900 stroke support groups
- Implementation of the first-ever consensus statement of guidelines for stroke prevention, published in the Journal of the American Medical Association (JAMA)

NSA has enlisted the assistance of affiliate groups across the nation and established a broad network of grassroots outreach. NSA is also supported by the Stroke Center Network, an alliance of clinicians, researchers, and health care providers from some of the nation's best hospitals. ❖

For more information, visit [www.stroke.org](http://www.stroke.org) or call **1-800-STROKES**.

## A HEALTHY BALANCE

### Smart Exercise after Stroke

#### **Richard Macko, M.D.**

Department of Neurology and Gerontology  
Baltimore VA Medical Center  
Baltimore, MD



Stroke is the leading cause of disability in the United States. Each year, 750,000 Americans suffer a stroke, two thirds of which are left with neurological deficits such as paralysis, that persistently impairs function. For many stroke survivors, this leads to reduced activity levels, which worsen disability as a result of physical deconditioning. The lack of exercise can worsen or lead to diabetes, heart disease, and may increase the risk for another stroke. This has led to public health consensus statements by the Surgeon General and the National Institutes for Health promoting regular activity for all Americans to improve cardiovascular health and fitness. Unfortunately, no such formal recommendations exist for those that have suffered a stroke.

Conventional stroke rehabilitation is important for the recovery of daily living activities, but includes little formal exercise and usually ends within 3 - 6 months. This is because recovery is widely considered to be limited to within the initial 3 - 6 months after the stroke. Researchers at University of Maryland are investigating a new "task-oriented exercise" model that challenges this time window. Based on new discoveries that task repetition is crucial for learning after brain injury, we have

combined repetitive motion training with aerobic exercise to improve cardiovascular fitness and walking function after stroke. In this program, participants with hemiparesis (paralysis on one half of the body) are provided progressive aerobic walking exercise on a special treadmill under close supervision. Remarkably, initial findings show that the exercise training appears to help rewire critical brain pathways to improve leg strength, walking function and balance, even years after the stroke. This brings new hope that stroke survivors can fight back against the disability of stroke with exercise, no matter how long it has been since they completed their conventional rehabilitative care

While such promising therapies combining task-repetition with exercise are still experimental, there are many ways that stroke survivors may improve their neurological function and fitness levels after conventional rehabilitative care has ended. It is increasingly recognized that disuse of a partially paralyzed arm or leg will worsen neurological disability, as well as promote physical deconditioning. Simply increasing daily activity using the affected limb(s) may improve recovery and enhance the benefits of any ongoing rehabilitative care. We have found that stroke survivors with hemiparesis are half as fit and require nearly twice as much energy to walk, as their walking is inefficient. Both are improved by aerobic walking exercise training. For many stroke survivors, a simple program of exercise, such as walking, may increase cardiovascular fitness and stimulate better leg function. Stroke survivors, no matter how many years have elapsed since their stroke, are recommended to discuss with their health care providers a plan for safe and medically supervised exercise to reduce their neurological disability and improve their cardiovascular health. ❖

## BOTTOM LINE

### What is fecal incontinence?

**William E. Whitehead, Ph.D.**

Co-Director of UNC Center for Functional GI & Motility Disorders, at Chapel Hill, NC



#### What is fecal incontinence?

Fecal incontinence is passing fecal material (bowel movement) when you don't intend to. Although, this can happen to anyone if they have bad diarrhea, we diagnose it as a medical problem only if it happens repeatedly in someone who has a mental age of at least four years.

“Skid-marks” on your underwear: Is that fecal incontinence? For every person who passes actual fecal material in their clothes, there are 6-10 others who just stain their underwear. This is a milder form of incontinence, which has different causes than losing fecal matter. It can usually be eliminated by medical treatment.

#### Accidentally passing gas: Is that fecal incontinence?

Most people pass rectal gas up to 20 times per day. This can be very embarrassing, but it happens so frequently that most doctors would not call it fecal incontinence. However, your doctor can sometimes help you reduce the odor or the amount of gas you pass.

#### What causes fecal incontinence?

- Hemorrhoids or rectal prolapse (bulging of the rectal lining through the anus) may cause minor incontinence by making it hard to clean up or by blocking the sphincter muscle from closing completely.
- Diarrhea, especially when there is a strong urge, can cause fecal incontinence. Patients are more likely to have fecal incontinence if they have ulcerative colitis, Crohn's disease, or infectious diarrhea, and about 20% of patients with irritable bowel syndrome have occasional fecal incontinence because of diarrhea.
- Constipation can cause fecal incontinence, especially in children. A large amount of hard bowel movement in the rectum can cause the involuntary sphincter muscle to remain open, and liquid or soft bowel movement can leak out.
- Childbirth injuries. During childbirth, there is a tremendous stretching of the muscles in the pelvic floor, which can damage the nerves or tear the sphincter muscles.
- Diabetes mellitus. Fecal incontinence can result from injuries to the sensory nerves, which tell us when the rectum is filling up and when we need to squeeze the sphincter muscle. This may

happen after you have had diabetes a long time, or it can be caused by spinal cord injury or stroke.

- Ulcerative colitis or radiation treatment can cause the rectum to lose its elasticity and become stiff. This makes fecal material shoot through the rectum too quickly for us to squeeze the sphincter muscles to prevent leakage.
- Dementia and difficulty in walking or undoing buttons or zippers can also contribute to incontinence.

#### Who has fecal incontinence?

About 2% of people living in their own homes and 45% of nursing home residents have fecal incontinence. It is 20 times more common in nursing homes because many people enter a nursing home as a result of having fecal incontinence. Fecal incontinence is more common in children and in the elderly than it is in young and middle-aged people. Among children, boys have it more often than girls, but in adults, it affects equal numbers of men and women.

#### How is it diagnosed?

Your doctor can often tell if your fecal incontinence is related to constipation or diarrhea just by asking you questions and examining you. However, if this examination suggests that there is a different cause, two tests can help your doctor choose the best treatment:

- Anorectal manometry. This test measures the strength of the anal sphincter muscles as well as testing the elasticity of your rectum and your ability to feel when your rectum is full.
- Anal ultrasound. This is a test of the thickness of muscles surrounding the anal canal; it is used to identify patients with a tear in the anal sphincter muscles.

#### How is fecal incontinence treated?

- Imodium or other antidiarrheal drugs are used when fecal incontinence is related to diarrhea.
- Laxatives combined with a daily schedule to try to have a bowel movement is effective in about 60% of patients with constipation-related fecal incontinence.
- Pelvic floor exercises can be used to strengthen weak sphincter muscles.
- Biofeedback helps patients learn how to squeeze their sphincter muscles or improve their rectal sensation by using machines to monitor how well they are doing.
- Surgery: The simplest operation is to sew the ends of a torn sphincter muscle together. Other techniques involve creating a new sphincter by wrapping a different muscle around the anal canal or putting in an artificial sphincter. ❖

Reprinted with permission from the UNC Center for Functional GI & Motility Disorders, at Chapel Hill, North Carolina, from autumn 2002 “Digest.” To receive a copy of “Digest,” email [donna@med.unc.edu](mailto:donna@med.unc.edu).

## PERSONALLY SPEAKING

### Some Caregiving Advice

**Katherine Oliver** has been nursing since 1957. She worked in New York for many years, and in 1995 she relocated to Charleston, SC, where she worked at Bishop Gadsden and at the Franke Home. She began working at Southern House Calls last year in February.

**Q: What are your primary duties as a caregiver?**

A: I assist the patients with their meals, baths, medications, exercises, and getting dressed. But I also encourage them to do for themselves.

**Q: And how do you encourage them?**

A: Let the patient know that you'll help them, talk to them, but encourage them to do as much as they can for themselves.

**Q: Tell me more about the caregiver's role when assisting the patient with exercise.**

A: The therapists give the patients certain exercises to do, and the caretaker, should maintain those exercises at home. If the patient does not practice their exercises, they're not going to get better.

**Q: How do you care for patients who have no functional ability?**

A: Keep them comfortable, clean, and dry.

**Q: What are some signs to alert a caregiver that a patient may be incontinent?**

A: Medical history may tell you that the patient is incontinent, but

sometimes, the caregiver has to look for it: check them after they eat. . .check periodically to see if they are dry.

**Q: How do you discuss incontinence with your patients?**

A: Sometimes they are ashamed and embarrassed because they can't control incontinence. They feel let down, but I tell them there are other people living with incontinence too.

**Q: What are some ways to manage a patient's incontinence?**

A: At home, the caregiver can appoint certain times to go to the bathroom, especially after the patient eats. If the patient uses a walker or wheelchair, get the furnishings out the way so there is easy access to the bathroom . . . The patient should wear loose clothing, so that they are comfortable and able to use the bathroom easily.

**Q: What are your suggestions for hygiene and odor control?**

A: The patient must remain clean. You need to sterilize the bathroom, the toilet, and the area where the patient sits. Whether they void in their bathroom, chair, or bed, keep the area clean, odor-free, and dry. ❖

For additional information, contact these organizations:

**American Society on Aging**

[www.asaging.org](http://www.asaging.org)  
1-800-537-9728

**National Institute on Aging**

[www.nih.gov/nia](http://www.nih.gov/nia)  
1-800-222-2225

Consult the NAFC Resource Guide for products, services, and supplies, which members can view online at: [www.nafc.org](http://www.nafc.org).

## A COLLECTIVE VOICE

### Unique Workgroup Forms to Develop Recommendations for Assisted Living

**Karen Love**

Founder and Chair, Board of Directors, Consumer Consortium on Assisted Living

The Assisted Living Workgroup (ALW) formed in August 2001 at the urging of the U. S. Senate Special Committee on Aging when then-chair Sen. John Breaux (D-LA) asked a group of assisted living stakeholders to develop recommendations to ensure consistent access to quality care for assisted living residents. Sen. Larry Craig (R-ID), the present committee chair, is also very committed and supportive of this effort.

A broad-based coalition of national organizations formed voluntarily to develop these recommendations. The participants in the ALW are a strong, diverse cross-section of relevant interests and expertise in assisted living, ranging from assisted living nurses, activity professionals, consultant pharmacists, physicians, social workers, dietitians and administrators to providers, ombudsmen, regulators, consumers and consumer advocates, pioneers, and individuals with disabilities.

The adopted goals of this innovative work effort were to develop recommended guidelines for state regulations, federal policy, and facility operations. To meet these goals, the ALW created seven topic groups: Resident Rights and Facility Ethics; Direct Care; Operations; Medication Management; Staffing; Affordability; and Accountability and Oversight. Eventually one hundred and one recommendations were passed.

In a letter to the ALW, dated August 15, 2002, the Special Committee on Aging expressed the need for the effort to develop a strong and clear definition of assisted living. Section one includes the main text of the definition. Section two addresses single occupancy, and the final section addresses levels of care in assisted living.

After an 18-month effort, the majority of the ALW participants are pleased with the degree of agreement that has been achieved, given the many different perspectives involved. As is expected in any effort to reach consensus, not all organizations agree with all the recommendations. The strength and value of the report will be both the consensus reached on the majority of the recommendations and the explanations of the divergent opinions expressed in the supplemental positions. ❖

## FROM THE PATIENTS

By Elizabeth Bozeman, MD & Betsy Omesis, RN, BSN

**#1. I am embarrassed to ask about this problem, but I've noticed that I leak urine after I have just emptied my bladder. My pants show spots as a result. I don't even want to use the restroom in public places for fear others will see the leakage. What can I do about this? I feel like a little boy again.**

We call this urinary leakage, which occurs just after emptying your bladder, "postvoid dribbling" (PVD). This is not truly urinary incontinence and is usually created from small amounts of urine trapped in the urethra after voiding. As the sphincter muscle relaxes along with the prostate, this small amount of trapped urine dribbles out. Postvoid dribbling is one of many symptoms of benign prostatic hypertrophy (BPH). Beginning usually in the early 40's, a man's prostate gland, which wraps around the male urethra, begins to grow. This growth is normal, but in many men it begins to cause symptoms such as a decreased force of urinary stream, increase in urinary frequency, nocturia, hesitancy, and difficulty emptying your bladder. Often these symptoms respond to a medication or if severe may even require a simple outpatient surgical procedure.

**#2. Why do I find that in my 60's, I need to get up several times during the night to urinate? It almost feels like I am urinating more at night than during the day. What can I do about this? Will this grow progressively worse? Already, my quality of sleep is being hampered.**

Nocturia is the medical term for arising from sleep to urinate. This is a common symptom of BPH as described above. Women suffer from nocturia too and since they don't have a prostate there are obviously other causes as well. Interestingly, as we age, we tend to produce more urine during the night than we do during the day. This is in part due to loss of our blood vessels' ability to efficiently pump blood from our extremities to the kidneys. When we lie down flat at night, the blood can better circulate and the kidneys work "overtime."

Sleep often becomes lighter as we grow older and sometimes we awaken because of a sound or even a dream and then realize we could empty our bladder. Often the bladder diary, measuring intake of fluids as well as output, will help find the cause of nocturia. Causes could include an increased intake of fluids in the evening hours, especially caffeinated beverages or alcohol. Once the cause of nocturia is identified, steps can be taken to reduce or eliminate it.

**#3. I am only in my early '50's but I'm finding myself with sudden urges to empty my bladder like I've never experienced before. Is this a natural part of growing older? What's the cause? Is there something I can do to curb the urge?**

Sudden urges to empty your bladder could be caused by bladder irritants such as soda, tea, or coffee, a bladder infection, or a bladder tumor or stone. This gives you an increased sense of urgency. Another possible cause in men could be an enlarged prostate. The prostate enlarges and starts to close up the tube that empties from the bladder. This could lead to retention of urine and thus an urge to empty. When these urges are felt, you can do a Kegel exercise (a pelvic muscle exercise) by contracting your rectum as if not wanting to pass gas. These could be practiced on a daily basis. The NAFC has information on Kegel exercises. Be sure to see your health care professional to make sure of the correct cause.

**#4. I've heard there are certain foods and vitamins that help protect men from prostate cancer. But, are there certain foods and vitamins that help protect us from an overactive bladder?**

Yes. There are some foods and fluids that may irritate the bladder and cause urgency and frequency to empty. These are sodas, coffee, tea, alcohol, caffeine, carbonated beverages and acidic foods such as tomatoes and lemons. Eliminating these bladder irritants from your diet may reduce an overactive bladder. For a complete list of bladder irritants, contact NAFC. ❖

### Would you tell your story?

As a national consumer advocacy organization, local and national media often ask NAFC to provide the patient's point of view. We like to accommodate these requests whenever possible because we want the word to spread that incontinence impacts the quality of life and effective treatment options are available.

In response to these requests, we are seeking to develop a consumer media contact list. If you would be willing to speak with a media representative regarding incontinence and/or treatment, please contact NAFC at **1-800-BLADDER** (1-800-252-3337). We will then contact you for additional information. Please know that NAFC will never release your name and contact information without your prior approval.

## IN THE SPOTLIGHT

# The Book Nook

By Nancy Muller, NAFC Executive Director

With the abundant number of books on retail shelves covering pregnancy and childbirth, one would think that everything women need to know about pelvic health had been written. Perhaps so, until the advent of **Pelvic Health & Childbirth**, by Magnus Murphy, MD, and Carol L. Wasson (Prometheus Books, 2003). Since the leading factor for the development of pelvic floor dysfunction in women is vaginal delivery, much more needs to be understood by women of all ages about the high risks of pelvic floor injury sustained during childbirth. Childbirth is also a leading causal factor of urinary and fecal incontinence, sexual dysfunction, chronic pelvic pain and sagging, and protruding pelvic organs. Nerve and tissue damage, follow-up surgery, and a progressive discussion of vaginal birth versus elective cesarean are all covered in detail by Murphy and Wasson.

Its contents empower the reader to make informed choices about both a birthing plan when pregnant, as well as subsequent care and treatment, even years later, for injury sustained in the life-giving event of pregnancy and childbirth. The foreword by Linda Brubaker, MD, is an essay worthy of reading by itself.

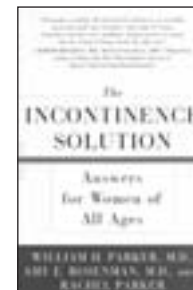
This summer another book on pregnancy, **Ever Since I Had My Baby**, by Northwestern University urogynecologist Roger P. Goldberg, MD, MPH, will be published (Crown Publishing Group, 2003). It provides a newly expanded perspective on reproductive health, by illuminating a number of often-overlooked connections between obstetrical events and their gynecological repercussions. Whether you are an expectant mother or already a mother, this book will enhance your ability to make informed decisions regarding your birth plan and help you know what to expect in the years that follow childbirth. The author clearly illustrates the anatomical change that is the most common culprit of stress incontinence during or after childbirth: weakening of the vaginal wall that lies beneath the urethra. Thinning and weakening of the walls of the urethra is also discussed so that the different treatment options can be more readily understood. Pelvic prolapse is discussed in detail, as are the use of and potential problems associated with pessaries. The book has important tips for restoring satisfaction, sensation, and self-confidence with sex after childbirth. The reader is delicately but factually



prepared for pelvic reconstructive surgery as well as apprised of emergent technology and therapies such as radio-frequency therapy, implantable devices, botox injections, acupuncture and percutaneous tibial nerve stimulation. Dr. Goldberg makes an otherwise complex topic very accessible to the reader.

**The Incontinence Solution** (Simon & Schuster, 2002)

written by William H. Parker, MD, Amy E. Rosenman, MD, and Rachel Parker, gives a straightforward explanation of causal factors for all types of female incontinence and related disorders that women suffer from over their adult lives, along with surgical and non-surgical treatment options. The chapter on diagnosis is superb for its completeness, clarity, and simplicity. This book answers those questions so many women typically have about “what’s normal.” The illustrations enable the reader to easily grasp every explanation along the way. Descriptions of surgical procedures are concisely presented without embellishment or unnecessary encumbrances for the reader. Because its contents are so accessible, I keep a copy of **The Incontinence Solution** on my desk should a telephone call from a consumer warrant a simple but clinically astute answer to an otherwise complex question.



Canadian physiotherapist Kelli Berzuk, PT, has just published, through the assistance of Nova Physiotherapy & Sports Fitness Clinic, a serious and thorough treatise on pelvic floor health and rehabilitation with her first book, **I Laughed So Hard I Peed My Pants!** (2002). The author lends extraordinary warmth and insight to discussing the value of the pelvic floor muscle functionality – sphincteric, supportive, and sexual – so that women of all ages can be motivated to protect and strengthen this essential element of their health. When a 30-second explanation of how to properly “do a Kegel” isn’t enough – and for the majority of all women it isn’t enough – this is the handbook to have for encouragement and instruction. In understanding what the pelvic floor was designed to do, Kelli Berzuk’s book allows women to better grasp how to keep the pelvic floor muscles functional. There is ample coverage on relaxation techniques, toileting posture, urge delay techniques, and much more.



While none of these books is intended to be a substitute for medical attention from trained professionals, the education and encouragement they provide enable the patient to participate in the care equation herself. While future research and concepts may lead to changes in some of the ideas presented by the authors, these four books provide a reliable arsenal of resources for women to direct the course of their own pelvic health. How refreshing!❖

## FROM THE HEADQUARTERS

Dear Reader,

As I write you from our new home in Charleston, South Carolina, it is fitting to share the chief reasons for having selected "The Holy City" for our headquarters.

While not the sprawling Texas Medical Center nor the monolithic campus of the Mayo Clinic, Charleston is considered a medical Mecca for thousands of patients and healthcare professionals. Here, we have access to a wide variety of patient populations, whether they are being treated for prostate cancer, cared for as post-partum OB patients, or rehabilitated following a stroke. In addition, we have access to educators in nearby schools of medicine, nursing, pharmacy, physical therapy and public administration. One of the largest and finest VA hospitals is in Charleston, as well as South Carolina's Geriatric Education Center. This puts us in closer proximity to experts for authoring articles, partnering for research, and collaborating on educational initiatives.

Yet another reason for our relocation is the fact that Charleston is a destination city, a lovely and hospitable environment for workshops, meetings, and conferences. This will allow us to better utilize our entire staff for event planning and management, without the added expense of traveling elsewhere every time we wish to host a happening.

Above all, we've been received warmly by the Greater Charleston community. I am grateful to BellSouth as a corporate partner for opening up its headquarters to accommodate our offices and to South Carolina Electric & Gas for its grant to cover moving expenses.

In the months ahead, you will be seeing the inaugural edition of DISCOVERIES, a new publication spotlighting the latest advances in research, therapies, and forthcoming product innovations for incontinence and related voiding dysfunction. Our website is being expanded to house new sections on stress urinary incontinence (SUI), overactive bladder (OAB), and benign prostatic hyperplasia (BPH). And several new handbooks for nurses are heading to press, including a pocket guide for supervisors in extended and adult day care.

How do we accomplish these monumental tasks? Only with your donations. Subscriptions to our newsletters cover just that: printing and postage and related production expense. Our outreach and new programs need your underwriting. I thank you in advance for your support of our endeavors, which are designed for so many others who, like you, need these resources. ❖

**- Nancy Muller, Executive Director**

## Susie Slone – A Tribute to a Generous Heart

**Lisa Brown**

Director of Program Development

Susie Goodwin Slone began volunteering her time at the Spartanburg, South Carolina headquarters of the National Association For Continence nearly 15 years ago. And until the recent relocation of the organization's headquarters to Charleston, Susie was a welcome and regular addition to the NAFC office.

Whether it was stuffing envelopes, data entry, assembling educational packets, or even answering the phone, Susie did it all with an accuracy that was never questioned. Susie's qualities as a volunteer are impressionable on anyone who works with her. Her dedication to the NAFC and the late hours she put in with us were tireless. Susie's volunteerism is just one of her many admirable qualities, but more importantly, I want to give tribute to Susie as a person.

Susie, one of seven children, was born in 1923 in Spartanburg, where she lived until the mid-1940s when she moved to Dayton, Ohio with her husband Sterling Slone, Sr.



Susie and Sterling enjoyed 42 years of marriage and were blessed with a son, Sterling, Jr., who later married Carol and together, had a daughter, Cynthia. Susie continued to live and work in Dayton, even after her husband died in 1984. When Susie retired, three years later, she returned to Spartanburg where her remaining siblings resided. Susie remained extremely close to her sisters and brothers, visiting often and taking family vacations together. Although Susie's siblings have all passed away now, Susie has continued to be a compassionate and strong source of support for her many nieces and nephews.

Susie's generous heart extends well beyond her family and NAFC to her friends, neighbors, fellow church members, and even strangers. In the fifteen years that I have personally known her, I've never heard her say an unkind word to, or about, anyone. I have often told Susie that she is the type of person I want to be "when I grow up." I am confident that she has touched all that have crossed her path in a positive, if not inspirational, way. ❖



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## Looking Forward...

Stay tuned for these upcoming articles in our next quarterly issue of **Quality Care**.

### In Focus

- Post Menopausal Women--the pelvic floor and SUI

### Special Features

- Job loss and Urinary Incontinence
- Coping as a Caregiver
- Report from National Women's Resource Center
- Latest Recipients of NAFC's Continence Care Champion Awards
- Risk factors and treatment of Rectal prolapse
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<sup>1</sup>R.A. Bologna, A. Gomelsky, J.C. Lukban, L.M. Tu, A.S. Holberg, & K.E. Whitmore, *Urology* 57-6A, 119-120, June 2001 (Abstract)

# National Association For Continence

The National Association For Continence is the world's largest and most prolific consumer advocacy organization dedicated to helping people who struggle with incontinence and related voiding dysfunction. In its third decade, the NAFC's mission is focused on public education and awareness, collaboration to disseminate information, and advocacy on behalf of the estimated 25 million adult Americans who suffer with incontinence.



## NAFC products & services:

- **Quality Care** newsletter (quarterly)
- **Discoveries and Resource Guide** to Incontinence Products & Services
- Books and Audio visuals
- Information Brochures and Programs
- Annual Membership, including a variety of benefits and discounts
- The NAFC website: [www.nafc.org](http://www.nafc.org) has advocacy links to D.C. and detailed coverage on Stress Urinary Incontinence, Overactive Bladder, and Benign Prostatic Hyperplasia.

## Did you know?

- An estimated 25 million Americans suffer from bladder control problems.
- Young people are affected too: athletes, young mothers, those with certain illnesses and birth defects.
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**Quality Care** is a quarterly newsletter for members of the NAFC.

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**Annual subscription rate:**

\$25 (Consumer Membership)

\$100 (Professional Membership)

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**Quality Care** is funded by member subscription fees and by industry sponsors whose products appear in this publication.

Readers who wish to obtain references supporting research statistics that are quoted in an article should contact the article's author.

The NAFC is a not-for-profit 501 (c) 3 organization broadly funded through consumer and professional memberships, individual contributions and grants from industry and private foundations.

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