

## **Karen Matthews: Report from Cairo**

### **International Continence Society 38<sup>th</sup> Annual Meeting 20<sup>th</sup>-24<sup>th</sup> October 2008 Cairo Egypt**

I would like to thank Conni for the second prize in the 2007 Conni Award. I put the prize towards the costs of attending the ICS 38<sup>th</sup> Annual Meeting in Cairo October 2008.

No trip to Egypt is complete without experiencing the ancient wonders and The Jewel of the Nile Tour was a magnificent experience. We marveled at The Pyramids, and even scrambled into the burial chamber of Khafre . Each ancient site brought another wonder such as the Temple at Kom Ombo where we saw the full moon rise. Abu Simbel is an ancient and modern marvel as it was moved during the construction of Lake Nasser.

Several other incredible things about Egypt were the people, 80 million and increasing by 1.7 million annually, in a country with next to no rainfall, only habitable because of the Nile.

(However it rained in Cairo on the last day of the conference, which had everyone racing for cameras and made the trip back to the hotel interesting). Incredible also was the traffic, I cannot describe the chaos nor how pedestrians cross the multi lane roads, waiting for a gap to move.

The Meeting was held at the International Conference Centre, Cairo. We caught the buses provided to and from our hotels each day and to the dinner at the Conference Dinner at Giza where a Sound and Light Show was held at The Pyramids in our honour.

I have chosen to report on the two Educational Courses I attended.

**“The Burden of Continence in the Elderly: Taking a Different Approach”**. Speakers emphasised a good assessment is needed for best management. Depression, impact of dementia, medications, past experiences and voiding pattern should be considered.

Dr Adrian Wagg, a geriatrician from the UK spoke on the **Preferences of the older person when receiving treatment**. Management is mainly incontinence pads, medications, indwelling catheter or behavioural

interventions such as scheduled toileting, habit training and prompted voiding.

However he referred to a number of studies where what was prescribed is not necessarily what the patients preferred.

Was the patient consulted or was the decision made by the physician, nurse or a relative? Presume competence of the patient, on their continence management. Research has shown patients prefer non invasive strategies such as scheduled toileting and medications. Decisions need to be made with the patient at the centre of the care planning.

Dr Wagg also stated the question of “aged” is arbitrary.

(One piece of research presented at the Meeting suggested that nocturia does not contribute to falls, however the average age of participants in the study was 68 years).

Dr Wagg also spoke on “**The pathophysiology of lower urinary tract in older people**” with discussion on nocturia its causes and management including insomnia and sleep hygiene. Nocturia is the most bothersome of lower urinary tract symptoms and the associated risks including falls, daytime somnolence and impact on spouse. “Insomnia in older men is a predictor for institutional placement”.

Professor Mary H. Palmer from USA delivered a talk on **Nursing Interventions for Caregivers**. The presentation was on primary, secondary and tertiary prevention strategies. Primary prevention interventions for someone at risk of incontinence include, maintain mobility, control pain, enhance toilet access, education of all involved, control chronic conditions and monitor medications. The importance of maintaining mobility, Prof Palmer suggested, is very important and may be more important than the influence of dementia. She also commented “there is a fatalistic attitude towards incontinence in elderly by carers”.

Mandy Wells who chaired this session also presented on **Dementia and urinary incontinence-evidence based interventions for frail elders “The Carers Perspective”**. There is very little research in this area. But the 2003 study by Liz Watt and Colin Cassells was described as seminal by the presenter.

One USA study showed that men with an incontinent wife are at a greater risk for depressive symptoms. There was no change for women who were carers in the same situation. A French study demonstrated the effects of on the health of care givers. Of 109 carers, 27 carers were taking tranquillisers, 17 sleeping tablets and 3 anti-depressants. And there were the effects on

relationships and finances contributing to the multi-faceted impact on the carer.

The bathroom became the most important place in the house.

## **Educational Course 11**

### **Assessment, Management and Treatment of Lower Bowel Dysfunction**

Presenters spoke of the difficulty people have in discussing bowel problems and the under reporting of this problem. Bowel dysfunction can cover constipation, faecal incontinence or incontinence of flatus, faecal loading and defaecation disorders. The bowel habit diary and use of the Bristol Stool Chart and dietary and fluid intake assist in assessment.

**Dr Christine Norton** told the attendees that even in patients with sphincter trauma, improvements can be made though modifying stool consistency, toilet habit, complete evacuation, psychological coping and toilet access.

Conservative management was described by **physiotherapist Patricia Evans** in order to manage functional constipation. Attendees were shown defaecation techniques/dynamics in order to understand the process.

**Continence nurse advisor, Rona MacKenzie** who works with post-natal women reported research has found under reporting of obstetric injuries. Practitioners who deliver, repair and deliver care are not always aware of the outcome of the event. Urgency of stool and urge faecal incontinence is indicative of external anal sphincter damage. Passive faecal leakage and incontinence of flatus is associated with internal sphincter damage. Rona discussed the recommendations for the diagnosis, management and treatment of obstetric and sphincter injury. Care is individual to the symptoms and needs of the individual, and will include a regular bowel routine and breakfast to take advantage of the gastro-colic response.

**Conservative management of anal incontinence: biofeedback, exercises and electrical stimulation, Julia Herbert, Specialist Continence**

**Physiotherapist**, discussed the causes of faecal incontinence. Again a thorough assessment is essential and discussed, matching what was found physically with the patient's story. Pelvic floor muscle exercises are used but there is little research on the optimum treatment regimen or length of training. A number of other modalities are discussed and combinations may be the answer, including diet, anal plugs and anal irrigation.

**Dr Norton presented on Neurological Bowel Management, Laxatives and Irrigation**, Loperamide is often the drug of choice, titrated to suit the individual. (However liquid Loperamide is not available in Australia). Research has shown rectal irrigation with tap water can improve bowel management in those with spinal cord injury.

The final speaker in this interesting session was **Dr A.M. Abulafi, Consultant Colorectal Surgeon**, who stated the introduction of sacral nerve stimulation (SNS) has had such an impact to the extent it rendered some surgical techniques virtually obsolete. The Stapled Trans Anal Rectal Resection operation (STARR) is a simple operation for obstructed defaecation due to rectocele and rectal intussusception.

The inclusion of a workshop on bowel management was appreciated by the attendees. At the end of both workshops there was keen discussion from the floor.

In conclusion I found the conference very worthwhile and the scientific program educational. It was wonderful to network with health professionals from around the world who share an interest in continence. We shared our personal experiences of bowel management in Cairo.

I recommend that continence nurse advisors take advantage of awards that are on offer in order to extend their experiences.

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