

## From the Founder

### The Way It Was – An Abbreviated Retrospective from NAFC’s Founder

**Katherine F. Jeter, EdD**



The majority of *Quality Care*’s readers remember when we didn’t have cell phones, Velcro, the internet, digital cameras, text messaging, and real time reporting of wars, catastrophes, and natural disasters.

Many of you, however, may take for granted the wealth of information available about bladder and bowel control issues, their treatments and management. Be assured the resources you expect and count on from the NAFC and from companies that manufacture absorbent products, surgical devices, and prescription medications are remarkably recent. Their evolution bears recounting during this 25th anniversary year of the National Association For Continence.

In 1968, I was introduced to the condition called incontinence by Dr. John K. Lattimer, Professor and Chairman of the Department of Urology at Columbia-Presbyterian Medical Center in New York City. He was a man before his time and recognized the social embarrassment and limitations that resulted from the absence of bladder control. Children could not go to public schools if they were not “toilet trained.” There were no absorbent products or devices to help them manage their condition. They were required to attend schools for the mentally and physically handicapped. Men who did not regain urine control after prostate surgery were made to feel responsible for this problem: they had done too much too soon, lifted something too heavy, gone back to work too early or simply had “failed” to recover properly. Dr. Lattimer was adamant that products, devices, treatment, and education were sorely needed. Unfortunately, few urologists shared his interest or concern and fewer companies thought there were enough patients to warrant research or product development.

In 1981, frustrated by the inertia and lack of progress, and now living in South Carolina, I decided to devote time and energy to bringing this subject “out of the closet.” I had learned that Procter and Gamble had developed an adult diaper but that it had not sold when they put it on store shelves in a test market in Boise, Idaho. They were forced to reach their customers by advertising directly to the consumer and sending the product to people’s homes in discreet packaging. The late Abigail Van Buren (Dear Abby) was the one who officially tackled the taboo. She agreed to tell her readers about a new organization called HIP, Help for Incontinent People, and the newsletter I had written. On one day, following the publication of her column we received 19,000 letters. That was more mail than the entire town of Union, SC, where HIP was headquartered, received on that Saturday. Within six weeks we had received 35,000 letters. All but a few were from adults. This was the first they knew that there were others with the same or similar problems. This was the first opportunity they had had to voice their despair, embarrassment, frustration, and desire for care and cure. Many of the headlines for that initial column called it “incompetence” instead of “incontinence.” The media were afraid to assist with feature stories for fear we would use words or terms that would shock their audiences or make them, the writers and newscasters, feel awkward. Even the American Association for Retired People (AARP) refused to help with the education campaign, saying that this was a “downer subject.”

In the 1980s, the manufacturers of Ditropan® (Oxybutynin), one of the very first drugs for urgency and frequency, invited me to visit the National Institutes of Health and the Food and Drug Administration to petition for the right to advertise their medication directly to the consumer on television and in print. Once that drug was approved, it cleared the way for all the advertising of prescription medications we see and hear everywhere.

Shelf space in pharmacies and grocery stores began to be dedicated to absorbent products. Gradually, signs appeared over the aisles to direct customers to the section, and the variety of products was expanded.

We were able to get the telephone number that we wanted when we moved the offices to Spartanburg, SC: 1-800-BLADDER. Audiences snickered and giggled when we told them how to reach us. I reminded them that a doctor's office with a number such as 1-800-HEADACHE or 1-800-KNEEPAIN would not elicit such a response.

HIP, as we called the organization in the beginning to make it easier for people to say and to minimize embarrassment as we chipped away at the stigma, had initiated a cultural revolution. By 1995, when I retired, the American Urological Association had developed many educational courses on the subject of incontinence in children and adults. The American Urogynecologic Society was encouraging gynecologists who wanted to specialize in the diagnosis and treatment of urinary incontinence and pelvic floor disorders in females. Nurses were beginning to dedicate their practices to the non-surgical treatments for bowel and bladder conditions. Senator Robert Dole, a good friend and supporter of HIP, had spoken out frankly about the particular concerns of men after prostate surgery and was instrumental in further demystifying and destigmatizing incontinence and erectile dysfunction. Our *Resource Guide*® featured pages of absorbent products, devices, skin care remedies, and organizations that might be helpful to people. The enduring popularity of this guide is illustrated by the fact that 2008 was the 14th edition.

The time has passed quickly. In my retirement I delight in knowing that the National Association for Continence, as HIP was renamed in 1996, continues to help countless individuals and to serve as an invaluable source of information for the public and for health professionals. Everyone desires to be in good health with body parts that function perfectly. When it is the bowels and bladder that produce symptoms, patients may face many challenges and hurdles before finding the best remedy, but they no longer have to suffer in silence and secrecy. In fact, incontinence can now be casually discussed at cocktail parties and around the water cooler. And the phone number, 1-800-BLADDER, is shared without restraint or ridicule. ❖

*Dr. Jeter has disclosed that she has no financial interests related to this topic.*

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## Minimally Invasive Office Procedure Options for Female Stress Urinary Incontinence

### **RODNEY A. APPELL, MD, FACS**

*Medical Director, Texas Continenence Center of the Vanguard Urologic Institute and Foundation  
Clinical Professor of Urology at Baylor College of Medicine and The University of Texas Health Sciences Center  
Houston, Texas*

Stress urinary incontinence (SUI) in women is associated with urethral hypermobility, meaning the urethra is poorly supported by the pelvic floor. SUI can also be associated with intrinsic sphincter deficiency (ISD) which means the urethra simply does not perform properly. In both cases, a woman can experience urine loss during activities that cause increased intra-abdominal pressure, such as coughing, sneezing, and exercise. Treatment for SUI has primarily involved surgery designed to support or strengthen the urethra and/or to maximize urethral pressure and improve the sphincter's ability to act as a closing valve. However, many women diagnosed with SUI do not proceed with definitive treatment because few options are available that are safe, non-invasive or minimally invasive, provide rapid recovery, and also provide long-term improvement in quality of life (QOL).

With respect to available treatments, non-invasive, non-drug treatment has been primarily confined to pelvic floor muscle training (Kegel exercises); unfortunately, these exercises have limited success in the treatment of SUI. In addition, women who do achieve improvement with these exercises must continue to do the exercises to maintain continence. Injection of bulking agents such as collagen or coaptite are approved for treating ISD, which is far less invasive than most SUI surgery, but may require repetitive treatments to maintain satisfactory dryness.

Surgery is generally considered the most effective means of treating SUI. However, many women are not considered suitable candidates for surgery, such as younger women who wish to have more children or those older than 75 years with other conditions that increase surgical and anesthetic risk. Additionally, many women are hesitant to undergo surgery because they are fearful or because they are unable to take the time off from work or family responsibilities to assure

### **Rodney Appell, MD, FACS**

#### **1948 - 2009**

NAFC is saddened to report that Dr. Rodney Appell passed away suddenly on January 19, 2008, shortly after submitting this article. Dr. Appell, a dedicated urologist and surgeon, served on the NAFC Board from 1989 - 2007, including a term as Chairman, and was recently elected to rejoin the Board for a new term. Insistent that our newsletter be reviewed routinely by clinicians for accuracy in content, he was instrumental in the formation of an Editorial Advisory Panel on which he served for 12 years. He also authored and reviewed numerous articles for *Quality Care*. In 2008, he was recognized as a NAFC Continenence Care Champion – the award will now be known as the Rodney Appell Continenence Care Champion Award. We will miss his longstanding support of NAFC and our mission, remembering him most for his unwavering allegiance to quality and integrity in all choices and his respect for the patient above all else. Our heartfelt sympathies go out to his wife and two sons. To read tributes to Dr. Appell and contribute to a special patient education fund in his honor, please visit our Web site at [www.nafc.org](http://www.nafc.org).



good recovery. Finally, surgeries do have complications and side effects, and they are not 100% effective in everyone. As a result, many women do not wish to take the risk for the proposed benefit.

Another non-surgical option for women with SUI caused by poor pelvic floor support (urethral hypermobility) is the Renessa™ system of radio-frequency (RF) collagen denaturation. (This procedure is NOT an option for the woman with ISD and thus does not compete with injectable bulking agents ) The Renessa procedure can be performed in a physician's office under local anesthesia in less than 30 minutes. A small probe, similar to a catheter, is inserted into the urethra; the probe contains four (4)

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electrodes that transmit RF to the bladder neck and the area of the urethra containing the sphincters. The low temperature heat alters the connective tissue in a way that improves support for the urethra and reduces urethral hypermobility (the tendency of the urethra to drop “out of position” with activities like coughing). The low temperature heat does NOT affect the lining of the urethra or bladder neck so there is no narrowing of the urethra or scar tissue development. Local anesthesia is all that is necessary so a patient can drive herself to the office, have the procedure, and drive herself home. The results of the original clinical trial in 173 patients have been published as well as the three year results, which have demonstrated the durability of the successful treatment. Seventy-four percent of women with moderate to severe SUI receiving this treatment experienced sustained improvement in QOL, and 58% of those treated no longer wear pads.

To date, this non-surgical procedure appears to be an alternative for women with SUI who want a non-surgical, in-office treatment which may provide durable relief of the symptoms of SUI and an improvement in their quality of life. ❖

*Dr. Appell has disclosed that he is a consultant for Boston Scientific Corp; American Medical Systems, Inc; Novasys Medical Inc.; Pfizer, Inc.; Watson Pharmaceuticals; Allergan; and Astellas. He provides grants/research support to SolaceTech; Novasys Medical Inc.; Boston Scientific Corp.; Contura, Inc.; and Pfizer, Inc.*

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## A Historical Perspective of Surgical Treatment Options for Stress Urinary Incontinence in Women

**By Amy Rosenman, MD**

*Geffen School of Medicine at UCLA*



Surgical treatment of stress urinary incontinence has been the mainstay of therapy, particularly in the United States, for many years. While surgery is still generally acknowledged to be the most effective treatment for stress incontinence, the myriad of operations that have been described attests to the fact that there is no one “best” operation for all patients. Even experienced surgeons disagree as to the preferred treatment.

There has been a dramatic change in the number and types of operations for SUI performed on women in the past 15 years. The vast majority of SUI procedures are now one of several different pubovaginal slings (i.e., slings placed in the region of the pubis and the vagina). The basic concept of the sling is that a piece of strong material is placed beneath the urethra as a supporting “hammock.” The sling thus corrects the poor anatomic support of the urethra and may also provide a degree of compression to the urethra.

There are many different sling procedures and the distinguishing features among them have important implications. Slings can be classified by the material used to create the sling, the position of the sling along the urethra, and the route used to place the sling. The most important development has been the use of synthetic slings placed at the middle portion of the urethra, termed “mid-urethral slings.” These operations have primarily been used for SUI patients who have loss of urethral support, also known as urethral hypermobility. These mid-urethral slings are placed loosely and appear to cause fewer problems with urination. Although synthetic materials had been used in the past, the complication rate was unacceptably high; the most common complications were urinary tract infection and erosion, but tissue ulceration, breakdown, and irritation were also reported. However, a number of modifications have significantly improved outcomes; these modifications include newer materials, a needle approach that minimizes cutting, and “tension-free” placement in the mid-urethra. As a result of these modifications, mid-urethral slings have become the

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most popular procedures in the United States and Europe. The TVT (tension-free vaginal tape) has been performed for over 15 years, and an impressive number of reports attest to the 10-year effectiveness. Because the sling is made of permanent, synthetic material, there is evidence that the long-term results are also good. The primary question relates to the very long-term safety of permanent material around the urinary tract and the risk of erosion into the bladder or urethra many years down the road. Like all surgeries for stress incontinence, the mid-urethral sling is not as effective when patients have had prior surgery. A high quality study demonstrated equal effectiveness to the Burch procedure (the former “gold standard” procedure) at six months and superior results at 5 and 10 years. The TVT type procedures are usually easier for the patient; they are generally performed as an outpatient procedure with general anesthesia, or sometimes under sedation with local anesthesia. There are now a number of competitive products offering slightly different sling materials and/or methods of placement.

While a very popular and effective procedure, the route used to deliver the TVT sling does not allow surgeons a full view of the pelvic organs. One increasingly popular technique is a transobturator (TOT) approach, which uses a different incision site that appears to reduce the risk of urethral and bladder injury. There are still other techniques that deliver synthetic slings, which are either meant to lower injury risk and/or achieve greater compression of the urethra.

Suspension procedures can be performed through the vagina or through the abdomen. Although abdominal suspensions are less popular than slings, the Burch procedure is still considered to be a good choice for female patients with stress incontinence especially if it accompanies another abdominal procedure. In the Burch procedure, an abdominal incision is made, the area where the urethra and bladder connect is surgically exposed, and several (usually four) sutures of either permanent or absorbable material are placed next to the urethra at the bladder neck and mid-urethra and tied to a strong ligament nearby on the pelvic bone. This procedure has been used for 50 years with good success and was considered the “gold standard” until the synthetic mid-urethral slings were introduced years ago.

Other procedures of historical interest are the anterior repair, which is performed for a bulging, dropping bladder (a type of prolapse known as cystocele) but is not useful for urinary leakage. If performed in a patient with leakage of urine, it will fail within five years in 65% of women, so it has been abandoned. A needle suspension without mesh was also performed in past years and also abandoned due to unreasonably high (55%) five-year failure rates. There were non-synthetic materials used to provide support, such as cadaveric (human donor tissue) or animal donor tissue. Most of these procedures have been abandoned as the body often reabsorbs these materials over time and the failure rates are higher than with the TVT and TOT. The use of screws and bone anchors has also been abandoned as excessively costly, possibly risky, and with no proven advantage.

Classic bladder neck slings may be appropriate for women who have had previous surgery for incontinence. Autologous tissue (tissue harvested from the patient herself, most often through a low abdominal incision or from the thigh) is often used, but this adds to the complexity and risk of the surgery. It requires both abdominal and vaginal incisions and is technically more difficult for the surgeon than other incontinence procedures. It also requires a longer recovery period for the patient and results in more problems with voiding, or passing urine, than other operations for incontinence. It is, however, successful in properly chosen patients.

In summary, many advances have been made in the field of surgery for stress incontinence. Today we can offer most women procedures that can be done on an outpatient basis and that provide very good long-term results. ❖

*Dr. Rosenman has disclosed that she is a member of the Speakers' Bureau for Pfizer, Inc. She is also a member of the American Urogynecologic Society Foundation Board.*



## The Latest Surgical Options For Male Stress Urinary Incontinence

**DANIEL RAPOPORT, MD FRCS**

*Fellow, Reconstructive Urologic Surgery  
Duke University  
Durham, North Carolina*

Male stress urinary incontinence (SUI) occurs most often as an aftermath of prostate surgery. Approximately 5 to 20% of men whose prostates are removed surgically will experience bothersome incontinence that greatly affects their quality of life. The underlying cause is most often a weakly functioning urinary sphincter (the muscle that surrounds the tube running through the penis from the bladder), but additional factors may also be present. The treatment of male SUI varies from conservative measures such as pelvic floor exercises to surgical solutions. Surgical options include injection of materials to bulk up the tissue in the area of the sphincter (so it closes the bladder neck more completely), artificial mesh slings to compress the urethra, non-compressive slings, and artificial urinary sphincter (AUS) implants.

The AUS implant remains the best option for surgical management of male SUI in many, but not all, patients. Based on many studies of patient satisfaction, it continues to be a highly successful option for many incontinent men. Introduced in its current form in 1983, this three-piece hydraulic system includes a tiny cuff to keep the urethra closed between urinations. It continues to be the “gold standard” procedure to which all others are compared based on its solid track record for almost three decades. However, there are several disadvantages to the AUS. First of all, the patient must manually compress a pump in the scrotum to open the sphincter. In addition, there is the potential for infection or erosion and the risk of injury if urethral instrumentation is required following device placement. Finally, it is likely that surgical revision or replacement will be needed over the life of the device. For these reasons, the procedure is generally reserved today for the most severe cases of incontinence.

Recently, more options for surgical management of male SUI have become available. The male AdVance® sling (AMS, Minnetonka, Minnesota, USA) represents a new surgical alternative for male SUI that provides excellent short-term results in well selected patients, based on clinical experience to date. The AdVance sling is a synthetic material or “tape” made of polypropylene that is placed under the urethra. As opposed to the earlier generation male slings, InVance® sling, the goal of this newer device is not to compress the urethra but rather to elevate and support it. Experts now believe that weak pelvic floor support of the urethra, referred to as urethral hypermobility, may contribute to post-prostatectomy male SUI. It is thought that the AdVance sling provides the needed support to help the urethra remain closed during exercise or straining. The advantages of the AdVance sling as compared to the AUS include a less invasive surgical approach, faster recovery, no need for manual operation of the device by the patient, and no need for revision or replacement of components. Disadvantages include the potential for postoperative urinary retention due to obstruction, infection of the material, erosion of the material into the urinary tract and failure of the therapy for patients with more severe urinary incontinence. The AdVance sling, however, is not considered an alternative or replacement to the AUS. Rather both are options for surgical intervention that are appropriate in different clinical situations. This means that patients need to be classified in specific clinical categories (i.e. mild stress incontinence versus severe stress incontinence) based on their symptoms and circumstances. Since this is a new treatment, there is no long-term data on whether this device is effective or safe over the course of many years.

Several pieces of clinical information are used to guide the decision regarding best surgical approach; these include severity of incontinence (determined by 24 hour pad weight testing), history of previous surgery for incontinence, risks associated with other health problems, history of radiation treatment of the prostate prior to removal, and patient preferences. At present, the general approach for men who are surgical candidates and who have stubborn SUI not responsive to pelvic floor muscle exercises is to divide men between

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the group that would likely benefit from a less invasive approach (e.g. an Advance sling) versus the group better suited to an artificial urinary sphincter. An endoscopic examination of the urethral sphincter may be valuable in determining the most appropriate surgical solutions for an individual patient. An endoscopy is performed by a urologist who passes an instrument into the interior of the urethra for inspection of the tissue. Patients whose urethral sphincters are not scarred appear to be good candidates for surgical support of their own sphincter (the Advance sling). On the other hand, those with a scarred urethral sphincter incapable of functioning may be better managed with “replacement” by means of an AUS implant.

Certainly, many men do not clearly fall into these simplified categories. It is often the case that a patient will have some features that favor one option as well as some that favor another. Also, the clinical factors that predict success with the newer options such as the Advance sling are still evolving. This will continue to be the case for each additional surgical option that appears in the future. It is therefore important for men to be educated about the problem and the treatment options that are available so they can set realistic goals for themselves and make well-informed decisions with their doctor before pursuing any surgical intervention. ❖

*Dr. Rapoport had disclosed that he has no financial interests related to this topic.*

## Financial Health

### THE IMPORTANCE OF ESTATE PLANNING

**Todd Kenney, Esq. , Kuhn & Kuhn, LLC, Charleston, SC**

Many of us have heard the term “Probate,” yet few of us have an understanding of what the term truly means. Probate is the process of re-titling assets. When an individual dies, all of the deceased person’s assets must be taken through this process to obtain title in the new owner’s name. The new owner may be a creditor or a beneficiary of a Will or Trust; if the deceased individual did not have a Will or Trust, the new owner may be an intestate heir. There is a common misconception that a Will avoids probate. This is simply not the case. A Will states who you wish to receive your assets at the time of your death. In contrast, a Living Trust will avoid probate so long as the assets are owned by the Trust.

There are many issues to consider when devising your estate plan; issues of taxation, family law, charitable gifting, and business entities combine with the most personal of family concerns. Attorneys that focus on estate planning are accustomed to this challenge and have experience in assisting their clients with planning to achieve personal and financial objectives. Improper planning could result in your assets not being distributed as you had anticipated. For example, Mary, a recent widow, has three grown children and she wishes to leave her estate to them equally. Her estate consists of a home worth \$100,000; an IRA worth \$100,000; and a certificate of deposit (CD) worth \$100,000. She intends for her home to pass to Child A, Child B is designated as the beneficiary of the IRA, and the CD has been made payable on death (POD) to Child C. Mary is now at ease because she knows

that she has minimized the value of the assets passing through probate and the children will each own one-third of her assets. However, Mary has not considered any debts that she may owe at her death, such as hospital bills or funeral expenses. The IRA and CD will avoid the probate process because they have named beneficiaries. These assets will pass directly to Child B and Child C, respectively, and will not be subject to the probate process. However, any debt that Mary has accumulated before her death will be paid from the share that was to pass to Child A. This could cause the home to be sold and the proceeds from that sale to be distributed to Mary’s creditors, leaving Child A with a lesser share than his siblings, or nothing at all. An attorney who specializes in estate planning can help you achieve your goals while avoiding this type of planning pitfall.

In addition to distributing assets to your children, individuals may also have charitable intent. Giving is always abundant during the holiday season. For example, during the recent holiday season, the average shopper spent more than \$800 on gifts. In addition to purchasing presents for family and friends, many individuals choose to make charitable donations. Gifts made to organizations that qualify as 501(c)(3) not-for-profit public charities, such as the National Association For Continence, are eligible for income tax deductions, so long as there is substantiating documentation. It is always best to consult an estate planning attorney to maximize your tax savings. ❖

# Personally Speaking

I have been receiving the NAFC publications for several years. I find them to be very informative and helpful in supplying information about current medical procedures and medications. They are also helpful when talking to your doctor. In fact, my doctor said it was a relief to talk to an informed patient.

The *Resource Guide*® published periodically is helpful in describing the supplies and equipment available, by mail, to deal with different problems.

These publications are so interesting and so helpful to those of us that must deal with incontinence that I support NAFC financially and encourage others to do the same. ❖

## Irene in California

*Irene is one of the many people who look to NAFC for answers and unbiased information on this common but often-untreated health issue. She, and everyone like her, is the reason we exist – to be a trusted resource for consumers.*

If NAFC has helped you by providing information to determine the type of incontinence you are experiencing, the latest products and treatment options, contact information for a healthcare professional in your area, or just peace of mind that you are not alone and there are solutions, we want to hear from you. Share your story or thoughts on how NAFC has played a part in improving your quality of life.

# A Collective Voice

## Acceso Para Todos – NAFC's Hispanic Outreach Program

Incontinence does not discriminate. It affects men and women of all ages and all races. But not everyone experiencing incontinence – or any health concern for that matter – has the same access to care, the same resources or the same support systems. As NAFC has grown over the past 25 years, so has the need to provide more specialized programming for different populations and to help underserved populations obtain the healthcare answers they need and deserve.

To that end, NAFC began a partnership nearly a decade ago with the Medtronic Foundation to better serve Spanish-speaking communities. The Medtronic Foundation is the primary philanthropic arm of Medtronic, a global leader in medical technology. The Foundation fulfills its mission of improving health by supporting organizations that respect the diverse background and needs of all people and are dedicated to providing patient advocacy, support and information regarding prevention and treatment options.

NAFC felt it was vital to ensure that language and cultural barriers did not keep incontinence information from reaching Hispanics, the fastest growing population in the US. A quick look at the U.S. Census Bureau provides these revealing statistics:

- In 1980, Hispanics accounted for 6.4 percent, or 14.6 million, of the US population. In 2006, Hispanics accounted for 14.8 percent, or 44.3 million, of the total U.S. population.
- From 2000 to 2006, the U.S. Hispanic population accounted for half of the nation's growth.
- From 2000 to 2006, the Hispanic population's growth rate was 24.3 percent, more than three times the growth rate of the total population.

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- South Carolina, home of NAFC's headquarters, experienced the third largest growth rate among all states at 57.4 percent.
- In 2005, the Hispanic population had the nation's highest uninsured rate at 32.7 percent.
- In 2007, more than 16 million Hispanics spoke English "less than very well."

With limited resources, NAFC turned to grant funds to begin a Hispanic Outreach Program. In 2000, NAFC received its first grant from the Medtronic Foundation for \$15,000 and quickly set about translating six of its most popular pamphlets into Spanish. This was to be the first of what was to become four phases.

In 2001, NAFC received a \$61,000 grant from the Medtronic Foundation for Phase II, and began the crucial task of engaging and educating healthcare professionals in the public health trenches. After selectively communicating with health departments across the country, it was evident that there were many professionals working in public health settings who were not fully versed in the topic of bladder and bowel control. To that end, NAFC produced a training broadcast for the CDC's Public Health Training Network about incontinence and its treatment and management options. Linda Brubaker, MD, and Jeanette Tries, MS, OTR, volunteered their time to join Executive Director Nancy Muller in the 90-minute satellite broadcast. The Illinois Office of Women's Health assisted in the production.

In 2005, NAFC received a two-year grant from Medtronic Foundation in the amount of \$120,000 for Phase III; this allowed NAFC to work with an advertising and communications firm to conduct focus groups with Hispanic women in three U.S. cities. From the information gathered in these focus groups, a televised public service announcement targeting Hispanic women was produced and aired through Univision, a leading Spanish-language media company in the United States, along with a print ad provided to newspapers and magazines in targeted cities.

The latest grant from Medtronic Foundation, again for \$120,000, has enabled NAFC to implement Phase IV, designed to dramatically enhance its Hispanic Outreach Program. Key information on the NAFC Web site is now viewable in Spanish, including a video featuring Jake Jacobo, MD, practicing urologist and native Spanish-speaker, answering frequently asked questions about men's prostate and bladder health ([www.nafc.org/espanol/ayude-para-hombres](http://www.nafc.org/espanol/ayude-para-hombres)). Gender-specific and culturally sensitive Spanish pamphlets on incontinence were designed for NAFC by a specialty advertising firm, and NAFC was also able to produce and air TV and radio PSA's targeting Hispanic men, again working with Univision. Perhaps most importantly, a native Spanish-speaking employee was hired to field calls and send out information for Spanish-speaking callers.

In addition to the Medtronic Foundation's generous support, NAFC has also worked with a national advisory task force of clinicians who serve large populations of Spanish-speaking patients to establish its project priorities and tailor its messaging. NAFC also utilizes a task force comprised of other leading consumer education and health advocacy organizations, including the American Diabetes Association, the National Multiple Sclerosis Society, and the National Alliance for Hispanic Health, to guide its efforts building on their experiences and successes.

NAFC is extremely grateful to the Medtronic Foundation for its partnership over the past eight years. NAFC will continue to improve its resources for the Hispanic population by working with community and healthcare leaders across the nation to ensure that Spanish-speaking people know that they are not alone when it comes to incontinence and help is available. Like others in healthcare, NAFC aspires to do its part to close the gap in health disparities facing minority and other disenfranchised populations in our country. ❖

# From the Headquarters: From the Book Bindery

*"This wonderful book by an accomplished specialist in treating incontinence is about far more than just the bladder, however important that elastic, muscular sac might be. Mind Over Bladder: I Never Met a Bathroom I Didn't Like! offers its readers friendly explanations, assurances laced with humor, and empowering guidance for directing a lifelong care plan for their own pelvic health."*

And thus I am quoted for the jacket of urogynecologist Jill Rabin's newly published book for women. Written with former patient Gail Stein, the co-authors fully satisfy their goal of helping women take charge over their condition in order to have control over their bladder for life. Available on [www.amazon.com](http://www.amazon.com), [www.barnesandnoble.com](http://www.barnesandnoble.com), and soon in retail bookstores across America, *Mind Over Bladder* is not like most books about health and self-help. The author-team weaves their own inseparable and personal stories and tips into a direct, no-nonsense text that makes the material accessible, understandable, and memorable. There are plenty of humorous and colorful stories to go around, like the image of one lying completely naked and enjoying a full body massage when the urge to urinate causes a sudden leap from the masseuse's table and sprint to the toilet.

There is also a rhythm to the read that makes it easy to digest, such as *Tech Terms* to take the mystery out of unfamiliar medical terminology, *Do's & Don'ts* to offer practical tips for those uncomfortable situations such as leakage during sexual intercourse, and *Believe It or Not* to draw the readers into a private realm with the authors' lives so they don't feel alone.

Detail is abundant in the explanations but just the right amount. Learn why the majority of those with stress urinary incontinence (SUI) are women, the difference between internal versus external sphincter deficiency, how the delivery of a baby can cause incontinence, and what you're supposed to know and do when you're giving a urine specimen. Included too are entire chapters on topics not normally covered sufficiently in other retail publications, such as the informative one on retention. The chapter on diet and daily habits doesn't just tell you to eat more fiber – something all of us already know. For direction and a sense of options, it gives a list of target foods sourced from the USDA and their fiber content by weight.

While lighthearted when the subject calls for relief, there's no fooling around either. You're told to, "Start doing those Kegels right away and continue doing them forever." The command is followed by a detailed set of instructions on how to do pelvic floor muscle exercises, photos and brand names of aids to help, and encouragement about biofeedback therapy. In fact, the illustrations throughout are terrific, such as the one on how a cystoscope works and what a cystoscopy procedure aims to find out.

For those with overactive bladder, combination therapy is recommended. That means medications combined with bladder retraining and Kegels. Like the rest of the book, this advice is music to our ears at NAFC and echoes our mantra.

While surgery for SUI and prolapse is discouraged until non-surgical remedies have all been tried and failed, the guidance on finding an appropriately trained and experienced doctor is spot-on. With objective explanations of surgical procedures, the book is balanced and sure-footed.

As if all of this is not enough, a rich and extensive glossary and set of references frame its encouraging, concluding remarks. If you (or girlfriend) need a bibliomate, order a copy today.



Nancy Muller

Executive Director

*Nancy Muller has been Executive Director of NAFC since 2000, signaling her entry into the not-for-profit sector. This year marks her 15th year working in healthcare. The first 15 years of her career were spent with W. R. Grace & Co. after she earned her MBA at the University of Virginia. A magna cum laude graduate of Duke University, she is a candidate for her PhD degree in health services research and administration at Virginia Commonwealth University.*

# Continence Care Champion Hall of Fame

Established in 2000 to recognize healthcare providers who excel in the area of diagnosis, treatment, and management, the Continence Care Champion Award raises awareness and elevates the importance of addressing incontinence in clinical practice. Chosen from among nominees ranging from freestanding, private practices to groups of departments working collaboratively across an entire medical center complex, this award recognizes an outstanding clinic or medical institution on the basis of its contributions to research, clinical practice standards, and education in the field of incontinence. For the majority of the awards, individuals are nominated by members of their society and an award recipient is then selected by representatives of NAFC's Board of Directors. However, for awards presented to members of the American Academy of Family Physicians, the process is open nationwide such that practitioners and patients alike may nominate a candidate who is subsequently chosen by a specially selected group from the NAFC Board of Directors.

Beginning in 2009, the award will be known as the Rodney Appell Continence Care Champion Award in memory of Dr. Rodney Appell, long-time NAFC Board member, distinguished urologist and surgeon, and past award recipient.

## **American Urogynecologic Society (AUGS)**

2000	John DeLancey, MD
2001	Linda Brubaker, MD
2002	Donald Ostergard, MD
2003	Peggy Norton, MD
2004	Tom Benson, MD
2005	Lewis Wall, MD, DPhil
2006	Anne Weber, MD, MS
2007	Kathryn Burgio, PhD
2008	Holly Richter, PhD, MD

## **Urodynamics/Society for Urodynamics and Female Urology (SUFU)**

2000	Ananias Diokno, MD
2005	Jerry Blaivis, MD
2007	Edward McGuire, MD
2008	Rodney Appell, MD

## **American Academy of Family Physicians (AAFP)**

2001	Toni Miles, MD
2005	John B. Murphy, MD
2006	Matt Toren Rosenberg, MD

## **Society of Urologic Nurses and Associates (SUNA)**

2002	Diane Newman, RNC, MSN, CRNP
2003	Betsy Omeis, RN
2004	Karen Sasso, MS, BS
2005	Joyce Colling, PhD, RN, FAAN
2006	Cheryl LeCroy, MS, BS

2007 Angela Joseph, MSN, RN, C, CURN

2008 Shannon D. Atnip, MSN, WHNP-BC

## **Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)**

2002	Carolyn Sampsel, PhD
2003	Jean Wyman, PhD
2004	Molly Dougherty, PhD, RN, FAAN
2005	Andrea McCrink, MSN, RP-C, RNC

## **Society of Women in Urology**

2001	Deborah Erickson, M
2002	Jenelle Foote, MD
2003	Kristene Whitmore, MD
2004	Lenaine Westney, MD
2005	Elizabeth Bozeman, MD
2006	Kathleen C. Kobashi, MD

## **American Geriatrics Society (AGS)**

2003	Joseph Ouslander, MD
2004	Catherine DuBeau, MD
2008	Patricia Goode, MD

## **American Physical Therapy Association (APTA)**

2002	Jane Frahm, PT
2003	Cheryl Wisinski, PT

## **National Association of Nurse Practitioners in Women's Health (NPWH)**

2003	Diane Smith, RN
2004	Helen Carcio, MS, BS
2005	Martha Klay, RN, MSN, APRN
2007	Diana Underwood, MS, RN-C, WHNP

## **The Wound, Ostomy and Continence Nurses Association (WOCN)**

2004	Mikel Gray, PhD, MSN, BSN
2005	Marta Lee Krissovich, MS, RN, NP
2006	Katherine N. Moore, PhD, RN

## **Association of Physician Assistants in Obstetrics and Gynecology (APAOG)**

2006	Paul Taylor, PA
2007	Esther McCorkindale, PA-C
2008	Breann Garbas, PA-C

## **Clinic or Medical Facility**

2003	UCSF
2004	UNM
2005	Seton Health

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