

IN FOCUS

Urinary Incontinence in Post-Menopausal Women

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Dr. Sand has disclosed that he has no financial interests related to this topic.

Prevalence of Urinary Symptoms

An estimated 25 million people in the United States are affected by urinary incontinence, but it is estimated that only 15% of consumers will seek medical help for their symptoms. While the most common type of incontinence in women is stress urinary incontinence (urinary leakage with physical stress from activities such as coughing, sneezing, lifting), urge urinary incontinence (involuntary urine loss associated with urgency) becomes more prevalent as women age, with a majority of post-menopausal women reporting mixed symptoms. These conditions have a significant effect on quality of life, with urge incontinence having a reportedly greater impact than stress incontinence.

Hormonal Changes

The effects of aging produce a number of risk factors for urinary incontinence, including lower estrogen levels, which lead to weakened muscles and tissues. It is unclear as to whether a lack of estrogen is a cause of urinary incontinence. However, without hormone replacement therapy, deterioration or atrophy of the vulva and vagina is common after

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in this issue

A number of conditions can cause voiding dysfunction, whether it be a transient, or temporary, case or one that is chronic. Young women might experience urinary or fecal incontinence after childbirth, men may experience urinary retention due to enlarged prostate, and, as we reviewed in our last issue of *Quality Care*®, neurological disorders, such as spinal cord injury, multiple sclerosis, and Parkinson's disease, may lead to urinary incontinence because of the existence of a neurogenic bladder.

Another common cause of incontinence is due to changes that take place during the aging process. When women age, for example, estrogen levels decrease. This may cause vaginal atrophy, and, consequently, urinary incontinence may develop. In this issue, we will discuss **Pelvic Health in the Post-Menopausal Woman**. Read on to learn about common conditions and their treatments. ❖

menopause, and urethral lining thickness has been shown to directly parallel vaginal lining thickness. It is believed that with thinning of the urethral lining comes an increase in urgency, frequency, and discomfort during urination. There are estrogen receptors in both the urethra and the bladder. The use of estrogen therapy has been controversial in the treatment of urinary incontinence, with some studies finding no changes in quality of life or incontinence episodes. However, estrogen supplementation has been found to subjectively improve symptoms of urgency and frequency.

Receiving Proper Diagnosis

Overactive bladder (OAB) is defined by the International Continence Society (ICS) as “urgency, with or without urge incontinence, usually with frequency and nocturia.” Because many of the symptoms of OAB, which can lead to urge incontinence, and urinary tract infections (UTI) overlap, it is essential to rule out a urinary tract infection in someone who first presents OAB complaints before initiating treatment. Likewise, it is also essential to document urinary tract infections in someone who is being repeatedly treated for frequent UTI's, as an OAB may in fact be the true cause of their complaints. By better recognizing the relationship between OAB and UTI's, women suffering from these symptoms can be better diagnosed and treated.

Be Prepared

Initial evaluation of post-menopausal women with urinary incontinence should include a complete medical history, physical examination with careful pelvic examination for vaginal weakness, prolapse of the uterus and vaginal walls, and urinalysis. A “Pap smear” of the urine should also be considered in those patients with microscopic blood in their urine. A voiding diary for 24 to 48 hours recording the number of times one urinates, the amount urinated, oral intake, and the frequency and character of leakage episodes can also provide useful information for both the physician and patient.

Visit our Online Store at www.nafc.org or call 1.800.BLADDER and request a copy of our bladder diary to keep track of your voiding patterns to share with your healthcare provider.

UTI, bladder cancer, weakness of the vulva and vagina, medication-induced side effects, not being able to empty the bladder, and psychological factors are all conditions which need to be ruled out. Testing needs to be done to demonstrate the urinary leakage and understand why it occurs. For women who complain of stress urinary incontinence (SUI), this may be as simple as a “stress test,” where the woman is asked to cough and strain with fluid in the bladder to observe whether any fluid leaks out at the same time she does this. Sometimes it is necessary to measure the pressure inside the bladder during filling in women who have urge incontinence (UUI). However, this process is difficult outside of a specialist's office.

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Chronic Pelvic Pain in Women

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Ms. Frahm has disclosed that she has no financial interests related to this topic.

Chronic Pelvic Pain Defined

According to the National Institutes of Health Conference in April 2002, chronic pelvic pain (CPP) is a complex and troubling problem that can significantly block many aspects of the quality of life of women.

In order for pain to be called chronic, it must have been present for six months. Typical characteristics of chronic pain are:

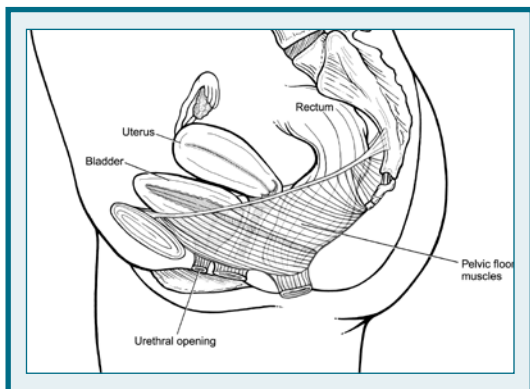
- Incomplete relief by previous treatments
- Pain out of proportion to tissue damage
- Loss of physical function
- Signs of depression
- Altered family dynamics, such as the joy of sexual intimacy

Pelvic pain may be located in the lower abdominal or pelvic regions of women and can include the internal and external genitalia (vagina and vulva). Pelvic pain encompasses a broad spectrum of painful conditions that may result from surgery or other medical problems.

Chronic pelvic pain (CPP) is not a widely publicized condition. Sixteen percent of 5,325 women in a recent Gallup poll reported problems with pelvic pain. Of this sixteen percent, 11% limited activity at home because of CPP, 11.9% limited sexual activity, 18.5% took medication, and 3.9% missed at least 1 day of work per month.

What Are the Causes?

Hysterectomy, surgical removal of the uterus, or womb, through the vagina or through an abdominal incision, and laparoscopic (abdominal) surgery, exploratory abdominal surgery through a small incision usually in the area of the navel, are two procedures that can result in chronic pelvic pain in some people. This is rare. Other conditions that could lead to CPP are: Uterine fibroids – benign tumors of the uterus. You don't have to keep repeating "womb" once you indicate it is an interchangeable term for uterus. The single most common indication for a hysterectomy, fibroids may cause pelvic pain and irregular vaginal bleeding. Treatment is usually surgical removal of the fibroids.



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Some other causes of chronic pelvic pain are:

Endometriosis – growth of endometrial cells (cells that line the uterus) outside the uterus. Endometriosis is the leading cause of pelvic pain and the leading reason for laparoscopic surgery and hysterectomy in the US. Treatment is hysterectomy or hormonal suppression of endometrial tissue growth.

Interstitial Cystitis a disease that involves chronic inflammation of the bladder wall, which can lead to scarring, ulcerations, and bleeding. Patients suffer frequent and painful urination, urinary urgency, difficulty urinating and resultant pelvic pain. Interstitial cystitis can also affect men (diagnosed as “prostatitis”), but women predominate. Treatment includes medications that help restore or soothe the inflamed lining of the bladder. Some are instilled directly into the bladder. Other medications work on decreasing nerve irritation. There is also sacral nerve stimulation, using the implanted device InterStim®. Patients may benefit from pelvic floor muscle relaxation training as well.

Vulvodynea – a chronic diffuse, unremitting sensation of burning of the vulva, including the labia, clitoris, and vaginal opening. The main symptom is pain or the sensation of burning, irritation, or rawness of the genitalia. Treatment options include medications, nerve blocks, and steroid injections into the painful area at the vaginal opening. Pelvic floor muscle retraining with emphasis on relaxation is also effective.

Vestibulodynia – a painful condition that may involve the entire vestibule or entrance to the vagina on one side of the vagina -or the clitoris – clitorodynia. It may be painful only when touched, making intercourse painful or prohibiting it completely. This type of vestibulodynia is called vestibulodynia provoked. There is also vestibulodynia non-provoked, which is painful all the time. It is the most common cause of painful intercourse in young women. Treatment options include medication, nerve blocks, steroid injections into the painful area at the vaginal opening. Pelvic floor muscle retraining with emphasis on relaxation may also be used.

If you experience pelvic pain, please discuss the problem with a healthcare provider who will help direct you to the proper treatment. Visit www.nafc.org to use our Find An Expert service or call us for an alternate referral to an expert, if you are not satisfied. ❖

National Women's Health Resource Center

Celebrating 20 years of service, the National Women's Health Resource Center is dedicated to providing health information about a wide variety of topics that concern women. The organization gives helpful tips about maintaining a healthy lifestyle regarding continence, weight management, osteoporosis, pain management and many other areas. Log onto www.healthywomen.org or call (877) 986.9472 to get informed today!

Clinical Trial Underway for OAB

NAFC is committed to doing everything in our power to ensure that individuals receive quality continence care. In carrying out our mission, we are constantly looking for ways to increase the scope of information we have available to the public and establish new methods of communicating our messages. Our goal is to supply you with easily accessible information so you feel fully equipped and comfortable to take action. You can play an integral role in your well-being. One way we can help you take control is to provide you with information about clinical trials that are taking place.

One research study you may be eligible for now, a phase III international multi-center clinical trial, is the Dignity Study. This study will determine the effectiveness and safety of an investigational minimally invasive procedure for controlling symptoms of overactive bladder (OAB) in patients with spinal cord injury or multiple sclerosis (MS).

Individuals with a spinal cord injury or MS often develop a neurogenic bladder, which is loss of bladder control caused by damage to part of the nervous system. This neurogenic bladder causes OAB, or symptoms of frequency and urgency that may include urge incontinence. Allergan, Inc. has developed a treatment that is being tested for its ability to cure or manage urinary incontinence that occurs in people with OAB specifically caused by spinal cord injury or MS. In a previous medical research study conducted by Allergan, the investigational procedure involving an injection into the bladder reduced the frequency of urinary incontinence in subjects being studied. The material injected and under study is Botulinum toxin type A.

Qualified participants will have had a spinal cord injury or have been clinically diagnosed with MS and experience incontinence due to an OAB. Potential participants will be evaluated to further determine their eligibility based on additional screening criteria. For participants, the investigational study injections, medical exams, and lab tests will be provided for free.

Interested? Visit www.dignitystudy.com or call 1.888.61.STUDY (1.888.617.8839) to complete a questionnaire to determine if you might qualify to participate.

This announcement and information about other clinical trial research related to the diagnosis and treatment of bladder and bowel control problems, voiding dysfunction including retention, nocturnal enuresis, and related pelvic floor dysfunction are now incorporated on the NAFC Web site. For more information about this study and other clinical research available, visit the Clinical Trial page in the Bladder and Bowel Health section at:

www.nafc.org/bladder-bowel-health/finding-help

Or call 1.800.BLADDER. ❖

I am currently going through menopause and lately, I have experienced some incontinent episodes. From what I have read, I think I am affected by stress urinary incontinence and urge incontinence (or perhaps overactive bladder). I have begun to do pelvic muscles exercises, and notice that I can keep from having leakage, but the urgency is still there. I realize I should talk more with my healthcare provider about this, but wanted to get your feelings first, so I am equipped to ask the right questions. My main question is whether problems with incontinence during menopause improve once through the “change of life?”

First of all, good for you! By including pelvic floor muscle exercises in your daily routine, you are taking steps to improve your strength and overall pelvic floor health. However, there are many factors that could be contributing to why your body is not responding to the PME, or “Kegel” exercises. Firstly, you want to make sure you are doing them correctly and often enough. You should begin with a set of five fast and 20 slow contractions, twice per day. If you already do that and are comfortable with them, you can add to that gradually at your own pace. Make sure you listen to the signs your body is giving you. You want to be committed to this exercise plan, but don’t overdue it!

NAFC has a popular leaflet that explains what pelvic muscle exercises are and how to correctly do them. Visit the NAFC Online Store at www.nafc.org or call 1.800.BLADDER to request a PME leaflet.

As far as incontinent episodes improving after menopause, you should talk with your healthcare provider in more depth about what is causing your particular type of incontinence. You may be experiencing vaginal atrophy (explained in the article on the opposite page), which is common after menopause. However, everyone’s situation differs based on health history, current health conditions, and how an individual’s body responds to a given treatment. Talk to your healthcare provider about the symptoms you are having and the two of you should be able to start a management or treatment plan that works best for you.

From what I can tell, I have finished going through menopause. It has been 12 consecutive months since my last period. During the past few months, I have noticed vaginal dryness, which I never have experienced in the past. Is this related to menopause? What can be done for vaginal dryness after menopause?

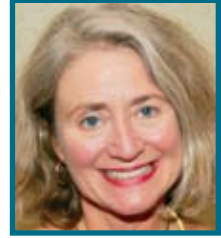
Vaginal dryness is common during and after menopause. Although this may be somewhat uncomfortable, especially during sexual intercourse, the dryness should not alarm you. In fact, simply applying a water-soluble lubricant such as Astroglide® or K-Y® Jelly to the skin’s surface can treat it. If this does not remedy the problem, talk to your gynecologist about your concerns. ❖

Vaginal Estrogen Therapy for Urogenital Atrophy

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Ms. Muller has disclosed that he has no financial interests related to this topic.



What is Urogenital Atrophy?

The organs concerned in the production and excretion of urine, together with the organs of reproduction, comprise the urogenital system in women. Loss of estrogen after menopause contributes to a thinning of the tissues lining the vagina. This is called “urogenital atrophy” and is derived from the Greek word for “wasting away.” Nearly half of all post-menopausal women experience symptoms of urogenital atrophy related to the bladder, including: recurrent bladder infections, urinary frequency and urgency, nocturia, and painful urination, or “dysuria.” Other symptoms include: vaginal burning, watery vaginal discharge, vaginal dryness, uncomfortable or painful sexual intercourse, and itching of the vagina and surrounding external organs including the labia. Unfortunately, it is estimated that only about one-fourth of all women experiencing symptoms seek medical attention.

Oral Hormone Replacement Versus Vaginal Estrogen

In the 1990’s many physicians routinely prescribed oral hormone replacement therapy (HRT) to treat urinary incontinence (UI) and guidelines by some professional associations were circulated promoting its use. However, a large, government-funded 2005 study found that not only does systemic HRT not relieve UI in postmenopausal women, estrogen (when taken alone) actually doubles the risk of UI in women who do not have symptoms before starting HRT. For those who do, symptoms are likely to worsen.

Immediately following news of this well-publicized study, many women automatically questioned the safety and effectiveness of local, low dosage estrogen administered vaginally for any symptom of urogenital atrophy.

Specifically in connection with improvement in symptoms of UI, studies remain limited. Research in Germany published in 1992 claimed topical estrogen as a “cornerstone” of effective treatment of stress (SUI) and/or urge UI in the postmenopausal woman. It documented quality of life improvement in 72% of subjects, reduction in frequency by almost 50%, and an improvement in urgency in 80%. Subjective improvement in symptoms of SUI was equally as dramatic. In the last few years, a study in Italy was published examining the benefit of vaginal estrogen therapy in postmenopausal women in preventing the post-operative onset of urgency and frequency, or “overactive bladder (OAB)” following the TVT sling procedure for SUI. Prior to surgery, the baseline rate of OAB in research subjects was 7%. In patients receiving

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vaginal estrogen for 6 months postoperatively, the incidence of OAB was only 4%, compared to 32% in those not receiving any vaginal estrogen therapy.

While considerably more research is needed to confirm such benefits for UI, the fact remains that local estrogen therapy is routinely and successfully being used safely in postmenopausal women for treating many symptoms of urogenital atrophy. Systematic overviews of multiple studies on the subject consistently find improvement in subjective assessment of symptoms associated with urogenital atrophy. Considered a therapeutic standard, it is particularly helpful in addressing dryness, burning/itching, and painful intercourse. For recurrent bladder infections, estrogen therapy is more effective than daily antibiotics because of its ability to restore the natural pH of the vagina that combats the growth of unwanted bacteria (bacteria from the rectal area known as uropathogens) causing infection.

Options are in the form of a vaginal cream, tablet, or ring that releases estrogen over a 3-month period before being replaced. Well-tolerated, these are all FDA-approved therapies, with few systemic effects. Generally, 4-12 weeks of therapy are needed for symptoms to resolve. Symptoms will return, however, in 4-6 weeks if therapy is discontinued.

For women treated for non-hormone-dependent cancer, management of urogenital atrophy is similar to that for women without a cancer history. Women with a history of hormone-dependent cancer should discuss their symptoms and preferences with their oncologist. For additional details, consult the North American Menopause Society at www.menopause.org. ❖

NOTEWORTHY NEWS

Medicare Policy Change Makes Life Easier

In a recent U.S. Medicare policy change, effective April 1, 2008, individuals using intermittent catheters are not forced to re-use them. Instead of Medicare covering only four catheters per month, the new policy states that now individuals can get reimbursement for single-use catheters. Therefore, individuals who use intermittent catheters can now use a new, sterile catheter each time they empty their bladder without the worry of where funding will come from to cover them.

This has been a much anticipated decision especially for people who rely on catheters to void such as individuals who live with neurological conditions such as spinal cord injury, multiple sclerosis, Parkinson's disease, or spina bifida. The re-use of catheters is a known contributor to urinary tract infections, which can be extremely uncomfortable, not to mention a costly. NAFC and other supporters of this policy change, such as Coloplast, want you to make the most informed decisions about your health as possible. To learn more, please visit:

www.coloplastmediakit.com/catheterpolicy ❖

Exercise and Stress Urinary Incontinence

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Dr. Nygaard has disclosed that he has no financial interests related to this topic.

The Facts

Stress urinary incontinence (SUI) refers to leakage of urine that occurs during physical activities, such as coughing, sneezing, walking, and lifting. The fact that many women who have SUI lose urine during exercise is not surprising given the impact exercise may have on the pelvic floor. Unfortunately, leakage leads many women with SUI to give up exercising.

However, for women who do not have major problems with urinary incontinence, leakage during exercise is still common. In one study, almost a third of middle-aged recreational athletes were incontinent during exercise. Exercises that involved repetitive bouncing, such as aerobics or running, were most likely to provoke incontinence. One-fifth of women who exercised recreationally stopped exercising because of incontinence.

Leakage during exercise is not limited to middle-aged women who have borne children. In several studies, over one-quarter of young college varsity athletes or physical education majors who had not undergone childbirth reported some leakage while participating in their sport. Of interest, while 67% of gymnasts reported some leakage, only 10% of swimmers (a much lower impact activity) did so.

Even younger girls can be affected. In a Danish study, the majority of girls between 13 and 16 years participating in competitive trampoline jumping demonstrated objective evidence of urine leakage while jumping. In another study, 31% of active physical education students reported occasional urine leakage, compared to 10% of the least active nutrition students. However, these women were equally likely to have occasional incontinence in other activities of daily life, regardless of whether they were athletes or not. This suggests that exercise does not cause incontinence by damaging structures, but more that the high intensity of exercise exceeds a woman's continence threshold.

Continence Threshold

This continence threshold is a theoretical concept that states that each woman has some innate level of force that her pelvic floor is able to withstand before leakage occurs. This threshold may be influenced by obesity, congenital or hereditary factors (such as muscle mass) or by acquired factors (such as neuropathy from childbirth or medications like alpha-blockers that decrease the urethral closure pressure).

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A Possible Predisposition

Many factors can predispose a woman to leak during exercise. A major consideration is the dynamic impact of her internal organs. With jumping or similar exertions, the pelvic floor has to withstand over 25 pounds of force from the viscera, or internal organs, slamming down on it. The feeling that some women get of something slamming down on their bladders when they jump off a stepping stool or curb is not far from reality!

At least some force to the pelvic floor gets propagated through the feet. Young athletes with more flexible feet (feet more able to absorb shock) are less likely to report leakage during sports than those with less flexible feet. It is also possible the pelvic floor muscles (also known as the “Kegel” muscles), like other skeletal muscles, fatigue during prolonged activity.

Finally, preliminary evidence suggests that collagen type and content in connective tissue may differ between women with pelvic floor disorders, like incontinence and prolapse, and those without these problems. Thus it is possible (but not confirmed) that the same collagen make-up that enables a gymnast to be extremely flexible may also predispose her to incontinence or prolapse.

Setting the Record Straight

Are women who exercise strenuously at risk of developing clinically significant incontinence later in life? Two facts suggest that the answer to this question is no. First, as noted above, athletes who lose urine during sports are not more likely to have leakage during daily life sorts of activities (like coughing or walking) than athletes who do not leak urine. Second, in a recent study that questioned female Olympians who competed 20-30 years ago, those that participated in high-impact sports (gymnastics and track) were not more likely to have more severe incontinence today than women who competed in lower impact swimming.

What should the incontinent exerciser do? Most importantly, she should not stop exercising! This becomes especially vital in middle-aged and older women. We know that being overweight is associated with incontinence, and we know that exercise is an important component of all weight loss programs. Thus, if incontinence keeps a woman from exercising, she is in a vicious cycle. Furthermore, recent information from the Nurses Health Study indicates that women who participate in mild to moderate exercise (such as brisk walking) are less likely to either have or to develop urinary leakage than women that are sedentary.

Available Treatment Options

While some women cope well by wearing pads during exercise, or by changing from high-impact to lower impact exercise, there are many other treatments available. Pelvic muscle strengthening (consistent and dedicated “Kegel” exercises) has been shown to cut down or

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... A Healthy Balance

stop leakage during exercise. Several studies have also examined the role of vaginal devices and urethral inserts in women with incontinence during exercise. Both are very effective and allow women to exercise without fear of leakage if they have mild stress incontinence. Finally, for women whose quality of life is impaired by the leakage, surgery can alleviate incontinence in most of the women who undergo it. Women with leakage during exercise who would like to explore various treatment options should discuss the problems with their healthcare provider.



... In Focus

Scheduled voiding (emptying the bladder at regular intervals based on the voiding diary) can be very helpful for both urge incontinence and stress incontinence. Pelvic floor muscle exercises have been shown to be helpful as well, especially for stress urinary incontinence. Sometimes medication is required to treat urge incontinence. If a woman does not respond to this first simple treatment, there are numerous other things that can be done to treat the condition. If a patient does not respond to conservative therapy or has more complicated conditions such as urinary retention (not being able to empty the bladder), blood in the urine, or a suspected neurologic cause of incontinence, referral to a urogynecologist or urologist should be considered for more complete testing. ❖

Preventative Health Screenings for Women Over Age 40*

Bone Health

Bone mineral density test	At least one test at age 65, earlier if you are at risk of developing osteoporosis
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Breast Health

Mammogram (x-ray of breast)	Every 1-2 years beginning at age 40
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Colorectal Health

Fecal occult blood test	Annually beginning at age 50
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Colonoscopy	Every 10 years starting at age 50
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Rectal exam	Every 5-10 years beginning at age 50 with a colon cancer screening
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Reproductive Health

Pap test and pelvic exam	Should take place every 1-3 years after having vaginal intercourse, and should begin no later than age 21
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* U.S Department of Health & Human Services, available at www.womenshealth.gov/screeningcharts

Talk to your healthcare provider about other screenings to put on your calendar.

FROM THE HEADQUARTERS

One of the greatest advocacy battles that we at NAFC fight is over the absence of the consumer's wishes, i.e., the patient, in choices about coverage and access to options in care and treatment. One of the ways we can help bring more solutions – that are also safer – to the table of options is to do our part to lower the cost of research.

A primary element of cost is clinical research to satisfy FDA requirements for releasing new drugs. On-going research is also needed after drugs and devices are in the marketplace to verify their safety once in widespread use. This research is part of post-market surveillance, an aspect of safety that is receiving heightened interest and attention, for good reasons.

The Center for Information & Study on Clinical Research Participation reports that there are approximately 50,000 clinical trials taking place in the U.S., but 80% are delayed a month or more because of unfulfilled enrollment. One out of every four volunteers drops out of a study after they have begun participation. The National Cancer Institute reports that less than 5% of cancer patients participate in clinical trials. If only 10% participated, studies could be completed in one year, instead of the 3-5 years that studies currently require.

Who is not participating? Although 61% of new cases of cancer occur among the elderly, only 35% of participants in cancer clinical trials are elderly, according to the Journal of Clinical Oncology. The AARP reports that approximately 20% of participants in all drug clinical trials are over age 65. The numbers are more dismal for minorities, who comprise over one-third of our entire population but who represent only 8% of participation in clinical trials. Such a disparity prevents the findings from research to be representative of the whole population.

Lack of such generalizability hurts the reliability of the data, leaving those segments vulnerable to adverse events. This can lead researchers to reach misguided conclusions. While a recent nationwide poll found that 94% of people recognize the importance of participating in clinical research, the Institute of Medicine tells us that very few patients are even aware they are eligible to participate. The next time you visit your doctor, ask what research is underway by his or her group or institution for solutions associated with bladder or bowel control problems, voiding dysfunction, or prolapse.

One of the most valuable aspects of being an American is that very sense of believing in the future and what is possible. Never give up believing in new solutions. Participate in clinical trials that aim to bring answers that help others...and possibly yourself.

I'm pleased that NAFC is now listing on our web site studies underway by leaders in the field of continence care, underwritten by Allergan.



Nancy Muller
Executive Director

