



Paris
24-28 February 2012



13th International EAUN Meeting, 25-27 February 2012
In conjunction with the 27th Annual EAU Congress

Programme Book



eaun

European
Association
of Urology
Nurses

Before you get there...
We have simple solutions for your
Safety!!



Workshop

Safety in urinary catheterisation.
Transurethral and suprapubic
drainage.

Sunday 26 February 2012
8:30 – 10:30
Room Havane Level 3

Welcome to the B.Braun session, with a unique safety concept in urinary catheterisation. The aim is to provide to patients and healthcare professionals global solutions to prevent Urinary Tract Infection in urinary catheterisation. Following the latest guidelines this workshop will give an overview about safety procedures including the challenges in reducing urinary nosocomial infection rates. Enjoy the session!

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B | BRAUN
SHARING EXPERTISE

Paris
24-28 February 2012



All sessions showing the webcast symbol will
be available online at www.eauparis2012.org
and in the EAU Resource Centre



European
Association
of Urology

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Welcome to the City of Light

Dear Colleagues,

It is a great pleasure to welcome you to Paris for the 13th International Meeting of the European Association of Urology Nurses (EAUN), organised with the wonderful support of Mrs. Abir Daif and Prof. Henry Botto from Suresnes, France.

For this year's programme, we have put great effort into offering a programme that will be attractive for nurses from *all specialties* within urology and in *different levels* of practice. This variation is found for example in the four workshops on Saturday morning (e.g. *Urodynamics* or the multi-approach workshop on the *Transfer of incontinent patients from home to hospital and vice versa*) and in the ESU courses.

To acknowledge your request from last year to not only learn how the latest EAUN guideline was produced, but also *what was concluded* from the literature, for the first time we have programmed a full two hour session on the topic of the guideline *Indwelling catheters in adults* with presentations by the authors themselves.

The EAUN has changed the Nursing tools workshop to a market place setup. We are interested to hear whether you like this interactive setup of the workshop with the topic Tools to *optimise nursing care in cancer patients*. In small groups you will be able to discuss nursing care aspects in cancer, such as exercise, erectile dysfunction, spinal cord compression and nutrition in this Sunday morning session supported by Amgen. Attendance is restricted to make this an intense learning experience!

There are several other important issues on the agenda, to name a few: Dr. Talli Taylor from London will lecture on *Assessment and management of osteonecrosis of the jaw* in cancer patients while Dr. Peggy Sau-Kwan from Hong Kong will give an update on *Ketamine-associated ulcerative cystitis, a new clinical entity*. Do not miss out!

New this year is the organisation of two ESU-EAUN courses on Sunday, one on *Urinary infections* and one on *How to write an abstract and make a poster*. The European School of Urology (ESU) has selected a top faculty for these courses to explain, in Course 1, how to structure an abstract, and in Course 2, give state-of-the art advice on how to prevent and handle UTI and urosepsis, including health care associated infections in different settings.

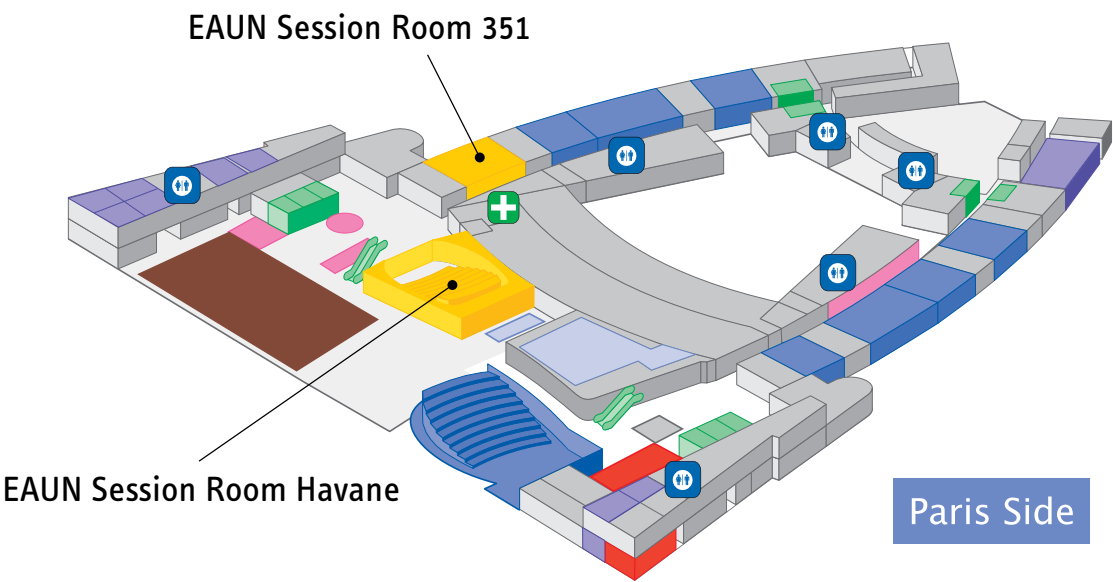
We also invite you to the classic *Welcome Reception* which will be held in Foyer Bordeaux after the Saturday programme; a good opportunity to catch up with old and find new friends. And don't forget to join the other social events in our programme such as the popular Urowalk and the EAUN Nurses' dinner in Quartier Latin!

The board looks forward to a very successful meeting, due to your high attendance and enthusiasm!



Level 3

Neuilly Side



Colour explanation

- Speaker Service Centre/Presentation Training Centre
- Session rooms
- Registration
- Press Area
- Meeting rooms
- Publication Area
- Elevators/stairs/escalators
- Toilets
- First Aid



General

General Information
Speaker Guidelines

General information

Abstracts

More than 1,193 EAU abstracts have been accepted for presentation during poster and video sessions at the 27th Annual EAU Congress in Paris. The EAU Abstract CD 2012 will be distributed to all congress delegates by FERRING PHARMACEUTICALS (booth 2M110 on level 2 in the exhibition). All abstracts and PDFs are available online at www.eauParis2012.org. The EAU Poster DVD 2012 will be distributed to all congress delegates by AMGEN (booth 1P73 level 1 in the exhibition).

The EAU Poster DVD 2012 is supported by an unrestricted educational grant from AMGEN
The EAU Abstract CD 2012 is supported by an educational grant from FERRING PHARMACEUTICALS

Access to the Session Rooms

Seating is regulated on a first-come, first-served basis. We recommend delegates to go to the session room well in advance of the session. Due to safety regulations, the organisers will close the access to the session room when all seats are taken. It is not allowed for delegates to stand in the aisles of the rooms.

Address and Accessibility Congress Centre

Le Palais des Congrès de Paris is easily accessible by public transport. The public transport system is easy to use and a very efficient way to get around the city. Congress delegates may collect a complimentary transportation pass in the registration area on level 3, see "Transportation Pass".

Address congress centre:

Le Palais des Congrès de Paris
2 Place de la Porte Maillot
75853 Paris Cedex 17, France

Metro / car parking:

The nearest metro station is "Line 1 – Porte Maillot-Palais des Congrès" which has direct access to the

congress centre. Car parking is available 24 hours a day at the congress centre.

Airport Shuttle Bus

The 27th Annual EAU Congress offers all delegates the opportunity to book a free shuttle bus from the Palais des Congrès de Paris to Airport Charles de Gaulle or Paris Orly Airport. Delegates who wish to use this service need to book at least 24 hours before departure time at <http://supershuttleparis.hudsonltd.net/res?USERIDENTRY=VIPARISEAU&LOGON=GO>. Alternatively, Air France shuttle buses depart next to the congress centre, in front of the Meridien hotel.

App - Your smart congress companion



The EAU Paris App will bring the 27th Annual EAU Congress to your smartphone. The application offers the best mobile overview of this scientific event – with instant access to congress abstracts, exhibition booth locations and the latest news from before, during and after the meeting! The EAUN programme is not (yet) included.

This year you will find a whole new set of features and you won't need internet access to navigate the information. Please, check under EAU 2012 in your App Store to get your smart congress companion.

Award Gallery

The EAU Congress features an EAU Award Gallery. Here you can find a complete overview of all awards that were handed out by the EAU this year. It will also feature information on past winners of the most prestigious prizes. It can be found on level 3 next to the EAU Resource Centre, be sure to visit it!

Badge Tracking System

Congress delegates have a barcode on their badge which enables them to leave their contact details with exhibitors in a quick and easy way. The barcode will also be scanned at the entrance of the session rooms to gather CME and statistic information.

Congress Hours

	Speaker Service Centre	Registration	Exhibition
Saturday, 25 February	07.00-19.30	07.00-19.45	09.00-18.00
Sunday, 26 February	07.00-19.00	07.00-19.30	09.00-18.00
Monday, 27 February	07.00-19.00	07.15-19.30	09.00-18.00

Badges

The badge classification is as follows:

Blue badge	: EAU member
White badge	: Delegate
Brown badge	: Nurse
Green badge	: Exhibitor
Red badge	: Press
Purple badge	: Accompanying person
Pink badge	: Day-, session registration
Yellow badge	: Organising staff

Bank, Exchange and Credit Cards

The national currency in France is the Euro (€). An ATM machine is available in the main entrance hall on level 0. An exchange office is available on level -1 near the Hotel Concorde La Fayette.

Car park

There is an underground car park under the Palais des Congrès which has direct access to the congress centre and is available 24 hours a day.

Certificate of Attendance

A Certificate of Attendance for the 13th International EAUN Meeting can be printed via the EAU website after the congress. You will need your registration number (under barcode on your badge).

Cloakroom / Luggage

The cloakroom is located in the foyer of the eURO Auditorium on level 0,5 and open during congress hours. Please be sure to collect all personal belongings at the end of the day.

Congress Bag

In the registration area, each delegate can collect a congress bag and an EAU and an EAUN programme book.

The EAU congress bags are sponsored by ASTELLAS

Daily Congress Newsletter: European Urology Today Special Edition

Special daily congress newsletters are available on Saturday 25, Sunday 26 and Monday 27 February. The first edition contains the Exhibition Overview.

The newsletters will also be available online at www.eauParis2012.org during and after the congress.

EAU Congress Office

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General information

EAU Education Office (European School of Urology)



The European School of Urology (ESU), working with European faculties, aims to provide high quality international educational courses in urology. The ESU has a special booth on level 3 (Hall Bordeaux) with extensive information on its activities. Registration for the courses can be made at the ESU registration desks at level 3. An ESU Courses CD 2012 will be distributed at the EAU desk next to the MILLENNIUM: THE TAKEDA ONCOLOGY COMPANY booth (booth 2M13 on level 2 in the exhibition) to all congress delegates.

The ESU Courses CD 2012 is supported by an unrestricted educational grant from MILLENNIUM: THE TAKEDA ONCOLOGY COMPANY

Fees ESU Courses (for congress registered delegates only)

	2 hrs.	3 hrs.
Residents and nurses (members/non-members)	€ 21.00	€ 21.00
<i>Prices are excl. VAT</i>		

EAUN ID Card

The EAUN ID Card functions as a membership card for all EAUN members. The card can not be used for registration purposes.



EAU Board

Chair: K. Fitzpatrick, Dublin (IE)

Vice-chair: B. Thoft Jensen, Århus (DK)

Secretary: W.M. De Blok, Amsterdam (NL)

Board members:

L. Drudge-Coates, London (UK)

V. Geng, Lobbach (DE)

U.L.M. Haase, Nieuwegein (NL)

S. Hieronymi, Frankfurt (DE)

Temporary board member:

S. Vahr Lauridsen, Copenhagen (DK)

EAU Square

The EAU Square (booth 1N03 on level 1 in the exhibition) consists of the EAU/EAUN Membership Booth, EBU Corner, ESRU Corner, EAU Milan 2013 Promotion Counter, Clinical Research Office and the EAU Historical Exhibition.

There is also information on European Urology and other EAU publications. The EAU/EAUN Membership Booth provides information on membership status and membership benefits. Non-members are welcome to visit the EAU Square for further information and to apply for EAUN membership.

Electricity

The electricity in France runs on 220 volts and the frequency is 50 Hz. Plugs have two round pins and a 3rd round male pin permanently mounted in the socket. A plug adaptor will be required if incompatible electronic devices are used.

Emergency Phone Numbers

In case of emergency call 112 for police, fire brigade and ambulance service. In case of an emergency in the congress venue contact a security guard immediately.

European Urology

European Urology, the official journal of the EAU, has been a respected urological forum for over 20 years and is currently read by more than 10,000 urologists across the globe. With an impact factor of 8.843 the Platinum Journal remains the leading scientific publication in the field of urology.

Come see European Urology for yourself - visit either European Urology (booth 2M120 on level 2 in the exhibition) or the EAU Square (booth 1N03 on level 1 in the exhibition).

Excursions, Paris information and Restaurant Reservations

Information on Paris and excursions will be available at the Concierge Desk in the registration area on level 3. The concierge will also be able to assist you with restaurant reservations.


Exhibition

An extensive technical exhibition will be held jointly with the congress. The exhibition is open to technical equipment manufacturers, pharmaceutical companies and scientific publishers. The official opening will take place on Saturday, 25 February at 09.00 hrs.

Exhibition Hours

Saturday, 25 February	09.00-18.00 hrs
Sunday, 26 February	09.00-18.00 hrs
Monday, 27 February	09.00-18.00 hrs

First Aid

There is a medical unit present for first aid in room 315 on level 3 indicated on the directional signs with . In case of emergency, contact a security guard immediately.

Guidelines

EAU Extended and Pocket guidelines are distributed free of charge to EAU members only. They are also available for purchase at the EAU web shop.

The distribution of the EAU Pocket Guidelines is supported by OLYMPUS

Historical Exhibition

The members of the EAU History Office have set up a historical exhibit located at the EAU Square (booth 1N03 on level 1 in the exhibition). The exhibit will present "The urologist and his instrument maker".

Hospitality Suites Companies

AMS	Level 2,5;	Room 231/232Mz
ASTELLAS	Level 3,5;	Le Club
COOK MEDICAL	Level 1,5;	Room 124/125/126/127Mz
OLYMPUS	Level 2,5;	Room 224/225Mz

Hotel Accommodation

The EAU has contracted the company K.I.T. Group GmbH to deal with the housing for the congress participants. K.I.T. staff will be available at the Hotel Desk in the registration area on level 3.

Insurance

The organisers do not accept responsibility for any personal damage. Participants are strongly recommended to arrange their own personal insurance.

Internet Corners

The EAU Internet Corners are at your disposal at different locations in the exhibition (booth 1P16 on level 1 and booth 2M150 on level 2). The internet corners offer free use of internet and printers. See also WiFi / Connect and Charge Area.

Language

All presentations during the EAU Congress and EAUN Meeting will be conducted in English, the official language of the EAU and the EAUN. There will be no translation provided.

Learning Objectives EAU Congress

The EAU Congress provides a forum for presenting

original unpublished data and sharing ideas for urological innovation as well as disseminating evidence-based knowledge of primary clinical relevance. Urologists and affiliated professionals attending the EAU Congress and EAUN Meeting will be able to:

- Review innovative techniques and scientific advances in the field of urology and its subspecialties
- Review the latest data and emerging trends from studies in clinical and translational research
- Enhance their knowledge of evidence-based approaches to the management of urological disease
- Gain new knowledge on emerging diagnostic and risk-assessment strategies in the management of urological disease
- Enhance their practical knowledge and skills by educational activities, including hands-on-training and courses
- Gain exposure to new developments in drugs and new cutting edge technology in the field of pharmaceutical research and medical technology through visiting the EAU Congress Exhibition
- Communicate, collaborate and network with representatives of a large international audience – medical professionals, national urological societies, patient groups, medical industry and the media.

Lost and Found

Found items should be returned to the Information Desk in the main entrance hall on level 0. If you lose something, please report to this desk for assistance.

Media Policy

Photography, filming and interviews during the congress (with the exception of the EAU Press Centre and EAU Press Conference Room) are prohibited without written permission from the EAU Communication Officer Ms. Ivanka Moerkerken (i.moerkerken@uroweb.org).

Message Service

A message service is available at the congress website: www.eauparis2012.org

You can use the congress website to retrieve your messages and to send messages to other congress delegates.

Mobile Phones

Mobile phones must be switched off during all sessions.

General information

Personal Planner

During the Annual EAU Congress, the Personal Planner can be accessed through the scientific programme of the congress on www.eauParis2012.org.

This application can be used to personalise congress schedules, print or export items to Outlook express calendars.

For more information, please visit the congress website: <http://www.eauparis2012.org/scientificprogramme/eau-personal-planner/>

Poster Builder Service

Poster presenters who created their posters for the 13th International EAUN Meeting through the EAU Online Poster Builder Service, can collect their posters at the Speaker Service Centre on level 3.

Prayer Room

A special room dedicated to prayer is located in room 364 on level 3.

Presentation Training Centre

For information on the presentation training centre see page 14.

Resource Centre

Urology Science and Learning

The 27th Annual EAU Congress will introduce delegates to the EAU Resource Centre: A new way to re-live the congress once it's over. The Resource Centre is a website (www.eauresourcecentre.org) that delivers EAU contents to users on-demand and allows to select lectures and presentations that might otherwise be missed, or watch them again. Before heading home, you can use the Resource Centre computers to make a selection of the sessions, presentations and seminars that were recorded. After you've made your selection, you will receive a unique code that allows you to view the contents on your own computer, at your convenience. The EAU Resource centre is located next to the registration area on level 3.

Safety

All bags may be subject to inspection. Security is present for your safety. Please take all personal effects with you when leaving a session room.

Smoking Policy

Smoking is prohibited inside the congress centre and in the exhibition area.

Speaker Service Centre

For extensive speaker information see page 14.

Taxi Service

Taxis will be available in the taxi rank in front of restaurant Chez Clement next to the congress centre (on the left side when you exit the congress centre). If you wish to book a taxi in Paris by phone we recommend to call the following company who has reasonable and fixed rates:

Taxis G7: +33 1 47 39 47 39

Transportation Pass

Congress delegates may collect a transportation pass in the registration area which is valid for 10 rides. The pass covers underground, tram and bus within the city limits of Paris (zone 1-2). Delegates are kindly requested to return unused passes to the special boxes which are located in the registration area. They will be donated to a local charity.

Upcoming Meetings

Posters and other information on upcoming meetings can be displayed in the "Upcoming Meetings" promotion area (booth 1PA09 on level 1 in the exhibition). It is strictly forbidden to put up promotional material at any other location in the building.

Webcasts (📺) & Live Streams (📺)

Many sessions will be webcasted via the EAU Resource Centre: www.eauresourcecentre.org. The webcasted sessions are indicated with a special logo in the synopsis and will be online within several hours after the session. The webcasts have not been edited and are exactly as presented. The statements and the opinions featured in the webcasts are solely those of the individual presenters and not of the European Association of Urology (Nurses). In addition to the webcasts there will be live streams of several sessions available at the congress website: www.eauparis2012.org. These sessions are also indicated in the synopsis with a special logo.

WiFi / Charge and Connect Area

Free wireless internet will be available throughout the congress centre except in the exhibition areas. Please search for EAU-WiFi and enter your first name, surname and email address. You will then be connected to the internet. A special Charge and Connect Area with tables and power outlets are available in the exhibition on level 1 (booth 1N01).



Visit **booth 1P115**
for more information.

Be flexible.

Cook Medical's Injekt® Cysto Flexible Injection Needle can be placed through either a flexible or rigid cystoscope, providing versatility for flexible injection into the lower urinary tract.

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Injekt® Cysto
FLEXIBLE INJECTION NEEDLE

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ESU Courses CD 2012 edition

All EAUN members are entitled to take home a copy of the European School of Urology (ESU) Courses CD. This CD contains summaries of the ESU courses that will be given in Paris. More information on the courses can be found in the EAU Programme Book.

**MILLENNIUM: THE TAKEDA
ONCOLOGY COMPANY**
exhibition booth: 2M13



Speaker guidelines

Speaker Service Centre

Only digital presentations will be accepted during the congress and all presentations should be handed in at the Speaker Service Centre (Level 3) at least three hours prior to the start of the session. Failure to do so could result in presentations not being available for projection when required. *If you have an early presentation, please hand in your presentation the previous day!*

Opening hours

Thursday, 23 February 14.00-19.00 hrs

Friday, 24 February 07.00-19.30 hrs

Saturday, 25 February 07.00-19.00 hrs

Sunday, 26 February 07.00-19.00 hrs

Monday, 27 February 07.00-19.00 hrs

Tuesday, 28 February 07.00-13.00 hrs

If you are a chair

Locate your session room in time. Please be in your session room at least 15 minutes prior to the start of the session. Please note that: Speakers should strictly observe timing. Discussants should must first clearly state their name, institution and country of origin.

If you are presenting a poster

Posters must be put up in the room 15 minutes prior to the start of the session. The poster boards are numbered and your poster should be mounted on the board which corresponds with your abstract number. Pushpins are available in the session room. Please remove your poster immediately at the end of the session. Do remember that time allotted to speakers in poster sessions is 8 minutes (including 2 minutes for discussion). A maximum of five PowerPoint slide is allowed during your poster presentation.

Disclose links to the industry

The EAUN requests that you disclose to the audience any links you may have with the industry related to the topic of your lecture at the beginning of your session. A link can be: Being a member of an advisory board or having a consultancy agreement with a specific company.

Presentation Training Centre

Mr. Paul Casella (Iowa, USA) gives Individual Presentation Skills Training Sessions to help improve presentation and delivery skills. The one-on-one half hour sessions are free of charge and available to all speakers. Please go to the Speaker Service Centre to make an appointment for this very popular training session.





Scientific Programme

	25 February Saturday		26 February Sunday		27 February Monday
Room	Room 351	Room Havane - Main room	Room 351	Room Havane - Main room	Room Havane - Main room
08:00					
08:15					
08:30	EAUN Workshop Catheter management	EAUN Workshop Urodynamics	State-of-the-art lecture Understanding principles, side effects and their management in targeted therapies for metastasised Renal Cell Cancer (mRCC), a new challenge for urology nurses	Sponsored Workshop Safety in urinary catheterisation. Transurethral and suprapubic drainage B. BRAUN	
08:45			State-of-the-art lecture EAUN Fellowships: Everything you always wanted to know about fellowships		
09:00					
09:15					
09:30					
09:45					
10:00			Break	Break	
10:15					Symposium Indwelling vs. intermittent catheterisation in voiding difficulties: What does it mean for patients, caregivers and society?
10:30	Break	Break			ASTRA TECH
10:45					Break
11:00				EAU-ESU Course - 1 Writing an abstract, making a poster Part 1	State-of-the-art lecture Ketamine-associated ulcerative cystitis, a new clinical entity
11:15	EAUN Workshop Incontinent patients - Transfer from hospital to home care and back	EAUN Workshop Optimisation of peri-operative care in advanced bladder cancer surgery	EAUN Workshop Shopping for tools to optimise nursing care in cancer patients		
11:30					
11:45					
12:00				Break	Break
12:15					
12:30				EAU-ESU Course - 1 Writing an abstract, making a poster Part 2	EAUN Urology Nursing Quiz
12:45					State-of-the-art lecture Focal cryoablation of prostate cancer
13:00		Break		Break	EAUN General Assembly
13:15		Symposium Optimising care for bladder cancer patients	Break		
13:30					Break
13:45		IPSEN & PHOTOCURE			
14:00				State-of-the-art lecture Innovative interactive multi media techniques in urology care	Poster viewing
14:15		Break	EAU-ESU Course - 2 Urinary infections Part 1	Break	
14:30	State-of-the-art lecture Cystectomy and bladder reconstruction: The nurse's role in France	EAUN Workshop Nursing solutions in difficult cases: Case studies		Poster viewing	Poster Abstract Session
14:45		Break	Break		
15:00		EAUN Opening		Poster Abstract Session	
15:15		EAUN Guidelines Catheterisation - Indwelling catheters in adults - Introduction	EAU-ESU Course - 2 Urinary infections Part 2		
15:30		Break			Break
15:45		Symposium The practical and motivational side of teaching men intermittent catheterisation: A workshop naming the challenges met while teaching men intermittent self-catheterisation COLOPLAST AS			Award Session Supported by AMGEN and FERRING PHARMACEUTICALS
16:00			Break	Break	
16:15				State-of-the-art lecture Assessment and management of osteonecrosis of the jaw	
16:30			EAUN Nursing Research Competition Learning session		
16:45					
17:00		Welcome reception Location: Foyer Bordeaux Level 03 COLOPLAST AS and the EAUN			
17:15					
17:30					
17:45					
18:00					
19:00			Urowalk 19.00 - 20.30		
20:30			Nurses' dinner 20.30 - 23.00		
23:00					

EAUN Workshop

08.30 - 10.30 **Catheter management**

Room 351 - Level 3



Chair: V. Geng, Lobbach (DE)

08.30 - 08.50 History of catheterisation

J. Mattelaer, Kortrijk (BE)

08.50 - 09.10 Catheterisation: Insertion and removal procedure of urethral and suprapubic

M. Vandewinkel, Malle (BE)

09.10 - 09.30 Care of the catheter: What is the evidence?

V. Geng, Lobbach (DE)

09.30 - 09.50 Bladder washout, instillation and irrigation

M. Gea-Sánchez, Lleida (ES)

09.50 - 10.10 Indwelling catheter and prevention of urinary tract infection

S.V. Lauridsen, Copenhagen (DK)

10.10 - 10.30 Practices and nurse's knowledge and skills concerning indwelling catheterisation in specialised healthcare

S. Salomaa, Lahti (FI)

Aims and objectives

In the pre-congress workshop catheter management we want to give some insights into the content of the new EAUN *Evidence-based Guidelines for Best Practice in Health Care* about indwelling catheters.

The participants should:

- Learn about the history of catheterisation
- Learn about the procedures of insertion, removal as well as care of the catheters, bladder washouts and instillations
- Know the risk of urinary tract infection (UTI) in combination with indwelling catheters as well as the prevention of UTI
- Hear about nursing knowledge and catheterisation

EAUN Workshop

08.30 - 10.30 **Urodynamics**

Room Havane - Level 3



Chair: U.L.M. Haase, Nieuwegein (NL)

08.30 - 09.05 **Standard and advanced evaluation and interpretations**
W. Schaefer, Pittsburg (US)

09.05 - 09.40 **Case study**
J. Groen, Rotterdam (NL)

09.40 - 10.15 **Ambulatory and video-urodynamics**
D.A.W. Janssen, Nijmegen (NL)

10.15 - 10.30 **Discussion**

Aims and objectives

Urodynamic testing provides extremely valuable and useful information for the care of urologic patients with voiding dysfunction, however it can be daunting to perform and interpret. This EAUN workshop will take the participant through an overview of the process from set up to interpretation.

Objectives:

- Focus on the importance of Urodynamics in Urology diagnosis.
- Highlight the importance of correct training to carry out this test.
- Expose participants to the practical aspects of set up.
- Demonstrate case studies to “pull it all together”
- Provide attendees with a chance to ask questions.

EAUN Workshop

11.00 - 13.00 **Optimisation of peri-operative care in advanced bladder cancer surgery**

Room Havane - Level 3



Chair: S. Hieronymi, Frankfurt am Main (DE)

11.00 - 11.20 **Approaching the cystectomy pathway**

K. Olsen, Hjørtshøj (DK)

I. Søndergaard, Århus N (DK)

11.20 - 11.40 **Importance of nutritional status and measurements**

M. Borre, Århus N (DK)

11.40 - 12.00 **Pre and post-operative exercise; The Danish training approach**

P. Eriksen, Århus N (DK)

12.00 - 12.20 **Pre-operative stoma care**

B. Kiesbye, Risskov (DK)

12.20 - 12.40 **Post-operative follow up (cancer follow up)**

I. Søndergaard, Århus N (DK)

12.40 - 13.00 **Discussion**

Aims and objectives

Objectives: To introduce the audience to fast-track pathways in urology practice

- To understand the main principles in a fast-track concept
- Update the audience on evidence based segments in the cystectomy pathway that can possibly improve patient-outcomes
- Ask the question every day; "what matters and what is the matter?" and why is the patient still on the ward?

EAUN Workshop

11.00 - 13.00 Incontinent patients - Transfer from hospital to home care and back

Room 351 - Level 3



Chair: B.T. Jensen, Århus (DK)

11.00 - 11.30 Optimising the connection between primary and secondary sector for the benefit of the incontinent patient
A. Christensen, Taastrup (DK)

11.30 - 12.00 Economic aspects of healthcare
R. De Graaff, Heemstede (NL)

12.00 - 12.50 The transition of incontinent patients in my country:

12.00 - 12.10 Danish experience
A. Vestermark, Hjørring (DK)

12.10 - 12.20 Irish experience
M. Power, Galway (IE)

12.20 - 12.30 Belgian experience
R. Pieters, Ghent (BE)

12.30 - 12.40 Austrian experience
D. Mair, Innsbruck (AT)

12.40 - 12.50 Estonian experience
I. Persidski, Tallin (EE)

12.50 - 13.00 Discussion

Aims and objectives

Objectives: To improve the transition between hospital and homecare settings to secure the rehabilitation for the incontinent patient

- An approach to optimise the cooperation between primary and secondary sector managing incontinence
- Introduce the audience to the significant relation between incontinence and socio-economics aspects in society.
- Inform the audience about the huge diversity in Europe on how to support the incontinent patient.

Sponsored Session

13.15 - 14.15 Optimising care for bladder cancer patients

Room Havane - Level 3

Symposium

Chair: F. Charnay-Sonnek, Strasbourg (FR)

- | | |
|----------------------|--|
| 13.15 - 13.20 | Welcome and introduction
F. Charnay-Sonnek, Strasbourg (FR) |
| 13.20 - 13.35 | The burden of bladder cancer: A patient perspective
K. Chatterton, London (GB) |
| 13.35 - 13.55 | Improving patient outcomes
C.J. Bunce, Barnet (GB) |
| 13.55 - 14.10 | The role of the nurse in optimising patient care
R.N. Knudsen, Århus N (DK) |
| 14.10 - 14.15 | Panel discussion and closing remarks |

Sponsored by IPSEN & PHOTOCURE

EAUN Workshop

14.30 - 15.00 **Nursing solutions in difficult cases: Case studies**

Room Havane - Level 3



Chair: S.V. Lauridsen, Copenhagen (DK)

14.30 - 14.40 DC12-01: Parasitic infestation in the urologic patient
N. Love-Retinger, New York (US)

14.40 - 14.45 Discussion

14.45 - 14.55 DC12-02: Penile cancer: Treatment of lymphoedema after removal of lymph nodes
M. Johansen, Copenhagen (DK)

14.55 - 15.00 Discussion

EAUN Lecture

14.30 - 15.15 **State-of-the-art lecture: Cystectomy and bladder reconstruction: The nurse's role in France**

Room 351 - Level 3



A. Daif, Suresnes (FR)
N. Kouzmina, Suresnes (FR)

Aims and objectives

- To highlight the importance of the nurses's role before and after a cystectomy and bladder reconstruction
- To introduce the nurse consultation to the audience
- To focus on the advantages of having a well-informed patient (advantages for the patient and for nurses)

EAUN Opening Ceremony

15.15 - 15.30 **EAUN Opening Ceremony**

Room Havane - Level 3

P-A. Abrahamsson, Malmö (SE)
K. Fitzpatrick, Dublin (IE)

EAUN Lecture

15.30 - 15.45

Evidence-based Guidelines for Best Practice in Urological Healthcare: Catheterisation - Indwelling catheters in adults, urethral and suprapubic - Introduction of the new EAUN guideline

Room Havane - Level 3



S.V. Lauridsen, Copenhagen (DK)

Aims and objectives

The aim of this session is to present the new guideline on “Catheterisation - Indwelling catheters in adults, urethral and suprapubic” and to explain how this evidence-based guideline was developed. The guideline presents the newest knowledge regarding care of the indwelling catheter and during this session some highlights will be presented. We will also address how nurses can use this guideline in daily practice.

Sponsored Session

16.00 - 17.00 **The practical and motivational side of teaching men intermittent catheterisation: A workshop naming the challenges met while teaching men intermittent self-catheterisation**

Room Havane - Level 3

Symposium

Chair: *B.T. Jensen, Århus (DK)*

Panel:

E. Chappel, Essex (GB)

J.T. Marley, Portadown (IE)

A. Vestermark, Hjørring (DK)

Aims and objectives

The main objective of this workshop is to address the psychological and motivational aspects of teaching men intermittent self catheterisation via a combination of lecture, cases and discussion building upon theory and demonstration.

The workshop begins with a short review of the theory supporting Clean Intermittent Catheterisation (CIC) and a demonstration of how to teach CIC by using a catheterisation model and a SpeediCath® Compact male catheter. The workshop is devoted to guiding the audience towards a successful outcome when teaching CIC.

Sponsored by COLOPLAST AS

Welcome Reception

17.00 - 18.00 **Welcome Reception**

Foyer Bordeaux - Level 3

Join your colleagues for light appetizers, wine and soft drinks at the Welcome reception in Foyer Bordeaux. The welcome reception is only accessible for delegates who are registered for the 13th EAUN Meeting

The Welcome Reception is sponsored by COLOPLAST AS and the EAUN

Sponsored Workshop

08.30 - 10.30

Safety in urinary catheterisation. Transurethral and suprapubic drainage

Room Havane - Level 3

Challenges in reducing high urinary nosocomial infection rate

W. Vance, Beelitz-Heilstatten (DE)

Discussion

Safe maintenance of transurethral and suprapubic catheters

M. Rew, Sheffield (GB)

Discussion

Safety approach in suprapubic percutaneous catheterisation

C. Kümmel, Göttingen (DE)

Discussion

A new approach for urinary nosocomial infection reduction with single catheterisation

P. Van De Poel, Sittard (NL)

Discussion

Aims and objectives

Welcome to the B.Braun session, with a unique safety concept in urinary catheterisation. The aim is to provide patients and healthcare professionals with global solutions to prevent Urinary Tract Infection in urinary catheterisation. Following the latest guidelines this workshop will give an overview about safety procedures including the challenges in reducing urinary nosocomial infection rates. The treatment of choice with a new approach in single catheterisation, the safety concerns in suprapubic percutaneous catheterisation and the self-maintenance of indwelling and suprapubic catheters will then be reviewed. The positioning of the respective procedures will be completed and discussed with healthcare professionals.

Sponsored by B.BRAUN

EAUN Lecture

08.30 - 09.30 **Understanding principles, side effects and their management in targeted therapies for metastasised Renal Cell Cancer (mRCC), a new challenge for urology nurses**

Room 351 - Level 3



L. Wood, Cleveland (US)

Aims and objectives

Aims: To provide urology nurses with information regarding the principles of targeted therapy in renal cancer and the management of side effects associated with these therapies.

Objectives:

- Identify current and investigational therapies used to treat renal cell carcinoma.
- Discuss nursing management strategies for treatment-related side effects associated with therapies for renal cell carcinoma.

09.30 - 10.00 **EAUN Fellowships: Everything you always wanted to know about fellowships**

Room 351 - Level 3



Chair: S. Vahr, Copenhagen (DK)

09.30 - 09.40 **Host experience**

W.M. De Blok, Amsterdam (NL)

09.40 - 09.50 **Fellow experience**

S.J. Borg, B'kara (MT)

09.50 - 10.00 **Discussion**

Aims and objectives

The EAUN fellowship programme is a programme especially developed for nurses. With this programme it is possible to find out what is going on in other clinics concerning urology nursing. "Fellows" and "hosts" that have participated in the EAUN fellowship programme will present their experiences. Willem de Blok, Netherlands Cancer Institute (NVI-AKL), will present his experience as host for the fellowship of Mr. Bruce Turner who visited the NKI-AVL in 2009 and Mrs. Bente Thoft Jensen (and 2 colleagues) in 2011. Simon Borg will present his experience as fellow in the Homerton Hospital NHS Foundation Trust in London in 2011. There will be ample opportunity to ask questions, bring forward hindrances and propose new possibilities for this programme. The EAUN board would like to adapt to the needs of the members to ensure the members will benefit fully of this opportunity to exchange knowledge and develop daily practice.

EAUN Workshop

11.00 - 13.00

Shopping for tools to optimise nursing care in cancer patients

Room 351 - Level 3



Exercise for the cancer patient

F. Dimeo, Berlin (DE)

Erectile dysfunction in prostate cancer

W. Hurn, Bristol (GB)

Spinal cord compression

H.A.M. Van Muilekom, Leiden (NL)

The importance of nutrition in the cancer patient

M. Borre, Århus N (DK)

Aims and objectives

The Market Place Session key objectives are to explore with nurses some of the wider aspects of cancer related issues for patients, the causes, diagnostic and assessment approaches and offer practical tools to allow nurses to address these issues, in order to help optimise patient care.

To achieve these goals, the Market Place Session will involve 4 workshops that will run in parallel, with each speaker delivering an interactive presentation for 20 minutes, followed by 10 minutes of audience discussion. Delegates will rotate between the 4 speakers.

The sessions will aim to encourage questions and discussion with the nursing audience, sharing knowledge and learning between urology nursing colleagues where the potential for clinical development and education within their own clinical areas can be considered.

ESU Course 1

11.00 - 13.30 **Writing an abstract, making a poster**

Room Havane - Level 3



Chair: N. Suardi, Milan (IT)

Faculty: J.T. Marley, Portadown (IE)
N. Suardi, Milan (IT)

Welcome and introduction

How to write an abstract

Questions and answers

How to make a poster

Questions and answers

Closing remarks – Take home messages

Aims and objectives

The course will enable the participants to write an abstract according to the EAU(N) standards as well as to prepare a poster to clearly illustrate the results of a scientific study. The course will explain how to structure an abstract in its different parts (introduction, materials and methods, results and conclusion). Finally, examples of good and bad posters will be shown and discussed.

EAUN Lecture

14.00 - 14.30

State-of-the-art lecture: Innovative interactive multimedia techniques in urology care - A big step forward or still one step too far?

Room Havane - Level 3



M. Vesterby, Silkeborg (DK)

Aims and objectives

A Danish Model for Healthcare Innovation: "How to Make a Hippopotamus Jump"

In this talk, you will be presented with the stories, experiences and results of an innovation project, which took place at the hospital and at the homes of patients. The goal has been to create solutions for needs that were identified during fast track procedures for orthopedic patients. The project tried to minimise anxiety for the patients and their caregivers/support persons and helped put the combination of pre-operative resources, patient empowerment, and Information and Communication Technology (ICT) on the agenda in the Danish Healthcare sector. The project has resulted in new procedures for education of patients and support persons. These procedures have given the involved departments a significant cost reduction and are now spreading to other areas of treatment and hospitals in Denmark and abroad. You will be presented with a brief summary of the use of ICT in the healthcare sector today and what to expect in the future. You will also hear about one method for creating the space and means for revolutionary innovation in the healthcare sector, i.e. making the hippo jump, based on an interdisciplinary model for innovation with a holistic approach.

ESU Course 2

14.00 - 16.30

Urinary infections

Room 351 - Level 3



Chair: H.M. Çek, Istanbul (TR)

UTI (microbiology, resistance issues, antibiotics)

F.M.E. Wagenlehner, Giessen (DE)

Healthcare associated infections in urology (including infections acquired during hospital stay, outpatient procedures, long term healthcare facilities and treatment at home)

H.M. Çek, Istanbul (TR)

Coffee break

Catheter care in urological practice and in general practice

M.E. Jacob, Dublin (IE)

Urosepsis (as a serious complication of healthcare associated infections; early signs of urosepsis and initial management of urosepsis)

F.M.E. Wagenlehner, Giessen (DE)

Clinical cases

Abstract Session

14.45 - 16.30

Poster Session

Room Havane - Level 3



Chairs: V. Geng, Lobbach (DE)
S. Hieronymi, Frankfurt am Main (DE)

- p1 Optimising intravesical therapy in octogenarians with non-muscle invasive bladder cancer**
K. Chatterton, S. Amery, G. Zisengwe, A. Mukwahuri, J. Kinsella, T.S. O'Brien, F. Dickinson (London, United Kingdom)
- p2 Development of an evidence based central hospital Bladder Catheterisation Protocol**
J.G.L. Cobussen-Boekhorst, A. Pacilly, I. Kwaaitaal (Nijmegen, The Netherlands)
- p3 Evidence based guideline for urinary catheterization, selection of catheter type, meatal cleansing and selection of fluid in the catheter balloon in adult persons admitted to hospitals or outpatient clinics**
B.R. Villumsen, H. Bro, B.M. Pedersen, M. Svejstrup, S. Lomborg (Holstebro, Viborg, Herning, Denmark)
- p4 Comparison of hydrogen peroxide dressing combined with povidone iodine versus povidone iodine alone in the management of Fournier's gangrene**
A. Wanzam, M. Gyereh, A. Afoko (Tamale, Ghana)
- p5 Nurse specialist assisting in robotic surgery**
J. Petersson, B.S. Laursen (Aalborg, Denmark)
- p6 Use of clean intermittent catheterization (CIC) in the control of hospital acquired infections following prolonged use of indwelling urinary catheters**
M. Gyereh, E. Yahaya, A. Wamzam, A. Afoko (Tamale, Ghana)
- p7 Proactive management of patients with bone metastases secondary to urological malignancies: Best practice and useful tools**
L. Drudge-Coates, T. Jensen (London, United Kingdom; Århus, Denmark)
- p8 Significance of nursing measuring nutritional status in cystectomy patients, a retrospective analysis**
N. Love-Retinger, M. Borre, M. Kent, D. Sjoberg, G. Dalbagni, B. Thoft Jensen (New York, United States of America; Århus, Denmark)
- p9 The role of the surgical nurse in the surgery of living donors' kidney**
G. Viladomat, I. Pueyo, C. Ayet (Barcelona, Spain)

EAUN Lecture

16.45 - 17.30

State-of-the-art lecture: Assessment and management of osteonecrosis of the jaw

Room Havane - Level 3



T. Taylor, London (GB)

Aims and objectives

This session will explain how to assess and manage patients presenting with, or at risk of developing, Osteonecrosis of the Jaw (ONJ). It will include:

- The reasons why ONJ affects the jaws specifically
- The signs the clinician should look out for
- What to tell the patient to expect if it does occur
- The symptoms the patient may expect if an ONJ develops
- Risk factors that predispose to ONJ
- Strategies for prevention
- Practical tips for ongoing management
- Treatment options available if ONJ develops

EAUN Lecture

16.45 - 17.45 EAUN Nursing Research Competition

Room 351 - Level 3



Chair: R. Pieters, Ghent (BE)

Report from the research competition winner of 2010

16.45 - 16.55 **Adherence to fast-track programmes within urology nursing care 2008-2010**
E. Grainger, Århus (DK)

16.55 - 17.00 **Discussion**

The nominees of 2012 and their research projects

17.00 - 17.10 **RP12-01 Avoiding urinary tract infections in patients practising intermittent catheterisation**
H.J. Mulder, Groningen (NL)

17.10 - 17.15 **Discussion**

17.15 - 17.25 **RP12-02 Which factors make clean intermittent (self)catheterisation successful?**
J.G.L. Cobussen-Boekhorst, Nijmegen (NL)
E. Van Wijlick, Nijmegen (NL)

17.25 - 17.30 **Discussion**

17.30 - 17.45 **Making a research plan: What is possible and what you need to know**
E. Grainger, Århus (DK)
J.T. Marley, Portadown (IE)

Sponsored Session

10.15 - 11.15 Indwelling vs. intermittent catheterisation in voiding difficulties: What does it mean for patients, caregivers and society?

Room Havane - Level 3

Symposium

Chair: R. Peeker, Gothenburg (SE)

- 10.15 - 10.30 Hassan - A movie about love, sex and lust for life!**
- 10.30 - 10.45 Indwelling vs. intermittent catheterisation - differences for the patient, caregivers and society - What are the obstacles?**
R. Peeker, Gothenburg (SE)
- 10.45 - 11.00 Indwelling catheter, only when needed - A project in Jönköping Sweden**
I. Erlandsson, Jönköping (SE)
- 11.00 - 11.15 Discussion**

Aims and objectives

Background: In the western part of the world, Clean Intermittent Catheterisation (CIC) is considered the treatment of choice for many voiding disorders. In other parts of the world, old outdated methods such as pressure voiding and indwelling catheters (IC) are still being used. However, the usage of indwelling catheters is widespread also in the western health care system, despite the fact that experience has told us that CIC is a better choice. What are the consequences of this outdated approach for the caregivers, patients and society? What can be done to make a change in approach?

Aim: To show real life consequences of catheterisation, for different stakeholders. Valuable discussions concerning what practical measures can be made to ensure indwelling catheter use is kept at a minimum level.

Objective: Elevate intermittent catheterisation in favour of indwelling catheterisation and consequently show how intermittent catheterisation can be a life saver. To give inspiration to work with projects in order to break old treatment patterns.

Sponsored by ASTRA TECH

EAUN Lecture

11.30 - 12.00

State-of-the-art lecture: Ketamine-associated ulcerative cystitis, a new clinical entity

Room Havane - Level 3



P. Sau-Kwan, Hong Kong (HK)

Aims and objectives

The first 10 cases of ketamine-induced damage to the urinary tract (ketamine uropathy) in Hong Kong were reported in 2007. These young patients usually presented with dysuria, frequency, urge incontinence and painful haematuria. The condition was usually mistaken for bacterial cystitis and given multiple courses of oral antibiotics of no avail. The functional bladder capacity could be reduced to as small as 15 ml, driving the patient diaper dependant. Marked inflammatory changes with telangiectasis in the bladder mucosa were seen under cystoscope. Urodynamically these patients were either suffering from detrusor overactivity, poor compliant bladder or both conditions, with or without vesicoureteric reflux. Unilateral or bilateral hydronephrosis could be detected in up to 15% of the patients. In a few patients papillary necrosis was detected, while in some others the urinary tract was further complicated by ureteric stricture.

Quiz

12.30 - 12.45

EAUN Urology Nursing Quiz

Room Havane - Level 3

U.L.M. Haase, Nieuwegein (NL)

Aims and objectives

Test your urology nursing knowledge. The winner receives a free registration for the 14th International EAUN meeting in Milan, Italy

EAUN Lecture

12.45 - 13.15 **State-of-the-art lecture: Focal cryoablation of prostate cancer**

Room Havane - Level 3



12.45 - 12.50 For who is focal cryoablation a suitable therapy; how to exclude multifocal cancer

S. Hieronymi, Frankfurt am Main (DE)

H. Laws, Sunderland (GB)

12.50 - 13.00 What is meant by focal cryoablation?

S. Hieronymi, Frankfurt am Main (DE)

H. Laws, Sunderland (GB)

13.00 - 13.10 Follow up

H. Laws, Sunderland (GB)

S. Hieronymi, Frankfurt am Main (DE)

13.10 - 13.15 Discussion

Aims and objectives

Following minimal invasive therapies, the request for focal treatment soon increased. This of course includes an increased demand for nerve sparing procedures in the treatment of prostate cancer (PCA) to preserve potency and continence. But what does focal cryoablation of the prostate mean in detail?

This session will present the currently available focal treatments in PCA, and then focus on the different possibilities in focal cryoablation of the prostate. It will also look at what the European Study Group of Cryosurgical ablation of prostate cancer (ESGCP) recommends as the best treatment to start with.

Cryobiology and the technique will be explained and how to guide patients through their decision pro or con focal cryoablation. The follow up afterwards will complete this overview and should enable the audience to go home with increased knowledge about this inspiring treatment option.

EAUN Session

13.15 - 13.45 **EAUN Annual General Meeting (AGM)**

Room Havane - Level 3



Chair: K. Fitzpatrick, Dublin (IE)

W.M. De Blok, Amsterdam (NL)

L. Drudge-Coates, London (GB)

V. Geng, Lobbach (DE)

U.L.M. Haase, Nieuwegein (NL)

S. Hieronymi, Frankfurt am Main (DE)

B.T. Jensen, Århus (DK)

S.V. Lauridsen, Copenhagen (DK)

Abstract Session

14.00 - 15.45

Poster Session

Room Havane - Level 3



Chairs: L. Drudge-Coates, London (GB)
B.T. Jensen, Århus (DK)

- p10** Teaching self-catheterization for patients with neurogenic bladder. Nursing experiences from a spinal cord unit
M. Kloeser, B. Domurath (Bad Wildungen, Germany)
- p11** The impact of incontinence on the dependency scale, the care profile and the financing of Belgian residential nursing homes
S. Deryckere, K.C.M. Everaert, J. Trybou, R.G. Pieters (Ghent, Belgium)
- p12** Acute pain outcomes after open and minimally invasive robotic-assisted surgery for localised prostate cancer
H. Crowe, E. Beale, J. Lee, M. Botti (Melbourne, Australia)
- p13** Advising the patient's radical prostatectomy in the East-Tallinn Central Hospital urology department
A. Komp, I. Persidski (Tallinn, Estonia)
- p14** Long-term effects of pelvic floor muscle training (PFMT) vs extracorporeal magnetic innervation (ExMI) on post-prostatectomy urinary incontinence
S. Terzoni, E. Montanari, C. Mora, C. Ricci, A. Destrebecq (Milan, Italy)
- p15** Introducing a nurse-led transperineal saturation prostate biopsy service
J.E. Kinsella, L. Fleure, L. Vyas, P. Acher, P. Kumar, R. Popert, D. Cahill (London, United Kingdom)
- p16** Prostate cancer follow up. Do patients and health professionals want the same thing?
I.B. Vieira, H. Taylor (Gillingham, United Kingdom)
- p17** Mobile Advice & Testing Service (MATS): Introduction of a novel, nurse-led prostate cancer education and testing service
H.R. Crowe, P. Bugeja, A. Wootten, D. Murphy, B. Challacombe, A.J. Costello (Melbourne, East Melbourne, Australia; London, United Kingdom)
- p18** The impact of a nurse led urinary Memokath™ stent follow up clinic
N.J. Dickens, S. Kachrilas, C. Bach, P. Kumar, N.P. Buchholz, J. Masood (London, United Kingdom)

EAUN Session

16.15 - 16.30 Award Session

Room Havane - Level 3

Chair: K. Fitzpatrick, Dublin (IE)

- First Prize for the Best EAUN Poster Presentation
- Second Prize for the Best EAUN Poster Presentation
- Third Prize for the Best EAUN Poster Presentation
- Prize for the Best EAUN Nursing Research Project
- Prize for the winner of EAUN Urology Nursing Quiz

The Prizes for the Best EAUN Poster Presentations are supported by unrestricted educational grants from
AMGEN

The Prize for the Best EAUN Nursing Research Project is supported by an unrestricted educational grant
from FERRING PHARMACEUTICALS



Abstracts

P1

Room Havane, Level 3

OPTIMIZING INTRAVESICAL THERAPY IN OCTOGENARIANS WITH NON-MUSCLE INVASIVE BLADDER CANCER

Chatterton K., Amery S., Zisengwe G., Mukwahuri A., Kinsella J., Dickinson F., O'Brien T.S.

Guy's and St Thomas' NHS Foundation Trust, The Urology Centre, London, United Kingdom

Introduction & Objectives:

In 2000 3.4% of the European Union population was aged over eighty. This is estimated to rise to 6.5% by 2025 and 11.8% by 2050 (Zaidi, 2008). At our institution a third of patients with bladder cancer are aged over eighty. Understanding bladder cancer in the elderly should be an important goal of every bladder cancer service. As nurses we have addressed the specific problem of the tolerability of intravesical therapy, given the frequency of coexistent lower urinary tract symptoms (LUTS) in this population. Despite the fact that the potential for LUTS in octogenarians is much higher, we found that LUTS assessments were not routinely done prior to commencement of treatment by either the medic prescribing or the nurse administering.

Material & Methods:

Retrospective analysis of all octogenarian patients treated with intravesical therapy within our nurse-led clinic, between 2008 and 2011, assessing tolerability of treatment.

Results:

Thirty patients were identified with non-muscle invasive bladder cancer (NMIBC) who underwent intravesical therapy which included BCG, Mitomycin (MMC) or sequential EMDA MMC / BCG. The median age of the patients was eighty-one and their tolerance to treatment was monitored. 23% of patients had LUTS which limited treatment, 13% of which did not complete the prescribed course. 10% had an interrupted course of treatment, potentially compromising successful treatment outcome. Only one patient was assessed for LUTS prior to treatment, then subsequently underwent bladder outflow obstruction surgery, treatment then commenced and given successfully. Despite the fact that the potential for LUTS in this group is much higher, we found that LUTS assessments were not routinely done prior to commencement of intravesical treatment.

Conclusions:

If we are to optimize the best possible outcome in the octogenarians receiving intravesical therapy, a thorough LUTS assessment should be routinely performed. We have now incorporated a LUTS assessment within our multidisciplinary bladder cancer clinic, prior to commencement of nurse-led intravesical therapy. As part of the consent process, nurses administering treatment have an ethical and professional responsibility to ensure this is carried out to improve treatment tolerance and outcome.

P2

Room Havane, Level 3

DEVELOPMENT OF AN EVIDENCE BASED CENTRAL HOSPITAL BLADDER CATHETERISATION PROTOCOL

Cobussen-Boekhorst J.G.L.¹, Pacilly A.², Kwaaitaal I.²

¹University Medical Center St Radboud, Dept. of Urology, Nijmegen, The Netherlands, ²University Medical Center St Radboud, Dept. of Advisory Body, Nijmegen, The Netherlands

Introduction & Objectives:

Our hospital has a digital quality-documents-system. This system consists of central- and ward related protocols. There used to be central protocols concerning all different aspects of Bladder-Catheterisation. Over the years, wards developed their own ward Bladder-Catheterisation Protocols (BCP). The management board decided this must be changed in only one protocol for the whole institution. Focus should be on improving safety by adding risks, removing details, and it should be less patronizing. The purpose was to develop an evidence based central hospital Bladder Catheterisation Protocol.

Material & Methods:

A new central document committee (CDC) was setup, which facilitates wards to develop central protocols. They also monitor the uniformity of these protocols. The CDC explored all old BCP protocols. They transformed these protocols into one new concept-protocol. A hospital quality BCP workgroup was formed, including the Nurse Practitioner (NP) Urology. The NP Urology examined the concept-protocol on evidence, using the (concept) guideline 'indwelling catheter' of the EAUN, 2012, and continued developing the protocol. The concept-protocol was sent to a review group, consisting of delegates from different specialism. Comments were discussed, and when judged positively by the working group, they were changed. At last the protocol was judged on quality criteria for central documents. The final version was sent to the hospital management, and nursing advisory board. Implementation procedure was discussed by the working group.

Results:

19 central, and 11 ward related protocols about BCP were replaced by one protocol for adults and children, while the specific procedure in children was maintained. All subjects about BCP are easy to find by clicking on the content table. The new protocol is developed according to the latest evidence. After authorization it is placed on the digital quality-documents-system. Agreements were made about the responsibility, namely the Urology Department. Implementation was done by an article in an internal nursing journal, remark on the quality system, and a letter to all head nurses.

Conclusions:

The usability of the BCP is improved for professionals. Updating and judging such protocol is easier now. An evidence based document (EAUN guideline) on BCP is a great help to make a central protocol according to the last evidence. By asking a review group to judge the protocol there is more support, which makes implementation easier. Responsibility is clear, and collaboration between NP and CDC leads to better quality of protocols, in content and process.

EVIDENCE BASED GUIDELINE FOR URINARY CATHETERIZATION, SELECTION OF CATHETER TYPE, MEATAL CLEANSING AND SELECTION OF FLUID IN THE CATHETER BALLOON IN ADULT PERSONS ADMITTED TO HOSPITALS OR OUTPATIENT CLINICS

Villumsen B.R.¹, Bro H.¹, Pedersen B.M.¹, Svejstrup M.¹, Lomborg S.²

¹Regionshospitalet Holstebro, Dept. of Urology, Holstebro, Denmark, ²Hospitalsenheden Midt Og Vest, Dept. of Microbiology, Viborg, Herning, Denmark

Introduction & Objectives:

30-40% of nosocomial infections are urinary tract infections and in most cases related to urethral catheter. The primary objective of this evidence based clinical guideline is to reduce the incidence of catheter related infections by giving recommendations for cleaning the meatus area prior to catheterization, cleaning when the catheter is in situ, selection of catheter type and size as well as selection of fluid to fill up the catheter balloon in adult persons admitted to hospitals or outpatient clinics.

Material & Methods:

A systematic literature review was conducted from 1st of April 2009 to the 21st of June 2011. We searched the PubMed, Cinahl, Embase and Cochrane databases, a number of international guideline databases, websites and urological magazines. 10 articles became the evidence for the recommendations in the guideline.

Results:

The following recommendations is the result of the literature review:

- Insertion:
 - Prior to insertion the meatal area must be washed with tap water and even soap if the area is overtly unclean (B).
 - Cleaning of the meatal area while the catheter is in situ:
 - Cleaning must be done on a daily basis with tap water and soap or washing lotion (B).
- Catheter types:
 - Silver alloy catheters must be used for short-term catheterization (A).
 - Antibiotic impregnated catheters must be used for short-term catheterization for maximum one week (A).
 - Hydrogel coated latex catheter, silicone coated latex catheter or 100 % silicone catheter must be used for long-term catheterization (A).
 - The smallest catheter size must be used for drainage of the bladder (A).
- Filling the balloon:
 - The balloon must be filled with sterile water, normal saline or glycerine 10 % solution (B).
- Discussion

According to existing guidelines there are different recommendations for cleaning the meatal area prior to insertion of the catheter. We have found evidence stating that it is sufficient to clean the area using tap water and non-sterile equipment. The use of silver alloy catheters and antibiotic impregnated catheters is not a part of daily routine at Regionshospitalet Holstebro. They are more expensive than other catheter types, but economic evaluations support the use of silver alloy catheters.

Conclusions:

Because silver alloy and antibiotic impregnated catheters are not part of daily routine and more expensive than other catheters, these may be hard to implement in clinical practice despite economic evaluations. Take home messages: No need to use sterile solutions or equipment when cleaning the meatus area. Use silver alloy or antibiotic impregnated catheters for short term catheterization. Use sterile water, normal saline or glycerine 10% solution to fill the balloon. Developing an evidence based clinical guideline is a tremendous task! Only through hard work and endurance the project will succeed!

P4

Room Havane, Level 3

COMPARISON OF HYDROGEN PEROXIDE DRESSING COMBINED WITH POVIDONE IODINE VERSUS POVIDONE IODINE ALONE IN THE MANAGEMENT OF FOURNIER'S GANGRENE

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Introduction & Objectives:

Fournier's Gangrene is a severe form of necrotising fasciitis that has severe morbidity and high mortality. In Tamale Teaching Hospital, most patients would present late to hospital with an advanced state of the disease.

Material & Methods:

Since May 2010 to July 2011, 31 patients with Fournier's gangrene were admitted to our ward. Mean age of patients was 39 years (range 27 - 62). Patients were randomized to one of two groups based on the mode of wound dressing. Group I (15 patients) received extensive debridement and twice daily dressing in the first week using hydrogen peroxide followed by povidone iodine. Group II (16 patients) also received extensive debridement but had povidone-only dressing of the wound in the first week. In subsequent weeks all patients received normal saline dressing until the wounds healed up. None of our patient had diabetes mellitus.

Results:

In both groups culture and sensitivity results yielded mixed infection with Gram positive and Gram negative anaerobes (E. coli, Bacteriodes, clostridium spp, peptostreptococcus, S. aureus) and Gram negative aerobes (pseudomonads). Mean length of stay in hospital for Group I was 39 days +3 (p <0.05). For Group II Mean length of stay was 49 days +3 (p <0.05). It appears that hydrogen peroxide is important in the initial stages to control the anaerobes in the absence of more specific measures such as hyperbaric oxygen.

Conclusions:

Hydrogen peroxide has a role in Fournier's gangrene especially in the control of anaerobic infection. In low resource countries, twice daily dressing in the first week will hasten patient recovery and allow normal dressing with physiologic solution. There is the need to evaluate a group of Fournier's gangrene patients with diabetes mellitus.

P5

Room Havane, Level 3

NURSE SPECIALIST ASSISTING IN ROBOTIC SURGERY

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Introduction & Objectives:

In 2008, the Department of Urology, Aalborg Hospital, Århus University Hospital in Denmark, introduced robotic surgery for selected operations. In the beginning it was ever changing doctors who assisted the surgeon at robotic interventions. Experience showed however that assistance in robotic surgery is a specialized task which requires great experience and continuity wherefore the department in 2010 decided to train a nurse in this task. The department has put together a training program for robotic assisting nurses and compiled a function description.

Material & Methods:

The job description focuses on the many levels of complexity that characterizes clinical nursing and includes the following requirements for qualifications: - Authorization as a nurse - Experience as a theatre nurse, including experience with robot-assisted surgery - Practical skills at a complex level in terms of ability to perform with precision, accuracy, calmness, flexibility and security in the technical instrumental tasks. - Completed and passed course in laparoscopy Module 1 & 2 (www.MIUC.dk) - Diploma in Clinical Nursing - Motivating and inspiring will and ability to cooperate

Results:

The first nurse was educated in the autumn of 2010 and experience shows that the advantages are threefold: - a competent and stable assistant - someone to ensure high quality of the technical and instrumental nursing - someone to ensure full care for the patient.

Conclusions:

Developments in technology have led to decreasing demands for the theatre nurse, it is therefore important to ensure that skills and education are an integral part of the theatre nurse's education and function.

P6

Room Havane, Level 3

USE OF CLEAN INTERMITTENT CATHORIZATION (CIC) IN THE CONTROL OF HOSPITAL ACQUIRED INFECTIONS FOLLOWING PROLONGED USE OF INDWELLING URINARY CATHETERS

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Introduction & Objectives:

Prolonged Use Of Indwelling Urinary Catheter (IUC) Is Widespread In African hospitals. Many of these patients are older men with severe BPH/LUTS who often have repeated Acute Retention of Urine. These patients have no access to urologist due to the acute shortage. They therefore live poor quality lives with IUC. This study was undertaken to assess the role of CIC in reducing CAUTIs.

Material & Methods:

We investigated 22 patients who had been using indwelling catheters for a mean period of 38 months (16±43). Reasons for catheterization were: urethral distraction injury-8, BPH-14 with suprapubic catheterization. One of the patients with urethral distraction was a girl aged 4 years who was involved in a road traffic accident. IUC were inserted for an average of 3 weeks. Urine culture and sensitivity was done in our local laboratory of Tamale Teaching Hospital before the commencement of CIC. CIC was done initially with a nurse whilst patient was on admission and later by patient or relatives who had been taught the procedure.

Results:

Initial culture results yielded mixed infection with E.coli, Klebsiella sp and Pseudomonas 54%; E.coli and Klebsiella 27%, monoculture E.coli 13% and Klebsiella oxytoca 6%. Sensitivity patterns were similar for all cases. There was resistance to all antibiotics except Amikacin and Meronem. After intermittent catheterization for 24 weeks, culture results were as follows: E. coli sensitive to only Amikacin and Meronem 6%. E. coli sensitive to Nitrofurantoin, ceftriaxone, Gentamicin and Ciprofloxacin 91%. Klebsiella sensitive to Amikacin and Meronem 3%.

Conclusions:

In a low resource setting, where there is no opportunity for immediate surgical correction and where Carbapenems are not affordable, CIC is an alternative to achieving cultures sensitive to cheaper antibiotics. CIC probably achieves the above by reducing biofilms.

P7

Room Havane, Level 3

PROACTIVE MANAGEMENT OF PATIENTS WITH BONE METASTASES SECONDARY TO UROLOGICAL MALIGNANCIES: BEST PRACTICE AND USEFUL TOOLS

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Introduction & Objectives:

Primary urological malignancies (prostate, renal, bladder) commonly metastasise to the bone. Aside from pain, the true patient burden of bone metastases is characterised by the incidence of skeletal-related events (commonly defined as pathological fracture, spinal cord compression or the subsequent need for radiation or surgery to bone). While treatment options exist, there is a need to improve nurse and patient education to further improve patient management and outcomes.

Material & Methods:

A review of best clinical practice and validated tools to assess and manage patients with skeletal-related events, with the aim of improving quality of life.

Results:

Clinical practice is developing across Europe as more palliative and therapeutic options are approved and the trend moves from passive to active initiatives. Nurses have the opportunity to proactively improve the standard of patient management and good examples of best practice that have a positive impact on patient care have already been implemented. Examples including developing a bone support clinic, allow for the early detection and resolution of pending problems. In addition, regular outpatient visits provide a forum for essential patient education, including discussion of the risks of skeletal-related events, potential outcomes and prognosis. In the clinic, we have found that regular use of tools such as the analgesic ladder, brief pain inventory, quality of life assessment (e.g. QLQ-BM22 form to capture bone metastases-specific symptoms) and neurological assessment can help to effectively plan patient treatment and evaluate its success. Furthermore, through a holistic approach, nurse led clinics can increase patient compliance to treatment and facilitate proactive management of potential adverse events. A multidisciplinary team approach, in which nurses are integral is essential. Following this best practice, we review symptomatic patient X, who was referred by their physician to the bone support clinic where the attending nurse requested the required imaging/scans and laboratory work and performed basic physical and neurological assessments. Following multidisciplinary team review, an integrated patient care strategy was defined and implemented, encompassing further investigative procedures, initiation of new palliative/therapeutic treatments, ward admission, physiotherapy referral and community support arrangements.

Conclusions:

Sharing best practice and useful tools will impact clinical practice in a positive direction, reduce treatment variation and improve the standard of patient care and patient-reported outcomes across Europe. To achieve this, we would recommend that patients are reviewed on a regular basis (defined by each institute), using simple tools and assessments to monitor their progress.

P8

Room Havane, Level 3

SIGNIFICANCE OF NURSING MEASURING NUTRITIONAL STATUS IN CYSTECTOMY PATIENTS, A RETROSPECTIVE ANALYSIS

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Introduction & Objectives:

The length of stay (LOS) after cystectomy is an important outcome after surgery. The nurse plays an important role in the perioperative care of the patient by assessing the pre-operative and ongoing nutritional status. Early nursing intervention may enhance the post-operative rehabilitation. Several studies in the colorectal literature have shown that improving nutritional status decreases LOS and improves survival. The objective of our current study is to evaluate the impact of nutritional risk on the LOS in patients who underwent radical cystectomy for bladder cancer.

Material & Methods:

This is a retrospective analysis of 167 patients who underwent radical cystectomy in 2009 and for which the nutritional status, Charlson comorbidity score and BMI was available. A chart review was done and information on age, gender, BMI, Charlson Comorbidity Index were extracted. It is hypothesized that the nutritional risk status of a patient is associated with their LOS. To assess this relationship, we used a linear regression with LOS as the outcome and nutritional risk status (Low Risk, Medium Risk, High Risk), age, BMI, ASA (I/II v. III/IV), and Charlson Score (0, 1, or >1) as covariates.

Results:

There were 126(75%), 23(14%) and 18(11%) patients in the low, medium and high nutritional risk groups respectively. The adjusted mean LOS was 10.1, 9.4 and 9.1 for low, medium and high respectively. However these results did not reach statistical significance ($p=0.9$) after adjusting for age, BMI, ASA and Charlson score. On average patients in low risk group had a 1 day increase in LOS compared to the high risk group (95% CI -5, 3; $p=0.6$).

Conclusions:

The patients with poorer nutritional status had on average a shorter LOS in our study compared to patients with good nutritional status. While the difference in LOS was not statistically significant, the wide confidence interval did not exclude the possibility that nutritional status does have an important impact. However, if patients with poor nutritional status do not have longer LOS, it could be explained by a higher awareness of their deemed risk and therefore more intensive monitoring during their hospital stay. Nurses have an important role in daily monitoring and improving nutritional status and thus shortening the LOS. Further studies would be required to make a definitive conclusion about the effect of nutritional risk groups on LOS.

P9

Room Havane, Level 3

THE ROLE OF THE SURGICAL NURSE IN THE SURGERY OF LIVING DONORS' KIDNEY

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Introduction & Objectives:

In the recent years, living donor kidney transplantation has been significantly evolving, achieving better results than those by cadaver renal donor transplantation, being now the first choice when projecting transplantation. These differences are mainly due to a better receiver's basal diagnostic. All of the above mentioned, simply assert that the transplantations precocity as compared to the dialytic treatment becomes essential to the patient's survival which is, of course, our main aim. Living donor kidney transplantation also gets better results as regards the patients' survival, with survival rates in the last 5 years of 82% for the receivers of cadaver renal donor transplantation vs. 90.2% for the living donor renal transplantation. The raise of this surgical option leads to a change in the nursing work and therefore in nursing care, making it necessary to have a well-prepared and qualified nursing. Objectives: Our aim is to make the role of the surgical nursing in this process of living donor kidney donation known and to highlight the importance of the coordination of the surgical team in the process of extraction and implant after the application of a highly specialized nursing protocol.

Material & Methods:

The specialized nursing team will carry out the nursing team actuation protocol during the process of living donor kidney transplantation, offering specialized care, being: physiologic care at the surgical area entrance, anesthetic team care, as well as the whole team's. The surgical technique to apply will be the following: Laparoscopic Surgery; Left kidney's Nephrectomy. During the Nephrectomy surgery, must be highlighted, first the clamping of the renal artery, next, the renal vein. The organ's ischemic time, will be reduced to the minimum to successfully grant the implantation of the organ in the receiver. Here, the role of the transplantation surgical nursing is extremely important to coordinate simultaneous process. While extracting the organ they will coordinate the receivers' preparation to shorten the implantation time, thus obtaining a successful implantation.

Results:

As specially critical moments, requiring a deeply involvement of the specialized nursing team during the laparoscopic nephrectomy of the renal graft, the following surgical steps must be highlighted: the hand-assisted clamping of the renal artery, next, the hand-assisted clamping of the renal vein, to finish with the graft extraction, them being crucial moments for the quality and survival of the graft. The living donor kidney transplantation results are excellent and statistically better than those obtained with cadaver donors. (124 living donor' kidney cases of OCATT 2010). (Collaborative Transplant Study 1985-2009).

Conclusions:

Living donor kidney transplantation grants better life expectancy and survival. Thus making the presence of highly specialized nursing necessary in order to carry out the surgery with higher chances of success.

P10

Room Havane, Level 3

TEACHING SELF-CATHETERIZATION FOR PATIENTS WITH NEUROGENIC BLADDER. NURSING EXPERIENCES FROM A SPINAL CORD UNIT

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Introduction & Objectives:

Patients with a neurogenic bladder are an inhomogeneous group. 82.4% are depending on a wheelchair, 16.6% have an impaired hand function, 8.2% are with cognitive deficits. 63% of them use self-catheterization for emptying the urinary bladder. For this reason, we established an individual education program for teaching self-catheterization.

Material & Methods:

We examined the results of teaching courses (1 July 2010 until 30 June 2011) for 52 in-patients. All patients had different predispositions. 20 patients were women, 32 men. 28 patients had a spinal cord injury, 5 a multiple sclerosis, 5 an intracerebral paralysis, 3 a myelomeningocele. 11 had other neurological diseases. The neurogenic bladder was classified as overactive (N=41) and acontractile (N=10). Patients with hydrocephalus or multiple sclerosis and patients after brain injury were examined beforehand by a neuro-psychologist in order to assess cognitive abilities. The patients learned the intermittent catheterization method without gloves or mirror. The daily diuresis was supposed to not exceed 1.500mL with 4 to 5 catheterizations per day. Patients kept a micturition-/ catheterization- protocol.

Results:

Generally, the teaching results were satisfying. The patients needed approximately 5 to 6 teaching units to learn the self-catheterisation. Patients with impaired cognitive function (N= 5) needed more time (up to 30 units) to handle self-catheterization. 3 patients were not able to catheterize themselves. 1 woman had difficulty identifying the urethra because of her very high body mass index (BMI). 2 men with incomplete spinal cord injury with hypersensitivity had intensive pain in the bladder and urethra after catheterization. 7 patients had to use additional tools (i.e. mirrors, trouser-holders, aids to spread the legs). For 4 male patients it was difficult to insert the catheter into the meatus urethrae, so that we recommended use of a catheter with introducer tip, with a protective sleeve, or an extendable catheter. 2 out of 5 with spinal cord injury level below C04 were able to catheterize themselves with the support from other persons concerning the preparation of the catheter materials.

Conclusions:

Teaching catheterization is demanding in that it takes time and different needs have to be met. Catheter material and form have to be selected on an individual basis. The nursing staff needs to be highly qualified and experienced. Synchronization with physiotherapists, ergotherapists and neuro-psychologists is important. Despite these challenges, teaching catheterization is important in order to improve quality of life and independence of patients. Even patients with cognitive deficits and disabled hand function can learn to perform the self-catheterization in classes that take account of their special needs.

P11

Room Havane, Level 3

THE IMPACT OF INCONTINENCE ON THE DEPENDENCY SCALE, THE CARE PROFILE AND THE FINANCING OF BELGIAN RESIDENTIAL NURSING HOMES

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Introduction & Objectives:

The financing of residential care in Belgium is mainly based on the dependency status of the residents and consist of a daily fixed amount that mainly depends on the casemix of residents that remain in the nursing home. This casemix is determined by the dependency scale Katz and stipulates the dependence status of each patient. The residents are classified into five different care profiles classified from low dependency status to residents with a high dependency status. These care profiles are crucial in the funding of the institution and the manpower. Continence is one of the items of the Katz-scale. Improving the continence status of the residents nowadays leads to penalties in government funding. Consequently the funding will be higher in organisations who accommodate residents with a high dependency status. But this statement also affects the incentives for better care and self care support. Objectives: determine the impact of the item continence on the Katz-scale on the care profile and on the financing. Will a continence-care program lead to less financing?

Material & Methods:

Theoretical simulations were made on a file extracted from the database of the Christian National Health Service. This file contained anonymous Katz –scales of residents that remained in Belgian nursing homes during Oct 2009 – Sept 2010. Theoretical adjustments were made on the score of the item continence of the Katz –scale to determine the influence of this item on the care profile. To determine the influence on the financing a mathematical model from Probis Consultancy was used.

Results:

The item continence had no influence on the lower care profiles. Whereas this item had an impact of the higher care profiles. A score of 3 or more on the item continence is indispensable to be classified under the higher profile. For the highest profile items as orientation in time and place are also decisive. The financing was the highest in nursing homes who accommodated residents with a high dependency scale.

Conclusions:

The highest financing in the residential care is obtained in organizations who accommodate residents with a high dependency status. This conclusion proves that the actual financing model of the residential care in Belgium gives little incentives to deliver qualitative services. Since improving the continence status of the residents leads to penalties in government funding. A financing system based on the pay for performance principle is recommended.

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Room Havane, Level 3

ACUTE PAIN OUTCOMES AFTER OPEN AND MINIMALLY INVASIVE ROBOTIC-ASSISTED SURGERY FOR LOCALISED PROSTATE CANCER

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Introduction & Objectives:

In Australia each year, 12,000 men are diagnosed with prostate cancer and many elect to have surgery. In a climate of rapidly changing surgical technology, advances include minimally invasive surgery where it is expected that men will experience less postoperative pain and earlier recovery than those who have open surgery. The aim of this paper is to describe and compare acute pain outcomes of men immediately after two surgical approaches used for prostatectomy to treat localised prostatic cancer.

Material & Methods:

This study was part of a prospective, longitudinal, matched cohort study to evaluate and compare short (acute) and long term (up to 24-months) physiological, functional and psychosocial outcomes of men following open radical retropubic (RRP), robotic-assisted radical (RARP) and laparoscopic radical prostatectomy (LRP) for localised prostatic cancer. Repeated measures included pain and treatment outcomes, quality of life, symptoms and sexual and urological function. Acute pain outcomes were measured using the American Pain Society Pain Outcomes and the McGill-Melzack Pain Questionnaires applied via interview 24 hours after surgery. Pain intensity scores were derived via a 0-10 point numerical rating scale (NRS) from all participants (n=150 RRP, n=150 RARP). Analyses were conducted for two subgroups of men undergoing RRP (n=50) and RARP (n=50), randomly selected from the population of participating men.

Results:

In total, 229 (76.3%) patients had experienced pain in the previous 24 hours, 79.3% of the RRP men and 73.3% of the RARP men ($p>.05$). Mean pain scores at the time of interview were RRP=2.6 (SD=2.6) and RARP=2.9 (SD=1.8), $p=.965$. Worst pain scores in the previous 24 hours were RRP=5.8 (SD=2.9) and RARP=5.9 (SD=2.6), $p=.167$. RARP men experienced higher average pain, 3.4 (SD=1.8) than those having RRP, 2.9 (SD=1.7), $p=.014$. Men who underwent RRP were more likely to experience puncture wound pain, $p<.001$, while men who underwent RARP were more likely to experience wind pain, $p<.001$ and referred shoulder pain, $p<.001$. The location of pain also differed between cohorts; RARP men experienced pain in the general abdominal area ($p<.001$), penile tip ($p=.042$), and Right shoulder tip ($p=.001$), whereas RRP men experienced pain in the lower abdomen ($p<.001$) and in the surgical wounds ($p<.001$). RARP men were less likely to have their sleep interrupted by pain ($p<.001$). There was no difference in the effect of pain on the sensory, affective or evaluative experience of the two cohorts.

Conclusions:

The findings indicate that acute postoperative pain following surgery for localised prostate cancer is prevalent after surgery. There are important differences in the way pain manifests in patients who undergo RARP and RRP that have implications for the way men are prepared for surgery and how pain is managed.

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Room Havane, Level 3

ADVISING THE PATIENT'S RADICAL PROSTATECTOMY IN THE EAST-TALLINN CENTRAL HOSPITAL UROLOGY DEPARTMENT

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Introduction & Objectives:

As prostate cancer is an increasing health problem, the demands for the health care system are increasing accordingly and the quality of the service provided by doctors and nurses needs to be improved as well. It is important to estimate the quality of life in order to improve patients' ability to cope with changes in their life after radical prostatectomy. Patients need to know what kind of changes in the quality of life radical prostatectomy can bring. Nurses' task is to teach and support patients so they could cope and adapt with the changes in quality of life involved by a prostatectomy.

Material & Methods:

Describe the counselling of a radical prostatectomy patient in pre and post operation period. Method: Collect informal feedback about patients' knowledge involving changes in quality of life after radical prostatectomy. During the appointment of a nurse/physician a patient's knowledge about the changes in quality of life in post-operative period have been evaluated and, at the same time, the need for additional information has been estimated.

Results:

The most common changes in the quality of life have been analyzed. Patients are forwarded to the independent appointment of the urology nurse for pre and post operation monitoring. Conditions are created for the private and individual teaching of a patient in pre and post operation period. Patient's support persons (or family) have been involved. Active monitoring of patients after the surgery is conducted.

Conclusions:

In conclusion we can say that counselling the patients with a prostate cancer have been giving them enormous amount of support in order to cope with the changes in the quality of life after a radical prostatectomy. Our nurses advice patients about different factors that are changing the quality of life -urinary incontinence, erectile dysfunction, emotional problems, wound care, catheter care. PSA test is observed. Pelvic muscle exercises in pre and post operation period have been taught.

LONG-TERM EFFECTS OF PELVIC FLOOR MUSCLE TRAINING (PFMT) VS EXTRACORPOREAL MAGNETIC INNERVATION (EXMI) ON POST-PROSTATECTOMY URINARY INCONTINENCE

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Introduction & Objectives:

In a previous study we showed that PFMT and ExMI reduce urinary incontinence (UI) after radical retropubic prostatectomy (RRP), and ExMI reduces rehabilitation times by 40% (Terzoni S. UI after RRP. Efficacy of two conservative treatments managed by nurses. PhD thesis in Nursing Sciences. University of Milan; 2011). It is known that patients can achieve some degree of spontaneous recovery in six months after RRP, but few data exist regarding long-time effects of PFMT and ExMI (Hunter KF et al. Conservative management for post-prostatectomy urinary incontinence. Cochrane Database Syst Rev. 2007 (2)). This study compares the effects of PFMT and ExMI on UI, over a follow-up period of 12 months.

Material & Methods:

We recruited a non-randomized sample of 65 PFMT and 23 ExMI patients (the machine was at our disposal for only 6 weeks) rehabilitated for post-RRP UI in our hospital. The patients quantified leakages with 24-hours pad tests. During rehabilitation, PFMT patients had received 1 session per week and had performed daily exercises; ExMI patients had received three. After rehabilitation, both groups followed a protocol of daily maintenance exercises (Bortolami A. La riabilitazione del pavimento pelvico. Milan: Elsevier; 2011). We assessed all patients at 3, 6, and 12 months after rehabilitation.

Results:

The median daily leakage in the sample was 180 grams before treatment, and 5 grams after, with comparable initial symptoms (1) and significant leakage reduction ($p<0.05$) in both groups. The median number of sessions (PFMT=7, ExMI=14) was related to the initial leakage ($p=0.02$). Many PFMT patients experienced difficulties due to physical conditions and low awareness of pelvic muscles, and required up to 2 months of additional sessions. This fact did not influence their results (ANCOVA: $p=0.86$). The table summarizes our results.

	PFMT	ExMI	Leakage difference
Median age	69.50	69.00	
Median BMI	26.36	26.39	
End of rehabilitation-3 months	k=0.48, n=60	k=0.70, n=11	p=0.38
3 months-6 months	k=0.61, n=48	k=0.70, n=11	p=0.21
6 months-1 year	k=1.00, n=33	k=1.00, n=7	p=0.61

Concordancy in the PFMT group was low at 3 months, due to slight variations among the patients' leakages; however, the strong correlation ($\rho=0.81$, $p<0.001$) confirmed the persistence of the rehabilitation results.

Conclusions:

Our patients maintained the results of rehabilitation during the year. Both treatments led to clinically relevant incontinence reduction, with similar leakages in the two groups over time. ExMI should be used for quick muscle strengthening; after that, nurses should teach maintenance exercises to patients. PFMT can be effective in people with physical limitations and low awareness of their pelvic floor, provided that patients comply with rehabilitation programmes. Nurses play a crucial role in improving compliance, thanks to their therapeutic relationship with patients.

P15

Room Havane, Level 3

INTRODUCING A NURSE-LED TRANSPERINEAL SATURATION PROSTATE BIOPSY SERVICE

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Introduction & Objectives:

Transperineal saturation prostate biopsy (TPSBx) is the best technique to exclude patients with high risk prostate cancer from an active surveillance cohort previously diagnosed with a transrectal ultrasound guided biopsy (TRUSBx). This technique is challenging to learn and requires competency in both ultrasound imaging and needle placement technique. Surgical procedures requiring general anaesthetic have been traditionally carried out by surgeons or their trainees. We assessed the reaction of patients to the Prostate Cancer Advanced Nurse Practitioner (PCANP) carrying out this procedure in conjunction with an audit of complications compared to surgeons carrying out the same procedure.

Material & Methods:

Between May 2010 and May 2011, 100 patients underwent a TPSBx by the PCANP. We compared post-operative morbidity with 100 TPSBx carried out by the Consultant Urologist and his Registrar. Morbidity was assessed in respect to acute urinary retention, clot retention, haematuria, urinary infection (UTI) and urosepsis. Patient satisfaction was assessed with an anonymous questionnaire using Likert items. Finally the PCANP samples were reviewed by a consultant histopathologist for appropriateness and consistency of sampling and mapping.

Results:

2 patients in the PCANP group experienced acute urinary retention in comparison to 4 patients in the Consultant team group. No patients experienced clot retention, haematuria or UTI with subsequent admission in the nurse group in comparison to 2, 3 and 3 patients respectively in the consultant group. No patients in either group experienced urosepsis. Of 100 patients surveyed, 100% agreed or strongly agreed that the nurse gave an equivalent or better explanation of a biopsy procedure during the consent process compared to previous experiences. 98% agreed or strongly agreed that the procedure had been competently carried out by the nurse. Of those who had experienced a previous TP biopsy (n=33) 100% agreed or strongly agreed they had experienced the same or less side effects. 100% of patients strongly agreed that they felt their continuity of care had improved. Histopathology review showed that 93/100 of the PCANP samples were of an excellent quality. The remainder were of good or average quality.

Conclusions:

Patients appreciated the continuity of care and the information provided by the PCANP. Morbidity was reduced in the PCANP group. This may be due to the experience gained through greater number of procedures carried out. Consistency in sampling and mapping was maintained. A PCANP allows for excellent, focussed education and practical teaching for trainees.

P16

Room Havane, Level 3

PROSTATE CANCER FOLLOW UP. DO PATIENTS AND HEALTH PROFESSIONALS WANT THE SAME THING?

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Introduction & Objectives:

Prostate cancer patients who have undergone radical treatment are subsequently followed up in clinic by a doctor or a nurse. The benefits of this assessment are to detect disease recurrence, monitor treatment side-effects & to offer support & advice. It is possible that patients' priorities differ to those of healthcare professionals. The assumption that shifting the same follow-up to a different setting or from one health professional to another will somehow improve the care or cost of follow-up, is naïve. The aim of this study is to investigate the perceived benefits of routine follow-up & establish a preference of who should follow-up patients & where, in a group of patients & health care professionals. The results will be used to guide the development of our service.

Material & Methods:

A questionnaire was designed to evaluate patients' preferences for prostate cancer follow-up in our hospital. The questionnaire was offered to all patients attending clinic from 17/05/10–09/08/10. 48 patients (PTS) completed the questionnaire. It was also completed by 17 healthcare professionals (HPS) in the urology department. To understand how patients define follow-up & their views on choice, a focus group discussion was conducted in which 52 patients participated.

Results:

There was agreement between PTS & HPS that the main purpose of follow-up consultation was to review the PSA blood test & assess urinary symptoms. More HPS than PTS responded that the purpose of follow-up included holistic assessment (53% v 17%) & provision of advice & reassurance (47% v 21%). 67% of PTS wanted follow-up in the hospital compared to 53% of HPS. 71% of PTS wanted face to face consultation whereas 53% of HPS preferred telephone assessment or results by letter. There was general agreement that assessments should be carried out every six months, but 41% of HPS responded that the frequency of assessment should be individualised. 87% of PTS responded that it was important to have easy access to the urology cancer team. The group discussion confirmed that PTS preferred the traditional model of hospital based follow-up with face to face consultation. PTS felt strongly the need for reassurance which should come from someone with expertise. PTS felt unsure about follow-up outside of the hospital. Most importantly PTS wanted easy access to the urology cancer team & the urology nurse specialist was identified as being well placed to offer reassurance & to coordinate ongoing care.

Conclusions:

PTS prefer the traditional model of hospital based follow-up. If this is to change we need to work with our patients to develop a service that meets their needs. Patient-led follow-up could work, provided patients are confident that they have access to advice & support & are assured of referral back to the urology team if required. Nurses are ideally placed to play a key role in the development of such a service.

P17

Room Havane, Level 3

MOBILE ADVICE & TESTING SERVICE (MATS): INTRODUCTION OF A NOVEL, NURSE-LED PROSTATE CANCER EDUCATION AND TESTING SERVICE

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Introduction & Objectives: In Australia, as in other countries, there is confusion in the community about the need for prostate cancer (CaP) testing. Divided opinions amongst health professionals about the benefits or harm of CaP treatment add to this. As a consequence, many men in the recommended age group for CaP testing do not have access to information about their personal risk of developing CaP, in order to make a choice of whether or not to undergo testing. We established a workplace Mobile Advice & Testing Service to give men easy access to this information. We piloted the service and evaluated the effectiveness, feasibility and acceptance of the program.

Material & Methods: We reviewed existing guidelines for CaP testing and developed a testing protocol for the MATS. We created an education program for the workplace sessions about CaP testing and treatments, and associated risks and benefits. We modified an existing Prostate Cancer Knowledge Questionnaire (PCKQ) and developed a Quality Assurance (QA) questionnaire to assess the usefulness of the service. These were piloted and revised as required. Workplaces with predominantly male employees were contacted, invited to participate, and site visits scheduled. The first was an education session delivered by a male urologist, with time for questions and answers. Individual appointments with urology nurses were scheduled, with the opportunity for CaP testing at that time. PCKQs were completed prior to the education session and repeated at the completion of the consultation with the nurses, with the QA questionnaire. Pre- and post-PCKQs responses were compared. Demographic and general health related data were also collected. All testing results were reviewed by a urologist, and results sent to both participant and their General Practitioner (GP) with recommendations about future testing.

Results: 101 men attended the sessions at 3 worksites, 67 being in the target population (40 – 70 years). Comparison of pre- and post-PCKQs demonstrated improved CaP knowledge following the sessions.

PROSTATE CANCER KNOWLEDGE	None	Little	Moderate	High
Pre-PCKQ	11%	52.5%	31.5%	4%
Post-PCKQ	3%	31%	56%	10%

44% reported they do not regularly attend a GP. Of those in the recommended age for testing, 56% had not been tested. Of those who had been tested 86% reported they had a Prostate Specific Antigen (PSA), and only 53% a digital rectal examination (DRE). 7 of 101 attending the nurse consultations had an abnormal PSA and/or DRE and were recommended for urologist review and further investigation. The MATS experience was rated Highly Satisfactory – Satisfactory by all participants.

Conclusions: A nurse led MATS provides an alternative, convenient forum for men to obtain information about prostate cancer and to undergo testing if they wish to do so. It provides a model of care that could be adopted in many settings.

P18

Room Havane, Level 3

THE IMPACT OF A NURSE LED URINARY MEMOKATH™ STENT FOLLOW UP CLINIC

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Barts and The London NHS Trust, Dept. of Urology, London, United Kingdom

Introduction & Objectives:

As a result of expanding workload, we introduced an experienced clinical nurse specialist (CNS) to work as part of the endourology team. Part of the CNS's remit included setting up a nurse led clinic for patients who have Memokaths™ inserted. These are semi-permanent, segmental, metallic, nickel-titanium alloy stents with a thermal memory, effective for treating upper or lower urinary obstruction. Previously patients were seen in our stone clinic as there was no dedicated clinic for them to attend. By providing a nurse led follow up clinic we aim to ensure patients are reviewed in a timely manner and have a designated point of contact. We looked at the positive impact of this clinic on services for our patients.

Material & Methods:

Patients attend clinic for review by the CNS working to a protocol. Patients with ureteric stents have an x-ray, which the CNS compares to previous images to ensure the stent is in the correct position. For prostatic stents, the patient will undergo a flow rate study and residual bladder scan, which is compared to previous traces. Patients are seen at 6 weeks, 3 months, 6 months, 1 year, then annually following insertion of the Memokath. Patients whose stent remains in the correct position and are not displaying any symptoms of obstruction are given a follow up appointment as per protocol. Symptomatic patients and/or patients whose stent is dislodged on x-ray are either booked for further investigations to assess the degree of obstruction or added to the theatre list for intervention following discussion with a doctor.

Results:

To date, our endourologists have placed 236 stents. 159 of which are ureteric and 77 prostatic stents. Following assessment and review of the x-ray by the CNS, 23 ureteric stents went on to be removed as the ureteric stricture had spontaneously resolved. 27 stents were dislodged on x-ray and the patient was subsequently taken back to theatre for repositioning. 15 were removed as the patient required alternative treatment. Of the prostatic stents 28 were removed due to patient symptoms. To date the CNS has a caseload of 164 patients with a functioning Memokath in situ.

Conclusions:

By implementing a nurse led Memokath follow up clinic, patients are given ample time to discuss any issues, with the CNS forming a readily available port of call. The CNS provides an important role in ensuring patients are followed up correctly and that effective treatment plans are made for patients who require intervention. 12 patients are seen by the CNS bimonthly freeing up slots in the stone clinic for doctors to see new patients. These extra new slots generate an additional income of approximately £46 500 per year for our trust. This practice also promotes further development and expansion of a CNS role, which is beneficial for patients' care.

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EAUN Symposium

Ipsen and Photocure sponsored satellite symposium at
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Congress, Paris

Optimising care for bladder cancer patients

Saturday 25th February,
Salle Havane, level 3, 13:15 – 14:15

Chair

Françoise Charnay-Sonnek

Speakers

Kathryn Chatterton

Colin Bunce

Rikke Knudsen

Please see congress programme for full agenda

**For further information please visit the Ipsen booth
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Indwelling vs. intermittent catheterisation in voiding difficulties: What does it mean for patients, caregivers and society?

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