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16th International EAUN Meeting

21-23 March 2015, Madrid, Spain

Programme Book



in conjunction with
EAU15



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16th International EAUN Meeting

21-23 March 2015, Madrid, Spain



webcasts

16th International EAUN Meeting

www.eaumadrid2015.org/eaun



All sessions showing the webcast symbol in the
programme book will be available in the
Resource Centre at the EAUN Meeting website

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Association
of Urology

EAUN Industry Partners

The European Association of Urology Nurses gratefully acknowledges the support of the following companies for the programme of the 16th International EAUN Meeting:

AMGEN
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Industry Sessions

COLOPLAST

EAUN Awards

- First Prize for the Best
EAUN Poster Presentation - AMGEN
- Second Prize for the Best
EAUN Poster Presentation - AMGEN
- Third Prize for the Best
EAUN Poster Presentation - AMGEN



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A warm welcome to Madrid!

Dear Colleagues,

It gives me great pleasure to welcome you to the historic city of Madrid for the 16th International Meeting of the European Association of Urology Nurses (EAUN). In collaboration with our colleagues from the Spanish Urological Nursing Society (AEEU), Madrid promises to be innovative, dynamic, comprehensive and of course enjoyable!

Under the guidance of our newly formed scientific committee, the 2015 programme will provide key clinical and academic sessions keeping abreast of current evidence based care and discussion about the very nature of urology nursing and the changing tides. In our first plenary session we will consider the future of urological nursing and discuss the need for a common framework.

Our interactive workshops as always prove to be immensely popular, with topics this year ranging from Rehabilitation in urology cancer care to Ongoing challenges in health and sexuality in male patients. Urological surgery remains a key theme this year, with a collaborative workshop with the European Operating Room Nurses Association (EORNA) which will focus on the diagnosis and peri-operative care in prostate disease. In addition there will be an opportunity for you to join us on Sunday morning for the “Surgery in Motion” session as we are taken through various urological surgical procedures by video abstract presenters.

The traditional Urowalk and Nurses’ dinner & dance will take place on Sunday, the Urowalk finishing at the dinner venue.

It therefore leaves me to wish you all a very enjoyable time at the meeting!

Should you have any questions or suggestions please do not hesitate to speak to us during the meeting.



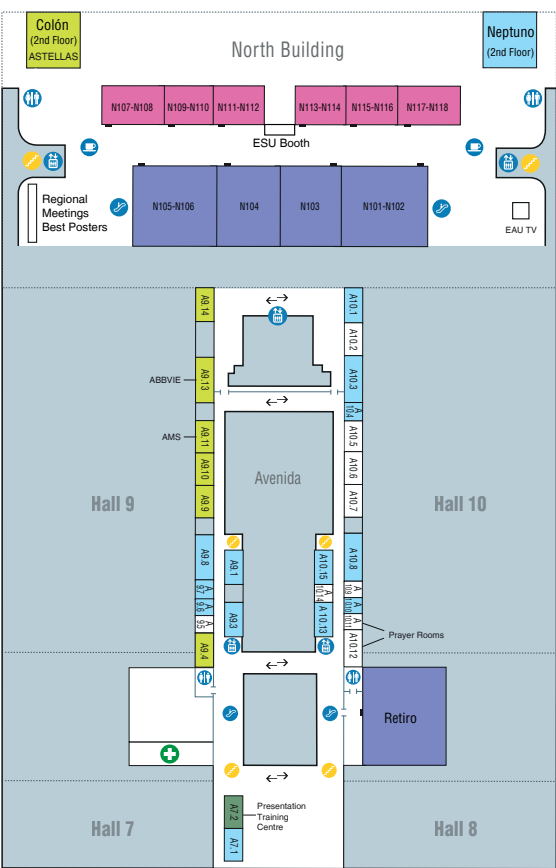
**Lawrence
Drudge-Coates**
EAUN Chair

Floorplan

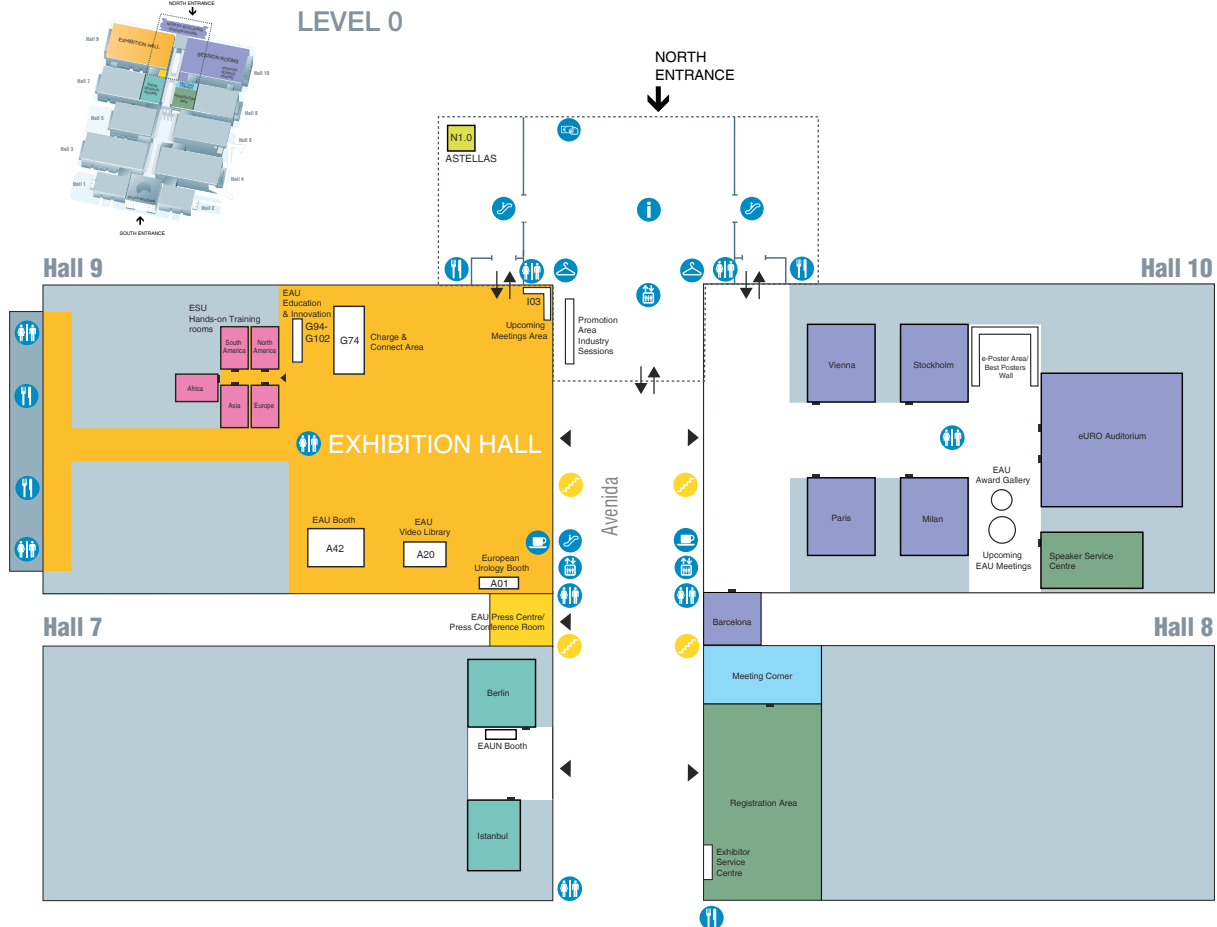
OVERVIEW VENUE



LEVEL 1



LEVEL 0





General

General Information
Speaker Guidelines

General information

Disclaimer

During the 30th Anniversary EAU Congress, the “Exhibition Booths” and “Industry Sessions” related to “prescription-only medicines” are only accessible to certified healthcare professionals, qualified to prescribe medicines, and pharmacists. Based on information provided by the registering party, the EAU will indicate on the congress badges if the bearer has accreditation to access the “Exhibition Booths” and “Industry Sessions” related to prescription-only medicines. The accredited delegates will have the letter “P” on their badges. It is the responsibility of the registering party to provide correct information and the EAU holds no responsibility with regards to the information provided. This measure is in accordance with the national and international pharmaceutical guidelines.

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 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

The Annual EAU Congress takes place at the IFEMA Feria de Madrid, which is located 30 minutes from the city centre, within walking distance from the underground station (line 8) and just a 10-minute drive from the airport. The closest metro to the congress venue is “Campo de las Naciones” station on Line 8, The station exit is at the South entrance of the venue. Line 8 connects the venue with the city centre and the different terminals of Adolfo Suarez Madrid Barajas Airport. All congress delegates may collect a complimentary transportation pass in the registration area. This pass is valid on all public transport within the city of Madrid during the congress, see also “Transportation pass”.

Address congress centre: IFEMA - Feria de Madrid
Avenida del Partenón 5, 28042 Madrid, Spain
T +34 91 722 3000, W www.ifema.es

App - Your smart congress companion



With the EAUN15 App you have instant access to the most important information of the 16th International EAUN Meeting via your smartphone.








You will be able to browse the complete scientific programme by day, topic, speaker, and create your own personal programme thanks to the planner. You can easily find the rooms and exhibitor stands on the floorplans and receive daily news. In your personal congress bag you can save all relevant information, which you can email after the congress so you can easily review all scientific content at a later stage. You do not need constant internet access and can use the app offline. Download the “EAUN 15” App from the App Store (iOS) or Play Store (Android). Once installed you can access the content with your congress registration log-in (MyEAU) or your EAUN member log-in (MyEAU).

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. EAU(N) bears no responsibility for data scanned by third parties.

Badge classification

The badge classification is as follows:

	Blue badge	: EAU member
	White badge	: Delegate
	Brown badge	: Nurse
	Green badge	: Exhibitor
	Red badge	: Press
	Yellow badge	: Organising staff
	P	: Entitled to prescribe medicines/pharmacist

Bank, Exchange and Credit Cards

The national currency in Spain is the Euro (€). ATM machines at the congress centre are available in the North Building, the South Building and on the Avenida at the two banks next to Hall 3 and Hall 4 (Bankia & Santander). For foreign exchange services, our recommendation would be that you use the foreign exchange centres located in the arrival halls of Madrid

Adolfo Suárez- Barajas airport or in the historic city centre: Change Express S.L., Gran Vía 16, 28013, Madrid or Exact Change, Pl. Puerta del Sol 12, 28013, Madrid.

Best Posters

The Best Posters Wall features the best scientific posters of the 30th Annual EAU Congress and the 16th EAUN Meeting. This high-tech plasma wall is accessible during congress hours in the foyer of the eURO auditorium. The best posters can also be viewed at the e-poster stations and through the congress website during and after the congress. See also “e-Poster Area”.

Business Centre

The Post office on the Avenida (between Hall 5 and 7) offers copy and print facilities. For more information on copy and print shops near the congress centre please go to the EAU Information desk in the North building (level 0).

Certificate of Attendance

A Certificate of Attendance for the EAUN Meeting will be available to print at www.eaumadrid2015.org/eaun as of Wednesday, 25 March 2015. Before obtaining your Certificate of Attendance, you will be requested to enter the number under the barcode on your badge to log in (type the number without the *).

Cloakroom / Luggage

The cloakroom is located in the main entrance hall and open during congress hours. Please be sure to collect all personal belongings at the end of the day.

CME Accreditation

The EAUN applied for accreditation of the 16th International EAUN Meeting for nurse specialists and nursing and care professionals in the Netherlands.

Congress Bag

Each delegate can collect a congress bag in the registration area in Hall 8.

Congress Hours

Registration

Thursday, 19 March	08.00-20.00 hrs
Friday, 20 March	07.00-20.00 hrs
Saturday, 21 March	07.00-20.00 hrs
Sunday, 22 March	07.00-19.30 hrs
Monday, 23 March	07.00-19.30 hrs
Tuesday, 24 March	07.00-12.00 hrs

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 in the North Building (level 1) with extensive information on its activities. The ESU Courses DVD 2015 will be distributed at the ESU booth (North building, Level 1) to all congress delegates.

The ESU Courses DVD 2015 is supported by an educational grant from TAKEDA ONCOLOGY

Fees ESU Courses (for congress registered delegates only) for Residents and nurses (members/non-members): € 23 (*Prices are excl. 21% VAT*).

Hands-on training Courses

Hands-on training courses are organised by the ESU in cooperation with the EAU Robotic Urology Section (ERUS), the EAU Section of Uro-Technology (ESUT) and the EAU Section of Urolithiasis (EULIS). The registration fee is € 26,- (nurses and residents) per hands-on training (excl. VAT).

Registration for the ESU courses and hands-on training courses can be made at the ESU registration desk in the registration area in Hall 8.

EAU Square

The EAU Square (booth A42 in the exhibition) consists of the EAU(N) Membership Booth, EBU Corner, EU-ACME Corner, Young Urologists / Residents Corner, EAU Munich 2016 Information Counter, EAU Research Foundation and the EAU Historical Exhibition.

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

EAUN Board

L. Drudge-Coates, London (GB), Chair
 S. Terzoni, Milan (IT), Chair Elect
 K. Fitzpatrick, Dublin (IE), Past Chair
 W. De Blok, Amsterdam (NL)
 S. Vahr, Copenhagen (DK)
 P. Allchorne, London (GB)
 S. Borg, St. Julians (MT)
 E. Grainger, Århus (DK)

General information

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EAUN Scientific Committee

S. Terzoni, Milan (IT), Chair

Bente Thoft Jensen, Århus (DK)

Jerome Marley, Newtownabbey (IE)

Lisette Van De Bilt-Sonderegger, Eindhoven (NL)

Rita Willener, Berne (CH)

Electricity

The electricity in Spain runs on 220 volts and the frequency is 50 Hz. Plugs have two round pins. A plug adaptor will be required if incompatible electronic devices are used.

Emergency Phone Numbers

In case of an emergency please call 112 for police, fire brigade or ambulance service. In case of an emergency in the congress centre please call +34 917 22 54 00 or contact a security guard immediately. See also "First Aid". To file a police complaint (for example cases of pickpocketing or theft, etc.) you can call the following number for assistance in several languages: +34 902 102 112.

Exhibition

An extensive technical exhibition will be held jointly with the congress in Hall 9. The exhibition is open to technical equipment manufacturers, pharmaceutical companies and scientific publishers.


Exhibition Hours

Saturday, 21 March 09.15-18.15 hrs

Sunday, 22 March 09.15-18.15 hrs

Monday, 23 March 09.15-18.15 hrs

First Aid

There is a medical unit present for first aid above Hall 7 on level 1, indicated on the directional signs with . In case of emergency, contact a security guard immediately or call +34 917 22 54 00. See also "Emergency Phone Numbers".

Insurance

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

Language

All presentations during the EAU Congress and 16th International EAUN Meeting will be conducted in English, the official language of the EAU. Translation to other languages is not available.

Learning Objectives

The EAUN Meeting 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. Delegates attending the EAUN International Meeting will be able to:

- Review emerging evidence, innovative techniques and scientific advances relevant to the field of urological nursing;
- Review the latest data and emerging trends from studies in clinical and translational research relevant to nursing and urological care generally;
- Discuss the evolving role of the EAUN in promoting higher standards of urological nursing care, urological nursing research and practice development;
- 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 through educational activities, workshops and courses;
- Gain exposure to new developments in evidence-informed, multi-professional urological care including medical technology, drug therapy, medical devices and new cutting edge 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 EAU Information at the North Building. If you lose something, please report to this desk for assistance.

Madrid Information

Information on Madrid will be available at the Madrid Information Desk in the registration area in Hall 8.

Media Policy

Registered press representatives may attend all scientific sessions, but are not allowed to attend the EAU Exhibition booths and industry sessions related to prescription-only medicines, as these are only accessible to certified healthcare professionals qualified to prescribe medicines, and pharmacists. Photographing during sessions is allowed for personal and non-commercial use only, i.e. photos cannot be published or reproduced in any way. Outside of the scientific session, you need written permission by the EAU for Photography, filming, and interviews at any location within the congress venue. Filming of the congress sessions is only possible for a few minutes (news coverage). Video recording of the congress sessions is subject to authorisation by the EAU Press Office. A written request must be submitted prior to the congress to Ms. Ivanka Moerkerken i.moerkerken@uroweb.org or during the congress at the EAU Press Centre. Requests will be approved on a case-by-case basis. Filming crews will have to be accompanied by a representative of the EAU Press Office.

Mobile Phones

The sound and flash lights of mobile phones must be switched off during all sessions.

Opening Ceremony and Awards

Participants and exhibitors attending the EAU Congress or the EAUN Meeting are welcome to attend the official Opening Ceremony on Friday, 20 March 2015, between 18.00 and 19.30 hrs. in the eURO Auditorium. During the Opening Ceremony the following EAU Awards will be delivered: Willy Gregoir Medal, Frans Debruyne Life Time Achievement EAU Madrid 2015 51 General Award, Crystal Matula Award, Hans Marberger Award, Innovators in Urology Award, Prostate Cancer Research Award 2015, announcement New Honorary Members 2015. EAUN Awards will be handed out the the EAUN Award Session, Monday, 23 March, 13.45-14 hrs. in room Berlin (Hall 7).

Personal Planner

Do not miss anything during this year's congress, use the EAU/EAUN Personal Planner!

- It is fully integrated with the scientific programme of the congress.
- You can select your priority sessions and add your private appointments.
- You can export it to your Outlook, Google Calendar or print it out.

Visit the congress website for more information:
<http://eaunmadrid2015.uroweb.org/scientific-programme>

Poster Builder Service

Poster presenters who created their posters for the Madrid Congress through the "EAU Online Poster Builder Service", can collect their posters at the Speaker Service Centre in Hall 10.

Poster DVD

A DVD with a collection of EAU scientific posters from the Madrid Congress will be distributed by AMGEN (booth C22 in the exhibition).

The EAU Poster DVD 2015 is supported by an unrestricted educational grant from AMGEN

Prayer Room

Special rooms dedicated to prayer for men and women are located in room A10.11 and A10.12.

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. Appointments for this very popular training session can be made at the Speaker Service Centre in Hall 10.

Press Centre

Journalists and medical/science writers can obtain free registration to the congress. Journalists receive a press pack, to be collected at the EAU Press Centre (1st floor). All press are invited to report to the EAU Press Centre to obtain the assistance and information they require. Internet access, printer and photocopier are provided.

General information

Resource Centre EAU15 Urology Science and Learning

All of the congress's scientific content, including abstracts, posters and webcasts will be available online on the Congress Website Resource Centre (www.eaumadrid2015.org). Content is constantly updated over the course of the congress and afterwards. Watch scientific sessions you may have missed, or reread the data of the latest research. You have access to the Resource Centre with your congress registration log-in (MyEAU), your EAUN member log-in (MyEAU) or with the number below the barcode on your congress badge (type the number without the *).

Restaurant Reservations

The choices for eating out in Madrid are endlessly varied. Traditional Spanish cooking is made up of unpretentious but tasty dishes offered in numerous restaurants. Paella, Cocido Madrileño (stew of lam and vegetables, or the typical tapas (manchego cheese, Albondigas) you name it and it's there. Please be aware that in Spain it is common to start eating dinner around 22.00 o'clock (CET). For restaurant suggestions, kindly visit the Madrid Information Desk in the registration area. Please note that the convention bureau cannot make any restaurant reservations, only provide suggestions and contact information.

Safety

The safety of all congress attendees is of utmost importance to the European Association of Urology. The IFEMA and EAU have taken security precautions to ensure the maximum possible safety for all EAU and EAUN 2015 participants. All bags may be subject to inspection. Please take all personal effects with you when leaving a session room.

Smoking Policy

The Annual EAU Congress and the concomitant exhibition have been designated as no-smoking events throughout the entire venue, including all meeting halls, functions, registration and catering areas. All the participants are kindly requested to respect the no-smoking policy.

Social Media

We are using social media at the congress to encourage an open discussion on urology (nursing) science and experiences at the congress. EAU(N) congress speakers, opinion leaders, delegates and media share their ideas, commentary and photos

on Facebook and Twitter. You can follow the EAU on Facebook via www.facebook.com/eaupage and the EAUN via <https://www.facebook.com/pages/European-Association-of-Urology-Nurses-EAUN/294743963887050> and on Twitter via @uroweb. Use #EAU15 or #EAUN15 to discuss the Congress, and join the conversation!

Taxi Service

Official taxi ranks are located outside the North Building. On the airport the taxis are available in the taxi rank outside by the terminal exists. There are several taxi consortiums working in the city of Madrid, three of which are Radio-Taxi Asociación Gremial: (+34) 91 447 51 80, Radio Teléfono Taxi / Euro Taxi (Wheelchair Accessible Taxis): (+34) 91 547 82 00 and Teletaxi: (+34) 91 371 21 31.

Transportation Pass

Congress delegates may collect a complimentary transportation pass in the registration area which is valid on 20-24 March 2015. The pass covers underground, tram and bus within the city limits of Madrid. It is recommended to travel by metro. The metro station at IFEMA congress venue is called "Campo de las Naciones". For more information about the Madrid Metro, check their website: <http://www.metromadrid.es>

Upcoming Meetings

Posters and other information on upcoming meetings can be displayed in the "Upcoming Meetings" promotion area 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 www.eaumadrid2015.org/eaun. 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 EAU(N). Webcasts are not accredited and no CME credits can be obtained by watching the webcasts.

In addition to the webcasts there will be live streams of several EAU sessions available at the congress

website: www.eaumadrid2015.org. These sessions are also indicated in the synopsis with a special logo.

WiFi / Charge and Connect Area

Free wireless internet, provided by the congress centre, will be available in all areas and session rooms. Please connect to the “EAU15” network, after which you will be prompted to fill in an individual user name and password. You will receive your user name and password when you pick up your congress badge at the registration area. A special “Charge and Connect Area” with tables and power outlets is available in the exhibition (booth G74). Here you can charge your mobile devices.



Apply for your EAUN membership online!

Would you like to receive all the benefits of EAUN membership, but have no time for tedious paperwork?

Becoming a member is now fast and easy!

Go to www.eaun.uroweb.org and click EAUN membership to apply online. It will only take you a couple of minutes to submit your application, the rest - is for you to enjoy!

www.eaun.uroweb.org

eaun

European
Association
of Urology
Nurses

Speaker guidelines

Speaker Service Centre

Only digital presentations will be accepted during the congress and all presentations should be handed in at least three hours prior to the start of the session at the Speaker Service Centre. 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, 19 March	14.00 - 19.00
Friday, 20 March	08.00 - 19.00
Saturday, 21 March	07.00 - 19.30
Sunday, 22 March	07.00 - 19.30
Monday, 23 March	07.00 - 19.30
Tuesday, 24 March	07.00 - 12.30



If you are a chair person

Locate your session room in time. Please be in your session room at least 15 minutes prior to the start of the session.

Kindly note that:

- Speakers should strictly observe timing.
- Discussants should first clearly state their name, institution and country of origin.

If you are presenting a poster

Posters must be put up on the board 15 minutes prior to the start of the poster viewing. 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 at the end of the day. A maximum of 5 PowerPoint slides is allowed during poster presentation.

Prize-winning posters

If a PDF of the poster has been submitted to the EAUN before the start of the annual meeting the winning posters will be made available in the digital best poster area.

Disclose links to the industry

The EAU(N) Scientific Congress Office 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 popular training session.



Scientific Programme

European Association of Urology Nurses Programme Overview, 21-23 March 2015



	21 March Saturday		22 March Sunday		23 March Monday			
Room	Room Istanbul	Room Berlin	Room Istanbul	Room Berlin	Room Istanbul	Room Berlin		
09:00		Plenary Opening Session The future of urological nursing - The need for a common framework: Time is running out	Workshop 5 Intravesical instillation in non-muscle invasive bladder cancer -With presentation of the new EAUN guideline-	Video Session Inside the body - surgery in motion	Workshop 13 Pelvic floor rehabilitation for lower urinary tract symptoms: What's new?	Workshop 12 Nursing solutions in difficult cases & case discussions		
09:15			Break			Break	Break	
09:30								
09:45								
10:00								
10:15			Break		State-of-the-art lecture BCG treatments for superficial bladder cancer	Workshop 6 Troubleshooting and quality of life in indwelling catheterisation	State-of-the-art lecture PSA, is it a Patient Stress Amplifier?	EAUN-ESU Course 2 Part 1 Female sexual assessment and rehabilitation
10:30	Workshop 2 Nursing challenges in urodynamics	Workshop 1 Contemporary issues in patient pathways and cancer treatment	State-of-the-art lecture Not only instillation: BCG perfusion for kidney and urethra	State-of-the-art lecture 3Tesla Magnetic Resonance Imaging for prostate cancer				
10:45								
11:00								
11:15					Break		Break	
11:30	EAUN Nursing Research Competition	Workshop 3 Ongoing challenges in health and sexuality in male patients	Workshop 7 Care pathway and rehabilitaion in bladder cancer surgery	Poster viewing	State-of-the-art lecture Antibiotics in urology: Present dangers demand future actions		EAUN-ESU Course 2 Part 2 Female sexual assessment and rehabilitation	
11:45			Workshop 8 Living with prostate cancer: Daily issues and quality of life			Poster Session 2		State-of-the-art lecture Fertility preservation during cancer treatment
12:00								
12:15								
12:30								
12:45			EORNA-EAUN Workshop 4 Diagnosis and peri-operative care in prostate disease			Break		
13:00								
13:15								
13:30								
13:45	Break	Break		Break				
14:00	State-of-the-art lecture Best practice principles in the urological care for people who have a learning disability				Poster viewing		Annual General Meeting	
14:15								
14:30								
14:45								
15:00			EAUN-ESU Course - 1 Part 1 Practical management of urological emergencies			Poster Session 1		Workshop 9 Urinary Tract Infection (UTI) in Clean Intermittent Catheterisation (CIC): What's new?
15:15								
15:30								
15:45	Break	Break						
16:00	EAUN-ESU Course - 1 Part 2 Practical management of urological emergencies	Industry Session Honoring sexuality in women with neurogenic disorders		Workshop 11 Clean intermittent catheterisation and self dilatation: Quality of life and success factors				
16:15								
16:30								
16:45								
17:00								

Plenary session

09.00 - 10.15 The future of urological nursing - the need for a common framework: Time is running out



Room Berlin

Chair: L. Drudge-Coates, London (GB)

Overall aims and objectives of the session

The treatment of urological diseases has become a multi-professional endeavour, and specialised urological nurses are a very important partner of the team to improve the overall quality of care for the benefits of our patients. Therefore, there is an unmet need to facilitate the continued development of urological nursing in all its aspects across Europe. The aim is to foster the highest standards of urological nursing care throughout Europe, to encourage urological research undertaken by nurses and to enable the broadcasting of its results. The European Association of Urology should therefore promote and support the exchange of experience and good practices to establish standards for training, certification and practice for European urology nurses.

09.00 - 09.15 Welcome to the 16th International EAUN Meeting

P-A. Abrahamsson, Malmö (SE)
L. Drudge-Coates, London (GB)
A.I. Garcia Martin, Madrid (ES)
M. Martin Valenciano, Madrid (ES)

09.15 - 09.30 The importance of defining a core curriculum of Urology Nursing Practice now

B.T. Jensen, Århus (DK)

Aims and objectives

In Europe, the level of education and practical training in urology nursing differs between countries and significantly impacts on the role and responsibilities of nursing.

The EAUN supports the idea of a common training framework for Specialised Urological Nurses in cooperation with the European Specialist Nurses Organisations (ESNO).

09.30 - 09.45 Definitions, research and 'Europe' on Urology Nursing Practice: Where do we stand

K. Fitzpatrick, Dublin (IE)

Aims and objectives

In this session we will make an endeavour to begin the trans European discussion on research in Urological Practice.

09.45 - 10.00 Educational programmes: How to create a common ground in Europe

J.T. Marley, Newtownabbey (GB)

10.00 - 10.15 Panel discussion

Moderator: L. Drudge-Coates, London (GB)
Panel: K. Fitzpatrick, Dublin (IE)
A.I. Garcia Martin, Madrid (ES)
B.T. Jensen, Århus (DK)
J.T. Marley, Newtownabbey (GB)
M. Martin Valenciano, Zaragoza (ES)

Workshop 1

10.30 - 11.15 **Contemporary issues in patient pathways and cancer treatment**

Room Berlin



Chair: J.T. Marley, Newtownabbey (GB)

Overall aims and objectives of the session

Patient Reported Outcome Measures (PROM) assessments in urology cancer care can provide a unique opportunity to assess both the short and longer-term impact of the disease and the treatment on quality of life. Furthermore PROMs can be used to evaluate and decide whether a patient needs an outpatient appointment. However, there is limited experience with implementing a system-wide initiative to collect and use PROMs for quality improvement in everyday clinical practice. The objectives are: to present a model for implementing PROMs in clinical urology practice for prostate cancer patients; and to present preliminary results from a PROM-study at 5 urology hospital departments across Denmark. Results on feasibility, patient/clinician compliance and satisfaction will be presented.

- | | |
|---------------|--|
| 10.30 - 10.35 | Introduction
J.T. Marley, Newtownabbey (GB) |
| 10.35 - 10.55 | Implementing patient reported outcome measures in clinical practice
L. Dørflinger, Copenhagen (DK) |
| 10.55 - 11.15 | Patient involvement in modern hospital treatment and care
To be confirmed |

Workshop 2

10.30 - 11.15 Nursing challenges in urodynamics

Room Istanbul



Chair: L. Van De Bilt-Sonderegger, Eindhoven (NL)

Overall aims and objectives of the session

- The nursing approach in diagnostic examination of patients with LUTS.
- The role of the nurse; tools to measure the effects of LUTS and how to use the results in patient education.

10.30 - 10.35

Introduction

L. Van De Bilt-Sonderegger, Eindhoven (NL)

10.35 - 10.55

Principles of urodynamics, bladder scans and flow rates

P.F.W.M. Rosier, Utrecht (NL)

Aims and objectives

Urodynamics involves the objective evaluation of the lower urinary tract (LUT) function. Those who perform urodynamics have to understand the anatomy and physiology of the LUT, but also of the physics involved. Furthermore, urodynamic testing requires that the tested person cooperates. To achieve this it's important to have a good understanding of psychology and social skills are also of utmost importance. Diagnosing functions in a physical area that is full of emotions is a challenge for every caregiver. The presentation will provide background knowledge for patient centred testing with optimal technical results and a reliable diagnostic outcome.

10.55 - 11.15

A practical nurse-led approach to the assessment and management of Lower Urinary Tract Symptoms (LUTS)

To be confirmed

Workshop 3

11.30 - 12.30 **Ongoing challenges in health and sexuality in male patients**

Room Berlin



Chair: I. Banks, Spa (IE)

Overall aims and objectives of the session

Hands on? You bet, this is a real workshop with an emphasis on 'work'. Top presenters to kick-off the discussion on an area often neglected, yet so vital to a man's wellbeing. Partners are not immune either so our speakers will deal with the broader areas of concern. I will seek active debate and useful conclusions. Come prepared, gargle first!

11.30 - 11.35

Introduction

I. Banks, Spa (IE)

Aims and objectives

Sexual health. So OK, this is not the easy option. Leave it up to someone else? Well folks, that someone might just be you and like any challenging role in nursing the satisfaction often exceeds the difficulty and embarrassment. So here is how to do it and do it well.

11.35 - 11.50

Nurses' communication with the patient

S.P. Fillingham, Kent (GB)

11.50 - 12.05

Understanding the help-seeking and support needs of men who have a urogenitary health issue

R. Mawhinney, Coleraine (GB)

Aims and objectives

There is a well-established perception that many men are generally reticent to discuss their health with anyone, especially if their needs are of a sensitive nature. Growing evidence suggests that some men are addressing their health concerns by accessing the Internet. This presentation aims to provide an insight into the information needs of men with a urogenitary health issue who have utilised the Internet as a resource for health.

12.05 - 12.20

Sexual disorders and sexual dysfunction following urological treatments

D.J. Ralph, London (GB)

Aims and objectives

This lecture deals with sexual dysfunctions arising from urological treatments. The main areas are related to the prostate: radical prostatectomy, TURP, and medical treatments for BPH. Discussion includes:

- Medical management of prostate cancer causing erectile dysfunction and poor libido
- Medical management of sickle cell priapism
- Catheters and urethral stricture management often cause erectile dysfunction and ejaculatory dysfunction.

An A-Z of all possible urological treatments causing sexual dysfunction.

12.20 - 12.30

Discussion

I. Banks, Spa (IE)

Aims and objectives

We will come to conclusions and look at how the unique mingles with the generic when it comes to sexual health and treatment. Get stuck in (hand washing facilities available!).

Research competition

11.30 - 12.30 EAUN Nursing Research Competition

Room Istanbul



Chair: R. Pieters, Ghent (BE)

Overall aims and objectives of the session

The nursing research competition aims to be a teaching moment for nurses who want to start a research programme or improve their skills in setting up a research programme. The presentation and discussion on the research plans of colleagues show the pitfalls, the objectives, the dos and don'ts.

The Nursing Research Competition session gives insights into:

- Planned projects in urology from the nursing view
- How to bring nursing procedures or questions about nursing procedures into research projects
- Developments which take place in the urological field
- Doing a project plan for research activities
- How research plans are presented.

11.30 - 12.30 *Jury:* J. Bjerggaard Jensen, Århus (DK)
V. Geng, Aglasterhausen (DE)
G. Karazanashvili, Tbilisi (GE)
J.T. Marley, Newtownabbey (GB)

11.30 - 11.40 **Life consequences after a radical prostatectomy; seen from a women's perspective**
A-K. Jönsson, Helsingborg (SE)

11.40 - 11.45 **Discussion**

11.45 - 11.55 **Improving male patients coping with urinary incontinence after prostatectomy**
H. Syhler, Copenhagen (DK)

11.55 - 12.00 **Discussion**

12.00 - 12.10 **Report from the research competition winner of 2014: Xbox 360 Kinect exercise for men receiving androgen deprivation therapy for prostate cancer**
B.R. Villumsen, Holstebro (DK)

12.10 - 12.15 **Discussion**

The winner of the Best EAUN Nursing Research Project 2015 will be announced at the Award Session Monday, 23 March, 13.45 hrs.

EAUN-EORNA Workshop 4

12.45 - 13.45 Diagnosis and peri-operative care in prostate disease

Room Istanbul



Chairs: M.J. Giao Valente, Porto (PT)
S.J. Borg, St. Julians (MT)

12.45 - 12.50

Introduction

S.J. Borg, St. Julians (MT)

12.50 - 13.15

Diagnosis, surgery, post-operative care and focal therapy in prostate cancer

M. Roupret, Paris (FR)

13.15 - 13.35

Intraoperative care in prostate surgery

S. Monsalve, Madrid (ES)

13.35 - 13.45

Discussion

Moderator: S.J. Borg, St. Julians (MT)
Panel: S. Monsalve, Madrid (ES)
M. Roupret, Paris (FR)
M.J. Giao Valente, Porto (PT)

State-of-the-art lecture

14.00 - 14.30 **Best practice principles in the urological care for people who have a learning disability**

Room Istanbul



M. Sowney, Newtownabbey (GB)

Aims and objectives

The key aim is to provide specialists in urological care with an awareness of learning disability and how they may adapt their skills to enable them feel more confident as professionals to provide safe, effective dignified assessments and interventions to people with learning disability, their families and or carers.

Poster session 1

14.00 - 15.45 **Poster session**

Room Berlin



Chairs: J.T. Marley, Newtownabbey (GB)
S. Terzoni, Milan (IT)

Overall aims and objectives of the session

The aim of this session is to update the delegates with recent research activities and findings in the development of evidence-based urological care.

Poster viewing: 30 minutes

Introduction by chair: 4 minutes

Presentations: 6 minutes for presentation and 2 minutes discussion

- 1 Psychosocial issues during the treatment of non-muscle invasive bladder cancer**
S.M. Wildeman-Cox, C. Van Golde (Rotterdam, The Netherlands)
- 2 A systematic review of the empirical evidence identifying the unmet supportive care needs of men living with and beyond prostate cancer: Are we there yet?**
C. Paterson, A. Robertson, A. Smith, G. Nabi (Dundee, United Kingdom)
- 3 Decreasing frequency pattern of intermittent self-catheterization in general urology**
A. Bassas, P. Martinez, G. Paganini, J.E. Batista (Barcelona, Spain; Buenos Aires, Argentina)
- 4 Incidence and impact of urinary tract infections (UTI) when starting intermittent catheterization (IC) and the affect on quality of life**
H.J. Mulder (Groningen, The Netherlands)
- 5 Nurse led female urinary tract infection clinic**
E. Robinson, I. Pearce (Manchester, United Kingdom)
- 6 Does pre-operative patient education improve patient satisfaction following robot-assisted laparoscopic prostatectomy?**
S. Zaretzer, S. Regev, G. Louie, S. Aharony, R. Tal, J. Baniel (Petach Tikva, Israel)
- 7 Post-operative pain and neuromuscular complications associated with patient positioning after robot-assisted radical prostatectomy**
E. Gezginici, O. Ozkaptan, S. Yalcin, Y. Akin, J. Rassweiler, A.S. Gozen (Ankara, Turkey; Heilbronn, Germany)
- 8 Factors related to catheter blockage in home nursing care patients with long-term indwelling catheters**
S. Maeda, T. Takiuti, Y. Kohno, H. Nakai, M. Fukuda, M. Moriyama (Kahoku, Ishikawa, Toyama, Japan)
- 9 My pathway – an APP developed for men who are undergoing RARP**
C. Englund, S. Nørregaard (Odense, Denmark)

ESU Course 1

14.45 -17.00 Practical management of urological emergencies

Room Istanbul



*Chairs: P. Anderson, Dudley (GB)
J.M. Gaya, Barcelona (ES)*

14.45 - 15.05	Testicular and penile emergencies: Testicular torsion, paraphimosis, penile fracture, priapism – Do's and don'ts P. Anderson, Dudley (GB)
15.05 - 15.15	Discussion
15.15 - 15.35	Haematuria/Urological trauma: Initial assessment and emergency management J.M. Gaya, Barcelona (ES)
15.35 - 15.45	Discussion
15.45 - 16.00	Break
16.00 - 16.20	Emergencies in uro-oncology W. De Blok, Amsterdam (NL)
16.20 - 16.30	Discussion
16.30 - 16.50	Urosepsis: An emergency requiring multimodality treatment To be confirmed
16.50 - 17.00	Discussion

Video session

09.00 - 10.15 Inside the body - surgery in motion

Room Berlin



Chair: S.J. Borg, St. Julians (MT)

Overall aims and objectives of the session

All nurses, irrespective of the department they work in, have queries regarding details of what happened during surgery. This session is meant to present, discuss and explain surgical videos which were submitted for presentation at the EAU congress.

For OR nurses it will be interesting to see how other hospitals perform a particular type of surgery or how a type of surgery that is not performed in their OR proceeds.

For nurses that are employed outside the OR, this session will for the first time enable them to see what happens during surgery inside the patient's body. As a result they may gain a better understanding of why patients have to be treated in a particular way pre- and postoperatively and be able to ask patients more specific questions to improve care.

- V36 Use of intra-operative indocyanine green and Firefly® technology to visualize the “landmark artery” for nerve sparing robot assisted radical prostatectomy**
To be confirmed
- V68 Ultra-mini-percutaneous nephrolithotomy in modified lithotomy position**
A. Hoznek, M.H. Kahn, J. Rode, P. Castellan, J. Desai, A. De La Taille (Créteil, France; Keighley, United Kingdom; Chieti, Italy; Ahmedabad, India)
- V47 Utility of imaging in pre and post operatory management of penile prothesis in F to M transsexual**
G. Liguori, N. Pavan, P. Umari, M. Bertolotto, S. Bucci, E. Belgrano, C. Trombetta (Trieste, Italy)
- V6 Urologic surgery laparoscopic access: Vascular complications**
A.W. Branco, L. Stunitz, S. Nichele, J.D. Scheffer, M. Gatti, D. Pessutti (Curitiba, São José do Rio Preto, Brazil)
- V59 Robotic-assisted laparoscopic pyeloplasty for lower pole uretero-pelvic junction obstruction in two duplex kidneys with differing incomplete ureteral duplication**
To be confirmed

Workshop 5

09.00 - 09.45 Intravesical instillation in non-muscle invasive bladder cancer - With presentation of the new EAUN guideline

Room Istanbul



Chair: S. Vahr Lauridsen, Copenhagen (DK)

Overall aims and objectives of the session

This session will highlight the scientific basis for this new guideline. The nursing interventions related to side-effects from intravesical instillation with mitomycin C and BCG will be presented. Furthermore, European regulations on safety aspects when performing mitomycin C and BCG instillations will be addressed.

09.00 - 09.05 Presentation of the new EAUN guideline on intravesical instillation in non-muscle invasive bladder cancer
S. Vahr Lauridsen, Copenhagen (DK)

09.05 - 09.20 Safe administration of BCG and mitomycin C
W.M. De Blok, Amsterdam (NL)

09.20 - 09.35 Handling of side effects
G. Villa, Milan (IT)

09.35 - 09.45 Panel discussion
Moderator: S. Vahr Lauridsen, Copenhagen (DK)
Panel: W.M. De Blok, Amsterdam (NL)
N. Love-Retinger, New York (US)
G. Villa, Milan (IT)

Workshop 6

10.15 - 11.15 Troubleshooting and quality of life in indwelling catheterisation

Room Berlin



Chair: V. Geng, Lobbach (DE)

Overall aims and objectives of the session

The participants should gain insights in:

- Nursing aspects and interventions for indwelling catheters
- Complications and troubleshooting with indwelling catheters
- Insights in quality of life when living with an indwelling catheter

10.15 - 10.20

Introduction

V. Geng, Lobbach (DE)

10.20 - 10.45

Management of complications

S. Ohlhorst, Zürich (CH)

Aims and objectives

Handling indwelling catheters is part of the daily routine for urological nurses. For the patient receiving the catheter is a disruption of habits, often creating a lot of distress. Furthermore indwelling catheters bear a remarkable risk for complications. One of the main tasks of the nurse caring for this group of patients is therefore to minimise these complications. This implies: firstly, to find the best therapeutic option for every individual patient and secondly, to prepare the patients optimally for handling their catheter safely. If complications still arise, they should be addressed according to the best evidence available. This presentation gives guidance on how these duties can best be approached.

10.45 - 11.05

Living with a bladder catheter; what patients, caregivers and nurses should know

M. Kappert, Doetinchem (NL)

11.05 - 11.15

Panel discussion

Moderator: V. Geng, Lobbach (DE)

Panel: S. Ohlhorst, Zürich (CH)

State-of-the-art lecture

10.15 - 10.45 **BCG treatments for superficial bladder cancer**

Room Istanbul



N. Suardi, Milan (IT)

State-of-the-art lecture

10.45 - 11.15 **Not only instillation: BCG perfusion for kidney and urethra**

Room Istanbul



G.N. Thalmann, Berne (CH)

Aims and objectives

BCG is the standard treatment for carcinoma in situ (CIS) and recurrent disease in non muscle invasive bladder cancer. For CIS of the urethra and the upper urinary tract it has proven to be of therapeutic value with good success rates allowing to preserve the organ. Because BCG is a live attenuated mycobacterium its use in treatment has potential dangers and side effects. Application methods, technical aspects, risks and outcome results will be discussed.

Poster session 2

11.30 - 13.15 **Poster session**

Room Berlin



*Chairs: J.T. Marley, Newtownabbey (GB)
S. Terzoni, Milan (IT)*

Overall aims and objectives of the session

The aim of this session is to update the delegates with recent research activities and findings in the development of evidence-based urological care.

Poster viewing: 30 minutes

Introduction by chair: 4 minutes

Presentations: 6 minutes for presentation and 2 minutes discussion

- 10 Beyond one's depth – the experience of postoperative complications following radical cystectomy**
L. Lydom, T. Thomsen (Copenhagen, Denmark)
- 11 Nutritional status and postoperative functional outcomes in patient undergoing radical cystectomy: A prospective observational study**
E. La Cognata, B. Necchi, L. Caiazza, A. Crescenti, M. Boarin, G. Villa (Milan, Italy)
- 12 Educational seminars increase confidence and decreases dropout from active surveillance**
J.E. Kinsella, M. Van Hemelrijck, P. Allchorne, D. Cahill (London, United Kingdom)
- 13 Undertaking diagnostic and surveillance cystoscopy training using a flexible cystoscope: A nurse-led educational initiative in the UK**
A. Robertson, K. Dewar, C. Paterson (Dundee, United Kingdom)
- 14 “Lets Talk About Sex”- a prospective audit of a nurse practitioner led sexual health and erectile dysfunction (SHED) clinic**
K. Schubach, D. Murphy, K. Gough (Melbourne, Australia)
- 15 Shock-wave lithotripsy: The impact of a designed nursing teaching protocol on patients with renal and ureteric stones**
H.A. Abdel Mawla, A.A. Shahat, R.A. Abdel Mawala, A.H. Hussein, Z.A. Latef Mohamed, M.A. Abdalla (Assiut, Egypt)
- 16 Nephrostomy catheter-dysfunction**
B.O. Nielsen, J. Avlastenok (Herlev, Denmark)
- 17 A prospective longitudinal study exploring the influence of psycho-social factors and self-management behaviours on HRQoL in men living with and beyond prostate cancer**
C. Paterson, A. Robertson, G. Nabi (Dundee, United Kingdom)
- 18 Retrospective analysis of patients' experience to intravesical Bacillus Calmette-Guerin (BCG)**
J. Alcorn, S. Biyani, P.M.T. Weston, S.K. Sundaram, R. Burton, A.E. Topping, S. John (Wakefield, Huddersfield, United Kingdom; Doha, Qatar)

Workshop 7

11.30 - 12.15 **Care pathway and rehabilitation in bladder cancer surgery**

Room Istanbul



Chair: B.T. Jensen, Århus (DK)

Overall aims and objectives of the session

Radical cystectomy is a highly morbid procedure even in the most experienced hands and postoperative morbidity and longterm complications remain a concern. Irrespective of the bladder removal itself, other aspects of the care pathway should be considered to optimise oncological, functional and patient perceived outcome.

11.30 - 11.50 **Bladder cancer and urinary diversion - an update**
F. Longo, Milan (IT)

11.50 - 12.10 **Can early rehabilitation impact quality of life following radical cystectomy?**
B.T. Jensen, Århus (DK)

Aims and objectives

Can early rehabilitation impact quality of life following radical cystectomy? For the first time a recent multidisciplinary study confirms that an early intervention is feasible and has a significant impact on health-related quality of life.

12.10 - 12.15 **Discussion**

Workshop 8

12.15 - 13.15 **Living with prostate cancer: Daily issues and quality of life**

Room Istanbul



Chair: B.T. Jensen, Århus (DK)

Overall aims and objectives of the session

Prostate cancer impacts significantly on health-related quality of life in all stages of the disease. A joint pan European research project supported by EAUN and EONS revealed a significant number of unmet needs and lack of supportive care from specialised nurses.

This session will focus on concrete recommendations for supportive cancer care and highlight special needs of the patient and his family.

12.15 - 12.35 **Being diagnosed with cancer: What does it mean to the patient and relatives**

I. Verdonck-De Leeuw, Amsterdam (NL)

12.35 - 12.55 **Guidance from the literature regarding exercise in the care of men who have prostate cancer**

J. Gracey, Newtownabbey (GB)

12.55 - 13.15 **Early ambulatory function in patients**

K. Dieperink, Odense (DK)

Aims and objectives

How nurses can support prostate cancer patients to prevent early and late adverse effects after radiotherapy.

State-of-the-art lecture

13.45 - 14.15 **OR efficiency: The robotic dance for patients and surgery**

Room Berlin



E. Rundin, Stockholm (SE)

Aims and objectives

In this session we will discuss:

- An overview of the work carried out in the centre
- The key principles of the 'standardised working system' employed to efficiently manage so heavy a surgical workload
- Explaining the 'Robotic Dance'
- An outline of the follow up routine and outcome measures
- Discussing the role nurses play in theatre and how they view the person centred care they provide
- The procedures we employ to ensure that in the midst of all the activity the patient does not disappear

State-of-the-art lecture

14.15 - 14.45 **RoboCare: Validation of a nurse-led robotic prostatectomy care pathway**

Room Berlin



E. Birch, Melbourne (AU)

Workshop 9

14.45 - 15.45 Urinary tract infection (UTI) in Clean Intermittent Catheterisation (CIC): What's new?

Room Berlin



*Chairs: M.J. Grabe, Malmö (SE)
L. Van De Bilt-Sonderegger, Eindhoven (NL)*

Overall aims and objectives of the session

Antibiotics are widely used and misused in all fields of urology both for treatment and for prophylaxis. With a dramatic increase in the resistance pattern of urinary tract (UT) pathogens (i.e. multi-resistant E. coli, ESBL, ESBLCARBA strains) on all continents and few new active antibiotics, there is an absolute need for a more rational use of antibiotics in all fields of urology. The present session focusses on a category of patients presenting with lower urinary tract dysfunction and using Clean Intermittent Catheterisation (CIC) regularly. Most patients are prone to asymptomatic bacteriuria (ABU) and recurrent symptomatic urinary tract infections (rUTI) often with a more complex resistance pattern. The aim is to present the current EAU and EAUN recommendations on management of ABU and rUTI in complex urological patients, to look ahead based on the ongoing research in the field, and to promote the role of nurses in infection control and combatting resistance development.

14.45 - 14.50

Introduction

M.J. Grabe, Malmö (SE)
L. Van De Bilt-Sonderegger, Eindhoven (NL)

14.50 - 15.10

UTI in CIC patient: Prevention and control from the nurse perspective

H.J. Mulder, Groningen (NL)

Aims and objectives

Overview of the latest literature on the subject.

Information and results of a Dutch multicentre observational study on the incidence and impact of urinary tract infections in patients starting intermittent catheterisation.

15.10 - 15.30

Fighting antibiotics resistance: Do nurses play a role?

M.J. Grabe, Malmö (SE)

Aims and objectives

The aims are to describe the underlying mechanisms of and the present state of resistance development of microbes found in the urinary tract with focus on the European continent. The objectives are to describe the methods to combat resistance development both in terms of practical management, increased knowledge about the use of antibiotics and its consequences, and infection control. The difference between community-acquired and healthcare-associated infection will be covered. The role of the nurses is critical among others at the front line of the contact with and care for the patients, infection control, direct involvement in research projects, and as "whistle-blowers".

15.30 - 15.45

Discussion

M.J. Grabe, Malmö (SE)
L. Van De Bilt-Sonderegger, Eindhoven (NL)

Aims and objectives

The session will be summarised and the take-home messages will be presented.

Workshop 10

14.45 - 16.45 **Market place session: Rehabilitation in urology cancer care**

Room Istanbul



Overall aims and objectives of the session

This session aims to encourage questions and discussion among the nursing audience, sharing knowledge and learning where clinical development and education within nurses' own clinical areas can be considered. The session involves 4 workshops that run in parallel: Each presentation is repeated every half hour, each time for a new group of 35 delegates (delegates move from stall to stall). The first 140 delegates who wish to enter the room are admitted.

14.45 - 16.45 **Topic 1: Sexual rehabilitation**
T. Shelton, Nottwil (CH)

14.45 - 16.45 **Topic 2: Cancer survivorship - Movement Matters!**
A. Campbell, Guildford (GB)

Aims and objectives

The aim of this session is to provide the rationale for exercise as part of a cancer care package. It will start with an update on and analysis of the current literature into the benefits of exercise on primary and secondary prostate cancer prevention. Recent evidence into the benefits of physical activity to combat prostate cancer specific side effects will be provided and research into the impact of exercise interventions pre-treatment, during treatment, post-treatment and in palliative care will also be discussed. Finally, this workshop will look at current guidelines and contra-indications with reference to exercise prescription using case studies and some practical exercise examples.

14.45 - 16.45 **Topic 3: ERAS (Enhanced Recovery After Surgery) as a positive prognostic factor for rehabilitation**
L. Lazorova, Pioltello (IT)
M.A. Risolo, Milano (IT)

Aims and objectives

Enhanced Recovery After Surgery (ERAS) is a multimodal perioperative care pathway designed to achieve early recovery for patients undergoing major surgery.

The main actor in ERAS program is the patient. The care team (nurse, surgeon and anesthesiologist) guides him so that he can play an active role at the healing process.

ERAS program is a continuous process that begins with the preadmission counseling, continued during hospitalization with the application of the Protocol and ends with weekly telephone check-up.

Different studies proved that application of ERAS protocol minimizes metabolic stress and organs dysfunction, promoting the early resumption of Activity Daily Living.

The application of ERAS protocol in Urology Care shows: an early return of bowel function, the halving of referred pain and an increase in compliance in the nursing process phases.

14.45 - 16.45 **Topic 4: Teaching rehabilitation exercises before surgery: why and when?**
I. Geraerts, Leuven (BE)

Workshop 11

16.00 - 17.00 Clean intermittent catheterisation and self-dilatation: Quality of life and success factors

Room Berlin



Chair: J.P.F.A. Heesakkers, Nijmegen (NL)

Overall aims and objectives of the session

Nowadays CIC is an accepted and promoted way for bladder emptying. Many patients learn how to perform CIC, and most technical aspects that determine the quality of performing CIC have been defined. Less insight is gained about the adherence to CIC and what the determinants of long-term CIC are. This session will try to answer the questions raised about the technical aspects as well as the long term continuation of CIC.

16.00 - 16.05

Introduction

J.P.F.A. Heesakkers, Nijmegen (NL)

Aims and objectives

To depict the various topics that are dealt with in this session about clean intermittent catheterisation and self-dilatation: quality of life and success factors

16.05 - 16.20

Poor quality of life in patients with urethral stricture treated with self-dilatation

J.P.F.A. Heesakkers, Nijmegen (NL)

Aims and objectives

The success factors and the long term uncertainties about successful management of CIC in patients with urethral strictures will be explained.

16.20 - 16.35

Self-dilatation in the Netherlands; an inventory

E.J.M. Martin, Tilburg (NL)

Aims and objectives

Presentation of the results of a survey held among Dutch continence care and urology nurses. We were especially interested in the way self-dilatation of the urethra is taught by nurses. The inventory is the outcome of this survey.

16.35 - 16.50

Which factors make clean intermittent (self) catheterisation successful? Long term results of the study

J.G.L. Cobussen-Boekhorst, Nijmegen (NL)

E.M.C.J. Van Wijlick, Nijmegen (NL)

Aims and objectives

In this presentation we will inform you about the long term results of our study. We will discuss challenges we met doing this research (inclusion, time, statistical analysis, writing an article) and we will conclude with recommendations for implementation and future research.

16.50 - 17.00

Discussion

Moderator: J.P.F.A. Heesakkers, Nijmegen (NL)

Panel: J.G.L. Cobussen-Boekhorst, Nijmegen (NL)

E.J.M. Martin, Tilburg (NL)

E.M.C.J. Van Wijlick, Nijmegen (NL)

Aims and objectives

Challenging topics that came to the table in this session on CIC and QoL will be discussed.

Workshop 12

09.00 - 10.00 **Nursing solutions in difficult cases & case discussions**

Room Berlin



Chair: S. Vahr Lauridsen, Copenhagen (DK)

Overall aims and objectives of the session

In guidelines it is common practice to describe/focus on typical cases, but we all know that there is also a need for information on nursing practice in atypical (difficult) cases. All nurses encounter problems in daily nursing practice and have found their own solutions or sometimes have not found a solution. In this session these challenging cases are presented and discussed offering delegates a unique opportunity to learn from each other's experience with atypical cases.

The submitted cases have been evaluated by an expert jury. Those who submitted the most interesting cases (as decided by the jury) were granted a free registration to the 16th International EAUN Meeting and were invited to present their case in this workshop.

09.00 - 09.10 **Bowel vs bladder in sacral neuromodulation therapy**
J. Jenks, London (GB)

Aims and objectives

Sacral Neuromodulation (SNM) is an established therapy in the management of pelvic floor dysfunction, specifically bladder and bowel incontinence. It is used in the UK, in accordance with the National Institute of Clinical Health and Excellence (NICE) Urological and colorectal guidelines as a treatment for patients refractory to conservative management methods and pharmacotherapy.

The objective of this difficult case is to highlight to the audience how combination therapy can achieve a successful outcome in complex SNM cases.

Specifically this 'Difficult case' study highlights a male urology patient with detrusor overactivity, whose SNM therapy, whilst efficacious for his detrusor overactivity, results in negative changes to his bowel habit. This resulted in a significant reduction in the patients quality of life. This case study draws on the complexities of maintaining efficacy of urological control with SNM therapy, when sub optimal colorectal side effects ensue as a direct consequence of the therapy. It demonstrates how a multi-modal, interdisciplinary and peer networking approach are needed. In this case adopting this approach culminated in the use of a triad of methods, that when used collectively achieved maintenance of bladder control, resolution of negative bowel side effects and a resultant restoration in the patient's quality of life.

09.10 - 09.12 **Discussion**

09.12 - 09.22 **Management of care when handling a complex surgical wound in a living-donor kidney transplant recipient**
T. Alonso Torres, Barcelona (ES)

Aims and objectives

Wound infection syndromes are frequent after a urological surgery. An alternative for the treatment of critical or chronic wounds in complex clinical situations is the Negative-Pressure Wound Therapy (NPWT). It should be pointed out that nursing care plays an important role in the prevention and management of wound care. The objective of this difficult case is to describe the process used to reestablish wound care in a living-donor kidney transplant recipient by NPWT.

09.22 - 09.24 **Discussion**

09.24 - 09.34 **Pain and risk of addiction to painkillers**
E.A. Grainger, Århus (DK)

Aims and objectives

The aim is to highlight the problems that occur, when the urological patient has a chronic or severe problem with pain.

The actual case will be compared with literature about pain treatment in patients with chronic pain and risk of addiction, and highlight the problems, that occur among the staff, when they have to treat a patient with severe pain. Especially the problems that occur, when the treatment is not successful.

09.34 - 09.36 **Discussion**

13.36 - 13.46 Treating 'complications' following treatment of bladder cancer

P. Allchorne, London (GB)

13.46 - 13.48 **Discussion**

13.48 - 13.58 Sperm banking in the cancer patient: An ethical question

N. Love-Retinger, New York (US)

Aims and objectives

Fertility preservation in the cancer patient population is a global concern. Infertility may affect up to 80% of cancer survivors as a result of gonadotoxic therapies. The aim of this presentation of a difficult case is to draw attention to the ethical questions that arise in caring for the young cancer patient about to undergo chemotherapy. The objective is to open the discussion among the European nurses who are caring and advocating for these patients.

13.58 - 14.00 **Discussion**

Workshop 13

09.00 - 10.00 **Pelvic floor rehabilitation for lower urinary tract symptoms: What's new?**

Room Istanbul



Chair: L. Van De Bilt-Sonderegger, Eindhoven (NL)

Overall aims and objectives of the session

- To provide participants with an overview of diagnostics and treatment modalities in urinary incontinence
- Practical tools for nurses on how to advise patients to train the pelvic floor after radical prostatectomy
- An overview of long term results after radical prostatectomy and the effectiveness of pelvic floor training/ education

09.00 - 09.05 **Introduction**
L. Van De Bilt-Sonderegger, Eindhoven (NL)

09.05 - 09.20 **Incontinence treatment: Where are we?**
E.J. Messelink, Groningen (NL)

Aims and objectives

An overview of diagnostics and treatment modalities in urinary incontinence. With special attention to the classification of pelvic floor muscle function.

09.20 - 09.35 **Pelvic floor training: The effect after radical prostatectomy and teaching exercise to difficult patients – a practical “how to”**
A. McGreal, Dublin (IE)

09.35 - 09.50 **Follow-up of men who had radical prostatectomy and how effective are pelvic floor exercises**
W. Naish, Redhill (GB)

Aims and objectives

Following radical prostatectomy many men are left with urinary incontinence. The aim of this presentation is to demonstrate how men are assessed for urinary incontinence following radical prostatectomy using a self assessment questionnaire, 3 day bladder diary and who taught them how to do pelvic floor exercises. Men were initially assessed between 4-6 weeks post surgery where they were taught to do pelvic floor exercises correctly. They were then followed up at 3, 6, 9 and 12 months. Levels of urinary incontinence varied between men at different stages, most men reached an acceptable level of incontinence at between 6 and 12 months. A small proportion of men have gone on to have incontinence surgery at 2 years. Pelvic floor exercises are the mainstay of reducing urinary incontinence post radical prostatectomy.

09.50 - 10.00 **Discussion**
L. Van De Bilt-Sonderegger, Eindhoven (NL)

ESU Course 2

10.15 - 12.45 **Female sexual assessment and rehabilitation**

Room Berlin



Chair: H. Elzevier, Leiden (NL)

Overall aims and objectives of the session

Urinary incontinence is common among the general population and affects female sexual function. This session will elaborate on how urinary incontinence affects sexual function, not only in women but it also has an effect on the sexual function of their partner. Furthermore, it will be discussed how health care providers are hesitant to discuss sexual problems, and further schooling is needed.

10.15 - 10.45 **Female sexual function in urological practice**
H. Elzevier, Leiden (NL)

10.45 - 11.15 **Female sexual function and incontinence**
M.D. Bekker, The Hague (NL)

11.15 - 11.45 **Coffee break**

11.45 - 12.15 **How to use questionnaires**
M. Van Gestel, Heerlen (NL)

12.15 - 12.35 **Case discussions**
J.A.C. Beekman, Veghel (NL)

12.35 - 12.45 **Take home messages**
H. Elzevier, Leiden (NL)

State-of-the-art lecture

10.15 - 10.45 **PSA, is it a Patient Stress Amplifier?**

Room Istanbul



S.G. Joniau, Leuven (BE)

Aims and objectives

The role of PSA as a marker for prostate cancer, in particular its usefulness in prostate cancer screening and early detection has been subject to much controversy during the last couple of years. This presentation will deal with the history of PSA and its role in a modern urological practice.

State-of-the-art lecture

10.45 - 11.15 **3Tesla Magnetic Resonance Imaging for prostate cancer**

Room Istanbul

T.H. Kuru, Heidelberg (DE)

Aims and objectives

Due to its high soft tissue contrast, high resolution, and ability to simultaneously image functional parameters, MRI provides accurate visualisation of the prostate gland. Anatomical T2-weighted MR imaging is the cornerstone of the prostate MR imaging examination. However, not every lesion which has low signal intensity on T2-weighted imaging represents cancer and this has an inherent limitation in specificity. Consequently, functional imaging techniques are performed to enhance the specificity. The following functional MR imaging techniques are applied in the prostate: diffusion-weighted MR imaging (DWI), dynamic contrast-enhanced MRI (DCE-MRI) and three-dimensional MR spectroscopy imaging (MRSI). mp-MRI plays an important role in the detection, localisation, staging, image-guided targeted prostate biopsy and the assessment of post treatment changes in PCa.

State-of-the-art lecture

11.45 - 12.15 **Antibiotics in Urology: Present Dangers demand Future Actions**

Room Istanbul



T.E. Bjerklund Johansen, Oslo (NO)

State-of-the-art lecture

12.15 - 12.45 **Fertility preservation during cancer treatment: The impact of the Urology Nurse as advocate for our patients**

Room Istanbul



N. Love-Retinger, New York (US)

Aims and objectives

- To educate the urology nurse on the importance of discussing with their patients the effect of therapies on their reproductive life
- Discuss therapies for preservation of fertility currently available

Special session

13.15 - 13.45 **Annual General Meeting**

Room Berlin



The Annual General Meeting is open to all delegates. Only full EAUN Members can vote.

Chair: L. Drudge-Coates, London (GB)

P. Allchorne, London (GB)
S.J. Borg, St. Julians (MT)
W.M. De Blok, Amsterdam (NL)
K. Fitzpatrick, Dublin (IE)
E. Grainger, Århus (DK)
S. Terzoni, Milan (IT)
S. Vahr Lauridsen, Copenhagen (DK)
G. Villa, Milan (IT)

Agenda:

- Welcome by the Chair
- Approval of the Minutes AGM 2014
- Approval new board member
- The report of the Chair with presentation of the achievements of 2014/2015
- Financial report
- Special Interest Groups (SIG) & Scientific Committee report
- Open forum (for proposals from the members, cards will be available at the EAUN booth)

Award session

13.45 - 14.00 **Award session**

Room Berlin

*Chairs: L. Drudge-Coates, London (GB)
G. Karazanashvili, Tbilisi (GE)
S. Terzoni, Milan (IT)*

Aims and objectives

- 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

Prizes for the Best EAUN Poster Presentations supported by an educational grant

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Industry Session

Industry session by COLOPLAST

16.00 - 17.00 Honouring sexuality in women with neurogenic disorders

Room Berlin

Chair: S. Elliott, Vancouver (CA)

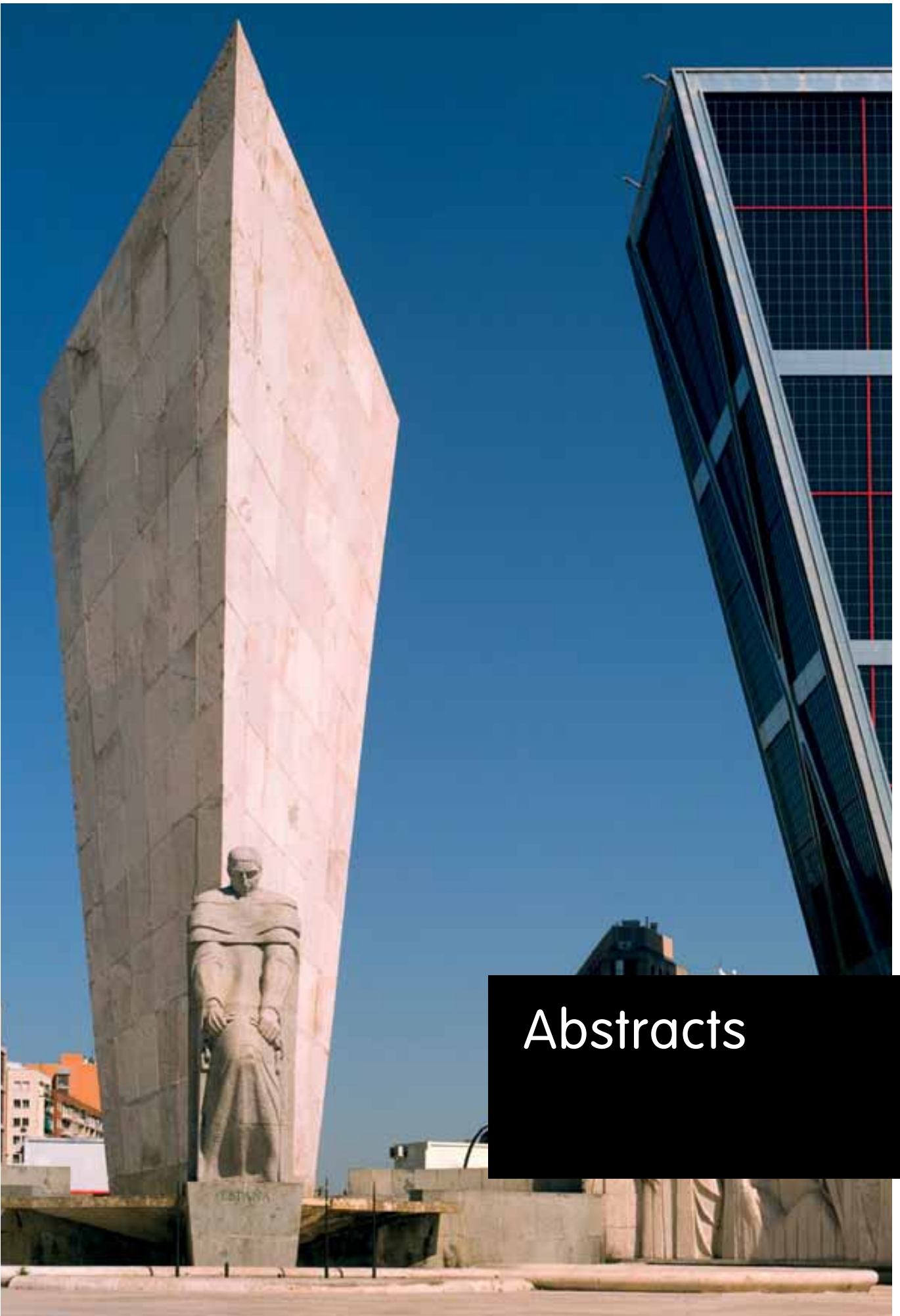
- 16.00 - 16.05 **Welcome from the chair**
S. Elliott, Vancouver (CA)
- 16.05 - 16.35 **Sexual rehabilitation in women with neurogenic disorders: What matters and how to help**
S. Elliott, Vancouver (CA)
- 16.35 - 16.55 **Urinary incontinence in neurogenic patients: Causes, solutions and specific things to think about**
J.P.F.A. Heesakkers, Nijmegen (NL)
- 16.55 - 17.00 **Concluding remarks**
S. Elliott, Vancouver (CA)

Aims and objectives

Sexuality in women with neurogenic disorders is as important, if not more so, as it is in women without neurogenic disorders. While sexual function is often affected, one of the most disturbing features of having a neurogenic lower urinary tract disorder is urinary incontinence. This can have a major impact on female sexuality.

Addressing female sexual rehabilitation and urological issues requires putting a great emphasis on quality of life and acquiring an understanding of patients' needs and expectations.

Sponsored by COLOPLAST



Abstracts

P1

Room Berlin

PSYCHOSOCIAL ISSUES DURING THE TREATMENT OF NON-MUSCLE INVASIVE BLADDER CANCER

Wildeman-Cox S.M., Van Golde C.

St. Franciscus Gasthuis, Dept. of Urology, Rotterdam, The Netherlands

Introduction & Objectives

The psychosocial impact of intravesical therapy, with BCG (Bacillus Calmette-Guérin) or Mitomycin (MMC), is an issue that we, as urological oncology nurses, are often confronted with, and yet there is still limited data available. Non-muscle-invasive Bladder cancer (NMIBC) is common and characterized by frequent relapse and progression. So far, most of the research that does exist is limited to the psychosocial impact of Muscle-Invasive Bladder cancer (MIBC). The aim of this study is to assess if patients, undergoing intravesical therapy with BCG or MMC, have psychosocial issues or needs and the impact thereof on their daily life, social, emotional and physical well-being.

Material & Methods

The study population consisted of 80 men and women undergoing intravesical therapy with BCG or MMC, aged between 40-95 years, participating from June 2013 to July 2014.

Method: The methods used were structured questionnaires, EORTC BLS-24 and the Distress thermometer.

Questionnaires were filled in at the end of the induction phase of BCG and MMC and 6 months later. Questionnaires were also filled in by patients during BCG maintenance therapy.

Data obtained from the study were analysed using the Statistical Program for Social Science (SPSS) for Windows.

Results

In our study, we observed a statistically significant difference in the psychosocial impact between the BCG and MMC patients ($p=0,001$). We also observed a statistically significant difference in the duration of treatment and psychosocial impact between the BCG and MMC patients ($p=0,001$). The results obtained from the Distress Thermometer showed that 32,1% of the patients indicated that intravesical therapy with BCG or MMC had an impact on their daily life, social, emotional and physical well-being (Score ≥ 5 on the Distress thermometer).

Specific items were; 27,6% of the patients had problems keeping emotions under control, 28% experienced tension and nervousness, 28% felt depressed and 32,5% complained of a lack of sleep.

A major issue was fatigue 55,3%. 39% of the patients had issues with their physical condition and 23,4% experienced muscle weakness.

The EORTC BLS-24 questionnaire showed that 62,6% complained of frequency, 35,9% experienced dysuria and 50,6% had to rush to the toilet due to an intense painful urge to urinate and 51% had nocturia.

The results obtained from the Distress thermometer and EORTC BLS-24 completed a second time, 6 months after treatment of intravesical therapy with MMC and BCG, showed an increase in psychosocial burden.

Results obtained from patients during BCG maintenance therapy also showed an increase in psychosocial burden.

Conclusions

Patients undergoing intravesical therapy, with BCG or MMC, experience physical and emotional problems.

Intravesical therapy with BCG has more of a psychosocial impact on emotional and physical well-being, than MMC.

The psychosocial burden of intravesical therapy with BCG or MMC increases after the induction phase and during BCG maintenance therapy.

In order to provide optimal care for patients undergoing intravesical therapy nurses need to be aware that intravesical therapy does have an impact on daily life, social, emotional and physical well-being and that there are patients with psychosocial issues that need to be addressed.

P2

Room Berlin

A SYSTEMATIC REVIEW OF THE EMPIRICAL EVIDENCE IDENTIFYING THE UNMET SUPPORTIVE CARE NEEDS OF MEN LIVING WITH AND BEYOND PROSTATE CANCER: ARE WE THERE YET?

Paterson C.¹, Robertson A.², Smith A.², Nabi G.¹

¹University of Dundee, Academic Urology Department, Dundee, United Kingdom, ²NHS Tayside, Urology Department, Dundee, United Kingdom

Introduction & Objectives

Men affected by prostate cancer are patient population in need of on-going person-centred supportive care. Our aim was to synthesis current available evidence with regard to the unmet supportive care needs of men living with and beyond prostate cancer.

Material & Methods

A systematic review was conducted according to the PRISMA Statement Guidelines. Electronic databases (DARE, Cochrane MEDLINE, BNI, PsychINFO, EMBASE and CINAHL) were searched to identify studies employing qualitative and/or quantitative methods. Methodological evaluation was conducted, and findings were integrated in a narrative synthesis.

Results

7521 references were retrieved, 17 articles met the eligibility criteria. Individual needs were classified in to the following domains: social needs (2/17: 11.8%), spiritual needs (4/7: 23.5%), practical needs (4/17: 23.5%), daily living needs (5/17: 29.4%), patient-clinician communication (5/17: 29.4%), family-related needs (7/17: 41.2%), physical needs (8/17: 47.1%), psychological emotional needs (9/17: 52.9%), interpersonal/intimacy needs (11/17: 64.7%) and health system/Information needs (13/17: 76.5%).

Conclusions

This systematic review has identified that men can experience a range of unmet supportive care needs with the most frequently reported being needs related to intimacy, informational, physical and psychological needs. Despite the emerging evidence-base, the current with-in study limitations precludes our understanding about how the needs of men evolve over time from diagnosis to living with and beyond prostate cancer. Whether demographic or clinical variables play a moderating role, only remains to be addressed in future studies. This review has made an important contribution by informing clinicians about the complex unmet supportive care needs of men affected by this disease.

P3

Room Berlin

DECREASING FREQUENCY PATTERN OF INTERMITTENT SELF-CATHETERIZATION IN GENERAL UROLOGY

Bassas A.¹, Martinez P.², Paganini G.¹, Batista J.E.¹

¹Hospital Quiron Teknon, Dept. of Urodynamics, Barcelona, Spain, ²Hospital Británico, Dept. of Urology, Buenos Aires, Argentina

Introduction & Objectives

To evaluate therapeutic response and morbidity in patients with voiding bladder dysfunction (VBD) performing intermittent self-catheterization (ISC) using a decreasing frequency pattern (DFP).

Material & Methods

In a 2 year-period, 27 patients with VBD and significant post void residual (PVR) (>100ml) were monitored (Ages from 32 to 82 years, mean 54.3). 15 were women and 12 men. An individualized session was done with every patient to teach ISC, as well as control visit in 5-7 days followed by alternative visits with continence advisor and urologist. Mean follow-up was 23.5 months (2-66). DFP consisted in gradually decreasing the number of ISC/day, when the PVR was consistently <100ml.

Results

Urodynamic Diagnosis - Of the 12 men, 6 had hypocontractile detrusor, 5 neuropathic dysfunction and 1 had VBD in a neobladder after a radical cystectomy. From 15 women, 7 had had an idiopathic acute urinary retention (AUR), 3 AUR after sling surgery, 3 neurogenic dysfunction and 2 painful bladder syndrome. The number of catheterizations and PVR diminished in the entire group using the DFP. 40.7% of the patients didn't need to continue with ISC after a mean time of 7.38 months. All women with painful bladder syndrome or AUR after sling were ISC-free after a mean time of 8 months. Aside from neuropathic patients, in the other groups the mean ISC/ 24h at the end of the follow-up was <1. Mean time to achieve a stable residual or absence of the same was 9.76 months (0.75-63). Therefore, neuropathic patients decreased their PVR more slowly. Urinary tract infection (UTI) (9 patients) in the beginning of the treatment was the only complication registered, being more common in males (58%) than in females (13%). One male patient required an emergency orchidectomy due to severe orchitis. In a telephone survey at the last follow-up, overall

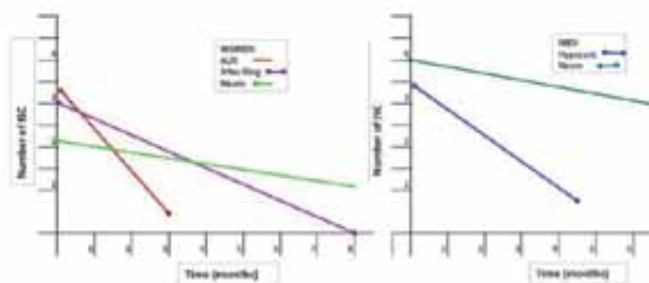


FIG 1. Time evolution in the mean ISC/ 24H in different urodynamic groups. The final point in neurogenic patients can't be shown.

Conclusions

ISC is a well-accepted and learned technique by patients with a minimum interference in everyday life. DFP allows most patients to decrease the frequency and almost half to be ISC free. Neurogenic patients do not respond as well to this pattern. The high frequency of UTI in men warrants close supervision and consideration of further measures.

P4

Room Berlin

INCIDENCE AND IMPACT OF URINARY TRACT INFECTIONS (UTI) WHEN STARTING INTERMITTENT CATHETERIZATION (IC) AND THE EFFECT ON QUALITY OF LIFE

Mulder H.J.

Martini General Hospital, Dept. of Urology, Groningen, The Netherlands

Introduction & Objectives

Poor bladder emptying is a common phenomenon in urology. Urine remaining in the bladder increases the risk of a urinary tract infection. In patients with incomplete bladder emptying, clean intermittent (self) catheterisation (IC) is a commonly recommended procedure to protect their bladder and renal health.

Normally, urine does not contain microorganisms. Bacteria growing around the meatus can be introduced into the urethra to manifest UTI. Catheterization can cause such introduction.

Recent literature states that approximately 30% of IC patients get bacteriuria and 7-10% of the patients using IC will get a UTI and need to be treated with antibiotics (Rew. 2003). However, these numbers seem to underreport the number of UTI found in daily practice. To detect a UTI urinalysis is needed.

Suffering from a UTI influences patients' quality of life (Ellis. 2000) and may lead to absence of work, taking more medicine etc. which contributes to an increase in costs.

In summary, UTI are commonly seen in IC patients. This can have great impact on patients and the health care system.

Material & Methods

We determined the incidence and impact of UTI in patients starting IC using a multi-centre prospective observational study. Four large general hospitals in the Netherlands are participating.

Subjects starting IC were followed for 1 year. At each study visit, a urine analysis was done and the subjects completed questionnaires (Rand 36 and Kings healthcare). Study visits occurred at baseline, after one, three and twelve months.

Additionally, we interviewed a random sample of subjects. All subjects received standard care; i.e. education for IC according to the Dutch guideline of the association of Dutch nurses and carers, department of continence care. A standard catheter as given in the specific hospital or to patients' preference was used.

A UTI in this study is defined as: the combined outcome of bacteriuria (10^5 CFU/ml) and pyuria (>10 white bloodcells/mm³) and one or more of the following symptoms; frequency, urgency, dysuria, stranguria, fever or haematuria.

The primary outcome measure is the occurrence of UTI. To assess the expected 30% incidence of a UTI in this population with a 95% confidence interval of plus or minus 5%, a sample of 384 patients is required.

Data is collected in a data management system and analysed in SPSS.

Results

Until November 2014 we analysed 139 subjects (76.3% male, 23.7% female). The mean age of the subjects was 66.9 (SD 15.9) years. Within 3 months after starting IC (median 27 days), 19.4% of all subjects got a urinary tract infection.

There was a significant decrease ($p=0.04$) of quality of life due to the bladder problems, after 1 month starting IC. Preliminary results did not reveal a correlation between a UTI and decrease in quality of life.

Conclusions

The incidence of UTI was markedly higher than stated in the literature, and already present at three months after starting IC. Especially around one month after starting IC, patients seem to be at risk for developing UTI. Patients report a decreased quality of life after starting IC, which could not be attributed to the development of UTI.

P5

Room Berlin

NURSE LED FEMALE URINARY TRACT INFECTION CLINIC

Robinson E., Pearce I.

Manchester Royal Infirmary, Dept. of Urology, Manchester, United Kingdom

Introduction & Objectives

Urinary tract infections (UTI's) are common in adult women of all ages. Recurrent UTI's represent a significant problem for women and a challenge for their healthcare professionals. A Consultant Urologist and a Urology Specialist Nurse developed a protocol driven nurse-led, female new patient UTI clinic in 2013. The clinic was set up to assess, investigate, manage and treat this group of patients based on current guidelines.

The purpose of this study was to;

- Analyse the data the clinic provides
- Assess protocol adherence
- Analyse patient outcomes

Material & Methods

Data was collected prospectively from December 2013 to September 2014 recording symptoms, physical examination findings, investigations performed, medical management, results and outcomes.

Results

Complete data was collected on 32 patients, with mean age 44 yrs, (range 16 – 89)

Presenting symptoms included;

- 8% haematuria
- 8% straining to void
- 18% loin pain
- 25% incomplete voiding

Management according to protocol showed;

- 100% post residual ultrasound scan
- 85% urine cultures (sent on positive dipstick)
- 82% serum glucose
- 6% urodynamics
- 28% flexible cystoscopy

Positive urine cultures showed;

- 12% Escherichia coli
- 4% Klebsiella
- 2% revealed mixed growth

Residual volume was identified in 19 patients with a range of 13-361 millilitres.

Treatments instigated were;

- 4% pelvic floor exercises
- 4% antimuscarinic
- 6% antibiotics
- 100% fluid intake advice

- 100% UTI avoidance leaflet
- 96% health promotion advice

Follow up management revealed 18% of patients were discharged and 13% did not attend further arranged appointments. 46% of patients were referred on to the consultant.

Conclusions

The nurse led female UTI clinic is an effective and safe means of assessing patients, performing appropriate investigations and implementing effective protocol driven management plans and provides an educative role to patients to promote health and providing a more holistic approach.

P6

Room Berlin

DOES PRE-OPERATIVE PATIENT EDUCATION IMPROVE PATIENT SATISFACTION FOLLOWING ROBOT-ASSISTED LAPAROSCOPIC PROSTATECTOMY?

Zaretzer S., Regev S., Louie G., Aharony S., Tal R., Baniel J.

Rabin Medical Center, Dept. of Urology, Petach Tikva, Israel

Introduction & Objectives

Robot-assisted laparoscopic prostatectomy (RALP) has overtaken traditional open retropubic radical prostatectomy (RPP) as the procedure of choice of men suffering from localized prostate cancer. Since our center's first RALP procedure, 3.5 years ago, over 270 cases were performed under our service. Despite the fact that existing evidence does not support the superiority of RALP over RRP in terms of oncologic or functional results, the prevailing view is that better overall results are expected with an "innovative" procedure. It has been shown that patients who underwent RALP had higher expectations regarding post-operative outcomes and were more likely to be dissatisfied, compared their RRP counterparts, with sub-optimal outcomes. In order to improve patient understanding and manage expectations, we initiated a pre-operative patient education program focusing on the operative procedure, potential short and long-term side effects and the expected recovery process. Our aim was to assess the effect of this program on post-operative patient satisfaction.

Material & Methods

The cohort consisted of 90 patients, 45 in each arm. Patients were randomized to a pre-operative education group and to a control group. Pre-operative education consisted of a dedicated session. Patients and their spouses were paired with a multi-disciplinary urology team (surgeon, nurse, physical therapist) up to three weeks before the scheduled operation and were provided information regarding prostate cancer and the surgical procedure while focusing on the robotic system. Aspects of pre- and post-operative clinical pathways were reviewed as well. Designated time for question and answers concluded the tutorial. Control group patients were given standard of care pre-operative explanations by the surgeon and the nursing team. On post-operative day 10 patients were asked to fill a designated questionnaire assessing their overall satisfaction. Pain, anxiety and distress level, and self-care ability were assessed as well.

Results

Mean patient age was 63.4 ± 9.0 years, without significant inter-group differences with respect to socioeconomic, education or past medical history. Overall satisfaction was significantly higher in the pre-operative education ($p=0.016$), however no difference was shown regarding their level of pain, distress, anxiety or self-care ability.

Conclusions

Pre-operative patient education prior to RALP surgery is essential in order to gain true understanding regarding the expected results and complications. This program enables realistic expectations and reduce post-operative regrets and dissatisfaction.

P7

Room Berlin

POST-OPERATIVE PAIN AND NEUROMUSCULAR COMPLICATIONS ASSOCIATED WITH PATIENT POSITIONING AFTER ROBOT-ASSISTED RADICAL PROSTATECTOMY

Gezginci E.¹, Ozkaptan O.², Yalcin S.³, Akin Y.², Rassweiler J.², Gozen A.S.²

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Introduction & Objectives

Robot assisted radical prostatectomy (RARP) has been used in a growing number for organ confined prostate cancer as a surgical therapeutic option due to various benefits. Although, RARP has positive effects on patients' outcomes and surgeons' comfort, low-lithotomy and steep Trendelenburg position during RARP can cause discomfort in patients after operation. In this study, we aimed to evaluate postoperative neuromuscular complications and pain related to the position.

Material & Methods

It was a prospective study with data of 534 patients who underwent RARP between September 2010 and June 2014. Patients were positioned in the operating room by the operating room staff and postoperative follow-up were performed by other independent two urologists. Patient's age, body mass index (BMI), comorbidities, previous operative and medical history, presence of implants, operation time, American Society of Anaesthesiologists (ASA) scores, postoperative complications associated with positioning, pain score according to Visual Analogue Scale (VAS) consultations, and hospital stay were recorded. The SPSS V.15 was used for statistical analyses. Significant p value was accepted when $p < 0.05$.

Results

A total of 71 (13.3%) postoperative complications which were associated with positioning were determined. Postoperative pain and neuromuscular injuries were observed in 54 (10.1%) and 27 (5%) patients, respectively. We found that ASA, BMI, and comorbidities were significant associated with postoperative pain levels in univariate analyses ($p=0.015$, $p=0.013$, $p=0.014$; respectively). Additionally, ASA, previous operations and comorbidities were significant associated with postoperative complications ($p=0.047$, $p=0.015$, $p=0.022$; respectively). According to our statistical analyses, when $BMI < 30$ and presence of any implant were significantly associated with postoperative pain in multivariate logistic regression analyses ($p=0.010$, $p=0.033$; respectively). Furthermore, having comorbidities was significantly associated with postoperative complications in multivariate analyses ($p=0.046$).

Conclusions

Patient positioning during RARP can cause patient discomfort and postoperative neuromuscular complications after operation. Patients with comorbidities and implant history can have a high risk for neuromuscular injuries and postoperative increased pain. Increased level of ASA may be more related with positioning complications. Operating room staff and also anaesthesia team should be very careful with the patients undergoing RARP in steep Trendelenburg and low-lithotomy position.

P8

Room Berlin

FACTORS RELATED TO CATHETER BLOCKAGE IN HOME NURSING CARE PATIENTS WITH LONG-TERM INDWELLING CATHETERS

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¹Kanazawa Medical University, Dept. of Nursing, Kahoku, Japan, ²Gifu University, School of Nursing, Ishikawa, Japan, ³Kanazawa Medical University, Dept. of Nursing, Ishikawa, Japan, ⁴Himi Municipal Hospital, Kanazawa Medical University, Dept. of Urology, Toyama, Japan

Introduction & Objectives

Many patients receiving home-visit nursing care use an indwelling catheter for a prolonged period of time. These patients developed various symptoms and complications, such as catheter blockage. Catheter blockage can cause serious complications so visiting nurses must be capable of preventing it from occurring. However, few studies have demonstrated the causes of catheter blockage in home nursing care patients with long-term indwelling catheters. Therefore, we sought to identify the causes of catheter blockage in home-bound patients with long-term indwelling catheters.

Material & Methods

Participants: 81 patients using long-term (6 months or longer) indwelling catheters while receiving home-visit nursing care.

Data collection: We asked managers at 18 home nursing care stations to respond to a questionnaire. The questionnaire contained questions about patient attributes, catheter management, and handling of catheter blockages. Data was collected between 24 October and 22 November 2014.

Data analysis:

Factor analysis comparing non-blockage and blockage group patients: Those who did not experience any catheter blockages between April and September 2014 were assigned to the “non-blockage group” while those who did were assigned to the “blockage group”. Comparative analyses of patient attributes, catheter management and catheter blockage-related symptoms were then performed using the Mann-Whitney U test or the Chi-square test.

Factor analysis of blockage frequency in blockage group: Comparative analyses of patient attributes, catheter management and catheter blockage symptoms and the blockage frequency in the blockage group were performed using the Mann-Whitney U test or correlation analysis.

Results

The study population consisted of 35 men and 46 women with an average age 81.64 years (60–102 yr). Mean duration of catheter placement was 37.78 months (6–213 mo).

Factor analysis comparing “non-blockage” and “blockage” patients: Intergroup differences were seen for the caregiver catheter management variables of “Checking of urine volume” ($p=0.012$), “Checking the flexion and distortion of the catheter” ($p=0.024$), and “Checking of urinary tract infection symptoms” ($p=0.033$). The frequency of all of these actions was low among caregivers in the blockage group. Moreover, there was a high incidence of catheter blockage-associated symptoms of “Cloudiness of urine” ($p=0.054$), “Floating objects in urine” ($p=0.096$), “Abdominal pain” ($p=0.041$), and “Lower back pain” ($p=0.098$) in the blockage group.

Factor analysis based on blockage frequency in the blockage group: A relationship to the number of blockages was seen for the catheter blockage-related symptom of “Decreased urine volume” ($p=0.006$). Mean number of blockages in patients with decreased urine volume was 7.0 times, and 2.5 times in those who did not exhibit “Decreased urine volume”.

Conclusions

The results of factor analysis comparing patients in the blockage and non-blockage groups showed that “Checking of urine volume”, “Checking the flexion and distortion of the catheter” and “Checking of urinary tract infection symptoms” by the caregiver were performed less frequently in the blockage group. Factor analysis of blockage frequency in the blockage group indicated that the blockages occurred more frequently in those with “Decreased urine volume” than in those without “Decreased urine volume”.

P9

Room Berlin

MY PATHWAY – AN APP DEVELOPED FOR MEN WHO ARE UNDERGOING RARP

Englund C., Nørregaard S.

Odense University Hospital, Dept. of Urology, Odense, Denmark

Introduction & Objectives

The prevalence of prostate cancer (PC) is rising. In 2012, 4316 men were diagnosed with PC in Denmark (1). At the Department of Urology at Odense University Hospital (OUH), we perform approximately 180 robot-assisted radical prostatectomies (RARP) annually.

The time given in the outpatient clinic is limited. It might be challenging for the doctor and nurse to inform the patient and his family about the surgery and answer questions within the timeframe given to them. Patients newly diagnosed with cancer are often not able to process the information given to them immediately after.

We believe that a lot of Danish men undergoing RARP have smartphones. Electronic media and devices are becoming more and more popular and the sale of smartphones is increasing. There is no APP available for men with PC that describes the disease and treatment options in Danish. We want to create an APP in collaboration with men who have undergone RARP. We expect the APP to include:

- A detailed description of the treatment and the follow up
- Brochures with patient information
- Animation movie showing pelvic floor exercises
- Links to relevant websites
- Articles written in Danish about PC
- An opportunity for the patient to save PSA-values (Prostate Specific Antigen)

The objective of this study is to develop an APP for men who are planned to have a RARP. We want to examine if patients who are offered the APP in addition to the usual consultation and written information are better informed than patients receiving the standard information.

Material & Methods

Inclusion criteria: Men who is offered a RARP at OUH

Exclusion criteria: Men who do not speak and understand Danish

Part One

Approximately 10 patients that have undergone a RARP are interviewed focusing on the information. The APP is developed according to the results.

Part Two

Prior to RARP, approximately 60 men are asked if they have a smartphone. Those who own a smartphone are introduced to the APP in addition to the standard information. Others receive the standard information.

A questionnaire will be handed to the 60 patients prior to discharge. The overall question is:

- On a scale from 1 – 10, how well informed are you? (1= not informed at all, 10 = totally informed).

The completed questionnaire is returned 10 days after RARP in the outpatient clinic. Results for the two groups

(introduced to the APP + standard information versus standard information) are compared.

The patients who are introduced to the APP are asked the additional questions:

- How confident were you using the APP? (Very confident, to some extent, less confident, not confident at all, do not know).
- How often did you use the APP? (5-10 times, 3-5 times, 1-3 times, not at all).
- What is your opinion of the APP? (Very good, good, bad, very bad, do not know)
- Do you have new ideas to the APP? (Describe)
- Have you looked for more information e.g. on the internet? (yes, no)
- Do you use APP's in general?

Timeframe:

Part One

1st of December 2014 – 1st of March 2015 Interview 10 patients and develop APP

Part Two

1st of April 2015 – 1st of August 2015 Evaluation of the APP using a questionnaire

Budget: Price for the APP 35.000 Danish kr. = 262.5 €

Results

Conclusions

The goal is to increase the level of knowledge by using the APP. We hope that the APP will help the patient and his family to get an overview of the treatment and the follow up at the right time. In addition the APP may reduce the calls from worried patients and their family members.

P10

Room Berlin

BEYOND ONE'S DEPTH – THE EXPERIENCE OF POSTOPERATIVE COMPLICATIONS FOLLOWING RADICAL CYSTECTOMY

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Introduction & Objectives

Radical cystectomy (RC) is a challenging and complicated surgical procedure. RC is associated with a high incidence of postoperative complications (1). However, knowledge of how the patients experience postoperative complications and the recovery from them is limited. The purpose of the study was to investigate the lived experiences of suffering and recovering from postoperative complications in the early period following RC.

Material & Methods

The study was carried out within a descriptive phenomenological approach, as described within the framework of Reflective Lifeworld Research (2). Data was collected from individual, semi-structured qualitative interviews with 5 Danish male patients. The mean age of the participants was 69.6 years. The included patients had suffered complications grade 2 or above, according to the Clavien-Dindo classification (3). Interviews were audio-taped and transcribed verbatim. Data were analysed using the four step analysis process described by Dahlberg et al. (2).

Results

The findings from the 5 interviews show that; Patients understood and interpreted postoperative complications as inherent to their treatment trajectory, not as an isolated adverse phenomenon. For patients, postoperative complications entailed: Physical and psychological suffering; Experiencing the body as foreign and out of control; Brooding about reasons and responsibility. Relatives were a major resource for patients during recovery. Nevertheless they too suffered the consequences of postoperative complications. However, their needs for support seemed to be insufficiently addressed.

The study was carried out as part of a master's thesis. More interviews will be conducted in order to reach a goal of 10-12 patients included in the study. The presentation at the EAUN conference will be based on the results from the first 5 interviews.

Conclusions

The findings suggest a need to focus on relatives as a vulnerable group, and to consider approaches to help patients regain control and feel at home in their body again. The results of the study can inform the development of evidence based goal-directed interventions aimed at securing the quality care for patients and relatives experiencing postoperative complications.

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P11

Room Berlin

NUTRITIONAL STATUS AND POSTOPERATIVE FUNCTIONAL OUTCOMES IN PATIENT UNDERGOING RADICAL CYSTECTOMY: A PROSPECTIVE OBSERVATIONAL STUDY

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Introduction & Objectives

The nutritional status is considered an incisive factor to determine postoperative outcomes after radical cystectomy (RC). In clinical practice patients are not generally fed by oral intake until a complete recovery of the bowel function is assessed; in fact a nutritional substitutive support is provided through total parenteral nutrition (TPN) or enteral nutrition (EN). This doesn't seem to have positive effects on the time of bowel activity recovery, on infectious complications rate and costs. On the contrary, the early introduction of oral feeding seems to lead to an improvement of clinical outcomes, and even the evidences available in literature supporting specific strategies are few. The aim of this study is to describe the impact of the nutritional support on functional outcomes in patients undergoing RC.

Material & Methods

A prospective observational study has been conducted in Dept. of Urology at San Raffaele Hospital (Milan) during the period April - September 2014, on a convenience sample of 25 patients undergoing RC with urinary diversion. Data relative to preoperative nutritional status, postoperative period, quality of postoperative nutrition and patients liking, recovery of Activities of Daily Living and complications have been collected. Data have been analysed by descriptive statistic.

Results

24% of the patients needed the use of TPN, discontinued on the average in postoperative day 4.8 (SD \pm 1.92); the regular nutrition has been restarted in day 7.4 (SD \pm 5.4); for 72% of the patients an early nutrition has been done within the third postoperative day after the removal of nasogastric tube (NGT) independently from bowel recovery. 12% of patients needed the suspension of oral nutrition for intolerance. The time of first flatus was on day 2.64 (SD \pm 1.29) and the complete recovery of bowel activity was on day 4.88 (SD \pm 1.59). On the first day of hospitalization the 80% of sample has been mobilized in chair and within the eighth day 94% of patients were independent. The average distance walked from the patients that used TPN was 26.67 m. (SD \pm 17.51) versus 88.42 m. (SD \pm 78.97) walked by patients that have done early nutrition. On the first day all patients were assisted for personal hygiene, whereas on third day 64% of patients were independent in toileting. The sleep-wake rhythm was restored in 84% of patients. The average of pain (Numerical Rating Scale - NRS), expressed by 52% of the patients, was on the first day: 2.62 (range 0-4), decreasing value during the hospitalization. The pain was well controlled with epidural catheter analgesia with NRS values that gradually decreased in consecutive days, involving a good tolerance to mobilization. 56% of patients showed postoperative nausea and vomiting, 16% had postoperative ileus. The length of stay was 11.44 days (SD \pm 8.29).

Conclusions

The introduction of early oral nutrition on patients undergoing RC is associated with an improvement of analysed outcomes, whereas the use of TPN is associated with an increment of complications. Furthermore, it emerged how the early removal of NGT associated with early oral nutrition, independently from the bowel activity, gives benefits, showing an improvement of patients' general condition. Further investigations are needed in order to confirm these preliminary results.

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Room Berlin

EDUCATIONAL SEMINARS INCREASE CONFIDENCE AND DECREASES DROPOUT FROM ACTIVE SURVEILLANCE

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Introduction & Objectives

EAU Guidelines recommend active surveillance (AS) over radical treatment for men with low risk prostate cancer. Despite radical treatment causing side-effects, up to 50% of men opt out of AS and into radical treatment within 12 months. Lack of support and education combined with anxiety of cancer progression are thought to drive this.

We aimed to reduce the dropout rate by introducing educational peer group seminars for men on AS. This study evaluates the impact of the seminar on the number of men dropping out of active surveillance and choosing to undergo radical treatment when not clinically indicated.

Material & Methods

We compared two groups of consecutive patients diagnosed with low risk prostate cancer as defined by the D'Amico classification system. Group A (n=127) were offered standard care (access to a nurse specialist and written information concerning active surveillance - Jan 2011-Jan 2012). Group B (n=117) were offered standard care and were invited to participate in an educational seminar delivered by the prostate cancer team (doctor and nurse). This group of patients were then given an educational seminar and offered further written information covering the safety of AS including imaging, biopsy, historical active surveillance co-horts, and diet and lifestyle advice. Time was made for questions and peer group discussion following the seminar.

We compared patient characteristics, pathology and outcome at 12 months between both groups (A and B) using descriptive statistics (i.e. t-test, chi-square test, and fisher's exact test).

	Group A (N=127)	Group B (N=117)	P-value
Mean Age, years (SD)	62 (7)	63 (7)	0.405
Mean PSA, ng/mL (SD)	9.52 (7.05)	8.46 (5.24)	0.190
DRE (%)			
Benign	44 (35)	45 (38)	0.513
T2	72 (57)	66 (56)	
T3	11 (9)	6 (5)	
Biopsy Gleason Grade (%)			<0.001
3+3	39 (31)	109 (93)	
3+4	88 (69)	8 (7)	
Patients dropping out of Active surveillance (%)			

Results

There was no difference in the distribution of patient characteristics between the two groups.

The addition of a seminar significantly decreased the total number of men dropping out of active surveillance, from 25% in group A to 11% of group B.

There were more patients with 3+4 disease in group A, which may in part explain the drop-out rate of 18(20%) however, an equivalent number of patients with 3+3 disease also dropped out - 14(36%).

Conclusions

Educational seminars delivered to groups of men with low risk prostate cancer appear to improve confidence in active surveillance and significantly reduce the drop out rate.

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Room Berlin

UNDERTAKING DIAGNOSTIC AND SURVEILLANCE CYSTOSCOPY TRAINING USING A FLEXIBLE CYSTOSCOPE: A NURSE-LED EDUCATIONAL INITIATIVE IN THE UK

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Introduction & Objectives

Nonmuscle invasive bladder cancer accounts for 75% of patients with bladder cancer. Bladder cancer is one of the most expensive malignancies in our healthcare system due to its life-long surveillance. There is a lack of randomised studies that establish the safety of reducing the frequency of follow up cystoscopies. Specialist nurses add value to patient care, while generating efficiencies for organisations through new and innovative ways of working. Traditionally, cystoscopy training has been delivered by clinicians, however, we share our evaluation of an innovative nurse-led cystoscopy educational course delivered in the UK for the first time.

Material & Methods

The course has been delivered over the past 2 years in the State-of-the-Art Cushieri Skills Centre, located in Ninewells Hospital & Medical School, University of Dundee. Educational outcomes include: theoretical principles, practical abilities in being able to handle a flexible cystoscope, and performing practical manoeuvres including the use of biopsy and grasping forceps. Practical training was supported using synthetic models, animal tissue models and a human cadaver.

Results

Attendees included specialist nurses, trainee urology clinicians, and general practitioners (with a specialist interest in urology). 100% of attendees felt confident in the safe handling and practical manipulation of the cystoscope. Aspects that healthcare professionals found most helpful included: human cadaver, interactive sessions, pigs bladders, video sessions, practical demonstration, and hands on experience. Areas for development included: timing of the course, equipment and refreshments.

Conclusions

Course feedback acknowledges that advanced urology specialist nurses can deliver high quality skills training to meet the learning requirements of local, national and international healthcare professionals within the safe practice of cystoscopes.

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Room Berlin

“LETS TALK ABOUT SEX”- A PROSPECTIVE AUDIT OF A NURSE PRACTITIONER LED SEXUAL HEALTH AND ERECTILE DYSFUNCTION (SHED) CLINIC

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Introduction & Objectives

Sexual dysfunction is often under-appreciated and under-diagnosed, particularly in cancer populations. A diagnosis of cancer and subsequent treatments can have a substantial impact on the quality of life of cancer patients and their partners. In 2009 a gap analysis at Peter MacCallum Cancer Centre (Peter Mac) identified considerable unmet sexual health need among our patients. In response to this, a Nurse Practitioner (NP)-led sexual health and erectile dysfunction (SHED) clinic was developed to provide men (in the first instance) and their partners with timely access to evidence-based information and consultation regarding erectile dysfunction and concerns about sexual health. Audit data is used to characterize the population attending the SHED clinic in a twelve-month period, as well as describe the main intervention received.

Material & Methods

A prospective audit of hospital datasets and records for new patients who attended the SHED clinic between November 2013 to November 2014. Descriptive statistics were used to summarize age, referral source, geographical region, attendees, sexual history, cancer treatment, whether treatment was nerve-sparing (for RARP patients only), prostate cancer stage and the main intervention received.

Results

69 new patients attended the NP-led SHED clinic from November 2013 to November 2014. Most (83%) patients were referred by a consultant and most (74%) attended the clinic alone. A majority (67%) had received treatment such as robotic assisted radical prostatectomy (RARP) and of those who received RARP most (70%) had received nerve-sparing treatment. Of the 69 men who attended the clinic as new patients, 40 (58%) stated that their sexual history was good. The main interventions received were information (44%), PDE5I (42%) and ICI (10%); 3 (4%) patients received no intervention.

Information interventions include psychosocial education, coping skills coaching and development of a tailored plan of care to help men and their partners manage erectile dysfunction.

Conclusions

Sexuality is a fundamental aspect of every individual. Since the SHED clinic was implemented in July 2013, approximately 300 patients have attended; 69 were new patients. The SHED clinic addresses unmet need and provides patients and partners with information and support to make an informed decision on how to manage their sexual concerns. This audit of the clinic will inform refinement and expansion of the NP scope of practice ensuring the clinic and role delivers a valuable and responsive service for patients at Peter MacCallum Cancer Centre.

P15

Room Berlin

SHOCK-WAVE LITHOTRIPSY: THE IMPACT OF A DESIGNED NURSING TEACHING PROTOCOL ON PATIENTS WITH RENAL AND URETERIC STONES

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Introduction & Objectives

Since its introduction, extracorporeal shock-wave lithotripsy (ESWL) has been a major advance in management of renal stone disease. It is a non-invasive, well tolerated, and effective method of treatment. However, it does carry some risks. Although its complications are infrequent, they are well documented in the literature. In order to provide a good healthcare, patients should not just be offered appropriate medical advice and procedures, but also be fully informed as to the condition, options of treatment and possible complications. Easy access to accurate medical information is very important to the patient and healthcare providers.

To assess knowledge and priorities towards shock-wave lithotripsy (SWL) for patients undergoing SWL. To evaluate the effect of implementing health education protocol on patients' knowledge and priorities towards SWL.

Material & Methods

Knowledge assessment and priorities questionnaires about SWL were introduced to 245 patients attending ESWL unit. Patients who work in medical field were excluded. For patients less than 15 years, questionnaires were introduced to parents or caregivers. The patients were divided into 2 groups. Group I contains 123 patients who did not have ESWL before. Group II contains 122 patients who had previous experience of SWL. Knowledge assessment was composed of 15 questions regarding SWL with maximum score of 45. Priorities questionnaire contained 15 aspects of SWL. Each aspect was rated on a numerical scale from 1 to 10 according to its importance for the patient. Then the patients were exposed to a health education protocol composed of information booklet and verbal education about SWL. Then knowledge assessment and priorities questionnaires were reintroduced to patients. Results of both questionnaires before and after the health education protocol were compared.

Results

Mean age of the patients was 35.2 ± 18 years. There were 167 males and 78 females. Regarding knowledge assessment, mean score of all patients before application of health education protocol was 3.43 [1.85 for group I and 5.02 for group II (t-test, $p < 0.001$)]. Mean score of all patients after application of health education protocol was 44.6 [44.59 for group I and 44.64 for group II (t-test, $p = 0.709$)]. This rise in the score was statistically highly significant (paired t-test, $p < 0.001$). Regarding patient's priorities, the most important aspect was stone clearance followed by procedure explanation, early return to normality and discussion of progress. After application of health education protocol, statistically significant increase in importance occurred for 10 aspects specially the availability of information booklet.

Conclusions

Both first time patients and patients with previous experience need to improve their knowledge related to ESWL. Stone clearance is the first priority for patients. Health education protocol improves patient's knowledge and clarifies their priorities towards SWL.

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Room Berlin

NEPHROSTOMY CATHETER-DYSFUNCTION

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Introduction & Objectives

Patients with hydronephrosis are often treated with nephrostomy catheters. A large number of patients are, however, admitted to emergency department because of dysfunctional nephrostomy.

The aim of the study was to:

- Visualize the number of patients admitted to emergency care with nephrostomy problems.
- Examine whether patients position during bandaging had significance to displacement of the nephrostomy.
- Examine how the nurse can participate in preventing displacement.

Material & Methods

Quantitative descriptive study based on data from Jan-Dec 2013:

- Diagnostic codes from department of Radiology (acute ultrasound nephrostomy)
- Review of 460 emergency referrals to department of radiology
- Diagnostic codes from medical journals ("mechanical" catheter problem)
- Review of 84 admissions to the hospital
- Measurement of abdominal circumference in 3 different positions at 10 patients with nephrostomy

Qualitative descriptive method:

- Questionnaire to 25 urological nurses with minimum 6 months experience, about what information they found the most important to communicate to patients with nephrostomy and to home nursing staff at discharge from hospital.
- Telephone interviews with 7 patients discharged from hospital with nephrostomy.

Results

In medical journals no specific diagnostic code is used for dysfunctional nephrostomy, but 56 of 84 admissions with the diagnosis "mechanical" catheter problem were patients with nephrostomy problems.

Days of admission ranged from 1 day to 15.

In average patients were admitted 3,14 days.

Lack of diagnostic code was supported with examination of referrals to Department of Radiology:

460 emergency referrals were due to:

- Dysfunction 135
- Autoremoval 41
- Hydronephrosis 249
- Infection 11
- Planned removal 24

Fixation/shift of bandage took place with the patient lying on the side.

Abdominal circumference was measured in 10 patients placed in 3 positions:

Sitting, standing and lying on the side.

All 10 patients had the largest circumference while sitting.

There was a difference of 2-7 cm from sitting to lying on the side.

The questionnaire revealed no consistency between nurses in regard to what information they found the most important to communicate to patients and home nursing staff. Just one nurse stated daily observation of bandage as important to communicate.

Telephone interview with discharged patients showed that:

- They were missing information in speech as well as in writing
- None of the patients were informed to observe the catheter/bandage daily
- Patients were provided with different aids.
- All patients had their dressing changed lying on the side.
- They experienced uncertainty from home nursing staff with regard to the nephrostomy care causing patients to be worried and insecure.

Conclusions

Department of Urology at Herlev Hospital have a large number of admissions due to dysfunctional nephrostomy in a magnitude, which financially influences the department as well as the quality of life for the patients.

Patients lack standardized information about care and daily observation of nephrostomy.

Dysfunctional nephrostomy may be caused by the way the patient is positioned during fixation and dressing change.

The findings will result in:

- Preparation of improved written information, which can be used by home nursing staff as well.
- A standardized nursing intervention for nephrostomy will be implemented.
- A study in cooperation with Department of Radiology to establish the significance of the position of the patient during fixation of dressing.

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Room Berlin

A PROSPECTIVE LONGITUDINAL STUDY EXPLORING THE INFLUENCE OF PSYCHO-SOCIAL FACTORS AND SELF-MANAGEMENT BEHAVIOURS ON HRQOL IN MEN LIVING WITH AND BEYOND PROSTATE CANCER

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Introduction & Objectives

Little is known about the influence of psycho-social factors on HRQoL, anxiety and depression in men affected by prostate cancer. Developing an understanding in this area can help to identify men who are at high risk of inadequate support and suggest directions for appropriately targeted interventions. Moreover, little is known about how men affected by prostate cancer mobilise social support in their self-management behaviours over time. This is the first study to test the effects of coping and social support on HRQoL and emotional outcome, and assessed the self-management behaviours of men affected by prostate cancer overtime.

Material & Methods

The study population was n=74 prostate cancer patients, 67.3 (SD 7.9) years with mixed treatment modalities. The EORTC QLQ-C30, PR25 and HADS were used to assess the dependant variables before treatment and at six months follow-up. Statistical analysis was performed in SPSS version 17.0 using parametric tests and non-parametric tests.

Results

A significant decline in QoL was observed at 6 months post diagnosis ($p<0.001$). Perceived social support before radical treatment was the most important social support construct that predicted better global quality of life and less depression at six months, explaining approximately 30% of the variance. Despite mens' self-management efforts and use of social support overtime, self-management self-efficacy significantly reduced at six months ($p<0.05$).

Conclusions

These findings provide support towards the development of a psycho-social intervention study to improve quality of life, self-management self-efficacy and improve patients' symptom management.

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Room Berlin

RETROSPECTIVE ANALYSIS OF PATIENTS' EXPERIENCE TO INTRAVESICAL BACILLUS CALMETTE-GUERIN (BCG)

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Introduction & Objectives

Bacillus Calmette-Guerin (BCG) is currently regarded as the most effective treatment available for the management of non-muscle-invasive bladder cancer (NMIBC). The aim of this study was to analyse the reasons for treatment interruption in everyday clinical practice in a large district hospital.

Material & Methods

Quantitative data regarding the clinical experience of BCG treatment received by patients during the period 1 January 2004 to 31 December 2011 was collected through a retrospective case notes review. The Connaught BCG strain was administered intravesically, at the dose of 81 mg diluted in 50 ml of saline solution, according to the South West Oncology Group schedule for 3 years, starting 21-30 days after TUR. Toxicity and causes of treatment interruption were recorded.

Results

A total of 234 patients received BCG of these 61% were > 70 years. Out of these 92% completed the induction cycle and 80% started on maintenance. A total of 56% completed 1 year and 5% finished 3 year of treatment. Treatment interruptions could be attributable to a lack of patient's counselling, as 43% received information and only 10% received any contact details for a clinical nurse specialist. Other reasons may be due to toxicity as 65% had at least one symptom, out of these 45% experienced symptoms within the first 35 days of treatment. The greatest reason for stopping treatment was toxicity, with 40% experiencing some form of pain e.g. cystitis.

Conclusions

Our study demonstrated that severe toxicity resulted in discontinuation of therapy in the majority. In addition, these preliminary data suggest interruptions could be attributable to a lack of patient's counselling and social isolation. A possible solution to the counselling would be to ensure that a clinical nurse specialist is present whenever a patient is counselled and is offered targeted support.



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Programme

- 16:00 - 16:05 Welcome from the Chair / Stacy Elliott, MD
- 16:05 - 16:35 [Sexual rehabilitation in women with neurogenic disorders:](#)
What matters and how to help / Stacy Elliott, MD
- 16:35 - 16:55 [Urinary incontinence in neurogenic patients:](#)
Causes, solutions and specific things to think about / John Heesakkers, MD PhD
- 16:55 - 17:00 Concluding remarks / Stacy Elliott, MD

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