

# 17th International EAUN Meeting

12-14 March 2016, Munich, Germany

## Programme Book



in conjunction with  
**EAU16**

[www.eaun16.org](http://www.eaun16.org)

**eaun** European  
Association  
of Urology  
Nurses

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# A warm welcome to Munich!

Dear Colleagues,

It gives me great pleasure to welcome you to Munich for the 17th International Meeting of the European Association of Urology Nurses (EAUN). With the support and close collaboration of our German urology nursing colleagues, this year's meeting in one of Germany's most cosmopolitan cities promises to be innovative, dynamic and comprehensive.

We have prepared a remarkably wide range of topics that cover key issues in urological nursing. In our first plenary session we will consider the challenges and opportunities for urology nurses, and the German perspective on how to develop and enhance the role of urology nurses. We are also delighted to have two collaborative EAUN-European School of Urology (ESU) courses that address instillation therapy in non-muscle invasive bladder cancer (NMIBC) and urinary stones. Our state-of-the-art lectures will examine ethical dilemmas in urological practice, the practice and impact of female genital mutilation to topics such as probiotics in urology care.

"The enhanced recovery after surgery" is a very current issue that will be tackled in the International Perspectives Session, no doubt a thought-provoking session with guest speakers coming from the US and China who will give insights on how this approach is adopted and put into practice in very different healthcare systems. We will also take a look into the challenges of urology care in the community and debate the multidisciplinary team approach.

We also invite you to the traditional Urowalk and Nurses' Dinner & Dance on Sunday. The Urowalk will end at the venue of the dinner. Moreover, we have three Industry Sessions this year, so there is something for everyone!










With this compact but thorough programme, the EAUN organisers wish you not only a very informative meeting but also an enjoyable experience. And should you have any questions and suggestions, do not hesitate to inform us during the meeting.











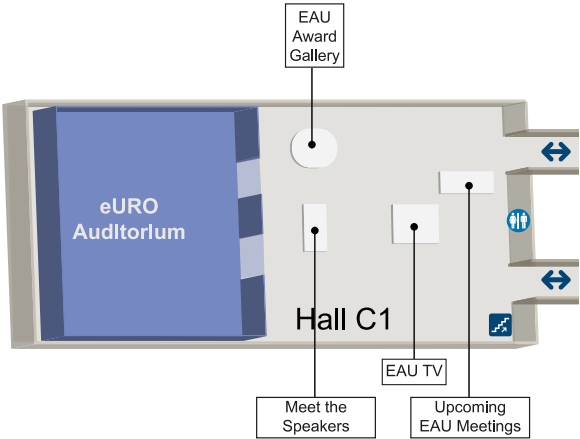
**Lawrence  
Drudge-Coates**  
EAUN Chair

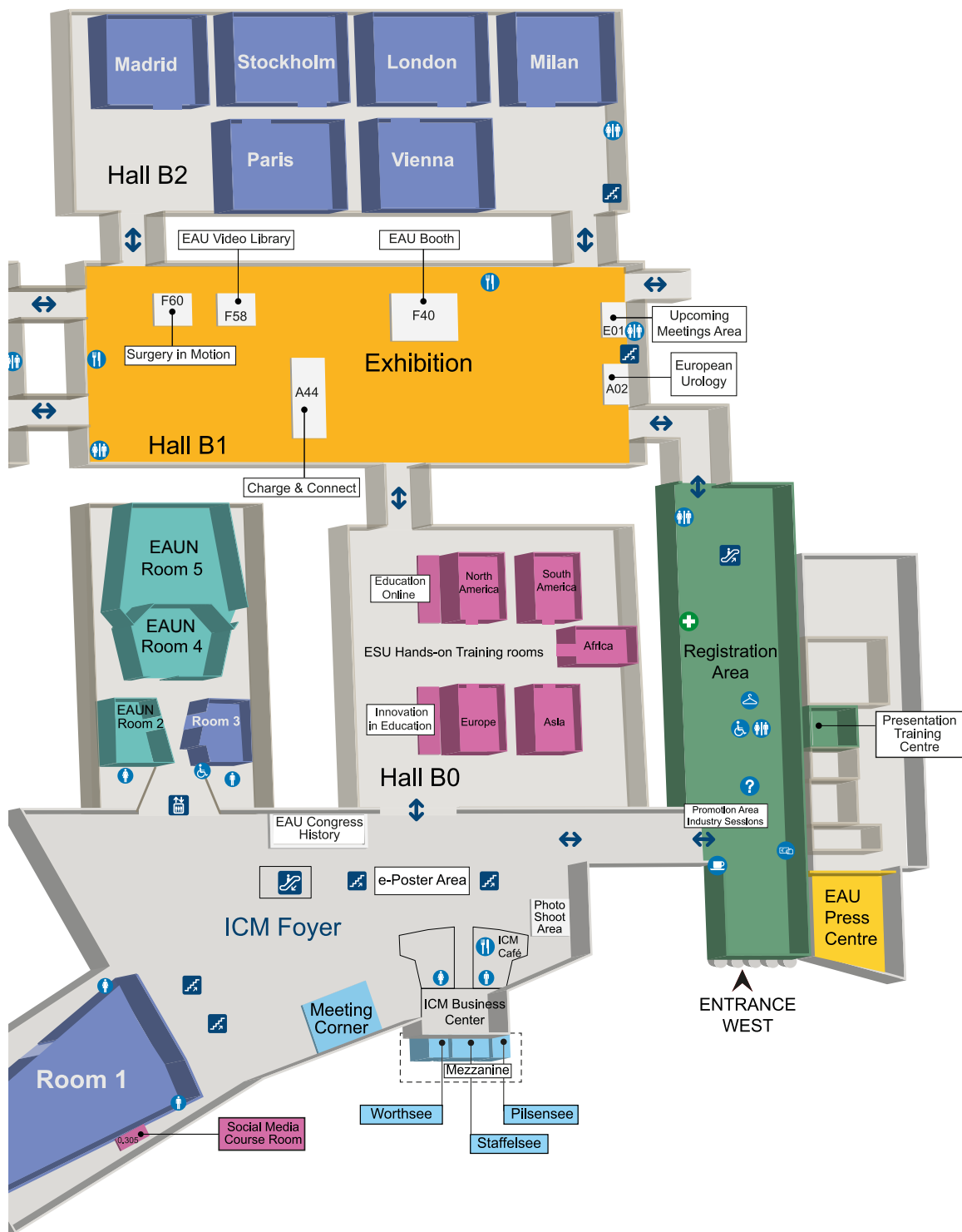
# Floor Plan

## Level 0

General Information	
	First Aid
	Restrooms
	Information
	Coat Check
	Café
	ATM
	Toilet for the Disabled
	Escalator/ Stairs
	Elevator

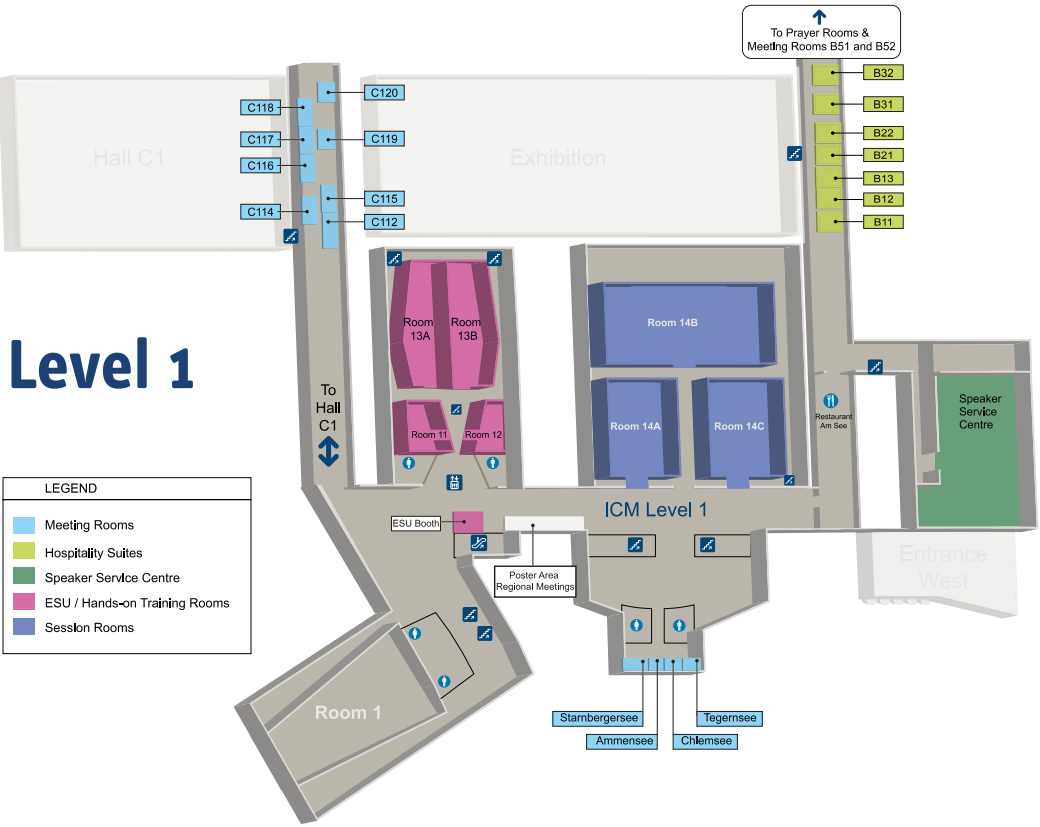
LEGEND	
	Exhibition
	Registration Area / Presentation Training Centre
	Session Rooms
	Meeting Rooms / Meeting Corner
	Hospitality Suites
	Press
	ESU / Hands-on Training Rooms
	EAUN Rooms



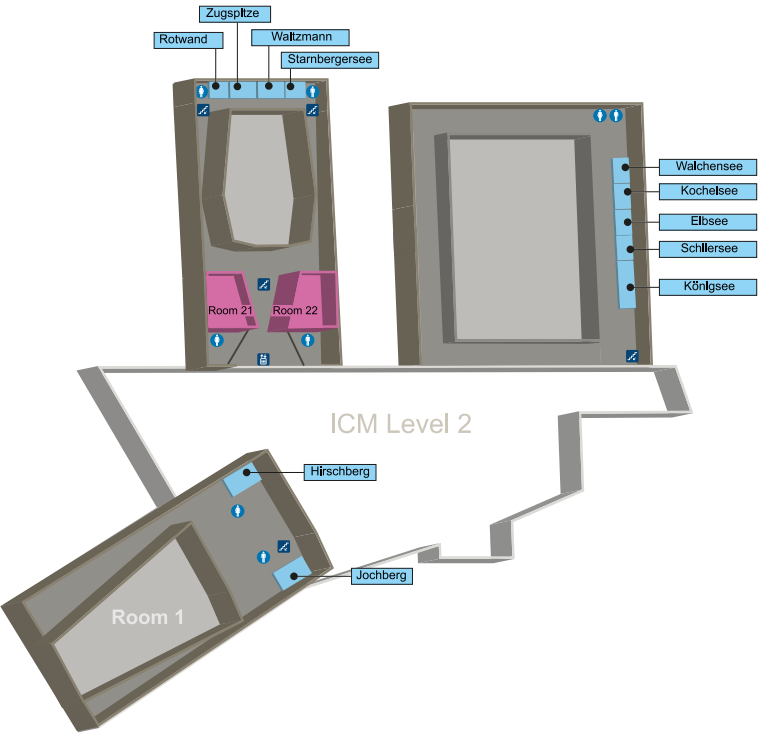


# Floor Plan

## Level 1



## Level 2







# General

General Information  
Speaker Guidelines

# General Information

## Abstracts

All abstracts and posters will be available online at [www.eau16.org/resource-centre/](http://www.eau16.org/resource-centre/) and through the congress App as of 11 March 2016.

## Access to the Session Rooms

Only congress delegates with a valid badge, have access to session rooms. Seating is regulated on a first-come, first-served basis. Due to safety regulations, the organisers will close the session room when all seats are taken. It is not allowed to stand in the aisles of the rooms.

## Address and Accessibility Congress Centre

ICM – Internationales Congress Center München  
Messe München  
Entrance West  
Messegelände  
81823 München  
Germany  
T +49 89 949-20720  
[www.icm-muenchen.de](http://www.icm-muenchen.de)  
[www.messe-muenchen.de](http://www.messe-muenchen.de)

The 31st Annual EAU Congress takes place at the ICM & Messe München in Munich, which is located a 15 to 30 minute drive from the city centre, a 35 minute drive from the airport and within walking distance from the public transportation. The closest stop to the congress centre is Messestadt West. The congress centre is located directly on the A94. If you want to reach the congress centre by car, you can take exit München-Riem (Exit Nr. 5). The parking garage is open two hours before the event begins and closes two hours after the event ends. The garage will remain accessible during the other hours for leaving, but with dimmed lights and no elevators operational. Take Entrance West to enter the congress centre.

## App - Your Smart Congress Companion

With the EAUN16 App you have instant access to the most important information of the 17th 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 booths on the floor plans and will 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.

The 17th EAUN Meeting App and the 31st EAU Congress App are combined. You can either search for 'EAUN 16' or 'EAU 16'.

## 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

## 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 statistical information. The EAU bears no responsibility for data scanned by third-parties.

## Bank and Exchange

The national currency in Germany is the Euro (€). ATM machines at the congress centre are available in the Registration Area (Entrance West), at the entrance to the Underground station "Messestadt West" and in the parking garage. For foreign exchange services, our recommendation would be that you use the foreign exchange centers at the Munich Airport "Franz Josef Strauß", at the Central Station and in the Munich City Centre.

## Best Posters

The best scientific posters presented at the 31st Annual EAU Congress and the 17th EAUN Meeting can be viewed at the e-poster area (accessible during congress hours in the ICM foyer on level 0) and through the congress website as of 11 March 2016.

## Business Centre

A business centre is located in the ICM foyer (level 0). The business centre offers internet, copy and print facilities and will be available to all congress participants during the congress.



## Congress Hours

	Registration	Cloakroom	Speaker Service Centre	EAU Sessions	EAUN Sessions	EAU Industry Sessions	Exhibition	Press Centre
<b>Thursday 10 March</b>	08.00 – 20.00		14.00 – 19.00					
<b>Friday 11 March</b>	07.00 – 20.00	08.00 – 21.30	07.30 – 18.30	08.30 – 21.00		16.45 – 17.45		08.00 – 18.00
<b>Saturday 12 March</b>	07.00 – 20.00	07.00 – 20.00	07.00 – 19.30	07.30 – 19.30	09.00 – 18.15	18.00 – 19.30	09.15 – 18.15	08.00 – 18.00
<b>Sunday 13 March</b>	07.00 – 19.30	07.00 – 19.45	07.00 – 19.30	07.30 – 19.15	08.00 – 18.00	17.45 – 19.15	09.15 – 18.15	08.00 – 18.00
<b>Monday 14 March</b>	07.00 – 19.30	07.00 – 19.45	07.00 – 19.30	07.30 – 19.15	09.00 – 14.15	17.45 – 19.15	09.15 – 18.15	08.00 – 18.00
<b>Tuesday 15 March</b>	07.00 – 12.45	07.30 – 13.45	07.00 – 13.00	08.00 – 13.15				08.00 – 12.45

## Certificate of Attendance

A Certificate of Attendance for the 17th International EAUN Meeting will be available to print at [www.eaun16.org](http://www.eaun16.org) as of Wednesday 16 March 2016. Enter the numbers (without \*) under the barcode on your badge to login and complete the questionnaire to retrieve your Certificate of Attendance.

## Cloakroom / Luggage

The cloakroom is located in the Registration Area (Entrance West, level -1) and open during congress hours. Please be sure to collect all personal belongings at the end of each day. Do not leave any bags unattended.

## CME Accreditation

The EAUN applied for accreditation of the 17th International EAUN Meeting for nurse specialists and nursing and care professionals in the Netherlands.

## Congress Bag

Delegates can collect a congress bag in the Registration Area (Entrance West).

## EAU Booth & EAUN Booth

The EAUN Booth (Room 2, level 0) offers information on all EAUN activities, the EAUN programme book and the new EAUN guideline can be collected at the EAUN booth and there is a coffee corner and information from other nursing organisations. For information on membership status and membership application, you are welcome to visit the EAU Booth in the Exhibition (booth F40).

## EAUN Congress Office

Congress Consultants B.V.  
PO Box 30016, 6803 AA Arnhem,  
The Netherlands  
T +31 (0)26 389 1751  
F +31 (0)26 389 1752

[info@congressconsultants.com](mailto:info@congressconsultants.com)  
[www.eaun16.org](http://www.eaun16.org)

EAUN Congress coordinators  
Hanneke Lurvink  
[eaun@uroweb.org](mailto:eaun@uroweb.org)

Claudia van Ijzendoorn  
[c.vanijzendoorn@congressconsultants.com](mailto:c.vanijzendoorn@congressconsultants.com)

## EAUN Board

L. Drudge-Coates, London (GB), Chair  
S. Terzoni, Milan (IT), Chair Elect  
K. Fitzpatrick, Dublin (IE), Past Chair  
P. Allchorne, London (GB)  
S. Borg, Msida (MT)  
E. Grainger, Århus (DK)  
C. Tillier, Amsterdam (NL)  
S. Vahr, Copenhagen (DK)  
G. Villa, Milan (IT)

## 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)

## 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 ICM on level 1, with extensive information on its activities. Registrations for the courses can be made at the ESU registration desks in the Registration Area (Entrance West) and in the Self Service Area. The EAU(N)16 ESU Courses DVD will be distributed to delegates in the exhibition at booth C30.

# General Information

Fees ESU Courses (for congress registered delegates only) for Residents and nurses (members/nonmembers): € 25 (Prices are excl. 19% VAT).

## EAU Patient Information

EAU Patient Information is the trusted portal for Patients, Urologists and Nurses, offering evidence-based information on diagnostics, treatments and patient support. Delegates are welcome to visit the EAU Patient Information Corner and pick up their free copy of the EAU Bladder Cancer Consultation poster (first come, first served). The EAU Patient Information Corner is located at the EAU Booth in the exhibition (booth F40).

## Education Online

Education is one of the most important drivers to get urological care to the next level. EAU-ESU Education Online platform provides easy accessible interactive online courses to urological health professionals from all over the world. From urological guidelines to the newest techniques, EAU Education Online offers educational materials to learn anywhere and anytime. Our courses are directed by urologists from all over Europe, supported by the e-learning specialists of the EAU, delivering high standard, up-to-date courses. They comply with the EU-ACME and UEMS/EACCME for e-learning accreditation, and the information provided is in line with the EAU Clinical Guidelines. Come and visit Education Online in Hall B0.

## Emergency Phone Numbers

In case of an emergency please call 112 for fire brigade or ambulance service and 110 for police. In case of an emergency in the congress center please call +49 89 949 24 555 (or Extension 24555) which will lead to the security control room which is staffed 24 hours a day, or contact a security guard immediately.

## e-Poster Area

e-Posters are a medium to translate science to the congress delegates. e-Posters will explain the science in a new way: they can include oral explanations, videos, additional statistics, PowerPoint presentations etc. The added value of the e-Poster format will make this a more immersive and interactive experience. In addition to the Abstract Poster Sessions, where data will be presented by the authors themselves, all e-Posters will be made available at the e-Poster Area in the ICM foyer on level 0.

## European Urology

European Urology, 'The Platinum Journal', published continuously since 1975, is an international peerreviewed journal devoted to urology and related sciences and is published monthly. European Urology is the official journal of the European Association of Urology (EAU), a scientific society with more than 15,000 members from 120 countries worldwide. European Urology is available both in print and online and reaches over 20,000 readers. The Editor-in-Chief of European Urology is Professor James Catto. European Urology's 2014 impact factor is 13.938. Come see European Urology for yourself - visit either the European Urology (booth A02) or the EAU Booth (booth F40) in the exhibition.


## Exhibition

The exhibition is open to technical equipment manufacturers, pharmaceutical companies and scientific publishers and will be held in Hall B1. In the exhibition you can also find a Restaurant, a Catering Point (G12), the EAU booth (F40), the EAU Video Library (F58), the European Urology booth (A02), the Charge & Connect Area (A44) and the Surgery in Motion School booth (F60).

### Exhibition Hours:

Saturday, 12 March	09.15-18.15 hrs
Sunday, 13 March	09.15-18.15 hrs
Monday, 14 March	09.15-18.15 hrs

## First Aid

There is a medical unit present for first aid in the registration area (Entrance West), indicated on the directional signs with the first aid symbol . In case of emergency, immediately contact a security guard, or call the control centre via +49 89 949 24 555 or call for first aid assistance via +49 89 949 28 103.

## Food & Beverage

### Coffee corners

Here you can enjoy a coffee, tea, snacks or pastries.

ICM-Bar	ICM - Level 1
ICM-Café	ICM - Level 0
Käfer Tagesbar	ICM - Level 0
Coffee Corner	Hall B1 - Level 0 booth G12

### Restaurants

Bistro Bar	Hall B1 - Back of the hall (near entrance to Hall C1)
Käfer am See	ICM - Level 1

## Hands-on Training Courses

Hands-on Training courses in suturing and knotting (anastomosis or pyeloplasty), introduction to robotic surgery, urodynamics, fluorescence imaging, MRI Fusion biopsy, women's health, botulinumtoxin administration for OAB, TUR (b/p), enucleation techniques, Laser vaporisation and URS (semirigid and flexible) are organised by the ESU in collaborating with the EAU Section of Uro-Technology (ESUT), the EAU Section of Female and Functional Urology (ESFFU), EAU Section of Urological Imaging (ESUI), the EAU Section of Urolithiasis (EULIS) and the EAU Robotic Urology Section (ERUS). Renowned mentors and experts from these sections provide direct mentorship to HOT participants. The registration fee is € 40,- and € 26,- (nurses and residents) per Hands-on Training (excl. 19% VAT). Registration for Hands-on Training courses can be made at the ESU registration desks and in the Self Service Area in the Registration Area (Entrance West).

## Historical Exhibition

The EAU History Office is presenting an historical exhibit on "Joseph de Vries and his legacy to the EAU" (booth F40 in the exhibition).

## Industry Partners

We would like to thank our industry partners. Please refer to page 81 for the industry acknowledgements.

## 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 EAU16 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;

## Lost and Found

Found items should be returned to the EAU Info Desk at the Registration Area (Entrance West, level 0). If you lose or find something, please report to this desk for assistance.

## Media Policy

Registered press representatives may attend all scientific sessions. 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. Video recording of the congress or during the sessions is subject to authorisation by the EAU Press Office.

A written request must be submitted prior to the congress to Esther Baltes via [press@uroweb.org](mailto:press@uroweb.org) or can be submitted on site 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 light of mobile phones must be switched off during all sessions.

## Munich Information

Information on Munich will be available at the Munich Information Desk in the Registration Area (Entrance West).

# General Information

## Opening Ceremony and Awards

Participants and exhibitors attending the congress are invited to the official Opening Ceremony on Friday, 11 March 2016, between at 18.00 and 19.30 hrs. in the eURO Auditorium (Hall C1). During the Opening Ceremony the following EAU Awards will be delivered: Willy Gregoir Medal, Frans Debruyne Life Time Achievement Award, Crystal Matula Award, Hans Marberger Award, Innovators in Urology Award and the Prostate Cancer Research Award 2016. Furthermore, the new EAU Honorary Members will be announced. EAUN Awards will be handed out at the EAUN Award Session, Monday, 14 March, 14.00-14.15 hrs. in Room 5 (level 0). The Opening Ceremony will be followed by a Networking Reception in the foyer of the eURO Auditorium in Hall C1 until 21.00 hrs.

## 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 export them to your Outlook, Google Calendar or print them out

Visit the congress website for more information:  
[www.eau16.uroweb.org/scientific-programme/overview/](http://www.eau16.uroweb.org/scientific-programme/overview/)

## PosterSessionOnline Service

Poster presenters who created their posters for the Munich Congress through the "EAU PosterSessionOnline Service", can collect their posters at the Speaker Service Centre (Entrance West, level 1).

## Poster DVD EAU16

A DVD with a collection of scientific posters from the EAU16 Congress will be inserted in the congress bags.

## Prayer Room

Special rooms dedicated to prayer are located above Hall B6. When entering the building at Entrance West, take the escalator to level 1, and then continue along the atrium towards Entrance East until you reach the prayer rooms.

## 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 (Entrance West, level 0). 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.

## Resource Centre EAU16

All of the congress' scientific content, including abstracts, (e-)posters, videos and webcasts will be available online in the Resource Centre ([www.eau16.org/resource-centre/](http://www.eau16.org/resource-centre/)). Content is constantly updated over the course of the congress and afterwards. Watch scientific sessions you may have missed, or re-read the data of the latest research. You have access to the Resource Centre with your congress registration log-in (MyEAU), your EAU(N) member log-in (MyEAU) or with the number below the barcode on your congress badge (type the number without the \*).

## Security and Safety

The safety of all congress attendees is of utmost importance to the EAU. ICM / Messe München and the EAU have taken security precautions to ensure the maximum possible safety for all EAU16 participants. All bags may be subject to inspection. Do not leave any bags unattended at any time.

## Shuttle Buses

Shuttle buses will drive from Munich Airport to ICM / Messe München. These busses depart every 30 minutes and travel nonstop to the venue and to the airport. A one-way ride takes approximately 45 minutes and costs €8.50. A two-way ride costs €13.50.

These buses will collect and drop off at Terminal 1 and Terminal 2 of Munich airport, and at Entrance West of the congress centre.

## Smoking Policy

The 31st Annual EAU Congress and the concomitant exhibition have been designated as non-smoking events throughout the entire venue, including all meeting halls, functions, registration and catering areas. All the participants are kindly requested to respect the non-smoking policy.

## Social Media

We are using social media at the congress to encourage an open discussion on urology science and experiences at the congress. EAUN congress speakers, opinion leaders, delegates and media share their ideas, commentary and photos on Facebook and Twitter. You can follow the EAUN on Facebook and on Twitter via @EAUNurses. Use

#EAUN16 to discuss the Congress, and join the conversation!

## Speaker Service Centre

For extensive speaker information see page 14.

## Taxi

The travel distance is between 15 and 30 minutes from the congress centre to the various hotels in Munich, and about 35 minutes to the airport. There are taxi ranks outside Entrance West, which are manned at all times. Generally, you should hire the first taxi in the line, but you can pick any of them waiting at the stand, especially if you need a larger vehicle than the first one. You can also call a taxi to come pick you up via Taxi-München eG under +49 89 21 610 or +49 89 19 410 or via IsarFunk under +49 89 450 540.

## Transportation Pass

A special MVV logo providing complimentary transportation on public transport is printed on the badges of congress delegates. Free transportation is valid on 11 up to and including 15 March 2016 and covers underground, tram and bus within the city limits of Munich. Please note that this does not include lines to/from the airport. For more

information about the Munich public transportation check their website [www.mvv-muenchen.de/en](http://www.mvv-muenchen.de/en).

## Webcasts (W) & Live Streams (L)

Many sessions will be webcasted via [www.eau16.org/resource-centre/](http://www.eau16.org/resource-centre/). 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.

## Wi-Fi / Charge & Connect Area

Free wireless internet, provided by the congress centre will be available in all areas and session rooms except for the exhibition area. Please connect to the "EAU16" network, after which you will be prompted to fill in the barcode on your badge as password. A special "Charge & Connect Area" with tables and power outlets is available in the exhibition. 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](http://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](http://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 (Entrance West, level 1). 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	10 March	14.00 - 19.00
Friday	11 March	07.30 - 18.30
Saturday	12 March	07.00 - 19.30
Sunday	13 March	07.00 - 19.30
Monday	14 March	07.00 - 19.30
Tuesday	15 March	07.00 - 13.00

## 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 in Room 2, 15 minutes prior to the start of the session. The poster boards are numbered and your poster should be mounted on the board which corresponds with your poster number. Pushpins are available in the session room. Please remove your poster immediately at the end of the session. A maximum of 5 PowerPoint slides are allowed during standard poster presentations.

## Disclose links to the industry

The EAUN 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.

## Prize-winning posters

If a 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.



# Scientific Programme

# European Association of Urology Nurses Programme Overview, 12-14 March 2016



	Saturday, 12 March		Sunday, 13 March		Monday, 14 March	
	Room 5	Room 4	Room 5	Room 4	Room 5	Room 4
08.00			08.00-09.00 <b>Industry Session</b>			
08.30			The pivotal role of the nurse in managing mCRPC: Collaborating to improve patient care	08.30-09.00 <b>Thematic Session 6</b>  Evidence informed practice: Present and future (W)		
09.00	09.00-10.15 <b>Plenary Session</b>		09.00-10.30 <b>Thematic Session 7</b>  Neoadjuvant treatments for bladder cancer	Break	09.00-10.00 <b>Thematic Session 11</b>  Primary care challenges in urology (W)	09.00-10.00 <b>Thematic Session 12</b>  Painful bladder syndrome: Where do we stand? (W)
9.15	Revisiting the future of urological nursing (W)			09.15-10.30 <b>Thematic Session 8</b>  EAUN-ICS session (W)	Break	Break
10.00					10.15-12.30 <b>EAUN-ESU Course 2</b>  Urinary stones: From start to finish (W)	10.15-10.45 <b>State-of-the-art Lecture</b>  Probiotics in urology care (W)
10.15	Break					10.45-11.30 <b>Special Session</b>  Multidisciplinary Team in urology: Good in theory? Bad in practice? (W)
10.30	10.30-11.15 <b>Thematic Session 1A</b>  Challenges with teenagers in transition to adulthood (W)	10.30-11.15 <b>Thematic Session 2</b>  Tobacco and cancer: Is there something we still don't know? (W)	Break	Break		Break
10.45			10.45-11.15 <b>Poster Viewing</b> room 2	10.45-11.45 <b>Thematic Session 9</b>  Enhanced recovery after surgery: International perspectives (W)		
11.15	Break	Break	11.15-12.30 <b>Poster Session 2</b>	Break		11.45-12.45 <b>Thematic Session 13</b>  Self-care and quality of life in the urostomy patient (W)
11.30	11.30-12.30 <b>Thematic Session 1B</b>  Challenges with teenagers in transition to adulthood (W)	11.30-12.30 <b>Special Session</b>  Nursing solutions in difficult cases (W)				
11.45						
12.00						
12.30	Break	Break	Break		Break	
12.45	12.45-13.45 <b>Industry Session</b>  E-learning in healthcare: Does it make any difference?	12.45-13.45 <b>Special Session</b>  Hot topic lectures on Nurse cystoscopy and urodynamics for nurses (W)	12.45-13.15 <b>Special Session</b>  Nursing Research (W)	12.00-14.30 <b>EAUN-ESU Course 1</b>  Instillations in NMIBC: Indications and practical aspects (W)	12.45-13.15 <b>Special Session</b>  Patient Information on bladder cancer (W)	
13.15			Break		13.15-14.00 <b>General Assembly</b> (W)	
13.45	Break	Break	13.45-14.30 <b>State-of-the-art Lecture</b>  Ethics in urology (W)		14.00-14.15 <b>Award Session</b>	
14.00	14.00-14.30 <b>Poster Viewing</b> room 2	14.00-16.00 <b>Thematic Session 3</b>  Perspectives in prostate cancer care				
14.15						
14.30	14.30-15.45 <b>Poster Session 1</b> (W)		Break			
14.45			14.45-15.30 <b>State-of-the-art Lecture</b>  Female genital mutilation (W)	Break		
15.00			Break			
15.30						
15.45	Break		15.45-16.45 <b>Thematic Session 10</b>  Rare cases and diseases in urology (W)	15.45-17.15 <b>Special Session</b>  Market place session: Preparing for major urological surgery		
16.00	16.00-17.00 <b>Thematic Session 4</b>  Sexuality and cancer (W)	Break	Break			
16.15		16.15-17.00 <b>Thematic Session 5</b>  Guidelines presentation: Male External Catheters (W)				
16.45						
17.00	Break		17.00-18.00 <b>Video Session</b>  Nursing in motion (W)			
17.15	17.15-18.15 <b>Industry Session</b> Back to bone: Optimising patient outcomes in metastatic bone disease					
18.15						

Plenary Session

09.00 - 10.15    Revisiting the future of urological nursing

Room 5



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

- 09.00 - 09.05    Welcome to the 17th International EAUN Meeting  
L. Drudge-Coates, London (GB)
- 09.05 - 09.10    Welcome to Munich  
C.R. Chapple, Sheffield (GB)
- 09.10 - 09.30    New topics, challenges and opportunities  
L. Drudge-Coates, London (GB)
- 09.30 - 09.50    Developing the urology nurse's role: German perspective  
M. Lefevre, Offenburg (DE)
- 09.50 - 10.15    New topics, challenges and opportunities: A response

Thematic Session 1A

10.30 - 11.15 Challenges with teenagers in transition to adulthood

Room 5



Chair: K. Fitzpatrick, Dublin (IE)

10.30 - 10.35

Introduction

K. Fitzpatrick, Dublin (IE)

10.35 - 10.50

State-of-the-art lecture Teenagers in transition to adulthood: What do we know?

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

Aims and objectives

What is transition? What is known in literature about challenges with teenagers in transition to adulthood.

10.50 - 11.05

State-of-the-art lecture Practical challenges

W. Nugent, London (GB)

Aims and objectives

- Introduce client group
- Discuss challenges
- Obstacles of post
- Explain transition pathway and follow-up protocol
- Discuss survey results
- Provide overview of clinical nurse specialist impact for clients
- Recommendations
- Evaluation

11.05 - 11.15

Panel discussion

Panel: J.G.L. Cobussen-Boekhorst, Nijmegen (NL)  
K. Fitzpatrick, Dublin (IE)  
W. Nugent, London (GB)



## Thematic Session 2

10.30 - 11.15 Tobacco and cancer: Is there something we still don't know?

### Room 4



*Chair:* S. Vahr Lauridsen, Copenhagen (DK)

#### Aims and objectives of this session

Smoking continues to be the single largest preventable cause of death and is the most important risk factor for urinary bladder cancer. This session gives insight in the physiological changes of the body caused by tobacco smoking and knowledge about the impact of tobacco smoking on bladder cancer.

10.30 - 10.35

#### Introduction

S. Vahr Lauridsen, Copenhagen (DK)

10.35 - 10.50

#### State-of-the-art lecture **Smoke and its effects on the metabolism**

T. Thomsen, Copenhagen (DK)

10.50 - 11.05

#### State-of-the-art lecture **Smoking and bladder cancer**

S. Vahr Lauridsen, Copenhagen (DK)

#### Aims and objectives

This lecture deals with the influence smoking has on the development and recurrence of bladder cancer. Nursing interventions that help patients quit smoking will be presented as well as interventions that do not make a difference.

11.05 - 11.15

#### Discussion

*Panel:* T. Thomsen, Copenhagen (DK)  
S. Vahr Lauridsen, Copenhagen (DK)

Thematic Session 1B

11.30 - 12.30 Challenges with teenagers in transition to adulthood

Room 5



Chair: K. Fitzpatrick, Dublin (IE)

11.30 - 11.50 State-of-the-art lecture Ketamine abuse  
R. Leaver, London (GB)

11.50 - 12.10 State-of-the-art lecture Living with a stoma in teenage years  
T. Porrett, Peterborough (GB)

12.10 - 12.30 Panel discussion

Panel: K. Fitzpatrick, Dublin (IE)  
R. Leaver, London (GB)  
T. Porrett, Peterborough (GB)

## Special Session

11.30 - 12.30 Nursing solutions in difficult cases

### Room 4



*Chair:* E.A. Grainger, Århus (DK)

#### Aims and objectives of this 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.

**11.30 - 11.35** **Welcome and introduction**

E.A. Grainger, Århus (DK)

**11.35 - 11.45** **Metal pressure ulcer caused by indwelling urethral catheter**

A. Abramov, Petah Tikva (IL)

**11.45 - 11.55** **Engaging a fourteen year old boy with a neurogenic bladder, who has refused all services**

O. Crean, Dublin (IE)

**11.55 - 12.05** **Handling a case of encrustation uropathy. Management of nursing care**

T. Alonso Torres, Barcelona (ES)

**12.05 - 12.15** **Autonomic dysreflexia: Medical emergency, our experience in urology**

E. Robinson, Manchester (GB)

**12.15 - 12.25** **Complication to cystectomy**

M. Steitjeh, Århus (DK)

**12.25 - 12.30** **Closure**

E.A. Grainger, Århus (DK)

#### Jury

The submitted cases have been evaluated by an expert jury:

- Ronny Pieters (Urology Nurse), Ghent (BE)
- Eva Wallace (Urology Nurse), Dublin (IE)
- Helen Forristal (Urology Nurse Practitioner, sub-specialisation in uro-oncology), Dublin (IE)
- Steen Walter (Professor in Urology), Odense (DK)
- Stephane Leborgne (Research Nurse in Urology), Roussy (FR)

Those who submitted the most interesting cases (as decided by the jury) were granted a free registration to the 17th International EAUN Meeting and were invited to present their case in this workshop.

Special Session

12.45 - 13.45 Hot topic lectures on nurse cystoscopy and urodynamics for nurses

Room 4



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

- 12.45 - 12.50

Introduction

L. Van De Bilt-Sonderegger, Eindhoven (NL)
- 12.50 - 13.05

EAUN guidelines Snapshot presentation BAUN - BAUS cystoscopy guidelines 2015

M. Bagnall, North Shields (GB)
- 13.05 - 13.20

Hot topic lecture Challenges in urodynamics

P.F.W.M. Rosier, Nijmegen (NL)
- 13.20 - 13.35

Hot topic lecture Video urodynamics for neurogenic bladder

J. Groen, Rotterdam (NL)
- 13.35 - 13.45

Panel discussion

Panel: M. Bagnall, Wallsend (GB)  
J. Groen, Rotterdam (NL)  
P.F.W.M. Rosier, Nijmegen (NL)  
L. Van De Bilt-Sonderegger, Eindhoven (NL)

## Poster Session 1

14.00 - 15.45

### Poster session



#### Room 5

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

Poster viewing of 30 minutes in Room 2. Short introduction of 4 minutes by the chair of the session. Presentations will take place in Room 5. Standard presentations are 6 minutes in length, followed by 2 minutes for discussion.

#### Aims and objectives of this session

In this session, the posters selected by the jury among many high-quality works submitted by our delegates will be presented. The aim is to discuss practical topics, relevant clinical issues, and findings from research conducted by nurses and applied to everyday practice. Different fields of urological nursing will be covered, as well as related issues.

- 01 Incidence and impact of urinary tract infections (UTI) when starting intermittent catheterisation (IC) and the effect on quality of life (second preliminary analysis)**  
H. Mulder (Groningen, The Netherlands)
- 02 Embedding a Prostate Cancer Survivorship Pathway using PDSA cycle**  
P. Allchorne, J. Kinsella, L. Fleure, S. Clovis, K. Briggs, E. Hazel, D. Cahill, P. Dasgupta, I. Veal, S. Smith, J.S.A. Green (London, United Kingdom)
- 03 Preparing patients for the future using erectile dysfunction and continence seminars**  
P. Allchorne, J. Kinsella, K. Briggs, E. Hazel, P. Dasgupta, D. Cahill, J.S.A. Green (London, United Kingdom)
- 04 Comparison of the effect of support power of underwear and pelvic floor muscle training for reducing women's urinary incontinence**  
H. Okayama, S. Ninomiya, K. Naito, K. Nakanishi, Y. Saito (Otsu, Kyoto, Higashiomi, Ibaraki, Japan)
- 05 Effectiveness of the enlightenment using a leaflet of self-care for prevention and improvement of urinary incontinence in women**  
K. Naito, S. Ninomiya, K. Nakanishi, Y. Saito, H. Okayama (Higashiomi, Kyoto, Otsu, Osaka, Japan)
- 06 Development of a protocol for the prevention and management of long-term indwelling urinary catheter blockage for visiting nurses**  
S. Maeda, T. Takiuti, M. Moriyama, Y. Kohno, H. Nakai, M. Fukuda (Kahoku, Himi, Japan)
- 07 Are we listening? Patients' views of the bladder exstrophy transition service**  
M. Lester, R. Hurrell, B. Whitnall, I. Pearce (Manchester, United Kingdom)
- 08 The early implementation of oral diet in patients undergoing radical cystectomy improves postoperative outcomes**  
M. Boarin, P.M.V. Rancoita, A. Crescenti, R. D'Onghia, E. Gianandrea, G. Villa (Milan, Italy)
- 09 Prospective monitoring of nursing care in patients undergoing radical cystectomy**  
L. Vitøft, K. Strømvig, J. Meinung (Herlev, Denmark)



## Thematic Session 3

14.00 - 16.00 Perspectives in prostate cancer care

### Room 4



Chair: C.N. Tillier, Amsterdam (NL)

14.00 - 14.05

#### Introduction

C.N. Tillier, Amsterdam (NL)

14.05 - 14.30

#### State-of-the-art lecture **The suspected prostate cancer patient: From the community to treatment**

M. Kirby, Baldock (GB)

##### Aims and objectives

It has been demonstrated that screening has the potential to reduce mortality from prostate cancer, but there remain concerns about over diagnosis and treatment which would not otherwise have presented clinically. There is no national screening programme for prostate cancer in England, but men over the age of 50 years can request a test from their GP.

The Prostate Cancer Risk Management Programme (PCRMP), introduced in 2002, and revised in 2008/9, aims to ensure that men requesting a test are fully informed of the advantages and disadvantages of PSA testing and prostate cancer risk factors, prior to making a choice about testing. Age specific cut off levels of  $\geq 3$  ng/ml at ages 50-59,  $\geq 4$  ng/ml at ages 60-69, and  $\geq 5$  ng/ml at age 70 and over are recommended above which men may be referred to urology for further investigation. However, the patient pathway to referral is complex, with patients often having a history of recurring symptoms and re-testing of PSA. The aim is to discuss this journey.

14.30 - 14.55

#### State-of-the-art lecture **Active surveillance in prostate cancer: Where are we now**

F. Geese, Berne (CH)

##### Aims and objectives

Prostate Cancer (PC) is the most frequent cancer and is the third leading cause of cancer death among men in Switzerland. The incidence rate of PC is 29% of all cancers, with 5650 cases per year in Switzerland. Depending on the stage of disease at diagnosis, patients with PC have different options of treatment: active surveillance, watchful waiting, radical prostatectomy, hormonal therapy, chemotherapy and radiotherapy. Patients with PC are confronted with a life threatening diagnosis, and likely experience emotional burden and side effects after treatment, for example erectile dysfunction and incontinence. It has been documented that these side effects can lead to depression, distress and uncertainty. Moreover, it is well known that partners and family members of PC patients are presenting higher distress levels regard the patients with PC, and feel disempowered by the cancer diagnosis, the following treatment and the side effects too. Based on the described issues there is obviously a high need for professional support and counseling for patients with PC and their partners and family members. To deal the problem a multidisciplinary team approach is needed to empower patients with PC and their relatives in Switzerland.

14.55 - 15.20

#### State-of-the-art lecture **The relation between prostate cancer and mental health problems**

M.A. Van Stam, Utrecht (NL)

##### Aims and objectives

Mental health and its predictors in prostate cancer survivors compared with a with an age- and gender comparable cohort from the general population.

15.20 - 15.45

#### State-of-the-art lecture **Colour of food and prostate cancer**

T.B.C.

15.45 - 16.00

Panel discussion

*Panel:* T.B.C.  
F. Geese, Berne (CH)  
M. Kirby, Baldock (GB)  
C.N. Tillier, Amsterdam (NL)  
M.A. Van Stam, Utrecht (NL)

Thematic Session 4

16.00 - 17.00 Sexuality and cancer

Room 5



Chair: P. Allchorne, London (GB)

Aims and objectives of this session

- Background of sexuality and cancer
- What are the important issues with sexuality and cancer in urology?
- What is the role of a nurse in sexuality and cancer?
- Are there any future developments?

16.00 - 16.05

Introduction

P. Allchorne, London (GB)

16.05 - 16.25

State-of-the-art lecture Theoretical issues in sexuality and cancer

S. Quallich, Ann Arbor (US)

16.25 - 16.45

State-of-the-art lecture Practical issues in sexuality and cancer

N. Love-Retinger, New York (US)

16.45 - 17.00

Panel discussion

Panel: P. Allchorne, London (GB)  
N. Love-Retinger, New York (US)  
S. Quallich, Ann Arbor (US)

Thematic Session 5

16.15 - 17.00 Guidelines presentation: Male external catheters in adults

Room 4



Chair: S. Vahr Lauridsen, Copenhagen (DK)

**Aims and objectives of this session**

This session will highlight the scientific basis for this up-dated guideline. Nursing interventions related to the use and observation of the male external catheter will be presented as well as the perspective of a spinal cord injured man using male external catheters for several years.

- 16.15 - 16.30**    **State-of-the-art lecture** **Development of the new guideline**  
S. Vahr Lauridsen, Copenhagen (DK)
- 16.30 - 16.45**    **State-of-the-art lecture** **Male external catheter: In daily practice and evidence for nursing**  
J.G.L. Cobussen-Boekhorst, Nijmegen (NL)
- 16.45 - 17.00**    **State-of-the-art lecture** **Living life following spinal injury: A patient's lived experience**  
B. Jost, Hirschberg (DE)

## Thematic Session 6

08.30 - 09.00 Evidence informed practice: Present and future

### Room 4



Chair: V. Geng, Lobbach (DE)

#### Aims and objectives of this session

- To give a short overview about the EAUN guidelines and where they stood
- To show the problems working with this guideline
- To formulate expectations of guidelines from nurses and which help they could use to use guidelines in daily practice
- To learn from a practical aspect such as UTI prevention how to use guidelines

08.30 - 08.40 **EAUN Guidelines: An update**  
V. Geng, Lobbach (DE)

#### Aims and objectives

Since 2005 the European Association of Urology Nurses (EAUN) presents a new or updated guidelines every year. In the beginning they were written as good clinical practice brochures and later on they were written as evidence based guidelines. A short overview about development and the experience of working with guidelines will be given with a special focus on the EAUN Guidelines.

08.40 - 08.50 **EAUN Guidelines: What do WE need?**  
S. Vahr Lauridsen, Copenhagen (DK)

08.50 - 09.00 **UTI Prevention Plan based on guidelines in actual practice**  
A. Vestermark, Hjørring (DK)

#### Aims and objectives

The focus in our hospital has been to minimise CAUTIs through reducing the number of indwelling catheters (TUC/SPC) and/or catheter days.

In our baseline prevalence survey throughout the hospital in the spring we found lack of documentation on: Indications for TUC/SPC, ordering a physician and a plan for discontinuation or follow up care.

Subsequently the electronic patient journal format has been changed this summer. Now the agreed list of indications for TUC appears, and you have to choose one. You list what type and size of catheter has been administered. Furthermore you document a continuing care plan for the TUC and you have to consider and document whether the indication is still valid daily.



## Thematic Session 7

09.00 - 10.30 **Neoadjuvant treatments for bladder cancer**

### Room 5



*Chair:* P. Allchorne, London (GB)

#### Aims and objectives of this session

- What is the role of neoadjuvant treatments and bladder cancer?
- What is the role of a nurse looking after a patient receiving neoadjuvant treatment?
- What support should patients receive pre, during and after neoadjuvant treatments?
- What are the pros and cons of neoadjuvant treatments prior to surgery or radiotherapy?
- Are there any future developments?

09.00 - 09.05

#### Introduction

P. Allchorne, London (GB)

09.05 - 09.30

#### State-of-the-art lecture **Neoadjuvant treatments**

B.W.G. Van Rhijn, Amsterdam (NL)

#### Aims and objectives

- Rationale neoadjuvant chemotherapy
- Use of neoadjuvant radiotherapy and chemotherapy in the Netherlands, National Registry data
- Recent research from NKI-AVL supports use of neoadjuvant chemotherapy in cT3-4a N0M0 urothelial carcinoma of the bladder
- Outline of the bladder cancer clinic at NKI-AVL

09.30 - 09.55

#### State-of-the-art lecture **Nursing aspects of neoadjuvant treatments**

E. Van Der Laan, Amsterdam (NL)

09.55 - 10.20

#### State-of-the-art lecture **Quality of life in patients undergoing neoadjuvant treatments**

J. Borwell, Salisbury (GB)

10.20 - 10.30

#### Panel discussion

*Panel:* P. Allchorne, London (GB)  
J. Borwell, Salisbury (GB)  
E. Van Der Laan, Amsterdam (NL)  
B.W.G. Van Rhijn, Amsterdam (NL)

Thematic Session 8

09.15 - 10.30    **Joint session EAUN-ICS: How to set up a successful pelvic floor rehabilitation programme for urinary incontinence in practice**

Room 4



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

**Aims and objectives of this session**

To provide the participants with practical information about correct assessment of patients with urinary incontinence, as well as examples of techniques to teach pelvic floor muscle exercises to patients correctly.

- 09.15 - 09.20    **Introduction**
- 09.20 - 09.50    **Fundamentals of physical assessment**  
K. Bø, Oslo (NO)
- 09.50 - 10.20    **Teaching exercises effectively: From theory to practice**  
S. Terzoni, Milan (IT)
- 10.20 - 10.30    **Discussion**

## Thematic Session 9

10.45 - 11.45 **Enhanced recovery after surgery: International perspectives**

### Room 4



*Chair:* K. Fitzpatrick, Dublin (IE)

10.45 - 10.50

#### Introduction

K. Fitzpatrick, Dublin (IE)

10.50 - 11.05

**State-of-the-art lecture** **USA: Best practice in major surgical care - "Sharing practice across the pond"**  
N. Love-Retinger, New York (US)

11.05 - 11.20

**State-of-the-art lecture** **Denmark: From evidence to practice - The challenge**  
B.T. Jensen, Århus (DK)

#### Aims and objectives

It is well known that implementation of recent gained evidence is a challenge in clinical practice, and more than 40% of evidence gained is unfortunately never implemented because of barriers between administrators and healthcare professionals.

However, in the past 20 years the concept of an enhanced recovery programme in surgery is thoroughly scientifically documented. So why is implementation of the concept still lacking?

This lecture will provide you with first hand experience and identify barriers for implementation.

11.20 - 11.35

**State-of-the-art lecture** **China: Status of fast track from an eastern perspective**  
W. He, Wuhan (CN)

11.35 - 11.45

#### Panel discussion

*Panel:* K. Fitzpatrick, Dublin (IE)  
W. He, Wuhan (CN)  
B.T. Jensen, Århus (DK)  
N. Love-Retinger, New York (US)

## Poster Session 2

10.45 - 12.30 Poster session

### Room 5



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

Poster viewing of 30 minutes in Room 2. Short introduction of 4 minutes by the chair of the session. Presentations will take place in Room 5. Standard presentations are 6 minutes in length, followed by 2 minutes for discussion.

#### Aims and objectives of this session

In this session, the posters selected by the jury among many high-quality works submitted by our delegates will be presented. The aim is to discuss practical topics, relevant clinical issues, and findings from research conducted by nurses and applied to everyday practice. Different fields of urological nursing will be covered, as well as related issues.

- 10 **Urodynamic features and artefacts in patients with neurogenic lower urinary tract dysfunction**  
W. Pagel, B. Götzfried, T. Makris, J. Mallmann, A. Ungricht, M. Widmer, L. Leitner, U. Mehnert, T.M. Kessler (Zürich, Switzerland)
- 11 **Changing perspective! Patients with prostate cancer and their partners giving an insight into their experiences of disease and optimal potential of an advanced practice nurse counselling support program in Switzerland**  
F. Geese, R. Willener, S. Zehnder, E. Spichiger (Berne, Switzerland)
- 12 **An interactive app to improve quality of care to patients with a nephro-stoma**  
K. Melchiorson, H.K. Larsen, K. Veng, L. Gotfredsen, E. Fijn, S.H. Volmar, S. Yaqoubi, D. Straka, B.T. Jensen (Århus, Denmark)
- 13 **Pre-operative stoma site marking on urostomy versus complications**  
A. Ruiz Pérez, A. Palomino Martínez, E. Franquet Barnils, M. Plans Marcobal, A. Izquierdo Leal, S. Bosch Colette, T. Alonso (Barcelona, Spain)
- 14 **A nurse-led clinic for suspected prostate cancer: 3 Year service evaluation**  
V. Khatri, R. Ballesteros, C. Brown, G. Muir, L. Drudge-Coates (London, United Kingdom)
- 15 **The use of chewing gum for postoperative ileus prevention in patients undergoing radical cystectomy**  
M. Boarin, V. Di Monte, G. Villa (Milan, Italy)
- 16 **Choice and insertion of the urinary catheter: Comparison of urology vs internal medicine department nurses**  
L. Balin (Karmiel, Israel)
- 17 **The prevalence and risk factors of urinary incontinence and overactive bladder in Japanese women**  
S. Ninomiya, K. Naito, K. Nakanishi, H. Okayama (Kyoto, Higashi-Omi, Otsu, Japan)
- 18 **A retrospective study comparing TRUS biopsy infection rates of men attending a one stop Rapid Access Prostate Clinic in an Irish hospital in 2015**  
M. O'Brien, S. Bowen, L. Casey, T. Conroy (Dublin, Ireland)

## EAUN-ESU Course 1

12.00 - 14.30 **Instillations in NMIBC: Indications and practical aspects**

### Room 4



*Chair:* M. Rouprêt, Paris (FR)

#### Aims and objectives of this session

This course will cover a description of the uro-oncological background of NMIBC and the indications for instillation therapy on the one hand and of the current gold standard in the implication of instillation therapy into the clinical management on the other hand. Since intravesical chemotherapy and BCG vary decisively in side-effects and practical aspects and pose specific problems for urologists and nurses, which are intertwined, the course will address each group of agents separately but in a joint presentation by nurse and urologist. Following the course, the audience should be able to point out the main background and rationale for the use of instillations in NMIBC and the and gold-standards in its applications and also know how to address practical problems.

- |                      |   |
|----------------------|---|
| <b>12.00 - 12.20</b> | <b>Risk factors of NMIBC driving treatment decisions: Which instillations for whom?</b><br>K. Hendricksen, Amsterdam (NL)   |
| <b>12.20 - 12.30</b> | <b>Discussion</b>   |
| <b>12.30 - 12.50</b> | <b>Instillations in the context of TURBT and follow-up: When and how to do it right?</b><br>M. Rouprêt, Paris (FR)  |
| <b>12.50 - 13.00</b> | <b>Discussion</b>   |
| <b>13.00 - 13.15</b> | <b>Break</b>  |
| <b>13.15 - 13.35</b> | <b>Practical aspects and management of adverse events in intravesical chemotherapy: The urologist's and the nurse's perspective</b><br>W.M. De Blok, Utrecht (NL)<br>M. Rouprêt, Paris (FR) |
| <b>13.35 - 13.45</b> | <b>Discussion</b>   |
| <b>13.45 - 14.05</b> | <b>Practical aspects and management of adverse events in intravesical BCG: The urologist's and the nurse's perspective</b><br>W.M. De Blok, Utrecht (NL)<br>K. Hendricksen, Amsterdam (NL)  |
| <b>14.05 - 14.15</b> | <b>Discussion</b>   |

## Special Session

12.45 - 13.15   **Nursing research**

### Room 5



*Chair:*   R. Pieters, Ghent (BE)

#### **Aims and objectives of this session**

This nursing research session 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 nursing research session gives insights into:

- Planning projects in urology from the nursing view
- How to bring nursing procedures or questions about nursing procedures into research projects
- Doing a project plan for research activities
- How research plans are presented.

**12.45 - 13.15**

#### **Beyond the bedside: Evolving your practice through nursing research**

N. Love-Retinger, New York (US)

Unmoderated Poster Session

13.15 - 17.00 Poster viewing

Room 2

Aims and objectives of this session

Although not chosen for formal presentation, the EAUN Scientific Committee has invited nine authors to share their work in our poster area in Room 2 on Sunday afternoon. The authors have been asked to be present near their poster in the session breaks at the dedicated viewing time taking the opportunity to discuss their work with the other delegates.

Unmoderated posters do not qualify for entry into the abstract competition.

Timings poster viewing:

- 13.15 - 13.45
- 14.30 - 14.45
- 15.30 - 15.45
- 16.45 - 17.00



State-of-the-art Lecture

13.45 - 14.30 Ethics in urology

Room 5



Aims and objectives of this session

What kind of support do we need? Therapeutic obstinacy and other complex situations.

13.45 - 13.50

Introduction

G. Villa, Milan (IT)

13.50 - 14.20

Ethical dilemmas in everyday clinical practice

M. Rabe, Berlin (DE)

14.20 - 14.30

Panel discussion

Panel: M. Rabe, Berlin (DE)  
G. Villa, Milan (IT)

State-of-the-art Lecture

14.45 - 15.30 Female genital mutilation

Room 5



14.45 - 14.50

Introduction

E.A. Grainger, Århus (DK)

14.50 - 15.20

Female mutilation: Challenges for nursing practice in European countries

M. Comfort, London (GB)

15.20 - 15.30

Panel discussion

Panel: M. Comfort, London (GB)  
E.A. Grainger, Århus (DK)

## Thematic Session 10

15.45 - 16.45 Rare cases and diseases in urology

### Room 5



*Chair:* S. Terzoni, Milan (IT)

#### Aims and objectives of this session

This session will provide delegates with relevant information about uncommon conditions that can be found in urology patients. In everyday practice, sometimes patients present with unusual diseases or problems; it is often difficult to find relevant literature and practical information for timely managing such situations; the speakers of this session will discuss rare conditions and provide practical solutions and indications.

15.45 - 15.50 **Introduction**

S. Terzoni, Milan (IT)

15.50 - 16.15 **State-of-the-art lecture Urogenital tuberculosis**

E. Kulchavenya, Novosibirsk (RU)

#### Aims and objectives

Is Urogenital Tuberculosis (TB) really a rare disease? It probably is an often underdiagnosed disease, as doctors who are not familiar with TB would not recognise it. Prostate TB seems to be a rare disease - but 77% of men who died from TB of all localisations had prostate TB which had mostly been overlooked during their life time. Urogenital TB has no specific features, used to hide under the mask of another disease.

This lecture on Urogenital TB will explain to the audience the classification of urogenital TB, risk factors and diagnostic algorithm; and will cover the general principles of the therapy and surgery for urogenital TB. Participants will be able to see extremely rare cases, and they will know when urogenital TB should be suspected.

16.15 - 16.40 **State-of-the-art lecture Schistosomiasis**

L. Drudge-Coates, London (GB)

#### Aims and objectives

- To provide an overview of Schistosomiasis with specific attention to Schistosomiasis haematobium
- Outline the pathophysiology, diagnosis and treatment and the implications for urology nursing practice

16.40 - 16.45 **Conclusion**

S. Terzoni, Milan (IT)

## Special Session

15.45 - 17.15 **Market place session: Preparing for major urological surgery**

### Room 4

*Chair:* B.T. Jensen, Århus (DK)

#### **Aims and objectives of this 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 20 minutes, 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.

15.45 - 15.50

#### **Introduction**

B.T. Jensen, Århus (DK)

15.50 - 16.10

#### **Topic 1: Proactive smoking intervention**

A. Munk Nielsen, Århus (DK)

16.10 - 16.30

#### **Topic 2: Proactive alcohol intervention**

L. Lydom, Frederiksberg (DK)

16.30 - 16.50

#### **Topic 3: Proactive physical intervention**

A. Krintel Petersen, Århus (DK)

#### **Aims and objectives**

Recent research suggest that boosting physical capacity and functioning prior to major surgery can reduce morbidity and improve postoperative rehabilitation.

Preoperative physical exercise training (pre-rehabilitation) aims to enhance postoperative mobilisation and thereby minimising the reduction in muscle mass, physical capacity and function caused by the surgical stress response.

The aim of this session is to present some theoretical considerations underlying the recommendations of exercise-based pre-rehabilitation. Furthermore, there will be an introduction and discussion regarding practical aspects of preoperative exercise training.

16.50 - 17.10

#### **Topic 4: Proactive nutritional intervention**

G. Villa, Milan (IT)

#### **Aims and objectives**

Despite recognition of malnutrition as a major risk factor for postoperative complications and increased length of stay, routine nutrition screening and perioperative nutrition support is still poorly implemented. Fear of anastomotic leaks and post operative ileus are still reasons cited for delays in commencement of oral diet, despite substantial evidence refuting these concerns.

The aim of this session is to provide the rationale for nutritional intervention in major urological surgery.

17.10 - 17.15

#### **Summary and conclusion**

B.T. Jensen, Århus (DK)

## Video Session

17.00 - 18.00 **Nursing in motion**

### Room 5



*Chair:* S.J. Borg, Msida (MT)

#### **Aims and objectives of this session**

- To disseminate informative videos on what Urology Nurses are doing across EU and beyond
- To provide a medium that empowers Urology nurses to share their experiences with fellow nurses across many borders
- The opportunity to show the ever increasing expertise and competence being reached Urology Nurses and become a reference point for others to follow
- To inspire Urology Nurses to look beyond their current comfort zones and elevate their practice to new heights

#### **A new strategy to encourage nurses to join the urology department**

D. Kisslig, H. Bumann, R. Willener (Berne, Switzerland)

#### **Robotic surgery and Nurses, a good mix?**

C.N. Tillier (Amsterdam, The Netherlands)

#### **Working with Da Vinci surgical system**

B. Keil (Heilbronn, Germany)

#### **My visit to Afrika**

B. Keil (Heilbronn, Germany)

Thematic Session 11

09.00 - 10.00 Primary care challenges in urology

Room 5



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

Aims and objectives of this session

The aim of this session is to explore some of the obvious and hidden challenges in providing the often desired but seldom achieved ‘seamless transition’ from hospital to home for people with urological care needs. Through presentations from two eminent practitioners and via discussion with the audience we will meet the objectives of identifying unmet needs in both our patients and ourselves as the curators and providers of care. Through examining our own practice in the light of evidence we will be able to consider where and how our own practice needs to change and what might assist it to do so.

09.00 - 09.05

Introduction

J.T. Marley, Newtownabbey (GB)

09.05 - 09.30

From home to the hospital: Unmet needs of our patients

I. Banks, Spa (IE)

09.30 - 09.50

Out of hospital: Better planning / involve primary care

M. Kirby, Baldock (GB)

09.50 - 10.00

Panel discussion

Panel:

I. Banks, Spa (IE)

M. Kirby, Baldock (GB)

J.T. Marley, Newtownabbey (GB)

## Thematic Session 12

09.00 - 10.00 **Painful bladder syndrome: Where do we stand?**

### Room 4



*Chair:* G. Villa, Milan (IT)

#### Aims and objectives of this session

In this session we will discuss an overview of painful bladder syndrome and the state of the art about this problem.

09.00 - 09.05

#### Introduction

G. Villa, Milan (IT)

09.05 - 09.30

#### State-of-the-art lecture **Painful bladder syndrome / Interstitial cystitis: An overview**

P. McDermott, Cottingham (GB)

#### Aims and objectives

Interstitial Cystitis (IC) more correctly known as Painful Bladder Syndrome (PBS), a condition that falls under the heading of chronic pelvic pain syndrome. Symptoms include chronic vaginal and urethral pain in women and some types of prostatitis in men (Reid and Rosario, 2008). The aim and objectives of this session are to identify the history and epidemiology of interstitial cystitis, analyse the associated symptoms, diagnosis and treatment.

09.30 - 09.55

#### State-of-the-art lecture **Painful bladder syndrome: Where are we now?**

E.J. Messelink, Groningen (NL)

#### Aims and objectives

Aims:

- To inform the audience on the modern ideas on bladder pain syndrome
- To clarify definitions and mechanisms of chronic pain in general and bladder pain in particular
- To demonstrate the use of the EAU guidelines in daily practice

Objectives:

- Provide a clear view on pain mechanisms and their importance for treating patients with bladder pain syndrome
- Provide tools and tips for daily practice
- Provide information on new concepts, like 'explain pain'
- Provide an idea of where we are going in the near future

09.55 - 10.00

#### Panel discussion

*Panel:* P. McDermott, Cottingham (GB)  
E.J. Messelink, Groningen (NL)  
G. Villa, Milan (IT)



State-of-the-art Lecture

10.15 - 10.45 Probiotics in urology care

Room 4



- 10.15 - 10.20 Introduction  
L. Van De Bilt-Sonderegger, Eindhoven (NL)
- 10.20 - 10.45 Probiotics in urology care: Where do we stand?  
L. Van Driel-Rooks, Rotterdam (NL)

EAUN-ESU Course 2

10.15 - 12.30 Urinary stones: From start to finish

Room 5



Chair: O. Traxer, Paris (FR)

Aims and objectives of this session

After following this course, the participants should have a better understanding of:

- Epidemiology, risk factors and indication for treatment for kidney stones
- How a Holmium laser works
- How to sterilise and maintain flexible endoscopes
- The set-up of an operating room for complex procedures in endourology: PCNL and combined treatment
- The step by step technique for PCNL and RIRS

10.15 - 10.30 Epidemiology, diet and EAU guidelines  
O. Traxer, Paris (FR)

10.30 - 10.45 Disposable equipment for flexible URS  
B.K. Somani, Southampton (GB)

10.45 - 11.00 Step by step technique for flexible URS  
O. Traxer, Paris (FR)

11.00 - 11.15 How to sterilise your flexible endoscopes  
H.W. Oussoren, Amsterdam (NL)

11.15 - 11.30 Break

11.30 - 11.45 Holmium laser: How does it work?  
O. Traxer, Paris (FR)

11.45 - 12.00 How to maintain reusable laser fibers  
H.W. Oussoren, Amsterdam (NL)

12.00 - 12.15 How to prepare the OR before PCNL  
H.W. Oussoren, Amsterdam (NL)

12.15 - 12.30 Step by step technique for PCNL  
B.K. Somani, Southampton (GB)

Special Session

10.45 - 11.30 Multidisciplinary Team in urology: Good in theory? Bad in practice?



Room 4

Chair: P. Allchorne, London (GB)

Aims and objectives of this session

- What is a multidisciplinary team?
- What is the importance in holding multidisciplinary team meetings?
- Should everyone have input in to the care of a urological patient?
- What is the role of a nurse within the multidisciplinary team?
- What are the pros and cons of a multidisciplinary meeting?
- Are there any future developments?

10.45 - 11.25 Debate Merging and sharing nursing and medical competencies

10.45 - 11.05 Pro  
R. Gledhill, Birmingham (GB)

11.05 - 11.25 Con  
J. Green, London (GB)

11.25 - 11.30 Panel discussion

Panel: P. Allchorne, London (GB)  
R. Gledhill, Birmingham (GB)  
J. Green, London (GB)

## Thematic Session 13

11.45 - 12.45 **Self-care and quality of life in the urostomy patient**

### Room 4



*Chair:* B.T. Jensen, Århus (DK)

#### Aims and objectives of this session

Stoma care includes skills and counselling about living with an ostomy, stomal and peristomal skin care, and skills needed to change an ostomy pouch. The ability to manage an ostomy appliance independently is the single most important factor for predicting positive psychological adjustment to life with a stoma. Practising the skills related to changing an ostomy pouch is a first step toward independence and acceptance following stoma surgery. The patient's ability to collectively perform these skills is defined as stoma self-care. Stoma self-care education requires cognitive, affective, and psychomotor learning. Affective learning begins with willingness to view the urostomy, leading to participation in stoma care, and recognition of the advantages of independence linked to self-care. This lecture will inform the audience of recent evidence on stoma self-care including early education.

11.45 - 11.50 **Introduction**

B.T. Jensen, Århus (DK)

11.50 - 12.05 **State-of-the-art lecture** *Stoma complications: A matter of quality of life*

B. Kiesbye, Århus (DK)

#### Aims and objectives

Going through removal of the bladder due to cancer and ending up with a urostomy is a major change for many patients. It is hard work to learn to cope with it and get back to normal life. Bodyimage and physical activity can be challenged and especially when patients experience complications such as leakage and skin problems. Competence and skills in nurse counselling are very important.

12.05 - 12.20 **State-of-the-art lecture** *Rare cases in stoma care: Solving uncommon problems*

N. Love-Retinger, New York (US)

12.20 - 12.35 **State-of-the-art lecture** *Efficacy of preoperative teaching in stoma care*

B.T. Jensen, Århus (DK)

#### Aims and objectives

This lecture will inform the audience of recent evidence of early education and introduction to self-care.

12.35 - 12.45 **Panel discussion**

*Panel:*  
B.T. Jensen, Århus (DK)  
B. Kiesbye, Århus (DK)  
N. Love-Retinger, New York (US)

Special Session

12.45 - 13.15 Patient information on bladder cancer

Room 5



Aims and objectives of this session

Well-informed patients are better equipped to talk about issues that worry them, to share the information about the way they experience their condition and treatment. This encourages a meaningful dialogue between the doctor and the patient, leading to better care. The mission of the EAU Patient Information initiative is to provide reliable patient information on urological diseases which takes into account the latest scientific evidence, expert recommendations, and the needs of patients. EAU Patient Information is in line with the EAU Guidelines and enables patients to ask their health care professionals the right questions. The newly added topic of patient information on bladder cancer adds the third big uro-oncological topic (after PCa and RCC) and closes another gap in the task to achieve the best-possible support for our patients.

12.45 - 12.50 Introduction  
L. Drudge-Coates, London (GB)

12.50 - 13.15 Launch of EAU Patient Information on bladder cancer  
T. Bach, Hamburg (DE)

## Special Session

13.15 - 14.00

### General assembly

#### Room 5



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

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

*Board:* S. Terzoni, Milan (IT), Chair Elect  
K. Fitzpatrick, Dublin (IE), Past Chair  
P. Allchorne, London (GB)  
S. Borg, Msida (MT)  
E. Grainger, Arhus (DK)  
C. Tillier, Amsterdam (NL)  
S. Vahr, Copenhagen (DK)  
G. Villa, Milan (IT)

#### Agenda

- Welcome by the Chair
- Approval of the Minutes AGM 2015
- Approval of the new board members (vote by members)
- Report of the Chair and achievements of 2015/2016
- Report ESUN activities
- Reports Finances & Scientific Committee & Special Interest Groups (SIG)
- Acknowledgements
- Official handover Chairmanship

Special Session

14.00 - 14.15 Award session

Room 5

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

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

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



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Abstracts

P1

Room 5

## Incidence and impact of urinary tract infections (UTI) when starting intermittent catheterisation (IC) and the effect on quality of life (second preliminary analysis)

Mulder H.

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

### Introduction & Objectives

Poor bladder emptying is a common problem in urology, increasing 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. Catheterisation is a known cause of moving bacteria from the meatus area into the, normally sterile, urethra and in this way may start UTI. Recent literature states that approximately 30% of CIC 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. 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. This study aims to determine the incidence and impact on health-related Quality of Life (QoL) of UTI in patients starting IC.

### Material & Methods

We performed a multi-centre prospective observational cohort study in four large general hospitals in the Netherlands. 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 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 blood cells/mm<sup>3</sup>) and one or more of the following symptoms; frequency, urgency, dysuria, stranguria, fever or haematuria. The primary outcome measure is the occurrence of UTI.

### Results

These results are based on the interim analysis of the first 275 subjects (83% male, 17% female) of whom 135 were followed for three months and 59 for one year.

45% of the subjects (n=102) practised IC 1-2 times a day, 9% (n=20) 3 times a day, 40.5% (n=91) 4-6 times a day and 5.5% (n=12) once a week or less.

25.7% (n=58) of the subjects developed an UTI (median 40.5 days). Subjects practising IC 3 times per day seem to be more at risk to develop a UTI (40% n=8, chi-square(3)=7.5 p=0.058).

In the first month 22.7% (n=36) of the subjects were called in sick; of which 66.7% (n=24) caused by bladder problems. Still there is no evidence found that any catheter type influences the incidence of UTI.

### Quality of Life Results:

According to the interviews done in a random selection of 19 subjects, most of the subjects state that in the first period of practising IC they find it hard to adjust. They feel insecure. They do not know if they are practising IC in the right way.

### Conclusions

The incidence of UTI is markedly higher than stated in the literature. Especially around one month after starting IC, patients seem to be at risk for developing an UTI especially in subjects practising IC three times a day. Starting IC influences peoples quality of life and several patients find it hard to adjust to the new situation. During the first month of IC, bladder problems are the main cause of sick-days in patients.

Embedding a Prostate Cancer Survivorship Pathway using PDSA cycle

Allchorne P.<sup>1</sup>, Kinsella J.<sup>2</sup>, Fleure L.<sup>1</sup>, Clovis S.<sup>1</sup>, Briggs K.<sup>1</sup>, Hazel E.<sup>1</sup>, Cahill D.<sup>2</sup>, Dasgupta P.<sup>1</sup>, Veal I.<sup>1</sup>, Smith S.<sup>1</sup>, Green J.S.A.<sup>3</sup>

<sup>1</sup>Guy’s and St Thomas’ NHS Foundation Trust, Dept. of Urology, London, United Kingdom, <sup>2</sup>The Royal Marsden NHS Foundation Trust, Dept. of Urology, London, United Kingdom, <sup>3</sup>Barts Health (Whipps Cross), Dept. of Urology, London, United Kingdom

Introduction & Objectives

A new survivorship pathway has been designed and implemented using a plan do study act (PDSA) cycle with patients to ensure it improves patient experience along with quality of care. It supports patients living a healthier/active life after treatment. 4 educational seminars have been integrated at different points of a patient’s cancer journey. The interactive group sessions aims to support patients to cope with/managing side effects, and addressing their concerns including discharge. This work describes its assessment.

Material & Methods

Using qualitative methods.  
250 questionnaires investigated patient experience, consequences of treatment and side effects up to 18 months post treatment. Three focus groups were conducted, 20 patients treated for their prostate cancer with 4 different treatment options. The 2nd: 15 participants from different ethnicities ensuring multicultural perspectives. 3rd: A multidisciplinary focus group to discuss with health professionals concerns & experiences. Holistic Needs Assessments identified patients concerns; physical, emotionally, spiritually, practically and socially were used to identify where patients need more support during their cancer journey. Every patient completes a feedback questionnaire on their experience attending the seminar session, & whether it gave them the confidence to self-manage their symptoms. A retrospective audit of the andrology and continence service was conducted to assess how many new post treatment referrals were received 6 months after the new survivorship pathway was implemented.

Results

Figure 1: Pre-treatment Seminars

	Brachytherapy	Robotic Surgery	External Beam Radiotherapy
Were you satisfied with today’s seminar?	100%	100%	100%
Do you feel more confident in coping with your recovery after following this seminar?	98%	100%	98%
Would you have preferred individual appointments to discuss all of today’s issues?	4%	0.6%	15%
Did you feel comfortable asking any questions in a group setting?	93%	99.4%	96%



Figure 2: Erectile Dysfunction and Continence Seminar

	Robotic patients only
Were you confident before this clinic in dealing with issues that might arise following treatment?	72%
Do you feel more confident in coping with your recovery after attending this seminar?	98%
Were you satisfied with today's seminar?	100%
Would you have preferred 3 individual appointments to discuss all of today's issues?	4%
Did you feel comfortable asking any questions in a group setting?	97.2%

Figure 3: Discharge Seminar

	All Treatments
Were you confident before this clinic in dealing with issues that might arise following treatment?	85%
Do you feel more confident in coping with your recovery after following this seminar?	100%
Were you satisfied with today's seminar?	100%
Did you feel comfortable asking any questions in a group setting?	93%

All patients completed evaluation forms to assess each seminar session. The majority of patients felt more confident to self-manage their symptoms. The new survivorship pathway also reduced the amount of phone calls and counselling hours, and over a 6 month period there was a 100% reduction in new referrals to the existing clinics that addressed common treatment side effects.

### Conclusions

The new survivorship pathway using seminars is now successfully embedded without any extra financial resources, effective for both patients and healthcare professionals with increased patient satisfaction managing more patient without any extra resources.

P3

Room 5

## Preparing patients for the future using erectile dysfunction and continence seminars

Allchorne P.<sup>1</sup>, Kinsella J.<sup>2</sup>, Briggs K.<sup>1</sup>, Hazel E.<sup>1</sup>, Dasgupta P.<sup>1</sup>, Cahill D.<sup>2</sup>, Green J.S.A.<sup>3</sup>

<sup>1</sup>Guy's and St Thomas' NHS Foundation Trust, Dept. of Urology, London, United Kingdom, <sup>2</sup>The Royal Marsden, NHS Foundation Trust, Dept. of Urology, London, United Kingdom, <sup>3</sup>Barts Health (Whipps Cross), Dept. of Urology, London, United Kingdom

### Introduction & Objectives

Post RARP patients were seen by the andrology and continence nurse specialists (CNSs) within 10 days after their surgery. Due to the increased number of RARPs performed access to the CNSs was becoming problematic with no extra manpower, capacity or resources. The current situation needed to change, a new survivorship model was implemented to address patients unmet needs within an acceptable timeframe, increasing patient satisfaction and outcomes.

### Material & Methods

A qualitative study approach was used; A seminar session was integrated into the patient recovery pathway 4 weeks post RARP. The andrology & continence CNSs ran group seminars weekly educating patients how to manage & cope with their ED/incontinence. All patients completed an evaluation form after they attended a seminar.

### Results

20 seminars were reviewed, 138 patients completed evaluation feedback questionnaires, patients age ranged between 61-70 (48%), (31%) 51-60, (11%) 71-80, (8%) 40-50 and 2% were unknown. Representation of different ethnicity groups, 59.4% (82) Caucasian, 29.0% (40) Black, 3.6% (5) Asian, 1.5% (2) other, 5.8% (8) unknown and 0.7% (1) mixed ethnicity.

98% of men felt they benefited and gained more knowledge and confidence to be able to cope after the seminar. Only 2% of men were unsure if the seminar helped them, these men would preferred individual consultations.

Fig 1. Post treatment ED/continence Seminar

	Definitely No	No	Unsure	Yes	Definitely Yes
Asian				4	1
Black				20	20
Other			1		1
Caucasian			1	42	39
Unknown			1	7	
Mixed				1	

135 men were more confident after their seminar with coping, 3 men who couldn't cope with symptoms beforehand felt they could cope afterwards, and only 3 men unsure beforehand were not confident after the seminar.

97.2% (134) felt comfortable asking questions in a group setting, 2.1% (3) were unsure and only 0.7% (1) definitely did not feel comfortable in a group setting. There were no differences between ethnicity and patients feeling uncomfortable talking in a group setting about personal issues. 10% (14) of patients would have preferred individual appointments and 6% (8) were unsure. However, 11% (15) of patients would have preferred additional separate sessions or were unsure but out of those 11% only 4% (5) of patients wanted individual consultations.

Retrospectively the clinics were analysed for new referrals over a 6 month period, there had been a 100% reduction in referrals post RARP, allowing the CNSs to review an extra 250 patients per year with no extra resources or finance.

Fig 2. The thematic analysis produced themes from the free text on the questionnaire:

Theme	Quote
Environment for patients	“WAS LIGHT HEARTED SO RELAXED BUT TO THE POINT OF ISSUE CONCERNED”  “CLARITY, OPENESS, LACK OF EMBARRASSMENT, PROFESSIONAL ADVICE AND HEARING OTHER PEOPLES EXPERIENCE”  “PUT AT EASE, FRANK, SENSITIVE, INFORMATIVE”
Peer Support	“HEARING OTHER PEOPLES PROBLEMS AND KNOWING THAT YOU’RE NOT ALONE”  “THE OPPORTUNITY TO HEAR ABOUT OTHER PEOPLES EXPERIENCES AND TO ASK QUESTIONS”

**Conclusions**

Implementation of a new survivorship pathway addressing ED & continence as a group, has proven to be efficient and cost effective. The andrology & continence service has increased their through patient flow without extra resources or manpower. Patients physically & psychologically benefited from group discussions, they were comfortable talking in group settings & demonstrated no inequalities between ethnic groups. Patients found peer support invaluable.



P4

Room 5

## Comparison of the effect of support power of underwear and pelvic floor muscle training for reducing women's urinary incontinence

Okayama H.<sup>1</sup>, Ninomiya S.<sup>2</sup>, Naito K.<sup>3</sup>, Nakanishi K.<sup>1</sup>, Saito Y.<sup>4</sup>

<sup>1</sup>Shiga University of Medical Science, Dept. of Nursing, Otsu, Japan, <sup>2</sup>Graduate School of Medicine, Kyoto University, Dept. of Human Health Science, Kyoto, Japan, <sup>3</sup>Biwako Gakuin University, Dept. of Childhood Care, Higashiomi, Japan, <sup>4</sup>Aino University, Dept. of Nursing, Ibaraki, Japan

### Introduction & Objectives

Pelvic floor muscle training (PFMT) is recommended by the guideline for preventing and improving urinary incontinence. However, the PFMT is not commonly adopted by women as a self-care, because of difficulty in understanding of adequate contraction or continuing it. Therefore, we have been investigating a new self-care method for preventing and improving of stress urinary incontinence by using support power of underwear which elevates urinary. But, the effect for improving urinary incontinence symptoms has not been compared with the PFMT or control group at our previous single-arm pilot study (Ninomiya, 2014). The aim of this study is to compare the effect of the support power of underwear with that of the PFMT for improving women's urinary incontinence symptoms by randomized controlled trials.

### Material & Methods

Japanese multiparous women (30-39 years) with urinary incontinence symptom were randomly classified into underwear group, PFMT group, and control group. 110 subjects from which all data could get during 18 weeks were chosen for analysis. The underwear group wore SLIMup-Pant with Style Science (Wacoal Corporation, Kyoto, Japan) for 8 hours a day, 12 weeks. Style Science is a functional underwear with a cross structure which stimulates the quadriceps femoris muscle, and promotes a large-stride during walking. The muscles of buttocks can be strengthened by walking more than 6000 steps per day, while wearing this underwear during the daytime for 12 weeks. The PFMT group conducted 3-minute training more than 3 times a day, for 12 weeks. The control group spent ordinal life without extra things. Times of urination a day, urinary incontinence a week, and Japanese version of the International Consultation on Incontinence Questionnaire - Short Form were assessed before the trial, 6 and 12 weeks during trial, and 6 weeks after the trial. As for the analysis, Wilcoxon signed-ranks test and Bonferroni correction were carried out. This study was conducted in accordance with the Declaration of Helsinki.

### Results

Times of urinary incontinence a week of the underwear group and PFMT group after 6 and 12 weeks significantly decreased compared with those before the trial, although the control group showed no significant decrease. And, the symptoms 6 weeks after the trial have no significant change from those of 12 weeks of trial (Table 1.)

Table 1. Urinary Incontinence a Week

	A: before the trial	B: 6week (during the trial)	C: 12week (end of the trial)	YD: 6weeks after the trial	A vs B	A vs C	C vs D
	Median (25th, 75th percentile)			P-value			
Underwear Group	2.0 (1.0, 5.0)	1.0 (0.0, 4.0)	0.0 (0.0, 2.0)	0.0 (0.0, 1.0)	0.001**	<0.001**	0.192
PFMT Group	2.0 (1.0, 4.0)	1.0 (0.0, 3.0)	0.0 (0.0, 1.0)	0.0 (0.0, 1.0)	0.005*	<0.001**	0.484
Control Group	1.5 (1.0, 3.8)	1.5 (1.0, 3.0)	1.0 (0.0, 3.0)	0.5 (0.0, 1.8)	0.528	0.573	0.046
Wilcoxon signed-rank test and Bonferroni correction *p							

## Conclusions

It is thought to be effective for improving women's urinary incontinence symptoms to wear the supporting underwear or conduct the PFMT for 12 weeks. Because of no degradation of the effect after 6 weeks, the effect is expected to continue. It is necessary for further investigation of continuity of the effect.

P5

Room 5

## PEffectiveness of the enlightenment using a leaflet of self-care for prevention and improvement of urinary incontinence in women

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### Introduction & Objectives

We have verified the effectiveness of pelvic floor muscle training and the supportive underwear as self-care for prevention and improvement of urinary incontinence. A leaflet to inform the effectiveness of pelvic floor muscle training (PFMT) and the supportive underwear was prepared. The aim of this study is to investigate the effectiveness of the enlightenment using a leaflet.

### Material & Methods

Firstly, a leaflet and questionnaire about the leaflet was distributed to 1,000 women who had gynaecological examination. The questions were as follows; the helpfulness of the leaflet, the way of interested self-care, and the symptoms of urinary incontinence. Three months later, the status of achievement of self-care for prevention and improvement of urinary incontinence was surveyed. Descriptive statistics was used for the analysis. This study was conducted in accordance with the Declaration of Helsinki.

### Results

The answers of 552 women were analysed (the response rate: 55.2%). The profiles of the respondents were age 45.1±12.5 (mean ± standard deviation) years old, body mass index 21.5±3.2 kg/ m<sup>2</sup>, parity 1.7±1.2 times, and prevalence rate of urinary incontinence 57.6%. Ninety-two percent of the women had read a distributed leaflet. Eighty-eight percent of the women answered that the leaflet was helpful. Thirty-nine percent of women had an interest in PFMT, and 15% had an interest in supportive underwear. Total of 242 women were surveyed 3 months later (the response rate: 43.8%). Fifty-eight percent of the women had read the leaflet once again. Thirty-eight percent of the women had practised PFMT, and 3% implemented supportive underwear. On the other hand, 56% of the women did nothing. Forty-two percent of the women, who had practised any of self-care, were continuing it even now.

### Conclusions

Eighty-eight percent of the women answered that the leaflet was helpful. In addition, 3 months later, 42% of the women were continuing any of self-care. It is considered that motivation to self-care using a leaflet is effective. Future issues are to compare the effect of the enlightenment by a leaflets with nurse's guidance.

P6

Room 5

## Development of a protocol for the prevention and management of long-term indwelling urinary catheter blockage for visiting nurses

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### Introduction & Objectives

Long-term use of an indwelling urinary catheter at home is associated with complications, including urinary tract infection and catheter blockage, which are the main reasons for emergency care by visiting nurses. Visiting nurses monitor the indwelling urinary catheter of patients at home in Japan and therefore must be able to prevent and manage catheter blockage. However, no guidelines for the prevention and management of catheter blockage. The present study aimed to develop the Visiting Nurse Urinary monitoring (VNU) - protocol for the prevention and management of long-term indwelling urinary catheter blockage for visiting nurses.

### Material & Methods

Objective: The protocol comprises the procedures that visiting nurses should perform to prevent and help manage catheter blockage.

Preparation process:

Step 1: Literature review

Step 2: Basic investigation to identify the factors that influence the development of catheter blockage

Step 3: Development of a draft protocol based on the literature review and basic investigation results

Step 4: Modification of the draft protocol based on examination of the results of the simulated use of the protocol drafted by one urologist, three visiting nurses, and the present authors

### Results

The protocol was developed by following steps 1 to 4. Three protocol types were developed (A, B, and C). Figure 1 shows the names of protocols A, B, and C and indicates the objective of visiting care in each.

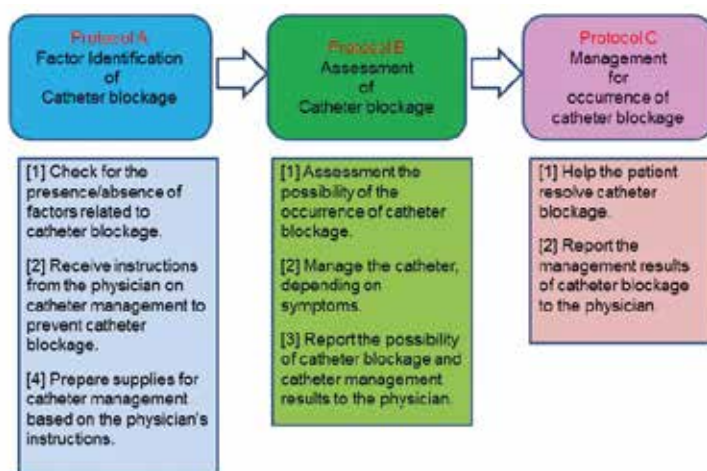


Figure 1: The VNU-Protocol structure

Protocol B is intended to provide guidance to visiting nurses so that they can observe patients for symptoms of catheter blockage, detect catheter blockage, and appropriately guide family caregivers and patients, then report to physicians depending on symptoms.

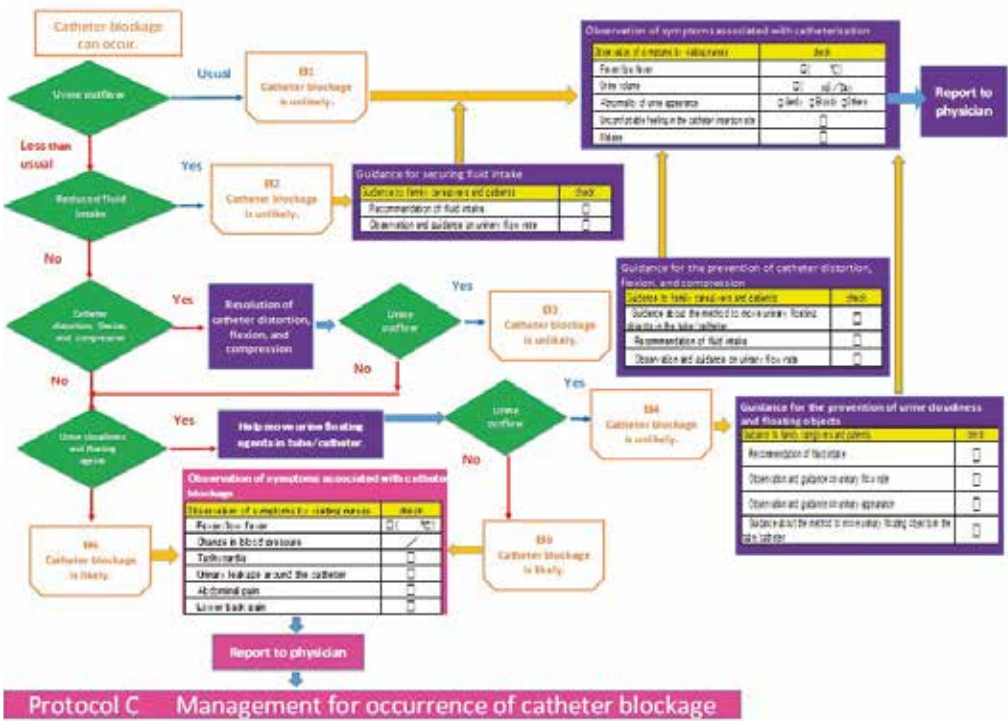


Figure 2: Practice of the VNU-Protocol B

### Conclusions

The protocols were developed based on the literature review and basic investigation results and are therefore consistent with the clinical needs of visiting nurses. The use of tree diagrams made the protocol useful for visiting nurses in terms of the collection of information on catheter blockage and decision-making regarding the treatment or management of catheter blockage. The protocols will be revised to a final version based on feedback from nurses working in home nursing stations.

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Room 5

## Are we listening? Patients' views of the bladder exstrophy transition service

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### Introduction & Objectives

Bladder exstrophy (BE) is a rare, complex birth defect involving the urinary, reproductive and intestinal tracts, as well as the musculoskeletal system resulting in a variety of abdominal, genital and orthopaedic abnormalities. Our hospital is only one of two centres in the UK commissioned to manage these patients. In 2009 we established the transition service for BE patients to provide a seamless move from paediatric to adult services and to facilitate a long lasting relationship between the patients and all members of the multidisciplinary team (MDT) with a view to providing comprehensive life long care.

Age 13 - 16: Dedicated BE MDT evening clinic held in paediatric out patient dept

Age 16 - 18: MDT specialist nurse/psychologist led transfer clinic held in paediatric out patient dept

Age 16+: Full transfer to adult sector and continuity with MDT facilitated by day time clinic appointment

### MDT members:

- Paediatric Consultant Urologist and Urology Specialist Nurse
- Clinical Psychologist
- Adult Consultant Urologist and Urology Specialist Nurse
- Consultant Gynaecologist

Aim: To seek the views of patients with regard to their experiences of the BE transition between children's and adult services.

### Material & Methods

A subjective, prospective anonymous postal questionnaire was sent in July 2015 to all 23 BE adult patients assessing:

- Children's evening clinic
- Nurse-led discharge clinic
- Adult clinic

### Results

In total 19 completed questionnaires were returned for analysis.

#### Evening clinic:

- 66% said they felt ready to move to adult services
- 72% of patients said they had been asked whether they felt ready for the move to adult services before being moved
- 81% stated they found it helpful to meet all members of the MDT at their clinic appointments
- 77% reported that they found the written information given to them about the transition service helpful
- 87.5% found the personal transition health care plan helpful
- 91% stated they found their own copy of their hand held notes helpful

#### Nurse led transfer clinic:

- 93% felt this clinic was useful in preparing them for transfer to the adult sector
- 75% stated they had been given enough information about the differences between the children's and adult services
- 54% had been given an opportunity to visit the adult hospital before transfer and of those, 90% found it helpful
- 55% said they were not bothered by the move to adult services, however, 33% said they were scared.

#### Adult clinic:

- 93% reported it was helpful to see all the MDT members
- 95% felt they were listened to in the clinic.
- 84% stated they felt it was easy to talk to the MDT members
- 89% felt all their questions were answered
- 100% said they were treated well and that their views and worries were taken seriously.
- 100% said the help they receive is good and they would all recommend to a friend with BE to be cared for here.

#### Conclusions

This audit demonstrates the importance of building a lasting relationship with young BE patients whilst they are still under the care of the paediatric team to help allay their anxieties and for the patients to begin the process of taking responsibility for their continuing healthcare needs as adults.

There is an ongoing dialogue with BE patients to ensure the service responds to their needs and expectations.

#### Changes implemented:

- Improved dialogue to ascertain when patients feel ready for transfer
- Ensure all patients offered a nurse-led discharge clinic visit
- Peer mentorship programme implemented

(Graphs will be included in poster)

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Room 5

## The early implementation of oral diet in patients undergoing radical cystectomy improves postoperative outcomes

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### Introduction & Objectives

Nutritional status in patients undergoing radical cystectomy (RC) is considered a significant factor in determining postoperative outcomes. In clinical practice patients are fed by a nutritional support in place of oral nutrition as total parenteral nutrition (TPN) or enteral nutrition, which have not demonstrated positive effects on bowel function recovery time, infectious complications rates or the length of stay (LOS). The early introduction of oral feeding seems to improve these outcomes. The aim is to describe the impact of oral nutritional support on functional outcomes in patients undergoing RC and comparing these results with those reported in literature of patients treated with TPN.

### Material & Methods

A retro-prospective observational study was conducted in the Department of Urology at San Raffaele Hospital (Milan) on patients underwent RC with urinary diversion using an ileal conduit, from May 2014 to October 2015. Twenty-three patients were recruited and recorded outcomes included: bowel function, Activities of Daily Living (mobilization and personal hygiene), tolerance to oral feeding, quality of sleep, intensity of pain, postoperative complications and LOS.

### Results

Patients consumed a liquid diet on postoperative day (POD) 1.52 in average, a semi-solid diet on POD 3.30 and a regular diet on POD 5.61; therefore, they were fed earlier compared to those treated with TPN in literature ( $p=0.014$ ). Average flatus passage was reported on POD 2 and first defecation on POD 4.17, which was considerably earlier compared to findings from other literature studies for TPN ( $p<0.001$ ;  $p=0.025$ ).

Postoperative pain reported by patients on POD 4 was 0.74 (Numeric Rating Scale). Predictably, pain intensity and the number of patients who reported it decreased during hospitalization. Suspension of continuous pain therapy occurred on POD 3.09. A good pain control allowed greater tolerance to mobilization. In fact, patients were able to mobilize autonomously on POD 2.96.

The cumulative walking distance within the first 4 days was longer in patients treated with oral feeding (328.26 meters) than those who received TPN in literature (100.00 meters). Patients performed personal hygiene autonomously on POD 2.78.

The quality of nocturnal sleep improved during hospitalization; only 8.70% of the sample reported an interrupted sleep in POD 5.

Nausea and vomiting were the most common complications, reported by 60.9% of patients.

The sample reported a lower mean time to discharge of 10.83 days, compared to patients treated with TPN ( $p<0.001$ ).

There was a difference in mean LOS between the two urinary diversions: 8.94 days for RC with ileal conduit and 17.60 days for RC with neobladder. This finding was not observed in previous studies.

### Conclusions

The early implementation of oral diet in patients undergoing RC with urinary diversion, compared to the postoperative use of TPN, is associated with an improvement of evaluated outcomes, allowing an early patient recovery and a decreased LOS.



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Room 5

## Prospective monitoring of nursing care in patients undergoing radical cystectomy

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### Introduction & Objectives

The incidence of muscle invasive bladder cancer in Denmark is around 800 a year, with stage T2-4a, No -N1, Mo cancers primarily being treated with radical cystectomy (RC) often robot assisted (RARC). Several studies show that fast-track surgery has a positive effect on the postoperative recovery after RARC. A decrease in heart and lung complications and a shorter hospital stay are some of the positive effects. Studies also points to the persistence of serious complications, the most frequent, lack of nutrition intake, nausea and paralytic ileus. We present results from a patient database established to assess if we comply with the recommendations of the clinical guidelines.

### Material & Methods

The nursing care in the database are based on the evidence underlying the recommendations in the RARC fast-track programme and contains data from 47 and 55 patients from 2013 and 2014 respectively. Only cancer patients undergoing RARC are included. Indicators we have measured are: Sociological data (number of patients, age and sex), method of surgery (by assisted robot: yes/no), length of stay, 30 day re-admission rate, patient information (pre-surgical conversation, written/oral: yes/no), pain (post-operative day (POD) 1-4, Numeric rating scale (NRS) 0-10), nutrition (POD 1-4, recommended points in percent), activity (POD 1-3, time out of bed), weight (pre-surgical compared with POD 1), bowel-function (POD 1-5, yes/no), nausea/vomiting (POD 1-5, yes/no).

### Results

The length of stay has fallen from 10 to 8 days (median), with 30 day readmission rate falling from 47% (2013) to 42% (2014). Both oral and written information is considered optimal. Pain treatment without the use of morphine appeared to be satisfactory with over 50% of patients having no or mild pain POD 1-4. Ingestion of > 75% of the recommended protein and energy intake is only achieved to a limited extent. The target of 3 hours' activity POD 1 improved from 56% (2013) to 77% (2014). 85% had flatus POD 2 and 80% faeces POD 3. Furthermore, we can see that the daily documentation has improved from 2013 to 2014.

### Conclusions

The database provides a comprehensive overview of the results of nursing care for patients undergoing RARC surgery. We have improved in key areas such as pain, activity and bowel function. Our big challenge is still, in spite of several interventions, lack of sufficient nutrition intake. The next step from 2016 will be to implement new procedures to minimize nausea. With the database we will prospectively be able to monitor the outcome of changes in the nursing care and evaluate potential problems and trends in patient treatment.

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Room 5

## Urodynamic features and artefacts in patients with neurogenic lower urinary tract dysfunction

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### Introduction & Objectives

Urodynamic investigation (UDI) is the gold standard to assess neurogenic lower urinary tract dysfunction (NLUTD). In high volume urodynamic centres, UDI is often performed by a nurse specialist supervised by a clinician. UDI is a technically challenging and invasive diagnostic tool susceptible to artefacts, which might lead to inappropriate patient management. We therefore aimed to investigate urodynamic features and artefacts as well as necessary remedial action in patients with NLUTD.

### Material & Methods

A consecutive series of 100 patients (39 women, mean age  $54 \pm 17$ y; 61 men,  $53 \pm 17$ y) with NLUTD undergoing UDI were prospectively assessed. UDI was performed by a nurse specialist supervised by a clinician according to "Good Urodynamic Practice" recommended by the International Continence Society. All patients underwent same session repeat UDI (i.e. 200 urodynamic traces were assessed). Urodynamic traces were permanently screened during investigation according to a standardised protocol regarding quality, plausibility and artefacts. Before uninstalling the patient, urodynamic traces were cross-checked by the supervising clinician and discussed with the nurse specialist.

### Results

The cause for NLUTD was spinal cord injury in 58/100 patients (58%), Parkinson's disease in 7/100 (7%), multiple sclerosis in 6/100 (6%), spina bifida in 5/100 (5%) and another neurological disorder in 24/100 (24%). Reasons for stopping the UDI were urinary leakage in 43/100 patients (43%), strong desire to void (SDV) in 40/100 (40%), pain in 7/100 (7%), autonomic dysreflexia (AD) in 5/100 (5%), and vesico-uretero-renal reflux in 5/100 (5%). Of the 100 patients, 41 voided spontaneously and underwent pressure flow study in addition to filling cystometry. In 29% (48/200) of urodynamic traces, at least one artefact (in total 75 artefacts) was detected. Most artefacts were caused by the rectal catheter (40%, 30/75), e.g. incorrect initial pressure or pressure decrease during UDI. Vesical catheter related artefacts (e.g. inappropriate pressure transmission or expelled catheter) were found in 16% (12/75). Other sources for hardware related events were conduction problems of the EMG signal (13%, 10/75) and the flow-meter (5%, 4/75). Using a standardised quality protocol, 95% (71/75) of all artefacts could be detected resulting in remedial action by the nurse specialist directly during the measurement.

### Conclusions

In patients with NLUTD, UDI are often stopped for other reasons than SDV, such as urinary leakage, pain, AD or vesico-uretero-renal reflux. In addition, many neurological patients will not be able to void spontaneously. Urodynamic artefacts were detected in 29% of our traces and using a standardised quality protocol resulted in remedial action by the nurse specialist directly during the measurement in almost all cases. Thus, familiarity with urodynamic features and artefacts is essential to assure appropriate patient management.

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Room 5

## Changing perspective! Patients with prostate cancer and their partners giving an insight into their experiences of disease and optimal potential of an advanced practice nurse counselling support programme in Switzerland

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### Introduction & Objectives

Prostate cancer (PC) is the most frequent cancer and is, with 14.9%, the third leading cause of cancer death in Swiss men. The incidence rate of PC is 29% of all cancers, with 5650 cases per year in Switzerland. Depending on the stage of disease and the chosen treatment, patients experience side effects and emotional burden. Furthermore, partners experience higher distress levels than the patient and feel disempowered by the cancer diagnosis and the following treatment. To support patients with PC and their partners more efficiently, an Advanced Practice Nurse (APN) counselling support programme, with a psycho-oncological approach, was initiated in 2013, in a Department of Urology, Switzerland. The APN counsels patients with PC and their partners before and after radical prostatectomy (RP) and at the follow-up consultations after 3, 6, 12, etc. months postoperatively. Nine months post-operative or if needed patients and partners are counselled by phone. Main topics are erectile dysfunction, sexuality, couple communication, incontinence, distress, uncertainty, fear, physical activity and nutrition. The APN screens and assesses the needs of patients and partners and coordinates the activities within the interdisciplinary team. The aim is that patients and partners are cared according to their personal need from diagnoses until palliation. There is a lack of publications reporting experiences and needs of patients with PC and their partners. In Switzerland, patients and partners experience with the disease of PC and RP have not been investigated yet in relation with an APN counselling support programme. The purpose of this study thus is to explore experiences and patients' and partners' perspective on the APN counselling support programme.

### Material & Methods

A qualitative approach, content analysis according to Mayring, is used. At the Department of Urology, 10 patients with PC and RP and 10 partners are included between September and December 2015. Participants are interviewed individually in person or by phone. Following an interview guide disease experiences and the APN counselling support programme are explored. Interview data are then systematically summarized.

### Results

The study is ongoing and results will be presented in March at the EAUN conference 2016. Results are expected to show patients' and partners' sensitivity regarding genetic counselling, their perspective on PC and RP within the Swiss health care system, as well as their experiences with participating in the APN counselling support programme and partners' reasons for taking or not taking part in the programme.

### Conclusions

The results will give a deeper insight in patients and partners needs and will be used to adapt the APN counselling support programme to be more patient-centered and need-oriented.

P12

Room 5

## An interactive app to improve quality of care to patients with a nephro-stoma

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### Introduction & Objectives

Increasing inquiries by ways of telephone calls from primary healthcare nurses concerning patients with catheter problems have led to considerable acute admissions to the Department of Urology. The aim of this project is to provide the primary nurse with a supporting tool which is handy and easy to access and use. By supporting the primary nurse in proactive trouble shooting, it may be possible to prevent acute admissions for the benefit of the patient and the healthcare provider.

### Material & Methods

The acute care unit approached the Department of Quality, Development and Innovation for a possible digital solution. A pilot investigation was made initially to provide a so called need-assessment. A consecutive registration of patients with catheter problems was performed for a period of one month, in February 2015. The categories of the investigation were threefold: nephro-stoma catheter problems, haematuria and catheterisation. All patients arriving with one of these problems or all calls from primary nurses concerning these problems were registered.

### Results

The investigation showed that most of the inquiries were related to patients with a nephro-stoma catheter. Based on the pilot registration a specific APP approaching nephro-catheter problems has been designed. The development of the APP is "a cross sector" project and made by the Department of Urology in cooperation with a group of students from Århus University, Business School and Department of Quality, Development and Innovation. The APP features both a video and a "step by step" guide of how to trouble shoot dysfunction and change the bandage of a nephro-stoma catheter performed by an expert. The digital solution challenge traditional care. However, the tool may facilitate and optimize the transition between health care sectors. A follow-up registration of all patients with nephro-stoma catheter problems as well as interview with the nurses working in primary care, will be performed one year after the tool is implemented. Results from the pilot study will be presented.

### Conclusions

The tool is considered to reflect true nurse tradition of "bedside learning" and is very welcomed by the primary settings. The goal is to avoid unmet needs managing the nephro-stoma catheter and prevent unnecessary harm to the patients. Currently ongoing evaluation is taking place by potential frequent users. It is expected the APP will support the primary nurse in preventing acute admissions and advanced urology problems. In addition, increased nursing skills in this field may increase the quality of life for the patients with a nephro-stoma catheter and reduce costs.

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Room 5

## Pre-operative stoma site marking on urostomy versus complications

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### Introduction & Objectives

The correct position of the stoma by the pre-operative stoma site marking reduces the appearance of complications. Therefore, this improves the quality life of the patient. In the Centre, there were performed in an annual average of 80 surgical procedures accompanied of different types of techniques. The pre-operative stoma site marking was realized by a specialist nurse at the stoma therapist consulting. Objective is to describe the post-operative complications, which presented the patients who had a radical cystectomy with ileal conduct and/or ureterostomy with a preoperative stoma site marking before the surgery.

### Material & Methods

Observational, descriptive, exploratory survey started in April of 2013 with a monitoring of 2 years and which includes a sample of 68 adults. The variables were: anthropomorphic information, position of the stoma, stoma site marking, complications, and number of visits and day for the solution of possible problems. The study used an adhoc-designed questionnaire that included: patient, family members, and the caregiver evaluated the stoma site marking and the adaptation of the devices during their everyday life. The procedure consisted in to studied three moments stoma site marking: initial, recommended, and definitive. The goal of procedure is to secure the correct position, there were performed a first marking at the consult, where there was a proof device placed during 48-72 hours. This was assessed with the patient for a better setting of position and stoma site marking. Afterwards, it was made a definitive pre-operative marking.

### Results

From 2013 to 2015 were studied 8 women and 60 men, with a median age of 70 years. During the monitoring time here was a loss of 2 patients. The 68 patients had a radical cystectomy with ileal conduct 73% and ureterostomy 27%. Related to the satisfaction of the comfort and difficulties with the proof devices: 75% agreed, which what was recommend at the consult before the surgery by the stoma therapist and; 100% of the population were satisfied with the recommended and agreed marking before the surgery; 90% of the cases (which were visited before the surgery for the marking at the consult) coincided with the post-operative position of the stoma; and 10% of the sample, didn't agreed with the position of the stoma. This was related with the surgical technique. The complications were 42.6%: 24% dermatitis, hernia, and retraction, 17.6% dehiscence, 7% epithelial hyperplasia and 3.4% granuloma. The 97% were detected at the stoma therapist consulting and they require a median of 1.9 visits and a rank of 1 to 90 days for the definitive resolution.

### Conclusions

The index of complications for the presented patients with urostomy is lowering associated with other studies. The type of complications that we had at the consult were solved with 1 other 2 visits more during the monitoring of 2 years; except 1 patient, which presented a hernia with retraction and lack of continuity after peristomal skin and he need 90 days for his resolution. Actually we are preparing a project about counselling group where they learn how to manage the devices during the post-operative time and where they express their difficulties and thoughts their daily life.

P14

Room 5

## A nurse-led clinic for suspected prostate cancer: 3 year service evaluation

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### Introduction & Objectives

Time to diagnosis and treatment has been shown to impact survival in many cancers. In the UK, all urology departments are required to see new referrals for suspected prostate cancer within 2 weeks. Studies to date have focused on the appropriateness of the referrals, effective and consistent triage and the poor yield of confirmed cancer cases. The aim of this study was to evaluate a nurse practitioner led approach for the assessment and management of men with suspected prostate cancer.

### Material & Methods

A protocol driven nurse led assessment service was designed for new cases of possible prostate cancer. In June 2012 after initial training and supervision, all referrals underwent direct nurse vetting and assessment in nurse led clinics. Assessment included a full medical history, digital rectal examination, bloods, lower urinary tract assessment and sexual health review. Subsequent diagnostic investigations were then requested based on clinical findings. Clinical outcomes were measured prospectively for all patients. A qualitative questionnaire was sent to the first 100 men.

### Results

From June 2012 - June 2015, 558 men were seen for assessment. The initial waiting time from GP referral-initial urology assessment was reduced from 8.4 to 4.4 days (52%). After initial assessment 279 men (50%) were referred for further cancer diagnostic tests.

223 (40%) patients were sent for biopsies, of whom 150 (67.3%) were diagnosed with cancer.

25 (4.4%) men were diagnosed with metastases at presentation and commenced on hormone therapy without biopsy; 17 (3%) were clinically malignant and commenced on w/waiting, and 2 non metastatic patients with very high PSA levels but multiple co-morbidities were also commenced on hormones.

12 (2.2%) men declined prostate biopsies.

Of 100 questionnaires 63 (63%) responded. 86% were "very satisfied" with the nurse led service, 90% satisfied with seeing a nurse practitioner, with 95% of patients reporting a clear understanding of the diagnostic process.

### Conclusions

A nurse led clinic can cut waiting times for men with suspected prostate cancer, while delivering excellent levels of care and diagnostic performance. Patients appear very happy with the service they receive.

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Room 5

## The use of chewing gum for postoperative ileus prevention in patients undergoing radical cystectomy

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### Introduction & Objectives

Radical cystectomy (RC) is a surgical procedure for which it is difficult to reduce the morbidity and promote an early recovery. Postoperative ileus (POI) is a temporary impairment of intestinal motility and a frequent complication after RC with urinary diversion. It is characterized by abdominal distention, absence of bowel sounds and bowel movements, as well as by the passage of flatus; symptoms include nausea, vomiting, abdominal pain and cramps. This results in an increase in length of hospital stay (LOS), patient discomfort and increased health care costs. Different studies have investigated the efficacy of the chewing gum use, as a form of sham feeding in the immediate postoperative period, in accelerating the resolution of POI after several abdominal surgical procedures. The aim is to determine whether the use of chewing gum in patients undergoing RC promotes a faster recovery of intestinal motility.

### Material & Methods

A literature review was conducted by consulting the principal databases (MEDLINE, CINAHL and Cochrane Database of Systematic Reviews). Considering the lack of primary studies [only 1 randomized controlled trial (RCT) and 1 quasi-experimental study] and the consequent absence of meta-analysis/systematic reviews investigating the specific effectiveness of the chewing gum use in RC, some studies conducted in patients underwent other abdominal procedures with a similar impact on POI and comorbidity were also included. References of the acquired articles were also evaluated for further relevant studies.

### Results

Twenty-four articles were analysed including: 1 guideline, 9 meta-analysis/systematic reviews, 10 RCTs, 1 quasi-experimental study and 3 narrative reviews. Despite the diversity of type of surgery, all considered studies, in the first place the evaluated meta-analysis/systematic reviews, show for patients who received the chewing gum, a significant reduction in the time of first flatus and faeces, a reduction in the time of first bowel movements, without significant side effects; not all included studies instead have found a significant decreasing in postoperative morbidity and LOS. Furthermore, some studies results demonstrated a significant heterogeneity. A guideline of 2013, which provides practice indications for patients undergoing RC management, recommends the use of chewing gum in clinical practice immediately after surgery (Cerantola et al., 2013).

### Conclusions

The use of chewing gum seems to be a safe, simple and inexpensive way to enhance recovery of bowel function, stimulating intestinal motility, although it is not appropriate for all patients and it is probably still a little known procedure. It is necessary to conduct RCTs with an adequate methodological rigour to document the benefits and risks of its use in patients undergoing RC. However, it is possible recommending to health care professionals the administration of chewing gum in patients after RC, considering his appreciation and monitoring the effectiveness on intestinal function, upon the recognition of possible patient's conditions that might contraindicate its use.

P16

Room 5

## Choice and insertion of the urinary catheter: Comparison of urology vs internal medicine department nurses

Balin L.

Medical Center of The Galilee, Karmiel, Israel

### Introduction & Objectives

At one time or another, almost every hospital department receives patients with a permanent or temporary catheter. Sometimes the patient arrives from home already catheterized, and sometimes the decision to catheterize the patient is made in the Emergency Department. Nurses have a substantial role in the decision and process of urinary catheterization. In order for the nurse to make the proper decision concerning the catheter type and the insertion process, he/she must have the necessary knowledge and experience. According to research studies that have been conducted, it has been found that nurses are not aware of all the factors that must be considered in the choice of catheter that is correct for each individual patient. We wanted to know whether there is a relationship between the type of department in which the nurse works and his/her level of knowledge on the topic of choosing and inserting a catheter, after consideration of variables such as nurse's age, schooling, number of weekly work hours and professional seniority. We also examined the need for establishing such a training course on catheterization for nurses, and the importance of the nurse's experience in the process of catheter insertion and care. The ultimate aim of this study was to contribute to the establishment of a unique training programme for nurses in catheter insertion and care.

### Material & Methods

This was a cross-sectional study, with 167 nurses from various departments of Galilee Medical Center, Nahariya, Israel, and 26 nurses from urology departments in three other Israeli hospital completed questionnaires on knowledge and comprehension, composed specifically for this study.

### Results

The study found a statistically significant difference in knowledge of the urinary catheter insertion and care between nurses working in a urology department vs. nurses from other medical departments. The former group had a significantly higher level of knowledge than did the latter group. A significant correlation was also found between the number of weekly work hours and level of knowledge. About 80% of nurses do not request guidance on catheter insertion for a new patient. Results showed a significant correlation between the type of department and the habitual practice of meatal care for a catheterized patient. No correlation was found between age or seniority and level of knowledge.

### Conclusions

The findings of this study led to the establishment of a training programme, and a continuation of the same research study among nurses in another framework – Kupat Holim, the largest HMO in Israel.



P17

Room 5

## The prevalence and risk factors of urinary incontinence and overactive bladder in Japanese women

Ninomiya S.<sup>1</sup>, Naito K.<sup>2</sup>, Nakanishi K.<sup>3</sup>, Okayama H.<sup>3</sup>

1Kyoto University, Human Health Science, Graduate School of Medicine, Kyoto, Japan, 2Biwako Gakuin University, Dept. of Childhood Care, Faculty of Education Welfare, Higashi-Omi, Japan, 3Shiga University of Medical Science, Dept. of Nursing, Otsu, Japan

### Introduction & Objectives

In women, the prevalence of stress urinary incontinence (SUI) and overactive bladder (OAB) are high. However, in Japan, there is no large scale epidemiological survey of lower urinary tract symptoms (LUTS) including women under age 40. Additionally, the risk factors of LUTS in Japanese women are not clear. The aim of this study was to estimate the prevalence and risk factors of SUI and OAB in Japanese women.

### Material & Methods

A population-based, cross-sectional internet-based survey was conducted in Japan. Five thousand women aged 20-79 years were selected to answer demographic questionnaires, the Japanese version of the International Consultation on Incontinence Questionnaire-Short Form, and the Overactive Bladder Symptom Score (OABSS) for the previous month. Descriptive statistics were used to evaluate the prevalence of urinary incontinence and OAB. Logistic regression analysis was performed to determine risk factors associated with SUI and OAB. This study was conducted in accordance with the Declaration of Helsinki.

### Results

The responses from 4,804 women were analysed. The overall prevalence of SUI was 16.7% (included SUI, 13.0%; mixed urinary incontinence, 3.7%). The overall prevalence of OAB diagnosed by the OABSS was 8.1%. The rates of both SUI and OAB were increased with age (Table 1). Risk factors for the development of SUI were age, BMI  $\geq 25$ , childbirth, and constipation. Risk factors for the development of OAB were age, BMI  $\geq 25$ , and constipation (Table 2).

Table 1. The prevalence of urinary incontinence and overactive bladder by age group in 4804 Japanese women

Age group	20-29	30-39	40-49	50-59	60-69	70-79
	n=487	n=1344	n=1571	n=936	n=391	n=75
Urinary incontinence, %						
Stress urinary incontinence	7.2	9.9	13.7	17.7	16.4	14.7
Urge urinary incontinence	1.4	2.1	3.9	4.8	8.7	10.7
Mixed urinary incontinence	1.6	1.9	3.9	5.9	5.1	9.3
Other urinary incontinence	1.8	1.0	0.7	1.1	0.3	0.0
Overactive bladder (OAB), %						
OAB diagnosed by the OABSS	6.8	6.5	8.3	9.5	10.0	12.0
Daytime frequency, $\geq 8$ /day	30.2	35.0	39.6	42.4	46.5	44.0
Nocturia, $\geq 1$ /day	19.3	25.2	31.3	38.0	52.9	62.7
Urinary urgency, $\geq 1$ /week	27.7	24.0	29.8	33.1	34.5	40.0
OABSS; Overactive Bladder Symptom Score.						

Table 2. Logistic regression analysis of risk factors associated with SUI or OAB in unadjusted and adjusted models

	Model 1		Model2	
	P-value	Odds ratio (95% CI)	P-value	Odds ratio (95% CI)
Stress urinary incontinence				
Age (+1)	< 0.001	1.060 (1.046-1.064)	< 0.001	1.051 (1.023-1.080)
BMI ≥ 25	< 0.001	2.181 (1.703-2.792)	< 0.001	2.460 (1.882-3.216)
Parity ≥ 1	< 0.001	3.362 (2.777-4.080)	< 0.001	2.752 (2.239-3.383)
Constipation	< 0.001	1.260 (1.056-1.502)	< 0.001	1.512 (1.247-1.832)
Overactive bladder				
Age (+1)	< 0.001	1.039 (1.028-1.049)	< 0.001	1.041 (1.030-1.052)
BMI ≥ 25	< 0.001	2.287 (1.671-3.130)	< 0.001	2.411 (1.746-3.330)
Parity ≥ 1	0.446	1.091 (0.872-1.363)		
Constipation	< 0.001	1.607 (1.282-2.015)	< 0.001	1.782 (1.411-2.251)
Model 1: Unadjusted.				
Model 2: Stress urinary incontinence, adjusted for age, BMI, parity ≥ 1, and constipation Overactive bladder; adjusted for age, BMI, and constipation.				
BMI; body mass index.				

## Conclusions

SUI and OAB are highly prevalent in Japanese women. Aging, being overweight, and experiencing constipation were risk factors of both SUI and OAB. Although childbirth was risk factor of SUI, it was not one of OAB.

P18

Room 5

## A retrospective study comparing TRUS biopsy infection rates of men attending a one stop Rapid Access Prostate Clinic in an Irish hospital in 2015

O'Brien M., Bowen S., Casey L., Conroy T.

St. James's Hospital, Dept. of Urology, Dublin, Ireland

### Introduction & Objectives

Infections following trans-rectal ultrasound (TRUS)-guided prostate biopsies are increasing in incidence, specifically those due to antimicrobial resistant bacteria (Williamson et al 2013). The national policy on the prevention and management of infection post TRUS biopsy(2014) was published by the National Cancer Control Programme (NCCP) to help prevent infection following TRUS biopsy. This included advice on the optimum antimicrobial prophylaxis strategy. Traditionally, all patients undergoing TRUS biopsy in St James's Hospital were administered Amikacin 1 gram IV 30 minutes pre biopsy and Taravid 500mg P.O. pre and post biopsy. On July 1st 2015 our policy on antimicrobial prophylaxis changed as per the NCCP recommendations. Patients are now prescribed Ciprofloxacin 750mg 1 hour pre biopsy and a repeated dose 12 hours post biopsy. Men with risk factors for antimicrobial resistant Enterobacteriaceae revert to Amikacin IV pre biopsy.

### Aim:

To retrospectively review the infection & complication rates from the first 6 months of 2015 when patients received the traditional antimicrobial prophylaxis protocol and compare them to infection rates during the second 6 months of 2015 when patients received the new protocol as recommended by the NCCP.

### Material & Methods

Patients attending the RAPC for TRUS biopsy completed a questionnaire detailing patient demographics, time scales of additional side effects-if any-namely; pain, blood in urine, stool or semen. Of those who reported infection, we contacted the medical facility they attended to ascertain the nature of infection. Patient satisfaction was also surveyed.

### Results

Figures for the entire year will not be correlated until the year end. 157 men had a TRUS biopsy in the first 6 months and were included in the study. 90 questionnaires were returned to date, 3 of whom reported an infection. 2 were treated for urinary tract infection by their GP with oral antibiotics, 1 was admitted to hospital locally for IV antibiotics. Men's experiences related to side effects varied from none at all to 6 weeks. To date; 100% were satisfied with the service. Figures from the second 6 months should provide interesting comparative information.

### Conclusions

Comparative data of infection rates for the second 6 months for 2015 are incomplete at the time of submission but we anticipate this study will contribute to the existing data as to the optimum strategy to prevent and manage infection post TRUS Biopsy.

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Industry



EAUN Industry Session by WELLSPECT HEALTHCARE

12.45 - 13.45 E-learning in healthcare: Does it make any difference?

Room 5

Chair: B.T. Jensen, Århus (DK)

Aims and objectives of this session

Can we use digital solutions in healthcare and whom does it benefit?  
This session provided by Wellspect offers a brought perspective on different approaches and consequences of implementing digital solutions in practice.  
Do all people need a notebook or a smart-phone in the near future to assure appropriate care and education?  
Can we reduce unmet needs among our patients?  
Can we improve knowledge, quality of care and communication with the patients? And what's in it for healthcare professionals?  
The faculty of this session will touch base on the variety of questions and possibilities digital solutions add to healthcare.

12.45 - 12.50 Welcome and introduction of STOP UTI App  
S. Vahr Lauridsen, Copenhagen (DK)

12.50 - 13.15 The young digital generation: As patients and healthcare workers  
M. Rasmussen, Holte (DK)

13.15 - 13.40 How to use digital solutions and tools in healthcare: What to contemplate, is it effective and to whom is it beneficial?  
D. Stricker, Århus (DK)

13.40 - 13.45 Questions

Panel: B.T. Jensen, Århus (DK)  
M. Rasmussen, Holte (DK)  
D. Stricker, Århus (DK)  
S. Vahr Lauridsen, Copenhagen (DK)

EAUN Industry Session by AMGEN

17.15 - 18.15 Back to bone: Optimising patient outcomes in metastatic bone disease

Room 5

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

Aims and objectives of this session

- To consider and discuss the impact of bone metastases in urological cancer, with a focus on the changing treatment approaches in Metastatic Castration Resistant Prostate Cancer (mCRPC) and the subsequent practical considerations in decision making, in a clinical consultation
- To provide an overview of symptoms and their causes in patients with bone metastases
- To provide an overview of symptom assessment tools and maximising their use in the clinical setting to optimise quality of life

17.15 - 17.20 Introduction

L. Drudge-Coates, London (GB)

17.20 - 17.45 The shifting prostate cancer treatment paradigm: Implications of increased patient survival

B. Tombal, Brussels (BE)

17.45 - 18.10 Optimising the patient clinical consultation: Symptom assessment tools

B. Quinn, London (GB)

18.10 - 18.15 Questions

Sponsored by AMGEN

EAUN Industry Session by BAYER

08.00 - 09.00    The pivotal role of the nurse in managing mCRPC: Collaborating to improve patient care

Room 5

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

08.00 - 08.10    The impact of mCRPC and the evolving role of the specialist nurse  
L. Drudge-Coates, London (GB)

08.10 - 08.35    The patient journey in mCRPC: Key touch points for nurses  
B. Tombal, Brussels (BE)  
C. Remacle, Brussels (BE)

08.35 - 08.50    Strategies for effective patient education and adherence  
M. Nematollahi, Ontario (CA)

08.50 - 09.00    Questions from the floor

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EAUN Poster Presentation - AMGEN

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# Back to bone: optimising patient outcomes in metastatic bone disease

**Saturday 12 March 2016, 17.15–18.15**

**Room 5, Messe München, Munich, Germany**

## Programme

**Chair: Lawrence Drudge-Coates, UK**

### Introduction

**Lawrence Drudge-Coates, UK**

**The shifting prostate cancer treatment paradigm: implications of increased patient survival**

**Bertrand Tombal, Belgium**

**Optimising the patient clinical consultation: symptom assessment tools**

**Barry Quinn, UK**

**Q&A**



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## INVITATION

# The pivotal role of the nurse in managing mCRPC: collaborating to improve patient care

Sunday 13 March 2016 at 08:00–09:00 am

Room 5 of the ICM

**Chair** Lawrence Drudge-Coates (UK)

**Faculty** Bertrand Tombal (Belgium), Christine Remacle (Belgium), and Massey Nematollahi (Canada)

Visit the Bayer Pharma AG booth (A64) in Hall B1 of the Messe München



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Welcome to our symposium at EAUN 2016 in Munich, Germany

## e-learning in healthcare – does it make any difference?

*Chairman: Bente Thoft Jensen, Senior Researcher, Ph.D-MPH  
Room 5, March 12, 2016, 12:45–13:45*

**12:45 Welcome and introduction of STOP UTI App**

*Susanne Vahr Lauridsen, MEd, PhD stud, Rigshospitalet, Copenhagen*

**12:50 The young digital generation – as patients and healthcare workers**

*Mie Merete Rasmussen, Educational Consultant, The Capital Region of Denmark,  
Centre for Human Resources, Section for training skills and Competence development*

**13:15 How to use digital solutions and tools in healthcare.**

**What to contemplate? Is it effective and to whom is it beneficial?**

*Dorthe Stricker, Crowdfunding Manager, CrowdsWhoCare and Owner,  
New Media Mob – Social Media and Content strategies*

**13:40 Questions**



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HEALTHCARE



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