

Nursing management of prostate cancer in Italy

EAUN board member presents nursing approach at BAUN congress



Stefano Terzoni
EAUN Board member
Tutor Nurse
San Paolo Bachelor
School of Nursing
Milan (IT)

s.terzoni@eaun.org

The Italian experience

Italy's public healthcare system, founded in 1978, has no mandatory insurance for citizens. Prostate cancer is managed in both public and private hospitals and apart from urology and oncology units in general-purpose hospitals, several centres dedicated to cancer patients can be found in the country.

According to records of the Italian National Institute for Statistics (ISTAT), there have been more than 42,000 hospital discharges in 2010 for activities related to prostate cancer management in Italy, with the northern regions accounting for about 50% of this figure.



The author during his talk on prostate management trends at the BAUN congress

Urological nursing education

A clear distinction exists between the activities performed by doctors and nurse with the former responsible for screening and diagnosing the disease, and prescribing appropriate medical or surgical therapies. Italian nurses do not perform activities such as prostate biopsy, compared with their mainland European colleagues (such as nurses in the UK), and are also prohibited by Italian law to prescribe drugs.

Italian nurses are responsible for perioperative nursing and are involved in pain assessment and rehabilitation following prostate cancer therapies. Treatments include pelvic floor muscle exercises, functional electrical stimulation, biofeedback and extracorporeal magnetic innervation to help patients recover after surgery (e.g. urinary incontinence after radical prostatectomy). They also train patients to perform intermittent catheterisation and manage their urinary diversions.

Research is another key activity in Italian nursing practice, such as conducting comparative studies on rehabilitation treatments and validating clinical nursing scales which are used in assessing the characteristics of the surgical site after operations. Currently, one of my colleagues is collaborating with the EAUN guidelines group regarding the update of recommendations in managing urinary incontinence.

In Italy, academic nursing education was introduced in the early '90s and later underwent further upgrading with bachelor programmes (180 ECTS), master of science courses (120 ECTS), and doctorates (180 ECTS). Moreover, post-bachelor specialised urology courses are being offered in some major universities particularly in pelvic floor rehabilitation. Such courses typically include 24 hours per week of theoretical classes and 60% of practical training, for a total of approximately 300 hours (there are variations in actual hours since programmes differ).

Trends

There are few academic positions for nurses in Italy, but there is a good collaboration between the clinical and academic fields, with several bachelor and post-bachelor students writing their final dissertations on urological nursing topics

Another trend is that more urology nurses are involved in projects such as "Slow Medicine" through professional associations like the Italian Association of Urology Nurses, and the National Federation of Nursing Colleges. Such projects involve both physicians and nurses and are aimed at

reviewing healthcare procedures in various fields, including urology, based upon criteria of clinical evidence.

To reiterate, Italian nurses are closely involved in rehabilitation more than in other healthcare pathways when it comes to patients with prostate cancer. Although urological nursing research is still developing, recent trends are promising. Moreover, there is a need to strengthen evidence-based practice, which require the active participation of all nurse and the crucial role of professional associations.

Another important point are future strategies to improve post-bachelor education, particularly addressing the need for a standardised programme for urological nurses, and which can be implemented at the national level. This issue could be an interesting discussion point in the session entitled "What is Nursing Urology" during the annual EAUN meeting in Stockholm in April 2014. This topic can be discussed from a European point of view, so don't miss the opportunity of participating in this important debate! Stefano Terzoni, EAUN board member, during the EAUN lecture.

Key topics in uro-oncology such as radiation therapy, use of intermittent hormones to testicular cancer were tackled in the annual conference and exhibit of the British Association of Urological Nurses (BAUN) held last November 4 and 5 in Harrogate (UK).

Philippa Aslet, BAUN President, opened the two-day conference which focused on prostate cancer treatment during the first plenary sessions. Among the issues discussed were modernising diagnostic procedures, targeted HiFu, effects and treatment options of pelvic radiation, to name a few. Debates, poster viewings and a symposium were also part of the programme.

The European Association of Urology Nurses (EAUN) was well represented during the conference with Lawrence Drudge-Coates, uro-oncology clinical nurse specialist and lecturer at Kings College Hospital NHS Foundation Trust, speaking on the topic "Optimising the suspected prostate cancer referral pathway - The benefits of a nurse-led approach." The author also participated in the conference with the Eileen O' Hagan Lecture "Prostate Cancer: A European Nursing Approach," presenting his views on prostate cancer management trends in Italy.

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Preliminary Programme

Saturday, 12 April 2014

09.00	EAUN Opening
09.15	Lecture Presentation of the EAUN Guidelines for writing guidelines V. Geng, Lobbach (DE)
09.15	International panel discussion How is urology nursing evolving in European perspective
09.45	State-of-the-art lecture The Prostate Cancer Education Project (PrEP)
10.30	Workshop Nursing in robotics
10.30	Workshop Bladder dysfunction: From assessment to treatment Chair: K. Fitzpatrick, Dublin (IE)
11.15	Nursing Research Competition Chair: R. Pieters, Ghent (BE)
11.30	Workshop Testicular cancer: Hitting below the belt
12.30	Workshop t.b.c.
12.45	Lecture Renal cell carcinoma - an update on the SURTIME study of the EORTC A. Bex, Amsterdam (NL)

Sunday, 13 April 2014

13.30	EAU-ESU Course - 1 Hydronephrosis
13.45	Poster viewing
14.15	Poster abstract session
16.00	Workshop Penile cancer
16.00	Sponsored session
17.00	EAU Get-together
09.00	Workshop How to close the gap between research and practice Chair: S. Terzoni, Milan (IT)
09.00	Workshop Update on bladder cancer management Chair: K. Fitzpatrick, Dublin (IE)
10.00	State-of-the-art lecture Men's health in the European union, for better or for worse?
10.00	Inside the body - surgery in motion (videos)
11.00	Lecture Patient involvement in urological care
11.30	Poster viewing
12.00	Poster abstract session
12.00	Lecture Participation in a research project: The patient's perspective
12.30	Workshop Urological cancer as a chronic disease - early palliative care

Monday, 14 April 2014

13.45	Sponsored sessions
14.45	Intermittent catheterisation - how does this impact everyday life and sexuality
15.45	Market Place Session Pain in urological patients
16.15	Workshop The nursing role in new cancer developments
09.00	EAUN Workshop Nursing solutions in difficult cases
10.15	EAU-ESU Course - 2 Lithotripsy for OR nurses
13.15	General assembly Chair: K. Fitzpatrick, Dublin (IE)
13.45	EAUN Award session
14.00	Workshop Journal club - making sense of clinical articles R. Leaver, London (GB) J.T. Marley, Ulster (GB)
15.00	State-of-the-art lecture Chronic disease in the elderly
15.30	State-of-the-art lecture Fournier's gangrene

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Sue Stanbridge
Clinical Nurse
Specialist
North Shore Hospital
Waitemata District
Health Board
Auckland (NZ)

sue.stanbridge@
waitematahb.govt.nz

Sometimes small initiatives can make a big difference to patient care, and yet as a topic they may seem too 'simple' for presentations at a nursing conference.

The following poster titled "New prostate cancer diagnosis: Improving timelines of communication with patient's General Practitioner," was not only presented but also won first prize in the Nursing and Allied Health Poster Category at the 2013 Prostate Cancer World Congress. I believe this award recognised both the ability of this small, quality initiative to positively impact on patient care, as well as the ease with which it could be implemented at other urology centres.

As you read this column, you may recall small projects you have undertaken to improve the quality of care in your workplace. Did you consider sharing them with your colleagues either through columns like this one, presentation at conferences or publication in a nursing journal?

The more we share our initiatives with one another, the greater the opportunity we each have to contribute to the overall quality of care for urology patients. This is particularly true if you have taken the time to evaluate their impact on outcomes.

Support information

Receiving a diagnosis of prostate cancer can have a

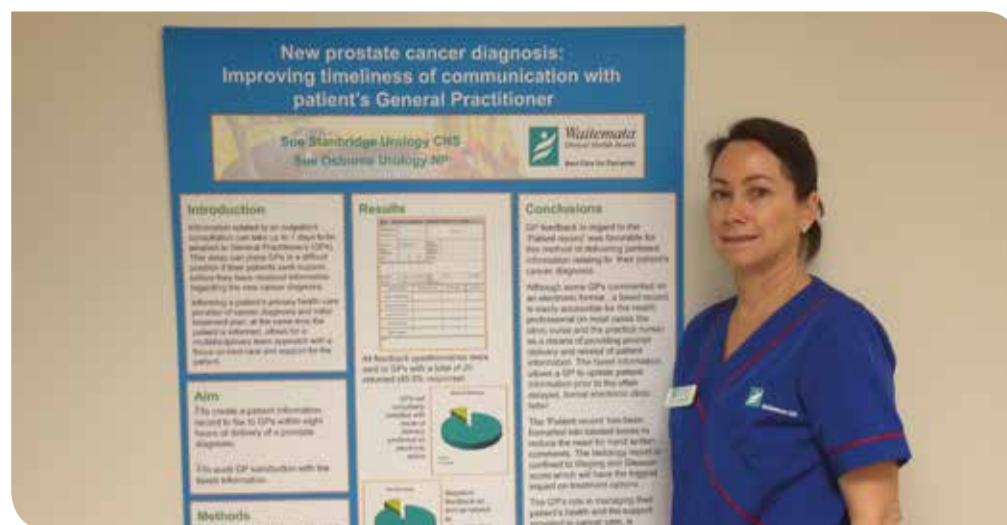
detrimental effect on a patient's psychological, physical and spiritual well-being. Patients who undergo a prostate biopsy to investigate an elevated prostate specific antigen (PSA) or abnormal digital rectal examination (DRE) within our District Health Board (DHB) return to the outpatient clinic approximately two weeks after their biopsy for their histology report.

Although support and information is given by the urologist and /or senior nursing staff during this appointment, a patient's understanding and uptake of information may be limited due to the stress of a confirmed cancer diagnosis. Patients may seek further assurance and clarification after the clinic appointment from their General Practitioner (GP), with whom they may already have an established therapeutic relationship. It makes sense therefore, to inform the GP of their patient's diagnosis and any discussed treatment plans in a timely manner, so they can provide appropriate support and information as part of a multidisciplinary model of care.

Timely notification

The motivation for an initiative to improve timelines of communication between our DHB and a patient's primary health care provider came from a complaint from a GP. The GP was unaware of his patient's positive prostate cancer diagnosis until contacted by his patient. He felt he was disadvantaged in his ability to provide appropriate support to his patient as he was unaware of the prostate cancer grading and staging. He was also not aware of the treatment options discussed or recommended to his patient.

The barrier to achieving timely notification was the heavy workload of the medical transcriptionists, preventing them from typing correspondence in a prompt manner. At the time of the complaint, letters were taking up to two weeks to be signed off and emailed to the patient's GP. This has subsequently improved with increased transcription staffing levels and improved processes but the average turnaround time is still around seven days.



The author posing by her prize winning poster at the 2013 Prostate Cancer World Congress

When the complaint was received the urology nurses acknowledged the anxiety caused by the delayed correspondence and the need to improve the timeliness of the communication of a cancer diagnosis to patients GP. The nurses discussed options to address the issues with members of the urology team and a decision was made to develop a single sheet patient record which could be easily completed and forwarded to the GP on the same day as the patient's clinic appointment.

The record would give the GP focussed information regarding their patient's diagnosis, formatted into labelled boxes to reduce the need for hand-written comments. The information would include the date of diagnosis, method of diagnosis, PSA, tumour stage, Gleason score, planned radiological investigations (if any) and treatment options. The treatment options would be rated by the urology health professional as either 'preferred,' 'potential' or 'unsuitable.'

The new process was implemented early in 2013 with clinic nurses ensuring the completed patient records were faxed through within hours of the patient consultation. It had been decided that the personalised patient record would be faxed to the GP as this mode of delivery was both prompt and practical. It was also anticipated that the fax mode of delivery would ensure the notification was not delayed in a queue of unread emails in the GPs 'inbox.'

Feedback questionnaire

A GP feedback questionnaire was then designed and used to audit the perceptions of GPs who received the faxed patient records. Over a period of five months questionnaires were faxed to all of the GPs who had previously received a faxed patient record.

A total of 44 questionnaires were sent with 20 returned. This was just under a 50% response rate. Two main questions were asked: Was receiving the

information by fax satisfactory? Was the format of 'Patient Record' satisfactory? GPs were also asked to comment on whether the receipt of the record resulted in any action on their part and if there was any further information they would have like included.

Results revealed that 93% of GP's were satisfied with a faxed mode of delivery, while 7% would have preferred electronic format. 86% were satisfied with the format of the record, while those that commented on improving the format requested an electronic version. 79% of GPs found the information provided was adequate.

Comments from GPs to improve information included providing a full histology report, more advice for the GP and legible handwriting! Fifty percent of the GP's indicated that receipt of the patient record prompted action on their part, including contacting their patients and updating the patient's charts. After reviewing the audit findings no modifications were made to the original patient record.

Patient record

The patient record is viewed as a simple tool that efficiently provides essential information to the GP prior to the more detailed clinic letter arriving. The tick box format limits the need for handwriting although the health care professional completing the record is required to write their name and title on the record for reference.

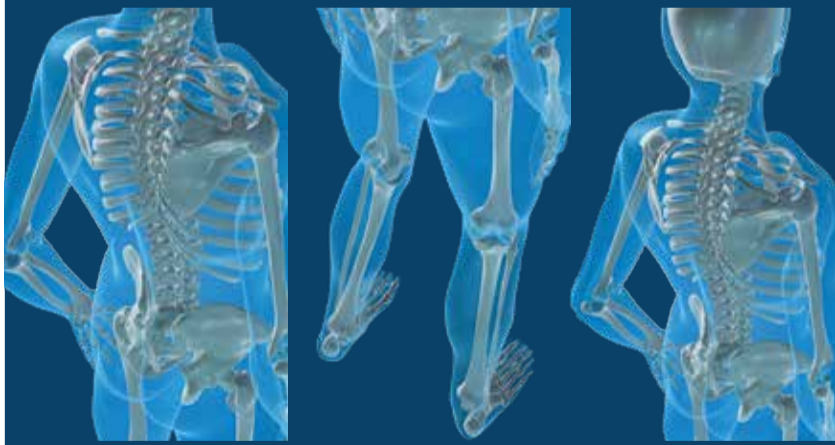
This change to improve inter-professional communication regarding a patient with newly diagnosed cancer recognises the GP's role in managing their patient's health. The GP's positive response in receiving this information and the success of this patient record has led to an extension of its use to 'potential' bladder and renal cancer patients, and where patients have been informed of the likely diagnosis either at the time of cystoscopy or following radiological imaging.

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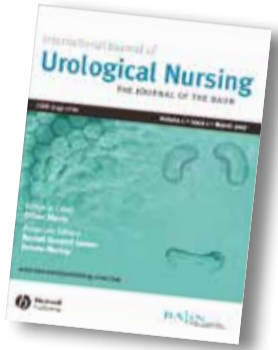
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Bente Thoft Jensen,
MPH-Ph.D.-Stud
Urology Department /
Centre of Voiding
Dysfunction
Århus University
Hospital
Århus (DK)

b.thoft@eaun.org

Co-authors: The Staff of Department of Urology, Centre of Voiding Dysfunction, Århus University Hospital

Bladder pain syndrome (BPS) was addressed in the last EAUN Meeting but little is known in clinical practice. The staff at The Centre of Voiding Dysfunction, Århus University Hospital (DK) set out to share their experience with Danish as well as European colleagues since this treatment modality is rather underestimated.

During the past years, we have been challenged by this group of patients at the Department of Urology at Århus University Hospital. Through this practical experience treating these patients, we are aware that good and effective treatment options are limited and there is much potential for improvement.

With this article the staff aims to call on attention to one alternative treatment option for BPS: The EMDA treatment. In EMDA treatment (Electromotive Drug Administration) lidocaine, adrenaline and Solu-Medrol are installed into the bladder and led into the bladder tissue through low voltage. The treatment will provide alleviation of the symptoms and perhaps even a significant reduction of bladder pains and thus a great improvement in the quality of life.

The aim with the treatment is to reduce:

1. The micturation frequency
2. The urge – the pressure on the bladder
3. Nocturnal micturation

Patient base

Since 2007, 37 patients have been referred to EMDA treatment. Of these only four were men. The common experience "in the first meeting with the patients" is that they are frustrated and have lost confidence and hope. In contrast, the possibility for treatment or reduced symptoms often represents a new hope for them.

Currently, there are nine patients in total who are treated regularly with EMDA treatment. Of these seven are women, which is in accordance with the fact that the condition is between five and ten times more frequent with women as with men. The age range between 29-80 years.

Patients referred to EMDA treatment are in need of highly specialised care and they usually reside in the western part of Denmark, which represents a population of approximately two million people. They have often had turbulent courses of clinical investigation; many had undergone all sorts of antibiotic treatment - and failed treatment attempts before they are referred to our department for evaluation and second opinion. Some patients had even been referred to psychologists to address the intractable pains.

In previous evaluations the urine has been tested with a dipstick test and urine culture several times. However, these patients need a more advanced assessment. At our centre, the patients are offered cystoscopy under anaesthesia. Additionally, the evaluation includes filling of the bladder and a biopsy of the detrusor muscle. In some cases, mast cells are found in the biopsy indicating interstitial cystitis.

In 10% of the cases, mucosal ulcers are found. This is called Hunner's ulcer. These ulcers coagulate and some patients will experience a substantial alleviation of their symptoms during the filling phase (mostly pain) when the bladder is expanded and the urine gets in contact with the "ulcer" in the mucosa.

Some will experience an improvement of their symptoms from bladder extension and in case of acceptable outcomes the procedure will be performed

under anaesthesia every 6 months. However, this treatment involves a risk of bladder rupture. Alternatively, it is also possible to try immunosuppressive treatment as a supplement to EMDA treatment. The final solution for these patients is a urostomy, although seldom.

Procedure

Before starting the EMDA treatment, a urine culture is required and is usually done by a GP. Furthermore, the patients must have functional bladder capacities of a minimum of 250 ml in order to be able to contain the drugs as well as the urine produced during the treatment. Therefore, the patients are advised not to drink more than two glasses of water before treatment and avoid any diuretic medication before treatment. The procedure will last approximately two hours, and they will be confined to their beds. Patients may need painkillers in the form of tablets Pamol, Burana, Tradolan or sup. MAP (morphine, atropine, papaverin) before, during the procedure or after treatment.

All women who have passed their menopause, will be treated with Vagifem.

"..Patient experience: EMDA treatment makes a big difference and can improve the quality of life..."

Currently the standard procedure includes three treatments within a four week's interval. The initialisation phase will be followed up by a consultation with an urologist approximately four weeks after the third treatment, where an individual consultation and a care plan will be discussed. However, in case of no side-effects or immediate improvement of the symptoms, EMDA treatment will continue without interruptions every fourth week under consultation with the urologist.

The majority of the patients, who will benefit from the EMDA treatment, will experience a relative "modest" reduction of the symptoms after the first rounds of treatment and the effects will usually appear gradually.

If the patient experiences continuous improvement the treatment interval will gradually be expanded beginning with a 3-4 days longer interval. The nurse will adjust expectations and side-effects with the patient. Patient reported outcome differs significantly and currently there is no clear recommendation on how quickly we can advance the treatment. Many patients fear that the bladder pains will return, when the intervals are expanded and therefore mutual expectations must be discussed before the interval will be expanded.

In patients treated according to standard procedure efficacy is usually seen after four to nine weeks. However, it is our experience that a few of the patients will experience an effect up to more than 12 to 26 weeks. In case of deterioration of symptoms, the interval may be reduced to four weeks again; the patient and the nurse will discuss the possibility to adjust the treatment in cooperation with the urologist. In absence of efficacy some patients quit the treatment fairly soon after initialization due to pain related to the catheter.

During treatment

The treatment is performed by means of using "an electrical instrument" that will lead low voltage into the bladder. The voltage will press the medication into the bladder tissue during treatment as opposed to GAG treatments where the drugs will only float in the bladder. The instrument is made in Italy and was originally bought to locally anaesthetise the bladder in connections with cystoscopy examinations in the OR.

The drugs are instilled through a special catheter (Ch. 16) which has a current-carrying coil installed. At the other end of the catheter, an electrode is attached which will be connected to the EMDA instrument.

Two flat electrode pads are placed on the skin over the bladder with a two-centimetre distance between them. The pads have been moistened with NaCl and coated with a thick layer of isolating electrode gel with the intention to avoid skin complications. Every pad has an electrode which will be attached to the EMDA instrument.

The treatment itself falls into two parts. The first part lasts 20 minutes and here the bladder is anaesthetised with 150 ml lidocaine 2% and 1.5 ml adrenalin 1%. Then the urine and the medication are drained from the bladder, and the bladder is now sedated. The second part represents the EMDA treatment itself, where lidocaine and adrenaline are instilled mixed with 500 mg Solu-Medrol. The mixture will stay in the bladder and the dwelling time is approximately 25 minutes. Solu-Medrol works locally in the bladder, less than 10% will go into the blood stream.

Catheter and pads are removed and the "contaminated" skin is cleaned with water. The skin may be slightly reddened but this will usually disappear on its own. Following the treatment the

patients will often feel urgency and will have more frequent micturition.

The general impression (qualitative statements from the patients) is that the patients who have received regular EMDA treatment in our department report a much better quality of life and new energy on daily basis. Unfortunately, they are not completely symptom-free between treatments and mostly still cope with painkillers.

Apart from the clinical markers it is a positive professional experience that EMDA treatment provides a relative difference and can improve the quality of life to a selected group of patients. Clinical studies investigating health related quality of life and clinical outcome will add to the body of evidence of this under-reported group of patients.

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