EAUN: Networking beyond borders

High regard for EAUN projects from European and overseas participants

At the EAUN meetings nurses from across Europe gather to discuss and exchange views on a wide range of issues not only related to clinical practice and specialised healthcare but also professional development.

In this article, we collected the views and assessment of some of the EAUN meeting participants. Their opinions and insights about the organisation, programme, activities and future prospects of urological nursing are reflected in their comments, providing us with pointers on how to further refine and improve future EAUN activities.

A multi-faceted organisation

I am a nurse practitioner working for almost 25 years at a urology department in the Netherlands and I have seen the growth of the EAUN organisation. In the early years, I once attended the annual congress when it was still a one-day programme with only about 100 nurses in attendance.

Hanny Cobussen-Boekhorst
Nurse Practitioner
Continence Care
Dept of Urology
UMC St Radboud
Hospital
Nijmegen (NL)
j.cobussen-boekhorst@uro.umcn.nl

Today, the EAUN meeting is a three-day event with parallel sessions, hands-on training courses, medical lectures and workshops. Thus, there is a wide range of topics to choose from depending on a participant's interests. And for Dutch nurses the congress is accredited, which is important. The social programme included a Nurses' Evening which proved to be really fun this year, including dancing at the end!! All these benefits for a reasonable fee!

However, these benefits and activities are only one of the many goals and services provided by the EAUN. Over the years the EAUN also develops and publishes guidelines, which were practice-based before, but are now evidence-based for the last four years. As of now, five of these guidelines were already published, and I am proud that I have contributed in preparing three of these guidelines.

As an international organisation, the EAUN is involved and collaborates with many other nurses groups around the world. I am impressed not only by the efficient and professional organisation of the congress but also the goal of the EAUN to provide an effective platform for a research project, including granting a prize to the best project.

The EAUN also provides group membership for national nurse organisations. In the Netherlands, the association of urology nurses and the association of continence nurses have this membership, which can boost interest on their organisation and highlight their activities. The urology nurse organisation has translated the EAUN guidelines for indwelling catheters, and the continence nurse organisation will translate the intermittent catheterisation guideline.

I expect the EAUN to grow stronger but they would need input and support from all of us, since we the members are actually the core of the organisation. I also find it inspiring to work with colleagues from other countries since we have a lot in common, and we can also learn a lot from each other!

Beyond borders

The EAUN congress offers a unique chance for European nurses to discuss current topics with their colleagues from other countries, and personally I find it interesting to discover that the interests, for example, of nurses in Denmark are similar to the interests of nurses from other European countries.

Networking among nurses across borders also begins in an international meeting like the EAUN congress which provides not only timely updates on urological diseases, but also presenting the latest services of medical companies. It helps that the medical congress as well as the nurse's congress is held at the same time and place, enabling both nurses and doctors to discuss urology and learn practical insights we can use in our own practice.

Elisabeth Lippert
Head Nurse
Urology Dept
Rigshospitalet
Copenhagen (DK)
elippert@rh.dk

In 2008 in Milan about 250 nurses from all over Europe participated, and this year that number has increased to more than 400 nurses. The EAUN has organised very interesting sessions such as the EAUN Market Place Workshop, which made possible intensive discussions on nursing issues that affect all nurses across Europe.

Presentations during the Difficult Cases session were also interesting, and I would strongly recommend that nurses contribute more actively to this session. Definitely, the EAUN has done much to bring a higher quality to the annual EAUN meeting, which contributes to the development of urological nursing in Europe.

Urological nursing organisation

Urological nursing organisations are a relatively recent development, with the Society of Urological Nurses & Associates (SUNA) being among the pioneers when it was created in the late 1960s. In the mid-1990s, the British Association of Urological Nurses and Australia & New Zealand Urological Nurses Society (ANZUNS) were established, and followed in 2000 by the European Association of Urological Nurses (EAUN).

Today, there are at least 22 urological nursing organisations worldwide, and most of these groups have well established links with their urological societies and benefit from these links such as support for annual scientific meetings.

Helen R. Crowe, NP, APRN
Epworth Hospitals
Dept. of Urology
Richmond, Vic. (AU)
helenrcrowe@gmail.com

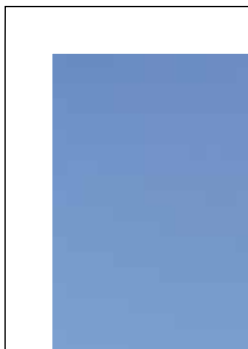
One of the challenges for nurses has been to forge active links between societies. Ms. Bente Thoft Jensen, in her capacity as EAUN chairperson, attended the ANZUNS meeting in Australia in 2010 and this visit raised the EAUN's profile among ANZUNS members. Several ANZUNS members have since joined EAUN and travelled to Europe to attend the annual meetings. These meetings are well-run and cover diverse topics.

EAUN is admired by other nursing organisations as it has been highly productive in its' relatively brief history with the establishment of the Fellowship Programme and the development of nursing guidelines in several languages, to mention some of its more high profile achievements. Distance aside (!) the EAUN is a very valuable urological nursing organisation.

Excellent conference

As part of the Global Alliance of Urology Nurses representing the Society of Urologic Nurses and Associates, I met representatives from the EAUN around 2008 as we began to forge relationships between our organisations for networking and knowledge sharing. I have been privileged to watch the EAUN grow into a thriving dynamic organisation. The organisation has strived to create an excellent conference for urology nurses each year and I was fortunate to attend two of those conferences.
I enjoyed the knowledgeable expert speakers and presentations at each meeting, but especially this last meeting in Milan which featured an excellent debate on prostate cancer testing, nursing solutions in difficult cases, marketplace presentations on embarrassing issues in urology and many other excellent topics.

One of the EAUN's greatest contributions are the evidenced-based clinical guidelines which offer excellent research-based information on several topics for urology nurses. I look forward to seeing more guidelines in the future. I have been very impressed with the EAUN leaders and their spirit of collaboration and networking.



Jeffrey Albaugh PhD, APRN, CUCNS
NorthShore
University Medical
Group
Chicago (USA)
jalbaugh@northshore.org

It is wonderful to see the EAUN's growth, get to know its members and strenghten my links with nurses from around the world to enhance our ability to offer excellent care. I certainly look forward to participating in future EAUN meetings.

Guidelines as reference point

I have not attended every EAUN congress, but the meetings I have attended in the last five to six years have gone bigger and better every year.

Moreover, the EAUN's achievements have not remained unnoticed particularly its guidelines series which are evidence-based, and which can serve as a really good resource or reference point when local nursing groups are developing their guidelines in their own country or hospital.

Elisabeth Bonns, Rn
Vaasa Central
Hospital
URHOT
Vaasa (FI)
elisabeth.bonns@netikka.fi

The EAUN has also witnessed a growth in its ranks due to its strategy of group membership. For instance, the number of Finnish members has grown explosively compared to five years ago. Nurses are also more skilled in the English language and have gained more confidence in publicly expressing their views during meetings. For members of Urhot, the Finnish association of nurses in urology, their group membership with the EAUN has raised the profile of the EAUN.

A unique role that the EAUN serves is its capacity to offer a platform where urological nurses can meet and orient themselves to other ways of nursing practice. Specialised nursing practice can differ from one country to another and the EAUN has made it possible for us to compare and be more aware of our own approaches and methods. At the end of the EAUN congress in Milan last March, I recall what one of my Finnish colleagues said: "Now I can go home and be proud of my work."

I hope that more nurses from Finland would actively participate in the abstract sessions and inform their overseas colleagues about their work. I also hope that the EAUN will continue to develop since it is important for us to achieve excellence in our practice of urological nursing. And I believe that aside from focusing on research, which is a good thing, we should also not neglect to further improve basic nursing practices, two areas which should attract more attention and emphasis in abstracts sessions and presentations.

EAUN launches "Catheterisation: Urethral Intermittent in Adults" Guidelines

Evidence-based guidelines to help nurses in catheterisation procedures

Susanne Vahr, CNS
EAUN Board member
Copenhagen (DK)

s.vahr@eaun.org

The EAUN has launched at the 14th International EAUN Annual Meeting held in Milan last March its fifth evidence-based guidelines, with urethral intermittent catheterisation and dilatation in adults as topic.

The new guidelines contain 17 chapters ranging from methodology to indications, complications, equipment to infection prevention, etc. The document contains 36 photos and figures showing many catheters, catheter sets and help devices, 4 diagrams and 2 flowcharts. The appendices include various catheterisation procedures and a checklist for patient information as well as an example of a voiding diary and a medical travel document.

It is a very practical document that aims to help nurses assess evidence-based management and use the recommendations to guide their clinical practice. As defined by Behrens, evidence-based practice is the "...integration of the latest, highest level scientific research into the daily nursing practice, with regard to theoretical knowledge, nursing experience, the ideas of the patient and available resources." Whenever possible the guideline text is based on evidence and in cases where evidence is missing, the recommendation is anchored on best practices.

The working process for this guideline was similar to other evidence-based guidelines issued in previous years, with a systematic literature search done in the summer of 2011. Three guideline group meetings were held in Amsterdam, while a follow-up meeting was held with only the attendance of the chair and vice-chair. Six video conferences were also held for the guideline members to finalise the text. A blinded review was then conducted with the participation of specialised nurses, urologists in various countries and a patient organisation representative.

One of the main questions addressed in this guideline is: "Is there any evidence for intermittent catheterisation and urethral dilatation for nursing interventions in different care situations such as preparation, insertion or care of intermittent catheters as well as catheter materials or complications?"

The first challenge we encountered was the fact that in the literature there are various definitions of the different techniques, and there is, at times, a lack of clarity in what is exactly meant by a certain technique. Moreover, definitions described in the literature were not coherent with experiences from actual practice.

Thus, the group decided to use these definitions of aseptic and sterile technique:

Sterile technique: Complete sterile technique is only used in operating theatres and in diagnostic situations. Sterile technique implies that all materials are sterile and catheterisation is performed with sterile gown, gloves, etc., that is, in full operating theatre conditions.

Aseptic technique: Implies the use of sterile catheter, disinfection or cleansing of the genitals, sterile gloves or use of tweezers to make sure the catheter remains sterile and the use of sterile lubricant if the catheter is not pre-lubricated.

The need for an updated definition of techniques used in intermittent catheterisation is a result of integrating the best available research and clinician expertise.

What the literature search also showed was that there is a lack of high-quality evidence regarding the choice of catheter, frequency of catheterisation and single-use versus reusable catheters. However, we found evidence for infection prevention.

The literature search also showed no evidence (LE 1b, GR A) to recommend cranberry supplements to prevent or treat UTI in patients performing intermittent catheterisation. Furthermore, nurses should observe protocols on hand hygiene before catheterisation to prevent cross-infection (LE 1b GR A).

Regarding urethral dilatation in adults, a Cochrane review from 2010 concluded that there is insufficient data to determine if urethral dilatation, endoscopic urethrotomy or urethroplasty is the best intervention for urethral strictures. No evidence was found for frequency of dilation.

Low-level evidence indicates that no higher level evidence was found in the literature when writing the guideline, but cannot be regarded as an indication of the importance of the recommendation for daily practice.

The guideline can be downloaded for free at **http://www.uroweb.org/nurses/nursing-guidelines/**, while the printed version can be ordered at the EAU web shop: **https://www.uroweb.org/publications/eaun-good-practice/**.

National societies that would consider translating these guidelines can find the rules for translation on the EAUN guidelines webpage or send a request directly to the EAUN at eaun@uroweb.org.

We would like to thank Coloplast, Hollister Incorporated and Wellspect HealthCare for providing sponsorship grants, making possible the publication of this independent guideline.

A nurse practitioner in urology

Challenges to a clinical research nurse in phase 3 clinical trials

Sue Osborne
Urology Nurse Practitioner
Waitemata District Health Board
Dept of Urology
Auckland (NZ)

Sue.Osborne@waitematadhb.govt.nz

A clinical trials nurse is a registered nurse who utilises knowledge of ethics, regulatory and data management aspects of clinical trials, in combination with scientific knowledge and the traditional nursing skills of observation, assessment, patient education and advocacy to care for participants of clinical trials. These nurses adjust their mind-set from a focus on a patient's individual experience of their disease and treatment, to one that includes how that experience affects the outcomes of a clinical trial protocol, and the future of a potential therapy for the disease involved.

Astute observation of each clinical trial participant and synthesis of the observations across the cohort will enable identification of commonalities that may identify an important medication side effect. Phase three clinical trials investigate a new treatment against the best existing (standard) treatment. Such clinical trials normally involve hundreds of people across multiple research sites. Clinical trial nurses in phase three studies record and report events, administering care with a commitment to the individual patient's outcome, and to the research question underlying the treatment. Clinical research nurses strive to advocate for their patients while ensuring the integrity of the clinical research.

Patients choose to participate in clinical trials for varied reasons. Some like the way a trial protocol allows them to potentially have access to newer and perhaps more effective treatments than those currently available to them outside of a clinical trial. Others find the thought of more regular check-ups, tests and support from doctors and nurses very reassuring. Others express a wish to contribute to answering a research question to help to improve future treatment for others. All seem to feel that participation means they are doing something positive about their health and taking an active role in their treatment. The nursing role in this process can be very satisfying, providing support, knowledge, advocacy and education to participants and their families, with the longer, more regular appointments allowing for more relaxed interactions and continuity of care.

Dual role

Since 2010 I have had the dual role of Urology Clinical Trials Nurse and Urology Nurse Practitioner at the Waitemata District Health Board, and both positions have provided me with an immense amount of job satisfaction. In New Zealand, Nurse Practitioner (NP) is a legal title for a nurse who has completed advanced education and training in a specific area. NPs have met the Nursing Council's requirements to assess, diagnose and manage health conditions. This includes having a clinically focussed master's degree and demonstrated expertise in the relevant scope of practice.

"...With pharmaceutical clinical trials, sponsors vary considerably in what tasks they will allow nurse practitioners to do...."

NPs practise both independently and collaboratively to promote health, prevent disease and manage people's health needs. They provide a wide range of patient assessment and treatments including ordering, conducting and interpreting medical tests, making diagnoses and implementing therapies, to helping manage patient's health needs. Leadership, integration of research, development of nursing practice and policy are also components of the NP role.

I started my nursing career 26 years ago as a registered comprehensive nurse in the urology and renal ward. My early years of practice and post-graduate study (culminating in a Bachelor of Health Science) prepared me for my first two senior nursing roles in urology- as a clinical nurse educator and as a clinical nurse specialist. The opportunity to learn the skills of a urology clinical trials nurse came later, and as with my other senior nursing roles, was due to opportunity rather than career planning! My passion for nursing and acquiring advanced urological nursing knowledge certainly prepared me for the challenge, but it was my willingness to say "Yes, I believe I can do that and am happy to commit to the learning required that resulted in the successful transition.

The same attitude was required as I pursued further post-graduate study that led to a Master of Nursing degree, and the further development of my nursing role into Urology NP, caring for adults who are undergoing assessment, treatment, rehabilitation and /or on-going surveillance for urological conditions in both in and out-patient settings.

While this evolution in scope of practice occurred, my experience as a Urology Clinical Trials Nurse also progressed. However, as I adjusted to the increase in autonomy permitted by the NP scope, I became increasingly aware of the barriers that prevented me from utilising the full depth of my skills as a clinical trials research nurse. The university where I studied offers a Masters of Nursing programme that is science-intensive and highly focused on assessment and diagnostic skills, pharmacology and prescribing practice. This formal education, along with my experiential learning, ensures that I bring specialist knowledge, critical thinking skills and an in-depth understanding of pathophysiology to my practice, as well as a familiarity with the lived experience of urological diseases. Despite my training, international pharmaceutical clinical trial sponsors do not allow me to be a sub-investigator nor to independently perform causality assessments and serious adverse event reporting as delegated tasks.

What are the rules that govern such decisions? The principal investigator is held responsible for the conduct of the clinical trial at a site and can delegate responsibilities to study staff qualified to perform the tasks assigned. The investigator should maintain a list of the appropriately qualified persons to whom significant trial-related duties have been delegated. This list should describe the delegated tasks and identify the training that individuals have received to qualify them to perform such tasks. Since New Zealand's nurse practitioner scope authorises the nurse to perform many 'medical tasks' independently, it would be considered appropriate for the clinical investigator to delegate to him/her such clinical trial tasks.

As long as the nurse practitioner is performing tasks for which he/she is qualified, it would be considered unnecessary for the clinical investigator to sign off on his/her notes. It would however be expected for drug and biologics studies, that the nurse practitioner be listed on the FDA Form 1572 so that the sponsor is aware that he/she is playing a major role in the conduct of the study at that site. Nurse practitioners would be required to meet the same regulatory requirements as other investigators. These include having a CV on file including credentials and appointments, and demonstration of GCP and ethics training.

With pharmaceutical clinical trials, sponsors vary considerably in what tasks they will allow NPs to do. At present, the requirements of a specific sponsor override local 'scope of practice' regulations. A protocol may specify the qualifications of the individuals who are to perform certain protocol-required tasks (e.g., physician, registered nurse), in which case the protocol must be followed even if local laws permits individuals with different qualifications to perform the task.

For example, if the country/state in which the study site is located permits an NP to perform physical examinations, but the protocol specifies that physical examinations must be done by a physician, a physician must perform such exams. Until recently this has been the case at our research unit, but I am pleased to report that this month, for the first time, an American prostate cancer pharmaceutical trial sponsor has allowed me as a nurse practitioner to perform physical examinations as a delegated task.

What of Nurse Practitioner as a principal investigator (PI) for a research study? The minimum requirements for a PI are based on the risks involved in the research project. The PI must be qualified by education, training and experience to assume responsibility for the proper conduct of research study and should meet all qualifications specified by the applicable regulatory requirements. Large multi-centre international pharmaceutical clinical trials such as the prostate cancer and Peyronie's protocols I have worked on are generally high-risk endeavours which are not suited to NP preparation, in my opinion. New Zealand protocols that are deemed minimal risk studies are a more promising prospect for this urology NP! I wonder if my EAUN urology / research nurse colleagues have the same dilemmas. I would be interested to hear your thoughts.

Nursing solutions for difficult cases

EAUN session on special nursing interventions elicits enthusiastic responses

At the 14th International EAUN Meeting held in Milan in March this year, the session on Nursing Solutions for Difficult Cases attracted positive comments with many of the participants expressing their appreciation for the interesting practical problem raised by the speakers.

Due to the enthusiastic response, the Difficult Cases session has become a regular feature in the EAUN's annual conference, informing urology nursing specialists of effective interventions and special handling procedures. After the lectures, the speakers and the audience also had the opportunity to discuss specific aspects.

DC13-01 Alcohol intake and Radical Cystectomy - how can we approach a safer patient outcome?

Ingrid Sondergaard, Rn
Århus University Hospital - Skejby
Dept. of Urology
Århus N (DK)

ingrsn@rm.dk

1. What was the problem you experienced in this patient?

When a patient is cleared for surgery - radical cystectomy - they will have counselling with a consultant and a nurse and is informed about the risks and possible complications postoperatively. This includes: infections; postoperative bleeding; thrombosis; delayed bowel function; death while in hospital and in the postoperative period.

The consultant has an obligation to ask the patient about conditions that will influence on the total outcome; this includes the preoperative intake of alcohol. It is known that a high alcohol intake (> 3 units per day) is a risk factor for overall complications, even death.

A female patient age 56, with a long medical record of bladder papillomas, now has bladder cancer. She was cleared and accepted Radical Cystectomy as the treatment. She did not hide the fact that her alcohol intake was higher than recommended: more than 50 units a week. Nobody in the team reacted.

Preoperatively the patient increased her alcohol intake. The operation was cancelled the day before, because the patient had symptoms of withdrawal. The consultant found it too risky to do the surgery due to the risk of complications, especially delirium. The patient was discharged to treatment for her alcohol abuse.

A month later she had the Radical cystectomy. In the postoperative period the patient often felt stigmatised - the staff questioned her about withdrawal symptoms whenever she was feeling different sensations in her body. This was very humiliating and offered a lot of tension between the patient and the staff. She was discharged after 8 days. Unfortunately, she had a severe relapse later.

2. Which nursing intervention did you provide?

The nurses and the team could have displayed a more pro-active attitude. It was not the first patient with a severe alcohol problem. Only one month before this case a male patient died after a radical cystectomy because of complications related to a high alcohol intake. At least the nurse could have commented on the amount of units of alcohol. The team think they have learned how important it is to act professional, but further progress must be initiated!

3. Which materials did you choose to help the patient?

1. We could have used a screening tool as a help to determine the severity of her alcohol problem. AUDIT (The alcohol use disorder test) is a validated screening tool. It is best to predict the effects of an on-going alcohol intake. AUDIT completed by the patient can help the consultant to determine how to treat the patient. Our consultants think that AUDIT in a moderated edition could be a tool in the counselling.

AUDIT

Alkoholvaner	1. Hvor tit drikker du noget, der indeholder alkohol?	Aldrig	Højst én gang om måneden	2-4 gange om måneden	2-3 gange om ugen	4 gange om ugen eller oftere
		0 point	1 point	2 point	3 point	4 point
	2. Hvor mange genstande drikker du almindeligvis, når du drikker noget?	1-2 genstande	3-4 genstande	5-6 genstande	7-9 genstande	10 eller flere genstande
		0 point	1 point	2 point	3 point	4 point
Alkoholafhængighed		Aldrig	Sjældent	Månedligt	Ugentligt	Dagligt eller næsten dagligt
	3. Hvor tit drikker du fem genstande eller flere ved samme lejlighed?	0 point	1 point	2 point	3 point	4 point
	4. Har du inden for det seneste år oplevet, at du ikke kunne stoppe, når du først var begyndt at drikke?	0 point	1 point	2 point	3 point	4 point
	5. Har du inden for det seneste år oplevet, at du ikke kunne gøre det, du skulle, fordi du havde drukket?	0 point	1 point	2 point	3 point	4 point
	6. Har du inden for det seneste år måttet have en lille én om morgenen, efter at du havde drukket meget dagen før?	0 point	1 point	2 point	3 point	4 point
Skader pga. alkoholforbrug	7. Har du inden for det seneste år haft dårlig samvittighed eller fortrudt, efter du har drukket?	0 point	1 point	2 point	3 point	4 point
	8. Har du inden for det seneste år oplevet, at du ikke kunne huske, hvad der skete aftenen før, fordi du havde drukket?	0 point	1 point	2 point	3 point	4 point
		Nej	Ja, men ikke inden for det seneste år		Ja, inden for det seneste år	
	9. Er du selv eller andre nogensinde kommet til skade ved en ulykke, fordi du havde drukket?	0 point	2 point		4 point	
	10. Har nogen i familien, en ven, en læge eller andre været bekymret over dine alkoholvaner eller foreslået dig at sætte forbruget ned?	0 point	2 point		4 point	

Denne side kan downloades fra DSAM's hjemmeside, www.dsam.dk

21

Fig. 1: Danish example of AUDIT FOR alcohol abuse: http://www.sst.dk/publ/Publ2010/CFF/Alkohol/Alkoholvaner.pdf

2. Alcohol intake is a difficult matter and can be a taboo. It takes special training to have this talk.

4. What were the results of your intervention?

We hope that we can achieve a better and safer outcome for patients who are at risk because of their alcohol intake. The topic needs further exploration.

DC13-02 Complicated ostomy and wound care after cystectomy and Bricker deviation (with complex co-morbidity)

Alice Van Der Scheer-Van Den Aakster, Rn
Antoni van Leeuwenhoek Hospital
Amsterdam (NL)

a.vd.aakster@nki.nl

Marjette Beije, Rn
Antoni van Leeuwenhoek Hospital
Amsterdam (NL)

m.beije@nki.nl

Co-author: Willem De Blok

1. What were the problems you experienced in this patient?

A patient with complex comorbidity (APR, Fam. PolyPosisColi, pulmonary embolism after chemotherapy) now has T3N2M0 urothelial cell bladder cancer, for which the patient had a Bricker-urinary diversion with complications and a new ileostomy. Complications led to a large abdominal wound, with the ileostomy in the middle and impossible wound care. Surgery is not possible because of the poor physical condition. General anaesthesia is not possible because of pulmonary embolism, high risk to get new fistulas because of chemo and adhesions. This is why the patient is given conservative treatment. Problems:

a. Long stay in hospital with very intensive (wound) treatment and nursing care.
b. Very difficult wound- and stoma care.
c. Hyper granulation after pinch grafting.
d. Necrosis after using wrong material by home care nurses, which was not communicated with our specialised ostomy/wound care team. As a result the wound got worse again.

2. Which nursing interventions did you provide?

a. Use of special protocol for 'long stay patients': holistic approach: social, physical and emotional. Two or three nurses are assigned to the high care patient. They draw up an individual counselling plan (multidisciplinary), directed by the assigned nurses with a weekly update by the assigned doctor who is in charge of the medical plan. Only the assigned nurses and the assigned doctor will communicate about (medical) topics. A day programme is made for the patient.

b. Very specialised wound- and stoma care. We used different types of wound managers (Convatec, Coloplast) and stoma care materials to avoid leakage and skin problems. The ostomy/ wound care was very intense: 12 hours a day!

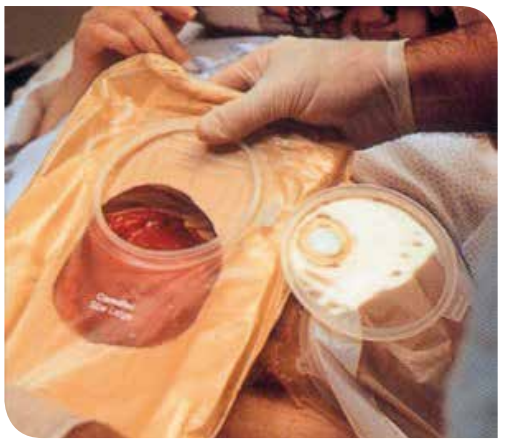


Fig. 1: Wound manager

c. Clinical nurse specialist performed pinch grafting because SSG was not possible because of the poor physical condition. After the pinch grafting the wound started to overgrow itself, this is called hyper granulation. We treated this with a silver nitrate pen.

Fig. 2: Pinch grafting

d. Because of the use of a Convex Ring for the stoma in the home situation, necrosis appeared. This was not communicated on short term, so it got worse. After a consultation in our hospital, the specialised ostomy/wond care team changed material and treated the necrosis.

3. Which material did you choose to help the patient?

We had to adjust our strategy all the time because of new wounds, damaged skin, necrosis, leakage of faeces, etc. We've used wound managers from Convatec and Coloplast, convex pouch from Eakin, curvex pouch from Welland, Easyflex from Coloplast, Hollister pouch, stoma powder, paste, Duoderm Extra Thin from Convatec, Varimate hydrocolloid from Eurotec etc.

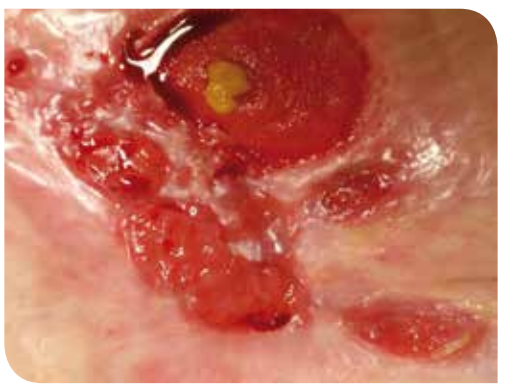


Fig. 3: Impressive growth with some hypergranulation after 3 weeks of pinch grafting

4. What were the results of your intervention?

The result after 10 months of complications, intensively wound- and stoma care is show in Fig. 4. The wound- and stoma care can now be managed by the patient herself with help of the home care nurses. The patient is still consulting the ostomy/wound care team and the specialised nurse for the pinch grafting. She manages to be out of bed most of the day with a new dressing of the wound/ ostomy. In the end with almost no leakage!

We don't often see these big problems with such a good result. Together with our patients we face challenging issues every day. We have great respect for the perseverance of our patients. Therefore, we want to thank them, and in this case especially Mrs. E., for their cooperation: without 'them', there would not be 'us'.

If you are a nurse and encounter problems such as described in this article in daily nursing practice and you have found your own solutions, the EAUN invites you to take photos and submit your case (with unsolved problems or your solution) for the next International EAUN Meeting in Stockholm. To describe the case you have use a form with a list of standard questions, including a description of the problem, the nursing intervention provided, the material you have chosen to help the patient and the final results. Please visit www.eaustockholm2014.org/15th-eaun-meeting for further information and to download the forms.

The submitters of the 10 best cases will be granted a free registration for the 15th International EAUN Meeting in Stockholm. We are looking forward to your Difficult Case before 1 December 2013!

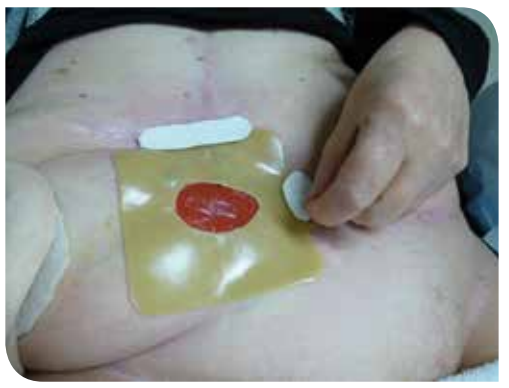


Fig. 4: Self-management by the patient

EAUN around the world

The EAUN Board have been involved in or attended the following activities throughout the world recently:

May 2013	3e POST EAUN Meeting, Ede, Netherlands
May 2013	EAUN Board meeting, Noordwijk, Netherlands
June 2013	EAUN Satellite Educational Meeting, Århus, Denmark
June 2013	European Men's Health Forum Roundtable Brussels, Belgium

Is your National Society organising a meeting and would you like the EAUN to be present? Contact our chair at k.fitzpatrick@eaun.org