The 19th International Meeting of the European Association of Urology Nurses (EAUN) held in Copenhagen last March attracted around 342 delegates from over 30 countries. With the participation of 45 faculty members together with the EAUN Board and EAUN Scientific Committee (chaired by Corinne Tillier), EAUN18 presented a comprehensive programme with 29 sessions and four courses.

Two European School of Urology (ESU) courses and two plenary sessions not only drew a high number of participants but also generated lively discussions. Networking and updates on membership took place at the EAUN Booth and the social activities included the Nurses’ Dinner held at Nørrebro Bryghus—two plenary sessions not only drew a high number of participants but also generated lively discussions. Networking and updates on membership took place at the EAUN Booth and the social activities included the Nurses’ Dinner held at Nørrebro Bryghus—activities which reflected the dynamic collaboration among European urological nurses.

Chronic bladder problems (report by E. Wallace) It was a pleasure to be part of Europe’s biggest urological nursing event as a member of the Special Interest Group (SIG) during the EAUN18 in Copenhagen. As a SIG committee member, we collaborated with our colleagues with the goal to deliver optimal patient care.

The SIG organised a one-hour session format with three (35-minute) talks followed by a discussion which was very well received. Thanks to Jeanette Verkerk-Geelhooi, who chaired the session despite a short notice after the chairperson cancelled due to health reasons.

The session took up the management of chronic bladder problems with Sharon Holroyd discussing the misunderstood on Urinary Tract Infections, Painful Bladder Syndrome (PBS), Interstitial Cystitis (IC), and Bladder Pain Syndrome (BPS). Veronica Phl (FR) shared her views on diagnosing and treating underactive bladder, while speaker Eva Wallace discussed the differential diagnosis for PBS/IC.

PBS/IC is a clinical diagnosis based on symptoms of urgency, frequency, and pain in the bladder and/or pelvis. “The complaint of suprapubic pain related to bladder filling and accompanied by other symptoms such as increased daytime and night-time frequency in the absence of urinary infection or other obvious pathology,” according to ICS 2002.

PBS is a very debilitating, chronic condition that is difficult to diagnose (Davis et al, 2015). It was first diagnosed in the 19th century by S.D. Gross in 1878. Two years later in 1878 Skene identified it as a chronic inflammatory lesion of the bladder wall. In 1951 G.L. Huggins, using eight case histories identified urge, frequency, nocturia, suprapubic pain, visible lesions / ulcers on bladder wall. This is now known as Hunners Ulcers, a rare condition with only 10-15% of cases actually showing ulcers (Gupta et al, 2015). In the UK, there are approximately 400,000 people with this condition (Nickel et al, 2010).

This complaint is seen predominantly in female patients (Cashley et al, 2012), and some clinicians doubt the validity or existence of the condition (Warren 2014). However, there can be a lack of consensus on the terminology (Shih & Inoue-Ita 2014). Further discussion considers around diagnosing PBS/IC, which is most often made when long-standing urinary frequency, urgency, and pelvic pain exist in the absence of a readily identifiable, such as signs, such as urinary tract infection. This was further discussed using some case studies.

Underactive bladder issues V. Phl discussed underactive bladder, a symptom suggestive of detrusor underactivity and is usually characterised by prolonged urination time with or without a sensation of incomplete bladder emptying, usually with hesitancy, reduced sensation on filling, and a slow stream. For those with UIAB careful neurologic and urodynamic examinations are required for correct diagnosis. In managing UAB, the avoidance of overactive bladder, prevention of overdistention, and reduction of residual urine are paramount. Conservative treatment can consist of: pelvic floor muscle strengthening, voiding retraining, double voiding, medication such asalpha-blockers, and intermittent self-catheterization.

UA is thought to be underdiagnosed and underrecognised and may occur in up to 15% of postmenopausal women. It is characterised by reduced bladder capacity caused by stiffening of the bladder wall, which reduces bladder capacity. Most patients have a decreased bladder sensation which can lead to difficulty with bladder emptying and sleep disturbance with a slow stream that reduces bladder capacity. Management of UA is titrated to the individual patient and should be symptom-based. UAB diagnosis is usually made using urodynamic studies, and is often made in patients with pain or urgency on urine loss. The diagnosis should be confirmed by: no specific pathognomonic findings with regards to detrusor pressure-volume curve, bladder biopsy, measurement of detrusor pressure-volume curve, and examination of the bladder wall and orifices.

IC/PBS is diagnosed when the symptoms occur with or without a sensation of incomplete bladder emptying, usually with hesitancy, reduced sensation on filling, and a slow stream. For those with UIAB careful neurologic and urodynamic examinations are required for correct diagnosis. In managing UAB, the avoidance of overactive bladder, prevention of overdistention, and reduction of residual urine are paramount. Conservative treatment can consist of: pelvic floor muscle strengthening, voiding retraining, double voiding, medication such asalpha-blockers, and intermittent self-catheterization.

IC/PBS is diagnosed when the symptoms occur without evidence for other causes (Taylor, B. 2007). A full medical history and physical examination are essential. Urinalysis and urine culture are also vital to rule out urinary tract infections (UTI). A voiding / bladder diary is helpful in establishing baseline voiding frequency. Other tests include a pelvic examination, bladder biopsy, urine cytology, and very rare a potassium sensitivity test, and it turned out that nobody in the audience had used this test.

There are no specific radiographic, ultrasonographic, imaging findings specific for PBS/IC, unless when ruling out alternative diagnoses. Cross-section

Sharon Holroyd delivers a lecture on painful bladder syndrome in the Thematic Session on Chronic bladder problems, organised by the EAUN Special Interest Group

EAUN18: New perspectives in urological nursing
Highlighting Painful Bladder Syndrome, BCA to leadership issues

Dr. Stefano Terzoni passes on the Chair chain to Dr. Susanne Vahr, the new Chair of the EAUN

Vahr, the new Chair of the EAUN

Laura Noble
Uro-Oncology Clinical Nurse Specialist
Freeman Hospital
Dept. of Urology
Newcastle upon Tyne (UK)

Laura.noble@nuth.nhs.uk

Laura Noble
Uro-Oncology Clinical Nurse Specialist
Freeman Hospital
Dept. of Urology
Newcastle upon Tyne (UK)

Laura.noble@nuth.nhs.uk

Eve Wallace, RN
National Rehabilitation Hospital
Dept. of Urology
Dublin 7 (IE)
ewallace2c@gmail.com

Eve Wallace, RN
National Rehabilitation Hospital
Dept. of Urology
Dublin 7 (IE)
ewallace2c@gmail.com

Vaskilli Katsarou
Head Nurse
Santorini General Hospital
Athena (GR)
vkatsarou@hotmail.gr
Complementary and Alternative Medicine (CAM) in urology

Despite weak evidence, adoption of CAM widens in many countries

For those who are entrenched in modern medicine, it may be difficult to think of alternative medicine and urology as being practiced together. Nevertheless, the use of non-traditional therapies to treat many different diseases is on the rise in many countries, including Western nations.

The United States has seen an increase in complementary and alternative medicine (CAM) usage from 1990 to 2007, as reported in the National Health Interview Survey in 2007. The user profile in Switzerland was comparable to other countries, such as Germany, United Kingdom, United States and Australia.

In their surveys in 2002 and 2007, the National Center for Complementary and Alternative Medicine (NCCAM) reported that 30% to 75% of patients suffering from cancer globally use CAM therapies that include biological, herbal, and dietary-based approaches. This report stated that about 60% of men with prostate cancer utilize some of these CAM treatments. In the US alone, 83 million adults spend $37 billion per year on CAM, which accounts for over 5% of the total out-of-pocket expenditure on health care.

The NCCAM has grouped CAM into five major domains. These include:

- Alternative medical systems, such as homeopathy, traditional Chinese medicine, and Ayurveda.
- Mind-body interventions, such as meditation, prayer and mental healing.
- Biological-based therapy, such as vitamins, minerals, amino acids, herbal and special diets.
- Manipulative and body-based methods, such as chiropractic manipulation and massage.
- Energy-based therapies, such as biofeedback therapy.

In 1999, the American Urological Association (AUA) established a “Committee on CAM” with Dr. William Fair, known as the “Father of CAM in Urology” as the first chairman. It was his own experience with cancer that led him to incorporate complementary techniques as a means to complement, not replace, conventional therapies. Dr. Fair believed in using a scientific approach to these treatments and techniques and held some of these CAM therapies for urologic diseases that have been studied as are follows:

- Phytosterogens and isoflavones (soy products, green tea): General nutrition, fruits and vegetables. Many reports suggest that calorie restricted diets low in saturated fats but rich in fibre, canostanols, phytosterogens and isoflavones may reduce the incidence and improve the course of LUTS, BPH, prostate and even prostate cancer. This type of diet can be seen in the Asian populations versus the Western populations, which may explain the lower incidence of prostate diseases observed there.
- Phytotherapeutic preparations (saw palmetto): African plum tree bark, South African star grass (root, pumpkin seeds): Plant extracts are commonly preferred as the first choice of therapy in many centres. I will centre, however, use the new information I have learned with and renewed confidence continue to manage the side effects as effectively as possible, thereby ensuring patients are able to continue their treatment.
- I also asked questions regarding a practice that we have done historically, which is to take UE, FBC and UFT bloods following each cycle of BCG. We planned to review this as we felt it was not relevant unless the patient have had significant side effects from their treatment. The opinions of the experts were helpful which enabled me to provide some feedback to my colleagues at our centre. This resulted in this practice being withdrawn and the decision of taking blood post-treatment is now left to the clinical decision-making of the nurse-specialist providing the individual patient care.

In my view, the leadership course was effective as it improved my knowledge on the essential skills and techniques in leadership. I also gained insights on how to communicate with patients, teams, colleagues and surgeons. The programme was truly valuable to participants and we had opportunities to interact with various healthcare professionals from all over Europe.

I value the experience and insights since these can be useful in implementing the recommendations of management consultants, and thereby improving patient care and the way we work.

A reminder- now is a good time to plan for next year’s abstract sessions. There are four ways to submit your work, either an abstract, video, poster or free paper. We look forward to meet you in 2019!

Nora Love-Retinger, MS, RN, CURN, OCN Memorial Sloan Kettering Cancer Center Dept. of Nursing New York (USA)

lovene@mskcc.org

Networking is an important part of the annual meeting

In recent years, the range of complementary and alternative medicine (CAM) treatments for urologic disease has expanded. This has led to increased interest in the role of CAM in urology. However, the evidence for the effectiveness of these treatments is varying, and more research is needed to better understand their potential benefits and risks.

The purpose of this article is to provide an overview of the current state of CAM use in urology, and to discuss some of the key issues that need to be addressed in future research. The article will focus on CAM therapies that have been studied in the context of urologic diseases, including phytoestrogens, isoflavones, and phytotherapies such as saw palmetto.

Phytoestrogens and isoflavones: These compounds are found in soy products and green tea, and are believed to have potential benefits for urologic health. For example, soy products have been shown to reduce the risk of prostate cancer in men with a family history of the disease. However, the evidence for this benefit is limited, and more research is needed to clarify the role of phytoestrogens in the prevention of prostate cancer.

Saw palmetto: This herb has been used for centuries to treat BPH, and has been shown to reduce the risk of progression to significant LUTS. However, the evidence for the effectiveness of saw palmetto is mixed, and more research is needed to better understand its potential benefits and risks.

In conclusion, CAM use in urology is expanding, and the evidence for the benefits of these treatments is varying. More research is needed to better understand the potential benefits and risks of CAM in urology, and to develop evidence-based guidelines for the use of these treatments in clinical practice.
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