EAUN18: New perspectives in urological nursing

Highlighting Painful Bladder Syndrome, BCa to leadership issues

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The 19th International Meeting of the European Association of Urology Nurses (EAUN18) 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 attendance but were also marked with enthusiastic 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 an 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 (15-minute) talks followed by a discussion which was very well received. Thanks to Jeannette Verkerk-Geelhoed, 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 problem with Sharon Holroyd discussing the misunderstanding on Urinary Tract Infections, Painful Bladder Syndrome (PBS), Interstitial Cystitis (IC), and Bladder Pain Syndrome (BPS). Veronique Phé (FR) shared her views on diagnosing and treating underactive bladder, while speaker Eva Wallace discussed the differential diagnosis for PBS/IC.

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

PBS/ IC / PBS is a clinical diagnosis based on symptoms of urgency, frequency, and pain in the bladder and/or pelvis. "The complaint of supra-pubic 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 1876. Two years later in 1878 Skene identified it as chronic inflammatory lesion of the bladder wall. In 1915 G.L Hunner, 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 (Ghosh & Imoh-Ita 2014). Further discussion continues 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 signs, such as urinary tract infection. This was further discussed using some case studies.

Underactive bladder issues
V. Phé 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 UAB careful neurologic and urodynamic examinations are required for correct diagnosis. In managing UAB, the avoidance of upper tract damage, prevention of over distension, and reduction of residual urine are paramount. Conservative treatment can include timed voiding, double voiding, medication such as alpha-blockers, and intermittent self-catheterization.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5740034/

Nurses share their ideas on the development of a Curriculum on urology nursing at EAUN18

Another lecture took up differential diagnosis for PBS/IC which remains just as difficult today even more than a century after it was first described. There are no specific pathognomonic findings with regards patient history, physical examination, laboratory, or cystoscopy findings. The exclusion of other clinical entities remains the foremost goal of the work-up and evaluation of patients suspected of this condition.

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-sectional imaging, including magnetic resonance imaging (MRI), computed tomography (CT) scanning, and pelvic ultrasonography, may be performed when clinically indicated to evaluate for a suspected pelvic mass that is causing compression of the bladder or for an adjacent inflammatory process (e.g. diverticulitis). Cystography and voiding cystourethrography may be used to evaluate the bladder for other causes of lower urinary tract symptoms, such as intravesical masses, stones, bladder diverticula, urethral diverticula, urethral stricture, meatal stenosis and neurogenic or non-neurogenic voiding dysfunction (Rovner et al 2017).

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

Urodynamic Studies (UDS) are optional and not generally part of routine evaluation for PBS/IC. The findings maybe suggestive of an alternative diagnosis such as detrusor over-activity or pelvic floor dysfunction but there are no specific UDS findings. During UDS procedure on bladder filling, many patients do have increased sensation with decreased volume, however, pain with bladder filling that reproduces the patients' PBS/IC symptoms is very supportive of a diagnosis of interstitial cystitis.

Cystoscopy can be described as the most important diagnostic tool for assessing a patient who may have PBS/IC. In general, this is performed while the patient is under anaesthesia in order to provide sufficient bladder distention to examine for co-existing urethral and bladder pathology (e.g., transitional cell carcinoma) and features of interstitial cystitis, such as Hunner Ulcers and glomerulations. During cystoscopy, bladder capacity can also be evaluated. The characteristics of Hunners ulcer are rarely seen to confirm the diagnosis (Rovner et al 2017). Diagnosis can be made based on cystoscopic findings, for patients with PBS/IC and can be classified as either Hunner-type/classic IC (HIC), presenting with a specific Hunner lesion, or non-Hunner-type IC (NHIC), presenting with no Hunner lesion, but post-hydrodistension mucosal bleeding (Maeda D et al Published: Nov 20, 2015). Diagnosis is still one of the exclusions as there are no defined indicators, no aetiology or pathophysiology available.

Profound consequences
Over time it is clinically recommended to see a specialist for on-going symptoms to rule out any possible differential conditions prior to diagnosing interstitial cystitis. The consequences of a diagnosis of PBS/IC are profound since it is a chronic condition without universally effective therapy. Ward-Smith in 2009 stated that there is an estimated 13 million individuals experiencing some type of incontinence and 85% of these are women! In general the symptoms of PBS/IC are characterised by urinary frequency urgency, and/or pain pelvic and can affect the following types of conditions- infectious or inflammatory, gynaecologic, urologic, or neurologic.

There are also many complications which include reduced bladder capacity caused by stiffening of the bladder wall, which reduces bladder capacity. Most importantly, it can reduce quality of life due to frequent urination and lack of sleep that affect daily activities, social/work events, etc. Another important aspect of PBS/IC is the effect it can have on personal relationships and sexual intimacy. Patients can be affected by psychological /emotional issues which can also impact on their sexual health, caused by the difficulty dealing with the side effects of chronic pain, and the lack of sleep associated with interstitial cystitis can lead to depression. It is imperative that each person has individualised treatment plans to include a physical examination, appropriate clinical tests, all done in a timely manner for their diagnosis to increase their knowledge and awareness of condition.

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EAUN Award Winners

First Prize for the Best EAUN Poster Presentation

R. McConkey, C. Holborn

University Hospital Galway, Urology Department, Galway, Ireland; Sheffield Hallam University, Faculty of Health and Wellbeing, Sheffield, United Kingdom

With the poster *"Exploring the lived experience of gay men with prostate cancer: A phenomenological study"*

Second Prize for Best EAUN Poster Presentation

P.B. Svankjær, A. Holm Jensen, T. Søndergaard Sørensen, H. Haslund-Thomsen

Aalborg University Hospital, Clinical Nursing Research Unit, Department of Urology, Aalborg, Denmark

With the poster *"Grit in the waterworks – patient experiences of living with stones in the upper urinary tract"*

Third Prize for the Best EAUN Poster Presentation

J. Avlastenok, K. Rud, H. Køppen, L. Wendt-Johansen, H. Wested, P. Busch Østergren

Herlev Hospital, Department of Urology, Herlev, Denmark

With the poster: *"Quality of life of spouses living with men undergoing androgen deprivation therapy for prostate cancer"*

Prize for the Best EAUN Research Project Plan Presentation

V. Decalf, R. Pieters, K. Everaert, M. Petrovic, W. Bower

Ghent University Hospital, Belgium; Royal Melbourne Hospital, Australia

With the Nursing Research Project: *"Prevalence, incidence and associated factors of nocturia on the ward"*

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IC/PBS is a chronic, complex and poorly diagnosed condition. Pain is one of the primary symptom, which affects mainly the females. Often times they have suffered for many years with misdiagnosis, and overuse of antibiotics. Many would have tried multiple unsuccessful treatments, maybe be labelled as challenging and difficult, hypochondriac, anxious or mad. But inevitably, all will have a reduced quality of life. For the future, a general consensus on definition, diagnosis and treatment would be of benefit.

Thematic Session on BCa (Report by L. Noble)
At EAUN18 I attended the Thematic Session 10 on bladder cancer with the theme *"Evolution and Management of BCG,"* an area which I focus on as a urology clinical nurse with a sub-specialty in non-muscle invasive bladder cancer.

I found the session very useful in understanding the history, in detail, of Bacillus Calmette–Guérin (BCG), a drug which many nursing professionals do not fully understand, particularly the mechanisms of how it works. It was valuable to hear the insights of experts which gave me a better understanding of BCG as a complex drug.

With the worldwide shortage it was valuable to recognise how other disciplines try to plan and work around this, enabling me to inform my centre of how other healthcare professionals manage these shortages, reducing the negative impact on patients' treatment schedules. As I was also unaware of the

The Leadership Course was a first and very well-received

process involved in developing each batch, and the length of time this takes, it was beneficial to understand how these shortages can occur, with little warning, such as during incidents of 'a bad' batch.

The management of side effects and a patient-centred approach were also very informative issues. In my centre we take a very patient-centred approach and it was reassuring to see that we are providing this treatment at the same level as other centres. I will, however, use the new information I have learned and with 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 LFT 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 been 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.

Overall, my knowledge of BCG has greatly improved and I feel more confident in discussing the drug with patients and colleagues. In my view, the more knowledge we have regarding these drugs, the better then we can provide the right care and treatment to our patients. In my experience, when we can confidently respond to their questions, they develop more trust and can feel more relax during their treatment.

Leadership course (A report by V. Katsarou)
The Annual EAUN Meeting has made valuable contributions in high-quality urological nursing care by providing new scientific and practical inputs including medical technology, drug therapy and outcomes from current studies.

At this year's meeting in Copenhagen I participated in the interactive course *"Nurses in a Leadership role: Cultivating your leadership"* which presented recommendations on how to boost a leadership role, tips on how to overcome challenges in the workplace, distinguishing technical challenges from adaptive challenges, how to observe a work system, and receiving feedback on personal leadership.

In my view, the leadership course was effective as I 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 useful 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, research plan or a difficult case. We look forward to meet you in 2019!

Nurse delegates get a good idea of the tasks of the console surgeon in the robotics simulation HOT course

Complementary and Alternative Medicine (CAM) in urology

Despite weak evidence, adoption of CAM widens in many countries

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For those who are entrenched in modern medicine, it may be difficult to think of alternative medicine and urology as being practised together. Nevertheless, the use of complementary and alternative medicine 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 33.8% in 1990 to 42.1% in 1997 which has remained stable over the last decade. This appears to be similar to the European countries as reported by the Swiss Health Survey in 2007 and 2012. 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 spent over $50 billion per year on CAM, which accounts for over 11% 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, Qi Gong, Reiki and therapeutic touch.

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 them to the same standard as mainstream medicine.

Some of these CAM therapies for urologic diseases that have been studied are as follows:

- Phytoestrogens 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, carotenoids, phytoestrogens and isoflavones may reduce the incidence and improve the course of LUTS, BPH, prostatitis 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 prescribed as the first choice of therapy in many European countries and are increasingly used in the US. They are usually less expensive and regarded as 'natural' products. The STEP (Saw-palmetto Treatment for Enlarged Prostate) and CAMUS (Complementary and Alternative Medicine for Urological Symptoms) trials failed to indicate statistical significance; however, some clinicians point out some design flaws in these studies.
- Selenium, vitamin E, carotenoids, and zinc: Results from a double-blind trial of dietary selenium on non-melanoma skin cancer in high-risk individuals, showed a statistically significant lower incidence (63%) of prostate cancer than those receiving placebo. The role of vitamin E came from a result of a Finnish study in 1998 on men who smoked to evaluate whether either vitamin E and/or beta-carotene supplements could prevent lung cancer. There was a surprising result showing a 32% reduction in incidence and a 41% decrease in mortality from prostate cancer in the study subjects.
- Ginseng for Erectile Dysfunction (ED): Ginseng and erectile functioning are presently being looked at in a large Cochrane Review. Supplements have been used for centuries; however placebo-controlled studies have shown placebo responses of 25-41%.
- Cranberry juice and Urinary Tract Infections: The Cochrane renal group conducted a systematic review and concluded overall results indicate that, compared to placebo, cranberry juice and tablets may reduce the risk of developing symptomatic UTIs in sexually active women.
- Red wine consumption and prostate cancer: The agent responsible for the effect of reduction of cancer is supposed to be the polyphenol resveratrol, a naturally occurring plant antibiotic found in grape skins and red wine. The effects include antioxidant activity, immunomodulation, growth-inhibiting activity, anti-androgenic, anti-inflammatory and inhibition of angiogenesis.

Networking is an important part of the annual meeting

In addition to these biological based therapies, mind-body methods have also been studied in the urology patient:

- Acupuncture: 'Qi' or 'life energy' flows through meridians that connect the body organs. Interruption in this flow is thought to produce disease state. Some acupuncture points coincide with 'trigger points' which are anatomic sites of enriched innervation. Biophysiologic and imaging studies indicate that acupuncture triggers the release of neurotransmitters and other endogenous substances. Studies have found a 50-70% reduction of treatment-associated hot flashes in men with prostate cancer.
- Mind-body therapies: The role of mediation in health care has been subjected to study in the West for at least three decades. Its value in the management of chronic pain, hypertension, and symptoms associated with heart disease and cancer is well documented.

- Yoga: An exercise regime with a 5,000-year history. For patients with urinary incontinence, cystocele, rectocele, vaginal and uterine prolapse, chronic orchitis and interstitial cystitis, the practice of yoga postures can be beneficial. Yoga can increase a patients' self-awareness of muscles.
- Music therapy: Patients undergoing TURP showed a reduction in blood pressure and anxiety with music therapy.
- Biofeedback: This technique requires equipment such as electromyography, thermal biofeedback or electroencephalography. Studies have shown a hastened recovery of urinary control and reduction in severity of urinary incontinence.
- Physical activity: In a cross-sectional study of 111 prostate cancer patients treated with external beam radiotherapy, physical activity significantly improved sexual function. In a systematic review of 11 studies involving over 43,000 men detected an association between vigorous physical activity and reduced risk of BPH and LUTS.

The number of patients using CAM therapies is ever increasing world-wide. As practitioners in urology, we should avail ourselves of information, both scientific as well as that which has not been demonstrated by evidence, in this growing field. Understanding the compositions, actions and potential side effects of these therapies to complement our conventional treatments can only benefit in the healing of our patients.

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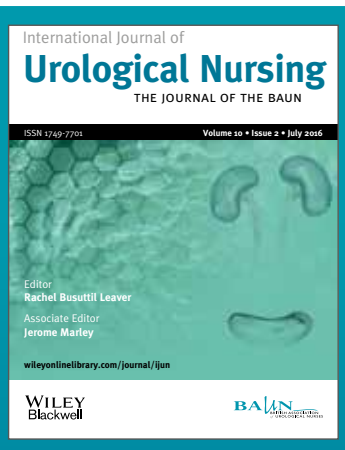

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