

# Urological passion

## The driving force behind my application to become an EAUN Board member



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Since 2013, EAUN has accompanied me in my professional life with all its evidence-based and educational resources. I realised early that if I wanted to make a difference in the further professionalisation of urological care, I had to change my position from a resource user to a resource developer. After a while, I got the opportunity to serve on the Scientific Committee of EAUN and to participate in the EAU Patient Information initiative.

After seven years of experience working for a non-profit organisation, I applied for EAUN Board membership. I was happy when the board approved my application. However, due to the Sars-COVID pandemic, EAUN members had no chance to vote on my Board membership. Therefore, the EAUN Board decided to accept me as EAUN Board Member Elect for one year until the members will be given the opportunity to vote at EAUN21 in Milan. To introduce myself to the EAUN members, I am happy to give a brief personal insight.

Originally graduated as a Registered Nurse in Germany, I decided to move to Switzerland in 2010 due to the greater opportunities there to graduate in Advanced Nursing Practice (ANP). After graduation, my first employment in Switzerland was at the University Hospital Bern in the Department of Urology, High Dependency Unit, in 2012. This department was specialised in surgical treatment of people with

uro-oncological tumours (e.g. bladder cancer, prostate cancer, kidney cancer, etc.). As a result, I was able to gain experience with these patient groups at an early stage of my career.

At the High Dependency Unit, I quickly noticed that especially men with bladder or prostate cancer had no possibilities to express and discuss their worries and fears. Unmet needs such as how to cope with the diagnosis and therapeutic side effects, e.g. sexual dysfunction, incontinence, and communication problems in a couple's relationship came to light. To meet unmet needs of relatives at the High Dependency Unit, a care model to include and empower them with comprehensive information was introduced.

### ANP counselling service

In addition to my work at the High Dependency Unit, I had the opportunity to gain research experience with the project "Development of a guideline for people with a long-term urinary catheter," led by Rita Willener, CNS. As a research associate, I was responsible for the systematic literature review, critical appraisal of studies/guidelines, the organisation and management of meetings and the development of a guideline adapted to the Swiss national context. The project resulted in a recommendation by the Swiss Society for Patient Safety and a publication.

*"... it needs more leaders who have experience in urological nursing and have sufficient research skills to make accomplishments of urological nurses visible..."*

In August 2013, I was promoted to an ANP position and was commissioned to develop a counselling service for patients with prostate cancer. Fulfilling an ANP role according to the PEPPA framework by Bryant-Lukosius (2004), coupled with the development of a counselling service, required various competencies, in particular leadership to

co-lead the project next to Rita Willener and to convince stakeholders to support the project. Already at the beginning of the ANP project, considerations were made how the counselling service could be evaluated. By means of a descriptive evaluation, it was shown at an early stage that the ANP counselling service had closed a health service gap with the provision of psycho-oncological care for men with prostate cancer and their partners. This awoke an increased interest in the innovative ANP counselling service, which had been implemented for the first time in this format in Switzerland. Highlights were when the ANP counselling service was awarded the Bernese Care Prize and the Phenomenon Award. An invitation to give a lecture at a Symposium by the Swiss National Cancer League, supported by the national government, was a good opportunity to spread the word about psycho-oncological care for men with prostate cancer and their partner.

### Boosting the theory-practice transfer

Further experience followed in haemato-oncological care, nursing practice development and quality management. At this stage, I realised that if I wanted to deepen my knowledge about the evaluation of nursing interventions, I had to become a research associate. A possibility arose soon and I started working in the Academic-Practice-Partnership (APP) of the University of Applied Sciences Bern and the University Hospital Bern, in November 2018.

The APP enables me to use my clinical experience of and knowledge about the implementation/evaluation of ANP roles in various settings. Advanced Practice Nurses often lack time during their clinical work and do not have the necessary methodological skills to evaluate their interventions and the effects of their role. Due to the position in the APP, I am able to support Advanced Practice Nurses in boosting the evaluation of ANP interventions.

Projects in which I am currently involved mainly relate to:

a) the evaluation of ANP roles for people with

oncological diseases (sarcoma, glioblastoma, etc.);  
b) the analysis of interface management problems and the potential of interprofessional collaboration in complex patient pathways;  
c) the application and evaluation of the Swiss interprofessional collaboration tool SIPEI.

In addition to my work as a research associate, I have been participating in a PhD programme since spring 2020. This programme will illustrate the contributions of APNs to the care of people with an oncological disease and their job satisfaction, in Switzerland.

*"Advanced Practice Nurses often lack time during their clinical work and do not have the necessary methodological skills to evaluate their interventions and the effects of their role."*

All in all, I would like to say that my passion and fascination for urological nursing has been a constant feature in my career. Also, my various commitments at the EAUN and EAU reflect that urology is the discipline that I support and promote.

I remember that when I was working as an Advanced Practice Nurse, I was often frustrated not to have sufficient research skills to evaluate ANP interventions. Nursing-evidence is one of the most important aspects of nursing practice development. From my point of view, it needs more leaders who have experience in urological nursing and have sufficient research skills to make accomplishments of urological nurses visible and show their benefits for patients.

I will be very happy when we can finally meet and exchange views in Milan at EAUN21. Until then, I wish all members good health!

Yours sincerely,  
Franziska

European Association of Urology Nurses

## "Spot-on" evidence-based nursing care New research and developments

Dear EAUN members,

**The growing evidence in urology nursing care is amazing!**

With this column, the EAUN SIG Groups want to put the spotlight on recent publications in their field of interest. This month's articles have been carefully chosen because of the scientific value from PubMed and represent different methods and approaches in research and development in urological nursing care.

We hope this initiative will have your attention and continuously provide information on "spot-on" urological nursing care. If you would like to inform us and your colleagues about new initiatives or exiting developments in one of the special interest fields you can contact us using the email addresses below.

Best regards

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The bladder cancer articles below will give you a sort of overview of what bladder cancer is, the natural history, risk factors treatment etc. Moreover, apart from the actual treatment algorithm, a further article about the family aspect and what it means to undergo treatment for both men and woman.

### Selected from PubMed

#### Bladder Cancer

- Anderson B. Bladder cancer: overview and disease management. Part 1: non-muscle-invasive bladder cancer. *Br J Nurs.* 2018;27(9):S27-S37. doi:10.12968/bjon.2018.27.9.S27. PMID: 29749774. <https://pubmed.ncbi.nlm.nih.gov/29749774/>
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- Pozzar RA, Berry DL. Gender Differences in Bladder Cancer Treatment Decision Making. *Oncol Nurs Forum.* 2017;44(2):204-209. doi:10.1188/17.ONF.204-209. PMID: 28222088. <https://pubmed.ncbi.nlm.nih.gov/28222088/>

#### Continence

- The relationship between psychological and physical secondary conditions and family caregiver burden in spinal cord injury: A correlational study. Conti A, Clari M, Nolan M, et al. *Top Spinal Cord Inj Rehabil.* 2019;25(4):271-280. doi:10.1310/sci2504-271. <https://pubmed.ncbi.nlm.nih.gov/31844379/>
- Majeed A, Sagar F, Latif A, et al. Does antimicrobial coating and impregnation of urinary catheters prevent catheter-associated urinary tract infection? A review of clinical and preclinical studies. *Expert Rev Med Devices.* 2019;16(9):809-820. doi:10.1080/17443440.2019.1661774. <https://pubmed.ncbi.nlm.nih.gov/31478395/>
- Meddings J, Manojlovich M, Ameling JM, et al.

Quantitative results of a national intervention to prevent hospital-acquired catheter-associated urinary tract infection: A pre-post observational study. *Ann Intern Med.* 2019;171(7\_Suppl):S38-S44. doi:10.7326/M18-3534. <https://pubmed.ncbi.nlm.nih.gov/31569231/>

- Mitchell BG, Fasugba O, Cheng AC, et al. Chlorhexidine versus saline in reducing the risk of catheter associated urinary tract infection: A cost-effectiveness analysis. *Int J Nurs Stud.* 2019;97:1-6. doi:10.1016/j.ijnurstu.2019.04.003. <https://pubmed.ncbi.nlm.nih.gov/31129443/>
- Dubbs SB, Sommerkamp SK. Evaluation and Management of Urinary Tract Infection in the Emergency Department. *Emerg Med Clin North Am.* 2019;37(4):707-723. doi:10.1016/j.emc.2019.07.007. <https://pubmed.ncbi.nlm.nih.gov/31563203/>
- Clarke K, Hall CL, Wiley Z, et al. Catheter-Associated Urinary Tract Infections in Adults: Diagnosis, Treatment, and Prevention [published online ahead of print, 2019 Sep 18]. *J Hosp Med.* 2019;14:E1-E5. doi:10.12788/jhm.3292. <https://pubmed.ncbi.nlm.nih.gov/31532742/>

#### Endourology

- Robotic versus open ureteroneocystostomy: is there a robotic benefit? Skupin P A, Stoffel J T, Malaeb B S, et al. Published Online:15 Jul 2020. <https://doi.org/10.1089/end.2019.0715>
- Impact of body mass index on outcomes following anatomic greenlight laser photoselective vaporization of the prostate. Pierce H., Goueli R., Al Hussein Al Awamh, B., et al. Published Online:15 Jul 2020. <https://doi.org/10.1089/end.2020.0077>
- Percutaneous microwave ablation of stage t1b renal cell carcinoma: Short-term assessment of technical feasibility, short-term oncologic outcomes, and safety. Guo J and Arellano R.S.. Published Online: 9 Jul 2020. <https://doi.org/10.1089/end.2020.0382>
- Early outcomes of robot-assisted radical prostatectomy following completion of a structured training curriculum: A single surgeon cohort study. Arjan S Sehmbi A., Sridhar A.N, Sahadevan K, et al. *Journal of Clinical Urology* 1-9, sage pub.com/journals-permissions DOI: 10.1177/2051415820938176 <https://journals.sagepub.com/doi/abs/10.1177/2051415820938176>



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# Spotlight on frailty in bladder cancer

## Is frailty an underestimated marker in clinical practice?



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**Perioperative and long-term functional and oncological outcomes following radical cystectomy (RC) for bladder cancer remain unchanged, despite advances in technique and perioperative management as well as neoadjuvant therapy. Is there something we overlooked? The article below gives an overview of what we know so far about frailty and RC.**

### High rates

The RC procedure represents an integral component in the management of advanced bladder cancer. However, it is associated with high rates of postoperative morbidity (up to 90%) and mortality rates between 0.8–8.3%. Patients suitable for RC are usually characterised as elderly and frail. They often suffer from other urgent medical conditions because of a heavy comorbid burden that should mandate pre-evaluation before scheduled surgery<sup>3</sup>.

Frailty is defined as a syndrome of physiologic decline and loss of functional reserve across organ systems, leading to vulnerability for disease and death<sup>4</sup>. Specific to RC, frailty is associated with higher complication rates and mortality<sup>5</sup>.

### Useful for clinical practice

The increased likelihood of pre and postoperative frailty calls for increased awareness to inform early risk assessment and qualify the shared decision process. However, most institutions performing RC do not routinely measure frailty in clinical practice. This could partly be explained by the absence of consensus on how to define and measure frailty in the urological community, despite a plethora of instruments, tools and scales according to the literature<sup>6</sup>. Finally, there seems to be little agreement on which of those tools are useful for clinical practice. Thus, there is currently no standard recommendation of the optimum tool for measuring frailty in RC.

Frailty is a dynamic phenomenon and seems to be modifiable while patients - according to most scales - can move between the status of being robust to pre-frail and frail. One well-known tool is the Fried Frailty Phenotype<sup>7</sup>, which defines frailty by the following criteria: impaired grip strength, gait speed, physical activity, unintentional weight loss and self-reported exhaustion. It seems to promote the concept of prehabilitation to modify or optimise deficits.

### Sarcopenia

An important and fundamental component of frailty is sarcopenia, which is defined by progressive and severe loss of skeletal muscle mass. A common method of assessing sarcopenia in RC patients is measuring psoas muscle volume on preoperative abdominal imaging. This is already done prior to surgery to determine disease stage and is thus easy to access for clinical use. However, standard cut-off values of psoas muscle volume for determining when patients are 'frail' (and thus at increased risk for postoperative complications and/or should change treatment direction) are yet to be established; they are warranted to facilitate early prevention of sarcopenia in clinical practice<sup>8</sup>.

Sarcopenia is, however, accepted as an important preoperative prognostic factor of overall and cancer-specific survival after RC<sup>8</sup> and is associated with increased 30-day and 90-day high-grade complications<sup>9-11</sup>. These findings support the association of certain components of the Fried Frailty Criteria with increased complications and stress the significant impact of preoperative physical fitness and nutritional status on postoperative outcomes of RC.

The physical decline including aerobic fitness and nutritional status are significant drivers in sarcopenia. Older patients, such as RC patients, who's average age peaks around 67, are less able to utilise amino acids for protein synthesis at muscle level, and almost 30% are at nutritional risk ahead of surgery<sup>12,13</sup>. In addition,

it is estimated that one third of patients undergoing RC is sarcopenic and would benefit from a combined intervention of physical exercises and nutrition with protein supplements to attenuate the loss of lean leg mass and strength and promote the recovery phase<sup>10,14</sup>.

### Prehabilitation

Today, it is generally accepted that exercises provide the best anabolic stimulus and nutrition potentiates the muscle protein response. Moreover, these two components are synergistically related. Therefore, a combined intervention should be offered in both the perioperative period and post discharge to counteract sarcopenia, maximise recovery and reduce long-term impairments<sup>14</sup>.

Although prehabilitation is not yet considered as standard treatment or is not offered due to concerns over a delay in cystectomy, this intervention may be a valuable preventive approach to modify well-known risk factors. Attempts to counteract frailty using multimodal prehabilitation programmes, including physical exercises and nutrition supplementation, have shown to be feasible, effective and lead to a positive change in patients' fitness and functional status<sup>12,15,16</sup>.

### Frailty assessment

Both retrospective and prospective studies using a preoperative frailty assessment have shown that frailty is associated with worse outcomes. Preoperative frailty assessments, based on patients' physiological fitness using the Fried Frailty Criteria or psoas muscle volume, have been the best predictors of worse outcomes on prospective cohorts<sup>5</sup>. Preoperative risk assessment before RC should incorporate objective measures of physiologic age, physical function, nutrition, lean muscularity, cognitive age, patient preferences and frailty. Future work is needed to validate the performance of existing metrics (= statistics) to improve the ability to predict perioperative complications and oncologic outcomes and to define and assess the effectiveness of specific prehabilitation interventions to counteract deconditioning in relation to surgery.

### Key points to consider in radical cystectomy in clinical practice

- Frailty is associated with worst postoperative outcomes after radical cystectomy.
- Frailty can be assessed using a frailty index or preoperative frailty assessment.
- Prospective studies show that preoperative assessments based on patients' physiologic fitness and nutritional status are likely to be most useful for radical cystectomy.
- Further research is needed comparing various frailty assessments to determine the best tool for clinical practice.
- Inclusion of preoperative frailty assessment in guidelines for muscle-invasive bladder cancer is warranted to improve implementation in clinical care.

From: Frailty and preoperative risk assessment before radical cystectomy. Burg, M L et al, Curr Opin Urol 2019, 29:216–219.

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# Synopsis of nursing research study

## Withdrawing from treatment for bladder cancer: Patient experiences with BCG instillations



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This is a report of the nursing study 'Withdrawing from treatment for bladder cancer: patient experiences of BCG instillations', which is awaiting publication in the *International Journal of Urological Nursing*. The primary aim of this mixed methods study was to explore how patients' experience with Bacillus-Calmette Guerin (BCG) treatment influenced their early withdrawal. We did not set out to investigate which strategies could potentially keep patients on treatment for a longer period, these became apparent as the research progressed. The reason for undertaking this research was the withdrawal rate of up to 86% (Lamm et al., 2000).

### Mycobacterium bovis bacillus

In the UK alone, there are 10,000 new diagnosis annually of bladder cancer. It is recognised as the second most common urological cancer in the UK and USA (Tobias & Hochhauser, 2010). BCG was first discovered at the turn of the 20th century, when Albert Calmette and Camille Guérin isolated an attenuated live strain of *Mycobacterium bovis* bacillus, a live vaccine against tuberculosis, known as BCG (Crispen, 1989). It was not until the late 1970s that BCG started to be used for bladder cancer following studies by Morales (Morales et al., 1976). So why the high withdrawal rate?

### Cumulative effect?

The answer may in part be due to the fact that very little is known about patients' experience with this intravesical treatment. Some authors have suggested that there is a cumulative effect of the BCG instillations on the patient leading to symptoms such as pain, flu-like symptoms, etc. (Berry et al., 1996; Heiner & Terris, 2008; Orihuela et al., 1987) which lead the patient to withdraw, but this does not take their experience with the treatment into account. A list of side effects can be found in the European Association of Urology Nurses guidelines for the intravesical instillation (Vahr et al., 2015). This study which was conducted in a large National Health Service Hospital Trust serving a metropolitan area in the North of England may offer some insight.

The study was undertaken in two parts: firstly a retrospective case note analysis, identifying trends such as symptomatology and the 'natural history' of BCG treatment. Secondly, a qualitative approach, interviewing patients and identifying themes from the subsequent data analysis.

### Four themes

What is interesting about this study is that it identifies four themes: treatment concerns, withdrawal influencers, unmet needs and treatment bereavement. Participants identified treatment concerns and withdrawal influencers as areas that concerned them most and influenced their decision-making processes. In more detail, these themes were made up of the following underlying factors:

- Treatment concerns were made up of influencing factors. These affected the quality or experience of the treatment and the attendant processes, such as physical or psychological distress. What supported these themes were dignity, physical effects, side effects and psychological and emotional distress.
- Withdrawal influencers emerged from the factors social impact, experience and effects on daily life. It was found that these factors intertwined to bring the patient to a point of stopping their 'cancer

treatment'.

- Unmet needs derived from communication, choices and the environment that the treatment is delivered in post treatment.
- Treatment bereavement, this is when patients talked about the loss and feelings experienced following their decision to withdraw from treatment. This highlights their personal journey and how they thought about their treatment and how they questioned themselves about their decision-making. This is particularly illuminated with the following quote:

*"I used to lie in bed and think, "I am not having this treatment and if that thing starts growing inside me again, I know they have got rid of it and it might not come back again but I am not having the treatment and I needed this treatment and I'm not having it".*

In concluding the study, nursing recommendations were presented such as education, environment, patient support and record keeping. A further recommendation was that healthcare professionals need to work with the patient and their extended support networks in a concerted effort to ensure patients complete their treatment. To read more about this study please see the following articles: Non-muscle invasive bladder cancer and bacillus Calmette-Guerin treatment: a review of the literature (Alcorn et al., 2014); BCG treatment for bladder cancer, from past to present use (Alcorn et al., 2014); Patterns of patient withdrawal from BCG treatment for bladder cancer: A retrospective time interval analysis (Alcorn et al., 2019); and Withdrawing from treatment for Bladder cancer: Patient experiences of BCG instillations (Alcorn et al. in press).

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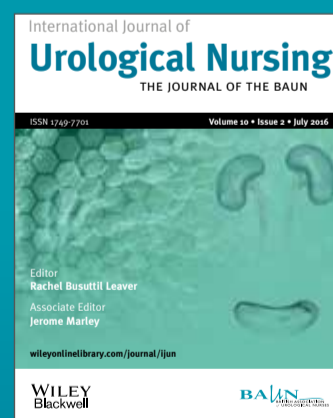
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