

**8th International Meeting of the
European Association of Urology Nurses (EAUN)
in conjunction with the**



Annual EAU Congress, Germany, 21-24 March 2007



Berlin 2007

8th International Meeting of the European Association of Urology Nurses (EAUN)

in conjunction with the 22nd Annual EAU Congress

**Berlin, Germany
21-24 March 2007**

Contents

Welcome to Berlin	3
General Information	5
Floorplan Congress Venue	6
General Information	7-10
Speakers' Guidelines	11
Scientific Programme	13
Overview	14
Wednesday, 21 March	15
Thursday, 22 March	16-18
Friday, 23 March	19-21
Abstracts	23
Oral Abstracts	24-33
Poster Abstracts	34-42
Abstracts Lectures	43
The pelvic floor – sexual and medical co-morbidities, A. Graziottin	44-45
Female sexual dysfunction: Clinical approach, A. Graziottin	46-51
EAUN Membership form	52

Welcome to Berlin

Dear Colleagues,

On behalf of the board I would like to welcome you to Berlin for the 8th Meeting of the European Association of Urology Nurses (EAUN). The meeting aims to provide an international open forum for the exchange of ideas, knowledge and research, which hopefully will continue to strengthen and improve urological nursing care locally and throughout Europe.

We represent different cultures both in the way we are organised and also in the way we provide urological nursing. The EAUN board will try to bridge whatever differences in approach we have by making interactive courses and symposia where all delegates have the opportunity to comment, discuss and share experiences.

The European School of Urology (ESU) will provide this year a two-part course for the EAUN covering metastatic prostate cancer and treatment for localised prostate cancer. The two sessions will be at 11 in the morning and from 1 to 2 pm. Your active participation in this course is important for our professional development.

Besides the ESU course on metastatic prostate cancer, do not miss the opportunity to attend a state-of-the-art lecture on evidence-based **UTI in women** or the symposium **Urinary tract dysfunction in MS patients**. The lectures will be given by highly experienced colleagues. More information about the courses can be found in the programme.

In the past year, the EAUN has been working to achieve these goals:

- to broaden and expand knowledge about our fellowship programme
- to network with local urological and incontinence associations promoting our organisation
- to improve our section in the European Urological Today newsletter with cross-sectional articles and chosen themes
- to work on or implement the long-term strategies identified by the four new board members and the new secretary in the EAUN office.

This year 29 nurses have submitted high quality abstracts and we are happy to present nine oral and nine poster presentations during the congress. Thus, we look forward to be inspired by their efforts.

Moreover, the EAUN's focus remains on the following objectives:

- to facilitate the continued development of urological nursing in all its aspects.
- to achieve the highest standards of urological nursing care throughout Europe
- to promote the exchange of experience and good clinical practice
- to establish standards and guidelines for training and good clinical practice across Europe

Finally, it will be a pleasure to meet you all in Berlin. I hope you will enjoy the sessions, actively participate and attend the General Assembly to make a real difference!

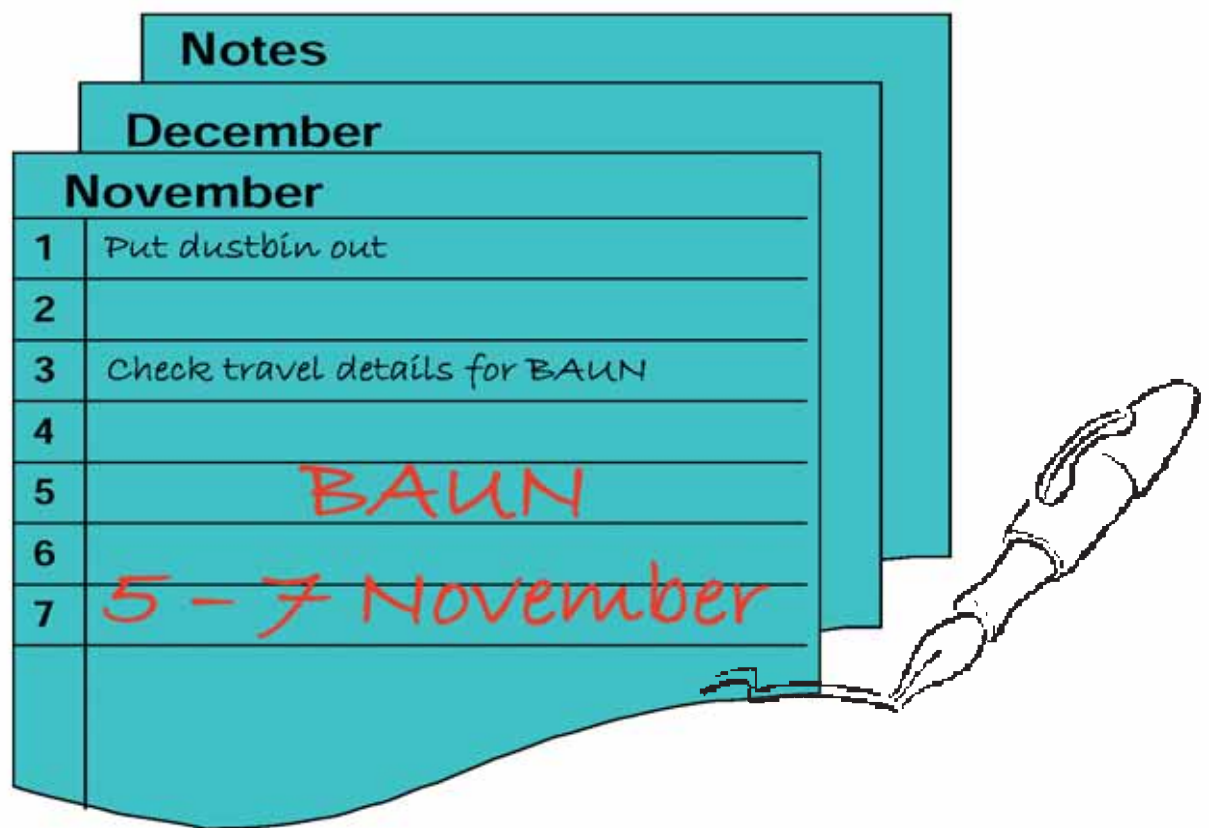


Bente Thoft Jensen.

Bente Thoft Jensen
Chair EAUN



Conference & Exhibition 2007



Put the date in your diary!

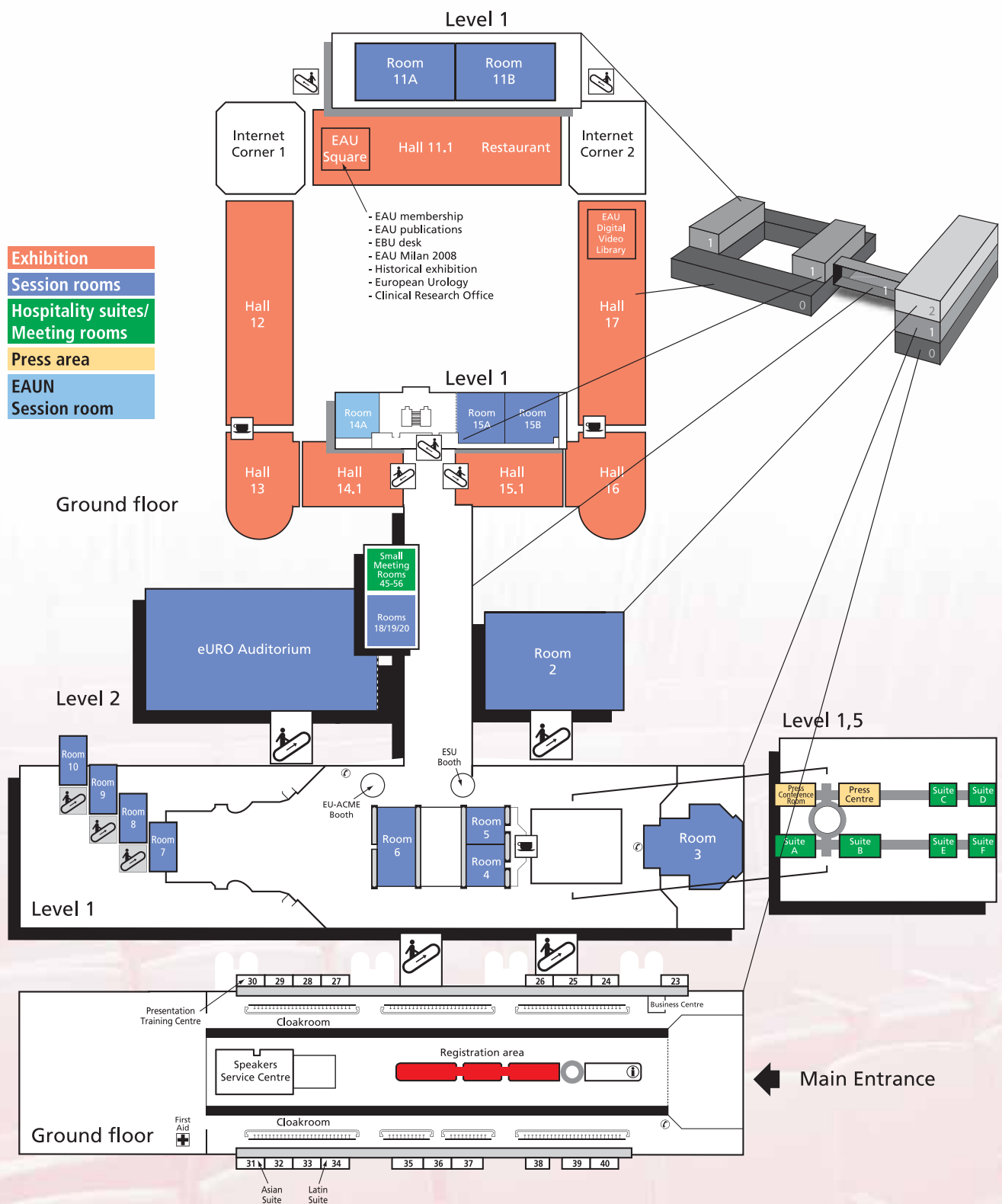
Telford International Centre, UK

For further details contact Fitwise Management Limited
Drumcross Hall, Bathgate, EH48 4JT
Tel: +44 (0)1506 811077
Email: info@fitwise.co.uk

General Information



Floorplan Congress Venue



General Information

Accessibility ICC/Messe Berlin

The ICC/Messe Berlin is easily accessible by public transport. Berlin has an excellent public transport system, connecting all parts of the city. With their congress badge, delegates will have free access to all public transport within the City of Berlin during the four days of the congress.

Address:

ICC/Messe Berlin

Messedamm 22

14055 Berlin

Germany

T +49 (0)30 3038 3067

F +49 (0)30 3038 3032

W www.icc-berlin.de

Badges

The badge classification is as follows:

Red : Congress delegate EAU member

Grey : Congress delegate non-EAU member

Green : Exhibitor

Blue : Health care professional/nurse

Orange : Press

White : Accompanying person

Yellow : Organising staff

Pink : Special registration

Bank and exchange

The national currency in Germany is the euro (€). Banks are normally open Mondays to Fridays 08.30-13.00 hrs. and 14.00-16.00 hrs. (17.30 hrs. on Thursdays). They are closed on Saturdays and Sundays. Exchange offices at airports and main railway stations are normally open 06.00 - 22.00 hrs.

The main international credit cards (VISA, Mastercard) are widely accepted in most large retail outlets, petrol stations, hotels and restaurants. Please beware, however, that smaller businesses may not accept creditcard payment and you are advised to check prior to purchase. Travellers cheques are best exchanged at an exchange office ("Wechselbüro") as they are not accepted as payment in general stores, restaurants and hotels. Banks also often decline to change travellers cheques.

Business Centre

A Business Centre is located in the entrance area (opposite to the registration desks). This service will be available to all congress participants throughout the congress.

Cellular phones

Cellular phones must be switched off during all sessions!

Certificate of Attendance

A Certificate of Attendance for the 22nd Annual EAU Congress is included in all congress bags. A certificate of Attendance for the 8th International EAUN Meeting is inserted the EAUN programme book.

Cloakroom/Luggage

The cloakroom is located in the entrance hall and is at participants' disposal during congress hours. Please be sure to collect all personal effects at the end of the day.

Congress bags

Each delegate can collect a congress bag which includes a programme book, abstract book and exhibition guide.

The congress bags are sponsored by **ASTELLAS**

Congress hours

Wednesday, 21 March	08.30 – 19.30 hrs
Thursday, 22 March	07.45 – 19.00 hrs
Friday, 23 March	07.45 – 19.00 hrs
Saturday, 24 March	07.45 – 14.00 hrs

Congress organisation

EAU Congress Office

Managing Directors

Jacqueline Roelofswaard (j.roelofswaard@uroweb.org)

Maurice Schlieff (m.schlieff@uroweb.org)

Congress Manager

Patricia de Bont (p.debont@congressconsultants.com)

Exhibition Manager

Henriet Wieringa (h.wieringa@congressconsultants.com)

Daily Congress Newsletter

Special daily congress newsletters are available on 21, 22 and 23 March 2007.

EAU Internet Corners

The EAU Internet Corners, in the exhibition area (between halls 12 & 11 and halls 11 & 17), are at your disposal to check the EAU website: **www.uroweb.org**.

Supported by an unrestricted educational grant from **ASTELLAS**

EAU Digital Video Library

The EAU Digital Video Library (booth 17/25) is operational during exhibition hours in hall 17. A wide choice of videos from the European Association of Urology including the videos presented in Berlin and at past EAU Congresses can be viewed on request on individual monitors. All videos can be copied to DVD, a service that is provided free of charge to all congress delegates.

Supported by an unrestricted educational grant from **ASTELLAS**

General Information

EAU Education Office (European School of Urology)

The European School of Urology (ESU), working with European faculties, aims to provide high quality international educational courses in urology. The ESU has a special booth on level 1 with extensive information on the activities of the European School of Urology. Registration for the courses can be made at the ESU Registration Desk in the registration area.

All congress delegates can collect an ESU Course CD at the booth of Sanofi-Aventis (booth 15/2).

ESU Course CD's are sponsored by SANOFI-AVENTIS



ESU is not responsible for any unavoidable last minute changes and will do their utmost to maintain the current programme.



EAU Square

The EAU Square (booth 11/38) in hall 11.1 consists of the EAU Membership Counter, the Publications Counter, the DVD Theatre, the EAU Milan 2008 Promotion Counter, the European Urology Counter, the Clinical Research Office and the EAU Historical Exhibition. The EAU Membership Counter provides information on membership status and membership benefits. Non-members are invited to visit the EAU Membership Counter to inquire about the many advantages for EAU and EAUN members and to apply for EAU or EAUN membership.

Electricity

The electricity in Germany runs on 220 volts and the frequency is 50 Hz. Wall outlets take plugs with two male contact pins. A plug adaptor should be taken along if incompatible electronic gadgets are used.

European Urology

European Urology, the journal of the EAU, has been a respected urological forum for over 20 years, and today is read by more than 9,000 urologists across the globe. With an impact factor of 3.542 the journal has become one of the world's leading medical periodicals.

To meet today's new challenges, we have introduced an innovative range of developments that will ensure European Urology continues to provide the best clinical guidance, research and education for urologists across Europe and the world.

See the new European Urology for yourself - visit either the European Urology or EAU booth at the exhibition.

Exhibition

An extensive technical exhibition will be held jointly with the congress. The exhibition is open to technical equipment manufacturers, pharmaceutical companies and scientific publishers.

Exhibition hours

Wednesday, 21 March	08.15-18.00 hrs.
Thursday, 22 March	09.00-19.15 hrs.
Friday, 23 March	09.00-19.15 hrs.

First aid

There is a medical unit present for first aid in the back of the entrance hall. In case of an emergency contact a security guard immediately.

Future Meetings Area

Posters and other documentation on future meetings can be displayed in the "Future Meetings Area" (booth 12/33) in hall 12. It is strictly forbidden to put up promotional material at any other location in the building.

Hotel accommodation

The EAU has contracted the company "KIT" in Berlin to deal with the housing for congress participants. The incoming requests were handled on a first-come, first-served basis.

KIT staff will be available for queries at the hotel desk in the registration area.

Commercial hospitality suites

American Medical Systems	Suite C
AMGEN	Suite D
Astellas	Suite E
Cook	Suite A

You can find these hospitality suites at the mezzanine floor of the foyer level.

Hospitality suites: Special Latin-American and Asian suites

During the 22nd Annual EAU Congress there will be special hospitality suites to welcome congress delegates from the Latin-American and Asian countries. You can find the suites at the mezzanine level in the entrance hall (rooms 31 & 34).

Insurance

The organisers do not accept responsibility for any personal damage. Participants are strongly recommended to arrange their own personal insurance.

Language

All presentations during the congress will be conducted in English, the official language of the EAU. There will be no translation provided except for the special EAUN programme where translation to German will be available.

Lost and found

Found items should be returned to the Information Desk in the entrance hall. Should you unfortunately happen to lose something, please report to this desk for assistance.

Messages & Service Points

You can use this interactive system to retrieve your messages and to send messages to other congress delegates. You can also easily find information on sessions and exhibition. Please follow the instructions on the message/service monitors at the various locations in the building.

Phone numbers

The most important telephone numbers in case of an emergency are: 110 for calling the police, 112 for the fire brigade, accident services and general emergencies.

Photo service

This year the EAU offers all congress participants the opportunity to have a professional studio photo made (free of charge) during the congress. Other photos taken by the official EAU photographer during the congress and the official social events can be downloaded, free of charge, after the congress through the congress website:

www.eauberlin2007.org.

Poster Builder Service

The EAU offers a Poster Builder Service that enables poster presenters to create posters for the 22nd Annual EAU Congress and the 8th International EAUN Meeting on-line. Posters are ready for pick-up in the Speakers Service Centre in the entrance hall.

Press Centre

Journalists can obtain free registration to the Congress at the Press Desk in the registration area (entrance hall). All media operators must show their credentials (press card dated 2007 and original assignment letter). Journalists will receive a voucher upon registration. It entitles them to a copy of the press pack, to be picked up at the press centre. All press are invited to report to the EAU Press Centre, located at the mezzanine floor of the foyer level, to obtain the assistance and information they require. Internet access, fax machine, printer and photocopier are provided.

For details about the EAU embargo policy please check:

www.eauberlin2007.org under "Press".

Restaurants

From a quick snack to a gourmet meal at a fine restaurant – the choices for eating out in Berlin are endlessly varied. Traditional Berlin cuisine tends to be rustic and hearty – Berlin meatballs and currywurst (sausage with a curry sauce) are typical examples. Eisbein (knuckle of pork) and "Berliner Weisse" (speciality beer) are also Berlin specialities. In Berlin, you can enjoy breakfast at any time of day. The in-crowd gathers at the many cafés until well into the afternoon, drinking coffee, enjoying international breakfast specialities and reflecting on the previous night's events.

Shopping

Go shopping or just window-shopping at over a dozen shopping malls, on the main shopping streets (Kurfürstendamm or Friedrichstrasse) or at the more quirky shops in Kreuzberg, Mitte or Prenzlauer Berg districts. KaDeWe, the famous department store on Wittenberg Platz, is the largest store on the European mainland – a shoppers' paradise of six floors. Galeries Lafayette in Friedrichstrasse brings a frisson of French elegance to the city. Malls such as the Arkaden on Potsdamer Platz and the Europa Center on Breitscheidplatz offer great shopping even in bad weather.

Smoking policy

Smoking is prohibited inside the congress centre and the exhibition areas.

Tourist information and excursions

Information on Berlin and excursions will be available at the Excursion Desk in the registration area.

Transportation

With their congress badges, delegates will have free access to all public transport within the City of Berlin on 21-24 March 2007.

General Information



ICC Berlin

The **Internationales Congress Centrum Berlin (ICC Berlin)** ranks among the biggest, most advanced and most successful congress venues in the world. It was built in just four years under the watchful eyes of architects Ralf Schüler and Ursulina Schüler-Witte. Since its opening the highly versatile communication complex - 320 metres long, 80 metres wide and 40 metres high - ICC Berlin is one of the most outstanding landmarks of postwar German architecture and the model for many new congress centers all over the world. With its 80 halls and rooms seating between 20 and 9,100, its versatile facilities, superb technical installations and comprehensive range of services, ICC Berlin is the perfect choice for any convention, show or concert. The complex is designed and equipped to cater for several events simultaneously. Spacious lobbies (5,500 m²) offer space for exhibitions, poster sessions and company presentations to accompany conventions. This is where the ATM (asynchronous transfer mode) communications system proves its worth: it ensures quick, safe and direct access to the Internet and Intranet.



Speakers' Guidelines

Speakers Service Centre - entrance hall

Only digital presentations will be accepted during the congress and all presentations should be handed in at the Speakers Service Centre at least two hours prior to the start of the session.

Opening hours

Tuesday, 20 March	14.00 – 19.30 hrs.
Wednesday, 21 March	06.30 – 20.00 hrs.
Thursday, 22 March	06.30 – 19.30 hrs.
Friday, 23 March	06.30 – 19.30 hrs.
Saturday, 24 March	06.30 – 14.00 hrs.

If you are a chair person

Locate your session room in time. Please be in your session room at least 15 minutes prior to the start of the session.

We remind you that:

- Speakers should strictly observe timing.
- Discussants should not speak without permission and must first clearly state their name, institution and country of origin.

If you are a speaker in an oral session

Locate your session room in time. Please turn in PowerPoint presentations at the Speakers Service Centre in the entrance hall at least two hours prior to the start of your session. Failure to do so could result in presentations not being available for projection when required. Facilities are provided for PowerPoint presentations only. Please be in your session room no later than 15 minutes prior to the start of the session. Do remember that time allotted to speakers in oral sessions is 10 minutes (including 2 minutes for discussion). Follow the chairs' instructions, in particular those regarding the timing of your lecture.

If you are presenting a poster

Posters must be put up in the room 15 minutes prior to the start of the session. The poster boards are numbered and your poster should be mounted on the board which corresponds with your abstract number. Pushpins are available in the session room. Please remove your poster immediately at the end of the session. One PowerPoint slide is allowed during your poster presentation. Also the PDF of your poster, supplied by yourself prior to the congress, will be projected during discussion of your abstract. In case you forgot to submit the PDF or PPT slide prior to the congress, you can still do this up to 5 hours prior to your session (in case of an early session the PDF/slide should be handed in on the previous day) at the Speakers Service Centre in the entrance hall.

Disclose links to the industry

The EAU Scientific Committee requests that you disclose to the audience any links you may have with the industry related to the topic of your lecture at the beginning of your session. A link can be: being a member of an advisory board or having a consultancy agreement with a specific company.

Presentation training centre

At this year's EAU Congress, as in previous years, you can take advantage of working with speaking consultant Mr. Paul Casella (Iowa, US) to help improve your presentation and delivery skills. The one-on-one half hour sessions are free of charge and are available to all

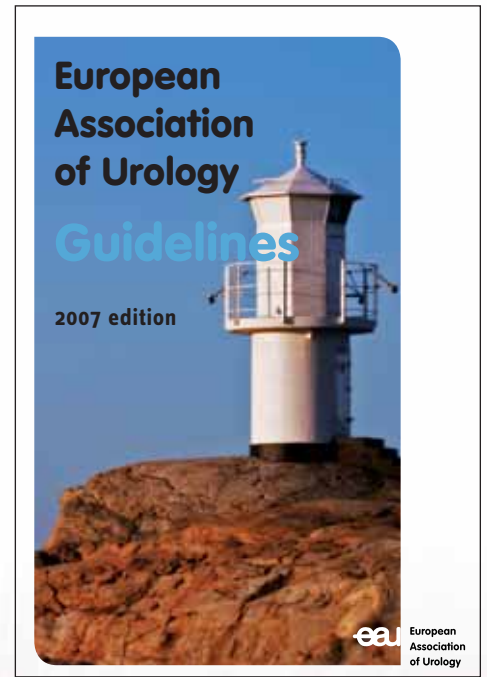


speakers. As these sessions have proved to be very popular in the past, please make your appointment at the Speakers Service Centre in the entrance hall; you can sign up for an appointment from Wednesday 21 March to Saturday 24 March. The presentation trainings are held in a room next to the Speakers Service Centre (see General Floorplan on page 6).

EAU Pocket Guidelines & CD – 2007 edition

Now also available for all EAUN members! These pocket guidelines for urologists contain updated information on diagnostic and treatment options in the urological field. With your badge you can pick them up at the

**Olympus exhibition booth:
Hall 15, Booth 6**



ESU Course CD – 2007 edition

All EAUN members are entitled to take home a copy of the European School of Urology (ESU) course CD.

This CD contains summaries of the ESU courses that will be given in Berlin. More information on the courses can be found in the EAU Programme Book.

Sanofi-Aventis exhibition booth: Hall 15, Booth 2



Scientific Programme



EAUN Programme Overview - Berlin, 21-24 March 2007

	21 March Wednesday	22 March Thursday	23 March Friday
Room	14A	14A	14A
08:00			
08:15			
08:30			
08:45		Symposium Effective management of male incontinence: Are we making the right decisions? Chair: J.T. Marley, Portadown (GB)	Lecture with cases The pelvic floor: Sexual and medical co-morbidities A. Graziottin, Milan (IT)
09:00			
09:15			
09:30			
09:45		Sponsored by COLOPLAST	Lecture Female UTI V. Geng, Lobbach (DE)
10:00			Break
10:15		State-of-the-art lecture Urinary incontinence in a technical era R. Pieters, Ghent (BE)	Poster viewing
10:30			
10:45		Break	
11:00			
11:15			
11:30		ESU Course Part 1 Metastatic prostate cancer Chair: T.M. De Reijke, Amsterdam (NL)	Poster Abstract Session Chairs: V. Geng, Lobbach (DE) J.T. Marley, Portadown, County Armagh (GB)
11:45			
12:00			
12:15			
12:30		Lunch	Lunch
12:45			
13:00			
13:15		ESU Course Part 2 Treatment of localised prostate cancer Chair: G.H.J. Mickisch, Bremen (DE)	Symposium Urinary tract dysfunction in MS: Why do patients go untreated? Chair: A. Kaufmann, Mönchengladbach (DE)
13:30			
13:45			
14:00			
14:15		State-of-the-art lecture Preservation of sexuality in urologic oncology S. Horenblas, Amsterdam (NL)	Sponsored by ASTRA TECH AB
14:30			
14:45		Break	Workshop Female sexual dysfunction: Clinical approach A. Graziottin, Milan (IT)
15:00			
15:15			
15:30			
15:45		Oral Abstract Session Chairs: U. Lindström, Malmö (SE) R. Pieters, Ghent (BE)	Break
16:00	EAUN Opening		Awards Sponsored by HOLLISTER EUROPE LTD
16:05	State-of-the-art lecture History of stone surgery T. Esen, Istanbul (TR)		
16:30		State-of-the-art lecture Uro-radiology for nurses H. Heynemann, Halle/Saale (DE)	EAUN General Assembly Chairs: R. Pieters, Ghent (BE) B. Thoft Jensen, Århus (DK)
16:45	Champagne Reception		
17:00			
17:15			
17:30	Sponsored by HOLLISTER EUROPE LTD	After Session Drinks	
17:45		Sponsored by ASTRA TECH AB	
18:00			

16.00 - 17.45

Plenary Session 1

Room 14A

16.00 - 16.05

EAUN Opening

16.05 - 16.45

State-of-the-art lecture **History of stone surgery**

T. Esen, Istanbul (TR)

14A-21-3010

16.45 - 17.45

Champagne Reception

Sponsored by HOLLISTER EUROPE LTD

08.30 - 17.15

Plenary Session 2

Room 14A

08.30 - 10.00

Symposium **Effective management of male incontinence: Are we making the right decisions?**

Chair: J.T. Marley, Portadown, County Armagh (GB)

08.30 - 08.35

Welcome

14A-22-2520

08.35 - 08.50

Overview (how many, why and cost implications lead to health economy)

M.R. Beynon, Petersborough (GB)

14A-22-2530

08.50 - 09.10

Treatment and management options (surgery, non-surgery, product usage)

M. Kirkham, Birmingham (GB)

14A-22-2550

09.10 - 09.30

Discussion: Are we making the right decisions?

- clinical evidence
- effective management
- people's input, vote

D. Williams, Liverpool (GB)

14A-22-2560

09.30 - 09.50

Effective patient education

J.T. Marley, Portadown, County Armagh (GB)

14A-22-2540

09.50 - 10.00

Discussion & Closure

Aims and objectives

To gain an overview of effective management of male incontinence, identify effective treatment strategies and management options, and get useful insights in how to perform patient education.

Sponsored by COLOPLAST

10.00 - 10.45

State-of-the-art lecture **Urinary incontinence in a technical era**

R. Pieters, Ghent (BE)

14A-22-2570

Aims and objectives

A nurse's overview of the currently available technical devices in the care for the incontinent patient.

10.45 - 11.00

Break

11.00 - 12.15

ESU Course Part 1 **Metastatic prostate cancer**



Chair: T.M. De Reijke, Amsterdam (NL)

11.00 - 11.05

Introduction

T.M. De Reijke, Amsterdam (NL)

14A-22-2580

Simultaneous translation from English to German will be provided

11.05 - 11.20	Clinical picture-diagnosis-natural history T.M. De Reijke, Amsterdam (NL)	14A-22-2590
11.20 - 11.35	Treatment alternatives stage by stage N.W. Clarke, Manchester (GB)	14A-22-2600
11.35 - 11.50	Nursing and pain management in patients with advanced prostate cancer L. Hohwü, Århus (DK)	14A-22-2610
11.50 - 12.15	Management of the clinical problems - Urologic and nursing perspectives - Case presentations and discussion N.W. Clarke, Manchester (GB) T.M. De Reijke, Amsterdam (NL) L. Hohwü, Århus (DK) R. Pieters, Ghent (BE) P.F. Slappendel, Arnhem (NL) B. Thoft, Århus (DK)	14A-22-2620 14A-22-2630 14A-22-2635 14A-22-2640 14A-22-2650 14A-22-2660
12.15 - 13.00	Lunch	
13.00 - 14.00	ESU Course Part 2 Treatment of localised prostate cancer	
	<i>Chair:</i> G.H.J. Mickisch, Bremen (DE)	
13.00 - 13.05	Welcome and introduction G.H.J. Mickisch, Bremen (DE)	14A-22-2670
13.05 - 13.35	Definitions of disease stages and treatment options Radiotherapy - external beam - brachytherapy Surgical therapy by radical prostatectomy - retropubic - perineal - laparoscopic - robot assisted Alternative approaches - watchful waiting - cryotherapy - HIFU G.H.J. Mickisch, Bremen (DE)	14A-22-2680 14A-22-2690 14A-22-2700 14A-22-2710
13.35 - 13.55	Post-operative complications - nursing perspective - erectile dysfunction - incontinence P.F. Slappendel, Arnhem (NL)	14A-22-2720
13.55 - 14.00	Conclusions and take home messages	14A-22-2730

Simultaneous translation from English to German will be provided



Thursday, 22 March

14.00 - 14.45	State-of-the-art lecture Preservation of sexuality in urologic oncology	
	S. Horenblas, Amsterdam (NL)	14A-22-2740
14.45 - 15.00	Break	
15.00 - 16.30	Oral Abstract Session	
	<i>Chairs:</i> U. Lindström, Malmö (SE) R. Pieters, Ghent (BE)	
01	Optimal nursing application of uroflowmetry J. Behets, J. Leen (Leuven, Belgium)	14A-22-2750
02	Feasibility study of intermittent self-catheterisation using the “no-touch” method with spinal cord injured patients during their first admission to the spinal unit S. Antolini, M. Menarini (Imola, Italy)	14A-22-2760
03	Review and project of applied research: Managing urinary incontinence after stroke - assessment guided promotion of urinary continence I.S. Wilbert-Herr (Faltigberg-Wald, Switzerland)	14A-22-2770
04	Hygiene and urinary tract infections after a cystectomy H. Thulin, G. Steineck, L. Henningsohn (Stockholm, Sweden)	14A-22-2780
05	Patient attitudes to nursing students in urology outpatients S. Bromage, J. Hu, M. Lester, E. Robinson, I. Pearce (Manchester, United Kingdom)	14A-22-2790
06	The nurse-led prostate assessment clinic S.J. Bromage, J. Dickens, K. Fraser, T. Ladds, I. Pearce (Manchester, United Kingdom)	14A-22-2800
07	Assessment of patients’ needs for sexuality-related information after genitourinary surgery D. Meshman, R. Tal, N. Yosef, Y. Goft, T. Goft, G. Lui, S. Zaretzer, F. Agabaria, D. Kedar, J. Baniel, P.M. Livne, J. Shmueli (Petah Tikva, Tel Aviv, Israel)	14A-22-2810
08	Ageing male and lifestyle, a primary and secondary prevention in the Dutch Andros Men’s Health Institute M. Bronkhorst, F. Ypma (Arnhem, The Netherlands)	14A-22-2820
09	Finnish prostate cancer patients’ sexual functioning and its influence on patient’s quality of life L. Kuivalainen (Joensuu, Finland)	14A-22-2830
16.30 - 17.15	State-of-the-art lecture Uro-radiology for nurses	
	H. Heynemann, Halle/Saale (DE)	14A-22-2840
17.15 - 18.00	After Session Drinks Sponsored by ASTRA TECH AB	

Simultaneous translation from English to German will be provided

08.30 - 17.00

Plenary Session 3

Room 14A

08.30 - 09.30

Lecture with cases **The pelvic floor: Sexual and medical co-morbidities**

A. Graziottin, Milan (IT)

14A-23-2570

Aims and objectives

- To present the importance of pelvic floor related co-morbidities from a perspective that can be useful to the clinical practice of nurses;
- To address the pathophysiological plausibility of co-morbidity between LUTS and FSD;
- To present different clinical cases accompanied by visual illustrations that enhance the ability of nurses to effectively deal with pelvic floor, gynecological and urological problems encountered in daily practice.

Abstract: See page 44

09.30 - 10.00

State-of-the-art lecture **Female UTI**

V. Geng, Lobbach (DE)

14A-23-2580

Aims and objectives

By the end of lecture participants will be able to

- understand causes, types and risk factors of urinary tract infections
- know the possibilities for diagnostics
- explain the common therapeutic aspects
- have some ideas about prevention of UTI's or to reduce the risk factors

10.00 - 10.15

Break

10.15 - 12.00

Poster Abstract Session

Chairs: V. Geng, Lobbach (DE)
J.T. Marley, Portadown, County Armagh (GB)

10.15-10.45

Poster viewing

P1

The effects of irrigation fluid on core temperature in endoscopic urological surgery

S. Mirza, K.J. Auyong, J. French, D. Jones, S. Panesar (Llantrisant, London, United Kingdom)

P2

How can the patient education be improved for patients leaving the hospital with an indwelling catheter of the bladder or kidney?

S. Witschi, C. Baumann, M. Schweizer, R. Willener (Berne, Switzerland)

P3

Information for patients with a radical prostatectomy: From a brochure to a workbook

J. Hendrickx, P. Imbrechts, J. Steven, H. Van Poppel (Leuven, Belgium)

P4

Clinical pathway for the Green-light Laser Vaporization of the prostate

E. López Alcina, **A. Real**, C. Piquer, J. Juan, M. Fabuel, F. Ordoño, J. Zaragoza (Valencia, Spain)

P5

Prostate cancer patients' knowledge expectations and sources of knowledge at the diagnosis phase

S. Rankinen, H. Leino-Kilpi (Turku, Finland)

Simultaneous translation from English to German will be provided



Friday, 23 March

Friday, 23 March

- P6** Is nurse education necessary in minimally invasive treatments of prostate cancer?
S. Hieronymi, U. Witzsch (Frankfurt, Germany)
- P7** Incorporating patients views within the design of Bladder Cancer Care
K. Chatterton, T. Jegede, S. Clovis, T. O'Brien (London, United Kingdom)
- P8** How to care for patients during their last span of life on a urology acute ward: A holistic concept
R. Willener (Bern, Switzerland)
- P9** Challenges in research collaboration between two surgical branches. Study nurse experiences
M. Halvorsen (Arendal, Norway)

Prizes for Best Oral and Poster Presentations will be awarded before the General Assembly at 15.45 hrs.

12.00 - 13.00 Lunch

13.00 - 14.30 Symposium **Urinary tract dysfunction in MS: Why do patients go untreated?**

Chair: A. Kaufmann, Mönchengladbach (DE)

- | | | |
|---------------|--|-------------|
| 13.00 - 13.10 | Welcome and introduction
A. Kaufmann, Mönchengladbach (DE) | 14A-23-2590 |
| 13.10 - 13.30 | Urinary tract dysfunction in MS
C.J. Fowler, London (GB) | 14A-23-2600 |
| 13.30 - 13.40 | Prevalence of sex, bowel and bladder dysfunction in MS - 2-5 years after diagnose
J. Frugård, Bergen (NO) | 14A-23-2610 |
| 13.40 - 13.50 | To teach CIC to MS patients - practical advice on when and how
C. Thorén, Stockholm (SE) | 14A-23-2620 |
| 13.50 - 14.25 | Workshop Why do patients go untreated and how can we avoid it? | |
| 13.50 - 14.00 | A urological-neurological network of neurogenic bladder dysfunction
A. Kaufmann, Mönchengladbach (DE) | 14A-23-2630 |
| 14.00 - 14.10 | A possible approach to standardised assessment and treatment of MS patients - a case from Norway
J. Frugård, Bergen (NO) | 14A-23-2640 |
| 14.10 - 14.25 | Plenary discussion about ways to improve diagnosis and treatment of MS patients with LUTS | 14A-23-2650 |
| 14.25 - 14.30 | Concluding messages | 14A-23-2660 |

Aims and objectives

Patients with MS may develop symptoms and encounter all sorts of difficulties. In many countries there is an attitude that you should not talk about the potential troubles, since that might depress patients. Unfortunately most patients will develop symptoms of urinary tract dysfunction, and many of them would not see the link between MS and LUTS. Under these conditions

Simultaneous translation from English to German will be provided

patients might unnecessarily end up in unpleasant situations that will have an adverse impact on their quality-of-life. We aim to discuss possible steps to ensure that patients with symptoms do not go untreated and suffer unnecessarily when treatment is often available.

Sponsored by ASTRA TECH AB

14.30 - 15.30 Workshop *Female sexual dysfunction: Clinical approach*

A. Graziottin, Milan (IT)

14A-23-2670

Aims and objectives

The workshop aims to present a first-level approach to diagnosis and treatment of FSD in order to boost the nurses' confidence in dealing with these issues in clinical practice.

Abstract: See page 46

15.30 - 15.45 Break

15.45 - 16.00 Awards

The following prizes will be awarded:

Oral Presentation - First Prize	500 Euro
---------------------------------	----------

Oral Presentation - Second Prize	250 Euro
----------------------------------	----------

Best Poster Presentation	250 Euro
--------------------------	----------

Awards are generously sponsored by HOLLISTER EUROPE LTD

16.00 - 17.00 EAUN General Assembly

Chairs: R. Pieters, Ghent (BE)

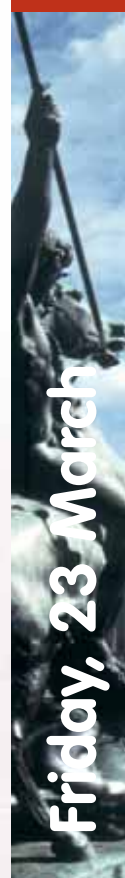
 B. Thoft Jensen, Århus (DK)

Agenda

- Welcome by the Temporary Co-chair
- Formal installation of new members and chair
- The report of the chair with presentation of the achievements of 2006/2007
- Goals for 2007/2008:
 - Position within the EAU
 - Meeting with National Societies
 - Master plan
 - Growth targets
- Questionnaire
- Subjects for the next Congress in 2008 in Milan
 - Proposals from the members will be accepted at this time.
- Any other business

**Translation from English to German is supported by an unrestricted educational grant from
FRESENIUS KABI DEUTSCHLAND GMBH**

Simultaneous translation from English to German will be provided





Abstracts



Abstracts

O1

OPTIMAL NURSING APPLICATION OF UROFLOWMETRY

Behets, J., Leen, J.

University Hospital Leuven, Urology, Leuven, Belgium

Introduction & Objectives

Uroflowmetry has become a routine investigation in patients with lower urinary tract symptoms (LUTS). It represents a truly non-invasive method to quickly identify a malfunction of the urinary system and represents a frequent nursing act. Correct instrumentation and appropriate patient assistance is vital to obtain the best results and has important implications on patient management.

We might reconsider whether the current knowledge about uroflowmetry among the nursing staff is sufficient to provide the best results at present. We aimed to assess shortcomings in the knowledge about uroflowmetry in our nursing staff and use these to construct guidelines to optimize the use of the uroflowmetry.

Material & Methods

A self-constructed questionnaire was used to assess the knowledge about the uroflowmetry in 10 nurses on the urology ward and 10 nurses at the outpatient clinic. The questions were concentrated around patient parameters (general health parameters such as age, sex, voiding habits, etc.), basic knowledge about the investigation (Qmax, average flow rate, flow time, voided volume, minimal required volume, etc.), prerequisites to be able to apply the method (full bladder, pelvic floor muscle relaxation, privacy, etc.) and issues on patient information (explaining the need of a full bladder, providing basic information on the clinical need for uroflowmetry to the patient, etc.).

A score from 0 to 10 was given for each nurse in each of the 4 domains of knowledge. The outcome of the questionnaire was used to construct guidelines on the optimal use of the uroflowmetry.

Results

From the questionnaire, both the ward and outpatient clinic nursing staff had sufficient knowledge about prerequisites to be able to apply the method. The outpatient clinic nursing staff scored better in the basic knowledge about the investigation. In both the ward and outpatient clinic nursing staff, a shortage of knowledge of the influence of patient parameters on uroflowmetry and a lack of distribution of patient information was apparent.

From this analysis, it became clear that there was a need for proper distribution of information towards the patients. Furthermore, work-shops on the basic knowledge about the investigation and basic interpretation of the uroflowmetry needed to be organised and implemented.

Conclusions

From our present analysis, a lack of basic knowledge about the uroflowmetry machine and interpretation of basic urodynamics was apparent among uro-nurses. There is a clear need of patient information brochures and nursing staff training regarding uroflowmetry. We have created an information leaflet for the patient, and written guidelines and regular workshops for nurses. A re-evaluation will be carried out in 1 year to further optimise the protocol.

O2

FEASIBILITY STUDY OF INTERMITTENT SELF-CATHETERISATION USING THE “NO-TOUCH” METHOD WITH SPINAL CORD INJURED PATIENTS DURING THEIR FIRST ADMISSION TO THE SPINAL UNIT

Menarini, M.

Montecatone Rehabilitation Institute, Spinal Cord Unit, Imola, Italy

Introduction & Objectives

Sterile intermittent catheterisation is most appropriate in acute situations and moreover within a hospital context; clean intermittent catheterisation (CIC) may instead be carried out once the patient has been discharged or, at any rate, outside a hospital environment. Recent experience has revealed that there is a third way of carrying out IC; namely the so-called “no-touch” method in which catheters fitted with a protective sleeve are used, allowing for catheterisation to be carried out without actually touching the surfaces of the catheter itself.

Material & Methods

Over the period between June 2005 and January 2006, 30 spinal cord injured patients, during their first admission to the Spinal Unit and who had never been discharged back home, took part in the study. The patients were all male and aged between 20 and 59 years (average age 35.5 years), 28 of whom with injuries to the dorsal or lumbar region (ASIA A,B,C) and 2 with cervical injuries (ASIA C), with non-contractile detrusor muscle (21) or urine retention induced by drugs for the treatment of a neurogenic hyperactive detrusor (9). All the patients carried out IC in place of urination, 12 of them had never previously experienced episodes of symptomatic UTI, 15 had experienced 1 or 2 episodes, 3 more than 3 episodes. The patients were invited to use the Flocath Quick® a ready to use catheter with protective sleeve, using the “no-touch” method, over a period of 15 days during their stay in the post-acute care area of the Spinal Unit.

Results

All the patients taking part in the study completed the trial period. The “no-touch” method was evaluated as being excellent, good and acceptable by 23%, 56% and 10% of the patients respectively; only 2 out of the 30 described it as unacceptable. 28 out of the 30 patients would use it as routine for carrying out self-catheterisation. Nursing staff gave a positive appraisal of the method. 8 patients out of 30 described it, overall, as excellent, 14 out of 30 as good, 6 out of 30 as satisfactory and just 2 out of 30 as unsatisfactory. The catheter was appraised in a very positive manner (excellent) in terms of opening the catheter itself and the sterile pouch of saline solution included in the catheter pack (30% of patients). 24 out of 28 patients would use the Flocath Quick® catheter for carrying out self-catheterisation using the “no-touch” method.

Conclusions

The possibility of using hydrophilic, self-lubricating catheters which allow for catheterisation to be carried out without either the patient's or carer's fingers coming into direct contact with the surface of the catheter itself, represents, in our view, important progress in the quest for an “all inclusive” aid. Further study needs to be conducted in order to ascertain whether the “no-touch” method effectively brings about a significant reduction in UTI amongst spinal cord injured patients carrying out intermittent catheterisation in a non-hospital context.

REVIEW & PROJECT OF APPLIED RESEARCH: MANAGING URINARY INCONTINENCE AFTER STROKE - ASSESSMENT GUIDED PROMOTION OF URINARY CONTINENCE

Wilbert-Herr, I.S.

Zürcher Höhenklinik Wald, Center of Neuro-Rehabilitation, Faltigberg-Wald, Switzerland

Introduction & Objectives

Urinary incontinence following stroke is a significant problem for the patients and their relatives that influences the well-being and care in the future. There are many therapeutic interventions available, their effectiveness is not known in detail yet. For nursing practice the ongoing question is how Urinary Incontinence can best be treated in a way that the patients daily life is arranged.

Material & Methods

The search for clinical trials was carried out in PubMed, CINAHL, and Cochrane Library, restricted to German and English papers published between 1989 and April 2006. Medical, nursing and physiotherapeutic interventions for treating Urinary Incontinence after stroke were described and analysed.

Results

The clinical trials were divided into process-oriented trials and those looking at particular interventions. The process trials could be separated into three different groups with an overall success of 82-95%, 50-56% and 23-36% in that order. Behavioural methods and medical interventions are obtainable. The studies of the most successful group enclose staff education and application of interventions based on an assessment procedure and a guideline. No clinical trial on particular interventions reached a result like the process-oriented studies.

Conclusions

Conclusion general: A multimodal course of action is necessary for treating Urinary Incontinence: special education of the nurses, operating in a problem-solving process, for example in the nursing process and providing care based on an assessment procedure and guidelines. Further research in the efficacy of individual interventions is needed.

Conclusion Practice: An Evidence Based Practice Project. A project of applied research is following the conclusions of the review. The Standard of Expert *Promotion of Urinary Continence in Nursing Care* of the German Network for Developing Quality in Nursing (DNQP, 2006) constitute the framework of the project. The process is based on the ICI Guideline *Initial Management of Neurogenic Urinary Incontinence/suprapontine cerebral lesion* and *Management of Urinary Incontinence in Frail Older Persons*. Interventions are coursed on the results of the review and on the guidelines. A flowchart for directing the process was developed. A process of screening for identifying urinary incontinence and a process of assessment accomplishing a differential view on urinary incontinence is used and a profile of dependent continence is constructed. After getting a profile interventions are planned accordingly.

HYGIENE AND URINARY TRACT INFECTIONS AFTER A CYSTECTOMY

Thulin, H.¹, Steineck, G.1, Henningsohn, L.²

¹Karolinska Institutet, Oncology and Pathology, Stockholm, Sweden, ²Karolinska Institutet, CLINTEC, Stockholm, Sweden

Introduction & Objectives

Urinary Tract Infections, one of the most common complications after radical cystectomy due to bladder cancer, affects quality of life. The cystectomized individual has to adapt to a new body function when emptying the urinary diversion. More or less extensive instructions about the importance of hygiene habits to avoid infections of the urinary tract are usually given.

Material & Methods

All 520 patients between 30-80 year cystectomized due to bladder cancer one year before the study start (2005) were identified at seven Swedish hospitals. Emigrated and people not talking Swedish language (n=29) were excluded. After exclusion the remaining study population was 491 individuals. Data were obtained by a postal questionnaire developed on the basis of successive in-depth interviews with patients. The questions were designed to evaluate possible urinary tract infections before and after the cystectomy, symptoms, hygiene habits and individual experience of the infection.

Results

Questionnaires were returned by 452 of the 491 individuals in the study group (92 percent). The incidence of urinary tract infections with symptoms during the previous year was 23 percent. The relative risk for urinary tract infections was similar in the group who always performed a proper hand wash before they handled their catheters or ostomy bandages as for those who didn't. The relative risk for urinary tract infections was not changed between those who showered every week compared to those who shower every day. In the group who had urinary tract infections the previous year the relative risk (95% C.I.) for low self-assessed quality of life was 1.8 (1.1-3.1).

Conclusions

Our data indicate that strict hygiene habits do not affect the risk for urinary tract infections for individuals with a urinary diversion after radical cystectomy due to bladder cancer. Urinary tract infections are common after radical cystectomy and it affects the quality of life negatively.

PATIENT ATTITUDES TO NURSING STUDENTS IN UROLOGY OUTPATIENTS

Bromage, S., Hu, J., Lester, M., Robinson, E., Pearce, I.

Manchester Royal Infirmary, Urology, Manchester, United Kingdom

Introduction & Objectives

The outpatient department can offer a wide range of training in urology nursing. As urology is becoming an increasingly outpatient based specialty and as there an increasing number of urology nurse-led clinics, student nurses may gain as much experience in this setting as compared to inpatient nursing. It is therefore extremely important that patients are comfortable with the presence of nursing students in this environment. We set out to determine patient attitudes towards nursing students in the urology outpatient department and whether opinions are related to patient age, ethnicity, or prior exposure to students.

Material & Methods

Questionnaires were given to all patients attending urology outpatient clinics until five hundred completed questionnaires were returned. The questionnaire consisted of nine questions concerning patient demographics and attitudes towards the presence of nursing students. Patients were also asked to grade their comfort with a student's presence from 0, indicating very comfortable, to 10 indicating very uncomfortable. Unpaired t tests were used to compare means scores between groups.

Results

Of the 500 completed questionnaires, 363 were from male patients and 123 from female patients, 14 failed to state their gender. Only 12% of patients had some degree of objection to the presence of student nurses and most patients (72%) had no preference as to the student gender. When mean values were derived for patients acceptance of the presence of student nurses, there was a significantly lower mean score, indicating more acceptance, in patients aged over thirty compared with those aged under thirty ($p < 0.0001$). This also applied to those who spoke English as their first language compared to those who did not ($p = 0.063$), and to those who had previously been exposed to nursing students compared to those with no exposure ($p = 0.0002$). Patients with an ethnic background from the Indian subcontinent recorded significantly higher mean scores, suggesting less acceptance of students than patients who claimed to be of white British ethnicity ($p = 0.0008$).

Conclusions

Overall patients are comfortable with nursing students attending their urological outpatient assessment. The patient groups that objected the most were those under the age of thirty, those who did not speak English as their first language, those who reported an ethnicity from the Indian Subcontinent, and those who with no prior exposure to students. It would be useful to know how we can improve on the perceptions that patients have to nursing students so that more patients are willing to support the learning opportunities that are essential for nursing students to maximise their training.

THE NURSE-LED PROSTATE ASSESSMENT CLINIC

Bromage, S.J., Dickens, J., Fraser, K., Ladds, T., Pearce, I.

Manchester Royal Infirmary, Urology, Manchester, United Kingdom

Introduction & Objectives

Nurse-led prostate assessment clinics have been shown to be both cost effective, and reduce the work-load of urologists. We set out to determine how closely guidelines were adhered to in our prostate assessment clinic (PAC) and whether the outcomes of these clinics were producing effective management plans.

Material & Methods

We analysed the notes of one hundred patients who attended the PAC at a single institution in 2005. We recorded presenting symptoms, examination findings, investigations performed and their results and outcome. In particular we determined whether the guidelines for investigations and management set out for this were followed, and whether there were any changes in these following a follow-up visit to a consultant-led clinic.

Results

The age range of the one hundred patients was 48 to 90, mean 67. The main source of referral was primary care (79%), with others referred from hospital doctors (20%), and privately (1%). The most common presenting symptom was nocturia (57%), but the majority (95%) of patient had a combination of symptoms. All patients underwent urinalysis and serum urea and creatinine tests. All patients had an attempted flow rate and residual volume ultrasound scan, although four were not able to complete this successfully. Prostate-specific antigen was tested appropriately in 96%, but not performed in 3% who fitted criteria for the test. A renal tract ultrasound was performed in all patients who met the criteria. Management was appropriate based on clinic guidelines in 92%. For those who had a variation on this management, 2% had been discussed with a consultant urologist, and 6% were considered alternative ways of managing the patient's symptoms in the follow-up consultant appointment. Following the consultant appointment 48% of patients had no change to the management initiated in the PAC, and 20% were discharged.

Conclusions

The nurse-led PAC is an effective means of assessing patients and consistently performs appropriate investigations and develops effective management plans. Urology specialist nurses may have further roles in the assessment of other common urological presentations, such as recurrent urinary tract infections.

ASSESSMENT OF PATIENTS' NEEDS FOR SEXUALITY-RELATED INFORMATION AFTER GENITOURINARY SURGERY

Meshman, D.¹, Tal, R.¹, Yosef, N.¹, Gof, Y.², Gof, T.², Lui, G.¹, Zaretzer, S.¹, Agabaria, F.¹, Kedar, D.¹, Baniel, J.¹, Livne, P.M.¹, Shmueli, J.¹

¹Rabin Medical Center, Beilinson Campus, Institute of Urology, Petah Tikva, Israel, ²The Israel College, Public Administration in Health, Tel Aviv, Israel

Introduction & Objectives

Sexual dysfunction is a prevalent problem in aging men with a significant impact on their quality of life. It is a multifactorial disorder and may involve many different domains, related to both psychological and physiologic insults. Sexual dysfunction is an important possible complication of genitourinary surgery; however it is often under-diagnosed and under-treated, as patients hesitate to report or admit sexual problems or to seek treatment for sexual dysfunction, even at urology clinic visits, during encounters with professional urologic staff. Awareness of patients' needs regarding sexuality-related information after genitourinary surgery will facilitate sexual dysfunction diagnosis and management. This study's objectives are to assess patients' needs for sexuality-related information after genitourinary surgery and the preferred method and setting for receiving this information.

Material & Methods

109 subjects were sampled in a convenience sample from patients who have undergone genitourinary surgery at the Urology Department, Rabin Medical Center, Israel. The distribution of a newly developed and validated questionnaire took place over a 2-month period from March to April 2006. Questionnaires were administered after surgery, at either the department, before discharge home, or at the outpatient urologic clinic during follow up visits.

Results

89 out of 107 subjects completing the questionnaire (83.2%) responded that they were interested in information regarding sexual issues, regardless of the type of genitourinary surgery, patients' age or education level. 22.3% and 21.7% of the study group received information, before and after surgery, respectively. 41.3% of subjects had no preference regarding the timing of information delivery, while 33.7% and 20.6% preferred to receive the information before and after surgery, respectively. 39% reported that they had some degree of sexual dysfunction prior to the surgery, however only 25% of them have been treated for this problem.

Conclusions

Patients percept lack of information regarding sexual issues. Therefore, health care professionals should provide sexuality-related information to patients undergoing genitourinary surgery as an integral constituent of comprehensive surgical care. Continued research in this area with larger sample size studies encompassing various ethnic and religious groups are needed to determine and address the specific needs regarding sexuality-related information among of males who undergo genitourinary surgery.

O8

AGEING MALE AND LIFESTYLE, A PRIMARY AND SECONDARY PREVENTION IN THE DUTCH ANDROS MEN'S HEALTH INSTITUTE

Bronkhorst, M.¹, Ypma, F.²

¹Andros Men's Health Institute, Lifestyle, Arnhem, The Netherlands, ²Andros Men's Health Institute, Uro-andrology, Arnhem, The Netherlands

Introduction & Objectives

Andros Men's Health Institute is the first private clinic concerning the urogenital and general health of the ageing male in the Netherlands. With a holistic approach a team of urologists and specialised nurses screen men for several age-related diseases. They look at the effect it has on the male's quality of life and give them advice. Four different programmes are offered for a better quality of life: diagnosis and treatment of:

1. Lower Urinary Tract Symptoms and Prostate Diseases (LUTS, BPH, PCa etc.)
2. Erectile Dysfunction (ED)
3. Late Onset Hypogonadism (LOH)
4. An intensive lifestyle counselling programme for the obese ageing male.

10% of these men have central obesity and many of them don't know how to lose weight and have problems maintaining a healthy lifestyle. Central obesity is mostly accompanied by hypertension, high cholesterol and insulin resistance. This cluster of symptoms, also known as the metabolic syndrome, increases the risk of cardiovascular diseases such as ED, diabetes melitus type 2 (DM 2) and low testosterone levels. Good dietary habits and sufficient physical activity play an important role in preventing and fighting these risks.

Material & Methods

We developed a methodical programme and formulated an attainable target, to improve knowledge, behavioural change and anticipation of high-risk situations and to measure effectiveness such as the reduction of metabolic risk factors. Clients will be coached for three months. During the one-hour intake, the nurse will discuss the questionnaire, filled in by the client. The method is explained and several measurements are taken: weight, BMI, waistline, fat percentage and blood pressure. At this point the blood values are already known. Subsequently the client is coached by telephone. The programme is ended by interviews and counselling of results. From Jan till Dec 2006, 46 men were included. The inclusion criteria are: 1. good motivation for obtaining a healthy lifestyle, 2. BMI, 27 or more. Patients with DM who inject insulin are excluded.

Results

We will show you the positive effect of good dietary habits, lifestyle and sufficient exercise on blood values, blood pressure, medication and both physical and mental health. It's an effective answer to many problems that can occur in the elderly male as a result of an unhealthy lifestyle. Clients feel fitter and are more able to move. Self-confidence is boosted.

After 3 months average reduction of:

- weight: 10 kg (3 - 17 kg),
- waistline: 10,5 cm (3 - 22 cm),
- triglyceride: 1.44 mmol/l (+ 2.7 till - 11.8),
- HbA1C: 0.69 % (+ 1 till - 5.9)

Testosterone increased with 2.3 nmol/l (-2.5 till 6.4).

Conclusions

Integrated care and a coordinated lifestyle programme are important for optimising gender specific quantity of life. The Andros Men's Health Institute fulfilled those needs with primary and secondary prevention and contributed in the quality of life of the ageing male.

FINNISH PROSTATE CANCER PATIENTS' SEXUAL FUNCTIONING AND ITS INFLUENCE ON PATIENT'S QUALITY OF LIFE

Kuivalainen, L.

Municipal federation of the Hospital District of North Karelia, urological outpatients department, Joensuu, Finland

Introduction & Objectives

There are over 4000 newly prostate cancer patients in one year in Finland. There are many aspects relation on patients health related quality of life. The purpose of the study was to explain what kind of sexual problems prostate cancer patients have after beginning the treatment in one year follow-up time. The sexual functioning was based on patients' health related quality of life.

Material & Methods

The sample size was 272 prostate cancer patients aged 45-90. The data was collected with interviewing patients before the treatment, four months after the treatment and postal-questioning 12 months after the treatment. There were used health related quality of life instruments 15D, EORTC QIQ C 30 and prostate cancer module. The data was analysed with SPSS-program using Kreskas-Wallis test.

Results

24% of patients with localized disease had normal sexual functioning. 83% of patients were interested in sex before beginning the treatment. Sexually active were over half of patients before the treatment and much less after the treatment. Two thirds of patients had difficulties getting or maintaining an erection or had ejaculation problems. Over half of patients felt uncomfortable about being sexually intimate. Prostatectomy and radiotherapy patients were as active sexually. Prostatectomy patients had more problems in getting or maintaining an erection and ejaculation than radiotherapy patients in one year follow-up time ($p = 0.000$).

Two thirds of patients with metastatic cancer had poor sexual functioning. Before the treatment 15 % of patients with metastatic disease were interested in sex and after the treatment 5 % and sexually active were only 2 %. Patients with metastatic cancer had more erectile difficulties and ejaculation problems than patients with localized disease. Patients who had poor sexual functioning and poor quality of life and other symptoms.

Nurses gave information to patients about sexual functioning. Patients who received enough information about sexuality for decision-making and participation in treatment had better health related quality of life. Younger patients wanted more information about the disease and treatment effecting on sexuality. Younger patients were dissatisfied with the information about sexual functioning related issues they received. Adequate information about sexual functioning improved quality of life. Nurses should consider the factors that influenced on patients' health related quality of life when they plan evidence based nursing for patients with prostate cancer.

Conclusions

On the basic of this study there were developed nursing interventions with prostate cancer patients in North Karelia Hospital District. All patients will have a chance to discuss about their disease, treatment and its impact on sexuality with nurses or the sexual therapist.



Poster Abstracts

P1

THE EFFECTS OF IRRIGATION FLUID ON CORE TEMPERATURE IN ENDOSCOPIC UROLOGICAL SURGERY

Mirza, S.¹, Auyong, K.J.¹, French, J.¹, Jones, D.¹, Panesar, S.²

¹Royal Glamorgan Hospital, Urology, Llantrisant, United Kingdom, ²Imperial College London, Surgery, London, United Kingdom

Introduction & Objectives

Irrigating fluids are commonly used in endoscopic urological surgery. Recent studies have shown benefit in using irrigant fluids warmed to body temperature to prevent undesirable effects of cooling, including impaired coagulation function, reduced levels of drug clearance and shivering resulting in increase in oxygen requirements causing potential myocardial ischaemia.

Material & Methods

Prospective observational study of 100 patients undergoing various types of endoscopic urological surgery including TURP, TURBT, PCNL and Cystoscopies, to determine the temperature difference between preoperative and postoperative core temperatures and to determine whether this change was related to the age, weight, type of anaesthetic, operation duration, type of operation, amount of irrigant fluid used and whether warming the fluid to 37°C made a difference.

All the above variables were recorded for each patient as well as the preoperative and postoperative temperatures and a statistical analysis was carried out.

Results

The mean age was 64years and the mean weight was 75 kg in the study. 76 patients had a general anaesthetic while 24 had a spinal anaesthetic. The study included 29 TURPs, 10 TURBTs, 6 PCNLs and 55 Cystoscopies. Age and type of anaesthetic did not correlate significantly with temperature change. As weight increased patients tend to preserve their core temperature more efficiently. The highest degree of temperature drop was in the PCNL group. There was a significant relationship between the duration of operation and temperature drop ($P<0.05$) as well as the amount of irrigation fluid used ($P<0.05$). Average temperature drop for patients who underwent irrigation with fluid at room temperature ($n=20$) was 1.37°C and 0.95°C for those whose fluids were warmed to body temperature ($n=80$). This difference was statistically significant ($P=0.03$).

Conclusions

There is a drop in temperature in most endoscopic operations on the GU tract and this appears to be multifactorial in origin, relating significantly to weight, amount of irrigation fluid used, type and duration of operation. Warming irrigant fluid to body temperature appears to significantly reduce the degree of temperature drop with consequent potential benefit.

P2

HOW CAN THE PATIENT EDUCATION BE IMPROVED FOR PATIENTS LEAVING THE HOSPITAL WITH AN INDWELLING CATHETER OF THE BLADDER OR KIDNEY?

Witschi, S., Baumann, C., Schweizer, M., Willener, R.

University Hospital of Bern, Department of Urology, Bern, Switzerland

Introduction & Objectives

In our current clinical setting, we have more and more patients leaving the hospital earlier and who still require a permanent catheter in the bladder or kidney for some time. They have to manage the catheter in their daily lives and our goal was to improve our method of patient education. The objective was to reduce there anxiety, facilitate their ability to manage the catheter safely and with good quality. Our novel technique of providing instructions guarantees an easiness of understanding.

Material & Methods

It s a well known fact, that an understanding of catheter management is easier, if someone can see and touch the equipment involved while learning. Our goal was to achieve an improved method of instruction that would allow patients to exercise with the involved equipment. Therefore, we developed boxes which contained the material and photographs.

Results

The boxes are established in our clinic and the nurses use them for instruction. Every nurse, working on the ward is able to educate patients the same way, this guarantees improvement of nursing quality and patient education.

Conclusions

The following conclusions are expected:

- Skills of nurses to educate patients is supported
- Security of handling is improved for the patient
- Patients satisfaction is improved
- Patients visit by his physicians can be reduced if he can handle his situation with more security
- Calls on our outpatient clinic can be reduced if the instruction is satisfying
- Unity of patient education in our ward is guaranteed

INFORMATION FOR PATIENTS WITH A RADICAL PROSTATECTOMY: FROM A BROCHURE TO A WORKBOOK

Hendrickx, J., Imbrechts, P., Steven, J., Van Poppel, H.

University Hospital Gasthuisberg, Urology, Leuven, Belgium

Introduction & Objectives

Information for patients who will go through an operation is very important nowadays. There is a lot of information available but what the patient needs is the complete information for his particular operation. The information that is given is not always written down and every professional in the health care process has his own information channel. What we need is one particular brochure with all the information and the possibility to write down and evaluate the progress in the health care process.

It must become a kind of workbook which is used by all health care professionals as well as the patient himself.

Material & Methods

Last year (2006) the doctors and nurses of the urological department decided to make a clinical path of the patient who must have a radical prostatectomy. All aspects of care were detected and evaluated by the whole team. They discussed the different phases in the care process, going from the decision for an operation till the very last consultation.. During these evaluation moments, they saw that the existing brochure was incomplete and not up to date. Following aspects were discussed in the final brochure: the normal working of the prostate, a to do list before the operation (examinations, home medication, exercises of the pelvic floor), the different aspects of care during the hospitalisation, procedures to leave the hospital with a urethral catheter, medication after the operation, a list of the most common problems after the operation and how to handle them, explanation of the several exercises to train the pelvic floor, the use of incontinence products and the daily life after the operation.

A new dimension in the care process was the role of the patient. He was instructed to note important observations concerning his urethral catheter and the wound aspect. After his catheter was taken out, he had to fill in a continence chart to evaluate the loss of urine. The exercises for continence were started and had to be continued at home on supervision of a trained physical practitioner. The brochure also contains several charts to evaluate the loss of urine, PSA determination, following consultations,.... All information had to be filled in so that all health care professionals could evaluate and discuss the complete progress of the patient.

Results**Conclusions**

The simple brochure at the start became a real work document not only for the doctor and the nurses but also for all health care professionals in and outside the hospital. The information that was written down was clear and complete. This new workbook was following the patient from his first consultation through the hospitalisation to the follow up consultations. It adds a new dimension to the care for a patient with a radical prostatectomy.

P4

CLINICAL PATHWAY FOR THE GREEN-LIGHT LASER VAPORIZATION OF THE PROSTATE

López Alcina, E., Real, A., Piquer, C., Juan, J., Fabuel, M., Ordoño, F., Zaragoza, J.

Hospital General de Valencia, Urology, Valencia, Spain

Introduction & Objectives

Clinical pathways constitute a powerful tool for reducing the variability that occurs in clinical practice. The results obtained with the use of a clinical pathway for patients undergoing green-light laser vaporization of the prostate for benign hyperplasia of the prostate (BPH) are presented.

Material & Methods

A prospective study was carried out on a cohort of 62 consecutive patients that had undergone laser vaporization for BPH after the application of a clinical pathway and compared with the results of the first 30 cases treated before the application of the clinical pathway. For the evaluation of the degree of satisfaction, patients were asked to fill out a questionnaire included in the pathway documents.

Results

No statistically significant differences were found between both groups for age, prostate volume measured by DRE and US, previous treatment for prostatism and anesthetic risk. With the application of the pathway, the mean duration of hospital stay was reduced from 2.1 days (range 1.2-2.5) to 1 day (range 0.8-1.5) ($p < 0.001$) and the duration of urethral catheterization from 31 hours (range 24-45) to 20 hours (range 15-22) days ($p < 0.01$). Statistically significant differences were found before and after the application of the clinical pathway for degree of compliance of the pre-established antimicrobial prophylaxis guidelines during hospitalisation and after discharge, and thromboembolic prophylaxis. The relative risk of complications after discharge was less after the application of the clinical pathway ($RR = 0.66$), although it was not statistically significant ($CI: 0.41-1.05$). 53 of the 62 patients included in the clinical pathway submitted the questionnaire without identifying themselves. Duration of hospitalization was considered adequate by 89%, and coincided with the programmed and actual duration according to 82.5%.

Conclusions

The application of a clinical pathway for patients undergoing green-light laser vaporization of the prostate for BPH has reduced costs by reducing the length of hospital stay and adverse effects. Furthermore, the variability of medical care has improved its quality.

PROSTATE CANCER PATIENTS' KNOWLEDGE EXPECTATIONS AND SOURCES OF KNOWLEDGE AT THE DIAGNOSIS PHASE

Rankinen, S., Leino - Kilpi, H.

University of Turku, Department of Nursing Science, Turku, Finland

Introduction & Objectives

Prostate cancer is one of the most common cancers in men all around the world. In Finland, the incidence rate was 115.3 per 100 000 men in 2004, and was highest in the 70 - 74 year age group. The survival rate is higher the longer time has passed from diagnosis. Early detection and improvement in the treatment of prostate cancer has decreased patient mortality. The deaths caused by prostate cancer were 806 in 2004.

While most of the patients are older men, patients structure their illness related knowledge individually. Patients' knowledge expectations are complex and changes over time. Not all prostate cancer patients expect same amounts of knowledge. In addition, there are also factors such as patients' previous experiences, patients' knowledge-seeking behaviours, received support, patients' understanding and memory influencing patients' knowledge expectations. This paper focused on patients' knowledge expectations and main sources of knowledge at the diagnosis phase.

Material & Methods

An electronic search in Ovid Medline and Cinahl databases was utilised, using MeSh search terms: 'prostatic neoplasm's', 'health knowledge', 'patient education' and appropriate variations of these search terms. Inclusion criteria were: prostate cancer, illness related knowledge, the diagnosis phase. The purpose of this systematic literature review was to analyze prostate cancer patients' illness related knowledge structuring.

Results

Prostate cancer patients' knowledge expectations vary during different phases of cancer. At the diagnosis phase, patients have to make treatment decisions. Therefore, patients want to gain knowledge about prognosis and stage of disease, treatment and its working, possible benefits and harms of treatment. For example, patients were interested treatment options if initial treatment is unsuccessful or cancer progresses. Patients expected less knowledge on effects on skin, sexual functioning, hair loss and changes of losing testicles. Background factors were associated with knowledge expectations. Younger men (<65) were more interested in knowledge concerning sexuality. Knowledge of the hereditary risk was ranked higher by men who had sons, those with a family history and men with lower education.

Prostate cancer patients' main sources of knowledge were talking to someone, reading a pamphlet, reading newspaper articles and using internet. Having access to the experiential knowledge from other prostate cancer patients was highly valued. Nurses were generally highly regarded as sources of knowledge because they had practical and specialist knowledge. In addition, patients knew that the received knowledge via internet required careful assessment.

Conclusions

The development of patient education requires that we know better which way prostate cancer patients structure their illness related knowledge base. Therefore it is important to know patients' cancer-related knowledge expectations and their sources of knowledge.

P6

IS NURSE EDUCATION NECESSARY IN MINIMALLY INVASIVE TREATMENTS OF PROSTATE CANCER?

Hieronymi, S.¹, Witzsch, U.²

¹Krankenhaus Nordwest/ Stiftung Hospital zum Heiligen Geist, Central Department of Surgery, Frankfurt, Germany,

²Krankenhaus Nordwest/ Stiftung Hospital zum Heiligen Geist, Department of Urology and Paediatric Urology, Frankfurt, Germany

Introduction & Objectives

The perception of minimally invasive therapies changed over the last few years. Due one hand to the increased proportion of elderly patients and on the other hand to more and more patients who would have been suitable for open surgery, but definitely refuse it on grounds of morbidity.

Initially special nurse education may seem unnecessary for this kind of therapy, because it seems that there is not much to do in the pre-, intra and postoperative nursing. But there are several specialties and a non-observance can cause severe problems which interfere with the benefits of a minimal invasive therapy.

Material & Methods

In our department prostate cancer can be treated with High Intensity Focused Ultrasound (HIFU) or Cryoablation besides radical prostatectomy. Both minimally invasive methods destroy the prostate tissue, either with heat (=HIFU) or with coldness/ ice (=Cryoablation).

In HIFU the patient is lying on his right side and the energy is applied by a transrectal ultrasound probe. The only "invasive" aspect of the treatment is the insertion of a transurethral and a suprapubic catheter.

In Cryoablation the patient is lying in a lithotomy position. Up to 25 needles, which create an iceball at their tip, are transperineally inserted, guided by transrectal ultrasound. The patient gets a suprapubic catheter for urinary drainage. Beside the normal preoperatively routine, in both therapies patients require very good bowel preparation to ensure optimal visualisation of the prostate by TRUS.

Normally no material for the pathology is extracted during the procedure. To become familiar with the technique there is a clinical application specialist (CAS) in the OR during the first procedures. Postoperatively patients can be mobilised at the day of surgery and full nutrition is possible at once. But there are several specialties to observe, i.e. the forbiddance of any rectal manipulation, smooth stool etc.

Results

Although we treated about 115 patients with HIFU and about 130 patients with Cryoablation we still observe problems in the nursing aspects. Often there are only small things which do not really affect the patient (e.g. preparation of papers for pathologist).

Nevertheless this waste of time for unnecessary work is missing in the rest of the day. But sometimes there are also serious mistakes.

This is usually the result of ignorance of what really happens during the procedures.

For the OR staff it is important to combine the requirements on sterility and patients security with the technique. In this part the CAS often can't help, because they are normally not nurses.

Therefore we try to develop written SOP (Standard Operation Procedure) to fix standards and give as much information as possible.

Conclusions

To ensure that benefits of minimally invasive procedures are not endangered by nursing mistakes due to ignorance, nurse education is also essential in these kinds of treatment.

INCORPORATING PATIENTS VIEWS WITHIN THE DESIGN OF BLADDER CANCER CARE

Chatterton, K., Jegede, T., Clovis, S., O'Brien, T.

Guy's and St. Thomas' Hospital NHS Foundation Trust, Urology, London, United Kingdom

Introduction & Objectives

A key feature of high quality care is that it should be patient focused. To ensure this transpires, patients' views need to be incorporated in the design of services.

Material & Methods

22 patients and partners were invited to attend a Bladder Cancer Patient Day to discuss their care with the medical and nursing teams. 10 Patients attended, in addition to 5 partners. This cohort of patients have or currently having different disease management. Including; radical surgery, intravesical treatment, chemotherapy/radiotherapy and surveillance for their disease.

Results

Key problems identified:

- Slow and confused communication with the General Practitioners
- Lengthy waits to access hospital system
- Fragmented diagnostic/treatment process
- Pain control at time of flexible cystoscopy
- Length of time between follow-up scans and consultations
- Different Doctors at consecutive consultations
- Confusion around prognosis
- Inadequate patient information
- No specific point of contact to alleviate anxieties
- Availability of appropriately trained nursing staff on the wards

Suggested solutions:

- Robust referral system
- One-stop diagnosis
- First consultation with consultant urologist
- Overhaul written, web and verbal information streams
- Bladder Cancer Clinical Nurse Specialist
- Pre-emptive contact with patients on day post-diagnosis
- Reform role of analgesia/antibiotics prior to flexible cystoscopy?

Conclusions

This patient day has provided key information to produce quality patient centred care within bladder cancer.

Demonstrating that a one-stop approach to outpatient centred care should become the gold standard to eliminate many of the problems identified.

P8

HOW TO CARE FOR PATIENTS DURING THEIR LAST SPAN OF LIFE ON A UROLOGY ACUTE WARD: A HOLISTIC CONCEPT

Willener, R.

University Hospital of Bern, Department of Urology, Bern, Switzerland

Introduction & Objectives

On a urology ward at a university hospital there are many patients with the diagnosis cancer. Not all of them will be cured after the treatment. Especially prostate cancer patients with bone metastases often suffer from pain and long term complications. Some of them will be hospitalised several times and at the end will die in the hospital.

On a surgical urology unit day to day work is often very hectic, nurses do not have enough time and patience to care for these dying patients. Again and again the situation was dissatisfying for all persons involved.

Material & Methods

The situation analyses showed that there were communication problems because there was no meeting with the patient, his or her family, physician and nurses together. There were no interdisciplinary shared decisions and understanding about the goal of care and the necessary procedures during the last days.

Results

A concept of communication and decision-making process in palliative care was developed, and implemented on the urology unit. The whole process is mapped in a flow-chart.

Interdisciplinary further education about palliative care topics such as pain management and nutrition were conducted.

Conclusions

- Consciousness and sensitivity for palliative care is enhanced.
- Interdisciplinary decisions are made together with the patient and family.
- Communication is clear and documented.
- Pain management is improved.
- Palliative care is a satisfying task for nurses.
- Patients and they're families are well supported and satisfied.

CHALLENGES IN RESEARCH COLLABORATION BETWEEN TWO SURGICAL BRANCHES. STUDY NURSE EXPERIENCES

Halvorsen, M.

Sorlandet Hospital Arendal, Urology, Arendal, Norway

Introduction & Objectives

A pilot study on voiding problems in patients with lumbar disc herniation scheduled for operation was initiated in nov-04 as a co-operation between orthopaedic surgeons and urologists. The urotherapist served as study nurse and performed the voiding tests. Based on experiences from the pilot study, three more studies have been established and are ongoing. This presentation deals with how considerable logistic problems in the pilot study were changed into nearly perfect collaboration in the ongoing studies.

Material & Methods

The pilot study consisted of 59 patients. The ongoing studies include so far 23 surgically treated patients (1), 32 conservatively treated patients (2) and 18 patients operated 2-4 years ago (3).

The voiding tests to be carried out are: The patients subjective impression of voiding problems, a symptom score questionnaire, uroflowmetry and residual urine measurement with ultrasound. In the pilot study the tests were done preoperatively, on discharge from hospital and 6 weeks later when seeing the orthopedic surgeon. In the ongoing studies (1&2) the tests are done preoperatively or at start of conservative treatment, after 6 weeks, 6 months, and 12 months. In previously operated patients (3) the tests are done only once to look for permanent damage.

Results

In the pilot study one patient did not even meet for the preoperative tests, 7 did not answer the questionnaire, 4 had not valid uroflowmetry and 5 not valid residual urine measurement. On discharge from hospital as well as at 6 week follow up 17 patients(29%) did not meet for the tests. All three tests were done only in 32 patients(54%). The responsibility for sending the patients to voiding tests belonged to the orthopedic staff. We early became aware of the too many dropouts. Despite of several meetings and pep-talks, the situation did not improve. Consequently, the responsibility was moved over to the study nurse. The following changes were made: Before the first voiding test the patients have to sign informed consent. They are informed about the purpose of the tests and they learn to prepare the bladder for a successful test. Written appointment is sent by post before every test day. If a patient not appears, a phone call is made for new appointment. Due to these changes the ongoing studies run much better. One out of 73 included patients have withdrawn. The others have met on scheduled time except in one single case.

Conclusions

Experiences gained from these studies show that binding appointments and good patient information are important factors for success. Organization of specific tests should be done by the collaborating part who performs the tests.

Abstracts Lectures



The pelvic floor – sexual and medical co-morbidities

Alessandra Graziottin MD

Director, Center of Gynecology and Medical Sexology

H.San Raffaele Resnati, Milan, Italy

Co-Director, Post-graduate Course of Sexual Medicine

University of Florence, Italy

The pelvic floor is the anatomic, static and dynamic structure that inferiorly closes the pelvis and sustains the pelvic and abdominal organs. Its role is increasingly recognized in the etiology of different medical (urologic, gynecologic, proctologic, physiatric) and sexual conditions, contributing to a significant comorbidity [1].

The role of the pelvic floor overlaps with other biological factors. Embriologic affinity, anatomic contiguity, hormonal sensitivity, vulnerability to reproductive, coitus-related and iatrogenic and/or traumatic events [2], further contribute to the frequent and yet neglected co-morbidity between Urinary Incontinence (UI), Lower Urinary Tract Symptoms (LUTS) and Female Sexual Dysfunctions (FSD), specifically genital arousal disorders [3], dyspareunia and orgasmic difficulties [4]. New reading of clinical data indicate that a significant (and yet neglected) co-morbidity is also present with proctological and bowel diseases [5].

Latent classes analysis of sexual dysfunctions by risk factors in women indicate that *urinary tract symptoms* have a RR = 4.02 (2.75-5.89) of being associated with arousal disorders (and its most frequently reported associated symptom: vaginal dryness) and a RR=7.61 (4.06-14.26) of being associated with sexual pain disorders [6].

The presentation will discuss this co-morbidity in the lifespan perspective, with special focus on predisposing, precipitating and maintaining factors –biological, psychosexual and context-related- the clinician should pay attention to, for a comprehensive diagnosis and a well tailored etiologically oriented treatment [7].

The *Overactive Bladder* (OAB) is a frequent but underreported condition, affecting from 11.4% to 17% of women over 40 year. Fear of rejection, shame, embarrassment, loss of self-esteem, all contribute to the difficulty the woman has in reporting to her own physician and asking for help.

Active investigation on the part of the clinician (physician and nurses) is key to avoid the “collusion of silence” that involves in a common denial both bladder and sexual problems. OAB is a taboo for many patients, as it conveys the fear and the threat of social rejection. Incontinence violates the social request of control, on mental impulses and on basic functions, like micturition, that is expected to be postponed to time and places socially appropriated.

Emotional and sexual intimacy may be crippled by OAB: sexual identity, sexual function and sexual relationship may all change for worse. Up to two thirds of affected women report to be less confident in courting and less willing to start a new history; one third prefers not to reach orgasm for fear of leaking when pleasure peaks. More than half the women affected by OAB report their feeling less feminine and less sexually attractive: the smell of urine instead of the “scent of woman” is difficult to be accepted by both men and women. “Feeling wet” not because one is aroused, but because of urinary leakage, may block every possibility of intimacy. Sexual co-morbidity is frequent. Dissatisfaction and avoidance of intimacy may be the conclusion of a repeatedly disappointing experience.

The criteria for the differential diagnosis between female ejaculation at orgasm and OAB associated leaking at orgasm will be presented, as they are increasingly relevant in the clinician’s practice [4]

Stress incontinence and its gynecological and sexual co-morbidities will be briefly discussed.

Post-coital cystitis is more frequent in hypoestrogenic conditions (hypothalamic amenorrhea, post-partum amenorrhea, menopause) when the vaginal pH increases; when the pelvic floor is hyperactive; when genital arousal is poor or absent; when irritable bowels symptoms are complained of; when systemic antibiotics have altered the colonic and vaginal ecosystems. Current observational data indicate that 40 to 61 % of women with recurrent cystitis do report dyspareunia when actively asked for this co-morbidity [8].

Special focus will be devoted to: 1) the rationale of assessing the vaginal pH, with the implicit evaluation of both the local ecosystems and the estrogenic tissue level in the vagina, and advantages in term of co-treatment of both sexual symptoms and LUTS when topical vaginal treatments are prescribed after the menopause; 2) the importance of assessing the pelvic floor tonus [1], and the rationale of relaxing the hyperactive pelvic floor in recurrent cystitis, dyspareunia and associated conditions, such as dyspareunia [9], vulvodynia [10], and obstructive constipation [1, 5]. A rich series of vulvar pictures will be presented to ease the learning.

Available treatment outcomes will be presented in detail.

The ultimate goal is to stress the logic of progressing from a well assessed medical and sexual *co-morbidity* to a woman-centered, cost and QoL saving *co-treatment*, with a comprehensive and yet easy to practice approach.

References

- [1] Bourcier A. McGuire E. Abrams P. 2004 Pelvic Floor Disorders Elsevier Saunders, Philadelphia
- [2] Graziottin A. (Chair), Alexander L.J., Banner L., Dennerstein L., Whipple B. Female Sexual Disorders section. In: Porst H & Buvat J (Eds), ISSM (International Society of Sexual Medicine) Standard Committee Book, Standard practice in Sexual medicine, Oxford, UK: Blackwell, 2006; 287-375
- [3] Giraldi A. Graziottin A. Sexual arousal disorders in: Porst H & Buvat J.(Eds), ISSM (International Society of Sexual medicine) Standard Committee Book - Standard practice in Sexual medicine, Blackwell, Oxford, UK, 2006
- [4] Whipple B. Graziottin A. Orgasmic disorders in: Porst H et Al. (Eds), ISSM (International Society of Sexual medicine) Standard Committee Book - Standard practice in Sexual medicine, Blackwell, Oxford, UK, 2006
- [5] Wesselmann U, Burnett AL, Heinberg LJ The urogenital and rectal pain syndromes (Review) (282 refs). Pain 1997; 73(3): 269-94
- [6] Laumann EO, Paik A. Rosen RC. Sexual dysfunction in the United States. Prevalence and predictors, JAMA 1999; 281, 537-544
- [7] Graziottin A. Leiblum S.R. Biological and Psychosocial Etiology of Female Sexual Dysfunction During the Menopausal Transition The Journal of Sexual Medicine 2005; 2 (suppl. 3): 134-146
- [8] Salonia A, Zanni G, Nappi RE, Briganti A, Deho F, Fabbri F, Colombo R, Guazzoni G, Di Girolamo V, Rigatti P, Montorsi F. Sexual dysfunction is common in women with lower urinary tract symptoms and urinary incontinence: results of a cross-sectional study. Eur Urol. 2004; 45(5): 642-8
- [9] Graziottin A. Sexual pain disorders: dyspareunia and vaginismus in: Porst H & Buvat J. (Eds), ISSM (International Society of Sexual medicine) Standard Committee Book - Standard practice in Sexual medicine, Blackwell, Oxford, UK, 2006
- [10] Bachmann GA.et Al. Vulvodynia: a state-of-the-art consensus on definitions, diagnosis and management J Reprod Med. 2006 Jun; 51(6): 447-456

Female Sexual Dysfunction: Clinical approach

- What Nurses want to know -

Alessandra Graziottin MD

Director, Center of Gynecology and Medical Sexology

H.San Raffaele Resnati, Milano, Italy

Co-Director, Post-graduate Course of Sexual Medicine

University of Florence, Italy

Introduction

Nurses have an increasing role in the health care system worldwide. Besides their competence, their *availability to listen* – verbally and non verbally – to patients, to their fears and concerns, give them the opportunity to become primary confidants of the many issues and questions diseases raise in the domain of *quality of life and sexuality*.

To *train nurses in sexual medicine* may significantly improve their competence in addressing critical sexual concerns, more frequent in the specialty of urology and gynecology, and increase the quality of support the health system can offer to patients. It may as well increase their professional satisfaction thanks to a more comprehensive and patient-centered approach.

For nurses who are willing to have a more structured learning about FSD, recent books [1-3] and web-sites will be indicated (see ref.), to ease their progressive confidence in this fascinating field.

Characteristics of women's sexuality

Women's sexuality is *multifactorial*, rooted in biological, psychosexual and contextual dimensions, and *multisystemic*, involving all the biological systems – hormonal, muscular, metabolic, vascular, nervous, immunitary – that contribute to an appropriate physical and emotional response [1-3].

More than in men, *co-morbidity*, the contemporary presence of more than one sexual disorder, is the hallmark of most complaints. Furthermore female sexuality is *discontinuous* throughout women's life for physiological (periods, pregnancy, breast feeding...) and contextual reasons, and strongly related to the *feelings for partner* and the *meaning* sexual intimacy has.

These potent psychosexual variables have somehow biased past researches, with an over focus on psychogenic etiologies and an almost substantial dismiss of the biological ones, with dramatic consequences in term of missed diagnosis and disappointing treatments, particularly when, like in dyspareunia, the understanding of pathophysiology of pain is key [4].

Diagnosis of FSD

From the clinical point of view, an integrated diagnostic approach is necessary to tailor treatment according to the individual and couple's needs, at best of our current scientific and clinical knowledge. The more recent classification of FSD is summarized in Fig. 1. However, definition of FSD is still a work in progress, for the increasing attempt to capture the wording that best defines women's sexual experience.

Preliminary key points in the diagnosis should be:

- accurate *listening to the complaint's wording*, to verbal and non verbal messages;
- definition of the *nature of the disorders*: desire disorder, arousal disorder, orgasmic disorder, sexual pain disorder (Fig. 1)
- its being *lifelong or acquired*, with special attention to the association with the pathologies and comorbidities the patient is currently complaining about;
- *generalized or situational*;
- *organic, psychogenic/contextual* or, as it is in most cases, *mixed*;
- *the severity of distress it causes to the patient*.
- of special importance, for nurses, is to help the patient to understand if the disorder is associated or caused by the medical condition they are being treated for. This is of the highest importance in urological and gynecological conditions: medical and sexual comorbidity is very

frequent in these contexts.

- *accurate examination of the woman*, and particularly of the external genitalia, of the vagina and of the pelvic floor may be very informative for nurses, besides physicians, as well. This is mandatory when genital arousal disorders, sexual pain disorders and orgasmic disorders are complained of; it may be useful even when sexual desire disorders are the leading complaint, to diagnose biologically rooted comorbidity of other FSD with acquired loss of libido [1, 3]

Co-morbidity with other FSD should indeed be accurately recorded with attention to which sexual disorder came first, together with the *meaning* of the symptom for the woman. Comorbidity with medical conditions –urological, gynecological, proctological, dismetabolic, neurologic etc- should as well be investigated.

The high association between sexual pain disorders and urogenital dysfunctions should be actively investigated. Latent classes analysis of sexual dysfunctions by risk factors in women indicate *that urinary tract symptoms* have a relative risk of $RR = 4.02$ (2.75-5.89) of being associated with arousal disorders and a relative risk of $RR=7.61$ (4.06-14.26) of being associated with sexual pain disorders, according to the epidemiological survey of Laumann et Al., 1999. [4]

The high comorbidity has indeed a plausible *pathophysiologic background*, particularly in hypoestrogenic conditions, in the progressive urogenital dystrophy, in the reduced vascular congestion around the vagina and the urethra, where an extension of the equivalent of male corpus spongiosum has been histologically demonstrated, and in the defensive hypertonic pelvic floor.

The worsening genital arousal disorders many women complain of, unless at least topical estrogen therapy (ET) is given, may cause vaginal dryness, dyspareunia and post-coital cystitis, usually appearing 24-72 hours after intercourse.

In stable couples, current *feelings for partner*, ie *quality of the relationship*, and *quality of partner's sexuality* (inclusive of general and sexual health) should as well be investigated [1-3].

The woman's *general health* should be examined, with special focus on conditions that may directly or indirectly impair the woman's mental and/or genital response.

Careful physical examination should be performed, as many physical problems are better diagnosed when attention is paid to vulvovaginal trophism, hypo or hypertonic pelvic floor conditions, inflammations, pain-map recording.

Treatment of FSD

According to the diagnosis, available treatments may be summarized focusing on the leading sexual complaint the woman is reporting. More attention will be devoted here to medical treatments, whilst psychosexual approaches will be briefly mentioned. Nurses more interested in the latter approach are referred to the detailed book of Leiblum and Rosen [2]

Key points in the medical treatment of:

a) Desire and central arousal disorders

Desire and central arousal ("I feel excited") consistently overlap from the neurobiological and psychosexual point of view. Comorbidity between desire disorders and central arousal disorders is extremely frequent in women. The two conditions are therefore usually treated in parallel and indeed do respond to the same treatment(s).

Desire disorders increase with age. Menopause has a further detrimental effect. Hormone treatment is indicated when desire disorders and associated FSD are acquired after the menopause and have a prominent hormonal etiology. [1,3, 5,6]

Specific symptoms and androgen's plasmatic levels in the lower quartile, or below the normal range for the age, suggest the diagnosis of the so called "Androgen Insufficiency Syndrome", according to the last Princeton consensus' criteria [7]. Androgen treatment may be indicated when low desire causes personal distress, thus causing the *Hypoactive Sexual Desire Disorder* (HSDD) .

Two reviews of RCTs on testosterone in estrogen repleted postmenopausal women indicate the efficacy of testosterone on all domains of women's sexual response, and some psychological benefits as well [8,9].

Specifically, recent RCTs have proven the efficacy of testosterone patches to improve sexual desire, sexual satisfaction and all domains of sexual response [10-13]. *Testosterone patches* (300mcg twice/week) have been approved in Europe, in July 2006, with the specific indication of Hypoactive Sexual Desire Disorder (HSDD) in surgically menopausal women.

Women and partners should be informed about the “lag time” (up to two, three months) between onset of treatment with testosterone patches and sexual improvement. This “waiting time” could be constructively used to address concomitant psychosexual issues (personal and/or partner related) and to (re)explore the sexual map after the difficult period of frustrating HSDD before the appropriate diagnosis has been made.

In spite of the available evidence, controversy still exists on the current indication of testosterone treatment in women with HSDD [14].

Hyperprolactinemia reduces sexual desire, besides causing amenorrhea. Hypoprolactinemic drugs are useful to restore sexual desire when prolactin is supraphysiologic.

b) Genital arousal disorders

According to the diagnosis, *acquired genital arousal disorders* may be treated with [1,3,5,6,15,16]:

- *Systemic or topical sexual hormones, either estrogens or testosterone or both:*
 - * Systemic estrogenic hormonal therapy (ET), with transdermal gel, with patches or oral pills, is the choice when central and genital arousal disorders are complained of, and when vaginal dryness is the leading complaint. In women with uterus, progesterone or progestins must be added , either in continuous or sequential treatment, to protect the uterus [5,6];
 - * Topical (i.e.vaginal) treatment with estradiol -two tablets a week or one every other day applied deep in the vagina- is effective as well when genital arousal disorder causes or is associated with dyspareunia, post-coital cystitis and orgasmic difficulties and when systemic treatment is not indicated or not desired [5,6];
 - * Recurrent vaginitis and cystitis from colonic germs may as well be improved by topical vaginal estrogens [15,16];
 - * Topical testosterone, (2% in vaseline jelly or petrolatum), applied daily to the external genitalia, over the vulva, in minimal quantity, may anecdotically improve the clitoral and bulb-cavernosal arousal response, easing vulvar congestion and the orgasmic response.
- *Pelvic floor rehabilitation and/or biofeedback*, that may improve perivaginal muscle tone and competence, thus increasing also partner's sensations. It may improve as well mild stress incontinence , co-morbid with genital arousal disorders [1,3].

If genital arousal disorder is in co-morbidity with pain and/or fear of it, pain related issues should be treated first.

c) Orgasmic disorders

Acquired orgasmic disorder may benefit from [1-3]:

- HT, topical (vaginal estradiol in tablets or vaginal creams and/or vulvar testosterone) and/or systemic, with or without androgens, if the leading etiology is hormonal;
- Pelvic floor rehabilitation, if there is this co-morbidity with hypotonic pelvic floor conditions;
- Appropriate pharmacologic and/or rehabilitative treatment when fear of leaking at orgasm is complained in association with urgency and/or when urge incontinence with an overactive bladder is diagnosed;
- EROS-clitoral device, indicated when there is an arousal co-morbidity;

When FSD comorbidity is diagnosed, i.e when all the sexual response is impaired, accurate treatment of *predisposing, precipitating and maintaining factors*, biological, psychosexual and/or contextual, should be proposed;

d) **Sexual pain disorders: dyspareunia and vaginismus**

Dyspareunia and vaginismus may interfere with all the dimensions of the sexual response (Fig.1). Co-morbidity of different FSD with sexual pain disorders should always be investigated in detail.

Specific issues involve the diagnosis and treatment of coital pain.

- Lifelong sexual pain disorders should be approached with a deeper understanding of the *pathophysiology of pain*, in its *nociceptive* and *neuropathic* component [17].
- Lifelong *dyspareunia* is reported in on average one third of our patients. Concomitant arousal disorders (unwanted pain is the strongest reflex inhibitor of genital and mental arousal) and libido disorders should as well be addressed. Co-morbidity with *vaginismus* should be diagnosed and treated.

Accurate recording of the “*pain map*”, is mandatory in both lifelong and acquired dyspareunia, as *location of pain and it's onset are the strongest predictors of its organicity*, that should be diagnosed and addressed [1,3,17]. Co-morbidity with urological (lower urinary tract symptoms, LUTS) and proctological symptoms (chronic obstructive constipation, irritable bowel syndrome, haemorrhoids, anismus) is frequent and should be recorded and addressed [18].

- Acquired dyspareunia requires an even more sounded medical approach. A step-care model of *dyspareunia* caused by *vulvar vestibulitis syndrome* (VVS) should address *predisposing, precipitating and maintaining factors*, according to the presenting Author, by [17]:
 - a) treating recurrent vaginal infections;
 - b) improving vaginal trophism, with at least topical estrogen, when indicated;
 - c) relaxing the tighten pelvic floor (with self massage, stretching, electromyographic biofeedback and/or pelvic physiotherapy);
 - d) reducing hyperalgesia (locally, with electroanalgesia or, in severe cases, with the ganglion impar block; systemically with tricyclic antidepressant or gabapentin in the most severe cases).
 - e) vestibulectomy may be considered in severe Vulvar vestibulitis syndrome (VVS), non responsive to conservative treatments.

Acquired co-morbidity in libido and arousal disorders is complained of in another third to half of women suffering from dyspareunia, according to the time of consultation from the onset of symptoms and should be treated accordingly.

Anxiety, fear of pain and sexual avoidant behaviours should as well be addressed. The shift from pain to pleasure is then key from the sexual point of view. Sensitive and committed psychosexual support to the woman and the couple is therefore mandatory.

Acquired vaginismus is usually overlapping with dyspareunia.

e) **Sexual satisfaction disorders**

They are a new controversial entity, not yet accepted in the international nosography. However, they should be considered in their biological and psychosexual meaning, per se and for the potential co-morbidity with other FSD.

Key points in the psychosexual treatment of FSD:

Individual psychosexual therapy

Lifelong desire and central arousal disorders (“I do not feel mentally excited”) (often in co-morbidity) may benefit from individual psychosexual or behavioural therapy, if sexual inhibitions, poor erotic skills, poor body image, low self confidence, but also previous abuse, are in play. Affective disorders, namely depression and anxiety, should be addressed, if present [1-3].

Lifelong “isolated” orgasmic disorders may benefit from a behavioral educational treatment, encouraging self-knowledge and eroticism with the experience of higher arousal sensations, use of vibrators or of clitoral device up to orgasm [2,3]. More often, however, the orgasmic disorder is associated with poor arousal, with or without performance anxiety. These conditions should therefore be treated together.

Lifelong vaginismus should be addressed with a behavioural therapy, progressive rehabilitation of the pelvic floor and pharmacologic treatment aiming at modulating the intense systemic arousal in the subset of intensely phobic patients. In the latter group, *comorbidity with sexual aversion disorder* should be investigated and previously treated [1-3].

Acquired FSD should be treated according to the leading etiological factor(s), biological and psychosexual.

Couple therapy

Couple issues should be addressed when the couple shares the same education-related inhibitions or communication difficulties, when symbiotic dynamics with poor differentiation are critical, or when conflicts and aggressiveness contribute to loss of desire [1-3].

Male disorders

Male Sexual Disorders (MSD) (premature ejaculation, erectile deficit, libido disorders...) should as well be diagnosed and treated, if he appears to be the "symptom inducer" and the woman is the "symptom carrier" [1-3].

This issue is of special importance for nurses working with male urological patients: in case of MSD, their suggestion that the couple should seek for help could prove to be of the highest importance to encourage both partners to consult together.

Conclusion

The complexity of FSD requires a dedicated diagnostic and therapeutic team, sharing a common pathophysiologic and psychodynamic cultural scenario, with the aim of offering the most integrated understanding of the meaning of the symptom and the most effective comprehensive treatment. Treatment's cost-effectiveness, requires an optimal balance between cost containment and quality of results in terms of diagnosis, effective treatment of FSD (and MSD!) with increase sexual pleasure and satisfaction for the woman and the couple.

In this quality scenario, trained nurses can be a critical part of the FSD team, addressing the first consultation with the patient and/or the couple, recording clinical data and questionnaires, and personally treating the pelvic floor-related sexual disorders after a specific training in this important rehabilitation area.

References

- [1] Graziottin A. (Chair), Alexander L.J., Banner L., Dennerstein L., Whipple B. Female Sexual Disorders section. In: Porst H & Buvat J (Eds), ISSM (International Society of Sexual Medicine) Standard Committee Book, Standard practice in Sexual medicine, Oxford, UK: Blackwell, 2006; 287-375
- [2] SR Leiblum R Rosen (eds) Principles and Practice of Sex Therapy 3rd ed New York, Guilford Press, 2000
- [3] Plaut M, Graziottin A, Heaton J, Sexual Dysfunctions, Abingdon, Oxford, Health Press, 2004
- [4] Laumann EO, Paik A, Rosen RC Sexual dysfunction in the United States. Prevalence and predictors, JAMA, 281: 537-44, 1999
- [5] Skouby SO and the EMAS (European Menopause and Andropause Society) Writing Group Position statements on postmenopausal hormonal therapy Maturitas 2004; 48:19-25.
- [6] Burger H. and the IMS (International Menopause Society) Writing group Practical recommendations for hormone replacement therapy in the peri and post menopause Climacteric 2004; 7:1-7.
- [7] Bachmann G, Bancroft J, Braunstein G, et al. FAI: the Princeton consensus statement on definition, classification and assessment. Fertil Steril 2002; 77: 660-665.
- [8] Somboonporn W, Davis S, Seif M, Bell R, Davis S Testosterone for peri and postmenopausal women Cochrane Database Syst Rev: CD004509; 2005
- [9] Alexander JL, Dennerstein L. Burger H, Graziottin A. Testosterone and libido in surgically and naturally menopausal women Womens' Health 2006; 2(3): 459-477.
- [10] Shifren JL, Braunstein J. Simon JA, et al. Transdermal testosterone treatment in women with impaired sexual function after oophorectomy. New Engl J Med 2000; 343: 682-688.
- [11] Buster JE, Kingsberg SA, Aguirre O, et Al. Testosterone patch for low sexual desire in surgically menopausal women: a randomized trial Obstet Gynecol. .2005; 105 (5 Pt 1): 944-52.
- [12] Simon J, Braunstein G, Nachtigall L, et Al. Testosterone patch increases sexual activity and desire in surgically menopausal women with hypoactive sexual desire disorder J Clin Endocrinol Metab. 2005; 90(9): 5226-33.
- [13] Davis SR, van der Mooren MJ, van Lunsen RH, et Al. Efficacy and safety of a testosterone patch for the treatment of hypoactive sexual desire disorder in surgically menopausal women: a randomized, placebo-controlled trial. Menopause. 2006; 13(3): 387-96.
- [14] Wierman ME, Basson R, Davis SR, Khosla S, Miller KK, Rosner W, Santoro N Androgen therapy in women: an endocrine society clinical practice guideline J.Clin Endocrinol Metab. 2006; 91 (10):3697-710

- [15] Graziottin A. Hormonal therapy after menopause: what clinicians want to know. In: Porst H, Buvat J. (Eds), ISSM (International Society of Sexual medicine) Standard Committee Book, Standard practice in Sexual medicine, Blackwell, Oxford, UK, 2006, p. 362-372
- [16] Goldstein I, Alexander JL Practical aspects in the management of vaginal atrophy and sexual dysfunction in perimenopausal and postmenopausal women. Review. J Sex Med. 2005; 2 (S.3): 154-65.
- [17] Graziottin A. Sexual pain disorders (Dyspareunia and vaginismus) in: Porst H & Buvat J (Eds), ISSM (International Society of Sexual Medicine) Standard Committee Book, Standard practice in Sexual medicine, Oxford, UK: Blackwell, 2006; 342-350
- [18] Wesselmann U, Burnett AL, Heinberg LJ The urogenital and rectal pain syndromes (Review) (282 refs). Pain 1997; 73(3): 269-94

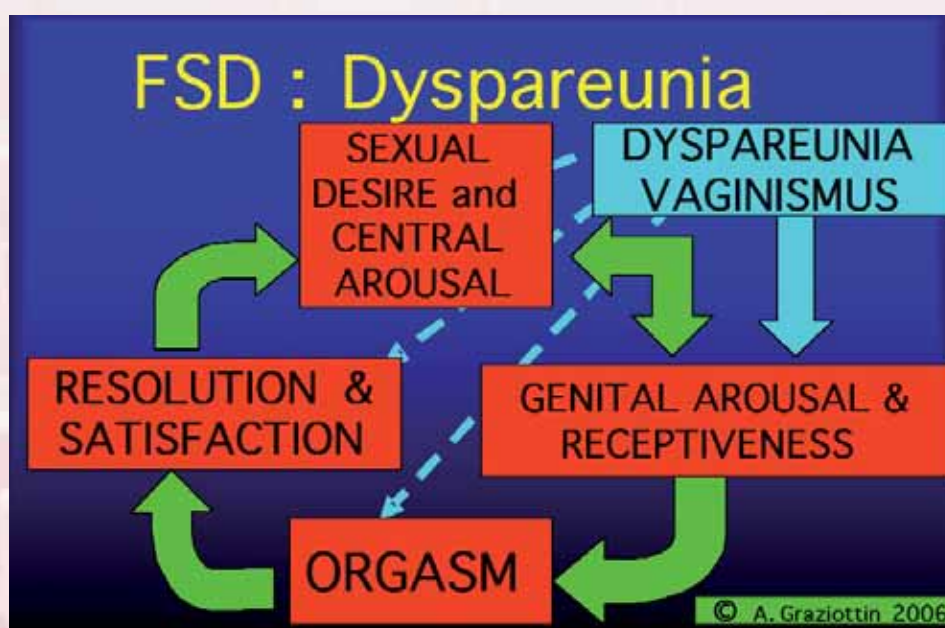
Web-Sites Educational Resources

- www.aasect.org (American Associate of Sexuality Educators, Counselors and Therapists)
- www.advocateweb.org/hope - (professional-client boundaries)
- www.afud.org (Association for Urological diseases)
- www.isswsh.org (International Society for the Study of Women's Sexual Health)
- www.nva.org (National Vulvodynia Association)
- www.sexualhealth.com - (Sex and disability)
- www.siecus.org - (Sexual Information and Education Council of the US)
- www.sstarnet.org (Society for Sex Therapy and Research)
- www.TWSHF.org (information for health care providers and clients)

FIG. 1 Impact of dyspareunia on different dimensions of the sexual response

This circular model, formulated by the presenting Author, contributes to the understanding of:

- a) frequent overlapping of sexual symptoms reported in clinical practice ("co-morbidity"), as different dimensions of sexual response are correlated from a pathophysiologic point of view;
- b) overlapping between sexual desire and central arousal;
- c) interaction between sexual arousal and orgasm;
- d) potential negative or positive feedback mechanisms operating in women's sexual function;
- e) the *direct* inhibiting effect of dyspareunia on genital arousal and vaginal receptivity and the *indirect* inhibiting effect on orgasm, satisfaction and sexual desire, with close interplay between biological and psychosexual factors



European Association of Urology Nurses Membership Application Form



I wish to apply for:

- ☐ **Full membership** € 30 /year
☐ A copy of my registration certificate is enclosed
- ☐ **Affiliate membership** € 30 /year
☐ A copy of my curriculum vitae is enclosed
- ☐ **Corresponding membership** € 30 /year
☐ A copy of my registration certificate is enclosed

! Please note: Applications that are not accompanied by the proper documents will be returned to sender.



Membership categories

Full membership

- Open to all certified European nurses and allied health care professionals working in urology nursing. Eligible to vote at the General Assembly.

Affiliate membership:

- Open to all European students, scientists or others who have an interest in urology nursing. Not eligible to vote at the General Assembly.

Corresponding membership

- Open to all certified non-European nurses, allied health care professionals and students with an interest in urology nursing. Not eligible to vote at the General Assembly.

All members receive:

Free subscription to European Urology Today, EAUN 'Good Practices in Health Care' booklets, reduction of congress fees, free access to the European Urology website and eligibility to participate in Fellowship/Exchange programme.



Personal data

Profession: ☐ Nurse ☐ Student ☐ Health care professional ☐ Other _____

Title: ☐ Prof. ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss

Family name: _____

First name: _____

Date of birth, Nationality: _____

Institution: _____

Department: _____

Address: _____

Postal code / Zip: _____

City: _____

Country: _____

Telephone (office): _____

Fax (office): _____

E-mail (office): _____

Home address: _____

Postal code / Zip: _____

City: _____

Country: _____

Telephone (home): _____

Fax (home): _____

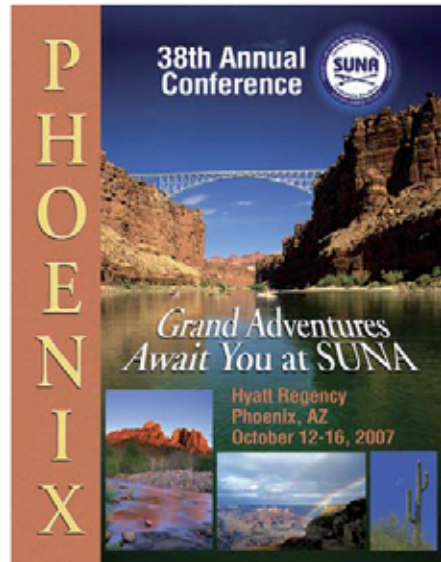
E-mail (home): _____

To which address do you wish your EAU correspondence to be mailed? ☐ Work ☐ Home

Please return this original application to:

European Association of Urology Nurses / membership department
 PO Box 30016 6803 AA Arnhem The Netherlands
 F: +31 (0) 26 38 90 674 E: eaun@uroweb.org





COME JOIN US!

October 12-15, 2007
38TH Annual Conference
Hyatt Regency
Phoenix, AZ

To register online or download a registration brochure, go to www.suna.org then click the "Events" tab, or call 1-888-TAP-SUNA.



Society of Urologic Nurses and Associates

What kind of nurse are you?

- ☐ Research, studies and documentation are important for both patients and health care professionals.
- ☐ I don't believe in research.



LoFric
Primo™

Safe, small and simple.

So far, over 25 scientific articles*, showing how well LoFric works, have been published. These studies concern both long-term and short-term use and prove how LoFric minimises the risk of injuries and complications. Most catheter-related problems can go undetected for as long as five years, but our test subjects show no signs even after several years of continuous usage. One of the reasons is the Urotonic™ Surface Technology – our very own patented surface layer that minimises friction, not only during insertion, but also during withdrawal.

The LoFric Primo comes with water and is ready-to-use, it is foldable to fit easily in your pocket and opens in several different ways. If you can think of a reason not to recommend it to your patients, we'd love to hear it.

