Milan

15-19 March 2013

14th International EAUN Meeting, 16-18 March 2013

In conjunction with the 28th Annual EAU Congress

Programme Book

eaun

European Association of Urology Nurses

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Join the European Association of Urology Nurses (EAUN)

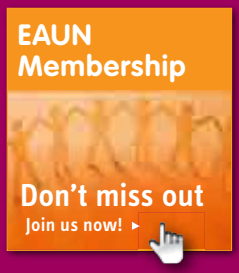
Be involved!

The EAUN has several membership categories catering to all professionals involved in urological nursing.

We invite you to become a member today!

Fast and easy electronic membership application
Preferred way of application for EAUN Membership is through our website: **www.eaun.uroweb.org**

Click on the Membership banner or on the link at the EAUN membership page to go to the electronic membership form. After filling out your details you must upload a digital passport photo (JPG) and a digital Proof of Status (PDF or Word file) to be able to complete your application. For queries concerning electronic membership application please contact the Membership Office at membership@uroweb.org



Join now!

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European
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of Urology
Nurses

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Welcome to Milan

Dear Colleagues,

It is a great pleasure to welcome you to Milan for the 14th International Meeting of the European Association of Urology Nurses (EAUN), organised with the wonderful support of Mrs. Cinzia Sanseverino of the Associazione Infermieri di Urologia Ospedaliera (AIURO) from Italy.

For this year's programme, we believe we have again succeeded in offering a programme that will be attractive for nurses from *all specialties* within urology and in *different levels* of practice. This variation is found for example in the four workshops (e.g. *Bladder installation* and the multi-approach workshop on *Alternative approaches for the improvement of daily life in urological patients*) and in the ESU courses that deal with both the benign and malignant diseases of respectively prostate and bladder, from a urologist' and nurse' point of view.

Like last year, when presenting the new EAUN guideline *Intermittent urethral catheterisation in adults* you will not only be explained how the latest EAUN guideline was produced, but also what was concluded from the literature, in a workshop with presentations by the authors themselves.

The Nursing tools workshop in market place setup was much appreciated last year due to its interactive nature. This year this format will again be used for a workshop entitled *Embarrassing issues in urology. Psychosocial consequences of incontinence, talking with a patient about sexuality, erectile dysfunction and female sexuality* are the subtopics to be discussed in the four corners. Attendance is restricted to make this an intense learning experience!

There are several discussion sessions on the agenda this year, to name a few: a debate on *Prostate cancer screening*, a panel discussion on *Bladder dysfunction* and a round table discussion around *Bone health* on Sunday afternoon. Also new is a session in which video abstracts are used to show surgical procedures, on Monday afternoon. Do not miss out!

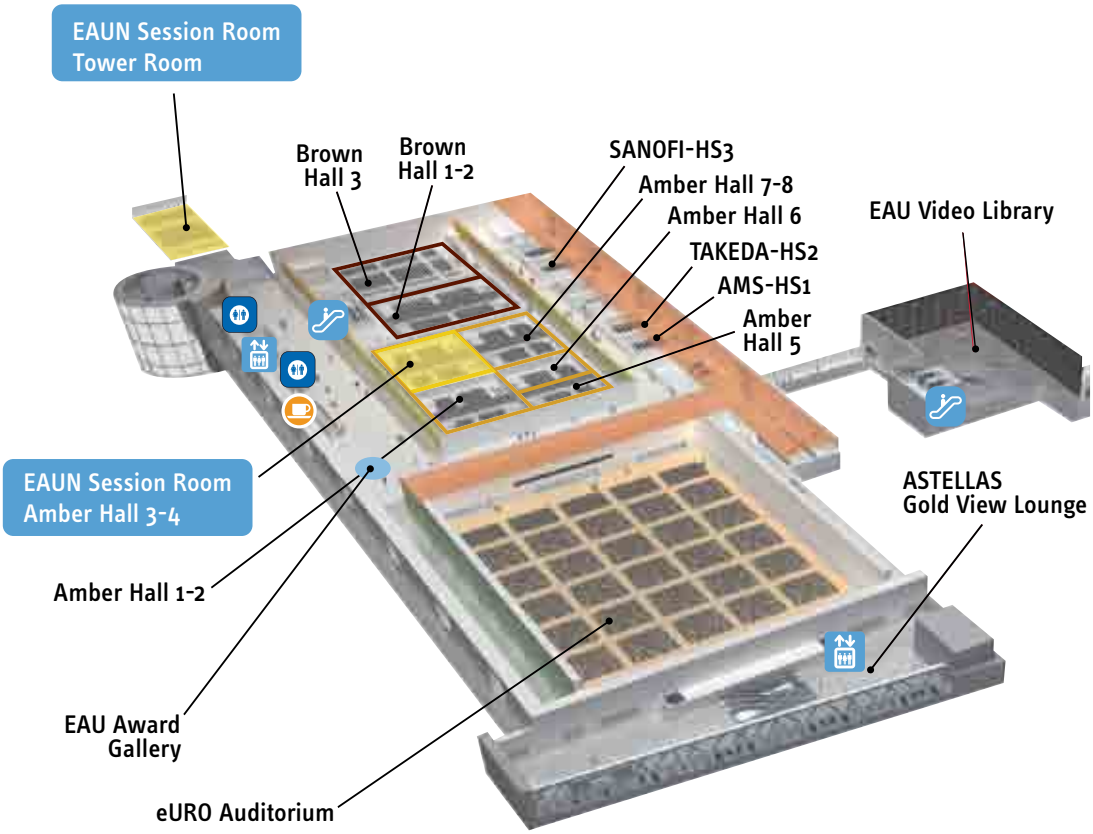
Finally, we offer a limited number of delegates the opportunity to register for an ESU-EAUN course on Cystoscopy with hands-on training in a 5-hour course on Monday. The course is supported by Olympus Europe Holding GmbH. A first for the EAUN!

We also invite you to the classic *EAUN Get-together* (sponsored by Wellspect HealthCare) which will be held outside Room Amber after the Saturday programme; a good opportunity to catch up with old and find new friends. And don't forget to join the other social events in our programme such as the popular Urowalk and the EAUN Nurses' dinner with live music!

The board looks forward to a very successful meeting, with your continued support and enthusiasm. Ciao!

Kate Fitzpatrick
EAUN Chair

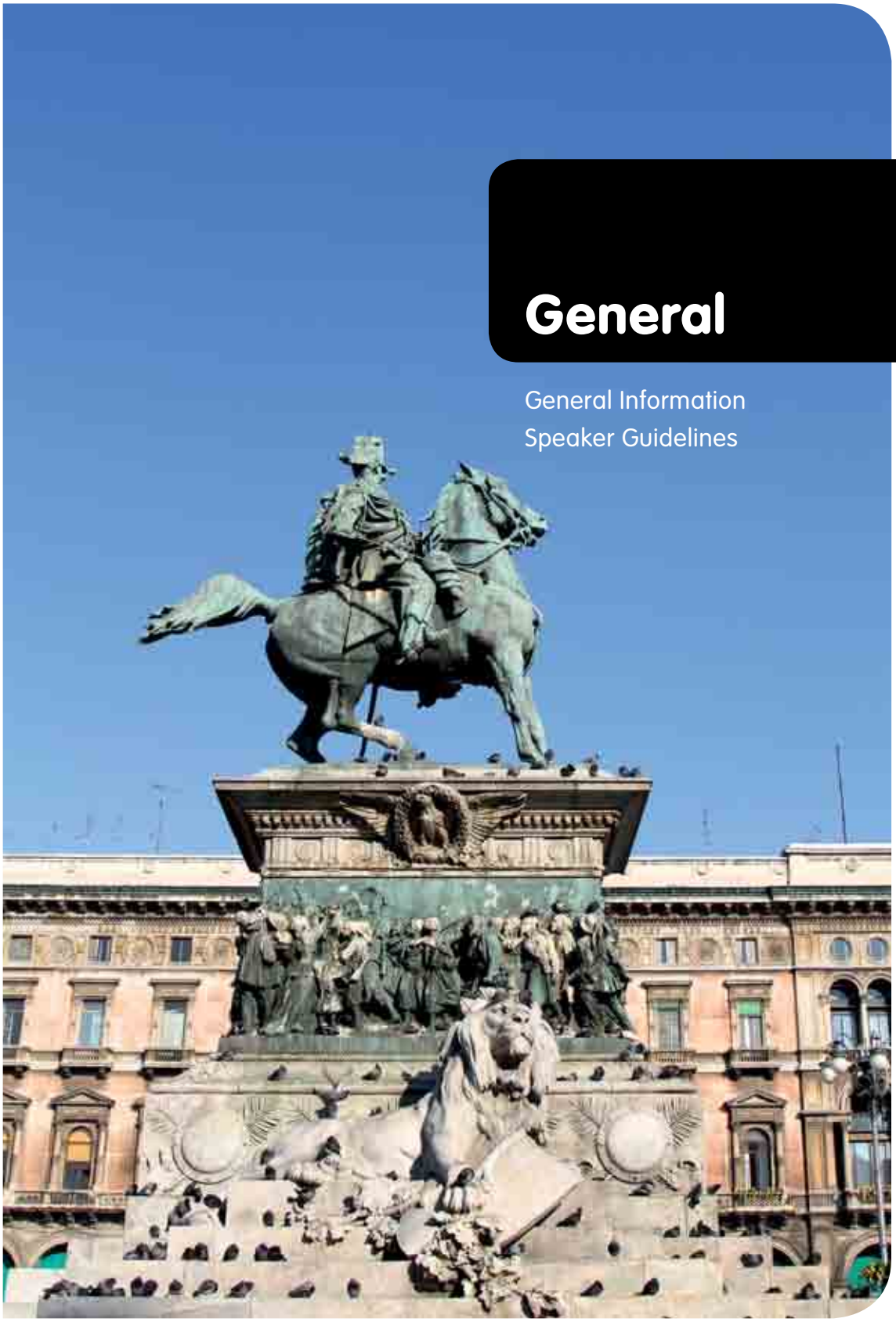
Level South 2 (S2)



- Coffee corner
- Elevators/stairs
- Escalators
- First Aid
- Toilets

General

General Information
Speaker Guidelines



General information

Abstracts

More than 1.200 EAU abstracts have been accepted for presentation during poster and video sessions in Milan. The EAU Abstract CD 2013 will be distributed to all congress delegates by FERRING PHARMACEUTICALS (booth E42 in the exhibition on level S0). The EAU Poster DVD 2013 will be distributed to all congress delegates by AMGEN (booth D20 in the exhibition on level S0). All abstracts and PDFs of the posters are available online at www.eaumilan2013.org/scientific-programme. Abstracts are also available through the congress App.

The EAU Poster DVD 2013 is supported by an unrestricted educational grant from AMGEN

The EAU Abstract CD 2013 is supported by an educational grant from FERRING PHARMACEUTICALS

Access to the Session Rooms

Seating is regulated on a first-come, first-served basis. We recommend delegates to go to the session room well in advance of the session. Due to safety regulations, the organisers will close the session room when all seats are taken. It is not allowed for delegates to stand in the aisles of the rooms.

Address and Accessibility Congress Centre

The MiCo – Milano Congressi can be well reached by public transport. The public transport system is easy to use and a very efficient way to get around the city. Congress delegates may collect a complimentary transportation pass in the registration area on level N-0. See also "Transportation Pass".

Address congress centre:
MiCo - Milano Congressi
Via Gattamelata 5 (Gate 14), 20149, Milan, Italy
T: +39 02 43 42 62 75, F: +39 02 48 01 02 70
www.micmilano.it

By metro:
The nearest metro station is "Amendola". From there complimentary shuttle busses (see also "Shuttle Bus") will bring participants to the main entrance of the congress venue.

Airport Shuttle Bus

From Milan Central Station (Stazione Centrale = Garibaldi Station) a shuttle bus goes directly to Linate (+/- 25 minutes) and Malpensa airport (+/- 60 minutes).
The Malpensa shuttle bus operates between 03.45 and 00.30 from Milan Central Station. The tickets cost € 10 and can be purchased on board. The Malpensa shuttle bus to the airport departs every 20 minutes. The closest bus stop from the congress venue is at Viale Teodorico.
The Linate shuttle bus operates between 06.00 until 23.00 from Milan Central Station. The tickets cost € 5 and can be purchased on board. The bus to Milan Linate airport departs every 30 minutes.

App - Your smart congress companion

The Congress Apps will bring the 28th Annual EAU Congress and the 14th International EAUN Meeting to your smartphone. The applications offer the best mobile overview of this scientific event with instant access to congress abstracts, exhibition booth locations and the latest news from before, during and after the meeting! This year you will find a whole new set of features and you won't need constant internet access to navigate the information. Please, check under EAU 2013 and EAUN 2013 in your App Store or Android market to get your smart congress companion.

Award Gallery

At the EAU Award Gallery you will find a complete overview of all awards that were handed out by the European Association of Urology this year. It also features information on past winners of the most prestigious EAU prizes. It can be found on level S2 between the eURO Auditorium and the catering point, be sure to visit it!

Congress Hours

	Speaker Service Centre	Registration	Exhibition
Thursday, 14 March	14.00-19.00	08.00-20.00	
Friday, 15 March	08.00-19.00	07.00-20.00	
Saturday, 16 March	07.00-19.30	07.00-20.00	09.15-18.15
Sunday, 17 March	07.00-19.30	07.00-19.30	09.15-18.15
Monday, 18 March	07.00-19.30	07.00-19.30	09.15-18.15
Tuesday, 19 March	07.00-13.10	07.00-13.30	

Badge Tracking System

Congress delegates have a barcode on their badge which enables them to leave their contact details with exhibitors in a quick and easy way. The barcode will also be scanned at the entrance of the session rooms to gather CME and statistic information.

Badges

The badge classification is as follows:

Blue badge	:	EAU member
White badge	:	Delegate
Brown badge	:	Nurse
Green badge	:	Exhibitor
Red badge	:	Press
Purple badge	:	Accompanying person
Pink badge	:	Day-, session registration
Yellow badge	:	Organising staff

Bank, Exchange and Credit Cards

The national currency in Italy is the Euro (€). Two ATM machines are available at the MiCo; one in the North wing on level N1 and one on in the South wing on level S1 on the balcony in the exhibition. A bank including an exchange office is available in the congress venue on level N0 near the entrance to the registration area. There are also banks near the congress centre, please go to the EAU Information Desk on level N0 for detailed information.

Best Posters

The Best Posters wall features the best scientific posters of the Milan Congress. This high-tech plasma wall is accessible during congress hours on level N0. The best posters can also be viewed through the congress website during and after the congress.

Business Centre

There is a Business Centre located on level S1 (balcony) of the exhibition which offers facilities such as computers, printers, copiers and internet.

Certificate of Attendance

A Certificate of Attendance for the Milan Congress can be printed online at www.eaumilan2013.org as of 20 March 2013. You will need your registration number (under barcode on the badge) to print the Certificate of Attendance.

Cloakroom / Luggage

The cloakroom is located in the registration area on level N0 and open during congress hours. Please be sure to collect all personal belongings at the end of the day.

Congress Bag

Each delegate can collect a congress bag in the registration area on level N0.

The congress bags are sponsored by ASTELLAS

Daily Congress Newsletter: European Urology Today Special Edition

Special daily congress newsletters are available on Saturday 16, Sunday 17 and Monday 18 March. The newsletters cover on-site news, congress session information and background information on a variety of subjects. The first edition also contains an Exhibition Overview. The newsletters will also be available online at www.eaumilan2013.org during and after the congress.

EAU Congress Office

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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 N-1 with extensive information on its activities. Registration for the courses can be made at the ESU registration desks in the registration area on level N0. The ESU Courses CD 2013 is distributed at the EAU desk next to the MILLENNIUM: THE TAKEDA ONCOLOGY COMPANY booth (booth D30 in the exhibition on level S0) to all congress delegates.
The ESU Courses CD 2013 is supported by an unrestricted educational grant from MILLENNIUM: THE TAKEDA ONCOLOGY COMPANY

Fees ESU Courses (for congress registered delegates only)

	2 hrs.	3 hrs.
EAU members	€ 32	€ 47
Non-EAU members	€ 47	€ 69
Residents and nurses (members/non-members)	€ 21	€ 21

Prices are excl. 21% VAT

EAU Booth

The EAU Booth (booth H17 in the exhibition on level S0) consists of the EAU(N) Membership Booth, EBU Corner, Young Urologists/ Residents Corner, EAU Stockholm 2014 Promotion Counter, EAU Research Foundation and the EAU Historical Exhibition.
There is also information on European Urology and other EAU publications. The EAU(N) Membership Booth provides information on membership status and membership benefits. Non-members are welcome to visit the EAU Booth for further information and to apply for EAU(N) membership.

Electricity

The electricity in Italy runs on 220 volts and the frequency is 50 Hz. Plugs have two or 3 round pins. A plug adaptor will be required if incompatible electronic devices are used.

Emergency Phone Numbers

In case of an emergency please call 113 for police, 115 for fire brigade or 118 for ambulance service. In case of an emergency in the congress centre please call +39 02 4342 7210 or contact a security guard immediately. See also “First Aid”.

Excursions and Milan Information

Information on Milan and excursions will be available at the Milan Info & Excursions Desk in the registration area on level N0.

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

Saturday, 16 March	09.15-18.15 hrs
Sunday, 17 March	09.15-18.15 hrs
Monday, 18 March	09.15-18.15 hrs

First Aid

There is a medical unit present for first aid on level S1 indicated on the directional signs with ✚. In case of emergency, contact a security guard immediately or call +39 02 4342 7210. See also “Emergency Phone Numbers”.

Guidelines

EAU Extended guidelines

The EAU extended urological guidelines edition 2013, are distributed at the EAU Booth (booth H17 in the exhibition on level S0). EAU members can collect the guidelines free of charge. This publication is also available for purchase.

EAU Pocket guidelines

EAU urological guidelines in pocket format including a CD are distributed by Olympus (booth C01 in the exhibition on level S0) to EAU members only.
The distribution of the EAU Pocket Guidelines 2013 is supported by OLYMPUS

EAUN Nurses guidelines

This year’s nursing guideline will be distributed to EAUN delegates during the Workshop Intermittent catheterisation and dilatation (Saturday, 8.30 hrs).
The development of the guideline was supported with educational grants from COLOPLAST, HOLLISTER INCORPORATED and WELLSPECT HEALTHCARE.

Historical Exhibition

The EAU History Office has set up an historical exhibit located at the EAU Booth (booth H17 in the exhibition on level S0). The exhibit will present “My other passion. The urologist as a collector”.

Hotel Accommodation

The EAU has contracted the company K.I.T. Group GmbH to deal with the housing for the congress. K.I.T. staff will be available at the Hotel Desk in the registration area on level N0.

Insurance

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

Internet Corners

The EAU Internet Corners are at your disposal at different locations in the exhibition on level S0 (booth A22 and booth F54). The internet corners offer free use of internet and printers. See also "WiFi / Charge and Connect Area".

Language

All presentations during the EAU Congress and 14th International EAUN Meeting will be conducted in English, the official language of the EAU. There will be no translation provided.

Learning Objectives

The EAU Congress provides a forum for presenting original unpublished data and sharing ideas for urological innovation as well as disseminating evidence-based knowledge of primary clinical relevance.
Urologists and affiliated professionals attending the EAU Congress and EAUN Meeting will be able to:

- Review innovative techniques and scientific advances in the field of urology and its sub-specialities
- Review the latest data and emerging trends from studies in clinical and translational research
- Enhance their knowledge of evidence-based approaches to the management of urological disease
- Gain new knowledge on emerging diagnostic and risk-assessment strategies in the management of urological disease
- Enhance their practical knowledge and skills by educational activities, including hands-on-training and courses
- Gain exposure to new developments in drugs and new cutting edge technology in the field of pharmaceutical research and medical technology through visiting the EAU Congress Exhibition
- Communicate, collaborate and network with representatives of a large international audience – medical professionals, national urological societies, patient groups, medical industry and the media.

Lost and Found

Found items should be returned to the Information Desk in the main entrance hall on level N0. If you lose something, please report to this desk for assistance.

Media Policy

Photography, filming and interviews during the congress (with the exception of the EAU Press Centre and EAU Press Conference Room) are prohibited without written permission from the EAU Communication Officer Ms. Ivanka Moerkerken (i.moerkerken@uroweb.org).

Mobile Phones

Mobile phones must be switched off during all sessions.

Personal Planner

Do not miss anything during this year's congress, use the EAU Personal Planner!

- It is fully integrated with the scientific programme of the congress.
- You can select your priority sessions and add your private appointments.
- If you are presenting at the congress – your faculty appointments will be automatically displayed.
- You can export it to your Outlook, Google Calendar or print it out.

For more information, please visit the congress website: http://www.eaumilan2013.org/scientific-programme/eau-personal-planner/

Poster Builder Service

Poster presenters who created their posters for the Milan Congress through the EAU Online Poster Builder Service, can collect their posters at the Speaker Service Centre on level N0.

Poster DVD

A DVD with a collection of EAU scientific posters from the Milan Congress will be distributed by AMGEN (booth D20 in the exhibition on level S0).

The EAU Poster DVD 2013 is supported by an unrestricted educational grant from AMGEN

General information

Prayer Room
A special room dedicated to prayer is located on level S3 (follow the signage on this level).

Presentation Training Centre
For information on the presentation training centre see Speaker Guidelines, page 14.

Press Centre
Journalists and medical/science writers can obtain free registration to the Congress. Journalists receive a press pack, to be collected at the EAU Press Centre in White Hall 1 on level N1. All press are invited to report to the EAU Press Centre to obtain the assistance and information they require. Internet access, printer and photocopier are provided.

Resource Centre
Urology Science and Learning
The Resource Centre is a website (www.eauresourcecentre.org) that delivers EAU content to users on-demand and allows to select content and webcasts of lectures and presentations that might otherwise be missed.

Restaurant Reservations
In many bars and restaurants the aperitif is accompanied by tasty appetizers.
To place your restaurant booking go to the Restaurant Reservations Desk in the registration area on level N0.

Safety
All bags may be subject to inspection. Security is present for your safety. Please take all personal effects with you when leaving a session room.

Smoking Policy
Smoking is prohibited inside the congress centre and in the exhibition area. An outside smoking area is available via an exit in the exhibition hall (level S0) between booth H01 and H02. Outside exhibition opening hours smoking is only allowed in front of the main entrance of the congress centre on level N0.

Speaker Service Centre
For extensive speaker information see page 14.

Taxi Service
There is a taxi rank available in front of the main entrance of the congress centre – Via Gattamelata 5 (Gate 14).

In order to book a taxi please go to the Milan Info & Excursions desk in the registration area (Level N0), they can guarantee the official rates are applied for the reservations made through them.

It is also possible to book car transfers to the airports at the TBlu desk in the main entrance (level N0).

Transportation Pass
Congress delegates may collect a complimentary transportation pass in the registration area (level N0) which is valid for unlimited travels from 15-19 March 2013. The pass covers underground, tram and bus within the city limits of Milan. The airport cannot be reached with this transportation pass. See also "Airport Shuttle Bus".

Upcoming Meetings
Posters and other information on upcoming meetings can be displayed in the "Upcoming Meetings" promotion area on level N0. It is strictly forbidden to put up promotional material at any other location in the building.

Webcasts (W) & Live Streams (L)
Many sessions will be webcasted via www.eaumilan2013.org. The webcasted sessions are indicated with a special logo in the synopsis and will be online within several hours after the session. The webcasts have not been edited and are exactly as presented. The statements and the opinions featured in the webcasts are solely those of the individual presenters and not of the European Association of Urology (Nurses). Webcasts are not accredited and no CME credits can be obtained by watching the webcasts.
In addition to the webcasts there will be live streams of several sessions available at the congress website: www.eaumilan2013.org. These sessions are also indicated in the synopsis with a special logo.

WiFi / Charge and Connect Area
Free wireless internet will be available throughout the congress centre except in the exhibition areas. Please search for the "EAU" WiFi.
A special "Charge and Connect Area" with tables and power outlets is available on level N1. The "Charge and Connect Area" allows you to recharge your laptops and phones while using WiFi.

Free online education for nurses

E-learning course

3-hour Course – 6 Modules – Case studies – Assessment

Bone Health and Urological Cancer

Official launch:
Sunday, 17 March, 17.00 hrs
Amber Room 3-4

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http://www.uroweb.org/nurses/educational-resources-for-nurses/

SUPPORTED BY AN UNRESTRICTED EDUCATIONAL GRANT FROM AMGEN

Download the App

and lighten your congress bag

Get the official EAUN Congress App from the Android Market or iPhone App Store - search for 'EAUN2013'

Scientific Programme
The entire programme book at your fingertips.

Abstracts
Browse abstracts on a wide range of topics.

News
Read the latest news, opinion articles and interviews.

Exhibition
Finding your way at the exhibition is now easier than ever.

Favourites
Save your favourite sessions to a handy list.

Free WIFI is available in all areas with the exception of the exhibition.

GET IT ON Google play

Available on the iPhone App Store

This EAUN Congress App will bring the 14th International EAUN Meeting to your iPhone or Android phone and can also be used offline - search for 'EAUN2013' in your store.

Visit the official website of the 14th International EAUN Meeting to find out more about the event - www.eaumilan2013.org/14th-eaun-meeting. To learn more about the EAUN - www.eaun.uroweb.org

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Speaker guidelines

Speaker Service Centre

Only digital presentations will be accepted during the congress and all presentations should be handed in at least three hours prior to the start of the session at the Speaker Service Centre (Level 0 - North Wing). Failure to do so could result in presentations not being available for projection when required. *If you have an early presentation, please hand in your presentation the previous day!*

Opening hours

Thursday, 14 March	14.00 - 19.00
Friday, 15 March	08.00 - 19.00
Saturday, 16 March	07.00 - 19.30
Sunday, 17 March	07.00 - 19.30
Monday, 18 March	07.00 - 19.30
Tuesday, 19 March	07.00 - 13.30

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.

Kindly note that:

- Speakers should strictly observe timing.
- Discussants should first clearly state their name, institution and country of origin.

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. A maximum of 5 PowerPoint slides is allowed during poster presentation.

Prize-winning posters

If a PDF of the poster has been submitted to the EAUN before the start of the annual meeting the winning posters will be made available in the digital Best poster wall.

Disclose links to the industry

The EAU Scientific Congress Office 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

Mr. Paul Casella (Iowa, USA) gives Individual Presentation Skills Training Sessions to help improve presentation and delivery skills. The one-on-one half hour sessions are free of charge and available to all speakers. Please go to the Speaker Service Centre to make an appointment for this popular training session.

Scientific Programme

EAUN Programme Overview, 16-18 March 2013

	16 March Saturday		17 March Sunday		18 March Monday	
Room	Amber Hall 3-4 - Level S2	Tower Room - Level S2	Amber Hall 3-4 - Level S2	Tower Room - Level S2	Amber Hall 3-4 - Level S2	Tower Room - Level S2
08.00			EAUN Workshop Market place session: Embarrassing issues in urology. Everything you always wanted to know, but were afraid to ask			
08.15						
08.30		EAUN Opening		EAUN Workshop Alternative approaches for the improvement of daily life in urological patients		ESU Course - 2 Bladder diseases and treatments Part I
08.45	EAUN Workshop Writing evidence-based guidelines	EAUN Workshop Intermittent catheterisation and dilatation			ESU-EAUN Cystoscopy Workshop	
09.00						
09.15						
09.30						Break
09.45						ESU Course - 2 Bladder diseases and treatments Part II
10.00		Break	Break			
10.15		AIURO Lecture Urological nursing in Italy: The national association, clinical research and education in the European context		Break		
10.30	Break					
10.45	EAUN Workshop Bladder instillation for interstitial cystitis and radiation cystitis			EAUN Session EAUN Nursing Research Competition		Break
11.00		EAUN Lecture Who takes care of the caretakers	Panel discussion Bladder cancer			EAUN State-of-the-art lecture Palliative care in urology
11.15						
11.30						EAUN State-of-the-art lecture Transition from paediatric to adult urology
11.45						
12.00		EAUN Workshop Nursing solutions in difficult cases & Case discussions	Debate Prostate cancer screening	EAUN State-of-the-art lecture The gender aspect		
12.15						EAUN General Assembly
12.30	Break			EAUN Lecture The online diary as a communication tool for patients and nurses		
12.45						Break
13.00		Break	Break			
13.15	EAU-ESU Course - 1 Prostate diseases and treatments Part I	Poster viewing		Break		EAUN State-of-the-art lecture Brachytherapy in urological cancer
13.30						
13.45		Poster Abstract Session 1	EAUN State-of-the-art lecture Nutritional aspects of pre-operative interventions			EAUN State-of-the-art lecture Urological disorders that challenge the surgeon
14.00				EAUN State-of-the-art lecture Penile carcinoma		
14.15	Break					
14.30						Break
14.45	EAU-ESU Course - 1 Prostate diseases and treatments Part II		Break	Break		Award Session
15.00			Panel discussion Bladder dysfunction: Overactive bladder syndrome, nocturia and pelvic floor issues	Poster viewing		EAUN Session Inside the body - surgery in motion (videos)
15.15		EAUN State-of-the-art lecture Health economics				
15.30				Poster Abstract Session 2		
15.45		Break				
16.00		Symposium CIC experience- making dreams a reality WELLSPECT HEALTHCARE	EAUN State-of-the-art lecture Complimentary medicine in oncology			
16.15						
16.30			Break			
16.45				Break		
17.00		EAUN Get-together Sponsored by WELLSPECT HEALTHCARE Location: In front of Amber Hall 7-8	EAUN Round table discussion Meeting the challenges of cancer related bone health Supported with an educational grant by AMGEN	Workshop Safety in urinary catheterization B. BRAUN		
17.15						
17.30						
17.45						
18.00						
18.15						
18.30			Urowalk 18.30 - 20.30			
18.45						
19.00						
20.30 24.00			Nurses' dinner 20.30 - 24.00			

EAUN Opening Ceremony

08.30 - 08.45 EAUN Opening Session

Tower Room - Level S2

P-A. Abrahamsson, Malmö (SE)
K. Fitzpatrick, Dublin (IE)

EAUN Workshop

08.45 - 10.00 Intermittent catheterisation and dilatation

Tower Room - Level S2

Chair: J.G.L. Cobussen-Boekhorst, Nijmegen (NL)

08.45 - 09.15 **Presentation and evidence-base of the new EAUN guideline *Best Practice in Urological Health Care: Catheterisation, urethral intermittent in adults and Dilatation, urethral intermittent in adults***
S. Vahr, Copenhagen (DK)

Aims and objectives: Introduction to the latest EAUN evidence-based guideline, with the objective to: Explain background to the guideline, give justification for producing the guideline, explane the role of the authors, the evidence-base of the guideline and the role of nurses in different countries.

09.15 - 09.30 **Indications and advantages/disadvantages of intermittent catheterisation and urethral dilatation**
N. Lumen, Ghent (BE)

Aims and objectives: The Indications for intermittent catheterisation and intermittent urethral dilatation will be discussed and outlined. The advantages of these techniques over others and possible disadvantages and complications will also be detailed.

09.30 - 09.45 **Procedures of intermittent catheterisation insertion and urethral dilatation**
A.J.M. Eikenboom, Gorinchem (NL)

09.45 - 10.00 **Prevention of urinary tract infections (UTI)**
J.G.L. Cobussen-Boekhorst, Nijmegen (NL)

Aims and objectives: To give a brief overview of UTIs in relation to intermittent catheterisation, current practice relating to monitoring, diagnosis and treatment of UTIs, and prevention / treatment options.

Aims and objectives
Aim: To give insight in the content of the new EAUN evidence-based guidelines for best practice in urological health care about intermittent catheterisation.
Objectives:
- Learn which patients benefit from intermittent catheterisation/urethral dilatation
- Understand the procedure for intermittent catheterisation/dilatation
- Understand the evidence behind catheterisation technique and choice of catheter
- Understand the risk of UTI in combination with intermittent catheterisation

A copy of the new guideline is available for all EAUN delegates and will be handed out during this session.

The new guideline was developed with financial support of COLOPLAST, HOLLISTER INCORPORATED, WELLSPECT HEALTHCARE.

EAUN Workshop

08.45 - 10.30 Writing evidence-based guidelines

Amber Hall 3-4 - Level S2

Chair: *V. Geng, Lobbach (DE)*

08.45 - 09.15 **Key attributes of quality guidelines**
K. Plass, Arnhem (NL)

Aims and objectives: Aim of this lecture is to provide an overview of generally accepted key attributes of quality guidelines. Guidelines are, in many ways, unique publications presenting the best evidence in a given area, aiming to improve daily practice. This is a most ambitious aim, also since assessing direct effects of guidelines on healthcare provision is not an easy matter. Also, new ideas and solutions for methodologically difficult areas for guidelines production emerge and, currently, the one topic all can agree on is that a "perfect" guideline does not exist. In particular for international panels, catering to a large audience, the challenges are even greater. This session intends to explore what is working well, and where potential gaps will likely occur.

09.15 - 10.30 **Clinical development in practice**

Moderator: K. Plass, Arnhem (NL)

Panel: H. Forristal, Dublin (IE)
V. Geng, Lobbach (DE)
J.T. Marley, Antrim (IE)

Aims and objectives
The panel discussion aims to give insight into the various issues when writing guidelines from the point of view of the author, teacher and user.

EAUN Lecture

10.15 - 11.00 AIURO lecture: Urological nursing in Italy: The national association, clinical research and education in the European context

Tower Room - Level S2

Chair: *K. Fitzpatrick, Dublin (IE)*

C. Sanseverino, Beinasco (IT)
S. Terzoni, Milan (IT)

Aims and objectives
This lecture illustrates the situation and perspectives of urological nursing in Italy. The laws introduced in the late 90s provided nurses new opportunities of clinical activity, education and research. Urology nurses can take care of patients both during hospitalisation and after discharge; this favours continuity of care. The need for answering the questions rising from professional care, leads nurses to find solutions through research. Examples include pelvic floor rehabilitation and patient education. Research can help consolidating the synergies between academic education and clinical nursing, through projects in healthcare facilities, dissertations, and publications. Several universities have started post-bachelor courses for urology nurse specialists. AIUrO promotes continuous education and visibility initiatives for urological nursing. The contribution of research, education and associations is fundamental to continue improving urological nursing, based on the needs of patients.

EAUN Lecture

11.00 - 11.45 EAUN lecture: Who takes care of the caretakers

Tower Room - Level S2

Chair: *V. Geng, Lobbach (DE)*

Nursing care or care for nurses
R. Caruso, Ferrara (IT)

EAUN Workshop

10.45 - 12.30 Bladder instillation for interstitial cystitis and radiation cystitis

Amber Hall 3-4 - Level S2

Chair: *W.M. De Blok, Amsterdam (NL)*

10.45 - 11.20 **Painful bladder syndrome, treatment options, historical development of treatment**
D.M Castro-Diaz, La Laguna Santa Cruz Tenerife (ES)

11.20 - 11.55 **The impact of painful bladder syndrome (interstitial cystitis) on daily life and psychosocial counselling**
L. Rasmussen, Nørresundby (DK)

11.55 - 12.30 **Bladder installation, technique and clinical environment requirements**
H.J. Mulder, Groningen (NL)

Aims and objectives

The session will offer delegates the opportunity to be updated on treatment options, techniques and psycho-social counselling for patients with painful bladder syndrome.

EAUN Workshop

11.45 - 12.45 Nursing solutions in difficult cases & case discussions

Tower Room - Level S2

Chair: *S. Vahr, Copenhagen (DK)*

11.45 - 11.55 **DC13-01: Alcohol intake and radical cystectomy – how can we approach a safer patient outcome?**
I. Soendergaard, Århus (DK)

11.55 - 12.00 **Discussion**

12.00 - 12.10 **DC13-03: Complicated ostomy and wound care after cystectomy and Bricker deviation (with complex co-morbidity)**
A. Van Der Scheer-Van Den Aakster, Amsterdam (NL)

12.10 - 12.15 **Discussion**

12.15 - 12.45 **Case discussions**

Moderator: S. Vahr, Copenhagen (DK)

Panel: J. Albaugh, Chicago (US)
L. Drudge-Coates, London (GB)
J.B. Jensen, Århus (DK)
N. Love-Retinger, New York (US)

Aims and objectives
In guidelines it is common practice to describe/focus on typical cases, but we all know that there is also a need for information on nursing practice in atypical (difficult) cases. All nurses encounter problems in daily nursing practice and have found their own solutions or sometimes have not found a solution.
In this session these challenging cases are presented and discussed offering delegates a unique opportunity to learn from each other's experience with atypical cases.

The submitted cases have been evaluated by an expert jury, which included Ronny Pieters, Ghent, Belgium (Urology Nurse), Eva Wallace, Dublin, Ireland (Urology Nurse), Helen Forristal, Ireland (Nurse practitioner in urology, sub-specialisation in uro-oncology), Steen Walter, Odese, Denmark (Professor in Urology) and Nevin Kanan, Istanbul, Turkey (Professor in Perioperative Nursing and Urology Nursing). Those who submitted the most interesting cases (as decided by the jury) were granted a free registration for the 14th International EAUN Meeting and were invited to present their case in this workshop.

In the second part of the session interesting cases will be discussed by a panel of nurse specialists.

Abstract session

13.15 - 15.00 Poster session 1

Tower Room - Level S2

Chairs: *V. Geng, Lobbach (DE)*
S. Hieronymi, Frankfurt am Main (DE)

Poster viewing 30 minutes
Introduction by chairmen (4 minutes) Presentations (6 minutes for presentation and 2 minutes for discussion per presenter)

1 **Pre-clinic multidisciplinary meetings are a useful tool for treatment decision making and stratifying patient follow-up**
J.E. Kinsella, M. Van Hemelrijck, A. Santaolalla, K. Duong, P. Reynolds, B. Challacombe, R. Popert, D. Cahill (London, United Kingdom)

2 **Intensive preoperative and additional community based urostomy counseling**
J.G.L. Cobussen-Boekhorst, J.M.M. Theunissen, J. Spierings, P.W.M. Van Roy, A. Smits-Van Der Camp (Nijmegen, Oss, The Netherlands)

3 **Therapeutic education to patient with urostomy**
M. Boarin, N.M. Lorusso, G. Villa, F. Montorsi (Milan, Italy)

4 **The Stoma Education Scale; a reliable and valid tool in urologic nursing- a pan European study**
B.T. Jensen, W. Blok, B. Kiesby, S.A. Kristensen (Århus, Denmark; Amsterdam, The Netherlands)

5 **Urinary catheter insertion and care: Knowledge and experience among hospital nurses**
L. Balin, H. Malka- Zeevi, I. Rabinovich, R. Kalman (Nahariya, Israel)

6 **Do nurses understand evidence-based recommendations for prevention of catheter-associated UTIs?**
D.K. Newman (Philadelphia, United States of America)

7 **The prevalence of urinary incontinence in hospitals: A starting point for a new policy?**
N. Berghmans, K. Everaert (Ghent, Belgium)

8 **Women's experience of urodynamic studies**
M. Jacob (Dublin, Ireland)

9 **Patient experience of the post operative period after nephrectomy, in an accelerated patient tract**
I-M. Thiele (Frederiksberg, Denmark)

Aims and objectives
The aim of this session is to update the delegates with recent research activities and findings in the development of evidence-based urological care.

ESU Course 1

13.15 - 15.45 Prostate diseases and treatments

Amber Hall 3-4 - Level S2

13.15 - 14.15 **Prostate diseases and treatments, Part 1 - Benign disease**

Chair: *P. Bastian, Düsseldorf (DE)*

- **Benign prostate hyperplasia**
  J. Farrell, Rotherham (UK)
- **Pathophysiology**
  J. Farrell, Rotherham (UK)
- **Diagnosis**
  P. Bastian, Düsseldorf (DE)
- **Treatment overview**
  I.M. Van Oort, Nijmegen (NL)
- **Questions and answers**
  Faculty
- **Take home messages**
  I.M. Van Oort, Nijmegen (NL)

14.15 – 14.45 **Break**

14.45 - 15.45 **Prostate diseases and treatments, Part 2 - Malignant disease**

Prostate cancer

- **Pathophysiology**
  H. Forristal, Dublin (IE)
- **Screening, diagnosis and staging**
  I.M. Van Oort, Nijmegen (NL)
- **Principles of active surveillance – which patient groups**
  P. Bastian, Düsseldorf (DE)
- **Management of localised disease**
  I.M. Van Oort, Nijmegen (NL)
- **Treatment approaches following biochemical failure**
  H. Forristal, Dublin (IE)
- **Management of metastatic disease/CRPC**
  P. Bastian, Düsseldorf (DE)
- **Questions and answers**
  Faculty

Take home messages
P. Bastian, Düsseldorf (DE)

EAUN Lecture

15.00 - 15.45 State-of-the-art lecture: Healthcare economics

Tower Room - Level S2

Chair: *K. Fitzpatrick, Dublin (IE)*

Healthcare systems across Europe: Impact on care and treatment
C. Normand, Dublin (IE)

Sponsored Session

16.00 - 17.00 CIC experience - making dreams a reality

Tower Room - Level S2

Chair: *K. Logan, Gwent (GB)*

Living the dream – forced to create a new one
S. Granholm, Frösön (SE)

What matters to patients? : The qualitative research evidence
K. Logan, Gwent (GB)

Helping patients to regain normality and integrity with CIC
K. Revedal, Segersäng (SE)

Aims and objectives

- Understand what matters to men when learning clean intermittent catheterisation (CIC), with the objective of highlighting the implications for nurses involved directly with patients being introduced to this new therapy
- To explore the qualitative experience of men learning CIC for the first time based on CIC user stories
- To review the evidence and discuss the impact this can have on quality of life
- To discuss the learning opportunity and to then reflect upon the nurses role and responsibilities in teaching and supporting men with CIC
- Translating the patient voice into clinical practice

Sponsored by WELLSPECT HEALTHCARE

17.00 - 18.00 EAUN get-together

Outside Amber Hall 7-8 - Level S2

Want to catch up with old friends? Perhaps make some new ones? Come join us for the EAUN get-together outside Amber Hall 7-8.
The EAUN get-together is only accessible for delegates who are registered for the 14th EAUN Meeting.

Sponsored by WELLSPECT HEALTHCARE

EAUN Workshop

08.00 - 10.00 **Market place session: Embarrassing issues in urology. Everything you always wanted to know, but were afraid to ask**

Amber Hall 3-4 - Level S2

Chair: W.M. De Blok, Amsterdam (NL)

Psychosocial consequences and preventive interventions for incontinence
E. Koldewijn, Eindhoven (NL)

Aims and objectives: The audience determines what will be discussed.
The role of the nurse in talking with patients about incontinence may be important. Also the place of the pelvic floor physiotherapist could be subject of discussion. And last but not least, what is the position of the nurse in the pelvic floor team.

Erectile dysfunction: How to teach a patient the use of a vacuum pump and intracavernosal injections
W. Meinhardt, Amsterdam (NL)

Talking with patients about sexuality
S.P. Fillingham, London (GB)

Aims and objectives: By the end of the session the participants will be able to:
- Define sexuality
- Be aware of sexuality as a multidimensional concept
- Examine the barriers to discussing sexuality with patients
- Examine the nurse's role in discussing sexuality
- Identify the skills needed to work effectively with patients' sexuality
- Consider sexuality in individuals with acute / chronic illness, disability or mental health needs
- Be aware of a cognitive behavioural programme to assist patients experiencing sexual / sexuality issues (PLISSIT)

Female sexuality
D. Robinson, London (GB)

Aims and objectives: Why is female sexuality a subject that is not often discussed? The delegates will learn how the topic can be brought out into the open; the speaker will share his experience on talking with patients about this topic.
Female sexual dysfunction is often an under recognised and under reported cause of morbidity in women attending urognaecology clinics. This may be due to the embarrassment of the patient or doctor or alternatively due to the fact that the correct questions are not asked. This lecture will focus on the prvealence of sexual dysfunction in urogynaecological patients in addition to clinical management and investigation.

Aims and objectives
In this interactive market place session, the opportunity is given to "shop" for knowledge and practical tools on different urological topics that can sometimes be difficult to talk about.
The session will aim to encourage questions and discussion with the nursing audience, sharing knowledge and learning where the potential for clinical development and education within nurses' own clinical areas can be considered.
The session involves 4 workshops that run in parallel: Each presentations is repeated every half hour, each time for a new group of 35 delegates (the delegates move from stall to stall).

EAUN workshop

08.30 - 10.15 Alternative approaches for the improvement of daily life in urological patients

Tower Room - Level S2

Chair: *B.T. Jensen, Århus (DK)*

08.30 - 08.35 **Introduction**
B.T. Jensen, Århus (DK)

08.35 - 09.05 **Cancer patient project including a nutrition care plan**
M. Borre, Århus (DK)

Aims and objectives: Nordic Lifestyle Intervention Study among Men with Prostate Cancer (NILS)
The number of men being diagnosed with early-stage disease has dramatically increased in the last decades. The majority of these men never develop aggressive or deadly disease. Active surveillance has become an important strategy in early prostate cancer in order to prevent a significant over-treatment. During this period of active observation most patients hunger for being able to make a difference themselves. Studies have observed associations between obesity, insulin resistance and hyperinsulinemia and increased risk of aggressive prostate cancer. On the other hand vigorous exercise and whole grain rye consumption decreases insulin secretion. NILS is a Danish clinical randomized intervention pilot-trial and a multidisciplinary study of men with prostate cancer.

09.05 - 09.35 **Healthy hormones**
L. Fleure, London (GB)

Aims and objectives
- To discuss the role of androgen deprivation therapy (ADT) in advanced prostate cancer and its short and long-term adverse effects
- To introduce a seminar-based program for men receiving ADT which aims to improve knowledge of treatment, improve side effect management and to help prevent long term metabolic effects
- To evaluate the service
- To discuss future plans for development and audit.

09.35 - 10.05 **How to implement healthy lifestyles in chronic paediatric urology patients**
W. Bower, Hong Kong (HK)

Aims and objectives: How to implement healthy lifestyles in children with chronic urological disease and the impact of chronic urological disorders when they get older (data from 20 years Danish cohort)

10.05 - 10.15 **Discussion**

Aims and objectives
In recent years prevention and optimisation of urological pathways has had top priority. However, is it possible to introduce more healthy initiatives in the daily management and improve patient outcomes? Could prevention potentially be part of the strategic process in the transition from being a child to an adult with a urological disorder?

EAUN Session

10.45 - 12.00 EAUN Nursing Research Competition

Tower Room - Level S2

Chair: *R. Pieters, Ghent (BE)*

Jury:
M. Borre, Århus (DK)
V. Geng, Lobbach (DE)
J.T. Marley, Antrim (IE))
R. Pieters, Ghent (BE)

Report from the research competition winner of 2012

10.45 - 10.50 **Which factors make clean intermittent (self) catheterisation successful?**
E.M.C.J. Van Wijlick, Nijmegen (NL)

10.50 - 10.55 **Discussion**

The nominees of 2013 and their research projects

10.55 - 11.00 **RP13-01 Optimising the implementation of fast-track nephrectomy pathways**
E. Grainger, Århus (DK)

Aims and objectives
To investigate:
- Whether existent barriers to fast-track programmes can be overcome.
- Core elements, which can facilitate the implementation journey and increase adherence to care-plans.
- Whether a standardised educational intervention programme will improve adherence among the nursing staff to the national recommendations to nephrectomy pathways, and is it necessary to repeat the education programme to keep up the adherence.

11.00 - 11.05 **Discussion**

11.05 - 11.10 **RP13-02 Complications related to a nephrostomy catheter**
R.N. Knudsen, Århus (DK)

11.10 - 11.15 **Discussion**

11.15 - 11.20 **RP13-03 Do catheter bags with inbuilt irrigation pumps reduce the incidence of acute urinary retention in patients undergoing high dose rate brachytherapy to the prostate?**
D. Stokes, Beaumaris (AU)

Aims and objectives
The aim of the project is to reduce, or eliminate the incidence of acute urinary retention caused by blood clots in men undergoing high dose rate brachytherapy to the prostate by introducing catheter bags with inbuilt irrigation pumps. Also to assess if catheter associated urinary tract infections will be eliminated as the pump irrigation bags are designed to eliminate the need for the system to be disconnected to perform manual bladder washouts. Hopefully this system will be adopted by the hospital for all patients with haematuria.

11.20 - 11.25 **Discussion**

11.25 - 11.30 **RP13-04 Water and lemon juice for the prevention of catheter encrustation**
G. Villa, Milano (IT)

11.30 - 11.35 **Discussion**

11.35 - 11.40 **RP13-05 The relation between the bowel management and the urinary tract infection rate in patients with spinal cord injuries. A study from the perspective of nursing**
M. Kloeser, Bad Wildungen (DE)

11.40 - 11.45 **Discussion**

11.45 - 12.00 **General discussion**

Aims and objectives
The nursing research competition aims to be a teaching moment for nurses who want to start a research programme or improve their skills in setting up a research programme. The presentation and discussion on the research plans of colleagues shows the pitfalls, the objectives, the do's and don'ts.

The session gives insights into
- Planned projects in urology from the nursing view
- How to bring nursing procedures or questions about nursing procedures into research projects
- Developments which take place in the urological field
- Doing a project plan for research activities
- How research plans are presented

Panel Discussion

11.00 - 12.00 Bladder cancer

Amber Hall 3-4 - Level S2

Bladder cancer panel discussion
A discussion including urinary diversion/stoma care, pain management, exercise, superficial bladder cancer, mitomycin

Moderator: S. Hieronymi, Frankfurt am Main (DE)

Panel: W.M. De Blok, Amsterdam (NL)
L. Drudge-Coates, London (GB)
B.T. Jensen, Århus (DK)
B. Kiesbye, Risskov (DK)
N. Love-Retinger, New York (US)

Aims and objectives
Bladder cancer is characterised by a wide range of occurances and subsequently knows a wide range of treatment options. This session should give you an overview of how this disease is dealt with in different countries and hospitals. The session will be held in a new format with a panel of experts (including nurses and a patient) discussing the topic by means of case studies.

EAUN lecture

12.00 - 12.30 State-of-the-art lecture: The gender aspect

Tower Room - Level S2

Chair: *S. Vahr, Copenhagen (DK)*

Do male patients have a gender too?
S.A. Madsen, Copenhagen (DK)

Aims and objectives
Male and female patients often have different needs regarding communication and care. In Urology the majority of patients are male. However, men's health and men's health psychology are very seldom part of the nurse curriculum. In this lecture the state of the art in men's health issuses will be presented, building upon the report 'The State of Men's Health in Europe' and several years' experience in educating nurses (and doctors) in communicating with the male patient.

Debate

12.00 - 13.00 Prostate cancer screening

Amber Hall 3-4 - Level S2

Chair: *W.M. De Blok, Amsterdam (NL)*

12.00 - 12.20 **Pro**
R.C.N. Van Den Bergh, Utrecht (NL)

12.10 - 12.20 **Con**
K. Brasso, Lyngby (DK)

Aims and objectives
To discuss prostate cancer screening based on the most up-dated information on effect of screening combined with the recent up-dates on efficacy of treatment in patients with low-risk prostate cancer, including:
- The recently published evidence on screening for prostate cancer.
- Effects of screening on morbidity, mortality, and quality of life.
- Outcomes of future analyses of screening studies.
- (Dis)advantages of prostate-specific antigen.
- (Dis)advantages of prostate needle biopsies.
- (Dis)advantages of different curative treatments.
- Considerations for the individual patient.
- Discuss possible future screening protocols.
- What to advise a patient on the outpatient clinic?

12.20 - 13.00 **Panel discussion: Prostate cancer screening**

Moderator: R.C.N. Van Den Bergh, Utrecht (NL)

Panel: K. Brasso, Lyngby (DK)
K. Flynn Thomas, Dublin (IE)
H.A.M. Van Muilekom, Leiden (NL)

Aims and objectives
The session will start with the pros and cons, followed by a response of the presenters to each others arguments. The panel will then discuss the following topics in more depth from various angles:
- How do the prostate cancer screening numbers correlate to screening for other diseases?
- Is it worth it? How to translate findings from screening studies to the individual patient.
- What are the risks for the individual patient when choosing for screening.
- What does a patient gain when choosing for screening?
- How to avoid side effects of screening in the future.
- Biomarkers, robots, and other future developments.

The aim of this session is to get an open and frank discussion about the pros and cons of prostate cancer screening. The objective is to help nurses in their patient education about prostate cancer and screening.

EAUN Lecture

12.30 - 13.15 The online diary as a communication tool for patients and nurses

Tower Room - Level S2

Chair: *V. Geng, Lobbach (DE)*

12.30 - 13.00 **Background and development of the online tool**
R. Vingaard Jørgensen, Aalborg (DK)

Aims and objectives: September 2009 the new health informatics tool The Online Patient Book was implemented as a part of the standard care to men with prostate cancer in a specified clinical practice. Considering patients' short stays in hospital, the aim was to meet the patients' information and communication needs, during their course of treatment.
An innovative and user-centred approach was an important part of the design process to ensure the system would meet the needs of the patients. Patients and healthcare professionals were involved by applying various participatory methods, such as interviews and design workshops.
Based on this research project, it is substantiated, that Web 2.0 applications can contribute to the accessibility of the healthcare professionals. The patient experiences the healthcare professionals as easy to contact, whereby potential problems and insecurity, are addressed. The contact to the healthcare professionals is flexible, as the tool is available at all time and everywhere. This continuity of care reduces the patients' dependency on the healthcare professional. And, it gives the patients a freedom to continue their normal daily life.

13.00 - 13.15 **Demonstration and experience with the tool**
R. Vingaard Jørgensen, Aalborg (DK)
A. Ringkjær, Aalborg (DK)

Aims and objectives
In this session you will learn something about development and background of the online diary commication tool. The speaker will give there expierence to the audience and will demonstrate the online tool

EAUN lecture

13.45 - 14.45 State-of-the-art lecture: Nutritional aspects of pre-operative interventions

Amber Hall 3-4 - Level S2

Chair: *B.T. Jensen, Århus (DK)*

13.45 - 14.15 **The influence of nutrition on patient outcomes - what is the evidence for pre-, peri- and post-surgical nutritional treatment or advice**
F. Bozzetti, Segrate (IT)

14.15 - 14.45 **Improving patient outcomes with nutrition in daily practice**
M. Borre, Århus (DK)

Aims and objectives
Nutritional status is very under-reported in urological care. Most evidence is about when treatment has failed and the patient is in palliative care.
However, is it possible to optimise patient-outcome after surgical treatment by increasing awareness and early nutritional intervention?

EAUN lecture

14.00 - 14.45 State-of-the-art lecture: Penile carcinoma

Tower Room - Level S2

Chair: *L. Drudge-Coates, London (GB)*

Penile carcinoma: Awareness, diagnosis and assessment
S. Horenblas, Amsterdam (NL)

Panel discussion

15.00 - 16.00 Bladder dysfunction: Overactive bladder syndrome, nocturia and pelvic floor issues

Amber Hall 3-4 - Level S2

Chair: *S. Vahr, Copenhagen (DK)*

15.00 - 15.05 **Introduction**
S. Vahr, Copenhagen (DK)

15.05 - 16.00 **Panel discussion: Overactive bladder syndrome, nocturia and pelvic floor issues**

Moderator: A. Graziottin, Milan (IT)

Panel: P. Abrams, Bristol (GB)
W. Bower, Hong Kong (HK)
C.R. Chapple, Sheffield (GB)
D. Mair, Innsbruck (AT)

Aims and objectives
- Review the pathophysiology of incontinence.
- Focus on more cost-effective diagnostic pathways and therapeutic strategies.
- Appreciate the precious role of nurses in:
  1) Early diagnosis of urinary incontinence;
  2) Empowering patients in their early reading of symptoms to anticipate the appropriate diagnosis;
  3) Reducing shame and self-blame incontinence conveys, to encourage patients to ask for medical help, the sooner, the better;
  4) Improving compliance and adherence to treatment strategies.
- Commit motivated nurse to encourage men and women to invest in their health expectancy, also from the continence point of view.

Abstract session

15.00 - 16.45 Poster session 2

Tower Room - Level S2

Chairs: *W.M. De Blok, Amsterdam (NL)*
L. Drudge-Coates, London (GB)

Poster viewing 30 minutes
Introduction by chairmen (4 minutes) Presentations (6 minutes for presentation and 2 minutes for discussion per presenter)

10 **Patient comfort during intravesical chemoterapy - a randomized trial comparing two methods of instillation**
B. Bonfils, M. Højgaard, J. Meinung, M. Kelsen, G. Lam Wrist (Herlev, Denmark)

11 **How a nurse led cystoscopy service for non muscle invasive bladder cancer improved the outcomes for patients, service providers and researchers in a major tertiary hospital in Australia**
P. Bugeja, E. Hayes, N. Sapre (Parkville, Australia)

12 **Developing a novel approach to follow up for patients with prostate cancer**
J.E. Kinsella, A. Ashfield, R. Popert, D. Cahill (London, United Kingdom)

13 **Onset, severity and duration of uro-genital pain after 3rd generation salvage cryoablation for recurrent prostate cancer: An observational study**
J. Broekhuis, J.R. Hamstra, M.M. Plooij, I.J. De Jong (Groningen, The Netherlands)

14 **The use of pre-operative rectal paracetamol reduces the need for post operative opoid analgesics in children undergoing urologic procedures**
A. Wanzam, A.B. Ayamga, A. Afoko, S. Al-Hassan, F.M. Sulemana, M.P. Gyereh (Tamale, Ghana)

15 **The use of chlorhexidine gluconate shower the night before surgery reduces surgical site infection in patients undergoing scrotal surgery**
M.P. Gyereh, B. Ayamga, A.A. Afoko, F.S. Sulemana, A. Wanzam, S. Al-Hassan (Tamale, Ghana)

16 **Importance of ultrasound determination of the urinary bladder volume for care in patients with spinal cord injury (SCI) who practice catheterization**
N. Raue, C. Hitschler, B. Domurath (Bad Wildungen, Germany)

17 **Neurogenic lower urinary tract dysfunction: The challenge of asymptomatic bacteriuria and urinary tract infections**
M. Widmer, A. Ungricht, T. Makris, N. Schölly, M. Walter, J. Wöllner, T.M. Kessler (Zurich, Switzerland)

18 **Urodynamics in spinal cord injury patients: Be aware of autonomic dysreflexia**
A. Ungricht, M. Widmer, T. Makris, N. Schölly, M. Walter, T.M. Kessler (Zurich, Switzerland)

Aims and objectives
The aim of this session is to update the delegates with recent research activities and findings in the development of evidence-based urological care.

EAUN lecture

16.00 - 16.30 State-of-the-art lecture: Complementary medicine in oncology

Amber Hall 3-4 - Level S2

Chair: *S. Hieronymi, Frankfurt am Main (DE)*

Complementary medicine in oncology
J. Hübner, Frankfurt (DE)

Aims and objectives
Cancer patients are highly interested in complementary and alternative medicine (CAM). This interest is rising according to recent surveys. Different authors report user rates between 10 to 80%.
Primary sources of information for patients on CAM are relatives and friends. Print media and the internet are used less often and the physician is hardly involved. Most patients do not inform their oncologists about the CAM methods they use. Moreover, 50% of the users consider CAM to be safe and effective. Thus, risks of CAM in oncology as side effects and interactions are not likely to be discussed and prevented. Physicians report feeling unconfident because of missing knowledge. Also, in training of other professionals as nurses, psycho-oncologists or physiotherapists, CAM is not part of official curricula.
The aim of the talk will be to provide basic knowledge on benefits and risks of CAM and to show how to integrate counseling on CAM in daily practice in oncology.

EAUN Round table discussion

17.00 - 18.00 Meeting the challenges of cancer related bone health

Amber Hall 3-4 - Level S2

17.00 – 17.10 **Launch of the EAUN e-learning course *Bone health and urological cancer***
L. Drudge-Coates, London (GB)

17.10 – 17.15 **Discussion**

17.15 – 18.00 **Round table discussion on bone health care for cancer patients – what are the challenges?**

Moderator: K. Redmond, Lugano (CH)

Panel: M. Borre, Århus (DK)
L. Drudge-Coates, London (GB)
B.T. Jensen, Århus (DK)
B. Tombal, Brussels (BE)

Aims and objectives
To share a unique EAUN development in bone health e-learning education. To discuss the current challenges of care for urological patients and their bone health needs. This aims to be an interactive session between the panel and audience to discuss and highlight these key issues.

Supported with un unrestricted educational grant from AMGEN

Sponsored Workshop

17.00 - 19.00 Safety in urinary catheterization

Tower Room - Level S2

17.00 - 17.25 **Introduction to NAUTI**
E. Belgrano, Trieste (IT)

17.25 - 17.50 **Best practices in urinary catheterization in hospitals**
C. Kümmel, Salzgitter (DE)

17.50 - 18.15 **How to get a reliable urine analysis for urinalysis?**
M. Madeo, Doncaster (GB)

18.15 - 18.40 **Solutions by B.Braun**
P. Van De Poel, Sittard (NL)

18.40 - 19.00 **Discussion & questions**

Aims and objectives
• Are you concerned by Nosocomical infections related to the Urinary Tract (NAUTI)?
• Do the implemented protocols comply with your standard guidelines?
• When a urine infection is diagnosed, are you sure of the urine sample quality?
Lots of questions raised....
If you are concerned by any of the above, join us at the B.Braun workshop to discover new & innovative solutions to prevent NAUTI.
Urologists, hygienists, nurses, all parties involved, we look forward to meeting you for a "sharing expertise" session to discuss "Safety in Urinary Catheterization!"

Sponsored by B.BRAUN

ESU Course 2

08.30 - 10.45 Bladder diseases and treatments

Tower Room - Level S2

08.30 - 09.30 **Bladder diseases and treatments, Part 1 - Benign disease**

Chair: L.N. Türkeri, Istanbul (TR)
E. Grainger, Århus (DK)

- Pathophysiology
- Bladder related conditions
- Case studies
- Treatment overview (medical and surgical treatment options)
- Questions and answers
- Take home messages

09.30 – 09.45 **Break**

09.45 - 10.45 **Bladder diseases and treatments, Part 2 - Malignant disease**

P.J. Boström, Turku (FI)
V. Khati, London (GB)

- Incidence and risk factors
- Initial presentation
- Initial investigations and diagnosis
- Case studies
- Questions and answers
- Take home messages

09.00 - 14.10 ESU-EAUN Cystoscopy course with hands-on training

Amber Hall 3-4 - Level S2

09.00 - 10.00 **Lower urinary tract**
- Anatomy and physiology of the bladder
- Embryology
- Anatomy and anomalies
- Pathology of the urological system
- Common diagnoses, video and images

F. D'Ancona, Nijmegen (NL)

10.00 - 11.00 **Practical aspects of cystoscopy**
- Indications and preparations for cystoscopy
- Legal aspects, experiences of nurses practising cystoscopies
- Case stories
- Role developmental aspects for nurses

W. De Blok, Amsterdam (NL)
L. Drudge-Coates, London (GB)

11.30 - 12.00 **History and development of the equipment, technical highlights/cleaning/handling of the equipment**
S. Boettjer, Hamburg (DE)

12.10 - 14.10 **Hands-on training with poptrainer and transurethral model**
S. Boettjer, Hamburg (DE)
W. De Blok, Amsterdam (NL)
L. Drudge-Coates, London (GB)
L. Van De Bilt-Sonderegger, Eindhoven (NL)
C.C.D.M. Sommers, Nijmegen (NL)

Aims and objectives
To be able to perform cystoscopies independently a broad theoretical knowledge is an important condition. This course aims to meet this need as well as offer some practical training in a safe environment. After the course the nurse will be ready to start complete training in their own country guided by trained healthcare professionals skilled in cystoscopies.

Max. 48 participants. Limited registration at the registration desk on a first-come, first-served basis. Separate registration fee applies. Participant can request a Certificate of Attendance from 20 March 2013. Possibly also ECTS points will be granted.

Supported by OLYMPUS EUROPA HOLDING GMBH

EAUN Lecture

11.00 - 11.45 State-of-the-art lecture: Palliative care in urology

Tower Room - Level S2

Chair: *L. Drudge-Coates, London (GB)*

11.00 - 11.20 **Palliative nursing care**
P. Fernández Ortega, Barcelona (ES)

Aims and objectives
To share with the audience nursing care experiences that patients affected with advanced urological tumours are receiving. I will present the Palliative organisation and Spanish perspective and also describe nurses competencies in attending to the special needs of these patients and families.

11.20 - 11.40 **Medication in palliative care**
D. Feuer, London (GB)

11.40 - 11.45 **Discussion**

EAUN lecture

11.45 - 12.15 State-of-the-art lecture: Transition from paediatric to adult urology

Tower Room - Level S2

Chair: *B.T. Jensen, Århus (DK)*

The pitfalls and opportunities of the transition
W. Bower, Hong Kong (HK)

EAUN Session

12.15 - 12.45 EAUN General Assembly

Tower Room - Level S2

Chair: *K. Fitzpatrick, Dublin (IE)*

V. Geng, Lobbach (DE)
S. Hieronymi, Frankfurt am Main (DE)
B.T. Jensen, Århus (DK)
S. Vahr, Copenhagen (DK)

Agenda

- Welcome by the chair
- Approval on new board structure
- Approval new board terms and new board members
- Approval of the Minutes AGM 2012
- The report of the chair with presentation of the achievements of 2012/2013
- Long-term Strategy, growth targets and budget
- Cooperation with other organisations
- Report on the meeting of the board with the presidents of national societies in Milan on Saturday
- Subjects for the next Congress in 2014 in Stockholm
- Proposals from the members will be accepted at this time
- Any other business

The General Annual Meeting is open to all delegates. Only Full EAUN Members can vote.

EAUN Lecture

13.15 - 13.45 State-of-the-art lecture: Brachytherapy in urological cancer

Tower Room - Level S2

Chair: *K. Fitzpatrick, Dublin (IE)*

Brachytherapy in urological cancer
D. Hacking, Waterford (IE)

Aims and objectives
I would like to summarise the history of brachytherapy for prostate cancer, the technological advances that have been made and the clinical outcomes the have been reported that have established this modality as a standard of care for patients with all risk categories of prostate cancer.

EAUN Lecture

13.45 - 14.30 State-of-the-art lecture: Urological disorders that challenge the surgeon

Tower Room - Level S2

Chair: *S. Vahr, Copenhagen (DK)*

Common benign adrological pathologies: Phimosis, hydrocele, varicocele - diagnosis, treatment and management
I. Eardley, Leeds (GB)

Aims and objectives
The aim of this session is to provide the delegates with insights in the difficult cases urological surgeons are often challenged with.

EAUN Session

14.45 - 15.00 Award session

Tower Room - Level S2

Chair: *K. Fitzpatrick, Dublin (IE)*

- First Prize for the Best EAUN Poster Presentation
- Second Prize for the Best EAUN Poster Presentation
- Third Prize for the Best EAUN Poster Presentation
- Prize for the Best EAUN Nursing Research Project

EAUN Session

15.00 - 16.15 Inside the body - surgery in motion (videos)

Tower Room - Level S2

Chair: *S. Hieronymi, Frankfurt am Main (DE)*

V44 **Left laparoscopic radical nephrectomy: Step-by-step**
R. Sotelo Noguera, O. Carmona, R. De Andrade, F. Santinelli, D. Subira, C. Ignacio, G. Fernández, R. Garza, J. Castro, F. Birkhauser, R. Cisneros, D. Canes, R. Clayman (Caracas, Venezuela; Buenos Aires, Argentina; Madrid, Spain; Boston, Irvine, United States of America)

V26 **Robotic cystoprostatectomy with nerve-sparing approach and intracorporeal construction of Hautmann neobladder: Saint Augustin technique**
D. Rey, E. Helou, M. Oderda, L. Lopez, P-T. Piechaud (Bordeaux, France)

V35 **Combined endoscopic surgery: Flexible retrograde ureteroscopy with percutaneous access in the supine position: Endovision**
O. Angerri, J.M. Santillana, F. Sanchez-Martín, F. Millan, H. Villavicencion (Barcelona, Spain)

V71 **Combined therapy of stress urinary incontinence and erectile dysfunction with the implantation of Advance (XP) and AMS 700 in a single procedure**
B. Amend, S. Kruck, S.K. Wilson, L. Hakim, B.S. Christine, J. Brady, E.R. Castane, C. Rojas-Cruz, A. Stenzl, J. Bedke, K-D. Sievert (Tübingen, Germany; Indio, Cleveland, Homewood, Orlando, United States of America; Barcelona, Spain)

V16 **Failure analysis and management of iatrogenic injuries occurring during robot assisted radical prostatectomy**
M. Addali, V. Zugor, A. Abdulhak, S. Poth, A. Schütte, C. Wagner, J.H. Witt (Gronau (Westfalen), Germany)

Aims and objectives
All nurses, irrespective of the department they work in, have queries regarding details of what happened during surgery. This new session is meant to present and discuss surgical videos, explain details and allows sufficient time for questions.
For OR nurses it will be interesting to see in which way other hospitals perform a particular type of surgery or how a type of surgery that is not performed in their OR proceeds.
For nurses that are employed outside the OR this session will for the first time enable them to see what happens during surgery inside the patient's body. As a result they may gain a better understanding of why patients have to be treated in a particular way pre- and postoperatively and be able to ask patients more specific questions to improve care.

Abstracts

P1 Tower Room - Level S2

PRE-CLINIC MULTIDISCIPLINARY MEETINGS ARE A USEFUL TOOL FOR TREATMENT DECISION MAKING AND STRATIFYING PATIENT FOLLOW-UP

Kinsella J.E.[1], Van Hemelrijck M.[2], Santaolalla A.[2], Duong K.[1], Reynolds P.[1], Challacombe B.[1], Popert R.[1], Cahill D.[1]

[1]Guy's and St Thomas' NHS Foundation Trust, Dept. of Urology, London, United Kingdom, [2]King's College London, School of Medicine, Division of Cancer Studies, Cancer Epidemiology Group, London, United Kingdom

Introduction & Objectives

Multidisciplinary team (MDT) meetings are an increasingly used tool to optimize management for men newly diagnosed with prostate cancer. These meetings are thought to not only improve patient management, but also the training experience of both clinicians and nurses. We evaluated whether pre-clinic MDT meetings improve both the patient experience as well as healthcare professional experience when managing follow-up patients.

Material & Methods

We introduced MDT meetings before each prostate cancer clinic in our Urology Centre in May 2012. These meetings were introduced as an educational tool to improve clinical training, but also to improve clinical efficiency concordance in decision-making and patient management. We compared management decisions made at pre-clinic MDT meetings with final decisions made following actual clinic at baseline, one and six months following implementation. We evaluated the training experience of clinicians and nurses before and after introduction of the pre-clinic MDT meeting.

Results

The table below illustrates how many patients were seen in each clinic at introduction, one and six months after introducing pre-clinic MDT meetings.

	Month 0 n=45 (%)	**Month 1 n=37 (%)**	**Month 6 n=71 (%)**
Number of newly diagnosed pts	5 (11)	3 (8)	7 (10)
Number of Follow up pts	40 (89)	34 (92)	64 (90)
Pts in appropriate clinic at time of presentation	29 (64)	24 (65)	62 (87)
Concordant decisions	33 (73)	23 (62)	63 (89)
Reasons for discordance			
Clinical reason	3 (25)	7 (50)	4 (6)
Pt choice	4 (33)	2 (14)	3 (38)
Other	5 (42)	5 (36)	1 (13)
Appropriate follow up guidance	34 (76)	27 (73)	68 (96)

The proportion of management and decision concordance between pre-clinic MDT and clinic improved from 73% to 89%. Moreover, more men presented in the appropriate clinic over time (64 versus 87%) and more men were directed towards the correct follow-up pathway (76 versus 96%).

Before implementing pre-clinic MDT meetings, four registrars, one consultant, and two clinical nurse specialists were asked to score how prostate cancer clinics met their clinical training needs. The mean score was 1.57 out of 5, and improved to 4 out of 5, five months after introducing the pre-clinics ($P<0.001$).

Conclusions: Pre-clinic MDTs improve patient management and the training experience of all healthcare professionals working within a busy prostate cancer service.

P2 Tower Room - Level S2

INTENSIVE PREOPERATIVE AND ADDITIONAL COMMUNITY BASED UROSTOMY COUNSELING

Cobussen-Boekhorst J.G.L.[1], Theunissen J.M.M.[1], Spierings J.[2], Van Roy P.W.M.[2], Smits-Van Der Camp A.[1]

[1]UMC St Radboud, Dept. of Urology, Nijmegen, The Netherlands, [2]Hoogland Medical, Dept. of Urology/Stoma, Oss, The Netherlands

Introduction & Objectives

In our university hospital yearly about 50 patients undergo urostomy surgery. Usually because of bladder cancer, sometimes for functional bladder problems. Over the last years a fast track program, with shorter hospital stay is implemented. A special patient care plan pre- and post-operatively was developed for this goal.

But despite of these interventions, we still observed that patients are reluctant to look at their stoma and to start stoma care. Sometimes due to this, time is too short to practice. This leads to patients who are not fully prepared for dismissal. In literature we found one study who investigated an additional preoperative counseling by community nurses. Remaining literature describes that preoperative counseling is important, but the effect of this only can be reached if instructions and psychosocial support are continued postoperatively.

Because not many community nurses in our country are specialized in this specific field, we discussed this issue with the medical device service (MDS), where our patients receive their appliances. We decided to do a study whereby the specialized nurses of this MDS visit the patient at home, after the preoperative counseling by the stomacare nurse of our department. During the counseling at home the specialized nurse also practice stoma care skills and answer questions.

Material & Methods

The stoma care nurse explains the study at the preoperative counseling, and asks permission at the patient for a home visit. Patient receives a letter to introduce the nurse from the MDS. The specialized nurse visits the patient within 2 weeks after receiving the registration. If the specialized nurse receives additional information, she discusses this with the patient and informs the stoma care nurse. Two questionnaire were developed; one to evaluate the home visit and one for the stoma care six weeks after dismissal. We decided to follow 25 patients until 6 weeks after dismissal.

Results

29 patients received pre-counseling. Of these in 3 patients the stoma surgery was cancelled, due to metastasis. And one patient passed away during follow up. Of the remaining 25 patients: 20/25 were male, mean age 68 (range 40-82) years, 23 undergo bricker derivation, 2 an ureterocutaneostomy. All patients agreed with the home visit, and were positive about it. 9/ 25 found the information given at home was new to them! 9/25 found information additional, mainly the practical stoma care issues. 8/25 found practicing stoma skills not easy.

After operation: 80 % had confidence in dismissal. After 6 weeks 5 patients still received stoma care from community nurses. Only 3/25 didn't see advantages of this additional counseling.

Conclusions

All participants and nurses were enthusiastic. Patients get the opportunity to discuss the stoma care again in their own home, and can practice stoma care principles in their own environment. We implemented this care in our fast track program.

P3 Tower Room - Level S2

THERAPEUTIC EDUCATION TO PATIENT WITH UROSTOMY

Boarin M.[1], Lorusso N.M.[2], Villa G.[2], Montorsi F.[1]

[1]Ospedale San Raffaele, Dept. of Urology, Milan, Italy, [2]Università Vita-Salute San Raffaele, School of Nursing, Milan, Italy

Introduction & Objectives

The patient after cystectomy with urostomy packaging has a negative impact on the life's quality and therefore requires specific educational interventions. Therapeutic education (TE) aims to help the person and his family in the management of the disease, organizing its activities according to their state of health, lifestyle to be adopted, early detection of complications. The aim of the review is to explore and to analyze educational needs, main informations and educational interventions to the patient with a urostomy for correct and effective self- management at home.

Material & Methods

A overview was carried out through a search in PubMed and CINAHL databases (limits: English, French, Italian languages; year of publication from 2002); 22 articles were selected. The research was carried out also in the grey literature.

Results

In management of patient with a urostomy, nurses have a key role because they help the patient to better understand the diagnosis, the prognosis, to encouraging the new condition adaptation through TE pathways, in order to deal with social and psychological issues, such as the perception of body image and sexuality alteration. The TE is largely implemented by nurses who, through specific interventions, seek to provide the patient with the necessary informations to understand the diagnosis, to facilitate postoperative recovery and the return to a independence state in their activities of daily living; it's important not only verbal communication but also the use of audiovisual instruments and the support of patients who already have urostomy, in connection to management and to stomal complications. From the literature seems that psychological distress appears as the result of an alteration in body image and the reduction of life's quality. To restore patient autonomy after surgery, it's important to talk to an expert nurse to clarify any doubts about sexuality, clothing, nutrition, changing and choice of device, prevention and management of eventual stomal complications.

Conclusions

The patient with urostomy experiences a series of issues related to change in physical aspect, relational aspect with other people, sexual and psychological adaptation, which can be faced through a TE pathway. Preoperative and postoperative TE can help the patient to deal with these issues, and contribute to improving his conditions in terms of educational interventions for the correct device management at home. It is necessary to implement specific interventions to improve the quality of nursing care to the patient with urostomy, such as training of specialized nurses and the promotion of training courses.

P4 **Tower Room - Level S2**

THE STOMA EDUCATION SCALE; A RELIABLE AND VALID TOOL IN UROLOGIC NURSING- A PAN EUROPEAN STUDY

Jensen B.T.[1], Blok W.[2], Kiesby B.[1], Kristensen S.A.[1]

[1]Århus University Hospital - Skejby, Dept. of Urology, Århus, Denmark, [2]Dutch Cancer Institute, Dept. of Urology, Amsterdam, The Netherlands

Introduction & Objectives

Patients undergoing cystectomy ad modum Bricker must accept living with a stoma. Being able to change a stoma appliance independently is the single most important factor for predicting positive psychological adjustment to life with a stoma. Providing patients with stoma self-care skills is crucial for improving patients' quality of life. A recent study (Kristensen et al) has validated the Stoma Education Scale as the first standardized tool to document the patients' level of stoma self-care skills. Showing robustness in a single centre study- It is warrant to investigate further evidence across European urological communities. A Dutch-Danish Fellowship was established to support and provide further evidence.

Aim of the study was to continue the validation process of the Stoma Education Scale in a European perspective by testing construct validity and reliability in a Dutch Danish comparative study. Secondly, to test whether Dutch results will support earlier findings.

Material & Methods

This study replicated the Danish study of the Stoma Education Scale. The scale was back and forth translated by the external Medical Knowledge Group and clinical experts in the Netherlands and Denmark. The study population included 12 patients in NL (and 12 in DK, respectively) with an uncomplicated course after elective radical cystectomy. Patients at NKI-AVL were randomly included from December 2011 to February 2012. Four nurses attended twelve patients' training sessions at different postoperative days. Each patient was taught stepwise how to change a stoma appliance due to a standardized plan. One experienced entero-stomal therapist acted as the instructor and three other nurses observed and scored the patient's self-care skills. Education Scale data were plottet using Bland-Altman Plots with Limits of Agreements. To investigate a possible common trend in stoma care, data were pooled using information from the Dutch and Danish study and tested.

Results

Analyzing the pooled data showed a statistically significant difference between beginners and advanced ($p=0.01$) (table 3). Performing sensitivity analysis improved the results showing a statistically significant difference between all three groups of patients ($p=0.02$; $p<0.001$ and $p=0.04$, respectively).When pooling data with the twelve scores from the Danish pilot study, results were improved and we found slightly narrower Limits of Agreements ranging from -3.7 to 3.2 (figure 4). Fifty-one out of 75 scores equal to 68% (95% CI: 56; 78) were within a difference of either 0 or 1 point. Sixty-four out of 75 scores differed with 2 points or less, equal to 85 % (95% CI: 75; 92).

Conclusions

The Stoma Education Scale continues to demonstrate robustness and provide stoma-therapy an exclusive tool. The results document an important trend of being independent of tradition of care, culture and settings. Further steps in the validation process are ready to be taken.

P5 Tower Room - Level S2

URINARY CATHETER INSERTION AND CARE: KNOWLEDGE AND EXPERIENCE AMONG HOSPITAL NURSES

Balin L., Malka-Zeevi H., Rabinovich I., Kalman R.

The Western Galilee Hospital, Nahariya, Israel

Introduction & Objectives

Background: At one time or another, almost every hospital department receives patients with a permanent or temporary catheter. Sometimes the patient arrives from home already catheterized, and sometimes the decision to catheterize the patient is made in the Emergency Room. Nurses have a substantial role in the decision and process of urinary catheterization. In order for the nurse to make the proper decision concerning the catheter type and the insertion process, he/she must have the necessary knowledge and experience. According to research studies that have been conducted, it has been found that nurses are not aware of all the factors that must be considered in the choice of catheter that is correct for each individual patient.

Material & Methods

Research goal: Examination of the relationship between the type of department in which the nurse works and his/her level of knowledge on the topic of choosing and inserting a catheter. The ultimate aim of this study is to contribute to the establishment of a unique training program for nurses in catheter insertion and care.

Research questions: Is there a connection between the nurse's place of work and level of knowledge in choice of and care for the catheter, after consideration of variables such as nurse's age, schooling, number of weekly work hours, professional seniority and type of department? We also examined the need for establishing such a training course on catheterization for nurses, and the importance of the nurse's experience in the process of catheter insertion and care.

Research method: A cross-sectional study, with 167 nurses from various departments, all working at Western Galilee Hospital, Nahariya. During departmental meetings, the nurses completed questionnaires on knowledge and comprehension, composed specifically for this study. The participants were also asked about their experience in catheter insertion and care.

Results

Findings and conclusions: It was found that nurses have a low level of knowledge on this topic. 92% reported that their professional experience was gained through catheter insertion and care while working at the hospital. More professional experience indicated a higher level of knowledge. No correlation was found between age or seniority and level of knowledge. The findings of this study led to the establishment of a training program, and a continuation of the same research study among nurses in another framework – Kupat Holim, the largest HMO in Israel.

P6 Tower Room - Level S2

UDO NURSES UNDERSTAND EVIDENCE-BASED RECOMMENDATIONS FOR PREVENTION OF CATHETER-ASSOCIATED UTIS?

Newman D.K.

University of Pennsylvania, Division of Urology, Philadelphia, United States of America

Introduction & Objectives

Hospital-associated infections from indwelling urinary catheters (IUC) are a major cause of patient mortality and morbidity. 32% of all hospital-acquired infections are urinary tract infections (UTI's), mainly from an indwelling urinary catheter (IUC). CaUTIs result in increased morbidity, mortality, hospital cost, and length of stay. Evidence-based research notes these infections are one of the preventable patient safety issues in the acute care setting. Nurses play a central role in catheter use but current practices are based on a paradigm of outdated routines put forth from nurse to nurse. Care of these devices needs to shift from outdated practice to contemporary evidence-based care. This Practice Inquiry Project evaluated evidence-based urinary catheter care by staff nurses following a hospital-wide initiative on prevention of catheter-associated urinary tract infections. The United State Centers for Disease Control and Prevention (CDC) evidence-based (EB) guideline on prevention of catheter-associated urinary tract infections (CAUTIs) recommends nursing care practices to prevent CAUTIs. Objectives of this study were to determine if components of an EB hospital-wide patient care initiative on prevention of CAUTIS are being practiced by registered nurses (RNs) on a daily basis and to describe nursing practice variations in application of the initiative.

Material & Methods

Prospective descriptive pilot study of patients with IUCs on eight units (4 high CAUTIs, 4 low CAUTIs) as noted in Chart 1, in a large academic center located in Eastern United States and the RNs (N=522) providing direct bedside patient care on these units.

Results

A total of 301 nurses (58% response rate) completed the survey noting an experienced group of clinical RNs as seen in Chart 1. Only 7.0% answered all EB questions correctly. Differences in knowledge depended on the number of years the RN had practiced. More inexperienced RNs (new to practice) would not independently make decisions about IUC removal (p=0.000) without an attending physician's order. More inexperienced RNs do not feel they have enough control over their practice to make decisions about IUC removal even though protocols are in place and resources are available. A higher percentage of experienced (RNs > 5 years) RN's (p=0.040) did not know the amount of bladder volume necessitating catheterization or reinsertion of an IUC. There were practice variations amongst nurses and have those variations may have impacted outcomes (e.g. CaUTI rates and number of device days). One out of 5 RNs (21.3%; N=64) were not able to identify indications for use of an IUC. High CaUTI units had a lower percentage of pre-connected catheter seals intact (59.6%) compared to 86.4% in the low CaUTI units (p=0.005). Units who had catheter seals intact, had a significantly (p=0.005) lower number of device days compared to those that did not have catheter seals intact.

Conclusions

This study demonstrated a significant gap in RN knowledge of EB recommendations of IUC indications and use. It also highlights the need for more intensive and on-going supportive education for RNs, particularly new RNs, as they appear to have difficulty in making independent clinical decisions about IUCs.

University of Pennsylvania IRB Approved Protocol # 813084
Spported by a grant from the Society of Urologic Nurses and Associates

P7 Tower Room - Level S2

THE PREVALENCE OF URINARY INCONTINENCE IN HOSPITALS: A STARTING POINT FOR A NEW POLICY?

Berghmans N., Everaert K.

UZ Ghent, Dept. of Urology, Ghent, Belgium

Introduction & Objectives

Our purpose was to evaluate the prevalence of urinary incontinence in the Belgian hospitals and to determine the need for a new policy for urinary incontinence.

Seeking help when confronted with the problem of urinary incontinence is still very difficult. We believe that offering help when patients are hospitalised for something other than their incontinence can constitute a solution for this problem.

Material & Methods

We used a multisite cross-sectional descriptive design. We composed the sample by consecutive sampling. We drew up the questionnaire out of two validated questionnaires (ICIQ- SF and IIQ 7) and we completed them with specific questions relevant for this issue. We distributed the questionnaires in two different hospitals: UZ Gent and GZA Sint Augustinus. In both hospitals we visited surgical as well as medical wards.

Results

Results showed that of the 439 participants, 31.7% appeared to be incontinent. 71.2% of them where women and 28.8% men. The youngest participant was 21 years old and the oldest was 97. The average age was 68.7 years. 36% of the participants was in the hospital because they needed surgery, 28.8% needed to be examined and 34.5% was there for a reason other than those mentioned in the questionnaire. We found that 35.3% of the participants lost urine once a week or less, 25.2% multiple times a week. 15.1% of the cases lost urine two or three times a week. Urine loss once a day was experienced by 18.7% of the participants. For the quantity of loss, we found that 75.5% experienced a minimum loss, 18.7% lost quite much and 3.6% suffered from a lot of urine loss. The majority of the participants (48.9%), mentioned a good quality of life (QOL), 22.3% scored their QOL as being average, 15.8% as being bad and 12.2% scored their QOL as being very bad. The mean score for QOL was almost the same for men and women (3.6 for men and 3.4 for women). 42.2% of those who were urinary incontinent searched for help. Of those who got help, we found that the treatment appeared to be effective in only 13.8% of the cases. The majority of the participants (54.7%) mentioned to have no expectations about the possible solutions for urinary incontinence. 58.2% of the participants did not wish to receive information from a continence nurse during their stay in the hospital.

Conclusions

We think that there is a need for a new policy concerning urinary incontinence. People should be better informed about the possible solutions and the effectiveness of the treatment should be improved, as well as better evaluated. Whether a hospitalization period is a good opportunity to start evaluating the incontinence remains open for discussion.

P8 Tower Room - Level S2

WOMEN'S EXPERIENCE OF URODYNAMIC STUDIES

Jacob M.

National Maternity Hospital, Urodynamics Clinic, Dublin, Ireland

[1]Memorial Sloan-Kettering Cancer Center, Dept. of Nursing/Urology, New York, United States of America, [2]Århus University Hospital, Dept. of Urology, Århus, Denmark, [3]Memorial Sloan-Kettering Cancer Center, Dept. of Biostatistics and Epidemiology, New York, United States of America, [4]Memorial Sloan-Kettering, Dept. of Urology, New York, United States of America

Introduction & Objectives

This abstract describes women's experiences of urodynamic studies. Gray (2000) defines the term urodynamic studies as a set of tests that measure bladder, urethral and pelvic floor muscle function. Urodynamic studies are focused on the lower urinary tract to investigate bladder filling and voiding function, to define bladder storage disorders accurately and to assess objectively the severity of voiding dysfunction (Guo et al., 2004).

Urodynamic studies are an important preoperative requisite for many women who present with urinary incontinence, particularly those who have mixed stress and urge urinary incontinence, those with recurrent incontinence following previous surgery and those with evidence of neurological symptoms (Chapple and MacDiarmid, 2000). Although generally well tolerated, some patients regard urodynamic studies as an unpleasant and painful procedure (Ku, 2004). The investigation is however, potentially distressing and embarrassing for the patient.

Although urodynamic studies has widespread use as an investigative procedure to identify the factors contributing to urinary incontinence, there is an absence of descriptive data on women's experiences of urodynamic studies. In comparison with American and British sources, there appears to be a dearth of information from Irish sources in medical, nursing or midwifery literature on the topic of women's experience of urodynamic studies. This has been the motivation for the research study into women's experiences of urodynamic studies as the professional role of the researcher involves a specialised clinic and patient case load.

Material & Methods

Descriptive qualitative methodology is the theoretical framework underpinning this study. The sampling method in this study is a non-probability sampling strategy using purposive sampling. Data collection was by means of semi-structured interviews with seven participants. Colaizzi's (1978) Framework for Qualitative Data Analysis was used to analyse the collected data.

Results

The findings centred on five major themes which emerged from the data; the role of the specialist midwife, attitudes towards urinary incontinence, experiences of urodynamic studies, women's recommendation for care related to urodynamic studies and perceived barriers to understanding urinary incontinence. These five themes incorporated twelve sub themes, which were used to provide the framework for discussing the researcher's findings within the context of the available literature.

Conclusions

The discussion highlighted the women's experiences of urodynamic studies and recommends key issues for practice, education and research.

P9 Tower Room - Level S2

PATIENT EXPERIENCE OF THE POST OPERATIVE PERIOD AFTER NEPHRECTOMY, IN AN ACCELERATED PATIENT TRACT

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Introduction & Objectives

Fast- Track surgery employs new surgical and anesthetic methods, in combination with improved pain management, early mobilization, nutrition and thorough information.
The objective is to empower the patients to Self-care, in the Post operative period, and thus faster being able to regain their normal levels of activities.
At home, the patients must cope with their physical reactions, and at the same time they mentally have to able to deal with a possible cancer diagnosis. Thus the patients are entrusted with a great responsibility for involvement and Self-care in regards to recuperation.
The purpose of this study is to gain insight into how patients experience and cope with their everyday life after a kidney operation in a 'Fast –track' kidney operation course.

Material & Methods

Inclusion: All patients at the Urology Dept, having had a laparoscopic radical nephrectomy in a standardized nursing & treatment track, performed from Feb. 2010 - June 2011, discharged at the latest 5 days after the operation. The patients were consecutively selected.
12 patients were included.
Exclusion: Patients who exceeded the 5-day time frame, and patients who did not understand, speak or write Danish.
The Method was a Qualitative study of the Patient perspective of the Postoperative period.
After discharge and for the following 2 weeks, the patients described their own coping of sickness and treatment in a diary. This was supplemented with a semi-structured follow-up interview app. 4 weeks after discharge. The study was analyzed based on Phenomenological text analysis.

Results

All of the patients perceive the operation as an overwhelming change in their lives.
Physically, they are challenged beyond their limits, but most are coping well. A new bodily anxiety occurs. They become more aware of small physical signals, being interpreted as relapse of kidney malfunction or relapse of cancer.
Mentally, the patients perceive that 'they don't recognize themselves', being so profoundly affected, that their identity is transformed from being a healthy person to a cancer stricken one.
The patients barely start the mental coping with the consequences of the operation during their 5-day of hospitalization, and they are still in a mentally unstable state of 'limbo', after the first month, when the interview is carried out.
Socially, they need time to pick up themselves, before they can cope with their surroundings.

Conclusions

The participants express a wish for individualized counseling, particularly during the first weeks after the operation.
They need guidance to find answers, and how to solve problems they had not foreseen, and guidance to process the new physical and mental challenges the operation has presented.

P10 Tower Room - Level S2

PATIENT COMFORT DURING INTRAVESICAL CHEMOTERAPY – A RANDOMIZED TRIAL COMPARING TWO METHODS OF INSTILLATION

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Introduction & Objectives

Patients having undergone transurethral resection of the bladder for low risk bladder neoplasms receive postoperative treatment with intravesical instillation of chemotherapy Mitomycin (MC).
Patients experience discomfort during MC treatment, including bladder spasms, pain and urgency leading to leakage and decreased compliance and ultimately resulting in premature removal of the instilled MC.
The aim of the study was to compare the subjective discomfort and compliance between two instillation methods: the MC instillation with catheter clamping (group A) and MC instillation with an open catheter connected to an elevated bag (group B).
The hypothesis was that an elevated urine bag should enable bladder contractions with no rigid resistance, while keeping the MC within the bladder by hydrostatic pressure, potentially reducing the patient's discomfort, compared to the raised bladder pressure with catheter clamping.

Material & Methods

This was an open-label prospective, randomized, controlled study with two arms, randomized 1:1 with 97 patients enrolled. Patients underwent 2 hours of postoperative intravesical MC instillation.
Every 15 minutes during the planned treatment period, patients documented subjective discomfort on a scale from 0-10, where 0 = no discomfort and 10 = maximum discomfort (see table 1). A cumulative score was calculated by adding the scores for the entire period.

Results

Of the mean cumulative discomfort scores, only urgency was reported significantly lower in Group B.

	Pain	Bladder spasm	Urgency	Incontinence	Burning
Group A (N=48)	9.7	7.2	20.1	3.3	7.2
Group B (N=49)	8.8	4.5	14.2*	2.0	8.2

Table 1: Mean cumulative discomfort scores during 2h treatment with instillation of intravesical MC.*= $p<0.05$, t-test

The number of patients completing the 2 hour treatment did not differ significantly (Group A 69% vs. Group B 82%, $p= 0.114$)

Conclusions

The catheter-to-bag instillation method caused the patient less subjective urgency compared to the clamped off catheter method. A non-significant trend of pain, decreased incontinence and decreased premature treatment termination was seen in the catheter-to-bag group.

P11 Tower Room - Level S2

HOW A NURSE LED CYSTOSCOPY SERVICE FOR NON MUSCLE INVASIVE BLADDER CANCER IMPROVED THE OUTCOMES FOR PATIENTS, SERVICE PROVIDERS AND RESEARCHERS IN A MAJOR TERTIARY HOSPITAL IN AUSTRALIA

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Introduction & Objectives
Nurse led flexible cystoscopy (NLFC) has evolved over the past decade with reports suggesting that adequately trained nurses can competently undertake flexible cystoscopy. We present our experience in setting up a NLFC service and the subsequent outcomes of comprehensive care on patients, service providers and researchers in a major tertiary hospital in Australia.
Traditionally, it had been the role of the Registrar and visiting Fellows to perform the cystoscopies. These very busy clinicians spend 12 months at this hospital with their primary focus being the acquisition of surgical skills and knowledge to treat patients effectively. Due to the high volume of cystoscopies required it had not been possible, for the available medical staff to cope with the demand. Patients had been on the waiting list for unacceptable lengths of time. Bladder cancer research was not possible due to the lack of a known or tracked cohort of patients.

Material & Methods
A NLFC service was established in 2009. The service involves the undertaking of surveillance cystoscopies, coordinating patients with non muscle invasive bladder cancer (NMIBC) including instillation of BCG, and coordinating a newly developed "one stop" haematuria clinic to expedite the screening of patients. A clinical pathway was instituted following EUA and AUA guidelines. A comprehensive database was developed where previously there had been none.

Results
362 patients had 1095 NLFC completed over a thirty two month period. 220 (21%) of cystoscopies had a suspected bladder cancer recurrence and were referred for a rigid cystoscopy. Of those, 134 (61%) revealed a recurrence. 61 (27%) had benign pathology on biopsy and 23 (10%) had normal rigid cystoscopy. There were two significant adverse events in patients who had prior risk factors. There was a 65% reduction in the waiting list for surveillance cystoscopy after introduction of the service. Of 60 patients who completed the feedback questionnaire, 97% had confidence and trust in the nurse and 93% were happy to have a FC performed by a nurse rather than a doctor. Patients presenting with macroscopic haematuria are seen within 23 days (9-53). Multiple clinical trials are being undertaken, a tissue bank has been set up and a doctoral student is undertaking his PhD in basic science using data and tissue from this cohort of patients.

ConclusionsResults from our NLFC audit compare favorably to other published reports. NLFC is a safe and feasible option when established alongside strong departmental support and comprehensive nurse training. NLFC clinics provide excellent continuity of care and follow up for NMIBC patients. This results in an efficient service, reduced waiting lists and a comprehensive cohort of patients for Bladder Cancer research.

P12 Tower Room - Level S2

DEVELOPING A NOVEL APPROACH TO FOLLOW UP FOR PATIENTS WITH PROSTATE CANCER

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Introduction & Objectives
Debate surrounding the need and effectiveness of cancer follow-up care is ongoing. We aimed to establish a novel shared care model of survivorship follow up for men following treatment for prostate cancer as an alternative to traditional clinic based follow up, to address quality of life issues whilst monitoring for cancer recurrence.

Material & Methods
Three separate treatment specific (Radical prostatectomy, Radiotherapy and hormone therapy) survivorship seminars were delivered to patients considered as having stable disease. The programme of these survivorship days included presentations designed to reinforce the role of primary care in cancer follow up as well as supporting patients in their efforts to cope with the side effects associated with treatment. Topics covered ranged from dietry advice to incontinence and erectile dysfunction. Evaluation of the programme was carried out through pre and post programme surveys.

Results
Analysis of the programme revealed 95% of participants felt the programme was excellent, better than the traditional cancer clinic follow up they had previously received.
Participants were questioned as to whether they would prefer to opt back into the traditional follow up appointment system or continue with the survivorship programme. Results were consistent; 19 (86%) of the Radical Prostatectomy group, 16 (89%) of the Radiotherapy, and 19 (100%) of the Hormone therapy groups confirmed they were happy to continue with the programme.

Conclusions
Treatment specific survivorship follow up programmes have the potential to dramatically improve patient experience, and may prove to be an innovative and cost effective way of delivering safe and high quality follow up care.

P13 Tower Room - Level S2

ONSET, SEVERITY AND DURATION OF URO-GENITAL PAIN AFTER 3RD GENERATION SALVAGE CRYOABLATION FOR RECURRENT PROSTATE CANCER: AN OBSERVATIONAL STUDY

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Introduction & Objectives

Newly onset of pain in the uro-genital region is a known complication after cryoablation of the prostate. Especially in salvage cryoablation after radiotherapy pain is reported in 5-15% of the patients. Little is known about the onset, severity and duration of the pain as well as risk factors. Knowing this information could be of help in counselling of patients and in guidance of pain medication during and after the procedure.

Material & Methods

Consecutive patients with recurrent prostate cancer after EBRT who were treated with cryoablation of the prostate between June 2010 and February 2012 were studied. All patients were free of pain prior to the cryoablation. A pain questionnaire, Visual Analogue Scale (VAS) scores and pain medication were registered daily for the first 14 days and weekly from 3-14 weeks post surgery.

Results

20 men were included in the study, mean age 69.5 years. All men completed the first 14 days, 16 men completed the full 14 weeks registration. The first 14 days 9/20 (45%) men reported pain, with a mean maximum VAS score of 2.8 on day 1. 3/20 (15%) did not use any pain medication at all, 16/20 (95%) used level 1 medication i.e. paracetamol or NSAID. One patient used a low dose opioid (tramadol) during the first 14 days, and two patients received piritramide (Dipidolor®) on the day of cryoablation. During the total 14 weeks period 5/16 (31.3%) of the men reported pain, with a mean maximum VAS score of 3.9 in the seventh week. In one patient pain and micturition problems were completely resolved by temporary CAD without need for pain medication since. 11/16 (68.8%) men did not report any pain at all during the 14 weeks. From week 12 to 14 all men were free of pain. 11/16 men (68.8%) did not use any form of pain medication during the 14 week registration period. From week 3-14 patients only used level 1 medication like paracetamol or NSAID for the reported pain.

Conclusions

Urogenital pain after salvage cryoablation was frequently reported (45%) but of low severity (VAS < 4.0). Duration maximum 12 weeks with Level 1 analgesics only in 95% of the cases.

P14 **Tower Room - Level S2**

THE USE OF PRE-OPERATIVE RECTAL PARACETAMOL REDUCES THE NEED FOR POST OPERATIVE OPOID ANALGESICS IN CHILDREN UNDERGOING UROLOGIC PROCEDURES

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Introduction & Objectives

Post operative pain is an unpleasant condition especially in children. The use of opoid analgesics may have serious consequences for children such as constipation, addiction and respiratory distress and requires special nursing. We investigated the effectiveness of rectal paracetamol in reducing post operative pain in children who underwent urological surgery in our department and if it could substitute post operative opoids.

Material & Methods

40 children aged 3 – 12 (mean age 6yrs) were investigated. The study began in December 2010 to December 2011. The children were randomized to receive paracetamol 10mg/kg (20 children – Group I) or Shea butter pellets as placebo (20 children Group II) half an hour prior to surgery. Post operatively the children were evaluated for pain based on complaints or response to nurse's enquiry about pain. The case breakdown was as follows: Hydroceles- 10 each; undescended testes – 5 each; open cystolitolapaxy – 5 each.

Results

TIn group I, three children (15%, $p<0.05$) complained of, OR admitted to having pain that required additional pain medication. In group II, 16 out of 20 children (80%, $p<0.05$) complained of OR admitted to having pain that required additional pain medication. In group I, all 3 children who had pain were among those who had cystolitholapaxy that also required catheterization. All 5 children in the other group that had cystolitholapaxy also complained of pain.

Conclusions

The use of rectal paracetamol preoperatively is effective in reducing post-operative pain. Since these children do not need parenteral pain relief they could be discharged earlier thereby reducing work load on nurses. These children would also be spared the need for strong analgesics with potentially undesirable side effects.

P15 Tower Room - Level S2

THE USE OF CHLORHEXIDINE GLUCONATE SHOWER THE NIGHT BEFORE SURGERY REDUCES SURGICAL SITE INFECTION IN PATIENTS UNDERGOING SCROTAL SURGERY

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Introduction & Objectives

Surgical site infection (SSI) is an undesirable outcome of surgery, that often denotes poor quality of care. It increases length of hospital stay and morbidity thereby leading to often avoidable cost escalation. We carried out our study to evaluate the efficacy of chlorhexidine gluconate (CHG) showers in reducing SSIs in patients undergoing scrotal surgery.

Material & Methods

We recruited 167 patients with hydrocele into the study from May 2010 to July 2012. The age range was 13 – 68 (mean – 34) years. They were randomized into 2 groups. Group I consisted of 87 patients who had CHG showers the night before surgery. They were instructed to wash the scrotum with CHG. Group II had 80 patients who had a normal shower with ordinary soap. All patients were operated upon by the same urologist. In both groups CHG was used to clean the surgical site just before surgery. In all cases patients were discharged home within 6 to 24 hours after surgery. No penrose drains were placed and no antibiotics were prescribed perioperatively. The wounds were dressed on postoperative days 2, 4, 6 by the urology ward nurses together with the urologist, during which event an evaluation was carried out.

Results

Reddening of the surgical site, increase in skin temperature, culture of pathogenic organisms from wound discharge were criteria for SSI. In group I, there was an SSI rate of 1.2% ($p < 0.01$) {1 out of 85 – reddening of skin}; whiles in group II the SSI rate was 7.5% ($p<0.05$) {6 out of 80- 3 cases of reddening of skin, two cases of positive culture and 1 case of increased skin temperature}. No allergies or other adverse events were recorded in the either group.

Conclusions

CHG showers significantly reduce SSIs when used the night before surgery compared with ordinary soap. CHG used alone just before surgery is less effective in preventing SSIs. CHG showers may be recommended before scrotal surgery since there is infinitesimal if any allergic reaction in our series. Reduced incidence of SSIs lessens work load on nurses.

P16 Tower Room - Level S2

IMPORTANCE OF ULTRASOUND DETERMINATION OF THE URINARY BLADDER VOLUME FOR CARE IN PATIENTS WITH SPINAL CORD INJURY (SCI) WHO PRACTISE CATHETERIZATION

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Introduction & Objectives

Patients with SCI usually have no sensitivity in the bladder. They cannot evaluate when the bladder has to be emptied. To avoid complications, it is thus important to know about the filling volume of the urine bladder (NHS Guidelines C040, 2011).

The aim of our study was to determine:

1. How reliable is the determination of the filling volume of the bladder using ultrasound in SCI-patients (Hakenberg et al, 1983)?
2. How reliable is the determination of the residual urine volume using ultrasound in the nursing routine for care in patients with SCI (Stoller et al, 1989)?
3. Are there any problems with the residual urine volume in patients with recurrent urinary tract infections when they use the intermittent catheterization for bladder emptying?
4. Does the position of the patient during catheterization have an influence on the completeness of bladder emptying (Massagli et al, 1989)?

Material & Methods

In our study, we examined 124 patients with SCI and multiple sclerosis. The age ranged from 18 to 74 years. The patient population consisted of 61 men and 63 women. The bladder was emptied through intermittent catheterization by the nurse staff or the patient himself. As an ultrasound device we used the Bladder Scan BVI 9400 (Verathon Medicale). To determine the bladder volume, we performed three ultrasound measurements of bladder filling volume before the bladder emptying and averaged over them. The filling volumes measured with ultrasound were compared with the volume of the urine that was emptied by catheterization. Afterwards, we measured the residual urine with an ultrasound device. We took account of the patient's position during catheterization (standing, sitting, lying) as well as of the kind of catheters used. Statistical analysis was performed using the t-test.

Results

With ultrasound, the mean filling volume was 297.5 mL; with intermittent catheterization it was 308.8 mL. The difference of 4% is not significant. In the paired t - test both volumes were identical and thus comparable ($p = 0.039$ 0.05), independent of the position the patient used for the catheterization. The residual urine after catheterization was 9.2 mL on average, with a standard deviation of ±15.2 mL. In patients with recurrent UTIs or bladder stones we did not measure a high residual volume.

Conclusions

1. Our study showed a clear correlation between the filling volume of the bladder measured with the ultrasound device and catheterized urine volume in patients with SCI.
2. The residual urine volume can also be determined with a bladder scan. A residual volume below 30 ml after catheterization can be accepted because all these patients were clinically unremarkable.

3. In patients with recurrent urinary tract infection and stone disease, we did not always recognize a higher residual volume after catheterization as a cause. Further examinations are necessary in these patients in order to clarify the situation.
4. The position of SCI- patients during catheterization has no influence on the determination of the filling or residual volumes.

P17 Tower Room - Level S2

NEUROGENIC LOWER URINARY TRACT DYSFUNCTION: THE CHALLENGE OF ASYMPTOMATIC BACTERIURIA AND URINARY TRACT INFECTIONS

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Introduction & Objectives
The integrity and function of the lower urinary tract is often affected by neurologic disorders. Depending on the type of the neurologic disease, a wide range of disturbances can occur. Recurrent urinary tract infections (UTI) have a major impact on quality of life and are one of the most challenging issues in the field of Neuro-Urology. Therefore, the purpose of the study was to investigate the incidence of asymptomatic bacteriuria and UTI in patients with neurogenic lower urinary tract dysfunction (NLUTD).

Material & Methods
A consecutive series of 185 patients (63 females, 122 males, mean age 49±16) with NLUTD undergoing urodynamic investigation (UDI) were prospectively evaluated. Prior to UDI, urine samples were collected by sterile catheterisation. At that time, no patient showed clinical signs of UTI. Patients were prospectively followed for assessing the rate of symptomatic UTI.

Results
The underlying neurologic disorder of the 185 patients was spinal cord injury in 120, multiple sclerosis in 23, spina bifida in 2, Parkinson's disease in 3 and other neurologic disorders in 37. The mean duration of the neurologic disorder was 11±15 years. Of the 185 patients, 56 (30.3%) voided spontaneously, 84 (45.4%) relied on aseptic intermittent self-catheterisation and 45 (24.4%) on an indwelling catheter. Evaluating the urine culture of the 185 patients prior to UDI showed that 70 (37.8%) patients had no bacterial growth and 115 (62.2%) had a bacterial growth. E. coli and Klebsiella pneumoniae were the most frequent bacteria. All patients were asymptomatic. During follow-up, the mean symptomatic UTI rate was 1.0±1.9 per year.

Conclusions
Although more than 60% of our patients had bacteriuria, the incidence of symptomatic UTI was about 1 per year, emphasising that asymptomatic bacteriuria is negligible and needs no treatment in patients with NLUTD. This implies that in asymptomatic patients with NLUTD urine analysis should be avoided due to a lack of consequences.

P18 Tower Room - Level S2

URODYNAMICS IN SPINAL CORD INJURY PATIENTS: BE AWARE OF AUTONOMIC DYSREFLEXIA

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Introduction & Objectives

Autonomic dysreflexia (AD) is a severe and potentially life-threatening condition in patients with neurogenic lower urinary tract dysfunction (NLUTD) due to spinal cord injury (SCI), especially when the lesion is at the level of T6 and above. The condition is characterised by extreme systolic blood pressure (SBP) increase and often by simultaneous heart rate (HR) decrease. Clinical symptoms may be general (throbbing headache, blurred vision and a feeling of anxiety) or more specific above the lesion level (profound perspiration, piloerection, warm skin and flushing due to vasodilation) and/or below the lesion level (pale and cold skin due to vasoconstriction). There are many trigger factors below the lesion level such as bladder and bowel manipulation (cystoscopy, intermittent catheterisation, colorectoscopy) or sexual stimulation. Urodynamic investigation (UDI) is inevitable to assess NLUTD in SCI patients but may induce AD. Therefore, the purpose of the study was to investigate the incidence of AD in patients with SCI during UDI.

Material & Methods

In a prospective study, a consecutive series of 192 patients (53 females, 139 males, mean age 54±17 years) with SCI underwent continuous non-invasive cardiovascular monitoring during UDI at our university SCI centre. SBP, diastolic blood pressure (DBP) and HR were recorded continuously during UDI. We defined AD according to the joint committee of the American Spinal Injury Association and the International Spinal Cord Society (Krassioukov A. et al., JRRD 2007).

Results

The overall mean SBP increase during UDI was 31±26 mmHg resulting in an incidence of AD of 58% (111/192, 30 females, 81 males). Of the 111 patients with AD, only 22% (24/111) were symptomatic (based on SBP increase, HR decrease and clinical symptoms) and these displayed a significantly higher SBP increase ($p<0.001$) and HR decrease ($p<0.001$) compared to asymptomatic patients with AD (87/111). In addition, patients with a spinal cord lesion at or above T6 (61/111) versus those with a lesion below T6 (50/111) demonstrated a significantly higher SBP increase ($p=0.008$) and HR decrease ($p=0.007$). Patients with AD suffering from a complete lesion (ASIA A, 33/111) tended towards a higher SBP increase ($p=0.09$) and showed a significantly higher HR decrease ($p=0.004$) compared to those patients suffering from an incomplete lesion (ASIA B-D, 78/111).

Conclusions

The study shows a high incidence of AD in SCI patients with NLUTD where approximately a fifth were symptomatic. Sudden hypertension can occur with or without clinical symptoms. Considering the significant risks involved with sudden hypertension, we highly recommend continuous cardiovascular monitoring during UDI in all SCI patients. If AD occurs during the examination, stop the UDI and empty the bladder immediately to avoid significant complications such as seizures, strokes, retinal bleeding or even death.

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MILLENNIUM: THE TAKEDA ONCOLOGY COMPANY exhibition booth: D30

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FIGHT UTI*

B.Braun Workshop

Safety in Urinary Catheterization

Sunday 17th March 2013

17:00 - 19:00

Tower Room, Level S2

*Urinary Tract Infection

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