



Milan

26-29 March 2008

9th International EAUN Meeting, 26-28 March 2008
In conjunction with the 23rd Annual EAU Congress

Programme Book



EAUN
European
Association
of Urology
Nurses

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Welcome to Milan

Dear Colleagues,

On behalf of the board I am pleased to welcome you to the 9th *International Meeting of the European Association of Urology Nurses (EAUN)*. We are happy that Milan will host the 2008 meeting.

We have lined up an impressive list of experts in urological nursing and in advance I would like to thank all the speakers, sponsors and the EAU for making it possible for us to meet in Milan.

Programme highlights: What's in it for me?

The congress will officially start on Wednesday at 16.00 hrs. The Opening Ceremony will be led by EAU Secretary General Per-Anders Abrahamsson who has extended tremendous support for the EAUN. In his keynote message, Prof. Abrahamsson will speak, amongst others, about the role and future prospects of the EAUN.

Also in Milan the EAUN will take the opportunity to launch the third edition in the 'Good Practice in Health Care' series with "*The Male External Catheter*". This booklet was made under the supervision of Mrs. Veronika Geng and in collaboration with representatives from EAUN-affiliated national associations and Hollister. All participants can pick up a free copy at the Hollister booth.

We are fully aware that the EAUN represents different cultures and this is reflected in both the way we are organised and also in how we provide urological nursing. The EAUN Board aims to bridge whatever differences in approach we have by offering interactive courses and symposia where all delegates can have the opportunity to comment, discuss and share experiences. Join for instance the ESU course on neurogenic bladder, the Astra Tech symposium on "no touch" catheterisation, the Danish lecture on establishing a Nursing Clearing House Institute (*How to implement new procedures*) and the lecture by Dr. Northouse on important aspects in family care related to prostate cancer, to mention a few.

New events in the EAUN annual meeting 2008

Furthermore, the EAUN will present a new segment, "*The Nursing Research Competition*". Do not miss the opportunity to attend this new exciting session. You can examine the latest developments and emerging research in urological nursing. Six nurses will present and discuss upcoming projects and will expect your contribution and input! Thus, we look forward for professional inspiration. A scientific committee will judge the most promising upcoming project and will select the winner. The prize will be given by a new sponsor, Ferring Pharmaceuticals.

Finally, I hope you will enjoy the sessions and fully benefit from the excellent learning and networking opportunities. I also encourage you to attend the EAUN General Assembly. We hope you will join us and help us realise our plans and new bylaws. The EAUN will need your voice as we strive for new goals and achievements in 2008.

Prego!



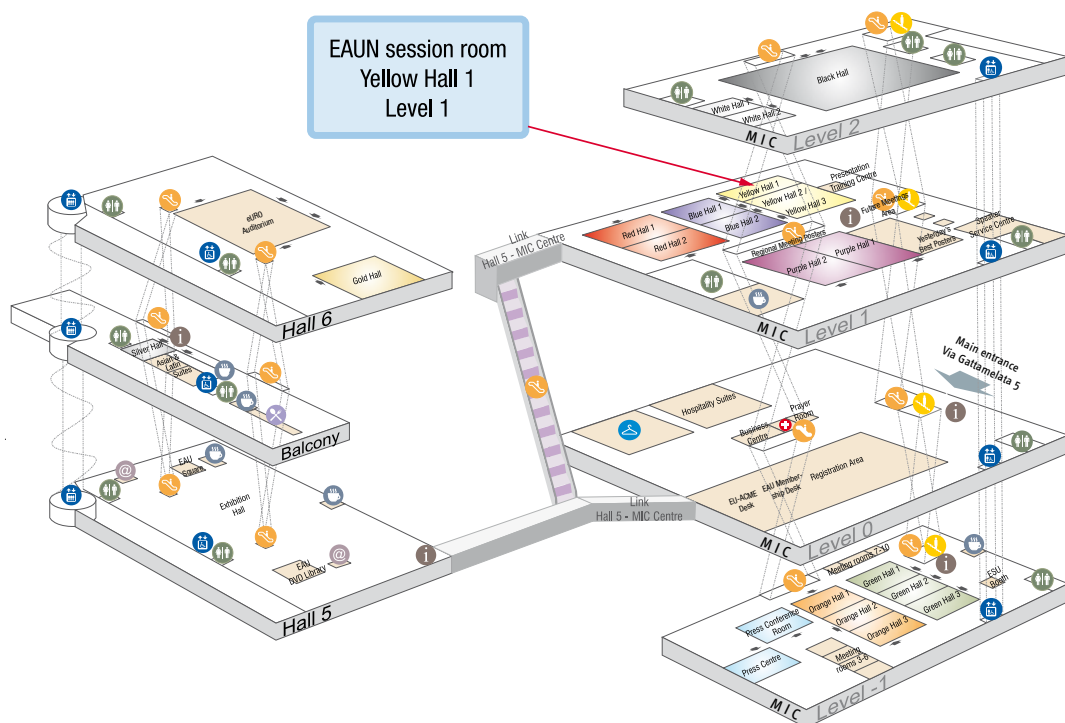
**Bente Thoft
Jensen**
EAUN Chair

Floorplan

Milano Convention Centre
(MIC)

Milan

26-29 March 2008



LINK

- Lift
- Reserved lift
- Escalator
- Stairs

SERVICES

- Toilet
- Internet corner
- Restaurant
- First Aid
- Cloakroom
- Info point
- Coffee point

The background of the slide is a collage of Venetian carnival masks and the Italian flag. In the foreground, there is a blue and white mask with gold filigree. Above it, a pink mask with a large pink feather is visible. To the left, a white mask with gold patterns and a pink feather is partially seen. The Italian flag (green, white, and red vertical stripes) is draped in the background.

General

General Information
Speaker's Guidelines

General Information

Accessibility MIC Milan

The MIC is easily accessible by public transport. Milan has an excellent public transport system connecting all parts of the city.

With a complementary transportation pass, congress delegates will have 2 free rides per day on all public transport within the city of Milan during the congress.

Address:

MIC - Milano Convention Centre

Via Gattamelata 5

20149, Milan

Italy

T +39 02 49977122

F +39 02 48010270

W www.micmilano.it

Badges

The badge classification is as follows:

-  Blue ID Card : Congress delegate EAU member
-  Grey ID Card : Congress delegate non-EAU member
-  Orange ID Card : Nurse EAU member
-  Brown badge holder : Nurse non-EAUN member
-  Green badge holder : Exhibitor
-  Red badge holder : Press
-  Purple badge holder : Accompanying person
-  Pink badge holder : Special registration
-  Yellow badge holder : Organising staff

Bank and Exchange

The national currency in Italy is the Euro (€). During the exhibition days an Exchange Office will be open at the balcony of hall 5 from 09.00-18.00 hrs. and an ATM machine will be available in the registration area.

Banks are normally open Monday to Friday from 08.30-13.30 hrs. and 15.00-16.00 hrs. and are closed on Saturdays and Sundays. Automatic cash machines are widely available.

Exchange offices at airports and main railway stations are normally open from 06.00 - 22.00 hrs.

The main international credit cards (VISA, American Express, Diners, Eurocard/Mastercard) are widely accepted in most large retail outlets, petrol stations, hotels and restaurants. Please beware, however, that smaller businesses may not accept credit card payment and you are advised to check prior to purchase.

Service is usually included in the bill in bars and restaurants, but tips are welcome.

Travellers cheques are best exchanged at an exchange office ('Cambio') as they are not accepted as payment in shops, restaurants and hotels. Banks also often decline to change travellers cheques.

Business Centre

A Business Centre is located on level 0, near the registration area. This service will be available to all congress participants throughout the congress.

Cellular Phones

Cellular phones must be switched off during all sessions.

Certificate of Attendance

A Certificate of Attendance for the 9th International EAUN Meeting is handed out at session room Yellow Hall 1.

Cloakroom/Luggage

The cloakroom is located on level 0, near the registration area and is at participants' disposal during congress hours. Please be sure to collect all personal effects at the end of the day.

Congress Bags

Each delegate can collect a congress bag which includes an EAU programme and abstract book. EAUN programme books are handed out at session room Yellow Hall 1.

The congress bags are sponsored by ASTELLAS

Congress Hours

Wednesday, 26 March 08.30 - 21.00 hrs

Thursday, 27 March 07.45 - 19.00 hrs

Friday, 28 March 07.30 - 19.00 hrs

Saturday, 29 March 07.45 - 13.30 hrs

Congress Office

EAU Congress Office

Managing Directors

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Daily Congress Newsletter

Special daily congress newsletters are available on 26, 27 and 28 March 2008.

EAU Central Research Office (CuraTrial)

The EAU Central Research Office initiates and co-ordinates, as well as refines investigator initiated, clinical research protocols. It also acts to facilitate all aspects of clinical research and expand the current network of active research centres and investigators - basic and clinical - both within the EAU member states and its international affiliates. The office will work to co-ordinate clinical and translational research in close liaison with the Basic Research Committee of the EAU Research Foundation. The EAU Central Research Office can be visited in booth A27 in the exhibition hall.

EAU Internet Corners

The EAU Internet Corners, in the exhibition area, are at your disposal at different locations.

Supported by an unrestricted educational grant from ASTELLAS

EAU Digital Video Library

The EAU digital video library (booth H13) is operational during exhibition hours in the exhibition area. A wide choice of videos from the European Association of Urology including the videos presented in Milan and at previous EAU Congresses can be viewed on request on individual monitors. All videos can be copied to DVD, a service that is provided free of charge for all congress delegates.

Supported by an unrestricted educational grant from ASTELLAS

EAU Education Office (European School of Urology)

The European School of Urology (ESU), working with European faculties, aims to provide high quality international educational courses in urology. The ESU has



a special booth on level -1 with extensive information on the activities of the European School of Urology. Registration for the courses can be made at the ESU Registration Desks in the registration area.

All congress delegates can collect an ESU Course CD at the booth of Sanofi-Aventis (booth E02).

ESU Course CDs are supported by an unrestricted educational grant from SANOFI-AVENTIS

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

EAU Historical Exhibition

The members of the EAU History Office have, once more, set up an historical exhibit located at the EAU booth A27. The exhibit will highlight the history of a fundamental element in the urological field "Urine" under the title "Urine, an important business".

EAUN ID Card

During the 9th International EAUN Meeting your EAUN ID Card will function as a congress badge for EAUN members. Please make certain to collect your EAUN ID Card in the registration area when you are registered as a congress delegate for the meeting. Non-EAUN members will receive a paper congress badge.

EAU Square

The EAU Square (booth A27) in the exhibition area consists of the EAU/EAUN Membership Booth, the Publications Counter, the DVD Theatre, EBU Corner, the EAU Stockholm 2009 Promotion Counter, the European Urology Counter, the Clinical Research Office and the EAU Historical Exhibition. The EAU/EAUN Membership Booth provides information on membership status and membership benefits. Non-members are invited to visit the EAU/EAUN Booth to inquire about the many advantages for EAUN members and to apply for EAUN membership.

Electricity

The electricity in Italy runs on 220 volts and the frequency is 50 Hz. Plugs have two or three round pins. A plug adaptor should be taken along if incompatible electronic gadgets are used.

European Urology

European Urology, the official journal of the EAU, has been a respected urological forum for over 20 years and is currently read by more than 9,000 urologists

General Information

across the globe. With an impact factor of 4.850, the journal has become the leading scientific publication in the field of urology. To keep up with the rapidly evolving world of medicine, technology and surgical techniques, European Urology is constantly updating and innovating its features and layout in order to provide the best clinical guidance, research and education for urologists across Europe and the world. Come see European Urology for yourself - visit either the European Urology booth F01 or EAU booth A27 at the exhibition.

Excursions and Milan info

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

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. The official opening will take place on Wednesday, 26 March at 08.15 hrs.

Exhibition hours

Wednesday, 26 March	08.15-18.00 hrs
Thursday, 27 March	09.00-18.00 hrs
Friday, 28 March	09.00-19.15 hrs

First Aid

There is a medical unit present for first aid on level 0. In case of an emergency contact a security guard immediately.

Future Meetings Area

Posters and other documentation on future meetings can be displayed in the "Future Meetings Area" on level 1. It is strictly forbidden to put up promotional material at any other location in the building.

Hotel Accommodation

The EAU has contracted the company "AIM Group - AIM Congress srl" in Milan to deal with the housing for congress participants. The incoming requests are handled on a first-come, first-served basis. AIM staff will be available for queries at the Hotel Desk in the registration area.

Hospitality Suites Companies

Astellas	Suite E
Cook	Suite A

You can find these hospitality suites at level 0, near the registration area.

Hospitality Suites: Special Latin-American and Asian Suites

During the 23rd Annual EAU Congress there will be special hospitality suites to welcome congress delegates from the Latin-American and Asian countries. You can find the suites on the balcony level in Hall 5 (not open on Saturday, 29 March).

Insurance

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

Language

All presentations during the congress will be conducted in English, the official language of the EAU.

Lost and Found

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

Media Policy

Photography, filming and interviews at congress (with the exception of the EAU Press Centre and EAU Press Conference Room) are prohibited without written permission from the EAU Communication Officer.

Messages & Service Points

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

Phone Numbers

The most important telephone numbers in case of an emergency are: 113 or 112 - police/carabinieri; 115 - fire brigade; 118 - ambulance service.

Poster Builder Service

The EAU(N) offered a Poster Builder Service that enabled poster presenters to create posters for the 23rd Annual EAU Congress and 9th International EAUN Meeting on-line. Posters are ready for pick-up at the Speaker Service Centre on level 1.

Prayer Room

A special room dedicated to prayer is located on level 0, next to the registration area.

Presentation Training Centre

At this years' EAU Congress, as in previous years, you can take advantage of working with speaking consultant Mr. Paul Casella (Iowa, USA). Mr. Casella gives 'Individual Presentation Skills training' that will help improve your 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 on level 1 to make an appointment for this very popular training session.

Press Centre

Journalists can obtain free registration to the Congress at the Press Desk in the registration area (level 0). All media operators must show their credentials (press card dated 2008 and original assignment letter). Journalists will receive a copy of the press pack, to be picked up at the press centre on level -1. All press are invited to report to the EAU Press Centre, located on level -1, to obtain the assistance and information they require. Internet access, fax machine, printer and photocopier are provided. For details about the EAU embargo policy please check: www.eaumilan2008.org under "Press".

Restaurants

From a quick snack to a gourmet meal at a fine restaurant – the choices for eating out in Milan are endlessly varied. Traditional Milanese cooking is made up of unpretentious but tasty dishes. There are numerous trattorias, inns and restaurants (including luxury ones) that offer traditional Milanese cuisine. Popular dishes include the classic Risotto alla Milanese (made with a bull-bodied beef broth), Cassouela (an extremely filling meat dish cooked with cabbage and other vegetables), and Cotoletta alla Milanese (a crunchy veal cutlet).

Don't miss enjoying an aperitif during 'happy hour', a ritual in Milan. The local classic is a Negroni, a potent blend of bitter Campari, gin, red Martini and ice. In

many bars and restaurants the aperitif is accompanied by tasty appetizers including pasta salad, salami and fried stuffed olives.

Smoking Policy

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

Taxi Service

A taxi service will be available at the Information desk at the main entrance of the venue.

Transportation

Congress delegates will receive a transportation pass which is valid on all public transport within the city of Milan during the congress. This pass will allow two free rides per day.

Webcasts

Various EAU sessions will be webcasted via www.eaumilan2008.org. The webcasted sessions are indicated with **WEBCAST** in the EAU programme book. The sessions will be online within 36 hrs.

These sessions are brought to you by PROUS SCIENCE and supported by an educational grant from ASTELLAS.

WIFI

Free wireless internet will be available within the MIC (not in halls 5 and 6) during the EAU Congress.



Speakers' Guidelines

Speaker Service Centre – level 1

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

Opening hours

Tuesday, 25 March	14.00 – 19.30 hrs
Wednesday, 26 March	06.30 – 20.00 hrs
Thursday, 27 March	06.30 – 19.30 hrs
Friday, 28 March	06.30 – 19.30 hrs
Saturday, 29 March	06.30 – 14.00 hrs

If you are a chair person

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

We remind you that:

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

If you are a speaker in an oral session

Locate your session room in time. Please turn in PowerPoint presentations at the Speaker Service Centre on level 1 at least two hours prior to the start of your session. Failure to do so could result in presentations not being available for projection when required. Facilities are provided for PowerPoint presentations only. Please be in your session room no later than 15 minutes prior to the start of the session. Do remember that time allotted to speakers in oral sessions is 10 minutes (including 2 minutes for discussion). A maximum of 10 slides is allowed. Follow the chairs' instructions, in particular those regarding the timing of your lecture.

If you are presenting a poster

Posters must be put up in the room 15 minutes prior to the start of the session. The poster boards are numbered and your poster should be mounted on the board which corresponds with your abstract number. Pushpins are available in the session room. Please remove your poster immediately at the end of the session. One PowerPoint slide is allowed during your poster presentation. Also the PDF of your poster, supplied by yourself prior to the congress, will be projected during discussion of your abstract. In case you forgot to submit the PDF or PPT slide prior to

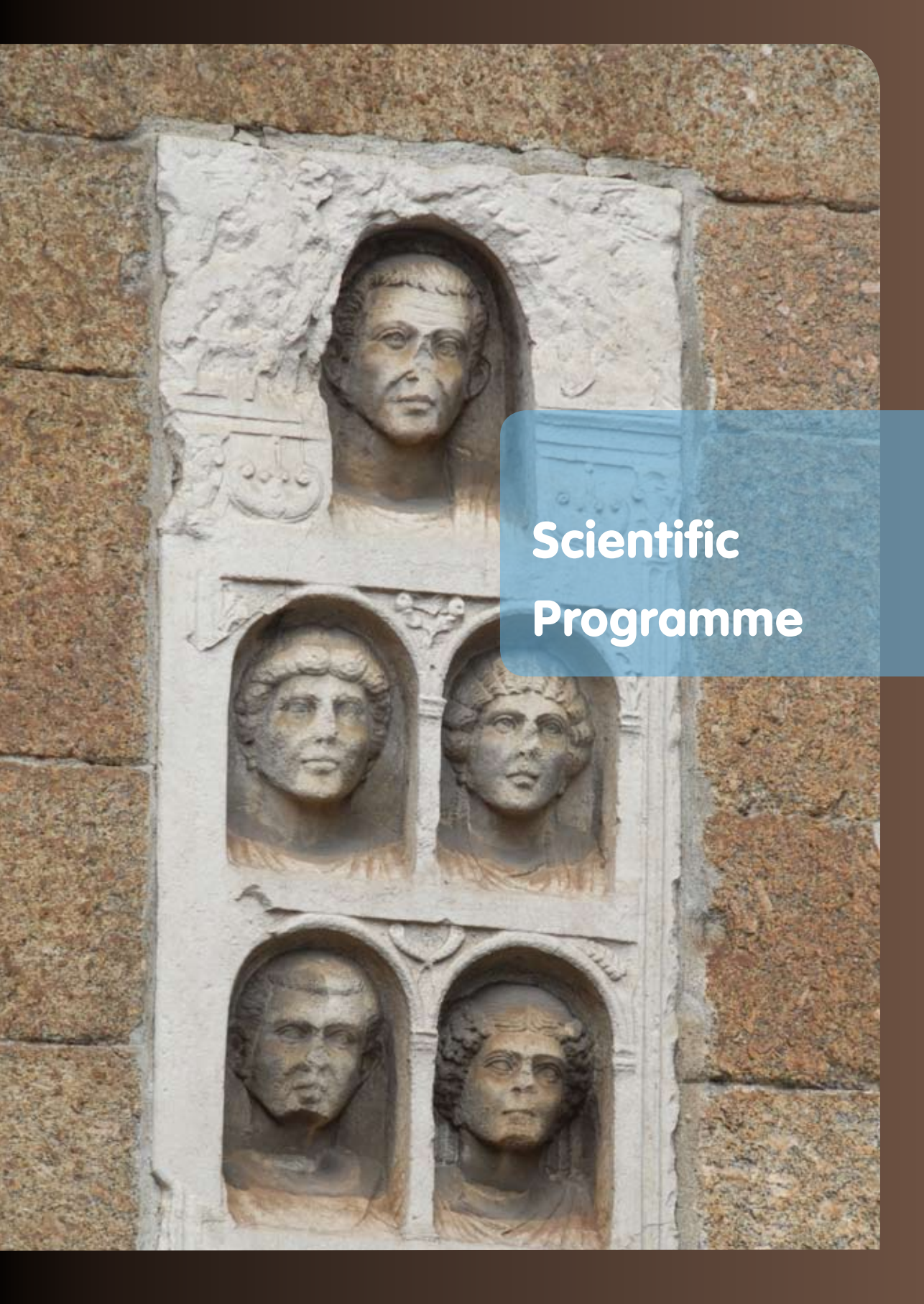
the congress, you can still do this up to 5 hours prior to your session (in case of an early session the PDF/slide should be handed in on the previous day) at the Speaker Service Centre on level 1.

Disclose links to the industry

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

Presentation training centre

At this year's EAU Congress, as in previous years, you can take advantage of working with speaking consultant Mr. Paul Casella (Iowa, US) to help improve your presentation and delivery skills. The one-on-one half hour sessions are free of charge and are available to all speakers. As these sessions have proved to be very popular in the past, please make your appointment at the Speaker Service Centre on level 1; you can sign up for an appointment from Wednesday, 26 March to Saturday, 29 March.



Scientific Programme

	26 March Wednesday		27 March Thursday		28 March Friday
Room	Yellow 1		Yellow 1		Yellow 1
08:00			Workshop Redefining cystoscopy with the EndoSheath Technology F. Debruyne, Arnhem (NL), P. Slappendel, Arnhem (NL) Sponsored by VISION-SCIENCES		
08:15				8.00 Bus leaves for Hospital visit	
08:30					Learning session EAUN Nursing Research Competition concluded with the presentation of an educational grant Chair: V. Geng, Lobbach (DE)
08:45			Workshop Nurse-led urology clinics - The UK experience T. Ladds, Manchester (GB)		
09:00					Prize supported by an unrestricted educational grant from FERRING PHARMACEUTICALS
09:15					
09:30			Break		Break
09:45					
10:00					
10:15					State-of-the-art lecture Prostate cancer: Family care for patients and spouses L. Northouse, Ann Arbor, MI (USA)
10:30					
10:45			ESU Course Neurogenic bladder Chair: J. Van Moorselaar, Utrecht (NL)	Hospital visit to Università Vita Salute San Raffaele - Ville Turro, Milan	Break
11:00					
11:15					
11:30		11.00 Bus leaves for Hospital visit			State-of-the-art lecture Metastatic urological cancers L. Fossion, Veldhoven (NL) E. Hermanussen, Bernhoven (NL)
11:45					
12:00					
12:15			Lunch		
12:30					
12:45					Lunch
13:00					
13:15		Hospital visit to Università Vita Salute San Raffaele - Ville Turro, Milan			
13:30			Oral Abstract Session Chairs: P. Slappendel, Arnhem (NL) R. Pieters, Ghent (BE)		Poster viewing
13:45					
14:00					
14:15					Poster Abstract Session Chairs: V. Geng, Lobbach (DE) K-D Plothe, Göttingen (DE)
14:30			Break		
14:45			State-of-the-art lecture Chronic urogenital pain management - guidelines update A. Baranowski, London (GB)		
15:00					
15:15			State-of-the-art lecture How to implement new procedures I. Madsen, Århus (DK) V. Kröll, Århus (DK)		Break
15:30					
15:45			Break		Award Session Supported by an unrestricted educational grant from HOLLISTER EUROPE LTD
16:00	EAUN Opening EAU Sec. Gen. P.-A. Abrahamsson/EAUN Chair B.T. Jensen				
16:15	State-of-the-art lecture Who was who in urology D. Schultheiss, Gießen (DE)		Symposium "No touch" catheterisation in a hospital setting Chair: T.E. Bjerkklund-Johansen, Århus (DK) Sponsored by ASTRA TECH AB		EAUN General Assembly Chair: B.T. Jensen, Århus (DK)
16:30					
16:45	Good Practice in Health Care The Male External Catheter - introduction V. Geng, Lobbach (DE), U. Konheiser, Unterföhring (DE) Supported by an unrestricted educational grant from HOLLISTER EUROPE LTD				
17:00					
17:15	Champagne Reception		After Session Drinks		
17:30					
17:45	Sponsored by HOLLISTER EUROPE LTD		Sponsored by ASTRA TECH AB		
18:00					

12.00 - 15.00 Hospital visit to Università Vita Salute San Raffaele - Ville Turro

Participants that are registered for this Hospital Visit have received a confirmation by e-mail or regular mail and the registration is listed on their entitlement list.

The bus to Ville Turro will be leaving at 11.00 hrs. at the Carlo Magno car park diagonally across the street from the main entrance of the Milano Convention Centre (walk to the right from the main entrance).

16.00 - 18.00 Plenary Session 1

Yellow Hall 1

16.00 - 16.15 EAUN opening

P-A. Abrahamsson, Malmö (SE), EAU Secretary General
B.T. Jensen, Århus (DK), EAUN Chair

Yel1-26-3010
Yel1-26-3020

16.15 - 16.45 State-of-the-art lecture **Who was who in urology?**

D. Schultheiss, Gießen (DE)

Yel1-26-3030

This lecture will give a survey on the development of urology as a speciality with a focus on leading protagonists from the last centuries. Several well known eponyms from our daily clinical work will be explained and will come to life through the biography of the related person.

16.45 - 17.00 Good Practice in Health Care **The Male External Catheter - introduction**

V. Geng, Lobbach (DE)
U. Konheiser, Unterföhring (DE)

Yel1-26-3040
Yel1-26-3050

A working group consisting of EAUN Members has written a new EAUN Good Practice in Health Care booklet. It will be introduced to the members during this session by the chair of the working group and a representative of the supporting company, HOLLISTER EUROPE LTD. A free copy is available for all EAUN members and for all participants of the 9th International EAUN Meeting at the exhibition, Booth D04 (Hollister), upon presentation of your badge or EAUN ID card and your entitlement list. Supported by an unrestricted educational grant from HOLLISTER EUROPE LTD

17.00 - 18.00 Champagne reception

This reception will be held in the hall adjacent to session room Yellow Hall 1.
Sponsored by HOLLISTER EUROPE LTD

09.00 - 12.30 Hospital visit to Università Vita Salute San Raffaele - Ville Turro

Participants that are registered for this Hospital Visit have received a confirmation by e-mail or regular mail and the registration is listed on their entitlement list.

The bus to Ville Turro will be leaving at 08.00 hrs. at the Carlo Magno car park diagonally across the street from the main entrance of the Milano Convention Centre (walk to the right from the main entrance).

08.00 – 18.00 Plenary Session 2

Yellow Hall 1

08.00 - 08.30 Workshop Redefining cystoscopy with the EndoSheath Technology

F. Debruyne, Arnhem (NL)

Yel1-27-4010

P. Slappendel, Arnhem (NL)

Yel1-27-4020

Aims and objectives

- To show the benefits of EndoSheath Cystoscopy and the differences from conventional cystoscopes for doctor; nurse; patient
- To present how to prepare the EndoSheath Cystoscope for use in less than 5 minutes
- Practical training and hands-on workshop for nurses

Practice sessions are possible during the breaks on Thursday at the back of session room Yellow Hall 1

Sponsored by VISION-SCIENCES

08.30 - 09.30 Workshop Nurse-led urology clinics - the UK experience

T. Ladds, Manchester (GB)

Yel1-27-4030

09.30 - 10.00 Break

10.00 - 12.00 ESU course Neurogenic bladder



Chair: J. Van Moorselaar, Utrecht (NL)

Yel1-27-4040

10.00 - 10.30 Pathophysiology and classification

M. Drake, Bristol (GB)

Yel1-27-4050

10.30 - 10.40 Case discussion

10.40 - 11.10 Therapy

H-J. Kirkeby, Århus (DK)

Yel1-27-4060

11.10 - 10.20 Case discussion

11.20 - 12.00 Nursing aspects: Functional diagnostics and treatment in normal wards

T. Schwennesen, Århus (DK)

Yel1-27-4070

H. Cobussen, Nijmegen (NL)

Yel1-27-4080

12.00 Closure

Aims and objectives

- You will be updated on general aspects of fysiopathology of neurogenic bladder
- You will be updated on new therapies and treatment options
- You will be informed on nursing aspects of the spina bifida patient as a representative of the neurogenic bladder patient

12.00 - 13.00 Lunch

13.00 - 14.30 Oral abstract session

Chairs: R. Pieters, Ghent (BE)
P. Slappendel, Arnhem (NL)

- | | | |
|------|--|--------------|
| 01-p | Nurse-lead extramural suprapubic catheter change: Evaluation of the UROBEL training programme
J. Behets, M. Vandewinkel, R. Pieters, P. Eelen, J. Hendrickx, J. Leën, E. Ruers
(UROBEL, Ghent, Belgium) | Yel1-27-4090 |
| 02-p | The role of the advanced nurse practitioner in clinical pathways for localized prostate cancer
W. De Blok (Amsterdam, the Netherlands) | Yel1-27-4100 |
| 03-p | The role of nurse in the performing urostomy
J. Zalewska, E. Mozer, W. Chrobot, K. Zagorska, E. Klimkowska, E. Wronska, R. Sosnowski, T. Demkow, T. Kalinowski (Warsaw, Poland) | Yel1-27-4110 |
| 04-p | Tumt, plft, treatment and follow up afterwards- a challenge for the nurse
E. Bonns (Vaasa, Finland) | Yel1-27-4120 |
| 05-s | The Linköping incontinence questionnaire (LIQ)- A simple instrument to quantify and classify urinary incontinence
H. Marklund-Bau, U. Edéll-Gustafsson, A. Spangberg (Linköping, Sweden) | Yel1-27-4130 |
| 06-s | Pro-act and act for stress incontinence therapy: Results and nursing implications
R. Basso De Marc, F. Rachelli, S. Malghera (Udine, Italy) | Yel1-27-4140 |
| 07-s | How satisfied are patients attending the urological out-patients department?
E. Robinson, M. Lester, S. Pisipati, I. Pearce (Manchester, United Kingdom) | Yel1-27-4150 |
| 08-s | Bothersome urinary symptoms and disease specific quality of life in patients with benign prostatic obstruction
H. Marklund-Bau, U. Edéll-Gustafsson, A. Spangberg (Linköping, Sweden) | Yel1-27-4160 |
| 09-p | The prevention of catheter related urinary tract infections
K. Kisiel, E. Szortyka (Bydgoszcz, Poland) | Yel1-27-4170 |

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

14.30 - 14.45 Break

14.45 - 15.15 **State-of-the-art lecture** Chronic urogenital pain management - guidelines update

A. Baranowski, London (GB)

Yel1-27-4180

Aims

To discuss the management of urogenital pain with an emphasis on the possible role for nurse led initiatives

Objectives

- To cover a systematic approach to understanding urogenital pain mechanisms
- To look at the latest EAU guidelines and their relevance to nursing
- To look at nurse led initiatives in the management of urogenital pain

15.10 - 15.15

Discussion

15.15 - 15.45 **State-of-the-art lecture** How to implement new procedures

I. Madsen, Århus (DK)

Yel1-27-4190

V. Krøll, Århus (DK)

Yel1-27-4200

Aims and objectives

- To introduce the background and the organisation of the Danish Centre for Clinical Guidelines
- To emphasise the need for developing the necessary resources that will lead to or enable nursing to be an e-knowledge based practice
- To establish and promote the role of the Danish Centre for Clinical Guidelines in facilitating knowledge exchange or sharing of Danish nursing expertise and skills, thereby building effective links between training, research and clinical practices
- To address the importance of using a knowledge-based nursing practice in order to improve the quality of nursing care that patients receive

15.45 - 16.00 **Break**

16.00 - 17.00 **Symposium "No touch" catheterisation in a hospital setting**

Chair: T.E. Bjerklund Johansen, Århus (DK)

16.00 - 16.20

Introduction and background and prevalence of bacteriuria and urinary tract infections in a hospital setting

T.E. Bjerklund Johansen, Århus (DK)

Yel1-27-4210

16.20 - 16.35

Aseptic "no touch" technique catheterisation - What is it and why?

T. Ladds, Manchester (GB)

Yel1-27-4220

16.35 - 16.50

Practical use of sterile and "no touch" technique in the spinal cord unit of a hospital

S. Caselli, Imola (IT)

Yel1-27-4230

16.50 - 17.00

Questions, panel discussion and closing words

Objectives

To present and discuss different intermittent catheterisation techniques used in a hospital setting

Aims

- To put light on prevalence of UTI in hospitals
- To share understanding about differences between sterile/clean and “no touch” technique in intermittent catheterisation
- To discuss the practical use of sterile and “no touch” technique in a hospital

Sponsored by ASTRA TECH AB

17.00 - 18.00**After session drinks**

This reception will be held in the hall adjacent to session room Yellow Hall 1.

Sponsored by ASTRA TECH AB

08.30 - 09.45 EAUN Nursing research competition

Learning session concluded with the presentation of an educational grant

Chair: V. Geng, Lobbach (DE)

The jury

- Willem De Bruijn, Arnhem (NL) (CuraTrial SMO & Research BV) Yel1-28-5010
- Veronika Geng, RN, Lobbach (DE) (EAUN Board) Yel1-28-5020
- Prof. Jens Peter Nørgaard, Copenhagen, (DK) Yel1-28-5030
(Ferring International Pharmascience Center)
- Jerome Marley, RN, Belfast (GB) (Research theory teacher) Yel1-28-5040
- Prof. Andrea Tubaro, Rome (IT) (EAU Research Foundation) Yel1-28-5050

The nominees and their research projects

R. Willener, Berne (CH): Yel1-28-5060

Patients experience of postoperative incontinence and of information given by nursing staff following transurethral resection and holmium laser enucleation of the prostate.

G. Zamboni, Verona (IT): Yel1-28-5070

Burnout and its correlates among nurses working in Urology: questionnaire survey in an Italian Region.

B. Kiesbye, Århus (DK): Yel1-28-5080

Training the Patients stoma management preoperatively- does it have any effect on how fast they manage postoperatively- and does it reduce the need for follow-up by homecare nurses?

W. De Blok, Amsterdam (NL): Yel1-28-5090

Is usage of digital questionnaires in the outpatient clinic feasible?

S. Vahr, Copenhagen (DK): Yel1-28-5100

Telephone consultations as a way to find the information needs of a cystectomised patient that are relevant when coping with the convalescence period.

H. Arneberg, Oslo (NO): Yel1-28-5110

Children with myelomeningocele (MMC)/spina bifida and bladder emptying using clean intermittent catheterisation.

Aims and objectives

The aim of the research competition is to encourage nurses to carry out their own research. Since the EAUN believes that by encouraging research we are in effect boosting the knowledge sharing between our members, we do not only consider big projects but also value those research plans with modest goals.

Additionally, through the presentation and discussion of the research plan, the main research investigator can share significant lessons on how to execute research projects. Authors of research plans get feedback on their submissions from specialists during this learning session. A substantial prize awaits the winner.

The research plan should satisfy the following requirements:

- The overall plan has to be feasible and well structured
- The topics selected should tackle key issues in the nursing profession
- The ultimate results should shed valuable insights on current nursing practices

The following prize will be awarded

- Prize for the Best EAUN Nursing Research Project € 2,500

Supported by an unrestricted educational grant from FERRING PHARMACEUTICALS

The full text of the Research plans discussed in this session can be found on our website, www.eaun.uroweb.org. Click on "Link to Research plans presented at past international EAUN meetings" under the heading Read more.

09.45 - 10.15 Break

10.15 - 11.00 State-of-the-art lecture Prostate cancer: Family care for patients and spouses

Outcomes of the intervention in a clinical trial

L. Northouse, Ann Arbor (US)

Yel1-28-5120

Session description

This plenary session will present research-based information about the effects of prostate cancer on both patients and their spouses. Several studies have identified that spouses of prostate cancer often report more distress than patients and seldom receive adequate support or information to manage the caregiving role. During this session, a new family-based intervention will be discussed that was offered to prostate cancer patients and their spouse caregivers. Details about intervention content and programme delivery will be discussed. Directions for future intervention research with prostate cancer patients and their spouses will also be identified.

Aims and objectives

- To examine the effects of prostate cancer on patients and their spouse caregivers
- To describe a family-based intervention (FOCUS Programme) that was developed to meet the needs of prostate cancer patients and their spouses
- To identify the outcomes of the FOCUS programme when tested in a randomised clinical trial

11.00 - 11.30 Break

11.30 - 12.30 State-of-the-art lecture Metastatic urological cancers

L. Fossion, Veldhoven (NL)

E. Hermanussen, Bernhoven (NL)

11.30 - 12.00 Laparoscopic cyst(oprostat)ectomy with Bricker urinary derivation

L. Fossion, Veldhoven (NL)

Yel1-28-5130

Aims and objectives

A short introduction to bladder cancer followed by a summarised overview of initial treatment for non-invasive bladder cancer, staging modalities according the EAU-guidelines and definitive treatment options for invasive bladder cancer.

The new approach for cyst(oprostat)ectomy is the laparoscopic one; a minimal invasive technique with many advantages. Different bladder replacement options are possible. In metastatic bladder cancer early chemotherapy regimens seem to be promising.

12.00 - 12.20 Nursing care in a laparoscopic cystectomy

E. Hermanussen, Bernhoven (NL)

Yel1-28-5140

Aims and objectives

This lecture deals with nursing care in laparoscopic radical cystectomy. A distinction is made between the pre-, per-, and post-operative phase. In the pre-operative phase the patient receives information about the diagnosis of bladder cancer, treatment modalities, physical preparation and the consequences of a stoma. The effects of anesthesia will be discussed in the per-operative phase. In the post-operative phase focus is on post-operative care, stoma care, outdoor patient follow-up and expertise.

12.20 - 12.30 Discussion

12.30 - 13.30 Lunch

13.30 - 15.15 Poster abstract session

Chairs: V. Geng, Lobbach (DE)
K-D. Plothe, Göttingen (DE)

13.30 - 14.00 Poster viewing

14.00 - 15.15 Poster presentations

- | | | |
|-------|---|--------------|
| P10-p | Patient education following transurethral prostate resection and radical prostatectomy
R. Willener (Berne, Switzerland) | Yel1-28-5150 |
| P11-p | A small thing with a big impact- a bag brings autonomy to the patients
R. Brunner Baccalà, R. Willener (Berne, Switzerland) | Yel1-28-5160 |
| P12-p | Can nurses substitute doctors? A project concerning quality control
B.T. Andersen, J.V. Hansen (Esbjerg, Denmark) | Yel1-28-5170 |
| P13-p | Implementing NANDA nursing diagnoses in a urology unit
B. Stalder, E. Kammermann, F. Grand, R. Willener (Berne, Switzerland) | Yel1-28-5180 |
| P14-p | Creating a standardized care plan for patients undergoing radical prostatectomy
J. Talos, A-M. Jonsson (Malmö, Sweden) | Yel1-28-5190 |
| P15-p | Health technology assessment of shared care when patients with long-term urinary catheter need catheterization
Ch. Englund, A. Lee, J. Olsen, Y. Stensdal (Odense, Denmark) | Yel1-28-5200 |
| P16-s | Prospective analyses after the impact of RALP using EORTC-Quality of life questionnaires
W. De Blok (Amsterdam, the Netherlands) | Yel1-28-5210 |
| P17-s | The role of urinary catheter in the developmenet of infection in patients with BHP
J. Rapaic, D. Stevandic (Novi Sad, Serbia) | Yel1-28-5220 |
| P18-s | The role of health education in the improvement of urostomy patients life quality
D. Stevandic, J. Bugarin, M. Kocetov (Novi Sad, Serbia) | Yel1-28-5230 |

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

15.15 - 15.45 Break

15.45 - 16.00 Award session

B.T. Jensen, Århus (DK)
U. Konheiser, Unterföhring (DE)

The following prizes will be awarded:

- | | |
|---|-------|
| • Prize for the Best EAUN Poster Presentation (Daily Practice) | € 200 |
| • Prize for the Best EAUN Poster Presentation (Scientific Research) | € 200 |
| • Prize for the Best EAUN Oral Presentation (Daily Practice) | € 300 |
| • Prize for the Best EAUN Oral Presentation (Scientific Research) | € 300 |

Supported by an unrestricted educational grant from HOLLISTER EUROPE LTD

16.00 - 17.00 EAUN General assembly

Chair: B.T. Jensen, Århus (DK)

Yel1-28-5240

Agenda

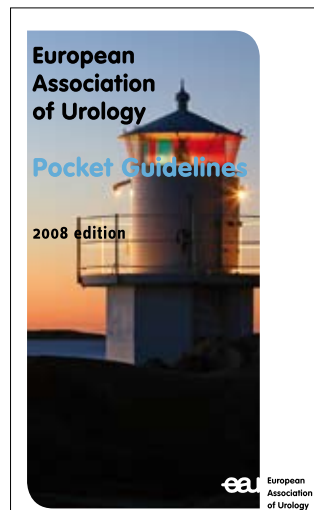
- Welcome by the chair
- Formal installation of new members and chair
- Minutes AGM 2007
- The report of the chair with presentation of the achievements of 2007/2008
- Presentation of the masterplan for 2008/2009:
 - Position within the EAU
 - Meeting with National Societies
 - Master plan
 - Growth targets
- Presentation of budget
- Presentation of adapted bylaws (see link to "Draft EAUN Bylaws" on our website www.eaun.uroweb.org)
- Membership fee as of 1 July 2008
- Questionnaire
- Subjects for the next Congress in 2009 in Stockholm
 - Proposals from the members will be accepted at this time
- Other business

Please collect your voting box at the entrance of the session room.

EAU Pocket Guidelines & CD - 2008 edition

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

**Olympus exhibition booth:
Hall 5, Booth F09**



ESU Course CD - 2008 edition

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

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

Sanofi-aventis Groupe exhibition booth: Hall 5, Booth E02





Abstracts

01-p

NURSE-LEAD EXTRAMURAL SUPRAPUBIC CATHETER CHANGE: EVALUATION OF THE UROBEL TRAINING PROGRAMME

Behets J.¹, Vandewinkel C.², Pieters R.³, Eelen P.⁴, Hendrickx J.¹, Leén J.¹, Ruers E.¹

¹University Hospitals Leuven, Dept. of Urology, Leuven, Belgium, ²Jan Palfijn ziekenhuis, Dept. of Urology, Merksem, Belgium, ³University Hospital, Dept. of Urology, Ghent, Belgium, ⁴National MS Centrum, Dept. of Urology, Melsbroek, Belgium

Introduction & Objectives: Until recently, suprapubic catheter (SPC) change was restricted to doctors or supervised hospital nurses. Since August 2006, the Belgian Law also considers the SPC change as an independent nursing act, although still limited by a medical prescription. This expands the working space from the urology department to the home care and nursing homes. In order to inform and adequately train the new group of involved nurses, Urobel (the Belgian association for urologic nurses) arranged several regional training sessions throughout the country in the spring of 2007. The aim of this work is to assess the outcome of the training and to identify specific issues and points for improvement.

Material & Methods: The training sessions consisted of a short description of the different available SPC-systems, the indications for SPC and possible complications. Then, a video-clip demonstrating the procedure was shown, together with tips and tricks from experienced nurses. Six months after one of the regional training sessions, all of the attending nurses were contacted by phone. Twenty-five nurses from the same nursing home and 40 nurses working in home care were interviewed using a self-constructed questionnaire. The questions focused on 2 topics: evaluation of the training session (speaker – theoretical + practical part) (score from 0 (poor) to 5 (excellent)) and the number of nurses who performed a SPC change following the training sessions. The outcome of the questionnaire was used to define the need for additional training and identify possible issues and points for improvement.

Results: An average score of 4/5 was given by the nurses who attended the training course. They were all satisfied by the set-up of the session, the quality of information given and the video-clip describing the procedure step-by-step. No one from the nursing home staff, and 6 nurses working in home care had already performed a supervised SPC change before. After the training, 2 nurses from the nursing home and 10 working in home care had performed at least one SPC change independently. In both groups, all changes were successful. Following issues and points for improvement could be identified: A few nurses had to wait for the medical prescription before they could go ahead. Three patients still preferred have the SPC change in the hospital, one patient specifically asked for a doctor to perform the procedure. Some nurses had the opportunity to carry out a SPC change, but did not go ahead with it due to fear of failure. Moreover, in the home care the cost of the catheters is still a lot higher in comparison with the nursing homes and hospitals.

Conclusions: Better awareness amongst doctors and nurses that SPC change has now become a nursing act could potentially lead to a further increase of SPC outside the hospital. In order to increase confidence, individual hand-on training sessions with an experienced nurse are being organized at request.

02-p

THE ROLE OF THE ADVANCED NURSE PRACTITIONER IN CLINICAL PATHWAYS FOR LOCALISED PROSTATE CANCER

De Blok W.M.

Netherlands Cancer Institute-Antoni van Leeuwenhoek Hospital (NKI-AVL), Dept. of Urology, Amsterdam, The Netherlands

Introduction & Objectives: In September 2005 an outpatient clinic for men with localized prostate cancer (PCA) started. At the same time the hospital started with the introduction of an advanced nurse practitioner (ANP). Improvement of quality of care by introducing new approaches in care was the main goal.

Material & Methods: The ANP started by developing a clinical pathway (CP) for patients with PCA. In this multidisciplinary approach to care, urologists and radiotherapists, and if needed, medical oncologists take part in diagnosis and selection of treatment. The ANP was involved in the following aspects of the CP: a-Medical history taking: reporting of medical and nursing findings. b-Informing, Supporting: assisting the patient in making choice of treatment. Essential elements of ANPs in the CP are: Preparing the medical chart prior to the first outpatient visit and facilitating follow up by using protocol directed patient visits, and informing patients that will undergo the robot prostatectomy. These patients are all preoperatively seen by the ANP. For informational purposes a patient meeting was introduced containing groupwise instruction and information. A survey among the first group (N=15) was held to measure contentment. Finally, the ANP is responsible for the teaching of hospital personnel considering aspects of prostate cancer treatment and conducting clinical trials.

Results: Acceptance of a nurse in a traditionally medical setting took some time. 2 years after the implementation, the ANP function found its place. Because of the centralized position the ANP evolved into a full member of the team in care for PCA patients and in spreading knowledge about PCA treatment. Alongside with the urologist, the ANP became the key figure for the patient. A survey held under the first 15 patients undergoing the group information meeting, reported that all 15 were satisfied about presentation, informational value, timing and the facility in which the presentation was held. The meetings often resulted in contact between fellow patients. The number of preoperative outpatient consults went down from a mean 6 visits to 3 per patient as a result of the group sessions, the consult with the ANP went down from over 1 hour to 20 minutes each. There is still room for improvement: a. For reason of continuity of care it will require a larger number of ANPs per department, b. implementation of patient questionnaires in evaluation of treatment toxicity.

Conclusions: Streamlining care and information to prostate cancer patients by the ANP was proven to improve efficacy and patients' satisfaction. Further study is required to evaluate the effects on quality of life. Expansion of the ANP function will be needed to reach continuity of care. Reaching timesaving effects whilst improving quality of care is efficient and is exemplary for the fact that the ANP role has found its place in the CP of the prostate clinic.

03-p

THE ROLE OF NURSE IN THE PERFORMING UROSTOMY

Zalewska J., Mozer E., Chrobot W., Zagorska K., Klimkowska E., Wronska E., Sosnowski R., Demkow T., Kalinowski T.

Oncology Hospital, Dept. of Urooncology, Warsaw, Poland

Introduction & Objectives: One of the method of treatment muscles invasive bladder cancer is radical cystectomy with Bricker urinary diversion. The quality of performed urostomy is very important and has influence for the future quality of life of the patients. The aim of this study was to establish nurse's role in performing urostomy and in the post operative care of the patients.

Material & Methods: Between January 2007 and August 2007, 19 radical cystectomy were performed (14 in man and 5 in women). Before operation, nurse establish the best place for future urostomy ("Marked urostomy") and she put a urinary bag to the skin in this place (bag was filled up with some water) for 24 h. During the cystectomy urostomy ("Performed urostomy") was performed and urologist defines how far the "Marked urostomy" is situated from "Performed urostomy". 3 months after the operation took place all of the patients were control at the out-patient clinic.

Results: Among all of the patients in 9 patients "Performed urostomy" where at the same place on the skin that "Marked urostomy". In 6 and 4 patients "Performed urostomy" was shift 1-2 cm and over 2 cm, respectively. During the first control after the operation all of the urostomy function well. 10 of them were concave, in those patients special care of urostomy were needed.

Conclusions: Co-operation during treatment of patient with muscle invasive bladder cancer between urologist and nurses is very important and needed. Performing urostomy in the best place is important for future patient's quality of life.

04-p

TUMT, PLFT, TREATMENT AND FOLLOW UP AFTERWARDS - A CHALLENGE FOR THE NURSE

Bonns E.

Central hospital of Vaasa, Dept. of urological outpatients, Vaasa, Finland

Introduction & Objectives: Tumt, Plft, microwave treatment of the prostate, is sometimes done instead of a normal turp. Patients with urinating problems usually come to the urotherapist for a check up before the tumt treatment. The nurse/urotherapist has to check up many things to see if the patient is suitable for the treatment if this hasn't been done before. The patients can go home after the treatment and the nurse has much to do before that. The nurse is a very important person for these patients before, during but also after the treatment. The treatment is done at the outpatients clinic.

Material & Methods: The nurses have a lot to do before, during and after the procedure. They have to take care of medication, nursing acts and information. They also prepare both the patient and the machine for the treatment. The nurses assist the urologist during the treatment but sometimes they also treat the patients themselves. After the treatment the patient comes for a check up to the nurse/urotherapist reception. We check the patients quality of life by asking questions before, and about 3 and 6 months after the treatment. We also measure the patients' urine flow and residual urine volume before and after.

Results: We have noticed that there has to be a nurse responsible for the treatment and nursing of these patients even though the urologist treats the patient. Bad or not enough information -> not so good qol. If enough good information is given, the patients are less frustrated and gets better qol This treatment has been a good complement or solution for many patients. They are satisfied with the care and they can always get help and advice if needed The nurse has to know what to do. If not she has to know who she can ask for help. She has to know when to contact the urologist. Sometimes the nurse just doesn't know enough - she is not a doctor! Sometimes this can be a big challenge! In both positive and negative sense.

Conclusions: Constant training of the nurse is needed! You never know enough! The patients are not always in good condition and that's why we have to check them up also before the treatment. This treatment would need more research by the nurses. How could we improve our nursing and give the patient a feeling of safety and security even after the treatment? More and better quality of the information? Do we have to check every patient 2 times after? The treatment results are quite good! Almost every patient with an indwelling catheter or cic before, do not need this after he has recovered from the treatment. But we need more research about this also. We have to establish a fact: the nurse is a very important person! If the nursing isn't ok, the entire treatment can fail.

05-s

THE LINKÖPING INCONTINENCE QUESTIONNAIRE (LIQ) - A SIMPLE INSTRUMENT TO QUANTIFY AND CLASSIFY URINARY INCONTINENCE

Marklund-Bau H.¹, Edéll-Gustafsson U.², Spangberg A.¹

¹Dept. of Clinical and Experimental Medicine, Dept. of Urology, Linköping, Sweden, ²Dept. of Medicine and Care, Div. of Nursing Science, Linköping, Sweden

Introduction & Objectives: Background: Urinary incontinence is a symptom that can affect patients with benign prostatic obstruction (BPO) both before and after intervention]. The International Continence Society (ICS) has defined urinary incontinence as “the complaint of any involuntary leakage of urine.” The symptom can be classified as urge incontinence, stress incontinence, mixed incontinence, and continuous incontinence and according to other relevant factors as for example frequency and severity. The prevalence of incontinence in the male population varies from 2.8-28 % depending on different definitions, age and other methodological issues. However, incontinence as a symptom due to BPO, is not well studied either before or after intervention. Results from a study with patients tentatively diagnosed with BPH reported incontinence in 37 % of 480 men. The aims of this study to develop and reliability test an instrument to evaluate incontinence, the Linköping Incontinence Questionnaire (LIQ) in men with LUTS. Secondly, to describe self-reported urinary incontinence in patients with symptomatic benign prostatic obstruction (BPO), before and six months after intervention.

Material & Methods: The reliability test of the homogeneity and of the stability of the instrument were performed on 122 patients either referred to the urological outpatients' clinic because of LUTS or who were waiting for TURP because of BPO. Patients with an indwelling catheter/CIC were not included. Seven patients had undergone an intervention before the re-test and were excluded. As the IPSS does not evaluate incontinence, an instrument for incontinence was developed, The Linköping Incontinence Questionnaire (LIQ). The frequency and severity of incontinence are combined into a score from 0 to 5 as the symptoms in the IPSS. Three additional questions are used to classify the type of incontinence. A native British professional translator translated the questionnaire into the English language. The stability of the instruments was tested with a test-retest (5 weeks), i.e. the patients answered the instruments twice before their visit to the outpatient clinic or their TURP.

Results: Before intervention, the prevalence of urinary incontinence in patients without an indwelling catheter/CIC was 46 % (n=414). Of these, 69 % (n=191) reported urge incontinence, 4 % stress incontinence, 20 % mixed incontinence and 6% were unclassifiable. After intervention, 16 % (n=532) reported incontinence; of which 45 % (n=87) reported urge incontinence, 16 % stress incontinence, 18 % mixed incontinence, 1 % continuous incontinence and 20 % were unclassifiable.

Conclusions: An incontinence questionnaire, The Linköping Incontinence Questionnaire (LIQ), that can be used with the IPSS has been constructed and reliability tested. The prevalence of incontinence before and after intervention, 46% and 16 % respectively, was higher than earlier reported.

06-s

PRO-ACT AND ACT FOR STRESS INCONTINENCE THERAPY: RESULTS AND NURSING IMPLICATIONS

Basso De Marc R., Rachelli F., Malghera S.

University General Hospital, Dept. of Urology, Udine, Italy

Introduction & Objectives: The aim of the study was the nursing management of a novel surgical technique for stress urinary incontinence named Adjustable Continence Therapy.

Material & Methods: The Adjustable Continence Therapy device consists of two opposing silicone balloons implanted para urethrally at the bladder neck, each connected to a titanium port situated in the scrotum to enable postoperative adjustments. The female version, named ACT is available in two lengths (8 – 9 cm), while the male version, named ProACT is longer (12 or 14 cm). The devices have the unique characteristic, which allow the postoperative adjustment of the volume in the balloons. 20 patients, 15 males and 5 females, who underwent the implantation of ACT and ProACT, were evaluated retrospectively. The surgery was performed between January 2006 and June 2006. The patients were evaluated with a disease specific questionnaire and the VAS (visual analogical scale) to evaluate objectively the degree of clinical resolution of incontinence. The clinical pathway was studied in order to improve the management of these patients searching a better integration between doctors and nurses

Results: Despite a high successful rate of the procedure, measured with the questionnaires and the VAS (65% of the patients were dry or substantially improved), only 8 patients out of 20 received appropriate information regarding the postoperative nursing management. The procedure required a monthly-based follow-up visits during each one the volume of the devices is adjusted to obtain the correct volume. Each patient requires a different volume in order to obtain the correction of the incontinence without obstructing the urinary flow. The main identified problem was a tendency to underestimate the incontinence and the discomfort caused by frequent follow-up visits the first 3-4 months. The presence of a continence advisor nurse would be of a great benefit in order to provide better and more appropriate information to patient candidate to ACT implantation.

Conclusions: The study has showed a great surgical success rate and a need of a better nurse managing of patients who underwent ACT implantation. From the study is evident that a continence advisory specialized nurse is crucial for a better coordination of information between the department and the patient. A procedure specific brochure discussed by the nurse, the patient and often also the patient's family was found to be a useful tool.

07-s

HOW SATISFIED ARE PATIENTS ATTENDING THE UROLOGICAL OUT-PATIENTS DEPARTMENT?

Lester M., Robinson E., Pisipati S., Pearce I.

Manchester Royal Infirmary, Dept. of Urology, Manchester, United Kingdom

Introduction & Objectives: There are about 40 million outpatient consultations a year in U.K., at a cost to the National Health Service of approximately £2.4 billion. With increasing public awareness and greater life expectancy, there is an increased burden on health care resources in all out-patient departments. This audit aimed to evaluate patients' perceptions and level of satisfaction with the services provided in our urological outpatients' department.

Material & Methods: All patients attending the urological outpatient unit over a 4 week period were asked to complete a standard questionnaire. This included basic patient demographics (age, sex and ethnicity) and, more specifically, the waiting time and adequacy of time for their consultation. Their opinion on the quality of consultation and their confidence in the doctor / nurse consulted were also recorded.

Results: In total, 468 patients completed the questionnaire. The waiting time for the consultation was less than 30 minutes in 81.8%, and 87% felt that their wait was not too long. The consultation time was felt to be adequate by 97.4% of the respondents. 97.8% felt that they were given the opportunity to ask questions and the answers were easily understood by 97.5%. 96.8% felt that they were satisfied with the extent of their involvement in deciding their management plan and 98% understood their care plan and follow-up. 97.4% of our patients expressed confidence in their doctor or nurse.

Conclusions: The quality of urological out-patient services offered in our unit is excellent. Most patients have a high level of satisfaction with urological out-patients consultations although a minority remain dissatisfied. Only 82% of our patients met the waiting time requirement set by Patient's Charter (all patients who attend out-patient clinics should be seen within 30 minutes of their appointment time), and further measures need to be considered to reduce the waiting time for consultations, such as an alteration of clinic template and appointment timing. Further work is required to determine the reasons for, and the causes of, the longer waiting times and dissatisfaction experienced by this small minority of patients.

08-s

BOTHERSOME URINARY SYMPTOMS AND DISEASE SPECIFIC QUALITY OF LIFE IN PATIENTS WITH BENIGN PROSTATIC OBSTRUCTION

Marklund-Bau H.¹, Edéll-Gustafsson U.², Spangberg A.³

¹Department of Clinical and Experimental Medicine, Dept. of Urology, Linköping, Sweden, ²Dept. of Medicine and Care, Div. of Nursing Science, Linköping, Sweden, ³Dept. of Clinical and Experimental Medicine, Dept. of Urology, Linköping, Sweden

Introduction & Objectives: The prevalence of lower urinary tract symptoms (LUTS) varies between studies and has been estimated to 20-25 % for middle-aged and 40-77 % for men 70 years and older. LUTS is defined from the individual's perspective and the symptoms are divided into three groups: storage, voiding, and post micturition symptoms. Benign prostatic obstruction (BPO) is a form of bladder outlet obstruction and may be diagnosed when the cause of the outlet obstruction is known to be benign prostatic enlargement (BPE). In LUTS/BPH management, an important goal is to relieve bothersome symptoms and their effect on quality of life QOL. The aim of this study was firstly, to describe self-reported urinary symptoms and bothersomeness, including disease-specific quality of life, in patients with symptomatic benign prostatic obstruction (BPO), before and six months after intervention. Secondly, to identify factors which predict the disease specific quality of life.

Material & Methods: Patients The study was performed on 572 of 720 consecutively treated patients aged 45-94 years, at a university hospital in the Southeast region of Sweden between 1998-2002. The treatment decision was based on the diagnosis of symptomatic BPO. Methods: The methods used were structured questionnaires. The patients filled in the questionnaires before and six months after intervention. The treatment interventions were divided into three groups: the TUIP/TUMT group, drug therapy group, and the surgery group. To study age differences, the patients were divided in four age groups: 40-59 yrs, 60-69 yrs, 70-79 yrs and ≥80 yrs.

Results: Before intervention there were significant differences between the age groups for the IPSS and the SPI instruments. After intervention there were no significant differences between the age groups. Before intervention, patients with an indwelling catheter/CIC were more impaired and after intervention, patients with an indwelling catheter/CIC improved most compared to patients without an indwelling catheter/CIC. Symptoms and disease specific quality of life improved most in the surgery group, intermediately in the TUIP/TUMT group and least in the drug therapy group. Explanatory factors for the patient's disease specific quality of life both before and after intervention were the bother of frequency and bother of having a weak urinary stream. Patients diagnosed with prostate cancer had five times lower odds ratio to have a good disease specific quality of life (score 0-1 bother question) after intervention.

Conclusions: The frequency and the weak stream items of the SPI were factors that best explained the disease specific quality of life. Symptoms and disease specific quality of life improved most in the surgery group, intermediately in the TUIP/TUMT group and least in the drug therapy group.

09-p

THE PREVENTION OF CATHETER RELATED URINARY TRACT INFECTIONS

Kisiel K., Szortyka E.

Centre of Oncology, Dept. of Oncological Urology, Bydgoszcz, Poland

Introduction & Objectives: A presentation of nurses procedures for the prevention of catheter related urinary tract infections conducted by nurses of the Urology Ward of the Oncology Centre of Bydgoszcz, Poland.

Material & Methods: The presentation will include general information concerning urinary tract infections, their causes, symptoms, nurses procedures in preventing urinary tract infections during catheterization and the analysis of patients' records.

Results: Based on record analysis and results of microbiological monitoring , following results were achieved: For the year 2006 - 37.5% of patients experienced urinary tract infections. For the year 2007 - still under evaluation.

Conclusions: Adopted standard guidelines allowed to keep urinary tract infections under 50%.

P10-p

PATIENT EDUCATION FOLLOWING TRANSURETHRAL PROSTATE RESECTION AND RADICAL PROSTATECTOMY

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Introduction & Objectives: Postoperative urinary incontinence following prostate operations is usually associated with radical prostatectomy (RP) and rarely with transurethral prostatectomy (TURP). In our department, there is a specialised nurse who deals with and supports all patients following radical prostatectomy in terms of teaching pelvic floor muscle exercises and educating them in the use of incontinence pads. Since, the risk of incontinence is much lower after TURP we don't offer this service to patients following TURP. Generally non-specialist nurses care for these men.

Material & Methods: In October 2006 we held an in-house training session for all nurses about incontinence following urological operations. The topics were incontinence protection, patient education and advice. As an internal evaluation thereafter, we interviewed patients following RP and TURP within one week from their hospital discharge by telephone. All patients during a period of three months (November 06 to end of January 07) were included. The aim was to find out if patients felt adequately educated and supported by nurses about incontinence problems. We were also interested in identifying if there were different approaches to nursing care by the specialist nurse and general nurses.

Results: A total of 27 patients were recruited. Though the majority of patients (9 of 11) following RP suffered urinary incontinence, all felt well supported and educated about incontinence problems and were very satisfied. In the TURP group, 50% of the patients (8 of 16) had dribbling of urine but only 3 of them had been informed about using incontinence pads. 4 of the 5 uninformed patients would have preferred being given information before going home.

Conclusions: Postoperative incontinence following TURP may be a frequent but temporary problem and patients are poorly informed about this by their nurses. It is therefore important for nurses to be well-informed about this problem and have the skills to educate their patients on how to deal with incontinence problems at home. In patients following RP, it is both advantageous and justifiable to have a specialised nurse educating and supporting these men. For patients following TURP, non-specialist nurses if appropriately trained could easily provide a similar service. Further research based on larger patient numbers is needed to acquire baseline information on early postoperative incontinence in order to both understand patients' attitudes and experiences as well as to develop intervention programs for the future.

P11-p

A SMALL THING WITH A BIG IMPACT- A BAG BRINGS AUTONOMY TO THE PATIENTS

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Introduction & Objectives: After big surgical interventions, such as ileal bladder substitute, ileum conduit, abdominal lymphadenectomy etc., patients are usually transferred to the competent station. After such abdominal surgery patients usually will have up to eight or more drainages. These patients have to be mobilised three times a day. The eight or more drainages have the following consequences:

- Total patient dependency on nurses
- Limitation on the movements especially when walking
- Unsightly appearance (different excrements of the body)
- Large work for the nurses, emptying different bags, fixing them with the safety-pins on the nightshirt, and fixing all the bags after the mobilisation on the bed.
- Risks of damaging the bags and the sheets during the manipulations with the pins

Material & Methods: A patient once walked with a plastic bag in his hand with all the drains bunched together. This gave us the idea, to create a bag out of a pillow cover and some bandages. This bag has proven its usefulness particularly through the reduction in work-time for the nurses, bringing independency to the patients and substantially increasing patient's freedom to mobilise. For this reason we developed our basic idea in order to provide a suitable working bag. We have asked a company, which already sells different products to our unit, to construct a prototype of this bag in one way material. Since this company has provided us these bags with their Logo, they don't charge them.

Results:

- The bag can be carried on the infusion bland as well as on the body.
- Providing the patient is healthy, greater mobility is permitted.
- The bag is made of bio- degradable material and can therefore be thrown away.
- Unnecessary work is avoided.
- Patients feels more self-assure and free when they move.

Conclusions:

- The feeling to be dependent on somebody is less.
- The intimacy is more likely without hindrance.
- The aesthetic has a positive effect for the patient and the visitors.
- The substantial increase in mobility has a prophylactic impact.
- The emptying of the bags can be done at fix times, which again causes less work and save time.
- The costs of laundry are avoided
- The unit does not have to incur additional charges.

P12-p

CAN NURSES SUBSTITUTE DOCTORS? A PROJECT CONCERNING QUALITY CONTROL

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Introduction & Objectives: For many years we had a common procedure in our day care unit, when we wanted to control the result of the treatment given to the patient with Lower Urinary Tract Symptoms - LUTS. Whether it was medical or surgical treatment, the patients - on the same day - always visited:

1. the nurse for making a new comparing uroflow and residual urine
2. the doctor for a following up talk, that helped deciding end of treatment or further examinations.

In 2005 we decided to change the procedure. In the future only the nurse should take care of this group of patients. It became up to her whether the patient needed a new talk to the doctor or he could be discharged after the visit. This procedure was caused by:

1. the doctor was always fully booked and maybe we hereby could give more space to the serious ill patients
2. the doctor discovered, that the patient often has got all the information, he needed by talking to the nurse.

With some roughly instructions, sanctioned by our urologist (a kind of "how to do it") we started. We, the staff, has been very happy for the arrangement, but what about the patient? We therefore want to investigate the patient satisfaction.

- do the patient get a sufficient and competent instruction?
- what does he think about leaving the system without talking to a doctor?
- is a standard able to secure a more homogeneous information/instruction to the patients?
- will the Score and the Qmax after the treatment have any importance for the patient in the matter of leaving the system?

Material & Methods: We want to investigate a consecutive group of patients treated for LUTS and discharged. The patients have been treated in 2 different hospitals and after 5 different methods. To secure that the patients get the same treatment and get around the same questions, no matter which urological nurse he visits, we decided at the same time to work out detailed standards, descriptions and checklist for the visit. We want to make a prospective research of the patient satisfaction. The patient will be given a questionnaire with 9 questions related to his actual visit and the decision made by him and the nurse. The patients are included over a period of 3½ months in connexion to being discharged after control. We use Principal Component Analysis - PCA - to depict the results. The results will be presented in a scoreplot as well as in a loadingplot.

Conclusions: Preliminary conclusion: After 15 patients at this time have answered our questionnaire it looks as if the subjective experience mean more to the patients than the objective results. Until now the analysis shows a high degree of satisfaction with the nurse, the information and the fact, that he's not going to talk to a doctor.

P13-p

IMPLEMENTING NANDA NURSING DIAGNOSES IN A UROLOGY UNIT

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Introduction & Objectives: NANDA nursing diagnoses are regularly developed and approved by the committee of North American Nursing Association (NANDA). A nursing diagnosis is a clinical judgment about an individual, a family, or a community response to an actual or potential health problem. Nursing diagnoses provide the basis for selection of nursing interventions to achieve favourable outcomes and the involved nursing staff responsible are accountable. Nursing diagnoses are concepts used to describe actual and potential health problems of clients. They describe clinical nursing practice in a uniform and structured manner. Starting position: In the year 2004 the Hospital Board of Directors decided to launch electronic patient recording. An electronic patient record requires a standardized nomenclature for nursing documentation. Therefore the head office of nursing decided to use NANDA diagnoses and developed an overall concept to implement nursing diagnoses hospital wide.

Material & Methods: Clinical nurse specialists lead the project and are responsible for the smooth running of the diagnostic process in the unit, while multipliers (appointed ward nurses) oversee and support this process on the wards. First the clinical nurse specialist and multipliers are educated in applying NANDA diagnoses. This group then develops a specific NANDA diagnoses profile for their unit and adapt nursing documentation to this profile. Finally all nurses in the unit are trained. Collateral regular discussion and reflection about different cases support the process of implementation. In addition regularly evaluation of NANDA diagnoses usage is planned.

Results: Multipliers are educated in NANDA diagnoses, act as support for nurses on the ward and evaluate. The specific nursing diagnoses profile for the unit is developed and nurse's documentation is adapted. So far, all 51 nurses from the unit have been educated through a one day session in:

- NANDA nursing diagnoses and how to apply the diagnostic process
- Profile of specific nursing diagnoses of our urology unit
- Adapted nursing documentation

Prior to the congress in March 2008, we expect further results regarding: The quality of nursing documentation with NANDA nursing diagnoses, details about the main NANDA diagnoses in our urology unit and about the main difficulties in implementing nursing diagnoses.

Conclusions: The overall concept from the head office of nursing to implement nursing diagnoses is extremely useful as well as applicable. It allows a structured approach to the process of development, implementation and education of nurses. The available monitoring instruments will guarantee continual evaluation and possible improvements.

P14-p

CREATING A STANDARDIZED CARE PLAN FOR PATIENTS UNDERGOING RADICAL PROSTATECTOMY

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Introduction & Objectives: This project was performed by two nurses at the Ward of the Department of Urology, Malmö University Hospital, UMAS, Sweden. There is a need for standardization and quality insurance in the Swedish health care system. Standardized Care Plans (SCP) are excellent tools for nurses in their daily practice, which includes taking care of all kind of patients and documentation of their work. Standardized care plans are based on recommendations and guide-lines from the National Board of Health & Welfare in Sweden and serves as a general plan with definitions of the basal level of care. In addition, SCPs represent important tools to identify and report complications and how these should be handled. The number of patients undergoing prostatectomy has increased considerable the last decade and there is a need for improvements in the pre- and postoperative care of these patients, including how they should be informed about their current disease and treatment. The age at diagnosis has decreased due to frequently used PSA testing and the today's relatively young patients with prostate cancer are much more interested in their disease and treatment than older men. With several years of experience from work with urology patients, we initiated the current project in order to optimize the care of our patients undergoing radical prostatectomy at Malmö University Hospital. Our main objective was to develop a high-quality SCP for patients undergoing radical prostatectomy for localized prostate cancer.

Material & Methods: Regular meetings within our project group and with a supervisor with great experience in SCPs (Karin Edlund, Nurse at Sahlgrenska University Hospital, Göteborg). Participation in a course of evidence based medicine. Medical records were studied in order to identify the most important content in our SCP. Review of scientific publications and guide lines related to SVP and prostate cancer.

Results: We have generated a SCP for patients with localized prostate cancer undergoing radical prostatectomy by an open procedure or by a robot assisted laparoscopic approach. Our document is based on quality insurance and we have excluded irrelevant procedures and minimized time spent on documentation. The plan is also an important element of security for recently employed nurses as well as a tool for further development and improvement in the care of the increasing group of patients undergoing radical prostatectomy.

Conclusions: Based on guidelines from the Swedish National Board of Health & Welfare, we have generated a SCP for patients undergoing radical prostatectomy for localized prostate cancer. Our plan is a security factor for all nurses working with this group of patients and it leads to improved quality in the care of our patients. Our SCP is also a platform for further improvements in the care of patients with prostate cancer and it will also encourage colleagues to develop SCPs for patients with other diseases.

P15-p

HEALTH TECHNOLOGY ASSESSMENT OF SHARED CARE WHEN PATIENTS WITH LONG-TERM URINARY CATHETER NEED CATHETERIZATION

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Introduction & Objectives: Patients with long-term urinary catheter need regular catheterization. Where the catheterization takes place is random and even though already many are in contact with their general practitioner or the local home care the catheterization often takes place on a highly specialized department of urology. A shared care model is wanted, developed across the secondary sector (hospital) and the primary sector (general practitioners and the local home care) for patients with long-term urinary catheter.

Material & Methods: The study was carried out as a HTA with a view to having a systematic and comprehensive evaluation of the conditions for the development and the implementation of a shared care model to ensure a uniform quality and the most appropriate use of resources for treatment with an indwelling catheter. The study is based on an international literature review as well as Danish empirical data. In the HTA four perspectives are examined:

- Technology: Danish Standard's recommendations for catheter placement were compared to four other national guidelines and the guideline on male catheterization from EAUN.
- Patient's aspect: Qualitative interviews with eight patients with long-term (more than one year duration) urinary catheter.
- Organization: Focus group interview with members of staff from the primary and secondary sector.
- Economy: Estimated costs of catheterization in the local home care, at the general practitioner's or on a hospital ward.

Results: The estimates show that from a health economic perspective it is an advantage that the majority of catheterizations are attended to by the primary sector and not by a department of urology.

Conclusions: By means of this HTA it has been illustrated what measures must be taken for the implementation of a shared care model

- To reach a consensus about the indication of catheter placement, how to place the catheter and what must be documented, a local evidence based guideline has been worked out on transurethral catheter placement. To be used by the staff in the primary sector as well as the secondary sector.
- Recommendations have been worked out for a patient information in writing.
- Recommendations have been worked out concerning where the catheterization should take place in each individual case.
- Recommendations have been worked out concerning a co-operative agreement to ensure that relevant knowledge about the treatment of the individual patient as well as relevant catheter data are available and updated.
- Recommendations have been worked out concerning a structured instructions programme in catheterization and management for doctors as well as the nursing staff from the primary care, so that a uniform quality is ensured.

P16-s

PROSPECTIVE ANALYSES AFTER THE IMPACT OF RALP USING EORTC-QUALITY OF LIFE QUESTIONNAIRES

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Introduction & Objectives: Robot assisted laparoscopic prostatectomy (RALP) is one of the treatments for localized prostate cancer (PCA) and was introduced at our hospital in April 2006. Prostatectomy has intensive effects on patients' genitourinary functions. We postulate that acceptance can be increased by accurate patient information. The advanced nurse practitioner (ANP) plays a significant role in informing patients. The use of QoL questionnaires by the ANP in patients counselling was prospectively studied. Based on these results, patients will be counselled pre- and postoperatively.

Material & Methods: Prior to the visit a questionnaire is sent via regular mail so QoL data is available at first visit. It contains questions related to medical history and EORTC validated questionnaires. Processing of the data is handled by the ANP. Records are kept in a MS Access ®database. Based on answers from the questionnaire an assessment is made before the 1st visit. We analyzed the results of the QoL general (EORTC QC30) and prostate specific (EORTC-PR25) pre and post treatment. The analysis was performed on answers of 55 men before and 6 months after treatment. Answers are given on a 4 point Leikert scale.

Results: (N=55) Relevant information for the diagnose is obtained from the questionnaire. The overall QoL measured in the EORTC QC30 showed no significant difference between before and after, for both the physical and the global aspects. In the EORTC-PR25 the domains 1 and 3 on voiding- and bowel complaints showed no significant difference comparing before and after RALP. Domain 2 (use of aids) was worse after RALP compared with before (9% experienced moderate to severe complaints after RALP). Domain 4 containing questions related to systemic side effects showed no difference before or after RALP. Domain 5 (libido and sexual activity) showed a similar score before and after treatment. Domain 6 (overall sexual function) was significantly lower after than before RALP. Largest difference was experienced in erectile function: 9% reported problems with obtaining or maintaining an erection preoperative whereas this was 49% postoperatively. Problems with ejaculation increased from 6% to 26% patients and fear of being sexually active increased from 7% to 24%. Moderate to severe problems with urinary continence increased from 16% to 46% postoperatively. In a subgroup of patients results one year after treatment revealed improvement in scores.

Conclusions: Previsit questionnaires contribute to a more speedy diagnosis and information process. RALP had impact on sexual function and urinary continence in half the patients 6 months postoperatively. This did neither affect overall quality of life nor the level of sexual activity. Knowing QoL outcome prepare us in our approach to patients. It encourages us to extend the method of questioning to a bigger scale and to investigate working with digital questionnaires using touch screen computers.

P17-s

THE ROLE OF URINARY CATHETER IN THE DEVELOPMENT OF INFECTION IN PATIENTS WITH BHP

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Introduction & Objectives: Every foreign body left in place increases the possibility of infection. Only aseptic handling of the urinary catheter, its regular replacement and education of the patient regarding catheter hygiene lessen the possibility of developing urinary infection. At the time health care bills and antibiotic abuse are diminished. Our aim is to show the influence of the urinary catheter as a foreign body in the development of urinary infection in BHP patients.

Material & Methods: From January to May 2007, 105 TURs of the prostate were performed at the Clinic of Urology in Novi Sad. Patients mean age was 68 years. The average postoperative hospital stay was 3 days. Beside of routine post-operative continuous bladder irrigation, manual irrigation was performed by medical technicians (nurses) as well.

Results: Out of 105 patients, 48 (45.7%) had an indwelling catheter before surgery. 17 (35.4%) patients out of 48 a positive urine culture. Among 57 patients without a catheter preoperatively, only 6 (10.5%) out of 57 patients had a positive urine culture. At discharge from the clinic, all patients had a urine culture check. The number of positive preoperative urine cultures remained unchanged. While before surgery 82 urine cultures were negative, after surgery only 56 remained negative. 31.7% of patients had a positive urine culture at their discharge, respectively. In 68% of the cases E. coli, in 21% Klebsiella pneumonia and in 11% other bacteria were cultivated.

Conclusions: By analysing the results we may conclude: Urinary catheter, as a foreign body, contributes to the development of urinary infection. Nurses at the urological clinic in Novi Sad, attach to principles of aseptic handling of manual irrigation of the bladder. Pathologic disorders, i.e. abscess of the prostate's capsule associated with BHP increases the possibility of urinary infection after surgery.

P18-s

THE ROLE OF HEALTH EDUCATION IN THE IMPROVEMENT OF UROSTOMY PATIENTS LIFE QUALITY

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Introduction & Objectives: Urostomy represents a radical change of life style. Habits social standing are dramatically changed. The authors aim to show the influence of health education on the process of resocialisation and improvement of life quality.

Material & Methods: From January 2005 through June 2007, 61 radical cystectomies were performed in the Clinic of Urology at the Clinical Centre of Vojvodina in Novi Sad. Patients mean age was 65 years. In 35 patients (57.4%) suprapubic urinary derivation (wet stoma) was performed.

Results: 20 patients (32.8%) attended a preoperative course where they got familiar with stoma care and base plate replacement. The rest of 41 patients (67.2%) were taught beginning the 3rd postoperative day. At discharge, 92% of operated patients mastered successfully the stoma care and base plate change, while 8% of patients needed additional education.

Conclusions: Health education conducted in form of live demonstration results in quality trained patients who are capable to improve considerably their life quality.



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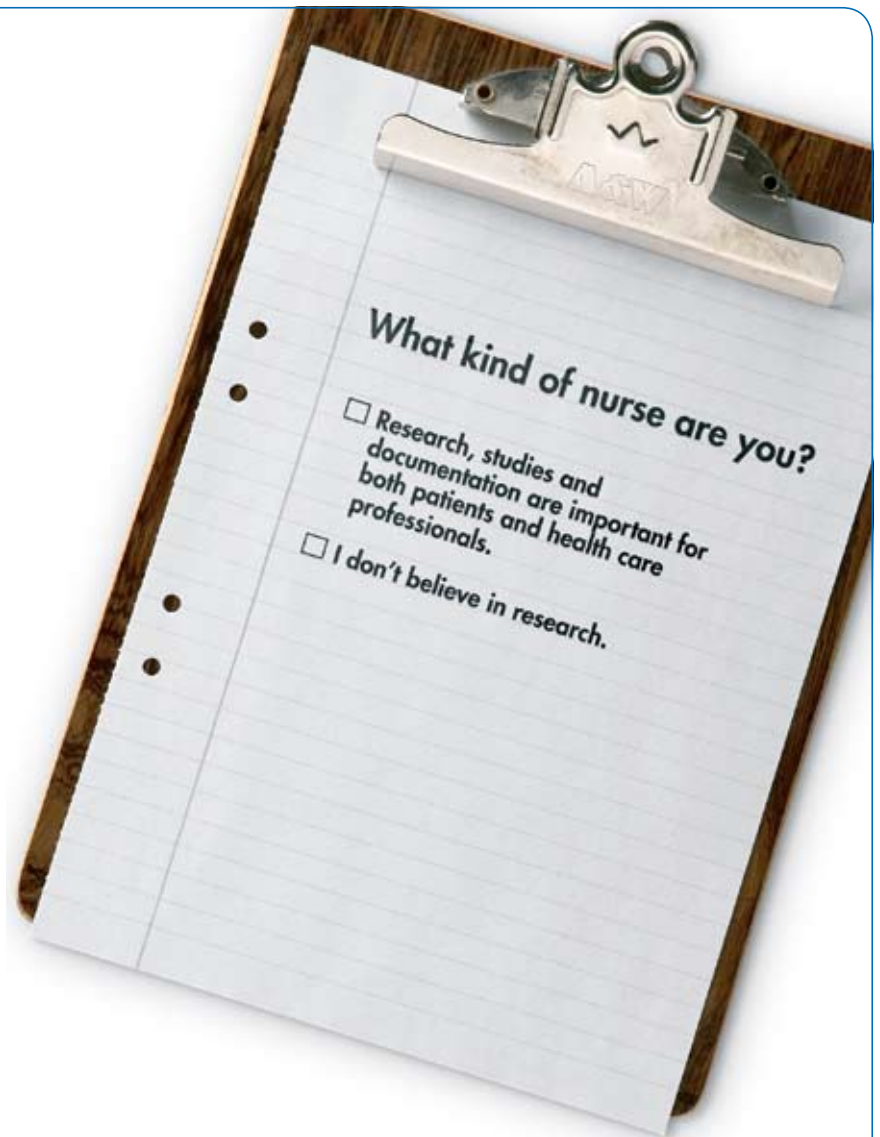
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