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At the 11th International EAUN Meeting in Barcelona, a special session was held where nurses were invited to present cases where they encountered tough problems in daily practice and to which they found their own innovative solutions.

The project started in Stockholm and for the recent congress held in Barcelona the EAUN issued another call to encourage nurses from across Europe and beyond to participate. After the evaluation by an expert jury the authors of the most interesting cases were invited to present at the EAUN’s Barcelona meeting.

Three cases were presented or accepted for the EAUN meeting with Nora Love-Reitinger from New York, NY (US) presenting the case “Nursing care of post ileal neobladder incontinence,” Montserrat Gue-Sánchez and Ana Quintanilla-Sanz from Lleida, Spain presenting a case “Lluis 1 Cancer 0,” and an accepted paper authored by Elaine Robinson of Manchester (GB). Her submission titled “Management of chronic papillomatous dermatitis in a patient with a urostomy,” was not presented for reasons beyond the organizer’s control but is presented here and on the website.

The presentations in Barcelona proved very interesting and the discussion with the audience made the session more dynamic since various viewpoints were actively exchanged. The full presentations can be viewed as webcasts at the EAUN website at http://www.eaubarcelona2010.org/?id=76652&b=2859 http://www.eaubarcelona2010.org/?id=76652&b=2853 The EAUN has also placed the submissions on the EAUN website, offering its members and web visitors a unique opportunity to learn from each other.

Descriptions of the cases are also found on this page. The submissions not only met the criteria of the jury but also impressed them with the thorough and careful work exerted by the authors. The selected authors who presented their cases were offered free registration for the 11th International EAUN Meeting in Barcelona, whilst non-members are also entitled to a free one-year membership of the EAUN.

Barcelona session features innovative nursing solutions

Difficult cases prompt dynamic exchange amongst participants

1. What caused the problem you experienced by ensuring continence in this patient?

This is a case report on a 36-year-old lady with Sipina Bifida who had a urostomy formed at the age of 5 years. This lady had never been in contact with Stoma Nurses or Urology Services in over 30 years and had apparently lost touch to follow up almost immediately. She had been managed by her General Practitioner. She subsequently developed skin problems which were initially diagnosed as chronic papillomatous dermatitis which formed an extensive prostruding crust around the entire circumference of her urostomy and she was unable to retain a bag on her stoma for more than a few hours. Urine constantly pooled under the flap onto her skin causing severe irritation. She was initially referred to the Department of Dermatology in a patient with a urostomy. This lady had never been in contact with Stoma Nurses or Urology Services in over 30 years and beyond to participate. After the evaluation by an expert jury the authors of the most interesting cases were invited to present at the EAUN’s Barcelona meeting.

2. Which nursing intervention did you provide?

The intervention required treatment by two different approaches:
Part A: As part of the post-operative nursing care of this patient, the patient had bladder irrigation, timed voiding, and Kegel exercises with positive results.
Part B: Again, the patient was treated with conservative management by re-instructing the patient on timed voiding and Kegel exercises. However, the patient continued to be frustrated with the lack of complete continence and therefore required further surgery with the implantation of an artificial urinary sphincter (AUS). Nursing care for this procedure was provided with positive results.

3. Which materials did you choose to get the patient continent?

Patient now has improved access to nursing support and will be closely followed up in the community setting.

4. What were the results of your intervention?

Patient now has improved access to nursing support and will be closely followed up in the community setting.

6. What caused the problem you experienced by ensuring continence in this patient?

This is a case report of a 58 y.o. male bladder cancer patient who underwent a cystectomy and formation of a neobladder. The patient experienced incontinence on two separate occasions: Part A: As a result of the neobladder surgery, the patient experienced moderate stress incontinence 6 months post-operatively. Part B: Two years after surgery, the patient developed a small bowel fistula to the neobladder which required exploratory laparoscopy and excision of the fistula. After the procedures the patient developed worsening incontinence.

7. Which nursing intervention did you provide?

The incontinence required treatment by two different approaches:

Part A: As part of the post-operative nursing care of this patient, the patient was taught bladder irrigation, timed voiding, and Kegel exercises with positive results.

Part B: Again, the patient was treated with conservative management by re-instructing the patient on timed voiding and Kegel exercises. However, the patient continued to be frustrated with the lack of complete continence and therefore required further surgery with the implantation of an artificial urinary sphincter (AUS). Nursing care for this procedure was provided with positive results.

8. What were the results of your intervention?

Patient now has improved access to nursing support and will be closely followed up in the community setting.

9. What caused the problem you experienced by ensuring continence in this patient?

This is a case report of a 58 y.o. male bladder cancer patient who underwent a cystectomy and formation of a neobladder. The patient experienced incontinence on two separate occasions: Part A: As a result of the neobladder surgery, the patient experienced moderate stress incontinence 6 months post-operatively. Part B: Two years after surgery, the patient developed a small bowel fistula to the neobladder which required exploratory laparoscopy and excision of the fistula. After the procedures the patient developed worsening incontinence.

10. Which nursing intervention did you provide?

The incontinence required treatment by two different approaches:

Part A: As part of the post-operative nursing care of this patient, the patient was taught bladder irrigation, timed voiding, and Kegel exercises with positive results.

Part B: Again, the patient was treated with conservative management by re-instructing the patient on timed voiding and Kegel exercises. However, the patient continued to be frustrated with the lack of complete continence and therefore required further surgery with the implantation of an artificial urinary sphincter (AUS). Nursing care for this procedure was provided with positive results.

11. What were the results of your intervention?

Patient now has improved access to nursing support and will be closely followed up in the community setting.

Co-author: Mr. Ian Pearce

Co-author: Ana Quintanilla-Sanz, RN

Co-author: Router Urology Specialist (UNES), Stoma Care Nurses and the Consultant Urological Surgeon.

The decision to insert a urinary catheter into her urostomy was made to try to reduce the urine leaking onto her already damaged skin. Unfortunately a few days later she found the catheter in her urostomy very uncomfortable and consequently had the catheter removed.

We also provided her with a new stoma appliance and urostomy seals in an attempt to improve adherence. Furthermore she was referred to the Community District Nurses and Stoma Care Service. The UNS provided ongoing hospital support, advice and follow-up. On the recommendation of the USH a referral was also made to the Dermatology department for advice regarding her immediate skin damage with a view to possible biopsy to exclude malignancy. We discussed the possibility of re-catheterising patient’s stoma with her prior to her appointment to facilitate possible skin biopsy. Patient was happy to be re-catheterising.

To provide continued support and further assessment home visits were undertaken by the UNS. It was apparent that the home circumstances that she lived in were poor and that she would benefit from improved social support.

The materials used to help the patient achieve and maintain continence and improve skin integrity were:

• A female urinary catheter size 12h (Teleflex Medical)
• A Urostomy bag (Select Convex Urostomy)
• Urostomy seals (Hydro Frame Hydrocolloid flange extensions).

4. What were the results of your intervention?

Following catheterisation, she has remained dry. Also the new urostomy appliance and seals have helped by adhering to the skin more snugly thus reducing the leakage and pooling of urine. The catheter remains in her urostomy.

A topical steroid has been prescribed by the dermatologist to try to reduce inflammation. However now due to the ongoing severe damage to the surrounding stoma skin a multi-disciplinary team decision has been made to re-site the stoma to the contralateral side of the abdomen as the skin has been irreversibly damaged. She has agreed to undergo this surgery. Pre-operative counseling and support has been arranged.

Co-author: Ana Quintanilla-Sanz, RN

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Self urethral dilatation still a viable option
Hong Kong nurses assess SUD tolerance among urology patients

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This study was undertaken to evaluate the effectiveness of self urethral dilatation (SUD) and its impact on the quality of life among urology patients. The study included 35 patients, 25 men and 10 women, undergoing SUD for the management of urethral strictures or other urological conditions. The mean age of the patients was 65.3 years (range 39-83), with the majority (77%) in the age group of 70-79 years. 72% of patients had previous surgery, including urethral dilatation (5%), cystectomy (6%), prostatectomy (14%), and urethral stricture (31%).

In the course of the study, the patients were monitored regularly for the effectiveness of SUD, which was assessed through the improvement in urine flow and the resolution of symptoms. The patients were taught the technique on SUD on a one-to-one basis with their caregivers, if applicable. A positive effect was observed on the arrangement of referring urologists.

The outcomes of the intervention included improved quality of life, increased sense of control, and verbalization of acceptance of the adaptation. Patients reported reduced stress and improved ability to perform daily activities. A significant reduction in seeking additional treatment and improved self-esteem were also observed.

The questionnaires returned showed high patient satisfaction with the SUD intervention. Patients reported significant improvement in their urine outflow, capable of starting and interrupting the jet of urine, and able to recognize the mictional urgency. They have adequate compliance to the SUD instruction. There were no reported complications, and the symptom subsided.

Co-authors: K.L. Chui, P.H. Wu, M.L. Li, C.F. Ng

Patients and methods
This is a retrospective review of patients who underwent SUD for urethral stricture disease from September 2000 to July 2009. During the study period, patients were referred by the urologist to their nursing unit for the education of SUD. All patients and their caregivers, if applicable, were taught the technique on SUD on a one-to-one basis.

The patients were followed-up regularly in our nurse-led clinic. Of the patients who also had cystoscopy for follow-up of the stricture, depending on the arrangement of referring urologists.

In the course of the study, the study enrolled 35 patients, 25 men and 10 women, using SUD for the management of urethral strictures and were included in this review. The mean age was 65.3 years (range 39-83), with the majority of patients in the age group of 70-79 years. 72% of study subjects presented with weak stream of urine and the remaining 28% presented with acute retention of urine.

The locations of the stricture were listed with the majority occurring at either the meatal (31%) or the bulbar (29%) region. Other sites included penile urethra (20%), bladder neck (14%), membranous (3%) and anastomotic site after radical prostatectomy (1%).

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