Suprapubic or urethral catheters: which are best?

Kathleen Hunter & Katherine Moore
University of Alberta Faculty of Nursing Edmonton, AB, Canada

Suprapubic catheters (SP) are a bladder drainage option for post-operative urethral/pelvic surgery or trauma, prostatic obstruction or urethral stricture, or in cases of difficult catheter insertion. People who require chronic catheterization who wish to be sexually active or who experience urethral discomfort related to the urethral catheter (UC) may find SP catheters more suitable. It has been suggested that people with SP catheters have fewer complications and in particular urinary tract infections (UTI). However, data on SP catheters which guide practice or address user preference and quality of life appear limited. In a search of the literature for studies in which suprapubic and urethral catheters were compared, we found 14 articles that addressed the question of whether one method was superior to another. The majority of papers reflected 3 categories:

- UTI
- Other upper and lower tract complications (calculi, carcinoma, urethral injury)
- Quality of life

Is UTI reduced with SP catheters?
Five studies compared the incidence or prevalence of urinary tract infection (UTI) between SPC and UC. Unfortunately, the studies used varying definitions to define UTI.\(^1\),\(^2\),\(^3\),\(^4\),\(^5\) However, despite varying definitions, there appears to be no difference in UTI between urethral and SP catheters.

Are upper or lower tract complications reduced with SP catheters?
Upper tract complications associated with both UC and SPC include renal dysfunction, hydronephrosis, vesicoureteral reflux, and urinary calculi.\(^6\) We found six papers that suggested an advantage of SP over urethral catheters, but findings were limited by retrospective data which is prone to recall bias or missing data, differing outcome measures and various methods of bladder management such as clamping, irrigating and changing intervals. Because of the low quality of the existing studies, it is not possible to say that upper tract health is made better (or worse) with a SP catheter.

Urethral Complications are reduced with SP catheters. It is not surprising that urethral injury would be limited for users of SP catheters. Indeed, protection of the urethra is a key reason for choosing a SP over a urethral catheter. We found two studies addressing this question and both confirmed an advantage of SP catheters for protecting against anterior urethral injury, urethral fistulae, scrotal abscess, and epididymitis.\(^3\),\(^7\)

Urethral Leakage and skin care can be problematic in both urethral and suprapubic catheter users. One case study was found emphasizing the need for secure anchoring of the suprapubic catheter to prevent traction on the stoma and subsequent skin breakdown.\(^8\) No articles were found that addressed exit site granulation, bleeding, or other skin care issues related to the catheter stoma site. Prior to the insertion of a SP catheter, good clinical practice should include video urodynamics to ensure bladder neck competency. If the bladder neck is not competent, inevitably the patient will have urethral leakage. In some cases, the bladder neck will be closed surgically but this is an invasive surgical procedure not suited to many frail patients.

Continued on page 2 & 3
Suprapubic or urethral catheters: which are best? continued

**Bladder calculi** are a known complication of indwelling catheters. The incidence of cysto- or renal-lithiasis in one paper was 65%. In the studies on incidence of calculi, there is clinical evidence that bladder calculi are not significantly different between urethral or suprapubic catheter users and one review noted that calculi were more likely in SPC users than intermittent catheterization users. Based on these findings, it is reasonable to assume that the presence of any indwelling catheter increases the likelihood of bladder calculi and that individuals using long term indwelling UC or SP catheters, who have recurrent lower urinary tract symptoms unrelated by antibiotics, should be assessed urologically for bladder calculi or other bladder pathology.

**Urothelial Cancer** is a reported complication of indwelling catheters. We found one retrospective study that indicated an overall incidence of 0.39% of urothelial cancers with no difference between urethral or suprapubic catheterization methods. The studies did not control for smoking, lifestyle choices or other bladder cancer risk factors.

**Quality of Life**

Five studies were found that focussed on living with and adjusting to a UC or SPC. Of these, three were qualitative that addressed the subjective aspect of living with an indwelling catheter and two were quantitative studies that also included some aspect of satisfaction or quality of life (QoL) regarding SPC. Findings were similar across the studies: people felt unprepared to care for the catheter post insertion; initial negative experiences moved to a more positive, optimistic viewpoint; individuals were affected by but adjusted to altered body image and altered sexuality; and all indicated the need for informed healthcare provider support. In addition, two of the excluded retrospective studies with no comparator provided anecdotal data that individuals with SPC perceived inadequate support to manage problems associated with catheter changes, problem solving, or skin care and, as a result, were obliged to make a significant number of visits to the emergency department. In a more recent study on catheter washouts, healthcare professionals identified a gap in knowledge about long-term catheter management and noted the need for further education in the area. Whether there has been a change in community healthcare providers’ confidence in managing suprapubic or urethral catheters needs further exploration. Although a perceived lack of healthcare support is reported, satisfaction with an SPC was high compared to the users’ previous experiences with urethral or intermittent catheterization. In one study, 52% of individuals indicated they were “full to almost satisfied” with the SP catheter (compared to 37% of clean intermittent catheterization users); in the same study, 11% SPC and 32% intermittent catheterization users reported “Never satisfied”.

**DISCUSSION**

The purpose of this review was to summarize the comparative data on quantitative and qualitative long term outcomes of suprapubic versus urethral catheterization in order to inform clinical decision-making information for both practitioners and patients considering a suprapubic catheter. The studies reviewed were characterized by retrospective designs and many were published over 20 years previously. In addition, much of the early data included only men with spinal cord injury or patients taking prophylactic antibiotics, and major changes in urologic management of individuals with neurogenic bladders mean that generalising findings to current populations with intractable incontinence is difficult. Despite these limitations, there appears to be an ongoing acceptance that little or no clinical difference exists between urethral and suprapubic catheterization in the long term with respect to UTI, calculi or vesicoureteral reflux. Urethral catheters pose issues related to urethra and bladder neck integrity; suprapubic catheters pose issues for skin care around the stoma site or urethral leakage. In the absence of an alternate bladder management strategy, the decision to utilize either a urethral or suprapubic catheter should be informed by the evidence and done in consultation with the individual. Further, qualitative studies indicate that initial acceptance is an issue but that over time, positive adjustments are made. Importantly, users reported that healthcare professionals may lack knowledge about catheter management. There is a clear need for research that addresses decision making leading to SP catheterization, prospective tracking from decision to insertion and follow-up, and the perceived benefit of the choice to have a SPC inserted. The review had a number of limitations. First, we did not include generic terms (e.g. complications, morbidity) in our search, a decision which may have limited the number of potentially relevant articles. Second, only abstracts from the International Continence Society meetings were searched. Inclusion of other conference proceedings may have yielded additional studies of interest. Finally, we did not include economic comparisons.

**Summary of clinical research and future research directions**

The current trend in long term catheter management is to minimize the use of indwelling catheters overall. Two comprehensive reviews of suprapubic catheter insertion have been done to guide safe practice. Risk factors for complications such as adhesions, small fibrotic bladder, history of radiation or pelvic surgery, urethral leakage, and bladder compliance must be taken into account when assessing a patient for placement of a suprapubic catheter. Existing evidence reveals that the incidence of upper and lower urinary tract complications between UC and SPC is similar, but SPC is associated with a lower incidence of urethral complications. Future studies of long term suprapubic catheterization should focus on controlled prospective investigations of all complications in long term SP catheters compared to other methods of bladder emptying. Critical to the prospective studies are definitions of UTI and reporting of both upper and lower tract complications that are consistent across studies. Finally, both health care professionals’ and users impressions of benefits and limitations of catheter methods need to be explored; such studies may not only inform our understanding of quality of life issues but also identify hidden health system costs. Further understanding of user issues, including the decision making process and perceived benefits, would help inform health care professionals’ recommendations regarding one method over another.

**CONCLUSION**

The purpose of this review was to evaluate the research activity comparing long term outcomes with suprapubic or urethral catheters with other bladder emptying methods. Of the 14 articles which met the inclusion criteria, the majority were retrospective reviews. Based on the current literature, it is clear that both urethral and suprapubic methods have associated clinical
problems and that either method should take into account the individual’s preference, risk factors, and available resources. It is important to have an understanding of the more subjective issues related to chronic catheterization. These include decision-making and preferences of clinicians and users and the sequelae related to skin care and urine leakage. Prospective studies may assist clinicians and users with informed decision-making on urine drainage method and long term management.


By Kathleen Hunter  
Katherine Moore

References:

Another conference has come and gone bringing with it many months of preparation but as always it was a worthwhile endeavour. The Hilton Hotel Trade and Convention Center served as the venue only steps away from the Saint John waterfront and the downtown core. Seventy three nurses from across Canada attended this year, each one bringing with them their own expertise in Urology and an eagerness to learn and share their knowledge.

No conference can happen without sponsors and exhibitors. There were twenty seven in attendance as well three not for profit groups. The attendees were able to network with them, as well as familiarize themselves with new technology, pharmaceuticals, products and literature. Many of the representatives joined in on the dinner and fun night activity as well.

The conference provided keynote speakers that addressed: Urological Emergencies and Trauma, Hormone Treatment and Bone Density, Menopause, Renal Calculi, Kidney Cancer, A Patient Perspective on Prostate Cancer and a Kidney Donor and Recipients perspective. The final Keynote speaker was Mark McIntyre, a Testicular Cancer survivor. He was both inspirational as well as entertaining. He walked the audience through his cancer journey and awareness raising hitchhike, as the “Gitchiker”, that took him across Canada.

The concurrent sessions were equally informative. The topics covered included Radiation Cystitis and Treatment Options, Kidney Transplant - The nursing Perspective, Intimacy and Sexual Health-post Cancer Treatment, Bladder and Brain Aging Together, Diseases of the Prostate, Urostomy - Nursing Implications, Long Term Indwelling Catheters, OAB and Botox and Radiation Therapy for Prostate Cancer.

The UNC offers a number of monetary awards provided through the very generous support of our Industry sponsors. It was great to see several poster presentations sharing research and information with our peers. The winning poster award went to Yvonne Appah. It was entitled “Indwelling Urinary Catheter Securement Practice in one Acute Care Medical- Surgical Setting” (Dr Katherine Moore accepted on her behalf as Yvonne was unfortunately unable to attend). Other awards handed out included the Award of Merit, which was presented to Liette Connor; the recipients of the UEC Attendance Awards this year were Sue Hammond, Jo-Anne Billing, Susan Marsh and Vickie Williams.

Friday evening we were treated to a guided bus tour of the Saint John area, a real conference high light, while on route to the Saint John Marina on the west side of the city for dinner and entertainment by “Gordioke”. It proved to be a beautiful fall evening, plenty of food, dancing and a little karaoke by some!

Start planning now to attend the conference in Ottawa, September 19th-21st, 2014. The local Ottawa chapter is organizing the event to be held at the Fairmont Chateau Laurier. The annual Urological Excellence Conferences are a great way to network with other nurses in the field of Urology as well as maintain necessary educational requirements. Keep your eyes on the UNC web site at www.unc.org for more up to date conference news.

By Nancy Carson RN, NCA
NB Provincial Rep.
UNC Award Winners

2013 Award of Merit presented by Fran Stewart to Liette Connor

2013 UEC Attendance Award Winners with Fran Stewart. Left to right: Susan Marsh, Vickie Williams, Fran Stewart, Jo-Anne Billings and Sue Hammond.

Winning Poster was awarded to Yvonne Appah. Katherine Moore and Liz Smits accepted in Yvonne’s absence. Posters were reviewed & winner chosen by Emmi Champion and Lisa Lynch

UNC National Sponsors

All of our National Sponsors were presented with plaques to recognize their generous support of the UNC.

Allergan - Gold Sponsor

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Laborie - Bronze Sponsor

1st Joint Conference of the Urology Nurses of Canada & the Canadian Nurse Continence Advisors

“Merging into a New Frontier”

September 18th - 20th, 2014

Ottawa, ON

Call for Abstracts opens in January!

Please visit www.unc.org to submit yours!

Submission deadline is February 28th, 2014.
Kingston Chapter News

The Kingston Chapter continues to be active in education. After the summer break we held a meeting with the Chief resident- Dr. Greg Roberts who presented on “Renal Stone Updates and Lithotripsy”.

In October we had a change in the UNC executive: Incoming President Kerri-Lynn Kelly R.N. NCA, Treasurer - Jennifer Lam RPN, and Secretary stays the same with Angela Leduc RN, NCA. We look forward to their fresh ideas and leadership.

The October meeting included presentation from the attendees at UEC Saint John N.B. Janet Giroux, Chris Greenlees, and myself. We shared the education that we learned and also went over the new website. It was great to share the other presentations through the additions on the website.

We are busy planning our annual Spring Evening Conference, to be held April 8, 2014. The main theme is oncology in the Urological population. The speakers are Dr. Mike Brundage - Radiation Oncologist, and Dr. Jason Izard - Urologist.

Sylvia Robb R.N. CCRP
Past President- Kingston Chapter

Edmonton Chapter News

The Edmonton chapter will be hosting “Urology Daze” 2014 on April 11, 2014 @ the Chateau Louis. Plans are well under way for this annual event. It has always been well attended in the past and we look forward to another successful day!

By Liz Smits
UNC Vice - President West

Victoria Chapter News

The Victoria Chapter is planning an evening Education Session for January. The chapter is once again starting to grow and revitalize after many of its members retired or moved on. We hope this will be the first of many such events!

By Jill Jeffery
UNC Treasurer

Cancer Support Groups

When individuals experience a diagnosis of cancer they deal with it by relying on two things: their own coping skills and the support systems around them. Family and friends are the most immediate source of support. It is not uncommon though for people to want to connect with others who have personal experience with the disease and in recent years we have seen the emergence of several national cancer support groups related to urology.

Initially support groups provide mutual support where people share common experiences, challenges and draw from the wealth of knowledge. There is help with transition from the old normal to the new normal and dealing with the loss of something that defines the individual, in other words the facts, feelings and future. The focus is mutual emotional support. Once these needs have been met, cancer patients often want to continue to be connected and now give back. The purpose has changed. Advocacy, education and fundraising become the focus.

The following is a mission statement of a cancer support group:
1. To provide support and enhance communication opportunities between patients and families.
2. To serve as an information source on the specific cancer.
3. To interact with the health community.
4. To cooperate with other groups with mutual interests.
5. To promote awareness of the specific cancer.

The goals of cancer support groups are achieved in many different ways. Local monthly meetings are common. Here, newcomers can meet the experienced survivors and be mentored; speakers from the health community give talks on topics pertinent to the specific cancer thus providing reliable information and social activities are arranged. Regional symposiums, conferences and retreats are organized, newsletters are circulated in larger cities and websites with local information are available.

Often the local websites are linked to national sites. The networking is extensive. Promotion of awareness reaches out to the local community. One group has developed a standard presentation on awareness. Members present to Rotary, Lions, church groups, steel workers, firefighters, government workers, and hockey teams, anybody who will listen. Tens of thousands of people are being informed and made aware by just one support group.

Here is a list of national websites for specific urology cancers with links to local groups:
1. Prostate Cancer Canada Network www.prostatecancernetwork.ca
2. Kidney Cancer Canada www.kidneycancercanada.ca
3. Bladder Cancer Canada www.bladdercancercanada.org

Kidney Cancer Canada even has a nurses’ network. You can become a member at www.kidneycancercanada.ca/kccnn

Benefits include the latest news in kidney cancer, updates on educational opportunities, clinical practice tools, nursing resources, patient resources, a members-only discussion forum and a directory of members for networking.

Support groups provide comfortable environments where interested men and women can learn about their specific cancer and form networks to share their learning with both the group and community.

Susan Hammond RN
NL Provincial Rep
TRUS STUDY

The TRUS study was initiated at Trillium Health Partners, the Credit Valley site in 2012 by Dr. Frank Papanikolaou. The goal of the study is to assess the prevalence of ciprofloxacin resistant bacteria in the patient population undergoing a Trans Rectal Ultrasound (TRUS) guided biopsy, and the potential risk factors which may make a person more vulnerable to carrying the resistant bacteria.

With the rise in prostate cancer, the percentage of TRUS guided biopsies to detect cancer has increased. Using fluoroquinolone antibiotics (usually Ciprofloxacin) before and after prostate biopsies decreases the number of possible infective complications. However the overuse of fluoroquinolones (commonly used to treat urinary tract infections), has lead to an increase in bacterial resistance to drugs of the fluoroquinolone class.

The purpose of the study is to:
- Determine the prevalence of carriage of ciprofloxacin resistant intestinal organisms in patients undergoing prostate biopsy.
- Determine risk factors for carriage of these resistant bacteria.
- Determine the rate of complications post biopsy during the study period.
- Treat patients who have ciprofloxacin resistant intestinal organisms with alternative anti-microbial medication.

The urologist ordering the TRUS biopsy informs patients about the study. The study is voluntary, offered to all patients who will be undergoing a TRUS guided biopsy. If the patient consents to the study they are provided with study information which informs them of the purpose, procedures, benefits, discomforts, risks and precautions associated with the study. It also explains that the patient has the right to refuse to participate.

An appointment is then scheduled for the patient with the study nurse, at a date prior to TRUS biopsy. Patients who consent to the study will be asked to complete a patient questionnaire and will have a rectal swab performed by the study nurse. The questionnaire will assess if the patient has any potential risk factors which may make a person more vulnerable to carrying the resistant bacteria. The rectal swab is sent to the Lab to determine if any resistant bacteria is present. If any are present, the patient will be given an alternate antibiotic regimen of IV Meropenem or Ertapenem, pre TRUS biopsy to prevent infection after their procedure. If the patient does not have any resistant bacteria they will be given the standard ciprofloxacin treatment. The rest of the biopsy procedure will remain the same in either case. Six weeks after the biopsy, patients are contacted by phone for a follow up interview to identify any complications after their biopsy. The study nurse determines if the patient had any symptoms of fever, pain or difficulty voiding post procedure. The nurse also asks if the patient required follow up with a urologist, family MD, ER, or walk in clinic for any reason.

The target number is 580 participants from the Greater Toronto Area to take part in this study over a two year period. To date the number of study patients recruited at Trillium Health Partners has been 286.

There is also an optional TRUS sub-study group for self-swab. This sub-study is being done to determine the following:
- if there is less discomfort if the study participant performs a self swab compared to the discomfort felt by having another individual perform the swab; and,
- if there is a difference in accuracy in determining the bacteria between the study nurse collected swab and participant collected swabs; and,
- if there is an increase in efficiency for the study participants to collect the rectal swabs themselves.

This sub group has two swabs collected from the participant; one self-collected and the other by the study nurse. In order to remove any bias, the order of who collects the first swab (study nurse or participant) will alternate with every participant. For example, participant 1 will have their first swab collected by the study nurse and then will be asked to perform a self-collected swab. Participant 2 will perform a self-collected swab first and then the study nurse will collect the second swab. The study nurse is not present while the participant is performing the self swab. In addition to being provided with prior verbal instruction by study personnel on how to perform the swab, there is also a diagram provided to the participant to help guide the self-swab method. The self-swabs and the nurse collected swabs will be labeled with different identifiers which only the research team will know. All swabs are sent to the lab where they will be processed. Once processed the research team will be able to compare whether or not the self-collected swabs show a similar result as the swabs collected by the study nurse. The goal is to have 141 participants participate in the sub-study. The benefits of self swab include patient convenience, increased patient comfort, cost savings, one less hospital visit and more timely results.

All study data collected by the study team will be analyzed and used for research purposes. Patient’s personal information is kept confidential and private. The Research Ethics Board oversees the ethical conduct of this study at Trillium Health Partners. It is expected that the study results will be completed and published two years from the start. To date approximately 30% of patients enrolled have been found to be positive for ciprofloxacin resistance and have had tailored prophylaxis treatment prior to their TRUS biopsy. I look forward to sharing the final outcomes with you in the near future.

Jo-Anne Billings RN
Trillium Health Partners, the Credit Valley Hospital Site
Primary Nurse Urology Ambulatory Care
While at the excellent UNC conference in Saint John in September, I was asked by several people what my specialty in urology was. I had never really spent much time thinking about this, until I had been asked by more than one person. Since my return home to Dartmouth, I have spent quite a bit of time thinking about it, and have talked to a couple of colleagues about it as well.

I have worked in urology for my entire career, close to thirty years, and have seen tremendous advancements in this time. The more I think about it, what I consider to be my “specialty” has not changed. My specialty is seeing people first, and patients second. I have been blessed with an excellent memory for names, and faces (just ask my coworkers!). I often remember great detail about patients’ lives that they have shared with me over the years. It makes them feel less nervous if you speak with them about their spouses, children, jobs, or whatever in the course of finding out about changes in the urology conditions as well. Time-wise, in our outpatient clinic, we don’t often have a lot of extra time to do this talking, so I see it as a talent to be able to make these connections with people in a short period of time.

Nursing has made immense advancements over the years of my career, but sometimes I feel something has been lost. People still need to feel they are cared for and important, especially when they are at their most vulnerable. A kind word, a soft touch to the arm, or an aside to make someone chuckle; can have a positive, long-lasting effect. We have to remember that patients are people first, always, and not their conditions (the bladder tumor in room 3, or the neobladder in room 6).

I think it is wonderful all the career advancements that are available to nurses now, but also think we need to remember the importance of nursing as a caring, giving profession.

Vickie Williams RN

Getting To Know Our UNC Members

Specialties?

The Urology Nurses of Canada extends an invitation to all nurses and allied health interested in urologic nursing to join the association.

The Urology Nurses of Canada is a National Association whose mandate is to enhance the specialty of urologic nursing in Canada by promoting education, research and clinical practice.

The activities of the Urology Nurses of Canada are designed to enrich members’ professional growth and development.

The UNC hosts an annual conference each fall and convenes for an educational meeting at the Canadian Urological Association annual meeting each June.

Membership in the UNC entitles you to receive 6 issues of Urological Nursing Journal, 2 issues of Pipeline, Annual Urological Excellence Conference information and discount on registration, UNC Membership Directory, web access to the UNC Constitution, UNC Standards of Urologic Nursing Practice and your personal access to UNC reports on the web.

For more information about UNC, contact: Gina Porter, Membership Coordinator at membership@unc.org or visit www.unc.org.

UNC Awards Program

Each year the Urology Nurses of Canada invite their membership to apply for the following awards:

The Research Award. This award is valued at $750.00 and is presented at the annual UEC. It has been provided by the generous support of our national corporate sponsors. Please refer to the criteria for further information.

The Scholarship Award. This award is valued at $750.00 and is presented at the annual UEC. It has been provided by the generous support of our national corporate sponsors. Please refer to the criteria for further information.

Two Nursing Education Initiative Awards, valued up to $500.00 each. This award is a reimbursement program providing financial assistance to Urology Nurses of Canada (UNC). These grants are available to support nurses engaging in continuing educational events for the enhancement of knowledge, professional skills and patient outcomes specific to the practice of urology. Funding of up to two awards is provided by the generous donations of national corporate sponsors and donations from UNC members.

There is no deadline to apply for this award.

Up to five UEC Attendance Awards, also valued at $500.00 each. This award is a reimbursement program providing financial assistance to Urology Nurses of Canada (UNC) members to attend the annual Urological Excellence Conference. Funding for this award is provided by the generous donations of national corporate sponsors.

The deadline to apply for this award was May 15, 2014. Those who win the award will be notified by June 15, 2014.

The Award of Merit - recognizes the individual who has made a significant contribution to the UNC. Please refer to the criteria for further information.

The UNC Chapter Award for new local chapters. The UNC will award $200.00 to a chapter that wishes to assist in starting another chapter. The award may be used for renting a room, providing food, acquiring a speaker or advertising. A letter requesting the award must be accompanied by a plan on how the award will be used.

All applications must be type written and/or sent electronically to vpcentral@unc.org. All award applications and criteria are available on the UNC web site at www.unc.org. Applicants will be contacted upon receipt of application.

The UNC is committed to developing, disseminating and implementing new knowledge in practice. We achieve excellence in clinical practice by encouraging and supporting our membership in their participation in research, knowledge acquisition and academic achievement.

If you have any questions regarding the awards please contact Sylvia Robb at vpcentral@unc.org.
I have come to the realization that, to quote Aristotle: “The more you know, the more you know you don’t know”. This epiphany occurred after I recently attended a lecture on prostate cancer at the UNC annual meeting in Saint John, N.B.

Having been a urology nurse for many years, I was quite familiar with prostate cancer and the many changes that have taken place in diagnosis and treatment. This lecture however caused me to reflect on the changes I have personally witnessed, and how these changes affected my role as a nurse. I have always seen my nursing role as a patient advocate, who not only assists in the physical care for my patients, but just as importantly, helps them emotionally, and assists in the understanding of their diagnosis and treatment options. After the lecture, my epiphany was that I am more unsure of my knowledge of prostate cancer now than I have ever been...so much has happened.

There are so many options today that it is difficult to explain it to my patients. Back in 1976, when my urology career started, it was easy. My most vivid memory of prostate cancer patients was handing out “little pink pills”, to almost all of the men, because this was pretty much the only treatment available. These pills were diethyl stilbesterol, 5mg; the female hormone that decreased testosterone levels in men’s bodies to slow the progression of the cancer. There were many side effects, especially cardiovascular, but it was the only treatment available besides orchietomy. This was often necessary because most men weren’t diagnosed until the disease had spread beyond the prostate. It was straightforward and easy to understand, and pretty much the norm until around 1989, when things began to change. PSA was discovered - prostate specific antigen, a blood test to identify prostate cancer before it had spread beyond the prostate, so patients could be treated for a cure.

It was almost an information explosion. Radical retropubic prostatectomy and radical external beam radiation could be done for a cure. Around 1990, something else happened. Those little pink pills were replaced by injections, LHRH agonists were approved. These were needles that suppressed the production of male hormones. These too had side effects, but nothing like those pink pills, and over the next several years, the following occurred:

- **1991**: Transrectal ultrasound and biopsy. This replaced the needle with the old finger cot. It helped with earlier and more exact diagnoses.
- **1994**: Brachytherapy; The insertion of radioactive pellets into the prostate that could radiate for cure.
- **1995**: Anti androgen pills were introduced.
- **1995**: The first prostate cancer support group meeting was held in Halifax. Patients began asking more questions about their disease. As well, they began looking into the psychological and social effects of prostate cancer on patients and their families.
- **1999**: Conformal radiation was made available in N.S. Doctors were able to use larger amounts of radiation that went specifically to the prostate, avoiding areas of the bowel and bladder.
- **1999**: PDE5 inhibitors were available for erectile difficulties.

By 2003, when I attended the UNC conference, hosted in Saint John, N.B., it was easy to assist patients to understand investigation and treatment choices. Every man was encouraged to have a PSA test by the age of 50, and if the PSA was elevated, cancer was diagnosed by a biopsy. He was given a choice of surgery or radiation. It was quite straightforward for a nurse to explain the pros and cons of each and to help guide him and his family to a decision. But since then, not so...

Since that 2003 conference, patients are on the internet reading and questioning. There is a debate over who should have a PSA. Should it ever be done? At what age? After discussion re the pros and cons with the ordering doctor? Then, if it is elevated, and a TRUS and biopsy confirm cancer, where to from there? Gleason scores, PSA doubling times, free and total PSA, more biopsies, active surveillance, HIU, Brachytherapy, clinical trials, radical prostatectomy, robotic prostatectomy, radiation, androgen -deprivation therapy (and if so, before radiation/surgery or after?) And for how long? Intermittent androgen blockade?

Patients read about this on the internet, and it can be very confusing for them. They don’t realize that much of it does not apply to them. They go to support groups and compare their diagnosis and treatment to other patients, and don’t understand they are comparing apples to oranges. Many men do not understand that their disease can’t be compared to another’s. Their treatment is dependent upon their age, Gleason score, and their personal wants and needs.

Trying to help patients in 2013 to understand prostate cancer is no easy task. Yes, we have come a long way since that conference in Saint John, in 2003, and definitely since I started urology nursing in 1976. What has helped me however, is writing this article, sitting, thinking and reflecting on the subject. I realize I will never know all the answers, but it is important to know what is available and new. Attending conferences, meetings and seminars; reading and having numerous colleagues across Canada that you can depend on to help you when you have concerns and questions. It was great to see so many of these colleagues, familiar faces, and meet some new ones at the UNC conference in Saint John. I wonder how things will have changed when they host again in ....2023!

Susan Marsh RN

### How to form a local UNC Group

1. Contact nurses and allied health in your area interested in Urologic Nursing.
2. Pick a topic and a speaker (for initial meeting).
3. Book meeting room
4. Contact local sales rep for potential support of meeting.
5. Advertise meeting and distribute information about the UNC.
6. Create local executive e.g. chairperson, secretary, treasurer.
7. Organize educational meetings/events.
8. Contact UNC provincial representative regarding local business meetings.
9. Encourage submissions of articles and upcoming events to “The Pipeline”.

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### UNC Representatives 2013-2014

#### UNC Executive

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<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>President</td>
<td>Frances Stewart</td>
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<td>Past President</td>
<td>Susan Freed</td>
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<td>Vice-President West</td>
<td>Liz Smits</td>
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<td>Vice-President East</td>
<td>Frankie Bates</td>
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<td>Vice-President Central</td>
<td>Sylvia Robb</td>
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<td>Membership</td>
<td>Gina Porter</td>
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<td>Sponsorship</td>
<td>Frances Stewart</td>
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<td>Treasurer</td>
<td>Jill Jeffrey</td>
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<td>Secretary</td>
<td>LuAnn Pickard</td>
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#### UNC Provincial Representatives

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<th>Region</th>
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<tr>
<td>West</td>
<td>British Columbia</td>
<td>Wendy Simmons</td>
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<td>Alberta</td>
<td>Linda Brockmann</td>
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<td>East</td>
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<td>Nova Scotia</td>
<td>Emmi Champion</td>
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<td>Newfoundland and Labrador</td>
<td>Sue Hammond</td>
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<td>Prince Edward Island</td>
<td>Kim Smith</td>
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#### Local Chapter news info: www.unc.org

**Victoria Info:** Jill Jeffery - Tel: (250) 658-5632

**Edmonton Info:** Liz Smits - Tel: (780) 407-6154

**Calgary Info:** Melisa Leslie - melisa.leslie@albertahealthservices.ca

**Regina Info:**

**Toronto Info:** Frances Stewart - bladderqueen@hotmail.com

**Kingston Info:** Sylvia Robb - Tel: (613) 548-7800

**Ottawa Info:** Susan Freed - freedoms@teksavvy.com

**Montreal Info:** Raquel DeLeon - raquel.deleon@muhc.mcgill.ca

**New Brunswick Info:** Gina Porter - gina.porter@horizonnb.ca

**Halifax Info:** Emmi Champion - emmi.champion@cdha.nshealth.ca

**Newfoundland Info:** Sue Hammond - Tel: (709) 368-0101
Coming Events

Urology Daze 2014
April 11, 2014
Chateau Louis Conference Centre
11727 Kingsway
Edmonton, AB
Keep the date open and watch for more information.

69th Annual CUA
June 28th to July 1st, 2014
Delta St. John’s,
St. John’s, NL
www.cua.org
Nurses meeting at CUA
Details to be announced

1st Joint UNC & CNCA Conference
Merging into a New Frontier
September 18th - 20th, 2014
Fairmont Chateau Laurier
Ottawa, ON
www.unc.org

44th Annual ICS 2014
October 20th - 24th, 2014
Rio de Janerio, Brazil
www.iscoffice.org

2014 Annual CANO/ACIO
October 26th - 29th, 2014
Hilton Quebec
Quebec City, QC
www.cano-acio.ca

Society of Urologic Nurses and Associates:
SUNA Annual Conference
October 31st to November 3rd, 2014
Disney’s Contemporary Resort,
Orlando, FL, USA
www.suna.org
find SUNA on facebook-
www.facebook.com/UrologicNursing

WHAT DO ALL THESE ABBREVIATIONS MEAN???

AUA - American Urologic Association
AQIIU - Association Québécoise des Infirmières et Infirmiers en Urologie.
CANO/ACIO - Canadian Association of Nurses in Oncology
CJA - Canadian Urologic Association
ICS - International Continence Society
NCA - Nurse Continence Advisor
PCCN - Prostate Cancer Canada Network
SUNA - Society of Urology Nurses of America
UEC - Urological Excellence Conference
UNC - Urology Nurses of Canada

If your chapter or organization has an upcoming event that you would like to advertise in the Pipeline, submit the information with contact email to uncpipeline@hotmail.com