ABSTRACT

INTRODUCTION: Continuous bladder irrigation (CBI) is often used to help manage hematuria and might be optimized by adding suprapubic inflow to increase urethral outflow. The objective of the present investigation was to develop an experimental model that would reliably measure urethral outflow through a 3-way transurethral catheter (UC) with and without the addition of suprapubic inflow using a variety of suprapubic catheters (SC) of different size combinations (Bard).

METHODS: A 1 L intravenous bag (Hospira, Inc.; Lake Forest, IL) was modified by inserting a 3-way UC into its outflow spigot and a 2-way SC into the front of the bag. The urethral outflows for each size of UC were measured in various combinations of 18F, 20F, 22F, and 24F 3-way UC with and without added inflows from 12F, 14F, and 16F 2-way SC. Water was used as the irrigant for both the urethral and suprapubic catheters and was drained by gravity from 3 L bags from a height of 140 cm. Urethral outflow was measured with a Dantec Urodyn 1000 uroflowmeter. Each run was done 5 times using outflows of at least 150 cc over at least 75 seconds. Means were compared by paired t test.

RESULTS: Three-way 18F, 20F, and 22F UC showed no significant or minimal improvement in outflows by adding 12F, 14F, or 16F suprapubic inflows. None of these 3-way catheters were able to handle the extra inflow from a 16F suprapubic catheter and the “bladder” became overly distended (OD). Three-way 24F UC showed maximal improvement in outflow when combined with 14F or 16F suprapubic inflows; OD was not a problem.

CONCLUSION: Additional inflow from a 14F or 16F SC will maximally increase urethral outflow by at least 3.6 cc/second only when combined with a 24F 3-way UC.

KEY WORDS: Continuous bladder irrigation; Transurethral catheter; Suprapubic catheter; Three-way catheter; Hematuria.

INTRODUCTION

Despite the best efforts of medical professionals, some patients develop urinary tract bleeding associated with recurrent clot retention that is not easily controlled. Initial management includes evacuation of clots, fulguration of bleeding sites, insertion of a larger 3-way transurethral catheter, beginning
continuous bladder irrigation (CBI) with or without chilled irrigant, and traction on the catheter [1] plus correction of abnormal bleeding parameters. Typically, the bleeding follows a transurethral resection of the prostate (TURP) or retropubic prostatectomy and fortunately is uncommon. When the bleeding cannot be controlled endoscopically, some urologists try to optimize the CBI by adding suprapubic inflow to increase urethral outflow in order to reduce clotting in the bladder. There is no other literature available which addresses this topic.

The objective of the present investigation was to develop an experimental model that would reliably measure urethral outflow through a 3-way irrigating transurethral catheter, with and without the addition of suprapubic inflow. The authors used a variety of catheters of different size combinations (Bard) in order to determine the optimal suprapubic and transurethral catheter combination that would maximize the CBI.

METHODS

An empty 1 L intravenous bag (Hospira, Inc; Lake Forest, IL) was modified by inserting a 3-way transurethral catheter into its outflow spigot and a 2-way suprapubic catheter into the midportion of the front of the bag; different bags were used for each test. Thirty cc were placed in the balloon of each 3-way catheter and 5 cc in the balloon of each 2-way catheter. The urethral outflows were measured for each of various combinations of 18F, 20F, 22F, and 24F 3-way transurethral catheters with and without added inflows from 12F, 14F, and 16F 2-way suprapubic catheters. Water was used as the irrigant for both the transurethral and suprapubic catheters and was drained by gravity from 3 L bags from a height of 140 cm. Transurethral outflow was measured with a Dantec Urodyn 1000 uroflowmeter. Each run was done 5 times using outflows of at least 150 cc over at least 75 seconds and was compared by paired t test.

RESULTS

Table 1 shows the mean outflow in cc/second from the 3-way transurethral catheter with its inflow alone and with the addition of suprapubic catheter inflow for a variety of catheter size combinations. Combinations that were significantly different at P ≤ .01 are indicated on the table with an asterisk. Three-way 18F, 20F, and 22F catheters were unable to handle the extra inflow from a 16F suprapubic catheter and the "bladder" became over-distended (OD). Therefore, when using a 3-way 24F outflow catheter, the statistically significant gains of 3.6 and 5.9 cc/second with the 14F and 16F inflow catheters, respectively, were considered the best results for clinical application.

DISCUSSION

Bladder irrigation is a procedure in which sterile fluid is used to prevent clot retention by continuously irrigating the bladder via a 3-way transurethral catheter. It is used typically in the early postoperative period following TURP. Infrequently, the bleeding from small vessels and open venous sinuses can be problematic and not controlled by simple CBI. This may require a return visit to the operating room for definitive evacuation of clots and fulguration of bleeding areas.

Use of a transurethral catheter with a greater cross-sectional port [2] with or without chilled irrigant and/or catheter traction may help but, uncommonly, the bleeding continues to be problematic. It is in this circumstance that the addition of suprapubic inflow placed via a percutaneously-placed catheter may be used to maximize outflow and reduce clotting within the bladder.

The results of the current study show that a 14F or 16F suprapubic catheter will maximally increase urethral outflow by at least 3.6 cc/second only when combined with a 24F 3-way transurethral catheter. The results may be different in the human experience due to vagaries of bladder compliance, particulate matter in the urine, and hematuria with clots.

It is not recommended that a suprapubic catheter be inserted when there is evidence of urothelial malignancy because of the risk of tumor seeding. In other circumstances, it provides a safe and effective means of optimizing CBI when the appropriate-sized catheters are used.

CONCLUSION

Additional inflow from a 14F or 16F SC will maximally increase urethral outflow by at least 3.6 cc/second only when combined with a 24F 3-way UC. This has the potential to offer urologists a new and specific means of reducing problematic clotting in the bladder.

Conflict of Interest: none declared

REFERENCES


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<tr>
<td></td>
<td>Without</td>
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<tr>
<td>18F</td>
<td>1.7</td>
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<td>20F</td>
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<td>22F</td>
<td>3.3</td>
<td>4.2</td>
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<td>24F</td>
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Extended Spectrum Beta Lactamases (ESBL)

Fact Sheet for Health Care Workers

What is Extended Spectrum Beta Lactamases (ESBL)?

Extended spectrum beta lactamases (ESBLs) are enzymes produced by some gram negative bacteria that can inactivate a wide range of antibiotics particularly penicillins and cephalosporins. E. coli and Klebsiella are the organisms most frequently associated with ESBLs. Colonization of the gastrointestinal tract is the most common presentation and less frequently the respiratory tract. The urinary tract and wounds are the sites most frequently infected with ESBLs. ESBL have been present in Europe and the USA since 1983. Only recently have these bacteria been detected in Canada in low, but increasing numbers.

What to look for (signs and symptoms of ESBLs)?

Most people with ESBL have no symptoms (asymptomatic). For the few people who develop symptoms of urinary tract infection, wound infection, pneumonia or blood infection, antibiotics should be used. ESBL infections present in the same way as non-ESBL-producing organisms. These infections can be serious; therefore, knowing a person has ESBL is important to ensure the most appropriate treatments are prescribed.

How is ESBL transmitted (spread)?

Poor personal hygiene, especially after using the washroom, can spread these bacteria. The spread of ESBL in a facility occurs most commonly through direct contact with someone who has ESBL contaminated environment, or on the hands of health care providers.

Careful cleaning of areas that might be touched by hands is important to reduce the spread of these organisms in a facility.

How is ESBL detected?

The laboratory can identify ESBL either by a screening swab of rectum that is ordered by the physician or Infection Control Practitioner or by a clinical specimen obtained from an infected individual. Laboratories perform tests to determine which antibiotics will be effective or not effective for treatment.

Who is at risk?

Patients: Some patients are at higher risk for acquiring ESBL. Some risk factors are:

- Prolonged hospital stays in a health care facility where ESBL cases have been reported.
- Treatment with antibiotics, especially cephalosporins.
- Recent surgery.
- Instrumentation (IV and urinary catheters).
- Prolonged hospitalization and/or admission to a high-risk unit.
- Exposure to patients with ESBL.
- Exposure to ESBL contaminated equipment.

Residents: LTC Residents can be at risk of ESBL. Some risk factors are:

- A hospital stay greater than 24 hours.
- Exposure to an ESBL positive person.
- Exposure to ESBL contaminated equipment.

(Continued on page 7)
It is time to recognize that “special” UNC nurse in your group. The one who has done that “extra something” for your chapter, your workplace, or your community.

Each year UNC proudly and publicly recognizes an individual who has made significant contribution through education, research or clinical practice or has achieved distinction through excellence in UNC promotion, UNC mentoring or other enhancement of the UNC Mission.

We have some exceptional people within our ranks and they need to be recognized.

The Award of Merit will be presented at the Urological Excellence Conference in Edmonton, Alberta.

Awards available are:

**Editorial Award**
This award will be given to a UNC member who has written an article, paper or editorial that has been published in the past year and has not been previously published.

**Research Award**
This award is available to a UNC member proposing research related to urological nursing practice in one of the following sub-specialties: urodynamics, biofeedback, endourology, sexual health, uro-oncology or incontinence.

**Scholarship Award**
This award is available to a UNC member who wishes to further his/her education as related to the practice of nursing.

This year $1000 will be granted for each of the Editorial, Research and Scholarship awards. These awards are made available through unrestricted educational grants given via our Corporate sponsorship Program.

The deadline for applications is August 31, 2010.

**Urology Nurses of Canada**
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 now entitles you to receive 4 issues of Urological Nursing Journal, 2 issues of Pipeline, Annual Urological Excellence Conference information and discount on registration, UNC Membership Directory, UNC Constitution, UNC:

Standards of Urologic Nursing Practice and your personal access to UNC reports on the web.

For more information about UNC, contact: Nancy Carson, Membership Coordinator at membership@unc.org or visit www.unc.org.
UNNC Info

UNC Representative 2009-2010

UNC Executive

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UNC Provincial Representatives

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Local Chapter news info: www.unc.org

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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 “Pipeline”.

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2010 PCCN Conference

September 22 - 25, 2010
Toronto, Ontario
The Royal York Hotel

The seventh annual PCCN national prostate cancer conference will be held this year between September 22 and September 25 at Toronto’s Royal York Hotel, so mark your calendars.

As in past years, the conference is an opportunity to display the unity of purpose necessary to raise public awareness and sustain and enhance the research, health initiatives, and support group activities that will win the fight against this disease. To that end, PCCN 2010 brings together prostate cancer survivors and their friends and family, medical practitioners and researchers, policy makers, and those involved in prostate cancer support group administration and in prostate cancer awareness and fundraising campaigns. This network, the Prostate Cancer Canada Network, is key to improving the odds for the approximately 25,000 Canadian men who are diagnosed with prostate cancer each year.

if you would like to learn more about the conference, register, or be a guest, please contact Helene Vassos, Director of Community Development, Prostate Cancer Canada by email or by telephone (416 441-2131 ext. 264).

Kingston Chapter News

We had a very successful chapter meeting in March with 2 speakers on Prostate Cancer. Dr. Robert Siemens spoke on Treatment options and Dr. Naji Touma spoke on Surgical options, including the robotic prostatectomy. The event was held at an outside venue and was sponsored by Paladin. We had an excellent turnout with 25 Health Professionals.

In May we held a Fundraising Book Sale for education and travel to the National meeting. We raised $740. Some of our physicians hopped on board and gave monitory donations.

Looking forward to seeing everyone in Nfld.

Sylvia Robb R.N.
President UNC-Kingston chapter

Halifax Chapter News

Our Annual Dine and Learn event was held on April 14, 2010. 65 nurses attended, from the surrounding area of Halifax. Our registration is free, provides a 3 course meal, and 3 guest speakers. We are talked about UTI from kids to adults, OAB in men mostly post TURP and Interstitial Cystitis. The costs for all this are paid for by the generosity of several of our drug reps. By dividing the cost it is quite cost efficient and a good way to get 60 plus nurses together once a year. We have for door prize 4 free memberships to the UNC as incentive to join.

Liette

more chapter news on page 10
Community: Healthy people living in the community are at low risk for getting ESBL infections.

Health care worker/Staff:
Health care workers are not usually at risk for ESBL infection. The chances of infection with ESBL do not increase even if you have been in contact with an individual with ESBL, e.g. at work. If you are immunocompromised the risk is still very small. Pregnant women who are otherwise healthy are not at increased risk of acquiring ESBL.

How is ESBL treated?
Treatment is only necessary for people with symptomatic infections. Consultation with an Infectious Disease specialist is recommended for those with symptoms of infection with ESBL. There is no effective way to “treat” asymptomatic colonization with eradication therapy. Carriers can frequently clear this organism without any treatment.

What are the Infection Control considerations?
Routine practices for all settings and contact precautions for acute care settings are required to limit the spread of microorganisms. Key points include:

- Hand hygiene with soap and water or alcohol-based hand sanitizer before and after contact with every patient/resident/client.
- Good environmental cleaning, including patient/resident/client equipment.
- When gloves are used, they must be changed and hands washed, between procedures performed on patients/residents/clients.

Special attention to environmental cleaning is required as ESBL can live in the environment for long periods if cleaning is not performed (days to months).

To reduce the risk of ESBL transmission in a health care institution, known ESBL positive patients/residents may be placed on contact precautions as directed by IPC. Refer to facility’s Infection Control Manual for details on routine practices and contact precautions.

Screening of contacts if required in a health care institution will be directed by IPC and/or Occupational Health. Environmental culturing is not recommended unless directed by IPC. Healthcare workers are not screened for ESBL unless a worker is linked to patient transmission. Good hand hygiene is the best way to prevent the spread of these organisms.

ESBL:
Extended Spectrum Beta Lactamases are bacterial enzymes with the ability to inactivate beta-lactam antibiotics, especially penicillins, ampicillin and cephalosporins, including extended spectrum. ESBLs are produced most commonly by *E. coli* and *Klebsiella pneumoniae*, but may be produced by other gram negative bacteria as well.

2.8.3 ESBL
ESBL-producing organisms are commonly isolated from urine, wound or skin and feces but have also been found in blood and the respiratory tract. A recent study by Apinsarthanarak et al. suggests that the length of time of colonization was not highly associated with baseline demographic or clinical characteristics, type of organism or severity of illness. However those who received oral antibiotics after discharge from hospital had significantly longer duration of colonization (154 days vs. 56 days). Recent experience in one British Columbian Health Authority suggests that colonization does not persist in those who have had treatment with clinical resolution and are otherwise in good health while others who are immunocompromised or have other co-morbidities may have persistent colonization after appropriate antibiotic treatment and clinical resolution. The proportion of those colonized with an ESBL who develop an infection is unknown.

3.11.3 Specific Treatment for ESBLs
Antibiotic options in the treatment of ESBL-producing organisms are limited. It is recommended that clinicians consult with a medical microbiologist or Infectious Disease specialist for assistance with treatment options. While most ESBL-producing bacteria remain sensitive to carbapenems, indiscriminate use of these antibiotics may lead to increased levels of resistance. 24,25,26

16. Apinsarthanarak, A., Bailey, T., & Fraser, V. Duration of stool colonization in patients infected with ESBL-producing *Escherichia coli* and *klebsiella pneumonia*. *Clinical Infectious Diseases*, 2008;(45); 1322-33

It's time to talk about it….Testicular Cancer

Over the years as a Urology Nurse, I have seen many young men diagnosed with Testicular Cancer, mostly treated successfully surgically and/or with Chemotherapy. As I get older, I see these young men in a different light. I now have a son in law, and his son to think about. Testicular cancer tends to occur in men ages 15-35, but can occur at any age. Men in this age group are generally healthy and may not have regular contact with health care professionals.

As with most cancers early detection can result in a complete cure and less intrusive treatment. Testicular self examination performed monthly may help detect testicular cancer.

The cause of testicular cancer is unknown. Some patients have a history of an undescended testicle. There may be a family predisposition.

Signs and symptoms include; a painless lump in the testis, an enlarged testicle, a feeling of heaviness in the scrotum. Rare symptoms include; hormonal imbalance that may cause breast enlargement, back pain or abdominal mass of nodes and shortness of breath due to spread to lungs (uncommon). Health professionals must follow up on any of these signs. Very few benign tumours are found in the testes so all lumps should be checked immediately. Surgery is usually the first step and is required for diagnosis. Usually a unilateral radical orchidectomy is performed. Testicular prosthesis is available and it can be placed at the time of surgery, or at a later date.

The workup should include a complete medical history and physical exam. Lab tests include tumour markers, HCG (human chorionic gonatropin), AFP (Alpha feto protein), LDH (lactate dehydogenase). Ultrasound scanning of the scrotum may be helpful. Chest X-ray and CT scan of abdomen assess the extent of the disease elsewhere.

If the patient wants to bank sperm for future use, the Sperm bank may require that HIV, MRSA, and HPV testing are done.

There are several types of testicular cancer. Germ cell tumours are divided into 2 groups, Seminomas and nonseminomas. Seminomas are the most common form (50%) usually confined to the testicle and are very sensitive to radiation and/or Chemotherapy.

Nonseminomas usually occur in men in their mid-twenties and are less sensitive to radiation but very sensitive to Chemotherapy. Non seminiomas are composed of various cell types.

Non germ cell tumours are rare and usually treated surgically.

After recently seeing yet another of these patients, I starting looking into what is being done to help with early diagnosis and support for young men and their families and friends during this stressful event in their lives.

The Canadian Testicular Cancer Association publishes brochures, posters and kits for teaching self exam of the testicles.

Their goals are:

♦ increase Testicular Cancer Awareness,
♦ promote TSE (testicular self examination),
♦ distribution of information to schools, health professionals, hospitals
♦ produce a TV commercial to promote TSE,
♦ support research and clinical studies.

They have a web site with excellent information for health care workers, patients and families. The brochures and posters are available for distribution anywhere they may draw the attention of young men, or perhaps their partners.

Their website:
www.tctca.org

Email contact:
info@tctca.org
Urologic Information Site:

For reliable Urologic Health Information you can now tell your patients to go to:

www.uroinfo.ca

To read about...

- Kidney
- Bladder
- Prostate
- Sexuality
- Infertility
- Stones
- Pediatric urology
- and more…..

The information on this website has been written by physician members of the CUA. Their aim is to provide important, honest, and balanced information to our patients, their family members as well as the general public, regarding their urologic health. Information is available in English and French.

The Poster Presentation and Short Paper Awards are presented at the annual UEC. Information about submitting your Abstracts is on the website, and is sent out to members each year.

**Poster Presentation Award**

Presenters of posters at the annual Urological Excellence Conference are eligible for this award. The recipient of this will have demonstrated excellence in poster presentation and meet the pre-established criteria for posters. The recipient will receive a $100.00 award from UNC.

**Short Paper Presentation Award**

Presenters of short papers at the annual Urological Excellence Conference are eligible for this award. The recipient of this will have demonstrated excellence in presentation and meet the pre-established criteria for short papers. The recipient will receive a $100.00 award from UNC.

**ATTENTION!!!!**

Your UNC Pipeline is looking for articles. If you are a Nurse working with Urology patients, you maybe able to write about your experiences, observations or perhaps a case study. If you are a UNC member, you can submit your newly published article for the Editorial Award.

More info or send your papers to:

uncpipeline@gmail.com
The 65th Annual Meeting of the CUA - CHARLOTTETOWN 2010,

The CUA will be held this June 26-29, in Charlottetown PEI. As with recent years they have provided support and recognition of the UNC, in the form of registrations, space for the UNC Booth, and a designated meeting time. The Booth displays UNC information, Posters, membership packages, copies of Pipeline and the Urologic Nursing Journals.

The booth is manned by UNC Executive and Provincial Representatives.

Frances Stewart, UNC President and Dianne Heritz  
Urologist will be giving a talk on Pessaries at the Monday afternoon meeting, held from 1600-1800.  
We look forward to this event as an opportunity to Network with Urology Nurses, Urologists and Sponsors in an atmosphere of learning and camaraderie.

St. John’s Newfoundland Chapter News

23rd Annual Urological Excellence Conference
Will be held in:
St. John’s, Newfoundland
September 23-25, 2010

Brochures and registration will be coming soon
Check the web-site for the latest news and make your plans to attend.
www.unc.org

Hotel for the Conference
Delta St. John’s Hotel and Conference Centre
120 New Gower Street
St John's
Newfoundland, A1C 6K4
Phone 709-739-6404
Fax 709-570-1622
Toll-Free 1-888-793-3582

Your Executive

Colleen has worked as an RN in the O.R. @ Rockyview Hospital for 39 years. In charge of Urology since '86, and Nurse Clinician of Urology since '96 when all Urology in Calgary was regionalized to the Rockyview Hospital, now look after 15 Urologists.  
Joined the UNC in 1990 and attended her first UEC in ’91.  
Was also a member of AUAA (which became SUNA) and did my CURN in ’96.  
Started the Calgary chapter of UNC in 2000 and have been involved since.  
Served as UNC Provincial rep (Alta) for a couple of years starting in 2000 and then as VP west from 2002-2006 and from 2008 til present.

The Vice-President collaborates with provincial representatives to promote the UNC Mission, objectives and Membership. Liaises with UNC executive on Regional events research and educational initiatives. Assist with the programming and planning of the Urological Excellence Conference when held within their region. Promotes research recognition.

Contact
Email: vpwest@unc.org

VP West
Colleen Toothill
Coming Events

Canadian Urological Association
65th Annual Meeting
June 27 - 29 2010
Delta Prince Edward
Charlottetown, PEI
www.cua.org

Urology Nurses of Canada at the CUA Meeting
Monday June 28, 2010
1600-1800 hrs
Details tba
www.unc.org

23nd Annual Urologic Excellence Conference
September 23-25, 2010
Delta Hotel
St John’s, NF
www.unc.org

40th Annual ICS/IUGA 2010
August 23-27, 2010
Toronto, ON
www.iscoffice.org

Society of Urologic Nurses and Associates:
SUNA Annual Conference
Oct 8-11, 2010
Westin Boston Waterfront Hotel,
Bostson, MA.
www.suna.org

SUNA 2011 Annual Symposium
61st Annual Meeting
March 10-12, 2011
Marriot New Orleans,
New Orleans, LA

2010 Annual CANO/ACIO
September 12-15
Westin Edmonton
Edmonton AB
www.cano-acio.ca

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@gmail.com