The prevalence of incontinence in men of all ages is certainly lower than that for women. Large studies have indicated that there is a 3% to 11% overall prevalence rate of incontinence in the male population with urge incontinence being the prominent symptom reported in 40% to 80% of patients. (Nitti,VW, Rev Urol. 2001; 3 (Suppl 1): 52–56).

A Canadian Urinary Bladder survey demonstrated 16% of men and 33% of women over the age of 40 have symptoms of urinary incontinence but only 26% have discussed it with their family Doctor (The Canadian Continence Foundation).

According to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), male incontinence affects approximately 17% of men over the age of 60. (Male Incontinence Overview 1998 – 2010 Health Communities.com.inc)

It is important to remember, although men tend to experience incontinence less often than women, in both sexes it can occur from neurologic injury, congenital defects, stroke, MS, Parkinsons, spinal cord injuries and physical problems associated with ageing.

A search of the literature falls short when dealing with incontinence in men and more predominantly when searching for conservative treatments. (Medline, Pubmed, Cochrane review) Most studies revolve around male incontinence associated with BPH or post radical prostatectomy. Hans et al found that OAB was primarily undiagnosed in almost 50% of all patients treated for LUTS) (Hans et al Urol. Int. 2011)

Treatment options range from conservative and behavioral management, medications and surgery. In all cases the least invasive should be the first choice of options for the patient. This article will focus on conservative TX, including pelvic floor rehabilitation, behavioral interventions and life style changes, Biofeedback and Stimulation Therapy and Transcutaneous Electric Nerve Stimulation (TENS) or Percutaneous Tibial Nerve Stimulation (PTNS).

Pelvic Floor Exercises (PFE) were first introduced by Dr Arnold Kegel in the 1950’s and unfortunately remain much underutilized to the present day. However, evidence shows that PFE’s started early in rehab pre/post radical prostatectomy (RP) can demonstrate a decline in SUI and bladder problems (Dorey 2001).

PFE’s before and after RP and Transurethral Resection of Prostate (TURP) are advocated to minimize or reverse incontinence in the first few weeks after surgery (Porru D Campus G et al) (Tbraek S, Klarskoko P et al 2007)

PFE should preferably be taught pre operatively. This will aid in isolation of the pelvic floor musculature, improve endurance and strength, as well as isolating the slow and fast twitch muscle fibers. It is suggested that PFE’s be deferred from day of surgery to day of catheter removal to reduce resistance and
pressure around the bladder neck, membranous urethra and anastomosis.

Maintaining an adequate exercise program is crucial to benefit. The literature varies substantially in exercise routines and unfortunately the evidence is poor in giving clear instruction in the number of PFE’s recommended or required to build up muscle bulk. Generally anything from 45 to 100 exercises can be cited as a home program, varying profoundly from center to center. Typically working up to a 10 second hold and resting 10 seconds is a good maintenance contraction. Our center recommends three sets of ten exercises twice daily.

The emphasis is on appropriate use (AU) of the pelvic floor during stress maneuvers that cause leakage. The patient is taught to contract their pelvic floor prior to activities that cause them to leak (moving from a sitting to standing position, bending over, coughing sneezing or any activity that causes increase in abdominal pressure. These are often referred to as the “Knack” in Europe. (Miller et al 1996)

Over exercising is not encouraged as it can cause fatigue of the pelvic floor musculature to the point of exhaustion. This can actually increase UI especially in the evening hours as the patient tires.

In patients’ that have impaired sensation or difficulty isolating the PF muscles, Biofeedback and Electrical Stimulation can be beneficial. (Harpel C Gillizlezer R et al )

Caution should be used in ensuring that new post op patients are cancer free (from pathology reports) before conducting stimulation therapy as the risk always exists that as the blood supply is improved to the area with the E stim , so too can the rate of cancer cell reoccurrence increase.

Six to twelve weekly sessions are typically recommended with the emphasis being on the home program intervention between treatments. Depending on patient compliance, the treatment time varies considerably from patient to patient. Expert opinion continues to be divided on the use of E stim.

With Percutaneous Tibial Nerve Stimulation, (PTNS) neuromodulation occurs through projections from post tibial nerve to sacral nerve plexus at the S2 – S4 junction. This treatment can be performed via a fine needle inserted percutaneously near the ankle. Alternatively Transcutaneous Electric Nerve Stimulation (TENS) can be used via surface electrodes. Treatments last 30 minutes and typically range from eight to twelve weekly sessions.

Life style changes such as increasing fluid intake, lowering caffeine intake and switching to decaffeinated products, avoidance of carbonated beverages and alcohol have been beneficial to irritative voiding symptoms. (Bryant et al 2002) (Dalosso et al 2004) The amount, type and spacing of fluids will affect the ability of the bladder to handle containment of fluids (i.e. refraining from “bolus drinking”)

Frequency / volume charts can establish baseline bladder capacity (BC) as well as intake consumption and types of fluid consumed and can be an extremely effective assessment tool. (Abrams, Klevmark 1996) Bladder retraining to increase BC and assist with urge suppression techniques are an important part of treatment for symptoms of urgency, frequency and UI. (Dorey 2006) This helps to reduce voiding frequency by resisting the sensation of the first urge to void and prolonging the interval gradually between voids using various techniques. PFE’s can be taught for SUI as well as urge suppression, especially when utilizing the fast twitch muscle fibres of the pelvic floor. Distraction techniques can also be beneficial especially for “Key in the door syndrome”. Several studies have demonstrated the efficacy of bladder training. (Fantyl JA Wyman JF et al 1991. Columbo M, Zanetta G et al 1990)

Obesity and smoking have both been linked to bladder irritability and detrusor overactivity. (Dalosso et al 2004 Haidinger et al 2000) Weight loss studies have shown significant improvement in UI following bariatric surgery and with as little as 5% weight reduction in more traditional weight loss programs.

All these behavioral interventions are safe and reversible but do require active participation of a motivated patient and the time and expertise of a knowledgeable clinician (Goodes, Burgio K et al 2010)

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**24th Annual Urological Excellence Conference**

**London, Ontario**
**September 15 - 17, 2011**

“Stream Into the Forest City”

The London Delta Armories

London Ontario hopes that you will join us for another exiting Conference. LuAnn Pickard and her committee have a great Program for you to learn the latest in Nursing and Urology. There will be many awards handed out and Posters to check out. The Conference will provide opportunities to meet fellow Nurses and Representatives from our Sponsor Companies. Without these Sponsors we would not be able to provide such a great experience for all of the Attendees. Be sure and visit all the booths and talk with their Exhibitors, they have a lot to show us. The weather should be beautiful.

Looking forward to seeing everyone there.
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Regina Info: Judy Pare: judy@crun.ca

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”.

PIPEGINE
The UNC Awards Program

New UNC Award Available
The newest UNC award is the Nursing Education Initiative. The nursing education fund is a reimbursement program funded by the UNC to provide financial assistance to UNC members.

Grants of up to $500.00 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. The applicant must be a member of the Urology Nurses of Canada for one year preceding the application. Applicants must be enrolled in a course or program that is directly related to the enhancement of their practice and the care of Urological patients. Funding cannot be provided without a receipt of payment and evidence of successful completion of the event or course, i.e. certificate of accomplishment, Transcript mark. Applicants cannot have received funding from the UNC in the previous year. More information and application form can be found on our web site www.unc.org.

Each year the Urology Nurses of Canada invite their membership to apply for the following awards categories: Research, Education Scholarship, and Editorial. These awards are valued at $1000.00, presented at the annual UEC and have been provided by the generous support of our industry sponsors. This year, UNC offers an additional award: the Nursing Initiative Award, which is valued at $500.00.

UNC offers two additional awards: The Award of Merit recognizes the individual who has made a significant contribution to UNC and the UNC Chapter Award for new local chapters.

Details on the awards, applications and contact info is available on the website www.unc.org

Or Gina Porter vpeast@unc.org
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.

CALL FOR NOMINATIONS - It is that time of year again!

Time to think about nominations for the UNC Executive positions that are up for election this year. If you know of someone who would do a great job or you are interested in a position yourself, please forward the name and contact information along with the position nominated for to Susan Freed at freeds@rogers.com. Each person nominated will be contacted to ensure they are interested in having their name stand. They will then be required to submit a short bio that will be available to all those attending and voting at the UEC in London in September. The duties for each position can be found in the constitution on the unc web site. Nomination will also be accepted at the UEC as well.

The positions that are up for this year are as follows: Membership, Secretary, Treasurer and Vice-President East as well as all the Provincial Representatives.

Please have nominations in to Susan Freed by September 1, 2011 to allow for nominees to be contacted. If you have any questions please feel free to contact any member of your UNC Executive.
Kingston Chapter News

In APRIL the Kingston Chapter held their first Urology Oncology Evening Conference. It was a success with 40 health care professionals attending.
We had pharmaceutical support for the dinner and registration. We held the event on Queens University campus, so the venue was at no cost.

There were 3 presenters.
The keynote speaker was Dr. Mike Leveridge, who spoke on Bladder Cancer.
Dietitian- Angela Hollett spoke on Nutrition for Prevention of Urological Cancers and Issues with Diet in the Palliative Care Population.
Social worker- Debora Stark spoke on Sexuality and Intimacy in the Palliative Care Population.
We provided evaluation forms to the attendees, and received a very positive response.

Sponsorship: Pfizer, Sanofi, Abbott, AstraZeneca, RONC, City of Kingston and Queens University.
We are considering a repeat performance next year.

In MAY we held a meeting to honour a former UNC member and former president, Marg Huddleston who passed away 1 year ago.
The speaker was Dr. Darren Beiko who spoke on "Outpatient Tubeless PCNL: Malpractice or Way of the Future?" Dr. Beiko gave his honorarium to the UNC to support education in Marg’s memory.

Sylvia Robb R.N.   Angela Tessier R.N.
President UNC     Secretary
Kingston Chapter

Vikki Whitley R.N.
Treasurer

St Johns Chapter News

Plans are underway for our annual ½ day Urology workshop to be held this year on October, 22, 2011. All of the chapter members have their individual tasks to look after over the next few months ensuring advertising, mail outs, speakers and there respective topics, prizes, lunch and sponsorship are all taken care of. We strive to ensure free registration and lunch for our attendees.

Possible topics include Prostate ultrasound, gold seed instillation, Gleason Grading Scale, Sacral Neuromodulation and our health topic MRSA/Communicable diseases. All speakers have yet to be confirmed at this time. This list may change but none the less be very interesting and informative.

If you find yourself in New Brunswick on this particular weekend please feel free to stop by the Saint John Public Library from 9 am – 1 pm for some lunch and learning. We also offer educational credits for attending.

Thanking all of the members in advance for their continued hard work leading up to and including the day of the workshop.

Lorraine Lambert
NB provincial rep

Edmonton Chapter News

The Edmonton Chapter held it’s Urology Daze on April 15th, 2011.
Intermittent catheterisation (IC) is a mainstay of management for individuals with neurogenic bladders and is accepted as part of normal practice by healthcare professionals. Although it is known that renal and bladder health are typically stable when individuals use IC, the procedure is not without complications including false passage, urethral damage and bleeding, urinary calculi, and urinary tract infections (UTI). Of these, UTI is by far the most commonly reported problem and can cause time missed from work or school, on-going use of antibiotics and risk of resistance, renal damage leading to chronic renal failure, and hospitalization.

Prevention of UTI is challenging and healthcare professionals recommend appropriate fluid intake for body size and ambient temperature (30 ml/kg), prevention of constipation, regular exercise and healthy eating. Catheterization routine should be approximately every 3-4 hours, determined on the results of functional bladder diary, uro dynamically confirmed bladder capacity, bladder and sphincter function, and presence of reflux and dyssynergia.

Defining a UTI has evolved from a positive urine culture only to more clearly focussed symptom presentation. In the mid 1980's, it was recognised that people using intermittent catheterization were frequently colonized but often had no other symptoms. At the time, it was routine to test the urine of individuals using IC (or with indwelling catheters) and prescribe antibiotics, a practice that has assisted in the progression to the critical issue of antibiotic resistance. Current practice is that no routine urine cultures are taken for either intermittent or indwelling catheterisation users (unless circumstances are exceptional) and that treatment is based on the following: positive urine culture with a single bacterial species >10^3 CFU/ml and the presence of some of the following symptoms: fever, chills, confusion, malaise, flank pain or CV angle tenderness, haematuria, suprapubic or pelvic discomfort, increased leg spasms, urgency, pain with catheter insertion. Foul odour or cloudy urine without other symptoms is not a reason for treatment and should be approached with increased fluids. For an excellent review of the topic of catheter associated UTI, see Hooton TM, Bradley SF, Cardenas DD et al. 2010.

In most rehabilitation centres, individuals are taught the principles of healthy bladder habits and voiding routine along with guidance on reuse of catheters once discharged into the community setting. Although there are a variety of effective ways to clean catheters (microwave, soaking in antiseptic solutions, soap and water), the majority of users wash their catheters with soap and water and leave them to air dry until the next use. Most will use their catheter for several catheterizations. There is no evidence that reusing the catheter for only one day is better for bladder health than using it (after being cleaned) for several days. Despite healthy living and carefully cleaning catheters for reuse, some individuals are plagued with chronic recurrent UTI. To try to manage this, or in an attempt to prevent any UTI, some also suggest sterile single use PVC or hydrophilic catheters rather than multiuse PVC catheters.

A common question is whether UTI is reduced when individuals use sterile rather than multiuse catheters. What does the research say? How can we make clinical decisions for best practice? To summarise the literature, there is insufficient evidence to state that sterile single use catheters provide more protection against UTI than multiuse catheters for community dwelling IC users (Moore et al, 2007; Getliffe et al. 2007). In acute care adult neurology, there is slight evidence of benefit of hydrophilic catheters in delaying the onset of UTI (Cardenas et al, 2011) but these results need to be replicated in other trials before practice should change.

In summary, the evidence to support sterile single use catheters over clean reused catheters remains inconclusive. Clinical complications reported in the literature do not vary with the type of catheter or number of times they are used. What does seem to be very important is a healthy life style and catheterizing on a routine that fits with functional bladder capacity and urodynamic findings. Research is needed in which this critical question is addressed. One study is underway in Edmonton in which children with spina bifida are using multiuse PVC as per standard practice or sterile single use hydrophilic catheters. The primary outcome is the number of symptomatic UTI; other outcomes are antibiotics for any reason, days missed from school,
satisfaction with both methods of catheterization. The study should be completed in 2012. Other studies are also necessary and this type of research is excellent and nurses are in a prime position to initiate them.

References:


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.

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

WHAT DO ALL THESE ABBREVIATIONS MEAN???

UNC - Urology Nurses of Canada
CUA - Canadian Urologic Association
UEC - Urologic Excellence Conference
CPCN - Canadian Prostate Cancer Network
NCA - Nurse Continence Advisor
AQIIU - Association Quebecoise des Infirmieres et Infirmiers En Urologie
SUNA - Society of Urology Nurses of America
AUA - American Urologic Association

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.
There has been a lot of information and misinformation regarding Botox and its use in Urology. The misconceptions about Botulinum toxin A need to be cleared up so that patients who will benefit from treatment will be helped.

Botox injection causes a temporary blocking of the presynaptic release of acetylcholine from the parasympathetic innervation and produces a paralysis of the detrusor smooth muscle. This in turn relaxes the muscle. The clinical effects are reversible and dose related. It's effects last approximately 6-9 months.

Botox has been extensively researched in Europe and in North America, and has been found to be safe and effective in treating Neurogenic Overactive Bladder and Idiopathic Overactive Bladder; trials are ongoing with Benign Prostatic Hypertrophy and Interstitial Cystitis, and look promising.

In comparison with the Antimuscarinic medications Botox has fewer side effects. The main side effect is urinary retention requiring intermittent catheterization. Every Botox patient needs to be aware of this side effect and how to manage self catheterizations. They should be physically and mentally able to perform CIC (clean intermittent catheterization). Other side effects are hematuria post procedure, and urinary tract infection. The patient who has not responded to oral medications or is not able to take them may be a good candidate for Botox bladder injections.

Nurses working in Urology Clinics where Botox is administered will need to be aware of the teaching required for CIC as well as the need for ongoing support of these patients. The patients should be monitored for UTI’s. Prior to the administration of the Botox the nurse may be required to do a work up including Urine cultures, urodynamic testing, and a detailed history to ensure the patient is appropriate for this procedure. The Nurse is often the one who administers the local anaesthetic, in the form of Xylocaine 1% without Epinephrine. 40-50 millilitres is instilled via a small single use catheter, and it is left in the bladder for approximately 30 minutes to induce anaesthesia. The Urologist then proceeds with the cystoscopic injections into the bladder usually a number of injections are required. The total dose is usually 200-300U of Botox reconstituted with Normal Saline.

Once the cystoscope is removed, the patient is able to go home. Follow up by the nurse is usually done by phone call in approximately two weeks, but the patient will need to have a contact number in case of problems. Nurses working with Spinal Cord Injury and MS patients ideally should be aware of the procedure and its implications to their patients.

In conclusion, Botox is proving to be a safe and effective treatment for Neurogenic and Idiopathic Overactive bladder conditions. The patient needs to be well informed of its effects and side effects. Other health professionals such as family practitioners, care givers, and Emergency room staff should be aware of the use of Botox in these patients, and treat them appropriately.

More in depth information on Research and Urology Articles on Botox-

European Urology 49 (2006) 664-650
The Journal of Urology Volume 174, 196-200, July 2006
Journal Compilation 2007 BJU International / 99, 247-262

Botox and Bladders: What's New?
By Brenda Bonde
Coming Events

24th Annual Urologic Excellence Conference
September 15-17, 2011
London Delta Armoires
London, ON
www.unc.org

41st Annual ICS/IUGA 2011
August 29– September 2, 2010
Glasgow, UK
www.iscoffice.org

Society of Urologic Nurses and Associates:
SUNA Annual Conference
Oct 28-31, 2011
Marriott San Antonio, River Center,
San Antonio, TX.
www.suna.org

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

2010 Annual CANO/ACIO
September 11-14, 2011
World Trade and Convention Centre
Halifax NS
www.cano-acio.ca

67th Annual CUA
June 24-26 2011
Banff Springs Hotel,
Banff Spring, AB
www.cua.org

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