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ESPU Nurse & Urotherapist Session
Scientific Programme

E-1 (0)

Can outpatient-clinic bladder training replace expensive inpatient training?

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See E-128 Session 16

E-2 (0)

Follow-up in the Utrecht Flow Study: correcting treatment failure

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See E-129 in Session 16

E-3 (0)

Try-out training as a diagnostic tool for structural urinary incontinence

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OBJECTIVE

To use 'try-out' training (TT) to determine treatment plans for selected children with incontinence and suspected structural defects of the bladder neck or urethra.

PATIENTS AND METHODS

TT was used in 11 children (nine girls, two boys) in 2003, with a duration of 2–5 days and extended to 10 days if the initial results were positive. TT includes training instructions, flowmetry and ultrasonography, and observation of the degree and frequency of incontinence. Girls have a jump-test to exclude stress incontinence. The need for maximum effort and motivation is emphasized. Seven girls had no vesico-urethral angle, six an open bladder neck, confirmed by video-urodynamics and ultrasonography, and three a previous reconstruction of the urethra or bladder neck.

RESULTS

For eight children TT was extended to 10 days; of these, one girl became continent, one improved with oxybutynin, one was referred to physical therapy, two had surgery and two are still in training. One boy was referred to a psychologist. For three children TT was terminated when it became evident that they could not become continent. Two girls had surgery and one boy is being treated with oxybutynin and clean intermittent catheterization. Of 11 children suspected of structural incontinence and need for surgery, after TT seven could be treated conservatively.

CONCLUSIONS

For children with urinary incontinence and suspected anatomical defects of the bladder neck or urethra, TT is a useful tool to prevent unnecessary surgery or prolonged training. In some cases TT may lead to control of incontinence.

E-4 (O)

Well done and go on! Cognitive bladder training: parents as supporters

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BACKGROUND

Parents play the role of supporters during cognitive bladder training for children with functional bladder problems; most parents need coaching to adopt this role.

METHODS

The role of supporter is often not an obvious one for parents. Causes can be previous long-term treatment with insufficient results, strife with their child, behavioural problems combined with incontinence, feelings of guilt, incomprehension and present-day hectic lifestyles. Recognition of this 'frustration' is an important condition to help parents change to the role of supporter during training. Much is asked of the child in terms of dedication and exercising new skills. It is an complete effort that needs support within the environment. The parents' contribution is an essential part of the programme. It is important that they assume a positive and stimulating attitude. We use the metaphor of top-class sport in our explanation. Like supporters of a sportsman, they have to encourage and maintain support for the child even when things are bad. The sportsman is able 'to reach the highest peak' by this unqualified and everlasting support. The role of supporter requires empathy with the child, taking action with tact, patience and time. Besides oral education and coaching we developed a brochure, 'Bladder training, advice for parents'.

CONCLUSION

If parents comply well with the role of supporter, cognitive bladder training has more chance of success. The parental education needs special attention to ensure that parents understand what is expected of them. Metaphors offer opportunities for identification.

E-5 (O)

A new treatment with macrogol 3350 plus electrolytes in children with encopresis and constipation

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See E–137 Session 16

E-6 (P)

Pelvic floor stimulation in the treatment of detrusor instability in children

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E-7 (P)

The role of urethral catheterization on uroflowmetry findings in children

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OBJECTIVE

To evaluate the effect of the urethral catheter on the results of flowmetry.

PATIENTS AND METHODS

During a crossover clinical trial patients referred to our urodynamic department for pressure-flow studies (PFS) were selected. PFS were performed once using a urethral catheter and then without it. Variables (voiding volume, maximum flow rate, mean flow rate and time to maximum flow rate) were recorded in each session. The effect of the urethral catheter on these variables was evaluated using an independent *t*-test, with $P < 0.05$ considered significant.

RESULTS

Between June 2002 and May 2003, 97 children (mean age 8.03 years, SD 3.1; 30 boys and 67 girls) had PFS. The underlying problems were UTI (43%) and VUR (39%). The maximum flow rate (23.2 vs 20.8 mL/s), mean flow rate (9.8 vs 9.1 mL/s) and time to maximum flow rate (10.9 vs 10.1 s) were not statistically different between the sessions with or with no catheter ($P = 0.27$, 0.2 and 0.53, respectively).

CONCLUSION

The presence of a catheter does not affect the variables of PFS.

E-8 (O)

New developments and applications of paediatric disposables, catheters, incontinence and urostomy materials

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BACKGROUND

Recently several new paediatric disposable items, single-use catheters, incontinence materials and urostomy appliances have become available in the Netherlands. However, it remains a challenge to select the right material for the child with urological problems. In this overview we describe the current available materials, and our indications and practical use.

METHODS

We made an inventory of the current available paediatric disposables, single-use catheters, incontinence materials and urostomy appliances in the Netherlands. We provide an overview of the materials used for children with urinary incontinence, urinary retention and with a vesicostomy. Also products for local skin-care will be discussed. The paediatric nurse specialists usually work with the principle of 'best practice' and always evaluate the treatment with the children and/or the parents. We present one or two cases to demonstrate specific problems that can occur in our patients. Also creative solutions with the available products will be presented for discussion. Reimbursement methods and the handling of the insurance system in the Netherlands will be explained.

CONCLUSIONS

The paediatric nurse specialist should be acquainted with the frequent occurrence of new materials and appliances for children. She/he must update this knowledge continuously. Also there is often a need to be creative with the available products for children of different ages and with different urological problems.

E-9 (0)

Bladder function in healthy children aged 0–6 years

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See E–126 Session 16

E-10 (0)

School toilets: a problem for European children

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OBJECTIVE

To ascertain why children and parents frequently describe problems with school toilets.

SUBJECTS AND METHODS

In two contrasting cities in Northern England (Newcastle upon Tyne, 394 pupils) and Southern Sweden (Goteborg/Molndal, 157 pupils), self-administered questionnaires were given to children aged 9–11 years. Researchers also administered questionnaires to head teachers, who recorded their observations of facilities according to predetermined basic standards.

RESULTS

Children from both countries found school toilets unpleasant, dirty, smelly and frightening, and that bullying occurred there. Many children avoided using the school toilets, i.e. 62% of boys and 35% of girls (in the UK) and 28% of boys and girls (in Sweden) avoided using the school toilets to defecate. The other results were similar in both centres.

CONCLUSIONS

European standards are needed for school toilets to prevent children developing problems, e.g. constipation, UTIs and incontinence.

E-11 (0)

Intermittent catheterization in schools: a collaborative agreement

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BACKGROUND

Many children and their families spend a considerable time and much determination mastering the technique of clean intermittent self-catheterization (CISC), and once accomplished it must then be introduced into the school environment. Personal experience showed that because there is little knowledge and understanding, and appropriate toilet facilities, many schools were reluctant to accept these children. To successfully integrate a child into the school of choice, a collaborative agreement, focusing on an individual approach, supported by consent, has therefore been developed.

METHODS

Multi-professional meetings are essential when devising the collaborative agreement. The nurse specialist undertakes the training of staff, and to protect both the child and the school, consent to use CISC is obtained from all parties and recorded in the agreement.

RESULTS

An audit of the collaborative agreement showed that schools and families found the agreement both helpful and supportive. Families reported that the agreement had given them 'a voice', whilst schools reported it

was an extremely useful resource if a problem arose.

CONCLUSIONS

Close multi-disciplinary working and co-operation, in partnership with children and their families, provides educational establishments with the knowledge and understanding to ease the path of children who use CISC during mainstream education. The collaborative agreement ensures that appropriate training is delivered and that by gaining written consent from both the child and the school, protection issues are addressed.

E-12 (0)

Development of a pre-admission clinic in paediatric urology

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BACKGROUND

Pre-admission clinics ensure that children undergoing surgery, and their families, are fully informed about procedures, can establish fitness for surgery and outline any further investigations required. This can then reduce cancellations/non-attendance, ensure that resources needed throughout the hospital stay are in place, and improve discharge planning. The challenge of setting up the clinic required auditing, and convincing management of the need to increase budgets to facilitate a full-time pre-admission nurse.

METHODS

A small audit was carried out over 3 weeks of 15 families attending the 'skeleton' clinic run 2 days per week to establish its utility to patients and their families. Second, a record was kept of potential problems resolved through attending the clinic that may have led to cancellation/non-attendance. A business plan was devised to present to the hospital board to try to obtain funding.

RESULTS

Of 15 questionnaires, 14 were returned, indicating that families attending for the first time felt less anxious about their child's surgery whilst appreciating 'familiar' faces of the nurse and play specialist. Families of children with ongoing urological problems were already knowledgeable about their child's condition and did not find the clinic as beneficial. Potential problems identified included previous cardiac problems, lost notes, changed addresses, diabetes and undiagnosed hypertension.

CONCLUSIONS

Managers were convinced of the potential benefits of this service and funding was obtained! There is an ongoing audit of the benefits of the clinic, indicating an improvement to the service and the patients' journey.

E-13 (0)

The young person's nephro-urological clinic: working together and the way forward

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BACKGROUND

More young people require transfer from paediatric renal and urology clinics to adult units. The aim of this study was to provide a clinic where renal and urology specialities came together, to offer a programme of continuous care, in an environment which nurtures independence and where all the needs of the young person could be met more effectively.

METHODS

The clinic is based in the adult renal outpatient department. The age for referral into this clinic is set at 16–25 years. The clinic is run by a consultant nephrologist and

urologist, both from the adult field. To maintain continuity for the clients the paediatric urology nurse specialists are in attendance, the aim being to support the client and their families in the adult environment before transferring them to adult nursing colleagues. It is hoped that this environment will encourage autonomy, allowing the young person to take ownership of their condition, while allowing the nurses to tackle issues such as noncompliance, sex education and substance abuse.

RESULTS

No results are available yet but the outcomes of all the young people referred to adult services in the last 5 years are currently being reviewed retrospectively. Whilst collecting data from all the referrals to the clinic, their progress will also be monitored over the next 5 years.

CONCLUSIONS

The hope is to achieve a 'seamless' service from paediatrics through to adult services over a 9-year period, with a reduction in noncompliance of treatment and increased life expectancy for these young people with nephro-urological conditions.

E-14 (P)

Development of the urology nurse specialist clinic

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BACKGROUND

Over the last several years there has been an expansion in nurse-led services within the National Health Service in the UK. This expansion has been generated to meet the increasing demands of the health service, by making better use of the nursing expertise available in many centres. This presentation describes the development of the Urology Nurse Specialist Clinic at Guy's & St. Thomas' NHS Trust. The clinic was set up to meet the increasing demands of the Paediatric Urology, Neurology and Nephrology services, to provide a consistent approach to the assessment, support and follow-up of children with bladder dysfunction. The philosophy of the clinic is working in partnership with the patient and family, medical staff, nursing colleagues, radiology and other support services, education and, in some cases, social services. Children are referred to the clinic for the following: preoperative preparation; postoperative follow-up; bladder function assessment; medication review; bladder retraining; renal function tests; and emergency review. The presentation will focus on the work of the clinic, its strengths and weaknesses, and further development of the service.

E-15 (P)

Refluxing primary obstructive megaureter: diagnostic and therapeutic approach in 20 neonatal cases

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BACKGROUND

Neonatal refluxing primary obstructive megaureter (RPOM) is a relatively common pathological association (1 : 20 VUR) and surgery is considered the treatment of choice. We report the retrospective details of 20 cases of neonatal RPOM to consider if the conservative approach is as successful as in neonatal uncomplicated VUR or POM when they are isolated.

PATIENTS AND METHODS

In a 13-year period, of 123 observed POM, 20 were also refluxing (25%, 17 unilateral and three bilateral). The mean age of the patients at diagnosis was 1.7 months; 16 had surgery, 12 soon after the diagnosis, because of impaired renal function or UTI, and four who were asymptomatic and who had surgery after a mean of 12.5 months, to allow bladder growth. The last four free of UTI but with unilateral RPOM and good renal function, were followed conservatively.

RESULTS

The four patients who had delayed surgery had no decrease in renal function nor UTI before surgery. They were followed for 9–31 months, during which their renal function

and washout time improved in all, ureteric dilatation completely regressed in three, improving in the most recent case. Two had a lower grade of VUR and VUR resolved in the remaining two.

CONCLUSIONS

These results emphasize that surgery is the standard of care in most cases but it is not immediately necessary. Conservative management is safe in selected asymptomatic neonates with preserved renal function. It may allow spontaneous regression of the RPOM during an adequate follow-up.

E-16 (O)

LUTS after renal transplantation in children

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See E–107 Session 13

E-17 (O)

Developing a hypospadias nursing service: improving the patients' journey

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BACKGROUND

The Manchester Children's Hospital was chosen as a pilot site in the Department of Health, NHS Hospital Improvement Partnership (HIP) programme. The aim of HIP is to provide optimum care for patients by improving clinical quality and enhancing patient safety. In response, the urology nursing service focused on improving the patients' journey for boys (and their families) scheduled for hypospadias repair.

METHODS

A parent-information leaflet is given to all parents before surgery, with contact numbers for a telephone advice service. After surgery families are given the option of early discharge for the child. Guidelines for postoperative care and a protocol for removing the dressing within the home were developed. Initially the dressing was removed at home by a member of the urology nursing team. With the co-operation and commitment of community paediatric nursing teams, a teaching package was developed for community use and dressings are now removed in the home by community paediatric nursing teams.

RESULTS

Anecdotal evidence suggests that care and dressing removal within the home has greatly improved the patients' experience. To gain a true evaluation, patient satisfaction surveys have been sent to all patients who have had their hypospadias repaired over the last year. We are currently analysing these responses.

CONCLUSIONS

By offering families more appropriate information and support, and the option of early discharge, the urology nursing service in partnership with community paediatric nursing teams has improved the patients' journey.

E-18 (O)

A preliminary evaluation of a new surgical technique to achieve voiding continence in children with classic bladder exstrophy

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BACKGROUND

A surgical technique, pioneered by J. Kelly (consultant paediatric urologist, Melbourne, Australia) involving soft-tissue reconstruction of the bladder neck, has been adapted by P. Cuckow (consultant paediatric urologist at Great Ormond St) and been in use since 1999. The object of the procedure is to increase outlet resistance at the bladder neck, to improve the ability to void normally, and to enhance the external appearance of the genitalia, especially in boys.

PATIENTS AND METHODS

In all, 14 children of varying ages who have a minimum follow-up of ≥1 year were assessed for the study.

RESULTS

The presentation will focus on bladder capacity, dry intervals, voiding characteristics and residual urine. We will also identify some of the challenges and dilemmas encountered by the nurse specialist and the importance of preoperative preparation, and a consistent follow-up and support in such a specialised group of patients.

E-19 (O)

A book for children/young adults born with bladder exstrophy

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See E-83 Session 8

E-20 (V)

'My bladder and me': a new information video for children about to undergo augmentation

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See E-88 Session 10