

136

The nurse-led prostate clinic

Julie Joyce and A.J. Pope *The Hillingdon Hospital, Pield Heath Road, Uxbridge, Middlesex UB8 3NN*

Introduction: There is an increasing role for specialist nurses in urology. We have recently introduced a nurse-led clinic for the assessment of men with bladder outflow obstruction.

Methods: GPs were encouraged to investigate patients according to a simple protocol and refer on a customized letter. All referrals are scrutinized for any other appropriate investigations arranged. Patients are sent written information about the clinic and attend for a single visit only. A standardized history is taken and flow studies and residual urine estimations are performed. The examination findings are checked by the consultant whose general clinic is in progress at the same time. A definite management decision is usually possible and written information about this is provided for the patient. Recommendations for further treatment under the care of his GP are made if appropriate.

Results: During the first 4 months, 53 patients were assessed. The main internal diagnoses were of symptomatic BPH in 51%, suspected prostate cancer in 17% and detrusor instability in 9%. The main outcomes were TURP (31%), watchful waiting (31%) and medical therapy (9%). Updated results will be presented.

Conclusion: This service has been well received by patients and GPs. Waiting times for new patients have been reduced and many follow-up clinic visits avoided. It is expected that this initial favourable impression will be sustained.

137

The selection of men with moderate lower urinary tract symptoms (LUTS) for non-surgical treatment in the community: is the urologist necessary?

Mohammed Akbar, Lee O'Hara, Jayne Lewey, Angela Billington and Thomas A. McNicholas *Department of Urological Surgery and Continence Advisory Service, North Herts NHS Trust, Lister Hospital, Coreys Mill Lane, Stevenage SG1 4AB*

Introduction: Urological resources are limited and demand is high. We established a series of specialist nurse-run clinics where patients referred by family practitioners (FPs) could be assessed and non-surgical treatment offered if appropriate.

Methods: Patients underwent symptom scoring, flow rates, transabdominal ultrasonography, urine testing and serum measurements of PSA and creatinine. Patients with significant symptoms or abnormalities were referred to a specialist urological unit. We reviewed this project to determine if major management errors were occurring.

Results: Between October 1992 and September 1995, 690 men were studied. Overall, 55% (380 men) were thought suitable for 'non-surgical' management without a specialist opinion; 75 men (19.7%) underwent a review by a urologist, a mean of 18.5 months later (range 4-43 months) and 54 men attended for review (72%). There was general agreement between the assessments. However, in five men the urologist indicated a significant risk of prostatic cancer (four by DRE, one by PSA). Only 19 men (35%) had a DRE by their FP before the assessment. Forty-five percent (310 men) were referred to a urologist. In 70 (19%) the studies were repeated with no significant differences being found. In 69, the specialist assessment and nurse assessment agreed with a minor difference in one patient. Further investigations were necessary in six men, the specialist chose medical treatment in 21 men, surgical in 32 and 11 (15%) were discharged on 'watchful waiting'.

Conclusion: Nurse assessment will select men with LUTS who need referral to a specialist. Others can be observed safely or treated medically in the community if more attention is paid to DRE and the referral of palpably abnormal prostates.

138

Clinical nurse specialist run pre-admission clinics – an effective, patient-friendly alternative to clerking by medical staff

P. Thornburn, A. Osborne, A.-M. Rollin, M. Millar, C.R. Charig and M.J. Bailey *Department of Urology, Epsom General Hospital, Surrey*

Introduction: The use of a pre-admission clinic (PAC) to induct patients before elective surgery has been shown to reduce last-minute cancellations either on anaesthetic grounds or because patients fail to attend for surgery. These clinics are usually run by medical staff (HS) but ours is now run by a Clinical Nurse Specialist (CNS).

Methods: Before initiating the PAC operated by a CNS, discussions were held with anaesthetic and nursing colleagues to agree a suitable protocol. For one month, patients were seen by the HS and CNS to identify any problems, then the CNS assumed full responsibility for the PAC. The effectiveness of the clinic was monitored and the outcome of 3 months of the HS clinic compared with 3 months of the CNS clinic in terms of detection of potential anaesthetic problems in the clinic, unexpected cancellations on the day of surgery and availability of investigations at the time of admission. Five hundred attendances at the PAC were audited.

Results: The CNS was as effective as the HS in identifying medical problems likely to cause cancellation of planned surgery. The appropriate investigations were more likely to be available at the time of admission following CNS assessment in the PAC.

Conclusions: A PAC operated by a CNS is an effective method of clerking patients for elective surgery. Additional benefits include freeing the HS/SHO for service or training commitments more appropriate to their needs and being able to use urological knowledge of our CNS to allay patients' anxieties about their forthcoming treatment.

139

Nurse-directed impotence therapy: improved compliance and understanding

L. Molloy and A.K. Nigam *Department of Urology, St. Bartholomew's & Royal London Hospitals, West Smithfield, London*

Introduction: With an increasing urological workload, nurses and urologists are constantly trying to redefine and expand the role of specialist urology nurses. One of the most appealing areas has been in the management of erectile dysfunction. This has stemmed from observations suggesting that compliance with therapy offered in a busy out-patient clinic is poor.

Methods: In our unit, a specialist urology nurse has been employed to counsel and train patients and their spouses in the use of intracavernosal pharmacotherapy, vacuum devices and penile implants. Over an 18-month period 234 patients were referred for this service; 184 (79%) attended their first appointment, 16 (9%) with their partner, 102 underwent instruction in injection techniques, 71 were taught to use the vacuum device and 23 underwent psychosexual counselling either in addition or alone. All patients were offered a 4-month follow-up and 88 (48%) returned. A detailed questionnaire to evaluate the service in terms of compliance with therapy was carried out.

Results: Compliance improved compared to published data and patient satisfaction scores were high. Compliance was better with self-injection compared to the vacuum device, prohibition by cost being the primary reason cited for non-compliance with the latter.

Conclusion: At present, all men referred with erectile dysfunction are evaluated by a urologist; we see the natural development of a nurse-directed service to include primary investigation as well as therapy.

Tele-cystoscopy: the nurse practitioners' procedure

H.J. Lewi, L. Fawcett and S. Hawkes *Broomfield Hospital, Broomfield, Chelmsford, Essex CM1 5ET*

Introduction: Outpatient flexible cystoscopy (FC) is an accepted procedure that allows an early outpatient diagnosis of intravesical pathology and minimizes hospital stay. Since November 1987 we have performed 1700 FC per year (approx 13000 to date). Whilst FC is a relatively easy procedure to perform it requires considerable medical input. FC by Nurse Practitioners is a feasible option provided that medical expertise is readily available to help recognize variations in bladder pathology.

Methods: In partnership with Pentax UK we have developed a Tele-Cystoscopy system that allows for distant monitoring of FC with an audio-visual link. The system used is the Pentax Endo Vision CCD video camera (attached to the Olympus CYF2 Flexible Cystoscope). The video camera is linked via the video composite signal output to an adjacent Sony PVM 2053 monitor (for operator use). A standard length BNC-to-BNC cable is used to link a second video monitor sited in a separate office/consulting room allowing for instant monitoring of the cystoscopic appearances. A simple two-way audio link allows advice or comment to be given at the time of cystoscopy.

Conclusion: With a Tele-Cystoscopy facility and appropriate distant consultant monitoring, FC can be successfully carried out by Nurse Practitioners as an early diagnostic outpatient procedure.

Further developments in urological specialist nursing

C. Grose, L. Martin, J. Warr, P.J.C. Brooman and P.H. O'Reilly
Department of Urology, Stepping Hill Hospital, Stockport SK2 7JE

Introduction: Following the successful introduction of a urological community nursing (UCN) service, a need was identified to develop the new role of the hospital-based specialist urological nurse. This was made even more necessary by expansion of our service to a Hub-and-Spoke development with doubling of the consultant numbers with no increase in pre-registration house officers (PRHOs).

Methods: Two urological practitioner nurses were appointed. Both were experienced urological ward sisters. A one-month orientation period, supervised by the senior UCN, included regular ward rounds, time spent with the PRHOs, and training in phlebotomy, male catheterization and urodynamics.

Results: Following this, Pre-admission Clinics were introduced, run by the UPNs and PRHOs together (40-45 patients weekly being seen 7-10 days before surgery). Within 6 months, a nurse-led Prostate Assessment Clinic (10 patients weekly) was introduced, and followed shortly afterwards by an Andrology Clinic (10 patients weekly). During this period, the senior UCN was trained up to first-assistant grade in theatre. In addition, two further UCNs were appointed to serve the Spoke district from the Hub HQ. Further developments include nurse-performed flexible cystoscopies.

Conclusion: This Unit now has six Specialist Urological Nurses (SUNs). The success of such a project depends on the appointment of experienced individuals and the support of other grades of medical and nursing staff. The distinction between community and hospital is vanishing, as experience in both is gained by all, allowing cross cover when needed (UCN + UPN = SUN; QED!). Specialist nurses are now indispensable members of a modern urological team.

Study comparing traditional medical and nurse-led clerking and shared-admission clerking

Heather Gould and Linda Prime *Bristol Urological Institute, Southmead Hospital, Bristol BS10 5NB*

Introduction: If the role of the qualified nurse is to continue to expand and develop to meet both the needs of the patient and the Health Service, then increasing multidisciplinary collaboration is essential.

Aims and methods: The purpose of the study was to develop and pilot a joint admission document (Doctor/Nurse) within the ward environment. It was considered that the introduction of a shared admission document would:

- 1) Reduce the time junior doctors spend admitting patients.
- 2) Reduce the duplication of documentation.
- 3) Enhance and expand the nurses' role.

The study consisted of 60 admissions (30 pilot and 30 traditional). These were divided into three pathways indicating the severity of proposed surgery. Protocols were used, which had been agreed by nursing and medical staff. Each admission was timed. The study lasted 2 months with each admission being undertaken by the same staff.

Results: Initial results were encouraging: 1) Medical admission time was reduced in each pathway with a mean traditional admission time of 20 min and a mean pilot admission time of 14 min. Although this is not a dramatic reduction, multiple admissions reduce the time significantly. 2) Reduction in the duplication of documentation was identified clearly.

3) The extension of the nursing role resulted in increased job satisfaction and increased multidisciplinary communication.

Conclusion: If 'shared admission clerking' is to become a daily role for the nurse, both medical staff and patients will benefit from a more efficient admission system.

A prospective, randomized, double-blind study to compare lignocaine gel and plain lubricating gel in relieving pain during flexible cystoscopy

Simon K.S. Choong, V. Meganathan, A. Razack, M. Gleeson and H.N. Whitfield *The Department of Urology, Central Middlesex Hospital, Acton Lane, Park Royal, London NW10 7NS*

Introduction: Studies of lignocaine uptake following topical urethral application of 10 mL have shown absorption to be slow and incomplete, with peak levels occurring between 15 and 60 min. Increasing the volume of lignocaine from 10 mL to 20 mL increases drug uptake from the urethra. On theoretical grounds, it would seem that if 20 mL of lignocaine gel were left in the urethra for a longer period than is currently practised, topical anaesthesia might be improved. This study was designed to test this hypothesis.

Patients and methods: Forty-seven men undergoing flexible cystoscopy were entered in a prospective, randomized, double-blind study into four groups receiving 20 mL of 2% lignocaine gel or plain lubricating gel for 5 min or 20 mL of 2% lignocaine gel or plain lubricating gel for 25 min. A penile clamp was used to retain the gel in the urethra. Patient discomfort was recorded using a 4-point descriptive pain scale and a 100 mm non-graphic visual analogue scale.

Results: The mean pain scores were 22.0 (lignocaine 25 min); 30.5 (lignocaine 5 min); 33.6 (plain 5 min); and 35.8 (plain 25 min).

Conclusions: Lignocaine gel was better than plain lubricating gel in reducing discomfort during flexible cystoscopy; 20 mL of 2% lignocaine gel applied intraurethally for 25 min provided better pain relief than when left for only 5 min, confirming the slow absorption of lignocaine gel across the mucous membrane.