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Award of Recognition

The Urology Nurses of Canada present an Award of Recognition to Bard Canada on the 10th Anniversary of the UNC. Thank you Bard Canada for supporting each annual Urological Excellence Conference, each issue of the Pipeline, and fostering the growth of the UNC through available human and physical resources.

Celebrating the 10th Anniversary

Urology Nurses in Canada: A Work In Evolution

The UNC is a national association with a mandate to enhance the specialty of urologic nursing in Canada by promoting education, research, and clinical practice. The activities of the UNC are designed to enrich member's professional growth and development.

The UNC founding "fathers" originated in Toronto, Ontario, where, in 1985, discussions began about planning a urology conference. In 1988 the first urology conference was held in Toronto and boasted 250 delegates representing mostly the province of Ontario. This group emerged as the Urology Nurses Interest Group (UNIG). The intent to form a national urology association was always prevalent. In 1990, our visionary leaders facilitated the link from a regional to a national perspective, which led to the UNC. The initial focus of the UNC was to provide an annual urology conference at various locations across Canada thereby providing the opportunity for networking and creating links with those interested in urologic nursing. To date annual conferences have been held in Toronto, Kingston, London, Ottawa, Halifax, and Montreal.

In September 1997, the UNC celebrates the 10th Annual "Urological Excellence Conference" in Edmonton, Alberta. In 1995, the UNC established a constitution with clearly delineated national objectives that include the development of national Standards of Practice in Urology. The UNC publishes a communiqué, the Pipeline, biannually, which serves to enhance communication about current issues, research, educational events, resources available (e.g. web sites and videos available to patients, the community, and health care professionals and information about advancing technology).

The UNC recently acquired affiliate status with our physician colleagues, the Canadian Urological Association (CUA). Membership in the UNC is comprised of nurses from most provinces and represents a very small portion of the more than 200,000 registered nurses across Canada. The UNC is organized at a national,

regional, and local level; is not self financed; and greatly benefits from corporate sponsorships to see initiatives to fruition.

The UNC is a "Work in Evolution". The UNC has the challenges of being a small specialty in nursing, with several sub-specialties, challenged to thrive in an environment faced with restructuring, reengineering, and rightsizing. The economic realities, combined with geographical barriers, potentate "specialty isolation." Nurses who once perceived themselves as "urology nurses" are threatened by layoffs, nurse replacements, and relocation. Promoting and maintaining membership in a small specialty such as the UNC has its challenges.

Enhancing communication, collaborating with colleagues, creating opportunity to promote education and evidence-based urologic nursing practice, and establishing standards are crucial in today's rapidly changing environment. Never before has the need been greater! The UNC is extremely fortunate to have enthusiastic, dynamic executive board members with expertise in clinical practice, research, and education who offer their time voluntarily and who are committed to growth and viability of the UNC. While the UNC continues to evolve, we must not lose sight of the expertise available not only within Canada, but externally. After all, we are all walking on the same road - it all depends on what side of the road you walk - not to mention the challenges of construction along the way!

Susan M. Madden BScN, MEd President, Urology Nurses of Canada

Focus on Pain Management Modalities: A Multimodal Analgesia Protocol Utilizing Intrathecal Morphine In Radical Retropubic Prostatectomy

As the number of radical prostatectomies performed for clinically localized prostate cancer continues to increase, we must search for improvements in peri-operative analgesia. Early mobilization and return of bowel function impact on complication rates, length of stay, costs and quality of patient care.

Epidural use has become commonplace, but usually requires more specialized nursing care. We have developed a protocol using a singleshot intrathecal morphine/bupivicaine spinal injection, combined with systemic NSAIDS.

Our goal was to use a simpler regional technique (spinal) to achieve pre-emptive analgesia as effective as epidural, but without the need for post-operative infusion pumps on the wards. This protocol has been implemented in a prospective study to evaluate its effectiveness. This study was carried out using patients following our care map. The protocol consists of 0.5% bupivicaine and 0.4 mg morphine administered intrathecally, just prior to induction of general anesthetic. Minimal systemic opioids are used as necessary. IM ketorelac 30 mg is given at the end of the case, followed by pr naproxen 500 mg x 4 doses, then po naproxen 250 mg tid. Bolus PCA morphine and Tylenol #3 is available as needed. Twenty six (26) consecutive patients with T1a-T2c Nx Mo adenocarcinoma of prostate, age 49-70 years, completed the protocol.

Average length of stay was 5.1 days, which is a one day improvement over our caremap pathway. The caremap was originally developed using epidural analgesia. Side-effects were minimal, with two cases of easily-controlled pruritis on the OR day and a motor block lasting less than four hours in three cases which resolved by six hours. All maintained T11 blocks or higher upon arrival to PACU. Small incisional seromas were noted in 20% of cases. On phone call, no patients were re-admitted at an outside hospital. Average blood loss was 930 cc's vs

1250 cc's in the control group. Bowel function on day one was 100% vs. 28% with epidural analgesia. Diet as tolerated on day two was 100% vs. 35% with epidural analgesia. Activity as tolerated was achieved at 1.9 days vs. 2.0 days. Notable differences in bowel function, diet and activity may be attributed to the care map and effects of the local anesthetic. Using a standard pain score from 1 to 10, the average score on the operative day was 1.4 at rest and 2.9 with activity, and 0.8 and 2.6 respectively on day two.

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These scores did not differ significantly in comparison to epidural analgesia. However, by day 4 the pain scores decreased to 0 at rest and 0 with activity compared to 0.6 and 2.2 with epidural analgesia. Most patients required minimal PCA morphine, and PCA pumps were discontinued at 2.3 days on average. PO opioid use was 33% vs. 0% day one, 55% vs. 14% day two. Notable changes occurred day five with 5% vs. 42%, and day six with 0% vs. 35% usage.

In conclusion, this protocol is comparable to commonly used epidural protocols in effectiveness. It is safe, simple and obviates the need for epidural infusion pumps on the ward. Overall, length of stay was shortened with this protocol as compared to our prior experience with epidurals using the same caremap. As a result, we have shortened the care map length of stay, and eliminated the PCA morphine pumps. We are embarking upon a direct comparison of this regimen to an overnight epidural/NSAID approach and plan to study the relative effects of NSAID's on wound healing/seromas.

Presented at the Canadian Urological Association, 52nd Annual Meeting, Quebec City, June 1997.

Dr. Chris Morash is a Urologist, Dr. John Penning, Anesthetist, Susan Madden, Clinical Nurse Educator at the Ottawa Civic Hospital , Ottawa, Ontario