Management of Urinary Incontinence Following Radical Prostatectomy

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Prior to the appointment of a urology oncology nurse specialist within the study site, patients diagnosed with prostate cancer would receive their cancer diagnosis from a urologist. At that same visit, the urologist would inform them of their treatment options and the possible complications of each option. The decision to proceed with a radical prostatectomy was often made at this visit, or possibly the next visit. Patients were referred to the continence team postoperatively, after removal of their urinary catheter. The majority found that their bladder control was poor, and although this had been discussed pre-operatively with the urologist, many had very little memory of the discussion. This lack of recollection was understandable, as patients had to deal with their diagnosis while considering the treatment options. For those proceeding with surgery, uppermost in their minds was to remove the cancer.

When working with patients with urology cancer, nurses will regularly care for men before and after radical prostatectomy. A critical review of the literature on the impact of urinary incontinence after radical prostatectomy is presented. Then by demonstrating how the theoretical knowledge and understanding can be transferred to practice, a detailed description of an innovative multidisciplinary team approach is presented. This can positively affect symptom management and improve the quality of service for patients undergoing radical prostatectomy.

Introduction

The impact of a urology oncology nurse specialist in the practice environment to assist with both pre and postoperative education needs of men undergoing genitourinary surgery for cancer was evaluated.

Objective

This study aimed to improve the preoperative process and teaching for men planning surgery for genitourinary cancers, including the delivery of pathology results. A secondary aim was to decrease the incidence of postoperative incontinence.

Methods

Male patients undergoing a radical prostatectomy were recruited. Patients who underwent surgery were evaluated both before and after the urology oncology nurse specialist role was established. Followup was via phone call interview and International Prostate Symptom Score questionnaire.

Results

Men who received the personalized education from the urology oncology nurse specialist had a higher return of continence postoperatively, as well as higher satisfaction scores with the outcome of their surgery, including higher quality of life scores.

Conclusion

The urology oncology nurse specialist role had a significant impact on the postoperative incontinence rate and provided a missing patient education piece that improved the overall patient satisfaction rate with oncology-related care.
rather than the possible consequences of postoperative complications (Moore & Estey, 1999). In this process, there was no nursing input providing support and information at the time of diagnosis or when planning treatment; similarly, there was no written patient information material made available. Ultimately, this resulted in patients and their families being poorly prepared postoperatively for the impact of urinary incontinence (UI) (Butler, Downe-Wamboldt, Marsh, Bell, & Jarvi, 2000).

Traditionally, it is medical staff who inform patients of their cancer diagnosis (Meredith et al., 1996). However, several authors question whether medical staff are in fact the best placed to deliver a cancer diagnosis to patients (Fallowfield, Jenkins, Farewell, Saul, Dully, & Eves, 2002; Faulkner, 1996; Maguire, 1996). Limited consultation time and the unsuitable environment of a busy clinic have been highlighted as possible factors which may adversely influence the quality of consultation (Faulkner, Argent, Jones, & O’Keefe, 1995). Often patients are overwhelmed with details about treatment, side effects, prognosis, and followup; after hearing the word “cancer,” they can become so shocked that the remainder of the conversation is usually lost (Faulkner, 1998). As a consequence of the nature and volume of the detail given to patients at this time, they can often suffer from information overload, resulting in an inability to recall and appreciate the implications of the diagnosis and treatment (Faulkner, 1998).

Literature Review

The incidence of UI after radical prostatectomy was examined, along with an assessment of how this symptom can affect a person’s quality of life. Computerized searches on Medline, CINAHL, PsycInfo, the British Nursing Index, and the Royal College of Nursing database from 1985 to present were done using the key words: radical prostatectomy, urinary incontinence, prostate cancer, quality of life, and symptom management.

Urinary incontinence is a common problem after radical prostatectomy and is often viewed by patients as the symptom which most disrupts their quality of life (Herr, 1997). According to Maxwell (1993), most patients (90%) regain total urinary control after radical prostatectomy but this can take up to a year to achieve, with a small percentage (2% to 4%) experiencing permanent incontinence. However, incontinence rates postradical prostatectomy vary considerably and appear to depend upon the definition of incontinence used (Moore & Domy, 1999).

Several physician-reported studies document a low incontinence rate ranging from 2% to 8%. A report by Zincke, Oesterling, and Blute (1994) demonstrated only a 5% incontinence rate, but this rate was defined as using three or more pads per day. Defining incontinence as requiring a pad for strenuous activity, Steiner, Morton, and Walsh (1991) reported an 8% incidence. Using a similar definition, Leandri, Rossignol, Gautier, and Ramon (1992) found only a 5% rate of incontinence. Eastham, Kattan, Rogers, and Scardino (1996) reported a 5% incontinence rate from their series of radical prostatectomy patients over a 5-year period but with yet another definition of incontinence: the leakage of urine with moderate exercise onto two or more pads daily. However, all these analyses are based on review of patients’ records and direct physician interview of the patient. This may not accurately reflect the true incidence because of poor physician assessment, inadequate documentation, or patients’ reluctance to directly report adverse events to their surgeon (Quinlan, Epstein, Carter, & Walsh, 1991).

In contrast, when patients report their personal experience of UI, the incidence is usually significantly higher. In a detailed survey by Heathcote et al. (1998), patients independently completed a questionnaire to determine the incidence and impact of side effects following surgery. These results showed 20% of patients reported postoperative incontinence. More specifically, 11% required pads at least once a week, 8% requiring one pad daily, with 1% requiring two or more pads daily.

In a study of 1,796 men who were continent before radical prostatectomy, Murphy, Mettlin, and Menck (1994) found that 330 (19%) reported they wore pads on a daily basis, with 4% of the men being totally incontinent after surgery. Fowler, Barry, and Lu-Yao (1993) found that 31% of patients in their study had some degree of wetness after their operation. Similarly, Litwin, Hays, and Fink (1995) observed daily urinary leakage in 40% of men who underwent radical prostatectomy.

From these results, it would appear that there is a significant difference between patient and physician in the assessment and definition of UI. It is also apparent that many early publications have underreported UI incidence postradical prostatectomy, with independent questionnaires detecting a higher incidence of complications (Bates, Wright, & Gillat, 1998). This has significant implications in the advice and counseling given to patients preoperatively regarding the incidence of incontinence after surgery.

In both the patient and physician-reported studies, there is little reference to the type of pads used, their absorbency, or to the subjectivity of each individual as to how often the pads needed to be changed (Abrahams et al., 2002). When number of pads used is the main guide to assessment of incontinence, these factors must be analyzed more closely and a level of standardization reached.

Ganz (1994) describes quality of life as being the patient’s appraisal of, and satisfaction with, his current level of functioning compared to what he perceives to be possible or ideal. In comparison to other similar ill-
nesses such as breast cancer, there has been a more limited number of studies on the effect on quality of life of patients receiving treatment for prostate cancer. Cassileth (1992) suggests that this may be because traditionally men have been reserved in disclosing their emotions. A second reason might be that interest and funding for prostate cancer research generally has been only recently established, as the incidence and impact of the disease was eventually realized (Beldegrun, Kirby, & Oliver, 1998).

It is widely accepted that all options for prostate cancer treatment can have a significant impact on a patient’s quality of life, and therefore should not be undertaken lightly (Bates et al., 1998; Kirby & Kirby, 1999). However, a recent study carried out by Moul, Mooneyhan, Kao, McLeod, and Cruss (1998) aimed at predicting morbidity factors for patients with prostate cancer receiving radical surgery concluded that although the side effects were high, the majority of men report the same quality of life pre-operatively and would apparently choose the same treatment again.

These findings agree with Frydenberg (1998) who, in a meta-analysis of quality-of-life studies in men coping with prostate cancer, found that most patients expressed their overall satisfaction with the surgical treatment and would choose to have surgery again. This was despite the higher level of incontinence and sexual dysfunction reported by these patients with radical prostatectomy. This would seem to imply that the overwhelming desire to remove the cancer completely outweighs the side effects of the radical prostatectomy for most patients.

Interestingly, however, Herr (1997) reported that this opinion can waver depending on how long the symptom persists. These results came from his questionnaire study assessing quality of life and coping in men who are incontinent after radical prostatectomy. Herr found that 83% of men who had surgery within 3 years of the study would choose the same treatment again. On the other hand, of those whose surgery was more than 3 years before the study, only 47% would make the same choice. These findings are supported by Waxman (1993) who reported that 5 years after radical prostatectomy, only 53% of patients still experiencing incontinence would choose surgery again, compared with 83% in the first 3 years. These results suggest that persistent incontinence may overshadow a patient’s earlier enthusiasm after having a successful operation. For some the price of cure may be later perceived as too high.

Urine incontinence may be perceived as a natural consequence of aging, but even so, may have a significant impact on a person’s emotional and social well-being (Colley, 2003). After radical prostatectomy this may have further impact as men attempt to cope with their diagnosis as well as recover following surgery. Physical and psychological symptoms such as confusion, depression, anger, reduced self-esteem, fatigue, anxiety, and insomnia are common (Kornblith, Herr, Ofman, Scher, & Holland, 1994). Due to feelings of stigmatization, men can become socially reclusive and be characteristically dependent on others. Many men are still employed at the time of their surgery and may be the main family wage earners; there may be an added concern of loss of income and increased need to return to work as early as possible (Braslis, 1995).

The effects of UI after radical prostatectomy on quality of life are also experienced by partners and can have an influence on relationships (Butler et al., 2000). It is reported that incontinence following surgery can have a negative impact on the relationship (McCann, Kolm, Main, & Schellhammer, 1999). However, Butler et al. (2000) reported that the majority of partners perceived the quality of their relationship to be unchanged, and for some it was now much better as a result of their experience. Wives and other family members have a major role to play in supporting men after radical prostatectomy. It is often they who must bear the brunt of, and compensate for, the changes to normal activities (Fan, 2002).

Issues about body image and sexuality may also surface, and can have far greater consequences than anticipated (Ofman, 1993). Sexuality in this context does not simply mean sex or sexual concerns; although sexuality is widely discussed as such in much of the literature. Reducing this to erectile function alone creates a superficial definition which fails to address its real meaning and importance in altering quality of life (Helgason et al., 1996). Following radical prostatectomy, men who experience UI may express concerns about visible wetness, urine odor, and the type of clothing that can be comfortably worn (Butler, Downe-Wamboldt, Marsh, Bell, & Jarvis, 2001). More profoundly, an inability to totally control one of his most basic and fundamental bodily functions can seriously threaten a man’s identity and masculinity (Ofman, 1993).

**Purpose**

Previously, patients were routinely given a 1-month review appointment with their urologist for their histology results after surgery or biopsy. All patients attended a very busy general urology clinic with only two doctors and approximately 45 patients per session. This allowed an average of only 8 minutes per consultation per patient. At this visit, the patient was informed of his diagnosis, possible treatment options and their side effects, further investigations or imaging studies, follow-up, and the potential prognosis. Due to the nature and volume of the information received, the individual had an inadequate opportunity to fully absorb and then discuss the implications of the diagnosis.
Staging investigations were usually ordered at this visit as well, resulting in a situation where medical staff were unable to provide a definite treatment plan as the study results were unavailable for review. The patient had to wait for the investigations to be completed, resulting in a further delay in order to receive results and initiate treatment. At times it could take up to 3 months from the initial diagnosis of prostate cancer to the time until a definitive treatment plan was initiated. This resulted in an inevitable increase in patient anxiety and uncertainty, with the possibility of disease progression. If radical prostatectomy was chosen as the treatment option, patients would have this carried out without any pre-operative support or information, and only had input from the continence team after the catheter was removed post operation.

Through audit and review of the current practice, it was established that a change of strategy was required, moving away from a fragmented approach with delayed intervention. The newly appointed urology oncology nurse, working with the continence nurses and physiotherapists, identified the need to improve the presurgical preparation for patients undergoing radical prostatectomy, in anticipation of improving outcomes.

The change needed was to create a structured multidisciplinary team involvement at all stages of the patient's cancer experience (National Institute for Clinical Excellence [NICE], 2002).

**Methodology**

**Sample size.** Convenience sampling was used for both aspects of the study which were audited separately. Regarding the nurse-led histology clinic, all those who were approached about the study participated; a total of 106 patients took part. All patients who had undergone a radical prostatectomy within the sampling period were contacted.

**Study design.** Under the new nurse-led histology program, all patients diagnosed with urologic cancer now receive their diagnosis directly from the Specialist Urology Oncology Nurse (see Figure 1). Following surgery or biopsy, patients are routinely given a half-hour appointment to see the specialist nurse, during which they receive and discuss their histology results. Appointments are made under exactly the same criteria as per urology clinic; when a cancer is diagnosed, the specialist nurse coordinates the further staging investigations and schedules a return appointment for the results. All patients are offered detailed written and verbal information about their diagnosis and provisional treatment options. Information is staged as appropriate for each individual case to minimize information overload and maximize patient understanding. A contact number for the specialist nurse is given for immediate access to further information or clarification. Subsequently, the patient attends the urology clinic already aware of his diagnosis and the results of the staging investigations, making the consultation more productive and meaningful for both patient and clinician.

Patients who are diagnosed with prostate cancer and are provisionally suitable for radical prostatectomy receive a specific booklet on the surgery. This information is reviewed at two, and sometimes three, visits with the specialist nurse (again with a half-hour appointment each time) to discuss the implications of the diagnosis and to assist in deciding choice of treatment. Incontinence is discussed in detail during these visits; patients are made aware of the risk of incomplete urinary control following radical prostatectomy surgery. This risk varies in the literature, depending on the definition of incontinence, and ranges from as little as 2% to as much as 31%, and implies a range of intensity of treatment required postoperatively to improve it (Eastham et al., 1996; Heathcote et al., 1998; Leandri et al., 1992; Moore & Dorey, 1999; Murphy et al., 1994; Steiner et al., 1991).

It is also emphasized to operative candidates that although radical prostatectomy has gener-
ally become the first-line treatment for younger, fitter men diagnosed with localized prostate cancer, there is no conclusive evidence that surgical treatment is definitely superior to any other in terms of long-term survival (Lu-Yao & Yao, 1997). Within the study site, the age of men having a radical prostatectomy performed ranged from 41 to 71 years, with a mean age of 62 years.

If he finally opts for surgery, the patient is referred by the urology oncology nurse for a preoperative assessment by the continence and physiotherapy team as per the guidelines developed. At this visit, after establishing their current continence status, a best and worst-case scenario is given regarding continence after surgery, along with realistic targets relating to expected duration until recovery of continence. This is extremely important in order to create realistic expectations for their recovery after surgery and minimize the sense of despair when reality prevails (Fan, 2002).

Patients are taught how to tighten their pelvic floor muscles prior to standing, coughing, and sneezing. Stress incontinence, experienced by most patients after radical prostatectomy, and caused by the decrease of the urethral sphincter capability following surgery, will improve with pelvic floor exercises (Dorey, 2001). Several studies assessing the effect of pelvic floor exercises have recommended them as a curative intervention for incontinence post radical prostatectomy (Moore & Dorey, 1999; Van Kampen et al., 2000; Wille, Sobottka, Heidenreich, & Hofmann, 2003), although it is accepted that further research is needed to evaluate their optimum benefit for these patients (Moore & Dorey, 1999). Advice is also given regarding avoidance of stimulant fluids (such as tea, coffee, and carbonated drinks) in order to reduce intravesicle irritation and the resultant frequency and urgency (Bryant, Dowell, & Fairbrot, 2002). This, in combination with correctly performed pelvic floor exercises, allows for retraining of the bladder to store urine for longer periods following the removal of the catheter (Fanti, 1998).

Removal of the urethral catheter post prostatectomy can be the most traumatic time for patients as it is then that they often experience incontinence for the first time (Fan, 2002). Although they may have been warned to expect poor control, actually experiencing it can be extremely stressful. Usually at this time patients not only require physical assistance in the form of pads or further teaching of pelvic floor exercises, but also may need psychological support in coming to terms with what is now the reality of urinary incontinence (Herr, 1997). For this reason, patients’ admission for removal of catheter is coordinated with an appointment for the same day with the continence and physiotherapy team, with the urology oncology nurse available if needed. This ensures specialist intervention when required, and because patients are always seen by the same team members, it promotes a continuity of care which is extremely important (NICE, 2002).

Depending upon their progress, patients are then regularly reviewed by the multidisciplinary team during the same visit. This allows for good communication among team members and for discussion of any issues which may arise to be discussed at one clinic visit, thus avoiding unnecessary visits and limiting delays (NICE, 2002). For example, patients may be continually wet without the expected improvement, thus requiring more intense physiotherapy input (Dorey, 2001). Another problem may be that although continence has returned, patients may be experiencing poor urinary flow pressure and could have significant post void bladder residual volumes. This might indicate an anastomotic stricture which requires prompt intervention by the continence nurse who can refer to the patient’s urologist that same day for assessment (Surya, Provot, Johansen, & Brown, 1990). Similarly, patients may have new or ongoing concerns regarding their cancer generally, which the urology oncology nurse can discuss, and communicate with the urologist as appropriate (Ofman, 1993). In addition, the urology oncology and continence nurses have 24-hour helplines which patients can access.

**Figure 2. Severity Index**

<table>
<thead>
<tr>
<th>(1) How often do you experience urinary leakage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Less than once a month.</td>
</tr>
<tr>
<td>2. One or several times a month.</td>
</tr>
<tr>
<td>3. One or several times a week.</td>
</tr>
<tr>
<td>4. Every day and or night.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) How much urine do you lose each time?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Droplets or little</td>
</tr>
<tr>
<td>2. More</td>
</tr>
</tbody>
</table>

The Severity Index is created by multiplying the results of questions (1) and (2).<br>1-2 = slight<br>3-4 = moderate<br>6-8 = severe<br><br>From Sandvik et al., 1993
Figure 3.
International Prostate Symptom Score (I-PSS)

<table>
<thead>
<tr>
<th>International Prostate Symptom Score (I-PSS)</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incomplete emptying</td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>2. Frequency</td>
<td></td>
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<tr>
<td>Over the past month, how often have you had to urinate again less than two hours after you finished urinating?</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>3. Intermittency</td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you found you stopped and started again several times when you urinated?</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>4. Urgency</td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you found it difficult to postpone urination?</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>5. Weak Stream</td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had a weak urinary stream?</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>6. Straining</td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had to push or strain to begin urination?</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>None</th>
<th>1 Time</th>
<th>2 Times</th>
<th>3 Times</th>
<th>4 Times</th>
<th>5 Times or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Nocturia</td>
<td>0 1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?</td>
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</table>

<table>
<thead>
<tr>
<th>Total I-PSS Score</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly Satisfied</th>
<th>Mixed</th>
<th>Mostly Dissatisfied</th>
<th>Unhappy</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Life due to Urinary Symptoms</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or severe symptoms, patients can be tentatively classified as follows: 0–7 = mildly symptomatic; 8–19 = moderately symptomatic; 20–35 = severely symptomatic.

The International Consensus Committee (ICC) recommends the use of only a single question to assess a patient’s quality of life. The answers to this question range from “delighted” to “terrible” or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for a doctor–patient conversation.
both occasions a telephone survey was performed by the continence nurse and physiotherapist, with each patient using a validated continence severity index questionnaire (Sandvik et al., 1993) (see Figure 2) and quality of life questions from the International Prostate Symptom Score Questionnaire (Cockett et al., 1994) (see Figure 3). The telephone audit, on both occasions, was carried out at 1 year following surgery, as by this time the optimum level of continence should have been achieved.

Findings and Results

Nurse-led histology clinic audit results of this new practice were extremely positive (see Figure 4). From 106 patients audited by questionnaire, following transrectal ultrasound and prostatic biopsies (77%; n=82), and transurethral resection of bladder tumor (23%; n=24), a total of 99% (n=105) expressed overall satisfaction at being told their diagnosis by a nurse. A data-collection tool was also devised to assess the time scale of appointments, ultimately resulting in 91% of patients diagnosed with prostate cancer being reviewed by the medical team within 5 weeks of their initial biopsy: these patients were fully staged, better prepared, and in the case of those requiring hormonal therapy, treatment had already started.

The audit results showed that prior to the service development, of the 25 men having radical prostatectomy, only 32% (n=8) were seen pre-operatively by the continence team. Under the new program, 85% (n=41) of the 47 men audited were reviewed at least 2 weeks before surgery and taught pelvic floor exercises. The remaining 15% (n=6) were seen on the day of admission with surgery the following day. This resulted in an improved level of urinary control following removal of the urethral catheter, with only 49% of the 47 men (n=23) experiencing poor control, compared with 72% (n=18) of the 25 patients treated prior to the service development. Similarly, patients were generally regaining total continence over a much shorter period of time, often being discharged continent from the clinic within 2 months. Previously, as shown from the audit results, this would occur around 8 months post prostatectomy.

Overall, results using the severity index study reflect a significant improvement, with 55% (n=26) of patients treated under the new development dry and 30% (n=14) acknowledging slight drip leakage on strenuous exercise. Of the remainder, 9% (n=4) admitted to pre-operative incontinence and being no worse after surgery, while 6% (n=3) had poor continence levels either due to sphincter involvement from the cancer or other co-morbidity.

Patients’ quality of life was also much improved with the new approach. Most patients (97%; n=46) were delighted, happy, or pleased with their bladder control compared with only 68% (n=17) of the patients within the audit who were treated prior to the service development. The remaining 32% (n=8) had mixed feelings or were unhappy.

Study Limitations

An obvious limitation of this study is the small number of patients which limits generalization of the results. It is also accepted that the questionnaires used were basic and lacking in real depth, which can reduce the rigor of the study design, and may lessen the reliability and validity of the findings. It may also have been beneficial to contact the men earlier, and possibly at regular intervals, to ascertain their progress and establish when they reached their optimum level of control. Nonetheless, we believe the results of this study adequately show the positive results of this change of practice, and a larger and more detailed study is planned.

Nursing Implications

In health care, change is continuous and related to the consequences and implications of human, social, and cultural mutability. People are living longer, healthier lives and revolutionary advances in medical science and pharmacology have
stimulated changes in patterns of care which in turn bring new challenges for all the caring professions. Public expectation is also increasing with people demanding accessible health care delivered promptly and to a uniformly high standard. The nature and velocity of change may create difficulties for individual practitioners but it also facilitates opportunities for role expansion, innovative service development, and increased collaborative care. Health care professionals must work more in teams. Professional boundaries and barriers must be dismantled and a strategy developed which allows for the blending of all services and the best possible chance of achieving the ultimate common goal of total patient care. Ultimately, this study outlines a complete change of practice in caring for patients undergoing radical prostatectomy. It demonstrates how the creation of a modernized, collaborative approach can significantly improve quality, promote the best use of resources, and at the same time be acceptable to patients.

Conclusion
The benefit of a cancer treatment should outweigh the cost in patient suffering. In consenting to have a radical prostatectomy performed, it is essential that patients understand and agree to the possible compromises of treatment, having been fully informed of the controversies regarding the benefits and potential side effects of surgery. While it is important for physicians and other health care professionals to know that most patients can initially adapt to the side effects of radical prostatectomy, particularly incontinence, it is equally important that they appreciate that this adaptation does not mean that the symptoms are unimportant or easily managed.

Treatment of urinary incontinence post prostatectomy should begin at diagnosis when the surgery is planned and continued until it can be self-managed. With better quality information, increased patient involvement, and the care provided from a specialist multidisciplinary team, patients can be better prepared, both physically and psychologically, for the effects of urinary incontinence after surgery.

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