

International Continence Society 38th Annual Meeting

20-24 October, 2008
Cairo, Egypt

Report by: Virginia Ip

I would like to express my thanks to Conni for the financial support and encouragement to enable me to attend this international meeting.

The meeting was held at the International Convention & Exhibition Centre at Heliopolis, Cairo. This area is between the airport and downtown Cairo. The venue was surrounded by police and security during the time of our conference to ensure the safety of all those who attended.

As tourism is the country's major source of income, employing 25% of the workforce directly as well as at least another 20% indirectly to the industry. All the major tourist spots are stationed by at least the Tourist Police and security guards. However, I am not sure whether such measure was also due to the recent kidnapping of tourists 2 weeks before the meeting or the location being next to the Sadat Mausoleum. President Anwar Sadat was assassinated across the road in 1981.



2400 delegates attended this meeting, with about 10 nurses from Australia. Selvi Naidu and I represented New South Wales. Before the Scientific Meeting, I had the opportunity to participate the Nurses' Meeting for Pan -Arab Nurses Working with People with Bladder and Bowel Problems as well as three workshops. Here are the summaries:

Pan-Arab Nurses Working With People with Bladder and Bowel Problems

The title is somehow misleading as there were not many attendants who thought the meeting was solely for Arabic nurses.

In fact, it was an international nurses meeting, with only about 10 nurses from Arabic countries and 25 from other countries. The discussion panel included ICS nurses representatives as well as representatives from UK, USA and Egypt.

Mandy Wells from UK who is on the ICS Nurses' Group Education Sub -committee reported that this committee was organized 5 years ago. It is now opened to anyone who is interested in a nursing subject, e.g. physiotherapist or other allied health professionals.

Mandy Fader from UK showed the interactive nurses' website which will be formally attached to ICS website after the conference. Information on the website will include:

- Locate ICS Nurses members
- News & Events:

- Education and professional development (Directory of Courses)
- Professional development: the role of Continence nurse, in developing Continence service
- Clinical practice: assessment, measuring performance
- Research different projects, possibly to link up for international studies
- Forum for international discussions/dialogs

Prof. Mary Palmer who conducted the Nurses Research Interest Survey gave an overview of the results from 27 participants. In spite of currently there are 100 ICS nurse members; some might have trouble understanding that the survey was only for nurses who are currently doing research independently. So the survey will be circulated again.

The panels went on to discuss about the ICS's official journal, 'Neurourology & Urodynamics'. There were suggestions that nursing articles could be included as the supplement of the journal so to encourage more nurses to submit their articles as currently the requirement /standard for publication is the same for the medical professional. The panel and the participants agreed that lower the standard for nursing papers will discredit our contribution.

A representative from USA advised the audience that in 2 years time, there will be a PHD for Advanced Practice Practitioner as nursing specializes in University realize that other discipline, e.g. social worker, physiotherapist, their credit points for PHD is the same as the Master degree for Nursing. So universities are phrasing out the master degree and moving towards doctorate degree instead.



Professor in Nursing, Dr. Nadia Yanni Seif represented local nurses to give an overview of Middle East Perspective of Continence. She confirmed that the incontinence problem is too large to handle, with under-reporting being the major obstacle. Another Egyptian nursing professor reported that up to 70% women have different degrees of incontinence post child birth. Multiple child birth, early age pregnancy, too embarrassed to seek help, lack of knowledge, lack of resources for postnatal follow-up are common

problems. Culturally, it is a stigma to discuss incontinence issues so raising awareness will depend on health professionals being more proactive to ask patients as the women do not understand what incontinence is and would just learn to cope and endure

This is the first time that Egyptian nurses come to a nurse meeting, to be independent of their medical colleagues. They also pointed out that works of the nurse researchers are not acknowledged and it is difficult to get it published. All the Egyptian nurses are very keen to work together with nurses internationally.

Physiotherapy for Non-Physiotherapist Workshop

Due to the great interest shown in physiotherapy at the round table meetings at ICS, this workshop aims to guide other health professionals how to manage incontinence with physiotherapy.

Marjan Rakers Bergjk, who is a Pelvic Floor Physiotherapist from the Netherlands, started the session by giving a revision on the anatomy of the pelvic floor. Then she discusses the pelvic floor dysfunctions which include underactivity, overactivity and co-ordination disorders, as well as pelvic floor damage such as Muscle (myogene), nerves (neurogene), combination of myogene and neurogene, connective tissue damage.

Marjan pointed out that pelvic floor damage are caused by:

- Partus
- Pregnancy
- Trauma
- Hormonal
- Surgery of abdomen/pelvis
- Chronic load: adipositas, physical heavy labour, COPD (EXPLAIN)
- Oncology, radiotherapy
- Atrophy : inactivity, old age

Anamnesis pelvic physiotherapy can be used to treat:

- Micturition disorder
- Defaecation disorder
- Menstrual cycle
- Pregnancies, births rehabilitation
- Surgery in abdomen and pelvic floor region
- Sexual disorder
- Pain
- Toilet behaviour

She emphasized that "What you cannot feel, you cannot train" so if the patient cannot feel the pelvic floor muscles contraction, he/she cannot be trained to do the pelvic floor muscle exercises.

Some of the pelvic floor and stabilizers awareness technique included:

- Breathing
- Insert finger in anus for patient to feel
- Warm cloth under perineum
- Electrical Stimulation

- While performing examination of pelvic floor muscle with palpation, we need to check:
 - Tone - tension in the pelvic floor: under-active, overactive, normal activity
 - Power, endurance, co-ordination, reaction time
 - Proprioception / co-ordination, pelvic floor awareness (if you cannot feel it, you cannot train it)
 - Pain / trigger points

In addition to the pelvic floor, we should also look at posture and how the patient walks. To prevent the increase of abdominal pressure when bending down, we can

advise the patient to breathe out and relax the abdominal wall. Marjan also had suggested a Manual Controlled Exercise:

1. Awareness : finger in anus to check activity of pelvic floor muscles, check closure and relaxation
2. Coordination of pelvic floor muscles
3. Relaxation: must be able to relax first before contraction, e.g. when we ask patient to do shoulder contraction, he /she must be able to relax it first.

The result of these 3 stages could be recorded in a Myofeedback (Biofeedback) Strip.

As there is a relation between sexual abuse and pelvic floor problems, she strongly recommended that we must check this history first before examining any patients. In her practice, she also had the patient sitting on a Swiss ball to raise pelvic floor muscle awareness.

For patients with dysfunctional voiding, they were given a bladder scanner (hand-held type) to take home to check and print out residuals. For those who are interested in identify and treat trigger points, Marjan suggested to refer to Trigger Point Manual vol.2 by Trevelle & Simons (vol.1 is for upper body and vol.2 is for lower body). Physiotherapists in the Netherlands has produced guidelines in treating stress incontinence in English version, please go to www.kngf.nl

The last presenter of this workshop was Marijke c.ph.Slieker-tem Hove, the Headmaster education pelvic physiotherapist in the Netherlands. She told the audience that 11% ICS members were pelvic physiotherapists. To raise awareness of the pelvic floor, she used anatomical models, Swiss ball and webcam. When treating children with Spina Bifida who had pelvic floor dysfunction, she used a webcam to show the children how the anus "dance "-open and close, during the pelvic floor contraction and relaxation. She also used biofeedback in children to relax pelvic floor. For men with this problem, she recommended bulking agents on sphincter before pelvic floor muscles training. In addition to pelvic floor dysfunction, Marijke pointed out that physical therapy is also a very valid treatment for Interstitial Cystitis. It is most important that patient and health professional are working together as each has equal part to play.

Before closing the workshop, Marijke had the audience up doing pelvic floor muscles exercise – lifting one leg each time while contracting the pelvic floor muscles? The Netherlands way!

Update on the Management of Overactive Bladder Syndrome

The participants were given a handout of this workshop. For additional information, please go to <http://www.ttmed.com/urology>, Overactive Bladder Teaching Module chaired by Dr. Marcus Drake.

Hashim Hashim introduced the workshop by giving the definition and epidemiology of Overactive Bladder (OAB)

Definition of OAB:

Urgency, with or without urgency incontinence, usually with increased daytime frequency and nocturia

Abrams P et al. *Neurourol Urodyn*, 25 (3); 293 (2006)

There should be no proven infection or other obvious pathology

The symptoms of OAB:

- Urgency : the complaint of a sudden compelling desire to pass urine which is difficult to defer
- Urge (ncy) urinary incontinence : the complaint of involuntary leakage accompanied by or immediately preceded by urgency
- Increased daytime frequency : the complaint by the patient who considers that he/she voids too often by day
- Nocturia : the complaint that the individual has to wake at night one or more times to void

Abrams P et al. *Neurourol Urodyn*, 21:167-178 (2002)

Please note the frequency and nocturia complaint are subjective to the patient's interpretation, e.g. if patients thinks 6 voids per day is 'too frequent' than it is consider as 'frequency'

Definition of Detrusor Overactivity (DO):

- OAB is suggestive DO
- Involuntary detrusor contractions
- During the filling phase of cystometry
- May be spontaneous or provoked
- May be idiopathic or neurogenic
- Previously known as detrusor instability

Abrams P et al. *Neurourol Urodyn*, 21:167-178 (2002)

OAB vs. DO

- OAB is a clinical symptomatic diagnosis
- DO is a urodynamic diagnosis
- 82% of men with OAB have DO
- 58 % of women with OAB have DO

Hashim H et.al. *J Urol*; 175 (1):191-4 (2006)

At this stage, one physiotherapist in the audience suggested that a lot of men has overactive pelvic floor, it is important for them to learn how to relax the pelvic floor to facilitate voiding.

OAB needs accurate diagnosis and proper management. It should include:

- History –urological history such as :
 - 'Storage' Lower Urinary Tract Symptoms (LUTS) – urgency, frequency, nocturia, precipitating factors, duration of symptoms, Frequency of symptoms, type and degree of incontinence, pad usage, effect on Quality of Life, 'Which is your most bothersome symptom?'
 - 'Voiding ' LUTS – haematuria, flow pattern (hesitancy, slow stream, interrupted stream, post micturition dribbling
- Physical Examination :
 - Abdomen
 - External genitalia
 - Neurological examination of the lower limb and perineum, including reflexes

- Digital rectal examination (DRE) – check for anal reflex, tone, sensation and pelvic squeeze
- Feel prostate in men
- Check Pelvic Organ Prolapse in women –POPQ score
- Investigation :
 - Height and weight (BMI)
 - Urinalysis –‘dipstick’ to exclude infection (leucocytes & nitrites), haematuria (blood), Glucosuria (glucose)
 - Measure post-void residual
 - Voiding diary (4 days in women, 3 days in men)
 - Quality of Life questionnaire – ICIQ – UI (short form), ICIQ-OAB (Ref: Abrams P, Avery K, Gardener N, Donovan J. The international consultation on incontinence modular questionnaire: [Www.iciq.net](http://www.iciq.net). Journal of Urology 2005.175: 1063-1066)
- Treatment : conservative treatment, medical treatment, interventional therapies

Conservative Treatment of OAB Syndrome

The principles of treatment are to increase voided volume, decrease urgency and reduce urgency urinary incontinence episodes. These include:

Lifestyle interventions / behavioral modifications:

- Fluid and food intake:
 - Caffeine reduction
 - Fluid manipulation: decrease fluid by 25% but drinking more than 1 Litre /day and less than 3 litre /day (Hashim H, Abrams P. Fluid manipulation in the treatment of overactive bladder syndrome (abstract 1009) .Eur Urol Suppl 2007; 6(2):275)
 - Tea drinking (but not coffee) is associated with urgency incontinence (Hannestad YS, Rortveit G, Daltveit AK, Hunskaar S. Are smoking and other lifestyle factors associated with female urinary incontinence? The Norwegian EPINCONT study. BJOG 2003 Mar; 110 (3): 247-254
 - Both caffeine and alcohol can act as diuretics (Creighton SM, Stanton SL. Caffeine: does it affect your bladder? Br J Urol 1990 Dec; 66 (6): 613-614
 - Avoid drinking four hours before going to bed in the evening and voiding before going to bed if nocturia is a problem. Avoid water-content of foods such as vegetables and fruits(Hashim & Abrams as above on fluid manipulation)
 - In men, there seems to be a negative association between beer intake and subsequent OAB onset(Dallosso HM, Mathews RJ, McGrother CW, Donaldson MM, Shaw C, The association of diet and other lifestyle factors with the onset of overactive bladder: a longitudinal study in men. Public Health Nutr 2004 Oct; 7(7): 885-891
 - Diet Coke and caffeine free Diet Coke produce similar increase in urgency and frequency, compared to carbonated water or Classic Coke? problem is caused by artificial sweeteners, rather than caffeine (Cartwright R, Srikrishna S, Cardozo L, Gonzalez. Does Diet coke cause overactive bladder? A 4-way crossover trial, investigating the effect of carbonated soft drinks on overactive bladder syndromes in normal volunteers (Abstract 19). Neurourol Urodyn 2007 Aug; 26(5): 626-627
- Weight reduction in those with a body mass index greater than 30

- Cessation of smoking
- Supervised pelvic floor muscle training for at least three months : Patients are taught to tighten the pelvic floor when they get an involuntary contraction and also when changing positions (sitting up from lying down and standing up from a sitting position). This situation can result in urgency and urgency incontinence due to incontinence due to an involuntary detrusor contraction
- Electrical stimulation and / or biofeedback for patients who have trouble to contract or locate their pelvic floor muscles
- Bladder training for a minimum of six weeks including prompted and timed voiding toileting program
- Acupuncture and Transcutaneous Electrical Nerve Stimulation (TENS)

Medical (Pharmacological) Treatment of OAB Syndrome

The detrusor smooth muscle is supplied by the parasympathetic nerves (S2, 3 and 4). Acetylcholine is the main neurotransmitter, at the nerve endings, acting on the muscarinic receptors in the bladder and resulting in detrusor contraction.

Antimuscarinic drugs such as Oxybutynin, Tolterodine, Propiverine, Solifenacin, Darifenacin, Trospium, Fesoterodine are used to block muscarinic receptors in the bladder during filling phase, to reduce detrusor overactivity.-

Others:

- Topical Oestrogens for post –menopausal women
- Imipramine
- Propantheline
- ? Alpha-antagonists, e.g. tamsulosin
- ? Beta-agonists, e.g. terbutaline
- Prostaglandin synthesis inhibitors , e.g. flurbiprofen, indomethacin
- ? Calcium antagonists, e.g. nifedipine, diltiazem
- ? Serotonin norepinephrine reuptake inhibitors (SNRIs), e.g. duloxetine
- ? Potassium channel openers, e.g. pinacidil, cromakalim
- Desmopressin
- Gabapentin

Interventional Therapies:

- Intravesical therapy : Anticholinergics (Oxybutynin, Atropine), local anaesthetics, Vanilloids (Capsaicin, Resiniferatoxin), Botulinum toxin
- Neuromodulation : sacral nerve stimulation, posterior tibial nerve stimulation (also known as Stoller Afferent Nerve stimulation), pudendal Nerve stimulation
- Bladder denervations
- Bladder augmentation : detrusor myectomy, 'clam' cystoplasty

Hashim told the participants that as the 2008 edition, *Incontinence*, now at the printer, the 2005 edition is available free of charge, please check www.ics.org

Good Urodynamic Practice Workshop

This workshop was conducted by Gordon Hosker (scientist from UK), Werner Schaefer (Urogynaecologist from USA) and Christopher Payne (Urologist from USA). Although the workshop was for any health professionals or urodynamics technicians who were relatively new to urodynamics, I thought it would enhance my knowledge in this area.

Good urodynamic practice is to ensure all measurements are made to scientifically appropriate standards and to ensure consistency between all who carry out urodynamics. The current recommendations from the ICS regarding good urodynamic practice is that it should not be performed without precise indications and defined questions that can be answered by the results of the urodynamic study

The speakers showed us various equipment, some practical tips as well as how to interpret Urodynamic traces. The workshop had been recorded on webcast and will be online for the next 12 months at the ICS website. Here are the summary from the workshop's handout regarding most common urodynamic studies -

Recommendation for Uroflowmetry:

- Provide adequate privacy
- Void when patient feels a " normal " desire
- Was the void representative?
- Measure post-void residual
- Maximum (smoothed) flow rate should be rounded to the nearest whole number
- Voided volume and post void residual volume should be rounded to the nearest 10 ml
- The maximum flow rate should always documented together with voided volume and post void residual volume using a standard format :
VOID: maximum flow rate / volume void / post void residual,
e.g. VOID1: 17/180/20
VOID 2: 19/250/-
- A sliding average over 2s should be used to remove positive and negative spike artifacts
- Only flow rate which have been "smoothed" either electronically or manually should be reported
- If a flow / volume nomogram is used, this should be stated and referenced

Recommendation for Cystometry:

- Use a rectal balloon catheter to measure abdominal pressure
- Suitable sites for measuring abdominal pressure – rectum, upper part of vagina, abdominal stoma
- Use a transurethral double lumen catheter for the measurement of intravesical pressure and for bladder filling (some facilities use a nelaton catheter for filling and the vesical pressure line is 'piggy back' to the filling catheter)
- Flush all pressure lines to exclude air (air bubble compresses pressure so that the real pressure will be lower if air in line)
- Strict adherence to ICS standardization of Zero pressure and reference height:
 - Zero pressure is the surrounding atmosphere pressure

- The reference height is defined as the upper edge of the symphysis pubis
- Regular coughing during filling and before voiding to identify any problems
- Continuous , careful observation and assessment of the signals
- Avoid or correct artifacts immediately
- Should be interactive with the patient and the test have reproduced the patient's symptoms
- Findings should be documented immediately
- Repeat the test if the initial test suggests abnormality, or there are technical problems preventing proper analysis
- Regular checks of the calibration of equipment

Opening Ceremony and Welcome Reception

The delegates were formally welcomed at the Opening Ceremony and Welcome Reception on Tuesday 21st October. The 2008 Annual Meeting Chair, Prof. Sherif Mourad reported that many Africans with incontinence are without treatment and this was highlighted by the large number of abstracts submitted in first week to ICS. After the welcoming speeches by Chairs from Germany, Belgium and USA, the audience was treated to a special presentation by The famous archeologist and Egyptologist, Dr. Zahi Hawwas, who is the current General Secretary Council of Antiquities. Dr. Hawwas gave an insight of the treasures found in the King Tutankhamen's tomb and demystified his cause of death. It was a timely lecture for Selvi and me as we visited the Cairo Museum the day before and was so fascinated by the King Tut's collections. His famous burial mask, framed by bullet proof glass, is the centre of attraction and protected by armed and undercover police. He was not murdered but died of an abscess from a leg wound at aged18.

As this is a medical conference, Dr. Hawwas intrigued the audience with the discovery of a tomb which belongs to the first Egyptian physician / surgeon, Karr. Inside his tomb, there were tiny surgical tools used thousands of years ago. Among other discoveries were new hidden passages in the great pyramid and a brain cancer surgery patient who lived for nearly 2 years postoperatively.

It was amazing to know about the brain surgeries in those times, more extraordinary the successful ones. Dr. Hawwas is currently supervising many projects and the most ambitious one would be to locate the tombs of Mark Anthony and Cleopatra in Alexandria. So watch this space!

Before moving to the nearby Chinese Gardens for dinner, we were entertained by a troupe of 5 male dancers who performed the colorful 'spinning top' folk dances. For nearly 30 minutes, they just kept spinning under big cotton round skirts in unison. It was very spectacular site!



Gala Dinner at the Pyramids

The conference Gala Dinner was held on Thursday 23rd October, it was a truly unforgettable evening. The delegates were convoyed by coaches from the top of the hill and passed all the pyramids on the way down. At the foot of the Great Pyramids, ICS rolled out the red carpet, round dinning tables were placed not far from the Sphinx and the stage was set. After another warm welcome by our Annual Meeting host, Sherif Mourad, we were treated to a shortened version of the famous sound and light show.



Without doubt, seeing the pyramids is the top of the list for any visitors who come to Cairo. In the Giza Necropolis, the Great Pyramid of Giza is the oldest and largest of the three pyramids. It was built for 4th Dynasty Pharaoh Khufu (Cheops) and constructed over a 20 year period concluding around 2560 BC. It is believed to have been built as a tomb. The Pyramid of Khufu is the tallest man-made structure in the world for over 3,800 years. A few hundred metres south-west of the Great Pyramid lies the slightly smaller Pyramid of

Khafre, one of Khufu's successors who is also commonly considered the builder of the Great Sphinx, and a few hundred metres further south-west is the Pyramid of Menkaure, Khafre's successor, which is about half as tall. The wives of the pharaohs had much smaller pyramids nearby but only those of Menkaure are still standing.

This nightly laser show of the pyramids is a magic display of these three great pyramids as well as the three small pyramids of Menkaure's wives, with the magnificent Sphinx guarding these treasure tombs. This open air show lasts for about an hour in English, Japanese, German and French. During the colourful display, audience was told about the building process, the meaning of the inscriptions and the importance of the after life to the Pharaoh and his people.

After the show, dinner guests were served with Egyptian delicatessen and wine. While many people danced the night away, we had to admit that our fitness was not in the top form and we took the first coach back to our hotel. But it was a magical evening at a most unique and grand venue, one of the original Seven Wonders of the World!



International Painful Bladder Foundation (IPBF)

IPBF is a non-profit voluntary umbrella organization which promotes knowledge and awareness of interstitial cystitis (also known as painful bladder syndrome, bladder pain syndrome, and hypersensitive bladder syndrome) and associated disorders among patients, patient support groups, health professionals and the general public worldwide.

Through its website, free e- newsletter, congress booths, publications and presentations around the world, IPBF provides up-to-date information on the latest developments in the field of diagnosis and treatment of IC and associated disorder.

The foundation has produced a CD in October which details comprehensive information on IC, its diagnosis and treatment, IC & Associated Disorders, IC & Gastrointestinal Disorders, Sjogren's syndrome and Overactive Bladder Syndrome. I was also able to get a copy IC in Chinese from the conference booth.

Website: www.painful-bladder.org

For free e-newsletter and a copy of CD, please contact: info@painful-bladder.org

To contact IC support groups in Australia:

- Interstitial Cystitis Support Group of Australia :
P.O.Box 144
Richmond,
Victoria 3121
Contact: Katya Buc
katyabuc@hotmail.com
www.users.bigpond.net.au/ICSG
- Interstitial Cystitis Support Group
Mercy Hospital for Women,
Clarendon Street,
East Melbourne,
Victoria 3002
Contact: Christine Murray

World Continence Day

ICS Continence Promotion Committee (CPC) in conjunction with Pan Arab Continence Society had organized a public forum on 24th October. This concept was initially trialed at last year's meeting at Rotterdam. The forum aimed to inform public of partnership between ICS and CPC as well as to raise public awareness of bladder and bowel health issues.

The forum was open to CPC national organizations, professional associations such as physiotherapists and nurses, pharmaceutical companies, associated and community groups and other allied health care organizations.

Program included:

- Current Care of Urinary Incontinence in the Middle East
- Raising Continence Awareness – The Global Problem of Incontinence
- Patient Challenges to Accessing Incontinence Care
- Nurses Role in Managing Incontinence

- Collaborating to Increase Continence Awareness – Singapore Experience
- Understanding Interstitial Cystitis and the Painful Bladder
- Announce the first World Continence Week

World Continence Week Monday 22 nd June – Sunday 28th June 2009

This is the project of the ICS Continence Promotion Committee (CPC). The campaign is to address the increasing needs of the 200 million people who suffer from incontinence worldwide.

The local Continence organizations in each country will be linked through the ICS Continence Promotion Committee, which will provide guidance, support and promotional material to help them to run activities to promote continence awareness. The main purpose of this campaign is to globally facilitate Continence Awareness and promotion to improve health, wellness and quality of life in those who suffer the often silent problem of incontinence.

Post Conference Tour



After the conference, Selvi and I had the opportunity to visit the Citadel and the market in Cairo. Then we flew to Abu Simbel to see the two temples which were relocated when the Aswan Dam was built. We concluded our visit to Egypt by joining a Nile Cruise tour. For four days and 3 nights, we were sailing down the Nile River and visited some of the temples along the way. Our final destination was Luxor. When we went to the Valley of the Kings (burial temples for the Pharaohs), there was a real life excavation going on. It was exactly like what we saw on movies and TV documentaries. And no one could come to Luxor without seeing the Karnak Temple (the world's largest open museum)

Visit to Urology Centre, Singapore General Hospital

Before returning home, we visited our friend Mahmood who is a clinical nurse manager in the operating theatre at the urology Centre of Singapore General Hospital. Being the leading hospital in Singapore, it is a tertiary hospital which provides medical, nursing and allied health training facilities.

Mahmood took us around to see the outpatient, the urology ward and the different theatre rooms where we saw their Robots for Prostatectomy.

The Urology Centre services three to four thousands patients per month. It is a one stop shop – from having blood test, x rays, seeing the Urologists, Urodynamics, Continence Assessment, minor procedures are provided in a well co-ordinated manner. Currently there is a transit Urology nurse practitioner who is doing an



internship for 12 months before confirmation.

I had previously visited this hospital in 2003 and some of the staff are still there. The department still provides subsidized buffet lunch to all staff. May be that is the incentive!

Once again, I would like to express my gratitude for the support and encouragement from Glenys and her team at Conni: **Thank you!**