




KSS/South Thames Urology Meeting
Agenda/Abstracts Booklet

Ashford & St Peters NHS Hospital,
Education centre

Monday, 24th April 2017



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Introduction:

Welcome to Chertsey, the home of the third stump in cricket!

Yes, the town of Chertsey has a place in the history of cricket. "Lumpy" Stevens, the gardener of Lord Tankerville, was an outstanding bowler. He could deliver the ball between the 2 stumps frequently and caused disputes, as the bails were not knocked out. This led to the introduction of the third stump in the game of cricket in 1776.

With this in mind, we have arranged this STC meeting at St Peter's hospital to kindle new ideas and concepts for the future of urology that might perhaps create history.

We have the usual business meeting in the morning followed by the presentations from the trainees from both, KSS and the London deanery. A large number of high quality presentations were received and we were simply spoilt for choice! We have selected some thought provoking papers, which will hopefully generate good discussions. There will be the usual prizes for the best paper, which will be selected by independent judges.

We hope you will spend some time with the exhibitors in the postgraduate centre, as our sponsors have been very supportive. We are also very grateful to our secretary Jo Mucklow for helping as part of the organising committee.

Hope you enjoy this academic event at Ashford and St Peter's Hospital.

Ravi Kulkarni & Sachin Agrawal.

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Programme	
1000 – 1200	South Thames Deanery Meeting
1000 – 1200	KSS Deanery meeting
1200 – 1230	Joint meeting
1230pm – 1330	<i>Lunch</i>
1330 - 1500	Academic Session 1
1500 – 1530	<i>Tea</i>
1530 – 1540	College & Regional Update
1540 – 1650	Academic Session 2
1650 – 1700	Urology Catheter Project
	Award of Derek Packham Medal
1700 - 1730	<i>STC Update</i>
1730	Meeting, Close
1800	<i>Dinner</i>

The companies kindly supporting the meeting are listed below:

Boston Scientific, Astellas, Bespoke Medical Protection, Karl Storz, Allergan, Ferring, Cook Medical, Pierre Fabre, Olympus, Takeda, Wolf Richard (UK), Kyowa Kirin, Genesis, Hitachi

Our sponsors have had no involvement regarding the educational content nor has there been any involvement or any support provided for the content, logistics, selection of venue or any other meeting arrangements.

Academic sessions:

1330- 1500 Academic Session 1:

7mins per presentation, 3 mins questions

1. **A change in UTI incidence in our intradetrusor Botox patient cohort following changes in pre-operative protocol and antibiotic prophylaxis.** A Brewin, E White, R Walker, T Nitkunan. Presenting author: Dr. Anna Brewin
2. **Internet use in patients attending urology outpatient clinics and undergoing urological surgery- friend or foe?** Amelia Kerr, Amy Burrows, Patrick Olaniyi, Niyati Lobo, Charles Coker. Presenting author: Amelia Kerr
3. **Red Patches Detected at Flexible Cystoscopy: Are We Getting It Right?** Niyati Lobo, Ahmed Ali and Tim Lerner. Presenting author: Niyati Lobo
4. **Rectal swab cultures and targeted prophylactic antimicrobial regimes do not reduce the risk of sepsis following transrectal prostate biopsy:** Marios Hadjipavlou, Waseem Mulhem, Mazin Eragat, Charlotte Kenny, Chris Wood, Martino Dall'Antonia, Mohamed Y Hammad. Presenting author: Marios Hadjipavlou.
5. **Audit on the antibiotic management of upper urinary tract infections.** Olivia Jones, Christopher de Souza, Jade Harrison, Denosshan Sri, Rashmi Singh, Sarbjinder Sandhu. Presenting author: Olivia Jones
6. **Medium term outcomes and safety profile of Botulinum Toxin Type A intra-vesical injections in men with idiopathic detrusor overactivity.** Nicholas Faure Walker, Jane Watkins, Christopher Dowson, Sachin Malde, Claire
7. **Maximising Income from PCNL.** H Warren, K Keen, A Khan, S Willis, J Glass, G Noble, K Thomas, M Bultitude. Presenting author: Hannah Warren
8. **Factors affecting intrarenal pressure during flexible ureteroscopy and Laser lithotripsy.** Neophytos Petrides, Rajesh Krishnan. Presenting author: Neophytos petrides
9. **Point of Care INR testing on the day of surgery: a small prick with BIG results.** Kamran Haq, Donald Choi, Andrew Chetwood, Nimalan Arumainayagam. Presenting author: Kamran Haq

1530- 1640 Academic Session 2:

7mins per presentation, 3 mins questions

10. **Internet use in patients attending urology outpatient clinics and undergoing urological surgery- friend or foe?** Amelia Kerr, Amy Burrows, Patrick Olaniyi, Niyati Lobo, Charles Coker. Presenting author: Amelia Kerr
11. **Home and away: comparing mechanism of renal trauma and subsequent management in two major trauma centres in London and Adelaide.** S Rintoul-Hoad, J Makanjuola, C Brown, R Catterwell. Presenting author: S Rintoul-hoad
12. **Renal function loss after Cryoablation of Small Renal Masses in Solitary Kidneys - European Registry for Renal Cryoablation (EuRECA) multi institutional study.** Rudd I, Farrag K, Neilsen TK, Lagerveld BW, Keeley F, Guazzoni, G, Barber NJ, Sriprasas S. Presenting author: Iain Rudd
13. **Salvage robot assisted radical cystectomy (sRARC): a demonstration of our experience in technical feasibility and perioperative outcomes.** Kawa Omar , Parsons B, Rajesh Nair, Ramesh Thurairaja , Shamim Khan. Presenting author: Kawa Omar
14. **Exploring patient readmissions following Robot-Assisted Radical Cystectomy at a Tertiary Bladder Cancer Service.** Dimitrios Moschonas, Pavlos Pavlakis, **Jamie Lindsay**, Annelisse Ashton, Alison Roodhouse, Chris Jones, Ricardo Soares, Murthy Kusuma, Simon Woodhams, Michael Swinn, Hugh Mostafid, Matthew Perry, Krishna Patil Presenting author: Jamie Lindsay
15. **Evaluating prognostic factors for recurrence and mortality from upper tract urothelial carcinoma (UTUC) after nephroureterectomy (NU) from a 16 year experience.** P Brousil, M Ager, A Coscione, R Macarthur, S Sandhu, K Anson, B Ayres, P Le Roux, C Anderson. Presenting author: P Brousil
16. **The Prostate Cancer Diagnosis Pathway; Quality Improvement Against CWT Targets.** Philip James, Nimalan Aruminayagam, Senthyl Sellaturay, Sachin Agrawal. Presenting author: Philip James
17. **New haematuria NICE guidelines: what about the under 40s?** Ola Blach, Ahmed Ali, Tim Larner. Presenting author: Ola Blach

Abstracts

Academic Session 1

Mr Nimalan Arumainayagam

Mr Jai Seth

Title of presentation

A change in UTI incidence in our intradetrusor Botox patient cohort following changes in pre-operative protocol and antibiotic prophylaxis.

Authors Dr. A Brewin, Miss E White, Mr R Walker, Miss T Nitkunan,
Epsom and St Helier University Hospitals NHS Trust
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Abstract

Introduction

The incidence of UTI following intradetrusor Botox® in our Trust was previously found to be 33%. This led to changes in antibiotic prophylaxis and procedural protocol. Oral co-amoxiclav is now given for local anaesthetic cases. The protocol involves a urine specimen sent for culture 2 weeks prior, and an on the day check for UTI symptoms and urine dipstick.

The aim of this re-audit was to determine whether the UTI rate had altered since these changes.

Patients and Methods

Data was gathered from the 42 patients who were planned to receive intradetrusor Botox® between January and June 2016. Information from our Botox® database, clinic letters, operation notes and microbiology results were reviewed.

Results

One of the 42 planned procedures was cancelled due to UTI symptoms and positive urine dipstick on procedural day. 24/41 (59%) were under local. Idiopathic:neurogenic cases were 29:12.

10/37 (27%) pre-procedure urine cultures were positive ($>10^8$ cfu/l). The percentage of all organisms sensitive to Trimethoprim was 78%. All pre-procedure UTIs were treated with appropriate antibiotics.

8/41 (20%) patients had a proven UTI following intradetrusor Botox®. The percentage of all organisms sensitive to Trimethoprim was 43%. A positive urine culture was unrelated to clean intermittent self-catheterisation or diabetes.

Conclusion

There has been a reduction of post-Botox® UTI incidence from 33% to 20% following changes in the protocol. Changes in bacterial resistance patterns are seen post Botox® and this warrants further study

Title of presentation

Internet use in patients attending urology outpatient clinics and undergoing urological surgery- friend or foe?

Amelia Kerr, Amy Burrows, Patrick Olaniyi, Niyati Lobo, Charles Coker
Brighton and Sussex University Hospitals NHS Trust
Email: Amelia.kerr@bsuh.nhs.uk

Introduction

Patients are increasingly using the Internet for medical information, which may be of variable quality and cause unnecessary anxiety. This study aims to examine the use of the Internet and its impact among patients attending urology clinics and undergoing urological surgery.

Methods

Patients attending urology clinics or undergoing elective surgery at a teaching hospital were surveyed regarding their use of the Internet for information over a 2-month period.

Results

- 364 questionnaires were completed (162 patients attending clinic and 202 undergoing surgery).
- Patients attending clinic were more likely to use the Internet to seek information than those undergoing surgery (47% vs 24%) and more likely to discuss their findings with their urologist (58% vs 21%).
- The NHS and Wikipedia websites were most commonly used by both groups. The BAUS website was least commonly used.
- The majority of patients in both groups found that using the Internet led to an improved understanding of their condition, better communication with their urologist and an improved ability to make treatment decisions.
- Female patients, those < 65 years and those with malignant diagnoses in both groups were more likely to feel anxious after searching the Internet.

Conclusions

Internet use in patients attending outpatient urology clinics and undergoing elective urological surgery is common and, in most cases, allows patients to better understand and manage their condition.

Title of presentation

Red Patches Detected at Flexible Cystoscopy: Are We Getting It Right?

Niyati Lobo, Ahmed Ali and Tim Larner

Brighton and Sussex University Hospitals NHS Trust

Email: niyatilobo@gmail.com

Introduction

Red patches of urothelium are commonly seen during flexible cystoscopy and frequently biopsied to exclude CIS. At our institution, biopsies are performed under general anaesthesia. The objective of this study was to quantify the diagnostic yield of biopsy for red patches detected at flexible cystoscopy and to determine the association between trainee experience and frequency of GA biopsy.

Methods

We retrospectively reviewed all GA cystoscopies +/- biopsies performed for red patches detected at flexible cystoscopy between 30/11/15 and 30/11/16.

Results

70 patients underwent a GA cystoscopy +/- biopsy for a red patch detected at flexible cystoscopy.

32/70 (46%) were two-week wait referrals.

Mean age 69.5 ± 14.1 years

30% were ASA 3

18/70 (26%) with a red patch at flexible cystoscopy had a normal GA cystoscopy;

72% of these cases were booked by junior trainees.

Table 1. Histological diagnoses in red patch biopsies

Indication for flexible cystoscopy	n	Malignant pathology	Benign pathology	Normal mucosa
TCC surveillance	30	2/30	19/30	3/30
Haematuria	29	1/29	14/29	4/29
Recurrent UTI	6	1/6	4/6	0/6
Storage LUTS	3	0/3	2/3	0/3
Other	2	0/2	2/2	0/2
Total	70	4/70 (6%)	41/70 (57%)	7/70 (10%)

Complications occurred in 3/70 (4%), including one on-table arrest.

Conclusions

Red patch biopsy has a low diagnostic yield of malignancy. Junior trainees are more likely to list patients with red patches for GA cystoscopy ± biopsy. Approximately 25% of patients had normal GA cystoscopies; this represents poor theatre utilization and exposes patients to unnecessary perioperative risk. Based on these findings, we have introduced a departmental policy of a repeat flexible cystoscopy by a senior trainee.

Title of presentation

Rectal swab cultures and targeted prophylactic antimicrobial regimes do not reduce the risk of sepsis following transrectal prostate biopsy

Marios Hadjipavlou, Waseem Mulhem, Mazin Eragat, Charlotte Kenny, Chris Wood, Martino Dall'Antonia, Mohamed Y Hammad

Introduction:

Sepsis is a significant complication following transrectal ultrasound-guided prostate biopsy (TRUSBx). Ciprofloxacin is commonly used for prophylaxis, however there is emerging evidence for an increase in incidence of resistant enteric organisms worldwide. We investigate the effect of rectal swab cultures and sensitivities for targeted prophylactic antimicrobial regimes in reducing the risk of sepsis following TRUSBx.

Methodology:

All patients had confirmed negative urinalysis prior to biopsy. 609 patients (Group A) received a prophylactic antimicrobial regime of a single intravenous dose of gentamicin 240mg, rectal metronidazole 1g and oral ciprofloxacin 500mg twice daily for 3 days. Due to a significant incidence of ciprofloxacin and gentamicin resistance in patients admitted with sepsis following TRUBx, our local antibiotic recommendations changed. The subsequent 314 patients (Group B) had rectal swab cultures and sensitivities performed prior to biopsy. Patients with rectal flora organisms resistant to ciprofloxacin or gentamicin received targeted antimicrobial prophylaxis consisting of a single dose oral fosfomycin 3g, intravenous amikacin 750mg and rectal metronidazole 1g. Data was collected for rectal swab cultures, antibiotic regime used, readmission with sepsis within 14 days and blood or urine cultures results on admission.

Results:

In group A (standard ciprofloxacin-based regime), 12 of 609 (2.0%) patients were admitted with sepsis following biopsy. E.coli was the most common pathogen detected. Of the 7 patients with positive urine or blood cultures, 4 (57%) were ciprofloxacin- and gentamicin-resistant and 2 (29%) were ciprofloxacin-resistant only.

In group B, 57 of 314 (18.2%) patients had ciprofloxacin or gentamicin resistant rectal flora and received the targeted antimicrobial prophylaxis regime (36 ciprofloxacin-resistant only, 8 gentamicin-resistant only, 13 ciprofloxacin- and gentamicin-resistant).

Overall in group B, 5 of 314 (1.6%) patients were readmitted with sepsis despite receiving targeted combination of prophylactic antibiotics based on their rectal swab cultures. Of these patients, 2 had grown ciprofloxacin-resistant organisms on rectal swab and received the appropriate antimicrobial prophylaxis regime. The difference between the two groups was not statistically significant ($p=0.69$).

Conclusions:

The incidence of ciprofloxacin-resistant flora in our community is significant (18.2%). The risk of sepsis following TRUSBx was overall low, however the use of rectal swab cultures and targeted combination of antibiotic regimes did not seem to reduce the risk any further.

Title of presentation

Audit on the antibiotic management of upper urinary tract infections

Authors: O Jones, C de Souza, J Harrison, D Sri, R Singh, S Sandhu

Department of Urology, Kingston Hospital

Contact email address: oliviajones@doctors.org.uk

Introduction

Pyelonephritis is a common urological admission and treatment with appropriate antibiotics is essential in preventing its complications, prompt discharge and avoid readmission. We audited our trusts antimicrobial practice in pyelonephritis against national guidance and local antimicrobial resistance profiles. We explored our adherence to antimicrobial stewardship and implemented improvements to ensure appropriate prescribing.

Methods

A closed loop retrospective audit of patients admitted under the urology team due to pyelonephritis was carried out, evaluating their antibiotic treatment during admission and discharge against their cultures. The first cycle was between 1/3/16 – 1/6/16 and following implementations, a second cycle conducted between 7/12/16 – 7/3/17.

Results

71 patients were included in total (33 and 38 in cycle 1 and 2 respectively), with a mean age of 41. The first cycle demonstrated a significant number of patients discharged with inappropriate antibiotics (19%) due to antimicrobial resistance. Subsequent changes to the antibiotics at discharge were made and methods for ensuring results of delayed cultures are actioned appropriately saw a decrease in inappropriate antibiotic prescribing at discharge (6%). We noted an increase in resistance to our first line antibiotics Amoxicillin and Trimethoprim of 188% and 240% respectively across the two cycles. Interestingly no significant relationship was noted between discharge on inappropriate antibiotics with readmissions ($p=1.00$).

Conclusion

Antibiotic stewardship is important in attempting to reduce the incidence of resistant organisms. We have noted an increase in resistance patterns in the context of inappropriate antibiotic prescribing. Adapting methods for reviewing culture results has shown a clear improvement in antibiotic prescribing.

Title of presentation

Medium term outcomes and safety profile of Botulinum Toxin Type A intra-vesical injections in men with idiopathic detrusor overactivity

Authors: Nicholas Faure Walker, Jane Watkins, Christopher Dowson, Sachin Malde, Claire Taylor & Arun Sahai

Guys & St Thomas NHS Foundation Trust

Contact email address: nicholas.faure.walker@gmail.com

Abstract

Introduction: Intravesical Botulinum toxin injections for idiopathic detrusor overactivity (IDO) is supported by level 1 evidence but there is less data available for men than women.

Methods:

Patients received between 100 and 200 U OnabotulinumtoxinA. Outcomes were assessed from a prospective database using the incontinence impact questionnaire 7 (IIQ7) and urogenital distress inventory 6 (UDI6) scores. Urinary tract infection (UTI) was defined as urinary symptoms requiring treatment with antibiotics.

RESULTS:

Of 628 documented injections, 493 were for IDO. Of these 112 (22.7%) were for men. 60 men had 1 injection, 25 had 2, 9 had 3, 7 had 4, 3 had 5, 2 had 6, and 1 patient had 7, 8, 9, 10, 11 and 12 injections. Mean age for men was similar for women (54.1y vs 56.7y, $p=0.41$). Mean IIQ7 and UDI6 score changes from baseline to 4-12 week follow up was -6.8 and -4.1 ($p<0.01$) for men and -11.0 and -5.9 for women ($p<0.01$). However, no statistically significant difference between genders was observed at follow up (IIQ7, $p=0.137$; UDI6, $p=0.23$). De novo intermittent self-catheterization (ISC) was required by 20/65 (30.8%) men with follow up data to 4/15 (26.7%) of women ($p=0.04$). UTI was reported in 5 (7.8%) men and 3 (17.6%) of women with follow up data ($p=0.175$).

Conclusion:

Intravesical Botulinum Toxin injections for IDO are similarly efficacious at improving quality of life scores in men and women. Although the ISC rate was similar for men and women, UTI was reported less often in men.

Title of presentation
Maximising Income from PCNL

Authors: H Warren, K Keen, A Khan, S Willis, J Glass, G Noble, K Thomas, M Bultitude
Guy's and St Thomas' NHS Foundation Trust

Contact email address: hannahwarren@doctors.org.uk

Introduction

Hospitals receive payment for services based clinical coding, representing the health resources consumed.

Remuneration for PCNL varied significantly and often did not correlate with case complexity. We therefore set out to ensure we were coding accurately for PCNL.

Methods

Consecutive adults undergoing PCNL procedures were identified from coding department records from 1st January - 14th August 2016 and cross-checked with operating diaries. Coding data was compared to electronic patient records, operation notes and discharge summaries. Coding data for September was retrospectively corrected and the difference in income measured.

Results

Data from 50 PCNL procedures were analysed. The mean patient age was 58 (range 23 – 85) years, median post-operative length of stay was 3 days (range 1–14), and mean income per case £3494 (range £1,154 - £7,829). It was noted that procedural code 'M16.5 Removal of Nephrostomy Tube' was responsible for upgrading the HRG code from 'intermediate intervention' to 'major procedure'. All patients have nephrostomy tubes removed prior to discharge either on the ward or in the interventional suite, but this was inconsistently captured in coding data, resulting in lost income. Updating coding information for September 2016 resulted in a £19,769 uplift in income.

Conclusion

Improving accuracy of coding can lead to significantly increased tariffs for PCNL. We introduced a local coding policy to optimise the accuracy of clinical coding for PCNL, without increasing administrative burden for clinicians. We advocate regular meetings between clinicians and coders to identify opportunities for coding improvement

Title of presentation

Factors affecting intra-renal pressure during flexible ureteroscopy and Laser lithotripsy

Authors: Neophytos Petrides, Rajesh Krishnan

Kent and Canterbury Hospital

Contact email address: np262@cantab.net

Introduction

Pelvic pressure during renal surgery has been studied in animal models but has not been examined extensively in clinical studies. Our aim was to investigate the effect of access sheaths, preoperative stenting and irrigation methods on pelvic pressures and to assess the correlation between intra-operative intra-pelvic pressures and post-operative pain or sepsis.

Methods

Data were prospectively collected for 82 patients undergoing ureterorenoscopy and laser lithotripsy. Initial and end pressures were measured using an arterial transducer connected to a flexible ureteroscope. A visual analogue scale was used to assess post-operative pain.

Results

Mean final pressure with a syringe injection was 20.3cmH₂O, and with no-pressure irrigation 21.6cmH₂O. The peak pressure for syringe injection was 43cmH₂O, whereas for no-pressure continuous flow 56cmH₂O. The renal pelvic pressures were 14.29 mmHg with a sheath and 18.78 mmHg without ($p=0.08$). However if the pressure difference was taken into account there was a significant drop $p = 0.002$. There was no correlation between initial or final renal pelvic pressures and post-operative pain scores, and no cases of post-operative sepsis. There was no significant difference in mean post-operative pain scores between those who had post-operative stent drainage (mean 2.2) versus ureteric catheter drainage (mean 2.8).

Conclusion

None of the factors assessed in our study caused a difference in renal pelvic pressures, apart from access sheaths possible leading to a reduction. Increased renal pelvic pressures do not seem to be associated with postoperative sepsis or increased pain scores.

Title of presentation

Point of Care INR testing on the day of surgery: a small prick with BIG results

Authors: Kamran Haq, Donald Choi, Andrew Chetwood , Nimalan Arumainayagam

St Peter's Hospital Chertsey

Contact email address: kamranhaq@doctors.org.uk

Abstract

The National Health Service is experiencing a period of financial pressure. Trusts are increasingly looking to cut costs whilst maintaining or improving patient care.

Achieving these goals simultaneously is challenging, leading many trusts to focus on maximizing the utilization of existing resources to provide a better service without incurring extra costs.

This project identified POCT INR testing as a service that could improve the efficiency of the patient pathway for elective surgical procedures. In doing so, it could deliver a financially viable service with increased patient safety and satisfaction rates.

Prospective data analysis identified 190 patients suitable for POCT annually. Calculations showed that checking INR results in this manner would be time effective, saving 238 hours per annum compared to the established method. This time saving correlated to a significant financial saving when translated to increased theatre utilization and the removal of additional costs incurred by cancellations and overrunning lists. The service would also result in a safer, more predictable patient experience.

Based on this data, a business case was submitted to the trust proposing the installation of a POCT INR machine in the admissions lounge. This was approved and the service was established in February 2017. Reassessment of the pathway revealed an improved service being used by a higher than projected caseload. Audit of the POCT accuracy versus formal laboratory testing revealed no discrepancy. Introduction of this service has streamlined a previously inefficient process resulting in the delivery of a safer, more predictable patient pathway with clear financial benefits

Abstracts

Academic Session 2

Ms Tharani Nitkunan

Ms Katie Chan

Title of presentation

Home and away: comparing mechanism of renal trauma and subsequent management in two major trauma centres in London and Adelaide

Authors: S Rintoul-Hoad, J Mankanjuola, C Brown, R Catterwell

Institution: King's College Hospital

Contact email address: S.rintoul-hoad@doctors.org.uk

Abstract

Introduction and Objective:

The kidney is affected in 1-5% of all traumas, thereby representing a significant urological workload in trauma centres. We wanted to compare the pattern of trauma, severity of injury and management at two different trauma centres in two different continents.

Methods:

8 years of renal trauma data was compared between two major trauma centres: London 2009-2016, Adelaide 2004-2012.

Results:

119 patients were analysed from London, 89% male (n=106), average age 32 years; compared to 180 patients from Adelaide, 86% male (n=154), average age 37 years. Mechanism of injury differed between males and females.

The commonest cause of trauma in London was assault (37%, n=44); compared to Adelaide (10%, n=18). The commonest cause of trauma in Adelaide was motor vehicle accident (36%, n=65) (excluding motorbikes), compared to London (18%, n=22). Motorbike related trauma accounted for 25% (n=42) of trauma in Adelaide compared to 13% (n=15) in London. Sporting injury as the cause of renal trauma was similar; 13% (n=16) London, 14% (n=26) Adelaide.

Both centres had isolated renal trauma in 25% of cases. 13% of patients had embolisation in London (grade 2-4), compared to 5% in Adelaide (all grade 4-5); however Adelaide had a higher laparotomy rate of 1:5 compared to London 1:10. The grade 5 injury rate was similar, but London had predominately grade 3-4 injuries (33% and 38% respectively), whereas Adelaide had similar proportion of grade 1-4 injuries.

Conclusion:

Renal trauma patterns vary which leads to interesting comparisons including their management e.g. embolisation vs laparotomy. Standardised renal grading allows for international learning.

Title of presentation

Renal function loss after Cryoablation of Small Renal Masses in Solitary Kidneys - European Registry for Renal Cryoablation (EuRECA) multi institutional study.

Rudd I¹, Farrag K¹, Neilsen TK², Lagerveld BW³, Keeley F⁴, Guazzoni, G⁵, Barber NJ⁶, Sriprasad S¹

1: Department of Urology, Darent Valley Hospital, Kent, UK

2. Department of Urology, Aarhus University Hospital, Aarhus, Denmark

3: Department of Urology, St. Lucas Andreas Hospital, Amsterdam, The Netherlands

4: Department of Urology, Southmead Hospital, Bristol, UK

5: Department of Urology, Istituto Clinico Humanitas IRCCS, Clinical and Research Hospital, Milano, Rozzano, Italy

6: Department of Urology, Frimley Park Hospital, Camberley, UK

Introduction and objectives:

The presence of a small renal tumour (SRM) in a solitary kidney makes nephron sparing surgery and preservation of renal function imperative. The objective of this study was to estimate and quantify the loss of kidney function in solitary kidneys with SRMs after laparoscopic assisted cryotherapy (LAC) and to examine whether any of these patients required renal replacement therapy, from the European Registry for Renal Cryoablation (EuRECA) database.

Material and Methods:

Of the 808 patients from eight European centres in the database, 102 patients had SRMs in solitary kidneys. Patient demographics, Body Mass Index, ASA grade and their tumour particulars were collected. Renal function data in the form of estimated glomerular filtration rate (eGFR) and chronic kidney disease (CKD) stratification both preoperatively and at 3 months postoperatively were analysed.

Results:

The median (IQR) age was 67 (59-81) years, the median (IQR) BMI was 26 (23.9-28.9) kg/m² and the median (IQR) ASA score was 2 (2-3). The median (IQR) tumour size in cross-sectional imaging was 26 (19-38)mm. The mean pre-operative eGFR was 55.0 (SD 18.1) and the post-operative eGFR was 51.8 (SD 18.8). The change was -3.1 (-5.2, -1.0) (95% CI) units, which was statistically significant (P=0.004). The change in the CKD stages comparing before and after LCA was not significant (paired 2 tail t-test, P = 0.06). The decrease in the eGFR did not translate to any significant adverse outcome and none of these patients needed any form of renal replacement therapy at any time after surgery.

Conclusion:

To our knowledge this is the largest study of renal function following cryotherapy in SRMs in solitary kidneys. Cryotherapy in this imperative situation is safe and may be a treatment option to avoid dialysis.

Title of presentation

Salvage robot assisted radical cystectomy (sRARC): a demonstration of our experience in technical feasibility and perioperative outcomes

Authors: Kawa Omar, Parsons B, Rajesh Nair, Ramesh Thurairaja , Shamim Khan
Department of Urology, Guy's and St Thomas' NHS Foundation Trust
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Objective

To demonstrate technical feasibility of robotic-assisted salvage cystectomy and describe peri-operative outcomes.

Materials and Methods

Review of 245 patients from a prospectively maintained radical cystectomy database between November 2013 and October 2016 was performed. sRARC was defined in patients who underwent previous external beam radiotherapy or brachytherapy either for primary bladder or prostate cancer.

Results:

12 patients met the inclusion criteria (12-male); median age 72years(range54-88), median BMI 27kg/m²(22-37) and ASA score was 2(2-3)). Seven patients underwent radical external beam radiotherapy and 2 had brachytherapy for prostate cancer and 3 underwent chemo-radiotherapy for muscle invasive bladder cancer.

Diversion techniques included ileal conduit (n=10) and cutaneous ureterostomies (n=2). The mean operating time was 320 minutes(range 240-480) and length of stay was 8 days (range 6-30). The mean estimated blood loss was 360ml(range: 200-600).

One patient sustained an intraoperative rectal injury requiring a defunctioning colostomy. Median postoperative follow-up was 90-days (range: 29-1067). Two patients sustained Clavien-3 complications, two required post-operative re-admission within 90 days. Positive surgical margins were identified in two patients with prostate cancer. There were 3 recurrences in the follow-up period (2 pelvic recurrences 1 in prostate cancer and 1 bladder cancer, 1 urethral recurrence).

Conclusion:

We demonstrate technical feasibility of sRARC and acceptable short-term complication rates

Title of presentation

Exploring patient readmissions following Robot-Assisted Radical Cystectomy at a Tertiary Bladder Cancer Service

Dimitrios Moschonas, Pavlos Pavlakis, Jamie Lindsay, Annelisse Ashton, Alison Roodhouse, Chris Jones, Ricardo Soares, Murthy Kusuma, Simon Woodhams, Michael Swinn, Hugh Mostafid, Matthew Perry, Krishna Patil
Royal Surrey County Hospital, Urology Department

Introduction and Objective

Rehospitalisation rate is a care quality indicator after major cancer operations. We aim to examine the incidence and causes of early and late readmissions to hospital following robot-assisted radical cystectomy (RARC).

Method

A retrospective analysis was performed of 158 consecutive patients who underwent RARC at Royal Surrey County Hospital since the formation of a tertiary bladder cancer service in April 2013. Demographic, operative and postoperative data were collected for all cases and analysis of length of stay and patient readmission within 90 days was performed.

Results

Median length of hospital stay was 5 days (3-28). The incidence of 90-day readmission to hospital was 16% (26 of 158) and we found treatment complications to be the only factor significantly associated with readmission (Table 5). Three patients had more than one readmission. Thirty-two percent of readmissions were infection related (urinary, pelvic collection, lymphocele) and 24% gastrointestinal (ileus, small bowel obstruction). Four patients required an intervention, including two requiring general anaesthesia. Of the 30 incidents, 8 were considered as potentially avoidable (back pain, scrotal oedema, oral candidiasis).

Conclusion

The results from our centre demonstrate a short length of hospital stay with low early and late readmission rates. This illustrates a favourable patient outcome for a procedure associated with inherent morbidity as a result of minimally invasive approach and multimodal enhanced recovery protocol. The optimisation of the post-discharge network can further reduce rehospitalisation and minimise the service fragmentation that can exist within a tertiary referral facility.

Title of presentation

Evaluating prognostic factors for recurrence and mortality from upper tract urothelial carcinoma (UTUC) after nephroureterectomy (NU) from a 16 year experience

Authors: P Brousil, M Ager, A Coscione, R Macarthur, S Sandhu, K Anson, B Ayres, P Le Roux, C Anderson

St George's Hospital, Epsom and St Helier Hospital, Kingston Hospital

Contact email address: philbrousil@gmail.com

Introduction

UTUC is a rare but important disease, which lacks a robust evidence to generate consensus in management. Our analysis seeks to identify prognostic factors regarding recurrence, death and inform management after NU.

Methods

A retrospective analysis was conducted on 121 NU patients with a mean follow-up of 37 months. Tumour characteristics, mortality and the effect of uretero-renaloscopy on recurrence were determined. 32 patients were excluded due to inadequate data.

Results

Overall 28 (38%) patients had intra-vesical recurrence (IVR) at median time of 7mths. IVR was seen in 16 patients (28%) who didn't have prior bladder cancer (pBC). Of these, systemic recurrence was seen in 11% (median recurrence time 15 months). In the IVR group, the presence of T2-3 and multi-focal disease in the NU specimen was significantly higher ($p=0.04$, 0.02 respectively). The presence of G3, CIS, lympho-vascular invasion (LVI) was proportionately higher but not statistically significant. Ureteric tumour location did not predict IVR.

Pre-operative uretero-renaloscopy was not associated with recurrence or death. Overall mortality was 52% with median survival 19mths; 24% of patients died of UTUC (median survival 13mths). Statistically significantly higher rates of G3, T3, T4, CIS, LVI were seen in the UTUC death group. Multi-focality was not significantly higher in the UTUC death group. pBC and URS were not risk factors for UTUC death.

Conclusion

UTUC is an aggressive disease. More rigorous bladder surveillance is needed where multi-focality and invasive disease are present. The above mentioned prognostic factors mandate closer post-operative radiographic surveillance and possibly intervention.

Title of presentation

The Prostate Cancer Diagnosis Pathway; Quality Improvement Against CWT Targets

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Ashford and St. Peter's NHS Foundation Trust
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Introduction:

The Operational Standard (OS) for patients referred under the “two week wait” dictates that 85% of patients should undergo treatment (or be discharged from the pathway) within 62 days of referral. Due to increasing complexity of the diagnostic pathway of prostate cancer, this is difficult to achieve

At ASPH, we have mitigated this problem with the introduction of the “Prostate Pathway”.

Method:

Root Cause Analysis (RCA) was performed against all breaches in 2016, providing timeline data for Referral to MpMRI, and TRUS Bx. This was compared to 2017 data (following the introduction of the new pathway).

The Prostate Pathway will reduce the waiting times for MpMRI and subsequent TRUS biopsy, by pre-booking the investigations after receipt of referral. Eight slots have been reserved for both MRI and TRUS biopsy each week. These go ahead after clinician approval. This will improve performance against the OS.

Results:

In 2016, 50 out of 57 breaches (88%) related to the prostate cancer. Median of 23 days from Referral to MRI, and a median of 32 days from Referral to TRUS biopsy.

In 2017, only one prostate cancer breach has been recorded (8 days from Referral to MRI, 9 days to TRUS Biopsy.)

Conclusion:

The prospective data so far is limited, yet promising. RCA has revealed much improved performance in the time taken to reach a diagnosis, and we look well set to achieve the operational standards set by National CWT monitoring.

Title of presentation

New haematuria NICE guidelines: what about the under 40s?

Authors: Ola Blach, Ahmed Ali, Tim Lerner
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Introduction:

Visible haematuria (VH) is a cardinal presenting symptom of urinary tract malignancy. The current 2015 NICE guideline on Suspected cancer recommends referral to Urology using the suspected bladder cancer pathway in patients aged 45 and over with VH. This represents a considerable change from previous recommendations.

We sought to determine how many diagnoses of bladder cancer would have been missed in patients aged under 40 at BSUH had the current NICE guideline been followed.

Methods:

A retrospective review of bladder cancers diagnosed in patients under 40 years of age at BSUH since 2005 was undertaken.

Results:

14 patients (11 men and 3 women) diagnosed with bladder tumour were identified. Only 1 had symptomatic NVH, the rest had VH. Median age at diagnosis was 34 (range 20-39, IQR 11). 13 had cancer diagnosis (1 G1Ta, 9 G2Ta, 2 G3T1, and 1 CIS), and 1 inverted papilloma. Recurrences were observed in 3 cases (all G2Ta), of which one progressed to G3Ta. 2 patients underwent radical cystectomy.

Conclusion:

13 cases of bladder cancer would have been missed in patients aged under 40 had the current NICE guideline been followed. As such, we believe that all patients with unexplained haematuria should be referred via the cancer wait 2 week role.

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