St George's University Hospitals NHS
NHS Foundation Trust

South Thames Urology Regional Meeting

St.George's University Hospital NHS Foundation Trust

London

Thursday 16th November 2017

Programme

1000 – 1200 South Thames Deanery Meeting

Room 2-3, 1st floor Education Centre

1000 – 1200 KSS Deanery meeting

Room 5, 1st floor Education Centre

1200 – 1230 Joint meeting

Room 2-3, 1st floor Education Centre

1230 – 1330 *Lunch (and sponsors Exhibition)*

Dining Room, Ground floor Education Centre

1330 – 1500 Academic Session - Cancer

Room 2-3, 1st floor Education Centre

1500 – 1530 *Coffee break (and sponsors Exhibition)*

Dining Room, Ground floor Education Centre

1530 – 1700 Academic Session - Benign

Room 2-3, 1st floor Education Centre

1700 – 17.15 STC updates

1715 Award of the Derek Packham medal and prizes

17.30 Drinks at the University bar

18.30 Dinner

Sree Krishna South Indian Restaurant

192-194 Tooting High Street SW17 0SF

SPONSORS

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ACADEMIC SESSIONS

SESSION 1 – 13.30-15.00 – URO-ONCOLOGY

Chair persons: Mr Ben Eddy and Mr Hasan Qazi

1. 'Long Term Oncological Outcomes Following The Randomised Controlled Cystectomy: Open, Robotic and Laparoscopic (CORAL) Trial'
   Presenter: Kawa Omar

2. Re-audit of prostate cancer pathway at a DGH
   Presenter: Michael Ager

3. The Impact of pre-biopsy MP-MRI on prostate biopsy histology
   Presenter: Kiki Mistry

4. Looking beyond cancer detection: Is TRUS biopsy inferior to Template in predicting pathological margin status after radical prostatectomy in the mpMRI era?
   Presenter: Edward Bass

5. Audit of MRI/USS fusion targeted transperineal prostate biopsies
   Presenter: Charlotte Jones

6. The end of transfaecal biopsies: Can transperineal prostate biopsies be performed under local anaesthetic in the outpatient setting?
   Presenter: Francesca Kum

7. Robotic Fellowship Program Canterbury
   Presenter: Neophytos Petrides

8. Is the "two-week wait" cancer pathway in urology fit for use, or open to abuse?
   Presenter: Meghana Kulkarni

9. Onco-microTESE: an option for fertility preservation in azoospermic men with testicular cancer
   Presenter: Jemma Moody

SESSION 2 – 15.30-17.00 – BENIGN UROLOGY

Chair persons: Miss Rashmi Singh and Mr Andy Symes

1. Gender Differences in Acute Stone Admissions
   Presenter: Nyati Lobo

2. Long-term outcomes of Prostate Artery Embolisation for the treatment of symptomatic Benign Prostate Hyperplasia.
   Presenter: Kathie Wong

3. Rezum Water Vapour Therapy for Symptomatic Benign Prostatic Hyperplasia: Preliminary results from the first UK series
   Presenter: Max Johnston

4. Surgical management for symptom control of male genital lymphoedema
   Presenter: Tharani Mahesan

5. Where are the major delays in the referral pathway of patients presenting to a male fertility clinic with azoospermia?
   Presenter: Andrew Vicens-Morton

6. Preventing same-day cancellations by improving pre-operative assessment in patients undergoing urological surgery: a closed loop audit.
   Presenter: Natalie Ramjeeawon

7. Impact following Introduction of walk-in catheter clinic service on reducing catheter related hospital admissions.
   Presenter: Randeep Dhariwal

8. Trainee Satisfaction in Urology Higher Speciality training- Can we limit the impact of the workforce crisis?
   Presenter: Tharani Mahesan

THE DEREK PACKHAM MEDAL

We are delighted to be able to award the Derek Packham Medal together with the prizes for the best abstracts, thanks to the generous support of Derek's family, represented today by his son Bruce.

Derek Packham was a Consultant Urologist at King's between 1967 and 1990.

Apart from his love of surgery, he really enjoyed teaching, both undergraduate and postgraduate, and would have been very proud to see how many of his trainees have become both nationally and internationally recognized in their various fields.

After his untimely death from colon cancer in 2002, his widow and two sons decided to sponsor an annual prize in his name - the Derek Packham Memorial Medal - to be presented along with a cash prize to the trainee who , in the eyes of some of the region's leading consultant urologists, presents the best abstract at the Autumn meeting of the South Thames urology group.

This year, the cash prize will be £350 and there is also a runner's up prize of £150. Derek would have been delighted to know that in this way, he and his family are continuing in his support of the region's urology trainees

Title of presentation:
Long Term Oncological Outcomes Following The Randomised Controlled Cystectomy: Open, Robotic and Laparoscopic (CORAL) Trial

Authors:
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Abstract:
INTRODUCTION AND OBJECTIVES: The Cystectomy: Open, Robotic and Laparoscopic (CORAL) trial is the first three arm RCT demonstrating peri-operative and short-term oncological outcomes between the 3 surgical techniques. However, there remains a paucity of data demonstrating long-term oncological outcomes between the groups. We critically evaluate these outcomes at five-year trial follow-up.

MATERIAL & METHODS: From March 2009 to July 2012, 60 patients requiring radical cystectomy for muscle-invasive or high-risk non-muscle-invasive bladder cancer (HR-NMIBC) were equally randomized to three groups. The outcomes of interest were histopathological and oncological outcome. The Fisher exact test and ANOVA were used for statistical analyses and also Kaplan-Meier curves were used for demonstrating recurrence and survival. The curves were compared using Log-Rank test.

RESULTS: Sixty patients were randomized, 59 had radical cystectomy and 58 of patients were followed up for a median of 65 months (range 3-98). The mean age of patients undergoing ORC, RARC and LARC was 66.6, 68.6 and 68.6 years respectively. HR-NMIBC was 40% in ORC, 40% in RARC and 26% in LRC. Positive surgical margin (PSM) was 10%, 15% and 5% for ORC, RARC and LRC respectively. There was no significant relationship between surgical arm and PSMs (p=0.9). The mean lymph node (LN) retrieval was 18.8, 16.3, and 15.5 in ORC, RARC and LRC respectively. The differences in LN retrieval was only significant between ORC and LRC (p = 0.01). However, of note no port-site recurrences or peritoneal metastases were observed in the minimally invasive surgical cohorts.
Five-year recurrence free survival is 71%, 53% and 60% in LRC, ORC and RARC respectively. 5-year CSS is 69%, 64% and 70% in LRC, ORC and RARC respectively. 5-year OS was 61%, 55%, 66% in LRC, ORC and RARC respectively. RFS between the 3 groups was non-significant (p=0.87), the difference in CSS was non-significant (p= 0.57) and difference in OS was also non-significant (p=0.48).

CONCLUSION: There were no significant differences in RFS, CSS and OS between ORC, LRC and RARC. The absence of port site or intraperitoneal recurrence between the groups does not preclude minimally invasive surgery as an option for treatment.

Title of presentation:
Re-audit of prostate cancer pathway at a DGH

Authors:
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Abstract:
Introduction & objectives

Referral for investigation of CaP (prostate cancer) continues to rise and forms a substantial amount of cancer work. This is compounded by double reporting locally and centrally (CMDT) at our trust. We audited results of each meeting in 2014 to compare outcomes. We re-audit the above assessing progress and need for continual double reporting.

Materials & methods
A retrospective case note review was done on our electronic database over a 3-month period from January to March 2017. Patients with a new diagnosis of prostate cancer were identified and discussed in our local and central MDTs. Criteria assessed were change in results of radiology, pathology and outcomes. In addition, delays were reviewed.

Results
A total of 61 patients were referred. 31 in the same period in 2014. 58 were eligible for review. There was 100% concordance for CaP diagnosis, 96% concordance for number of positive cores and 77% concordance for Gleason grading. There was 1 (1.7%) change in radiology and management in comparison to 6 (15%) previously. 43 patents waited one week or more for CMDT discussion. 100% of changes in outcomes were communicated to the local MDT via a proforma introduced at previous audit compared to 80% in 2014.

Conclusion
Our data suggests that diagnosis and management of new prostate cancers is safe and comparable to CMDT. It also suggests that 74% of patients' management is delayed a week or more. We propose independent diagnosis, discussion and management of new CaP patients at our trust with scope for referral to central MDT for equivocal cases.

Title of presentation
The Impact of pre-biopsy MP-MRI on prostate biopsy histology

Authors
H. Thorman, K. Mistry, G. Rajkumar, T. Nedas, A. Emara, D. Peppercorn, K. Scott, R. Hindley

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Abstract
Introduction
Basingstoke was a participating centre in the PROMIS trial from 2013-15, recruiting 130 men. Our perception following the introduction of a pre-biopsy MRI was that there had been a significant change in the proportion of significant cancers detected on biopsy with a corresponding reduction of insignificant cancers. Our aim in this study was to compare the prostate biopsy histology in 2012 (pre trial involvement) with that of 2016 (post trial).

Methods
A search was performed to identify patients who underwent prostate biopsy in 2012 and 2016. We reviewed the proportion of men who had undergone a multi-parametric 1.5T MRI (MP-MRI) of the prostate pre-biopsy as well as the type of biopsy performed (TRUS or transperineal mapping TPM) and number of cores taken. The grade of cancer, number of positive cores and maximum core lengths were recorded.

Results
We identified 206 and 250 patients, of which 30% and 86.8% had pre-biopsy MP-MRI in 2012 and 2016 respectively. In 2012, 37.4% of patients underwent a TPM biopsy compared to 62.4% in 2016. There was an increase in the number of positive biopsy results from 69.9% to 81.2% ($X^2=7.92$, $p=0.005$). The number of grade group 1 cancers diagnosed decreased from 62.5% in 2012 to 24.6% in 2016 whereas the number of grade group ≥ 3 increased from 11.2% to 47.2%.

Conclusion
Our study has confirmed that the introduction of pre-biopsy mpMRI improves the diagnostic accuracy of prostate biopsies. This shift towards detecting an increased number of clinically significant cancers will likely have a significant impact on treatment allocation and longer term outcomes for our patients. We anticipate our experience will be shared by other centres as they switch to a pre biopsy MRI.

Title of presentation

Looking beyond cancer detection: Is TRUS biopsy inferior to Template in predicting pathological margin status after radical prostatectomy in the mpMRI era?

Authors

Edward Bass, Dimitrios Moschonas, Pavlos Pavlakis, Murthy Kusuma, Stylianos Chintzoglou, Krishnaji Patil, Christopher Eden, Matthew Perry, Stephen Langley

Institution

Guildford Hospital

Presenting author

Edward Bass

Background

Arguments regarding optimal diagnostic strategy in prostate cancer (CaP) continue. Whilst the bulk of existing data has focused on cancer detection, little has been done in regard to whether biopsy strategies have demonstrable effect on surgical outcome. Our aim was to assess the impact of biopsy method on nerve sparing robotic assisted radical prostatectomy (RARP) and positive surgical margin (PSM) rates.

Patients and Methods

We analysed our prospectively collected data of consecutive patients who underwent primary RARP following a diagnosis of CaP at a single referral centre between October 2010 and June 2017 was performed. All patients underwent multiparametric MRI (mpMRI) and either transrectal ultrasound guided (TRUS) or template transperineal biopsy. Data included presenting PSA (pPSA); patient age; clinical and radiological T stage; biopsy type and Gleason grade; d'Amico risk classification; whole-mount Gleason grade, prostate and tumour volumes; PSM status, site and length. PSM status was compared between groups.

Results

771 patients were included in the study, with 343 (44.5%) having undergone TRUS and 428 (55.6%) template biopsies. Median age was 66 [IQR 60-69] and median pPSA 7.2 [IQR 5.3-10.7]. Nerve sparing procedures were performed in 273 (79.6%) men following mpMRI and TRUS and 330 (77.1%) following mpMRI and template. PSM rates were significantly higher in the mpMRI and TRUS groups than in the mpMRI and template groups (P=0.005). Subgroup analysis demonstrated advantage of mpMRI and template in D'Amico high (p=0.04) and intermediate (p=0.04) risk groups.

Conclusions

MpMRI and template biopsy assists in surgical planning leading to better outcomes for patients. Targeted biopsy strategies may have consequences beyond cancer detection alone.

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Title of presentation
Audit of MRI/USS fusion targeted transperineal prostate biopsies

Authors
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Abstract

Introduction/ aims: The current prostate cancer diagnostic pathway at our institution includes PSA, clinical examination, and multi-parametric MRI (mpMRI) and TRUS biopsy. If initial biopsy results are not concordant with mpMRI findings an MRI/ USS fusion transperineal (TP) biopsy is recommended. We evaluated whether MRI fusion TP biopsy altered clinical management, the concordance of the mpMRI and the TP biopsy results, the concordance of histology from TP biopsy to radical prostatectomy specimens and the complications of TP biopsies.

Methods: Patients were prospectively recorded and retrospectively audited. All data was collected from electronic records/ patients' notes. MRI/ USS fusion TP biopsies were performed using NUADA Medical.

Results: 149 patients had MRI/ USS fusion TP biopsies. Age range 39-85 years (median 67 years), PSA range 2.3-87 (median 8.6). The most common reasons for TP biopsies was non-concordance between MRI and TRUS biopsy (48%). In 49% of the cases, there was a significant change in management. MpMRI correctly predicted Gleason ≥3+4 cancers on TP biopsies in 94% of the cases. Of those who had a radical prostatectomy, the prostatectomy histology was similar to the TP biopsies in 88%. Complications included urinary retention (10%) and infection (1%).

Conclusions: MRI fusion prostate biopsies demonstrate a superior diagnostic outcome compared to TRUS biopsy. In our institution our technique of MRI fusion TP biopsy has been shown to have concordance with mpMRI and prostatectomy histology giving us confidence to consider mpMRI and primary MRI fusion biopsies similar to the RAPID pilot.

Title of presentation
The end of transfaecal biopsies: Can transperineal prostate biopsies be performed under local anaesthetic in the outpatient setting?

Authors
Francesca Kum, Meghana Kulkarni, Nicholas Faure-Walker, Oussama Elhage, Paul Cathcart, Rick Popert

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Abstract

Introduction:
Traditionally, prostate biopsies have been performed in an outpatient setting via the transrectal (TRUS) approach. The PrecisionPoint™ transperineal access system enables both standard systematic template and targeted transperineal prostate biopsy, under local anesthetic. We present our histological outcomes and tolerability of this procedure.

Methods:
154 patients have undergone prostate biopsies using the PrecisionPoint™ system at our institution from April 2016 to September 2017. Initial cases were performed under general anesthetic (GA) to enable familiarization with the technique and local anesthetic (LA) protocol.

Median age was 65.4(36-84)years, median PSA 7.5(0.7-1374)ng/ml with a median prostate volume of 40(10-157)cc. Histological outcomes were recorded. Pain scores were assessed using the validated 'Visual Analogue Score' (VAS).

Results:
Cognitively MRI targeted biopsies were performed in 30(19.5%) patients; a further 30(19.5%) had targeted biopsies in addition to standard systematic biopsies; and 94(61%) patients underwent systematic biopsies without targets.

Of patients who had a cognitively targeted biopsy alone, 93%(25/27) of the primary biopsies were malignant. In patients who underwent systematic + targeted biopsy, 93% (25/27) of the primary biopsies were malignant. Of these, the target lesion was positive in 20/25 (80%) cases. Of the 75 cases who had primary systematic biopsies alone, 46 (61%) were positive.

When comparing LA transperineal vs. conventional TRUS biopsy methods, VAS scores were not significantly different (P=0.2).

Conclusions:
Prostate biopsies can be performed safely under LA in an outpatient setting using the PrecisionPoint™ system. This method of transperineal biopsy has potential to supersede the transrectal approach in the outpatient setting.

Title of presentation
Robotic Fellowship Program Canterbury

Authors
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Introduction: Robotic urological surgery for benign and malignant conditions has established itself as the mainstay of urological practice over the last decade. It is without a doubt that more and more surgeons are adding robotic skills to their armamentarium. Development of training fellowships is an invaluable tool in allowing urologists to develop those skills
Aim and Methods: Our aim was to identify and share the case load and case mix available, outline the learning process and report the result of all independently performed cases. Data were collected prospectively over one year.
Results: The programme included theoretical and practical components:
• Simulation using the Da Vinci® Surgical system built in training modules
• Dry Lab training in urethro-vesical anastomosis
• Attendance at Robotic surgical courses and conferences
• DVD and Video based discussions and tutorials
• Review of key robotic surgical literature
• Live surgical cases using stepwise modular training approach based on ERUS and BAUS guidelines.
Total number of robotic cases N=202 with emphasis on RARP
• RARP – 117 cases
• RARP and PLND– 41 cases
• Robotic Assisted Radical Cystectomy (RARC) – 15 cases
• Robotic Assisted Partial Nephrectomy (RAPN) – 10 cases
• Robotic Assisted Ureteric Reimplantation – 7 cases
• Robotic Assisted Pyeloplasty – 5 cases
• Robotic Assisted Nephro-Ureterectomy – 3 cases
• Robotic Assisted Radical Nephrectomy – 2 cases
• Robotic Assisted Bladder Diverticulectomy – 2 cases

RARP cases performed entirely independently from start to finish – 79 cases
15 Training cases had PLND
14 Training cases had nerve sparing procedure
There were no major complications in the series

Conclusion:
• A structured modular approach to teaching robotic procedures results in favourable parameters, despite having to overcome a learning curve effect

• The robotic experience in Canterbury, East Kent, UK provides sufficient number and variety of cases to prepare future robotic urological surgeons

Title of presentation
Is the “two-week wait” cancer pathway in urology fit for use, or open to abuse?

Authors
Miss Meghana Kulkarni, Ms Amina Addow, Miss Archie Fernando

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Abstract

Introduction

In 2000, the government introduced an initiative to expedite the pathway between primary and secondary care for patients with a suspected cancer diagnosis, termed the ‘two week-wait (2WW) pathway’. We evaluated the cancer detection rate for patients referred via this route to the Urology department at our institution to establish if 17 years after this policy was introduced it is still fit for purpose.

Methods

The rate of cancer detection in 9053 patients referred as ‘2WW’ between May 2012 and May 2017 was established. A more detailed sub-analysis of 1054 patients referred between January 2017 and May 2017 was then conducted. All patients were evaluated in a ‘one-stop’ diagnostic clinic, with on-the-day access to phlebotomy, urine analysis, cytology, flexible cystoscopy, ultrasound, non-contrast CT and MRI.

Results

9053 ‘2WW’ patients were seen between May 2012 and May 2017. 1663 (18.4%) of these patients received a cancer diagnosis.

1054 patients were seen between January and May 2017. 197 (18.6%) of these received a cancer diagnosis: 147 prostate; 23 bladder; 17 renal; 6 testicular; and 4 other malignancies.

The cancer detection rate by referral type is detailed in table 1. Non-visible haematuria yielded the lowest number of cancer diagnoses at 0.18%. 362 (34%) referrals did not adhere to the national 2WW criteria, with 20 (5.5%) of these these patients receiving a cancer diagnosis.

Conclusions

The aim of the 2WW pathway is to provide a streamlined and timely review of patients with likely malignancy. The incidence of cancer diagnoses at our institution in the 2WW cohort is 18% overall, with much lower rates seen in patients referred with non-visible haematuria and scrotal lumps. On the basis of these findings, we would recommend BAUS conduct a snapshot national audit of 2WW cancer diagnoses with subsequent updating of urology guidelines to prevent inappropriate allocation of resources and unnecessary anxiety for large numbers of patients.

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Title of presentation
Onco-microTESE: an option for fertility preservation in azoospermic men with testicular cancer

Authors
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Abstract

BACKGROUND AND AIMS: 6-24% of men with testicular cancer are azoospermic at diagnosis. Onco-microTESE is a microsurgical technique that extracts sperm from unaffected areas of the tumour-bearing testicle during the primary cancer surgery. It potentially avoids the need for surgical sperm retrieval from the remaining solitary testis. It is of particular use for patients with synchronous bilateral tumours, or a new metachronous tumour in a solitary remaining testis. This study describes our experience with this new technique.

METHODS: Retrospective analysis of all onco-microTESE procedures conducted between 2015-2017 at Guy's Hospital, London. All onco-microTESE were carried out on the tumour bearing ipsilateral testis.

RESULTS: 13 testes in 11 patients were operated on. There were: nine T1 seminomas, one T2 mixed germ cell tumour, one T2 pure embryonal carcinoma, one T1 leydig cell tumour and one metastatic papillary cystadenocarcinoma. Two patients had synchronous bilateral testis tumours at presentation. Four patients had previously had their other testis removed for metachronous tumour.Spermatozoa were successfully retrieved and frozen from 7/13 testes (54%). The mean patient age at the time of surgery was 32 years (range 19-37). Sperm was found on one side in both patients with synchronous bilateral tumours, and in 2/4 cases of metachronous tumour in a solitary remaining testis.

DISCUSSION: Onco-microTESE is a novel approach to fertility preservation in azoospermic testicular cancer patients. In order to identify those who may benefit from this approach, all men should undergo semen analysis at diagnosis prior to any orchidectomy. Although recent literature has shown that testicles with larger tumours are less likely to produce sperm, this observation was not confirmed in our cohort.

Title of presentation
Gender Differences in Acute Stone Admissions

Authors
Niyati Lobo, Chris Down, Rory Mercer, Theo Malthouse, Juliet Ariel, Ahmed Ali, Andy Symes, Charles Coker

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Abstract
Introduction: Acute renal colic due to an obstructing ureteric calculus is a common cause of inpatient urology admissions. We sought to examine sex-related differences in the presentation, management and outcome for patients admitted with acute renal colic at our institution.

Methods: Retrospective review of all hospital admissions for renal colic between September 2016-September 2017. For each admission, data on demographics, management and outcomes was collected. Differences between genders were compared using the Chi-squared and Student's t-test.

Results: 135 patients. F=55 M=80
Presentation (F vs M)
Diabetic: 8/55 (15%) vs 8/80 (10%)
CRP on admission: 82.1 vs 22.8; p<0.001
AKI: 20/55 (36%) vs 32/80 (40%)
Positive urine/blood cultures: 20/55 (36%) vs 3/80 (4%) ; p<0.001
Stone size: 7.3mm vs 7.3mm
Stone location: Proximal: 42% vs 34% ; Mid: 16% vs 11% ; Distal: 27% vs 51%

Management (F vs M)
Stent: 37/55 (67%) vs 43/80 (54%)
Nephrostomy: 5/55 (9%) vs 1/80 (1%)
Conservative: 9/55 (16%) vs 29/80 (36%)
ESWL: 3/55 (5%) vs 7/80 (9%)
Primary URS: 1/55 (2%) vs 0/55 (0%)

Outcomes (F vs M)
ITU admission: 7/55 (13%) vs 3/80 (4%); p<0.001
Mean length of stay: 4.8d vs 1.7d; p<0.001
Readmissions: 6/55 (11%) vs 6/80 (7%)

Conclusion: Women admitted with renal colic were more likely to have an associated infection than men. They also had significantly more ITU admissions and longer lengths of stay. This is important to consider when assessing the suitability of conservative management for female patients. Further studies are needed to confirm these findings

Title of presentation
Long-term outcomes of Prostate Artery Embolisation for the treatment of symptomatic Benign Prostate Hyperplasia.

Authors
Nisha Pindoria, Kathie Wong, Arum Parthipun, Shahzad Ilyas, Sharon Clovis, Tarun Sabharwal and Rick Popert

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Abstract
Introduction:
Prostate artery embolisation (PAE) represents a therapeutic alternative to surgery in symptomatic benign prostate hyperplasia (BPH) refractory to pharmacotherapy. We report on two year outcomes of PAE.

Method:
Between January 2014 and November 2015, hospital record data of consecutive patients considered for PAE were retrospectively analysed. Inclusion criteria included a diagnosis of lower urinary tract symptoms (LUTS), haematuria or acute urinary retention (AUR). Demographics, prostate specific antigen(PSA), International Prostate Symptom Score (IPSS) international index of erectile function (IIEF) and prostate volume were collected pre and post procedure. Patients were contacted by telephone in September 2017 or post in October 2017 to identify current IPSS, medication use and further surgery. Improvement in IPSS of > 4 was considered significant. PAE failure was defined as requiring further prostate de-obstructing surgery.

Results:

In total 122 patients were considered for PAE. Of these 100 underwent the procedure. Of the 22 patients who did not, 12 patients were considered unsuitable, 5 refused, 3 were unknown, 1 died and 1 was referred for urolift. Indications for PAE include LUTS, haematuria and AUR in 74%, 5% and 21% respectively. 66% of patients who underwent PAE for LUTS had a median follow up of 30 months. 62% of patients still had improvement in IPSS. 37% of patients underwent further de-obstructing surgery.

Conclusion:
PAE improved symptomatic BPH in 62% of patients at a median follow up of 30 months. Overall, PAE represents an alternative therapeutic strategy in patients whom surgical treatment is contra-indicated or associated with high risk.

Title of presentation
Rezum Water Vapour Therapy for Symptomatic Benign Prostatic Hyperplasia: Preliminary results from the first UK series

Authors
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Abstract
Introduction: Rezum water vapour therapy is an endoscopically delivered treatment for BPH and can be safely performed under local anaesthetic and sedation with early hospital discharge. We have evaluated Rezum therapy in a mixed group of men with symptomatic BPH.

Methods: Data regarding the Rezum cases were collected on a prospective database. Patients were planned for follow-up at 1, 3, 6 and 12 months post procedure. Mode of anaesthetic, number of treatments, time of treatment and complications are reported. Outcomes including prostatic volume, urinary flow rate, indwelling catheter presence and IPSS questionnaires are compared to baseline data.

Results: Of 31 cases, 22 were performed under local anaesthetic and sedation. A single patient required an overnight hospital stay. The mean operative time was 17.5 minutes. In 71% of patients the treatment included the median lobe. There was one grade 2 complication and one grade 3 (secondary haemorrhage). Prostatic volume reduced by more than a third from a mean of 48.8ml at baseline to 31.8ml 3 months post-operatively ($p=0.003$). Qmax increased significantly at 3 months post-operatively (8.4v18.4ml/s, $p<0.001$). 95.5% of patients were catheter free at 3 months. The mean IPSS score significantly improved at 3 months (17.1v4.6, $p<0.001$) with the quality of life score also improving.

Conclusion: Rezum is a minimally invasive procedure with low morbidity. It appears to improve lower urinary tract symptoms significantly for patients at 3 months. Future studies to further evaluate this therapy include longer follow-up, a comparison to gold standard treatments and a cost-effectiveness analysis.

Title of presentation
Surgical management for symptom control of male genital lymphoedema

Authors
Tharani Mahesan, Sylvia Yan, Kristiana Gordon, Peter Mortimer, Cathy Corbishley , Mark Soldin, Ben E Ayres, Nick Watkin

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Abstract
Introduction and Objective:
Male genital lymphoedema can be severely debilitating. Alongside poor cosmesis, affected men suffer with recurrent infections, difficulty directing spray and chronic leakage of lymph. Conservative management is widely accepted as the mainstay of treatment, with surgery for symptom control an option when these measures fail. Here we present our experience with surgery for male genital lymphoedema at our specialist tertiary centre.

Materials and Methods:
56 patients over 11 years underwent surgery for management of their male genital lymphoedema. All were referred into a specialist multi-disciplinary service, consisting of a lymphovascular medicine physician, reconstructive urologist and support nursing team. We report their aetiology, intervention and outcome.

Results:
Of 56 patients, 36 had congenital/primary lymphoedema. 20 patients had mixed peno-scrotal lymphoedema, a further 21 had associated lower extremity involvement. 2 had isolated penile and 3 isolated scrotal lymphoedema. 9 patients had trunk and upper limb extremity involvement alongside peno-scrotal lymphoedema.
27 patients underwent penile reconstruction and scrotoplasty. 16 underwent scrotoplasty and 2 underwent penile reconstruction alone. Circumcisions were performed on 7 men with a further 2 undergoing hydrocelectomy. 2 had suprapubic tissue removed to release a buried penis.
Long-term follow up is incomplete due to the wide geographical distribution of patients. Evidence suggests that at surgical follow up (between 2 and 6 weeks post operatively) most patients reported improvement in symptoms.

Conclusion:
Our joint lymphoedema clinic, combining the expertise of both urologists and lymphoedema specialists offers suitable patients unique access to surgery for symptom control. This case series, the largest reported worldwide, proves that such surgeries do offer excellent cosmetic and functional results

Title of presentation
Where are the major delays in the referral pathway of patients presenting to a male fertility clinic with azoospermia?

Authors
Andrew Vicens-Morton 1, Mark Lynch 2, Nick Watkin 3, Stephen Gordon 4, Majed Shabbir 1, Tet Yap1

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2- Urology department; Croydon university hospital
3- Urology department; St Georges hospital
4- Urology department; Epsom & St Heliers hospital

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Abstract
Introduction
Infertility affects 1:7 couples in the UK. It is thought that male factor infertility is the sole cause in 30% of these couples, and plays a part in a further 40% of couples. 1% of men with male factor infertility are azoospermic. We looked at the pathway of men with azoospermia requiring surgical sperm retrieval to identify the most significant delays to the pathway leading to their eventual management.

Methods
A prospective database of 102 male infertility patients referred to a male fertility specialist in two centres between 2015 - 2016 was analysed, and azoospermic patients were identified. The date of initial presentation to GP, the first contact with a urologist/fertility clinic and the first referral to male fertility specialist was noted.

Results
26 of men who were azoospermic and required surgical sperm retrieval were identified. The median time of infertility before presentation to primary care was 3 years (IQR 2 – 5 years). The median age of presentation to the male fertility specialist was 35 years (IQR 33 – 40) for the male and 34 years for the female (IQR 32 – 37). The median time from 1st GP presentation to 1st urology or fertility clinic presentation was 2.5 years (IQR 2.0 -3.8) . The subsequent time to 1st male fertility specialist appointment was 1 year (IQR 0.5 – 1.3). 12% (n= 3) of men were not azoospermic prior to being seen in the 1st urology/male fertility clinic; and a further 4% (n = 1) developed azoospermia between 1st urology/fertility clinic and the male fertility specialist visit.

Conclusion
Men who require sperm retrieval are suffering major delays, chiefly in presenting to primary care and subsequently the primary care referral to initial specialist referral. During this time, up to 1 in 6 men could potentially have avoided a surgical sperm retrieval procedure with a success rate of only 50%. Significantly, partner fertility also declines in these years and as all these patients will need assisted reproductive techniques (ART), this further impacts on pregnancy and birth rates. During the delay, patients also lose out on ART funding because of age criteria for both sperm retrieval and subsequent IVF/ICSI. Public health education on male infertility and prompt referral of men with male factor infertility to a male fertility specialist unit should be a priority.

Title of presentation
Preventing same-day cancellations by improving pre-operative assessment in patients undergoing urological surgery: a closed loop audit.

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Abstract
Introduction

The cancellation of elective surgeries not only represents a significant loss of revenue for the NHS, but also confers a large psychological burden on patients and results in a loss of training opportunities for registrars. At our institution, all patients attend a nurse-led preoperative assessment clinic supported by junior doctors. Anecdotally, we noticed a large number of same-day cancellations due to inadequate pre-operative assessment. Furthermore, junior doctors with limited knowledge of urological procedures reported feeling ill-equipped to provide preoperative assessment for patients, many of whom are elderly and comorbid.

Methods

A retrospective audit between 1st February 2016 and 1st February 2017 of all same-day elective cancellations was performed. Following the first audit cycle, a pre-operative assessment handbook was created and distributed to all junior doctors assisting with pre-operative assessment. A virtual results database for MSU results was also created. A re-audit was performed from August 2017 to September 2017. Junior doctor stress was collected using the State Trait Anxiety inventory, a validated clinical stress scale.

Results

106 same-day cancellations were identified in the first cycle. 43/106 (41%) were identified as being secondary to inadequate pre-operative assessment. Following intervention, we identified 25 cancellations; 9/25 (36%) were due to inadequate preoperative assessment. Furthermore, junior doctors had improved State Trait Anxiety Inventory scores following the implementation of the handbook.

Conclusion

Preliminary results suggest that the introduction of a pre-operative assessment handbook not only reduces same-day cancellations in patients undergoing urological surgery but also improves anxiety for junior doctors performing pre-operative assessment.

Title of presentation
Impact following Introduction of walk-in catheter clinic service on reducing catheter related hospital admissions.

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Abstract
Aim
To compare the number of patients who attend with catheter related problems to A&E, and are subsequently admitted, before and after the introduction of a walk-in catheter clinic.

Background
In 2016 there were 23.57 million attendances across England's A&E departments which was an increase by 5.2% from 2015 (1). This is approximately 3,200 more patients attending A&E each day.

In 2015/16 376,250 patients presented with urological conditions as the first recorded diagnosis which was a 9% increase from 2014/15 (2). With this increasing burden, it is more important than ever, to provide patients with more accessible services, where appropriate.

Methods
Electronic patient records (EPR) have been assessed, reviewed and data correlated with the A&E patient database to identify patients presenting with catheter related problems. The first audit included data between October 2015-16 and the second audit has included data between October 2016-17.

Results
Our A+E department has seen approximately 780 patients between October 2015 – 16 with catheter related problems. Interestingly, we also found that most patients were ambulant and presented within working hours (09:00 – 17:00), ideal candidates for the walk-in service.

Since the introduction of the walk-in catheter clinic, there has been a reduction to 468 catheter related attendances between October 2016 – 17. We shall present more detailed results during the meeting.

Discussion
Between October 2015-16 approximately 72% of patients attending with catheter related problems were discharged home which suggests that these patients could have been treated in the walk-in clinic, if it were available.

The cost of attending the walk-in catheter clinic is substantially less than attending A&E and therefore has a cost saving benefit but also overall provides a better patient experience.

Title of presentation
Trainee Satisfaction in Urology Higher Speciality training- Can we limit the impact of the workforce crisis?

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Abstract
Urology is headed for a workforce crisis. We have seen a 142% increase in unfilled consultant posts in the last two years and BAUS are predicting a potential shortage of 788 consultants over a 12 year period.

We aimed to examine the challenges to workforce retention in urology higher speciality training.

Method:
A ten item survey was designed and piloted, aimed at examining the attitudes and intentions of 32 urology higher speciality trainees towards their training.

Results
23 higher speciality trainees completed the survey, 12 male (52%), 11 female (48%). 13 (56%) were ST4 or below, one (4%) worked less than full time.
11 (48%) had considered leaving urology training whilst 10 (43%) said they would consider moving abroad. 17 of 23 trainees (73%) cited burnout as the most common reason for considering leaving. Poor remuneration and the lack of flexibility of a training post were the second and third most common reasons.
14 (60%) respondents said they were or would consider working less than full time. 15 of the 23 (65%) respondents would still apply for higher speciality training if they had to make the decision again.

Discussion:
The findings of the survey demonstrate a high rate of trainee discontent with urology higher training. Concerns about rota gaps, overwork and lack of flexible all contributed to dissatisfaction and influenced a decision to leave. High trainee dissatisfaction often translates into difficulty in recruiting.

A workforce crisis affects everyone. Whilst the situation may be unavoidable, we must take this opportunity to limit its impact. Failing to plan for such an eventuality, is planning to fail