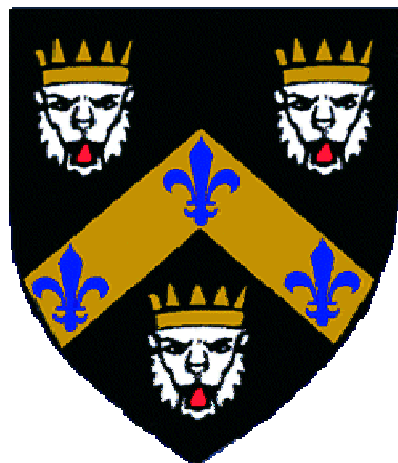


South Thames Urology Regional Meeting

April 27th 2010



Sherman Education Centre

4th Floor Southwark Wing

Guy's Hospital

Guy's & St Thomas' NHS Foundation Trust

Programme

1000 STC Meeting (STC only)

1230 Lunch with sponsors (All) – Sherman Education Centre

1330 Welcome and Introduction

1340 Presentations - 1st Session (6 mins presentation & 4 mins for questions)

An audit of the management of suspected renal colic

T Nitkunan, C Thomas, G Das
Mayday Hospital

Equivocal scrotal ultrasounds – the value of a second scan?

P Kheirandish, R Zakri, S Mukhtar, N Shrotri, R Krishnan
Kent and Canterbury Hospital

A randomised double blind placebo controlled trial assessing the safety and efficacy of botulinum toxin-A in the management of patients with bladder oversensitivity.

C Dowson, A Sahai, J Watkins, MS Khan, P Dasgupta
Guy's and St Thomas' Hospitals

The effect of the Regional Multidisciplinary Team Meeting on clinical decision making

J Brewin, J Dockray, S Sellaturay, C Brown, M Lynch, G Muir
Kings College Hospital

Five year follow up of 80W Green light laser photoselective vapourisation of the prostate (PVP) – a prospective single centre experience

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Greenlight HPS laser photoselective vaporisation prostatectomy audit

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Epsom & St Helier University Hospitals

Holmium Laser Enucleation of the Prostate: disproving the myths of the learning curve

S Ahmed, A Jones, F Newman, N Day, M Cynk
Maidstone and Tunbridge Wells Hospitals

1455 A Novel Simulation Program for Urology - Professor Dasgupta/ Mr Khan

1510 Coffee with sponsors

1540 Presentations - 2nd Session (6 mins presentation & 4 mins for questions)

Extraperitoneal laparoscopic guided cryosurgery for small renal masses – initial experience from a single UK centre

V Kalsi, S Willis, R Hindley , NJ Barber
Basingstoke and Frimley Park Hospitals

Factors associated with increased risk of complications from dynamic inguinal sentinel lymph node biopsy in patients with squamous cell carcinoma of the penis

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Upper tract imaging in patients with new diagnosis of non-muscle invasive bladder cancer

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The incidence and clinical significance of concurrent prostate and bladder cancer in radical cystoprostatectomy

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Hospital admissions with infection after TRUS biopsy, April-December 2009

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QE Hospital, Woolwich

Can the bone scan be omitted from staging for prostate cancer?

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Is LDR Prostate Brachytherapy appropriate for intermediate and high risk patients?

E Chadwick, D Georgakopoulos, R Laing, S Langley
Royal Surrey County Hospital

Application of the Bordeaux technique in robot-assisted radical prostatectomy improves immediate continence

J Withington, A Henderson, D Cahill
Guy's and St Thomas' Hospitals

1700 South Thames Website - M Bultitude

1705 Prize announcement and close of meeting

1730 Drinks/ Buffet food

Abstracts

An audit of the management of suspected renal colic.

T Nitkunan, C Thomas, G Das
Mayday Hospital

Introduction – Our hospital guidelines state that patients with suspected renal colic should be investigated with an intravenous urogram, if their age is less than 40 and with a CT if more than 40. The aim of the study was to determine whether we were following our hospital guidelines and to review the management.

Methods – We retrospectively reviewed the notes of all patients admitted during a three month period in 2009.

Results – Thirty six patients were admitted in this period with suspected renal colic. Twelve patients had CT scans, 21 had an IVU and three patients had both. For those aged <40, 13/17 had an IVU and for those >40, 10/19 had a CT. The median time to imaging from admission was 7.5 hours (range 1.5-40.2). 15/26 (58%) were managed with medical expulsive therapy, 10/26 (38%) had ureteric stent placement and 1 had extra-corporal shock wave lithotripsy.

Conclusions – In a three month period, there were 36 admissions for suspected renal colic. Ten of these were found not to have calculi. Time taken to imaging could be as long as 40.2 hours. 10/26 renal colic cases were managed with stent placement. This audit highlights the need for an A&E based protocol for the management of renal colic to reduce unnecessary hospital admission and shorten the diagnostic pathway. This protocol has now been approved and is in the process of being implemented.

Equivocal scrotal ultrasounds – the value of a second scan?

Kheirandish P, Zakri R, Mukhtar S, Shrotri N, Krishnan R

Kent and Canterbury Hospital

Introduction & Objectives: Ultrasonography is the imaging modality of choice for the scrotum. Nevertheless, inconclusive scrotal ultrasound (US) reports are often encountered leading to further investigation. We conducted a retrospective review of patients who had undergone repeated scrotal USS. We aimed to determine the value of a second US and its implications upon management.

Methods: We reviewed the clinical notes of individuals who underwent two or more US in 2008. Clinical factors assessed included mode of presentation, operator type (radiographer vs radiologist) and if the second ultrasound had altered management.

Results: 70 case records were analysed. Pain was the commonest mode of presentation (56%), followed by swelling (21%) and a palpable lump (16%). Four patients had suspected malignancy, sixty-six being benign. No change in diagnosis was observed between the first and second USS reports in 48 (68%) patients. This included all malignant cases. The remaining 22 cases (32%) resulted in new diagnoses of which 20 cases were associated with a change in management. However, no patients required surgical treatment as a result of the second USS.

62 of the original USS were performed by radiographers compared with 41 of the repeated USS (89% vs. 59%). Of the 22 patients with a change in diagnosis, the percentage of scans performed by radiographers did decrease between original and second US. (82% vs. 74%).

Conclusions: Repeat scrotal USS is useful in confirming an inconclusive underlying diagnosis. Significant changes in management are unlikely. Requesting a radiologist to supervise the repeat US may be considered

A randomised double blind placebo controlled trial assessing the safety and efficacy of botulinum toxin-A in the management of patients with bladder oversensitivity.

C Dowson, A Sahai, J Watkins, MS Khan, P Dasgupta
Guy's and St Thomas' Hospitals

Introduction: Randomised placebo controlled trials have shown Botulinum toxin-A (Botn-A) to be a safe and effective treatment for detrusor overactivity (DO). However, little is known on a subset of overactive bladder (OAB) patients with bladder oversensitivity. To address this we conducted a clinical trial in this patient population.

Methods: Patients with the symptoms of OAB but no evidence of DO with low first and normal desires to void and low cystometric capacity were recruited to this trial. The primary endpoint was change in maximum cystometric capacity (MCC). Secondary endpoints included change in OAB symptoms, other urodynamic parameters and quality of life (QoL) assessment. Patients were randomised to either 100 U Botn-A (Botox®) or placebo via a flexible cystoscopic technique. Unblinding was performed at 12 weeks. Data was compared using the appropriate non-parametric tests.

Results: An interim data analysis was performed because of an apparent poor response to treatment. Overall 10 patients received placebo and 10 received Botn-A. A significant rise in MCC in the botn-A group was observed at 12 weeks compared to placebo. Although a trend was observed for improvements in first and normal desire to void in the Botn-A group this did not reach statistical significance. Botn-A did not improve OAB symptoms or QoL when compared to placebo. Only 30% who received Botn-A perceived benefit following treatment.

Conclusion: The results of Botn-A use in bladder oversensitivity is disappointing. Although significant improvements are seen in MCC this does not translate into improvements in OAB symptoms or QoL benefit.

The effect of the Regional Multidisciplinary Team Meeting on clinical decision making.

J Brewin, J Dockray, S Sellaturay, C Brown, M Lynch, G Muir
Kings College Hospital

Introduction: Most patients with urological malignancies are discussed at a local multidisciplinary team meeting (MDM) and subsequently at a regional MDM. The aim of our audit was to analyse the effect of the regional MDM on clinical decision making.

Methods: Fifty consecutive patients were analysed to determine whether the regional MDM added to or changed the local MDM management plan. Four consultants analysed the decision making process using the Delphi process to objectively assess whether management had been altered.

Results: Of the 50 cases discussed at the regional MDM, the management plan was altered in eight of the cases. Of these eight cases, six of the changes were because new results were available at the regional MDM and two were true changes in patient management. Both of these changes were deemed to have only a small impact on patient management.

Conclusion: The regional MDM only altered patient management in two out of the 50 cases analysed and these changes had a small impact on patient management. This audit specifically examined the direct effect of the regional MDM on patient management and does not assess other potential benefits of the regional MDM such as education, improved communication between clinicians and improved co-ordination of services.

Five year follow up of 80W Green light laser photoselective vapourisation of the prostate (PVP) – a prospective single centre experience.

J Dockray, S Chandrasekara, K Walsh, F Liberale, G Muir
Kings College Hospital

Introduction and Objectives: To assess the medium term efficacy of Green Light laser prostatectomy in patients with lower urinary tract symptoms or urinary retention secondary to Benign Prostatic Hyperplasia.

Methods: A prospective analysis was carried out on 200 consecutive patients treated with 80W KTP-YAG prostatectomy with a minimum follow up period of 5 years. Total hospital stay, catheterisation time and complication rates were recorded for all patients. IPSS, QOL, IIEF-5, Qmax, post-void residual volume, trans-rectal ultrasound volume, and PSA were carried out at baseline, 3 months and 1 year. IPSS, QOL and IIEF-5 were assessed for all patients at 5 years and 20% of patients were invited to re-attend for flow studies, PSA and TRUS volume.

Results: Mean post-operative hospital stay was 5.7 hours and the mean post-operative catheter time was 15.7 hours. All patients with retention 46 (23%) managed to void without catheters after surgery. At five year follow up, 24 patients (12%) have died of intercurrent illness and another 10 (5%) have subsequently been diagnosed with prostate cancer. 24 patients (12%) were lost to follow-up. For the remaining patients significant improvements are seen with the mean values shown:

	IPSS	QOL	Peak Flow
Baseline	21.8	4.5	8.4ml/s
5 years	8.6	1.68	18.4ml/s

14 patients (7%) have had further outflow surgery (12 PVP/TURP/Open prostatectomy and 2 Bladder neck incisions).

Conclusions: The 80W KTP-YAG laser is a safe and effective method of treating bladder outflow obstruction due to BPH. Five year results are encouraging in this unselected group of patients.

Greenlight HPS laser photoselective vaporisation prostatectomy audit

H Alnajjar, J Bondad, D Magrill, S Gordon, P Le Roux
Epsom & St Helier University Hospitals

Introduction: In March 2008 we introduced Green-light photoselective vaporisation prostatectomy (PVP) as an option for patients with benign prostatic hyperplasia requiring surgery, including large prostates and patients in urinary retention. As part of our clinical governance all patients undergoing PVP are entered into a prospective audit measuring both validated Patient Outcome Measurements (POMs) and objective data.

Methods: All patients electing to undergo PVP were included (122 to date). Pre- and post-operative IPSS, AUA – QoL score, maximum flow rate (Qmax) and post-void residual volume (PVR) were recorded. Peri-operative data collection included lasing time, energy delivered, duration of catheterisation and inpatient stay.

Results: The mean age was 71 (44-89). Mean pre-operative Qmax was 9.0 ml/sec (1.8-29.6), PVR 268mls (0-2000), AUA QoL 4.4 and IPSS 23. Mean applied energy was 139,000J with mean lasing time 25 minutes. Mean length of stay was 1.4 days. Eighty-one percent of patients were discharged catheter free on the first post operative day. Of the 19 patients admitted with a catheter, 11 were discharged catheter-free. The mean post-operative Qmax was 16.0 ml/sec, PVR 99.0 mls, AUA QoL 1.5 and a mean IPSS of 7.3. The mean improvement in IPSS was 15. There were no major complications. Twenty of 122 patients complained of transient irritative LUTS or had microbiologically proven UTIs.

Conclusion: We found PVP with the GreenLight HPS a safe and effective treatment for BPH, with a short hospital stay, good short-term functional results and patient recorded outcomes, and a low incidence of peri-operative complications.

Holmium Laser Enucleation of the Prostate: disproving the myths of the learning curve

S Ahmed, A Jones, F Newman, N Day, M Cynk
Maidstone and Tunbridge Wells Hospitals

Introduction and Objectives: Holmium Laser Enucleation of the Prostate (HoLEP) has been shown to have comparable medium-term outcome to TURP with the advantage of less perioperative morbidity, particularly in larger prostates. However, HoLEP has not been widely adopted by urologists perhaps due to the perceived long learning curve. Our aim was to assess the HoLEP learning curve from our first 200 cases.

Material and Methods: Between December 2003 and July 2009, 200 consecutive patients underwent HOLEP by a single surgeon who had received mentorship in six cases. Outcomes were collected prospectively, and analysed in 20-patient cohorts including: resection weight, operative time (enucleation and morcellation), length of hospital stay and pre and post haemoglobin levels. Maximum urinary flow rates (Qmax) and post void residual volumes (PVR) were measured at baseline and 3 months post-operatively.

Results: The operative time remained stable throughout the cohorts with a mean of 59 minutes (range 10-180 minutes). Operative efficiency (resection weight per minute of operative time) was stable at a mean of 0.25g/min for the first 120 cases; this slowly improved thereafter reaching a mean of 0.4g/min for the last cohort. The learning curves of Qmax and PVR improvements at 3 months were flat. There were no significant differences in hospital stay and haemoglobin drop amongst the cohorts, and no patients received blood transfusion.

Conclusion: The HoLEP learning curve is not as long as widely perceived, with improvements in outcome parameters being consistent throughout the learning curve. Effective mentoring is essential to ensure optimal early outcome.

Extraperitoneal laparoscopic guided cryosurgery for small renal masses – initial experience from a single UK centre

Kalsi V, Willis S, Hindley R, Barber NJ
Basingstoke and Frimley Park Hospitals

Introduction: Minimally invasive ablative techniques such as cryosurgery and radiofrequency ablation have shown to be effective and are gaining in popularity in the treatment of small renal masses (SRM). Laparoscopic guided cryosurgery (LGC) for SRM is well established with the transperitoneal approach being generally reported. The aim of this study is to present results of LGC using an almost exclusive extraperitoneal approach from a single UK centre.

Methods: Data were collected for 25 adults (19 men, 6 women), mean age 69.4 years (42 – 90) with radiologically established SRM's, mean tumour size 2.6 cm (1.5 – 4.7). LGC was offered to elderly and/or patients with significant medical co-morbidities or those following recent major surgery. All treatments were standardised to 2 freeze/thaw cycles. Follow-up includes interval CT scans and blood tests.

Results: Twenty-three patients had an extraperitoneal approach; 2 transperitoneal. In all 24 SRM and 2 complex cysts were treated with 54% (14) of the lesions being on the left and 46% (12) on the right. All but 1 patient (96%) had a positive treatment response up to 1.5 years follow-up. The patient who failed initial treatment opted for re-treatment with LGC. Mean inpatient stay 1.92 days (1 – 7). Complications: 3 (12%) post-op bleeds all managed conservatively with no blood transfusion required; 1 (4%) ureteric injury eventually requiring a nephrectomy.

Conclusions: Extraperitoneal LGC is efficacious and truly minimally invasive in treating patients with SRM especially in whom standard treatment options may be considered too morbid. Inpatient stay and analgesia requirement is minimal, making a true day case procedure possible.

Factors associated with increased risk of complications from dynamic inguinal sentinel lymph node biopsy in patients with squamous cell carcinoma of the penis

S La-Touche, W Lam, B Ayres, C Corbishley, M Perry, N Watkin
St George's Hospital

Introduction: The aim of this study is to identify factors associated with complications of dynamic inguinal sentinel lymph node biopsy (DSNB) to further lower morbidity of the procedure.

Patients and Methods: A retrospective, comparative study was performed of patients who underwent DSNB between April 2005 and March 2010. Patients were categorised into 3 groups. Group A consisted of the first 50 patients (of 250), on whom ligaclips were the lympho-vascular control technique used. This group was compared with another 50 patients (Group B), in whom coagulation diathermy was primarily used. Incision length, operative time, number of nodes removed, antibiotic usage and co-morbidities were recorded. A prospective study was then performed on 30 patients, reverting to using ligaclips (Group C).

Results: In Group A, 88 inguinal basins were explored with a complication rate of 5.7%. In Group B, 75 groins were explored with a 24% complication rate ($p=0.0018$); mostly lymphocoeles with/without infection. Mean incision length was 4.1 cm for group A and 5.6 cm for group B ($p=0.0001$). Mean operative time was 15.8 mins for group A and 19.3 mins for group B ($p=0.0043$).

In Group C, 34 inguinal basins were explored with a complication rate of 5.8% ($p=0.0458$, versus group B). Mean incision length was 5.7cm and mean operative time was 21.6 mins. Antibiotic usage, co-morbid factors and mean number of nodes removed were similar in all groups.

Conclusion: Lympho-vascular control with diathermy is associated with a higher complication rate compared with ligaclips. A small but statistical increase in operative time and wound length is likely to be related to registrar training.

Upper tract imaging in patients with new diagnosis of non-muscle invasive bladder cancer

P Pietrzak, H Davidson, P Sangster, S Stetina, S Sandhu, J Dick, A Thompson, R Singh, R Morley
Kingston Hospital

Aims: This audit aimed to investigate the utilisation and detection of tumours with upper tract imaging (CT/IVU) in all newly diagnosed bladder cancer patients at Kingston Hospital NHS Trust. Our practice was evaluated with the 2009 EAU guidelines which question the necessity of upper tract imaging in patients with non-muscle invasive disease due to the low incidence (1.8%) of synchronous upper tract disease.

Methods: We retrospectively identified 139 patients who between January 2008 and September 2009 were diagnosed with new bladder cancer. The stage and grade of tumour was recorded as well as the modality of upper tract imaging.

Results: Results showed 76% compliance with our current imaging guidelines. Abnormalities of the upper urinary tract were identified in 10% ($n=72$) and 48% ($n=27$) of cases, of non-muscle invasive and muscle invasive disease respectively. Subsequent imaging and/or ureterorenoscopy failed to confirm the presence of synchronous tumour in any of these patients. 1 in 3 patients who had an IVU also had a CT.

Conclusions: This audit does not support the continued use of routine upper urinary tract imaging to identify synchronous lesions in patients diagnosed with bladder cancer. However due to its small sample size we recommend a multicentre audit to clarify this further. In cases where imaging is performed we recommend the use of CT.

The incidence and clinical significance of concurrent prostate and bladder cancer in radical cystoprostatectomy

AF Ismail, H Yamamoto, P Acher, F Tungekar, MS Khan
Guy's & St Thomas' Hospitals

Introduction: The frequency of prostate cancer in radical cystectomy specimen is highly variable in reported series (4%-54%). The clinical significance of incidental prostate cancer is unclear in this setting. We report the incidence of concurrent prostate cancer in radical cystoprostatectomy, and the outcomes in our cohort of patients.

Method: Between 2003-2008, 102 patients underwent radical cystoprostatectomy for bladder cancer. We reviewed our radical cystectomy database to determine the incidence, the Gleason score and staging for prostate cancer in these patients. We also report the outcome of the patients with concurrent prostate and bladder cancer in terms of tumour recurrence, disease-free survival and mortality.

Results: We identified 30/102(29%) men with prostate cancer following histopathological examination of radical cystoprostatectomy specimen. Gleason score of 7 or greater was found in 11/30(37%) patients. Most of the concurrent prostate cancer found were organ-confined (T2 in 28/30), with 2 cases of T3a disease. There were 5 cases with positive margin for the prostate cancer.

There were 41/102 mortalities in this cohort. The mortality in patients without prostate cancer is 29/72(40%), and 12/30(40%) in the group with concurrent prostate cancer. Only one death was caused by recurrent prostate cancer (patient had prostate cancer diagnosed prior to radical cystectomy).

Conclusion: Prostate cancer is common, and the finding of concurrent prostate cancer in cystectomy specimen may reflect the population epidemiology of prostate cancer. The finding of incidental prostate cancer appears not to affect the survival of patients following radical cystectomy.

Hospital admissions with infection after TRUS biopsy, April-December 2009

Jones C, Aggarwal R, Hammadeh M
QE Hospital, Woolwich

Introduction: Ultrasound-guided TRUS biopsy is the standard means by which a tissue diagnosis is obtained in suspected cases of prostate cancer. Sepsis is a well-recognised complication, given that the obtaining of biopsies via the rectum entails a risk transmitting bacteria directly into the bloodstream and urinary tract. This audit evaluated the incidence of post-procedure infective complications at QEH.

Method: A retrospective analysis was made of all those patients who had undergone a TRUS biopsy at QEH in the period April – October, and note was taken of those who had presented to our hospital within 1 week of their procedure. These patients were then scrutinized further, and in patients with a suspected infective complication investigation was made in terms of culture results, antibiotic treatment, biopsy result and risk factors for infection.

Results: 11 of 182 patients were admitted with infection, 9 of whom also had a positive urine or blood culture. This represents a rate of 4.9%, which excessive to a statistically significant extent when compared to the rates seen in other published series.

Conclusions: A statistically significant excess of morbidity from post TRUS infection has been demonstrated in this study. Patient characteristics (age, diabetes) and biopsy results (cancer, prostatitis) were examined with respect to an association with infection, but no significant risk factor was established. This accords with the published data, in which only concurrent steroid administration was found to increase the risk of infective complications⁵. This did not apply to any patient in this study. Traditionally, fluoroquinolones have been used in TRUS biopsy prophylaxis due to their broad spectrum of action and good bioavailability in the prostate. Recently, however, several studies have noted the advent of fluoroquinolone-resistant post-TRUS sepsis. 4 of 9 positive cultures in our study showed resistance to ciprofloxacin, and none of the remainder were described as showing ciprofloxacin sensitivity. A new prophylactic regime for our hospital was set out in December 2009. This incorporates a pre-procedure MSU and the avoidance of ciprofloxacin in patients with a history of resistance. Gentamicin is given prophylactically in addition to ciprofloxacin and PR metronidazole, and a 3 day course of oral antibiotics is prescribed post-procedure. The incidence of post-TRUS sepsis will be re-audited in due course.

Can the bone scan be omitted from staging for prostate cancer?

S Willis, H Walker, N Pereira, N Barber, B Montgomery, S Bott
Frimley Park Hospital

Introduction: There is currently a worldwide shortage of technetium-99m, the radioisotope used in nuclear medicine bone scanning. MRI prostate and bone scans are routinely used for staging patients with newly diagnosed intermediate and high-risk prostate cancer. We wanted to explore what proportion of bone metastases would show up on MRI, with a view to omitting the bone scan from the staging process.

Method: Between October 2004 and January 2010, all men presenting to Frimley Park Hospital with biopsy-proven prostate cancer with a PSA >10µg/l and/or a Gleason grade ≥3+4, who were suitable for radical treatment, underwent a staging bone scan and MRI (or CT if MRI contraindicated). Data was collected retrospectively.

Results: 125 patients were identified, with complete data available on 116. The median age was 71 and median PSA 14ng/ml. 17 patients (15%) had positive bone scans. In 8 of these patients (47%) with positive bone scans, MRI (or CT) confirmed bone metastases. In 7 patients (41%) with positive bone scans, MRI showed that the bony changes were not due to metastatic disease. Two patients (12%) had isolated rib metastases on bone scan, with no evidence of bony lesions on MRI; biopsy or interval scanning made a diagnosis of bone metastases unlikely. No patients had bone metastases on MRI but not bone scan.

Conclusions: All patients in this small series with positive scans had bone metastases identified on MRI or CT. We suggest that bone scans may not be required in this patient group, resulting in a saving of cost and technetium-99m. Greater numbers are required for confirmation.

Is LDR Prostate Brachytherapy appropriate for intermediate and high risk patients?

E Chadwick, D Georgakopoulos, R Laing, S Langley
Royal Surrey County Hospital

Introduction: Over 1600 patients have undergone 125 prostate brachytherapy (BXT) in our unit. Our centre has previously demonstrated that BXT is an effective and well tolerated treatment, particularly for low risk patients. We now focus on the outcomes of intermediate and high risk patients.

Methods: A prospective database of patients treated with BXT between March 1999 -March 2010 was analysed. Patients were stratified into low (42%), intermediate (29%) and high (11%) risk, as defined by the MSKCC Prognostic Index. Patients received 145Gy BXT alone (65%), BXT with neo-adjuvant androgen deprivation (NAAD) (22%), 45Gy external beam radiotherapy (EBRT) with 110Gy BXT (2%), or tri-modality therapy (10%). Data from patients with at least 3 years follow up were subjected to further analysis.

Results: Overall survival was 97% for both intermediate (n=438) and high (n=160) risk groups. Actuarial 7 year biochemical relapse free survival (bRFS) was 83% for intermediate and 82% for high risk groups. Actuarial 7 year bRFS was 83% for those receiving EBRT and BXT versus 82% for those receiving BXT alone. Actuarial 5 year bRFS was 91% for intermediate risk patients receiving NAAD and BXT versus 92% for intermediate risk patients receiving BXT alone.

Conclusions: The outcomes of combination therapy in selected intermediate and high risk patients compare favourably with those for patients with low risk disease

Application of the Bordeaux technique in robot-assisted radical prostatectomy improves immediate continence

J Withington, A Henderson, D Cahill
Guy's and St Thomas' Hospitals

Introduction: Our technique for radical prostatectomy has constantly evolved to improve early continence. The 'Bordeaux technique' describes division of the dorsal vein complex(DVC) without ligation or lateral urethral dissection with reported immediate continence of 80%. We introduced this to our robot-assisted radical prostatectomy(RARP) technique October 2009.

Methods: Prospective case-control study comparing 27 cases performed from October to December 2009 using the Bordeaux technique with all other cases performed from January to September 2009, all performed by a single surgeon. No significant differences in age or disease characteristics existed between the groups. Immediate continence was defined as pad-free at <2weeks. Continence at 6 weeks is also reported.

Results: The procedures were uncomplicated. Intra-operative blood loss was greater using the modified technique, though no patient required blood transfusion.

Oncological outcomes were comparable for the two techniques.

Early continence rates for laparoscopic radical prostatectomy (LRP) and standard and for RARP using the Bordeaux technique are presented in the table below. Immediate continence is improved significantly in the Bordeaux technique group, compared with standard RARP.

Conclusions: RARP with delayed endopelvic fascia incision and DVC division without ligation before oversewing preserves the urethral complex maximally. This translates into better immediate continence.

This single innovation has produced the largest stepwise improvement in immediate continence even at this early point in our learning curve.

	LRP	Standard RARP	Bordeaux technique RARP
	N = 43	N = 32	N = 38
Immediate continence	20%	28%	39%
6-week continence	49%	63%	66%

Directions

The Sherman Education Centre is on the 4th floor in Southwark Wing
(The walk way from London bridge station connects to the 2nd floor of this building)

Travelling to Guy's Hospital

 [Guy's Hospital site map](#) (PDF 998Kb)

 [Guy's - 2nd floor footbridge entrance map](#) (PDF 804Kb)

By tube

The nearest tube stations to Guy's hospital are:

- London Bridge - Northern and Jubilee lines (5 minutes' walk)
- Monument - District and Circle lines (15 minutes' walk)

By bus

These buses stop at London Bridge, London Bridge station or near Guy's hospital: 17, 21, 35, 40, 43, 47, 48, 133, 141, 149, 343, 381, 521, 701, RV1, C10, N21, N35, N47, N133, N343 and N381. (Night Buses stop at or near London Bridge.)

Allow 15-20 minutes to get from the bus stop to where you need to be in the hospital.

For further information about buses and tubes, please call Transport for London on 020 7222 1234 (24 hours) or visit [Transport for London website](#).

By train

London Bridge is the nearest railway station. For further information, please call National Rail Enquiries on 08457 484950 or visit [National Rail website](#).

By car

There is no general parking, although there is limited disabled parking, and a drop off facility. There is an NCP car park at the junction of Snowsfield and Kipling Streets, about a 2 minute walk from the hospital. However, this car park is often full. Charges are displayed at the entrance.

Congestion charge

Both Guy's and St Thomas' Hospitals are located in the congestion charging zone of London



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