South Thames Urology Meeting

Epsom Downs Racecourse

KT18 5LQ

Wednesday 6th May 2015

Programme

1000 – 1200	South Thames Deanery Meeting *Box 20, 4th Floor*
1000 – 1200	KSS Deanery meeting Box 29, *4th Floor*
1200 – 1230	Joint meeting Box 20, *4th Floor*
1230pm – 1330	*Lunch* *Derby Suite, 3rd Floor*
1330 – 1500	Academic Session 1
1500 – 1530	*Tea*
1530 – 1700	Academic Session 2
1700	Award of Derek Packham Medal
1800	*Dinner* Barley Mow Pub, 12 Pikes Hill KT174EA

1330- 1500 Academic Session 1

7mins per presentation, 3 mins questions

1. Is there a difference between renal sinus and capsular invasion in T3a Renal Cell Cancer (RCC)? A study comparing the outcomes after extirpative surgery. N Faure Walker, J Allen, R Nair, R Issa, P Le Roux, C J Anderson. St George's University Hospitals NHS Foundation Trust. Presenter: Nicholas Faure Walker

2. Zero ischaemia - the hero in partial nephrectomy. Archie Fernando, Mark Lynch, Christian Brown, Philippe Grange, and Gordon Kooiman. King's College Hospital NHS Trust. Presenter: Archie Fernando

3. Learning the lessons from 15 years of nephron-sparing surgery (NSS) for von Hippel-Lindau (vHL) disease. Muddassar Hussain, Tim S O'Brien. Guy's and St Thomas' NHS Foundation Trust. Presenter: Muddassar Hussain

4. Audit of the two-week-wait prostate cancer pathway at Croydon University Hospital: An audit based on the London Cancer Alliance prostate cancer pathway guidelines. Eleni Anastasiadis; Jonathan Makanjuola; Kathryn Waite; Mark Lynch. Croydon University Hospital Trust. Presenter: Eleni Anastasiadis

5. Magnetic Resonance Imaging–Ultrasound fusion targeted transperineal biopsy: 'Hitting the target or the bulls eye?" A concordance study with radical prostatectomy specimens. Wayne Lam, Sohel Samad, David Eldred-Evans, Marco Puglisi, Janette Kinsella, Ben Challacombe, Rick Popert. Guy's Hospital. Presenter: Wayne Lam

6. Should we do template biopsies more often? Results of single centre experience in diagnosing and follow up of Prostate cancer. A. Ali, S RintoulHoad, T Larner, C Coker. Brighton University Hospital. Presenter: Ahmed Ali

7. Training in robotic surgery – a comparison of outcomes of training versus non-training cases in 458 consecutive robiceassisted laparoscopic prostatectomy cases. Maria Vedanayagam, Rhana Zahkri, Babbin John, Edward Streeter, Ben Hearden, Paula Simpson, Julie Pain, Hugh Evans, Ben Eddy. Kent and Canterbury Hospital. Presenter: Maria Vedanayagam

8. Open versus robotic surgery – a single centre comparisonn of 1000 consecutive radical prostatectomies. Maria Vedanayagam, Rhana Zahkri, Babbin John, Edward Streeter, Ben Hearden, Paula Simpson, Julie Pain, Hugh Evans, Ben Eddy. Kent and Canterbury Hospital. Presenter: Maria Vedanayagam

9. Bladder neck sparing (BNS) robot assisted laparoscopic prostatectomy (RALP); does it improve continence? Zakri RH, Vedanayagam M, John B, Pain J, Hearnden B, Simpson P, Eddy B. East Kent Hospitals University Foundation Trust, Kent & Canterbury Hospital, UK.

1530- 1700 Academic Session 2

7mins per presentation, 3 mins questions

10. Shedding new light on Retroperitoneal Fibrosis (RPF) – lessons learnt from a multi-disciplinary service. Archie Fernando, James Pattison, Catherine Horsfield, David D'Cruz, and TIm O'Brien. Guy's and St Thomas' NHS Trust. Presenter: Archie Fernando
11. Spinal Nerve Root Stimulation as an effective therapy for refractory loin pain. Dr Pranab Kumar, Mr Arun Sahai, Professor Prokar Dasgupta, Dr Adnan Al-Kaisy. Guy's & St.Thomas' NHS Foundation Trust. Presenter: Dr Pranab Kumar
12. An audit of urology on calls: are we more than a catheter service? Rintoul-Hoad S, Ni Raghalleigh H, Larner T. Brighton and Sussex University Hospitals. Presenter: Sophie Rintoul-Hoad
13. Combined vaginal and vesicoscopic collaborative repair of complex vesicovaginal fistulae. Jonathan Makanjuola , Chryssanthos Kouriefs, Dudley Robinson, Linda Cardozo, Philippe Grange. King's College Hospital. Presenter: Jonathan Makanjuola
14. Nurse follow up facilitates BAUS continence surgery outcome data entry. Denosshan Sri, Easter Espinosa, Tharani Nitkunan, Roger Walker. Epsom and St Helier Hospital. Presenter: Denosshan Sri
15. Invasive minor operations in Urology – a shift towards the outpatient setting. Denosshan Sri, Andrea Tay, Azhar Khan. Kings College Hospital. Presenter: Denosshan Sri
16. Transfusion Protocols in Common Urological Procedures. Helen Teixeira, Holly NiRaghalliagh, Tim Larner. Royal Sussex County Hospital. Presenter: Helen Teixeira
17. Is shockwave lithotripsy more cost effective than ureteroscopy for the management of ureteric calculi? The Epsom and St Helier Experience. Kathie Wong[1], Christopher Rao[2], Katharina Nucken[1], Elizabeth Eversden[1], Stephen Gordon[1]. [1]Epsom and St Helier NHS Foundation Trust, [2]Queen Elizabeth Hospital Woolich. Presenter: Kathie Wong
18. Prostate Artery Embolisation - Initial experience of treatment of benign prostatic enlargement for large volume prostates (mean volume 135cc) at a single institution. S Samad, W Lam, P Brousil, A Shaw, O Nehikhare, S Pandian, S Clovis, T Sabharwal, R Popert. Guys and St Thomas' Hospital. Presenter: Sohel Samad

1700 Award of Derek Packham Medal

1800 Dinner - Barley Mow Pub, 12 Pikes Hill KT174EA

Is there a difference between renal sinus and capsular invasion in T3a Renal Cell Cancer (RCC)? A study comparing the outcomes after extirpative surgery.

N Faure Walker, J Allen, R Nair, R Issa, P Le Roux, C J Anderson

St George's University Hospitals NHS Foundation Trust

Presenter: Nicholas Faure Walker

Job Title of Presenter: St4 Urology

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Abstract:

Introduction:

The 2009 UICC TNM classification of renal cell carcinoma categorizes renal sinus (RSI) and perirenal fat invasion (PFI) equally as T3a. The study compares recurrence and survival outcomes between these two parameters after extirpative surgery.

Methods:

Patients with localized RCC who had RSI and PFI were identified from a prospective database (n = 974). Age, tumour size, grade, local recurrence, metastases, cancer specific survival (CSS), overall survival (OS), were compared using Mann-Whitney, Kruskal-Wallis and Wilcoxon statistical tests.

Results:

RSI alone occurred in 48 patients; median age 61.5 (group 1). PFI alone occurred in 31 patients; median age 65.1 (group 2). RSI and PFI together occurred in 28 patients; median age 68.5 (group 3). Group 1 patients were younger but not statistically different to groups 2 & 3 (p=0.175).

Median tumour diameter for groups 1, 2 and 3 were 7.5, 5.9 and 7.45cm (p=0.031). The only local recurrence occurred in a nephrectomy patient with RSI.

Mean Tumour grade was 2-3 in all groups and did not affect survival.

Metastases occurred in 14.9%; 12.9% and 24% across the groups (p=0.012).

OS was 88.5%, 83.7% and 64.3% at median follow up 3.1 years (p=0.036).

CSS was 92.3%, 95.9% and 82.1% (p=0.23).

No partial nephrectomy patients had local recurrence or metastases.

Conclusion:

RSI has a slightly worse CSS than PFI but the combination of both was associated with greater risk for metastases and poorer CSS and OS. RSI and PFI in partial nephrectomy patients does not confer worse prognosis.

Zero ischaemia - the hero in partial nephrectomy

Archie Fernando, Mark Lynch, Christian Brown, Philippe Grange, and Gordon Kooiman

King's College Hospital NHS Trust

Presenter: Archie Fernando

Job Title of Presenter: SpR

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Abstract:

INTRODUCTION

It seems intuitive that a partial nephrectomy (PN) technique that allows the tumour to be removed with a clear margin, without ischaemia to the non-tumour-bearing kidney, and carries a low risk of complications would be the ideal. We report one of the largest series of zero ischaemia laparoscopic PN, a technique that we believe allows this ideal to be achieved.

METHOD

Retrospective analysis of all patients who underwent laparoscopic PN between July 2008 and April 2015 with collation of data on margins, ischaemia time, renal function and complications.

During the laparoscopic 3-port technique the tumour is identified using intra-operative ultrasound. Tumour vessel, if seen, is ligated. The tumour is then excised using a harmonic scalpel without hilar clamping and any bleeders or calyceal breaches are sutured.

RESULTS

133 patients underwent 135 laparoscopic PNs. 11 patients were excluded as they required short periods of hilar clamping (median 17.5 mins). 124 patients had zero ischaemia PN. Mean age 56 years (20-86). Mean follow up 31 months. Median tumour size 37mm (15-120). Histology – malignant 101 (81.5%); benign 34 (18.5%). Margins: Negative – 120 (96.8%), <1mm – 6 (4.8%). Positive – 4 (3.2%), 1 local recurrence requiring completion nephrectomy, 3 no recurrence at median follow up of 18 months. Estimated blood loss – median 700mls (<50 – 6L); 4(3.2%) patients required transfusion. No patient required conversion to radical nephrectomy. Clavien complications: I 12(9.7%); II 6 (4.8%); IIIa 2(1.6%); IIIb (stents for urinary leak) 9(7.3%); IV 0(0%); V 0(0%). Renal function – median pre-op GFR 83. Change in GFR at 6 months post-op (absolute) – median 1 ng/ml/m2; mean 4 ng/ml/m2 (range -8 to 30). Change in GFR at 6 months post-op (%) – median 0.1%; mean 6.4% (range -13% to 38%).

CONCLUSION

If the ideal PN technique should be designed to deliver negative margin, zero ischaemia and minimal complications then laparoscopic zero ischaemia PN gets us closer to consistently delivering these goals than any other technique. This technique also provides excellent functional outcomes with a median change in GFR of 1 ng/ml/m2 post-op.

Learning the lessons from 15 years of nephron-sparing surgery (NSS) for von Hippel-Lindau (vHL) disease

Muddassar Hussain, Tim S O'Brien

Guy's and St Thomas' NHS Foundation Trust

Presenter: Muddassar Hussain

Job Title of Presenter: Urology Specialist Registrar

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Abstract:

Introduction: In vHL disease the National Institutes of Health (NIH) advocate NSS when solid tumours reach 3cm in diameter. There remain unresolved questions about the feasibility and long-term success of NSS - is it oncologically safe and do patients avoid dialysis?

Methods: Surgical, oncological and renal functional outcomes assessed in patients managed with nephron-sparing intent from a specialist vHL clinic since 1999. NSS involved maximal clearance of solid tumour and excision/deroofing of cysts.

Results: 63 patients. Median age 36 years (range 23-68). Median follow-up 50 months (range 6-180). 20/63 had radiological evidence of renal involvement. 3/20 managed by surveillance alone. 1/17 had planned radical nephrectomy (RN) for large tumour volume. 2/16 patients refused RN for large tumours.

NSS attempted in 21 kidneys in 14 (70%) patients and completed successfully in 18/21 (86%). 3/21 converted to RN. Median of 2 (range 1-9) tumours excised. Median size 32mm (range 28-44mm). 1 kidney managed by primary radio-frequency ablation.

4/14 patients underwent 5 further ipsilateral procedures (2 NSS, 3 RN) for recurrence at a median of 36 months (range 2-70).

After NSS, median loss of estimated GFR = 11.5 ml/min/1.73m2 (range -4-43). Three patients required dialysis, two transplanted.

One patient developed metastatic RCC after refusing treatment. 3/20 (15%) patients have died; one neurological cancer, one stroke, one peri-operative death from stroke post-NSS in Jehovah's Witness.

Conclusions: NSS is challenging but largely successful in the long-term. No patient has died from RCC and 85% of patients have avoided dialysis.

Audit of the two-week-wait prostate cancer pathway at Croydon University Hospital: An audit based on the London Cancer Alliance prostate cancer pathway guidelines.

Eleni Anastasiadis; Jonathan Makanjuola; Kathryn Waite; Mark Lynch

Croydon University Hospital Trust

Presenter: Eleni Anastasiadis

Job Title of Presenter: ST5 Urology

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Abstract:

Introduction: The London Cancer Alliance (LCA) guidelines outline the appropriate and timely investigation of men with potential prostate cancer, to comply with the national cancer treatment target of 62 days. We audited the prostate cancer pathway.

Methods: Two audit cycles were conducted – the first between 1st February 2014 – 31st March 2014. The second only evaluated men diagnosed with prostate cancer between July - December 2014. Data on date of referral, time to first appointment, time to MRI and prostate biopsy, and time to first treatment were collected from the MDT co-ordinator and patient records. Targets used are those laid out by the LCA (first appointment should be <8 days after date of referral, prostate biopsy < 14 days, MRI scan <10 days, first treatment <63 days). The first audit was presented and fed back locally.

Results: In the first cycle, 68 men were referred. 29/68 (42.6%) were diagnosed with a prostate cancer of which 6/29 (21%) were started on Active Surveillance (AS). In the second cycle, 37 men were diagnosed with prostate cancer of which 7/37 (18.9%) received AS. In the first cycle, targets were achieved for appointments in 38/68 (55.9%), for prostate biopsies 1/37 (2.7%), for MRI 1/16 (6.3%) and first treatment 1/29 (3.5%). In the second cycle the respective results were 17/37 (45.9%), 2/33 (6.1%), 2/35 (5.7%) and 30/37 (81.1%).

Conclusion: Overall, the audit has resulted in a large improvement in time to first treatment. Further areas for improvement are currently under consideration.

Magnetic Resonance Imaging–Ultrasound fusion targeted transperineal biopsy: 'Hitting the target or the bulls eye?" A concordance study with radical prostatectomy specimens

Wayne Lam, Sohel Samad, David Eldred-Evans, Marco Puglisi, Janette Kinsella, Ben Challacombe, Rick Popert

Guy's Hospital

Presenter: Wayne Lam

Job Title of Presenter: ST6

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Abstract:

Introduction

The use of magnetic resonance imaging – ultrasound fusion transperineal targeted biopsy (M-UFTB) is a novel prostate cancer (CaP) diagnostic technique, with the potential to improve sampling accuracy and disease localization. This study aimed to evaluate the ability of M-UFTB to accurately predict final surgical pathology.

Methods

Data collected prospectively at a single urology centre (May 2013 to December 2014). Inclusion criteria: patients with (1) suspicious CaP on MRI, Pi-RADS score 4 or 5; (2) localized CaP diagnosed on M-UFTB; (3) radical prostatectomy (RP) as definitive treatment. Exclusion criteria: patients who had previous CaP treatment prior to RP. All biopsies were carried out according to a standardized M-UFTB protocol. Concordance of index tumour location, highest overall Gleason-pattern, conventional Gleason pattern, and total Gleason score between M-UFTB and RP were assessed using the Goodman-Kruskal lambda statistic method.

Results

26 patients with 30 region-of-interests (ROI) suspicious for the index tumour were eligible. Mean PSA was 8.9 (range 2.4-16.3). Mean prostate volume was 43.1cc (range 16-100). Index tumour location (λ=0.90), total Gleason score (λ=0.88), and highest Gleason score (λ=0.87) were associated high concordances between M-UFTB histology and RP specimens. 10 (33.3%) foci had Gleason-pattern upgraded on RP histology. 4 (15.3%) were downgraded.

Conclusions

In our series, M-UFTB has high performance characteristics in localizing index prostate cancer, predicting final total and highest Gleason scores. However, Gleason patterns were still upgraded in a third of patients.

Should we do template biopsies more often? Results of single centre experience in diagnosing and follow up of Prostate cancer

A. Ali, S RintoulHoad, T Larner, C Coker

Brighton University Hospital

Presenter: Ahmed Ali

Job Title of Presenter: Urology SpR

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Abstract:

Our centre currently offers template biopsies (TB) to patients with (1) suspected lesion not amenable to TRUS (2) rising PSA with previously negative TRUS (3) patient factors (4) active surveillance protocol. All undergo multi-parametric MRI.

Aim: Identify the main role of template biopsies.

Methods

A database of all patients undergoing TB was kept between June 2013 and March 2015.

Results

105 patients underwent TB, 13 were excluded due to absence of report. Of the the first Group (46) that underwent TB for previous negative TRUS, 8 (17%) had significant prostate cancer (G7 or above); these gentlemen had undergone a total of 11 TRUS biopsies prior to TB. Their MRI reports were all suspicious for cancer; 5 reported as 'high probability'.

20 patients underwent TB as their first biopsy, half had prostate cancer ≥G7. This group all had MRI of 'intermediate to high' probability. All, except 1, had anterior disease.

In Active Surveillance group, about half of the patients were under diagnosed (either Gleason or volume). Interestingly, Most patients had anteriorly located, higher grade lesion already correctly identified by MRI.

Conclusion

Template biopsy has a role in diagnosing prostate cancer in the context of previous negative TRUS and active surveillance. Comparison needs to be made in the context of targeted and fusion TRUS techniques. MRI reports help clinicians with diagnosing prostate cancer but cannot solely be relied upon.

Training in robotic surgery – a comparison of outcomes of training versus non-training cases in 458 consecutive robiceassisted laparoscopic prostatectomy cases.

Maria Vedanayagam, Rhana Zahkri, Babbin John, Edward Streeter, Ben Hearden, Paula Simpson, Julie Pain, Hugh Evans, Ben Eddy. Kent and Canterbury Hospital. Presenter: Maria Vedanayagam

Kent and Canterbury Hospital

Presenter: Maria Vedanayagam

Job Title of Presenter: Specialist Registrar Year 4

Contact Email: maria.ved85@gmail.com

Abstract:

INTRODUCTION

Surgeon reported outcomes are becoming available for public access. Consequently there may be a reduction in surgical training due a perceived fear it may result in negative outcomes. In addition pressures on theatre efficiency may lead to reduction in training opportunities.

PATIENTS

458 consecutive patients underwent robotic assisted laparoscopic prostatectomy (RALP) from May 2011 to date. 291 were performed solely by a single fellowship trained surgeon who was also the supervising surgeon for 167 training cases within this cohort.

METHODS

A comprehensive electronic database was used to prospectively collect data at point of care. We reviewed patient demographics, surgical, oncological and functional outcomes.

RESULTS

The average bloods loss was 319 vs. 232mls in the training and non-training group respectively ($P<0.0001$). The average operative time (202.4 vs. 150.8 minutes) and time taken to perform the anastomosis (10.1 vs. 17.2 minutes) was greater in the training group ($P<0.0001$). The T2 margin rate was 19% in training cases and only 8.8% in non-training cases. There was no difference seen in complication rates. The average length of stay was the same, 1.12 vs. 1.09 days ($P=0.6$) in training and non-training cases respectively.

CONCLUSION

Training was found to have an impact on operative and console times, reducing theatre efficiency, an increase in blood loss and an increase in T2 margin rates. However there was no difference in complication rates and no significant increase in length of stay in hospital.

Open versus robotic surgery – a single centre comparisonn of 1000 consecutive radical prostatectomies.

Maria Vedanayagam, Rhana Zahkri, Babbin John, Edward Streeter, Ben Hearden, Paula Simpson, Julie Pain, Hugh Evans, Ben Eddy. Kent and Canterbury Hospital. Presenter: Maria Vedanayagam

Kent and Canterbury Hospital

Presenter: Maria Vedanayagam

Job Title of Presenter: Specialist Registrar Year 4

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Abstract:

INTRODUCTION

Robotic prostatectomy has become widespread internationally. We present the UK's first single centre comparison of open versus robotic surgery in 1000 consecutive patients.

PATIENTS

558 consecutive patients underwent open prostatectomy (ORP) by single surgeon between March 1997 and April 2011. Following introduction of robotic surgery in May 2011, 442 patients, in a fellowship trained single surgeon series, underwent robotic assisted laparoscopic prostatectomies (RALP) from May 2011 to date.

METHODS

A comprehensive electronic database was used by both surgeons to prospectively collect data at point of care. We reviewed patient demographics, surgical, oncological and functional outcomes.

RESULTS

The mean age was 61 vs. 63.9 years and patients were matched for pre-operative PSA (10 vs. 8.8) in the ORP and RALP group respectively. The operative time was similar at 163 vs. 168 minutes. The estimated blood loss was 1597mls vs. 262mls reflecting a higher transfusion rate of 14% in the ORP group vs. 1.5% in the RALP group ($p=<0.0001$). An overall positive margin rate of 34% vs. 24% was seen ($p=<0.0001$). The overall complication rate was 13.1% vs. 6.3% ($p=<0.0001$), T2 margin rate of 20% vs. 12% and mean hospital stay was 3.8 vs 1.1 days in ORP and RALP respectively. Earlier recovery of continence was seen in the RALP group.

CONCLUSION

This is the first UK comparative study between ORP and RALP. We have shown how safe implementation of robotic surgery has led to a shorter hospital stay, lower blood loss, transfusion rates and complication rates and improved functional outcomes.

Bladder neck sparing (BNS) robot assisted laparoscopic prostatectomy (RALP); does it improve continence?

Zakri RH, Vedanayagam M, John B, Pain J, Hearnden B, Simpson P, Eddy B

East Kent Hospitals University Foundation Trust, Kent & Canterbury Hospital, UK

Presenter: Rhana Hassan Zakri

Job Title of Presenter: SpR

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Abstract:

Introduction:

Maintaining continence, without compromising oncological outcome, remains one of the major challenges of radical surgery to the prostate. No consensus on technique is seen in literature. The urethral sphincter complex consists of two parts. The aim of a BNS is to preserve the internal lissosphincter.

Methods:

A prospective study of 213 consecutive RALPs, single surgeon at a regional cancer centre from Jan 2013 – Dec 2014. n = 86 in bladder neck spare (BNS) versus 134 in non bladder neck spare group (nBNS). Both groups were comparable. Continence was measured using the ICIQ validated questionnaire and pad usage at 6 weeks, 3, 6,12 months. We compared positive margin rates (PMR).

Results:

Mean ICIQ: 8.39, 6.39, 3.44, 3.48 for nBNS and 6.88, 3.44, 3.09, 2.73 for BNS at 6 weeks, 3, 6, 12 months respectively. Mean pad use: 1.5, 0.73, 0.31, 0.294 for nBNS and 0.92, 0.34, 0.186, 0.057 for BNS at 6 weeks, 3, 6, 12 months. Pad free rate: 36%, 58%, 78%, 88% for nBNS and 61%, 75%, 87%, 94% for BNS at 6 weeks, 3, 6, 12 months. Overall positive margin rate: 21.3% for nBNS and 32.6% for BNS. T2 and T3 PMR for nBNS was 10.1% and 33.3% respectively. T2 and T3 PMR for BNS was 17.8% and 48.8%. The majority were sited peripherally.

Conclusions:

BNS is feasible for establishing early continence post RALP. 61% of BNS were continent at 6 weeks. The increased PMR is concerning. Clarification of pre-op selection for BNS is required through randomized control trials.

Shedding new light on Retroperitoneal Fibrosis (RPF) – lessons learnt from a multi-disciplinary service

Archie Fernando, James Pattison, Catherine Horsfield, David D'Cruz, and TIm O'Brien

Guy's and St Thomas' NHS Trust

Presenter: Archie Fernando

Job Title of Presenter: SpR

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Abstract:

Introduction

RPF is an 'orphan' disease which does not fall into the domain of a single specialty. It is both challenging to diagnose and to treat. We report our 3-year experience of running an RPF service and the move towards a contemporary and systematic approach to RPF.

Methods

Prospective analysis of 72 patients managed through an RPF service since January 2012.

Results

72 patients. M=42 F=30. Median age 57 (range 36-79)

1) Tissue diagnosis: 55/72(76%)

Classification:

Para-aortic RPF 21/72(29%);

Vasculitic 3/72(4%); IgG4-related 16/72(22%)

Systemic autoimmune 4/72(6%)

Methysergide 1/72(1%); idiopathic 25/72(35%)

Neoplastic 2/72(3%)

2) Activity:

Raised ESR/ CRP 46/72(62%)

Positive CTPET 27/39 (69%)

- 20/27 (74%) raised markers
- 7/27 (26%) normal markers

3) Stents:

51/72(71%) had renal failure at presentation and 50/51(98%) were stented. 42/50(84%) had stent symptoms

4) Steroids:

46/72(64%) prescribed steroids. 28/46(61%) showed mass shrinkage with steroids. 1/28(3%) resolution of obstruction with steroids

5) Ureterolysis:

31/72(74%) underwent ureterolysis, mainly for failed medical/stent therapy

31/31(100%) stent-free, 23/31(74%) steroid-free and 30/31(97%) improved GFR post-ureterolysis

6) Relapse:

8/72(11%)

1/8(12%) 11 years post-diagnosis

Conclusion

Traditional management with stent and steroids appear to be suboptimal in this subgroup of patients.

The establishment of a multidisciplinary service has clarified the priorities for optimising care for patients with RPF:

Right diagnosis

Preserve renal function

Freedom from stents and steroids

Spinal Nerve Root Stimulation as an effective therapy for refractory loin pain

Dr Pranab Kumar, Mr Arun Sahai, Professor Prokar Dasgupta, Dr Adnan Al-Kaisy

Guy's & St.Thomas' NHS Foundation Trust

Presenter: Dr Pranab Kumar

Job Title of Presenter: Clinical Fellow in Neuromodulation (ST7 on OOPE)

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Abstract:

Introduction:

Neuropathic loin pain such as loin pain haematuria syndrome, nut cracker syndrome etc are uncommon but represent a difficult clinical challenge. Neuropathic pain is often debilitating, refractory to pharmacological treatment and could lead to major surgeries like renal autotransplantation or nephrectomy. But considerable morbidity is associated with these procedures and the pain can recur despite technical success. We describe the use of spinal nerve root stimulation (SNRS) in the management of these difficult conditions.

Materials/Methods: Patients referred to our institution with chronic neuropathic loin pain who were suitable for neuromodulation were included in this case series. Prior to permanent implantation a trial of stimulation using either a percutaneous or surgical approach was required to demonstrate both successful pain relief from stimulation and tolerability of the therapy. Cyclindrical neurostimulator leads was placed in the epidural space paramedian to the midline so that stimulation covered T9/10 down to T11/12 nerve roots to produce paresthesia covering the painful area. A multiple cathode configuration was used.

Results: 17 patients achieved success in trial stimulation and were implanted. 14 patients had almost complete pain relief with pain scores 1-2 out of 10 on a Numerical Rating Scale with reduced opioid use, and significant improvements in their global impression of change.

Conclusions: Our experience shows that SNRS can be used effectively for managing intractable loin pain not amenable to conservative therapy, and could be considered as a reasonable alternative before radical surgeries.

An audit of urology on calls: are we more than a catheter service?

Rintoul-Hoad S, Ni Raghalleigh H, Larner T

Brighton and Sussex University Hospitals

Presenter: Sophie Rintoul-Hoad

Job Title of Presenter: CT2 Urology

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Abstract:

Introduction:

Anecdotally it has been felt that during on calls the urology team receive many catheter-related referrals; and that a symbiotic relationship exists with other medical specialties, perhaps more so than other surgical specialties? Therefore patients referred for acute urology review have been audited. The aim was to understand referral pattern, potential areas for education and training opportunities.

Method:

Referrals to the urology team at the Royal Sussex County Hospital were recorded over 10-weeks (Jan-March 2015) and placed in a database.

Results:

256 referrals were recorded; 32% resulted in urology admission. 54% were referrals from GP (41) and A&E (96). A symbiotic relationship with many other hospital specialties is reflected in the remaining 46%; the renal team accounted for 15% of medical referrals.

Overall, 28% (71) referrals were related to catheters, equally divided between haematuria, urinary retention and catheter related problems; 44% resulted in admission under urology care.

A quarter of GP referrals related to testicular pain. A third of A&E referrals related to ureteric stones or an obstructed kidney. RCSH is a trauma centre, this accounted for 3% of referrals.

55 cases led to interventions: 76% required CEPOD surgery (23 ureteric stents and 3 scrotal exploration), 18% interventional radiology (7 needed nephrostomy) and 6% lithotripsy (3).

Conclusions:

Catheter related referrals represent a quarter of the workload; however the breadth of referrals seen at our centre correlates with training curriculum and surgical opportunities for trainees.

Furthermore it has highlighted areas of education such as catheters, haematuria and acute testicular pain. The database will be extended to record emergency surgery standards such as those by RCS and NCEPOD.

Combined vaginal and vesicoscopic collaborative repair of complex vesicovaginal fistulae

Jonathan Makanjuola , Chryssanthos Kouriefs, Dudley Robinson, Linda Cardozo, Philippe Grange

King's College Hospital

Presenter: Jonathan Makanjuola

Job Title of Presenter: ST5 Urology

Contact Email: jkmakanjuola@gmail.com

Abstract:

Introduction: We describe and demonstrate the feasibility of a minimally invasive surgical technique for the repair of complex vesicovaginal fistulae that may not be amenable to vaginal repair.

Methods: The data collected in our prospective database were operative time, estimated blood loss, intra-operative difficulties, length of hospital stay, post-operative complications and functional outcome. All patients had undergone pre-operative video urodynamics, examination and under anaesthesia and cystoscopy prior to any decision regarding surgery.

Results: 10 female patients with a median age of 44 (26-64), average BMI of 30 (18-36), ASA score 1 (n = 8) and 2 (n = 2) underwent vesico-vaginal fistula repair using a vaginal and vesicoscopic approach. All patients were referred to a tertiary referral uro-gynaecology unit. Iatrogenic fistulae occurred after caesarean section (n = 2) or after hysterectomy (n = 7) or cancer related (n = 1). The primary injury occurred following open surgery in 9 cases and laparoscopic surgery in 1 case. The repair was carried out by direct placement of the ports into the urinary bladder (vesicoscopy). All 10 operations were completed without any conversion to open surgery. Four ureteric reimplantations were necessary for ureteric involvement. There were no intraoperative complications. No early postoperative complications were documented, and the hospital stay varied from 2 to 8 days. The fistula repair success rate was 89% at a median follow-up of 30 months.

Conclusion: This surgical technique is feasible and offers an alternative approach to the classical open or laparoscopic transperitoneal approach. It supplements the vaginal approach for fistulae that are not suitable for pure vaginal approach, allowing close collaboration between the laparoscopic urologist and the gynaecological surgeon.

Nurse follow up facilitates BAUS continence surgery outcome data entry

Denosshan Sri, Easter Espinosa, Tharani Nitkunan, Roger Walker

Epsom and St Helier Hospital

Presenter: Denosshan Sri

Job Title of Presenter: CT2 in Urology

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Abstract:

Introduction

We have introduced a nurse led service following stress urinary incontinence (SUI) procedures. In view of the impending publication of SUI surgery outcome data on BAUS, we conducted an audit into the quality of data entry at the time of the procedure and at three months.

Method

A retrospective study of all SUI procedures performed at a district general hospital over a two year period (Jan 2013-Dec 2014) was performed. Theatre logs and patient records were obtained and compared with the BAUS database. The paired t-test was used to analyse continence outcomes.

Results

A total of 113 procedures were performed, with 91% logged onto the BAUS database. Of the 101 patients seen for follow up, 87 were seen in the nurse clinic and 14 in a clinician's. 9% of nurse follow ups were not logged onto the database, compared to 43% for clinicians. Nine patients were lost to follow up. Twelve patients were referred to a clinician following nurse follow up.

Major complications were rare, with bladder perforations in 2 patients and urinary retention in 4. 88% of patients reported either improvement in symptoms or being completely dry. This is reflected in a mean 13.9 point improvement in ICIQ-LUTS ($p=0.002$) and a mean 11.3 point improvement in ICIQ-UI scores ($p<0.0001$).

Conclusion

Our nurse led follow up results in safe and specialist post-operative care, timely BAUS data entry, reduces clinician workload and enables appropriate referral of complex or failed cases. We demonstrate good subjective and objective outcome post SUI surgery.

Invasive minor operations in Urology – a shift towards the outpatient setting

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Abstract:

Introduction

Delivery of surgery has begun to see a shift of minor procedures from the conventional operating theatre, and is being increasingly performed in the more cost effective outpatient setting. Our Urology department in a tertiary referral centre has introduced an invasive minor operations service in the outpatient department. We look into the quality and safety of the service offered.

Method

A retrospective study was carried out on patients treated at the Minor Operations Clinic (MOC), and those undergoing similar procedures in the Day Surgery Unit (DSU) over six months (July 2013-January 2014). Patients were invited to complete a satisfaction questionnaire at 3 month follow up, and Fisher's exact test was used to analyse outcomes.

Results

Forty-nine patients went on to have a surgical procedure in the MOC and 66 in the DSU. Circumcisions accounted for 58% of the total caseload. Mean patient satisfaction with the MOC stood at 4.3/5, with 87% stating they would recommend our service. Complications were rare, with infection seen in 8% and bleeding in 4% of all patients. There was a correlation between patient satisfaction and post-operative complication ($p<0.0078$) in our MOC group. There were significantly fewer complications in the MOC group 5 patients, than the DSU group, 17 patients ($p<0.002$).

A prospective re-audit of 16 cases in our MOC over a three-month period between August 2014 and October 2014 revealed improvement in patient satisfaction at 4.75/5 with 100% stating they would recommend our service. We had successfully addressed previous patient concerns such as improving privacy.

Conclusion

The MOC service delivers a high standard of care, is safe and a cost effective means of service provision for urology patients. We demonstrate good subjective patient satisfaction with our service. We feel that it can serve as a more suitable environment for the provision of minor local anaesthetic procedures than DSUs.

Transfusion Protocols in Common Urological Procedures

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Abstract:

Introduction

The issuing of type-specific blood products for transfusion requires two group and save samples; one historical and one within seven days. The cost of processing a sample locally is £75, and the issue of a unit of blood £125. Within our trust, there is no protocol for the routine pre-operative group and save/cross matching prior to elective urological operations, however this is the current practice. By investigating our current transfusion rate, we sought to establish if there was a clinical need, and if changing this practice would impact patient safety.

Methods

Patient information was collated using electronic theatre list records for 2014. The procedure performed was confirmed by cross-referencing electronic discharge summaries and histology reports. Numbers and timing of group and save samples, cross matching and blood transfusions were obtained from blood bank electronic reporting.

Results

270 elective procedures were identified; 110 TURBTs, 76 TURPs, 29 PVPs and 55 laparoscopic upper tract procedures. 86% of these patients had two group and save samples taken (the second within 7 days of their procedure). No patients required intra-operative or post-operative blood transfusion. Six patients were cross-matched, with all units returned to blood bank.

Conclusion

Surgical outcomes within our study have shown a low risk of clinically significant blood loss. Omitting the second group and save sample in these low risk procedures would represent a saving of £20,250. A change of policy within our trust would result in a significant cost saving without impacting patient safety.

Is shockwave lithotripsy more cost effective than ureteroscopy for the management of ureteric calculi? The Epsom and St Helier Experience

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Abstract:

Introduction

Shockwave lithotripsy (SWL) and ureteroscopy (URS) are recognised treatment options for patients who present acutely with ureteric calculi. We performed a cost-effectiveness analysis using our own institutional data and costs comparing the two treatments. We performed an alternative analysis using published data on success rates and NHS reference costs.

Method

Data on treatment outcomes of patients undergoing SWL for ureteric calculi was collected for a one-year period (1st August 2013 to 31st July 2014). A cost-effectiveness analysis was performed from an NHS perspective using a Markov model and data and costs from our institution.

An alternative analysis was performed using published data and NHS reference costs.

Results

Data was available for 65 patients. The mean age was 45(SD 12.75), mean stone size 8.23(SD 3.55), mean Hounsfield units on CT 953.23(SD390.21). The average pain score was 4.21(SD 2.23). Our overall success rate of SWL was 65%.

SWL was less costly than URS by £768.8(SD £323.1) and more effective 0.0096 QALY(SD 0.0307 QALY).

Our alternative analysis using published data and NHS reference costs showed that SWL also dominated; it was less costly than URS by £529, and more effective by 0.007 QALY. At a NICE threshold of £30, 000/QALY, ESWL was more cost-effective with a 75.76% certainty.

Conclusion

Our model demonstrates that SWL is a more cost-effective than URS. In our unit, we continue to offer patients SWL as an option for the treatment of patients with ureteric calculi.

Prostate Artery Embolisation - Initial Experience of treatment of Benign Prostatic Enlargement for large volume prostates (mean volume 135cc) at a single institution

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Abstract:

Introduction

Prostate artery embolisation (PAE), is a recently developed treatment for benign prostatic enlargement (BPE)-related LUTS. We present our initial experience of PAE as a treatment in a cohort with a significantly larger prostatic mean volume than documented in current literature.

Methods

Data was prospectively collected between January 2014 to December 2014 at a single tertiary urology centre. Inclusion criteria: patients with moderate to severe BPE-related LUTS or urinary retention refractory to medical therapy. Exclusion criteria: high-risk prostate malignancy. A standardised PAE technique via a femoral approach was used. Prospectively measured outcomes were collected.

Results

20 patients (median age 67, range 48-86) were recruited. Indications: BPE-related LUTS with or without low-risk prostate cancer (16), urinary retention with persistent haematuria (1) and acute urinary retention (3). Technical success, defined as bilateral arterial embolisation, was 90%. At three months, mean IPSS decreased from 22.3 to 8.7, QoL score improved from 4.9 to 1.8. Mean prostate volume reduced by 43% (134.8mls to 75.6mls), mean PSA reduced from 9.9 to 5.9ng/ml. Mean Q-Max increased from 14.2 to 20.7ml/sec. Only 1 out of the 3 patients with urinary retention had a successful outcome. Only 2 patients had a Clavien 2 complication.

Conclusion

Our initial results demonstrated improvements in clinical parameters in keeping with large published series of PAE. Patients with very large prostates may benefit from PAE, which is a safe, minimally invasive treatment for BPE-related LUTS. However patients with acute retention appear to have less favourable outcomes. PAE is not a contraindication for HoLEP