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Specialist Urology Training

# Kent, Surrey, Sussex and South Thames Regional Urology Meeting



11th May 2016

Darent Valley Hospital,  
Dartford, Kent



*Professional care, exceptional quality*

# Welcome



From the CEO  
Ms Susan Acott

Dear Colleague,

It gives me a great pleasure to welcome you to the Kent Surrey and Sussex (KSS) and South Thames Regional Urology meeting hosted by our Urology department in Darent Valley Hospital.

The meeting will be held in the Conference Centre at the iconic Brands Hatch motor racing facility.

I am sure that you will all have a useful day of deliberations on urological training issues and scientific presentations. I also hope that you will enjoy our hospitality.

I wish the meeting every success!!

Susan Acott  
Chief Executive  
Dartford and Gravesham NHS Trust  
Tel: 01322 428737

# Welcome



Ian K Dickinson  
Senior Urological Surgeon  
Chairman Organising Committee

Dear colleague

It is a pleasure to welcome you to the historic Brands Hatch Motor Racing circuit for the 50th KSS/South Thames Trainees Meeting.

The meeting will take the usual format with the Trainers meeting in the morning and the Trainee Presentations in the afternoon. Prizes will be awarded for the best two presentations and certificates for all presenters. Prizes will be awarded at a drinks reception in the adjacent Mercure Dartford Hotel to which everyone is invited and this will be followed by a three course meal at the hotel.

I would like to express my thanks to our colleagues in the pharmaceutical and instrument companies for their generous support both for this meeting and throughout the year in our hospitals.

Finally, I would like to thank my colleagues at Darent Valley Hospital for their help in planning and running the meeting.

Ian K Dickinson  
Senior Urological Surgeon  
Chairman Organising Committee.

# Information



## Dartford and Gravesham NHS Trust

Dartford and Gravesham NHS trust runs services at Darent Valley Hospital, Queen Mary's Hospital, Erith & District Hospital and Elm Court (Priory Mews).

Darent Valley Hospital is a modern hospital in Kent offering **professional care and exceptional quality. It offers a** comprehensive range of acute hospital based services to the local population. The care is provided in safe, comfortable and clean surroundings. The hospital specialties include day-care surgery, general surgery, urology, trauma, orthopaedics, cardiology, maternity and general medicine. Newer specialities are getting added.

The hospital buildings are run as part of a Private Finance Initiative (PFI). Darent Valley Hospital has excellent road and rail links to Kent, South East London and the rest of the South East of England.

The Trust works in partnership with the NHS South East Coast (Strategic Health Authority), NHS West Kent (Primary Care Trust/PCT), NHS Medway (PCT), Bexley Care Trust (PCT), Kent County Council, Social Services and its (PFI) Partners to ensure that the best possible care is provided, not just in hospital but also throughout the local health economy.

In short Darent Valley hospital is a progressive hospital with modern outlook providing high quality care to every patient.

# About the Urology Department

The urology department is part of the Directorate of Urology and Nephrology. The department has progressed considerably providing comprehensive urological care and making an academic mark with regular publications and presentations.

It has its own dedicated Redwood Ward and is housed in the award winning Poplar Unit. The President of BAUS Mr Adrian Joyce inaugurated the **Stone and the Kidney Centre**, in October 2013. The departments of urology and nephrology work together closely.

The department attracts tertiary referral for patients with urinary stones and superficial bladder cancer. The **Stone centre** with four consultants caters approximately to a million population. It has an in house lithotripter, holmium laser, and all modalities needed to treat complex stones. The weekly stone MDT is well established and has an advanced metabolic stone clinic.

The department offers blue light cystoscopy, intra vesical thermotherapy, template biopsies and fusion scans for prostate. It is also been providing cryotherapy for small renal tumours for over 7 years and has a large prospective database.

The department is research active and is one of the largest recruiters for NIHR portfolio studies for Urology in Kent. It has close links with the Kent and Canterbury Christ Church universities. We have research and clinical fellows pursuing MSc, MCh and MD programmes and over the years many of our fellows have obtained national training numbers.

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# Venue

11th May 2016

Brands Hatch, Longfield, Kent DA3 8PE

Conference at:

Brands Hatch Conference Centre



Meal at:

Mercure Hotel

Brands Hatch



Kent Surrey,  
Sussex & South  
Thames  
Urology  
Regional  
Meeting

Brands Hatch  
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Centre

11 May 2016

## Agenda

09.30	Coffee
10.00	KSS STC Meeting South Thames STC Meeting
11.30	Coffee
12.00	Joint KSS London STC meeting
12.30	Lunch and Exhibition
13.30	Trainee Presentations
15.00	Coffee
15.30	Trainee Presentations
17.00	Training update
17.30	Drinks and Canapés + Awards to prize winners at Mercure Hotel
18-30	Dinner – Mercure Hotel, De Havilland Suite.

**Venue:** Brands Hatch MotorSport Vision  
Conference Centre

**Address:** Brands Hatch Circuit,  
Fawkham, Longfield, Kent DA3 8NG

# Presentations

## Session 1

**13.30 to 15.00**

**Chair Persons:**

**Sanjeev Madaan and  
Eleanor Ray**

1. Targeting Antibiotic Prophylaxis to Reduce Infection Rates from Trans-rectal Prostate Biopsies  
I Rudd, S Saad, S Garnett  
East Sussex Healthcare NHS Trust
2. Transitional care and adolescent urology – current UK practice  
N Faure Walker, N Smeulders, D Wood, A Couchman  
Kingston Hospital NHS Foundation Trust
3. High intensity focused ultrasound as a salvage treatment for prostate cancer after external beam radiotherapy  
KE Chan, T Larner  
Brighton and Sussex University Hospital NHS Trust
4. Extending indications in robotic partial nephrectomy: the development of the practice after 200 cases  
Wayne Lam, Faisal Al-Khalidi, James Dargan, Gideon Belcher, Rick Catterwell, Simon van Rij, Ben Challacombe  
Guy's and St Thomas' NHS Foundation Trust
5. Assessment for early uretero-ileal anastomotic strictures with routine loopogram studies 3 months after cystectomy: diagnostic yield and lessons learnt.  
Kawa Omar, Christine Gan, Rajesh Nair, Tim O'Brien, Ramesh Thuraiaraja, Muhammad Shamim Khan  
Guy's and St Thomas' NHS Trust
6. The Effect of Clomiphene Therapy on Testosterone Levels  
Rebecca Hilbert, Harry Naerger  
Frimley Park Foundation Trust
7. Is Hyperthermic Mitomycin an effective second line treatment in non-muscle invasive bladder cancer?  
Maria Vedanayagam, Angela Elliott, Sanjeev Madaan  
Darent Valley Hospital  
Maria Vedanayagam
8. Procedures for Penile Urethral Strictures: Options and Outcomes  
I Rudd, D Evans, R Krishnan  
East Kent Hospitals University NHS Foundation Trust
9. Audit: the use of an algorithm in the follow-up of non-muscle invasive bladder cancer.  
E. Osinibi, T. Nitkunan  
Epsom & St Helier Hospitals

# Presentations

## Session 2

**15.00 to 15.30**

**Tea / Coffee**

**15.30 to 17.00**

**Chairmen:**

**Sri Sriprasad and**

**Faqar Anjum**

10. Classification and management of buried penis  
Wayne Lam, Tet Yap, Nick Watkin  
St George's University Hospitals NHS Foundation Trust
11. Risk Factors for UTI following bladder OnabotulinumtoxinA injections for refractory overactive bladder  
Z Evans, M Van Hemelrijck, D Eldred-Evans, J Seth, S Malde, J Watkins, A Sahai  
Guy's and St. Thomas' Hospital
12. An assessment of TURP set-up across the KSS region  
Maria Vedanayagam, Ian Dickinson  
Darent Valley Hospital
13. How racist is prostate cancer in Britain?  
Campbell AAE, Nair R, Raja J, Moonan A, Liban B, Anderson C J, Perry MJ, Issa R.  
St George's University Hospitals NHS Trust.
14. What Doses Are Our Patients Receiving? An Audit of Radiation Dose Associated with CT KUB, CT IVU, Ureteroscopy and PCNL  
Pareeta Patel, Niyati Lobo, Jonathan Makanjuola, Ian Honey, David Gallagher, Debbie Phillips, Giles Rottenberg, Susan Willis, Jonathan Glass, Kay Thomas, Matthew Bultitude  
Guy's and St. Thomas' Hospital
15. Ureterolysis in the Management of Ureteric Obstruction from Retroperitoneal Fibrosis (RPF)  
Niyati Lobo, Archie Fernando, Tim O'Brien  
Guy's and St. Thomas' Hospital
16. Long term follow-up with the Memokath 051 stent in benign ureteric obstruction  
Andrew Chetwood, Holly Ni Raghallaigh, Ravindra P Kulkarni  
Ashford and St. Peter's Hospital NHS Foundation Trust
17. The changing role of Trans-rectal Ultrasound guided prostate biopsies (TRUS) in the Era of Template biopsies and MRI imaging  
Dr. Pedro Ferreira, Mr. Ahmed Ali, Aakash Pai, Bruce Montgomery  
Frimley Park Hospital
18. Long Term Outcomes of Laparoscopic Nephro-ureterectomy with Transurethral Circumferential Excision of the Ureteric Orifice for Urothelial Carcinoma  
Aakash Pai, Muddassar Hussain, Ahmed Ali, Neil Barber  
Frimley Park Hospital

# Presentation

## Targeting Antibiotic Prophylaxis to Reduce Infection Rates from Trans-rectal Prostate Biopsies

Authors

I Rudd, S Saad, S Garnett

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East Sussex Healthcare  
NHS Trust

Presenting author

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### Introduction

Infection rates after trans-rectal biopsy of the prostate have increased dramatically in recent years. Organisms that are resistant to standard antibiotic prophylaxis are often implicated. Using rectal cultures to target prophylaxis has been shown to reduce infectious complications. Our centre introduced rectal cultures prior to biopsy but anecdotally infection rates remained high. We therefore audited our practice.

### Methods

We retrospectively analysed the records of all patients undergoing trans-rectal biopsy of the prostate over a three month period. After analysing the results and implementing changes we re-audited over a four month period.

### Results

99 patients had a biopsy in the initial period of which only 28.3% had a rectal culture performed. 1 patient required targeted antibiotic prophylaxis. The rate of post-procedure infection was 7.1%. Four of the seven patients with an infection had confirmed bacterial growth that was resistant to standard prophylaxis. The preventable expenditure in hospital bed costs alone was £14,500.

We raised awareness in the department of the the rationale for and practicalities of performing rectal cultures. We also ensured an adequate supply of equipment and adjusted the biopsy booking form and procedure checklist.

In the re-audit period 129 biopsies were performed of which 80.6% had a rectal culture performed. 8 patients required targeted prophylaxis. The infection rate was only 1.4%. No patients who had a rectal culture performed had a post procedure infection.

### Conclusion

The increased use of rectal cultures to target antibiotic prophylaxis for trans-rectal biopsies was associated with a reduction in infection rates from 7.1% to 1.4%. This simple measure provided a cost saving which is estimated to exceed £58,000/year.

# Presentation

## **Transitional care and adolescent urology – current UK practice**

Authors

Mr N Faure Walker, Ms N Smeulders, Mr D Wood, Mrs A Couchman

Institution

Kingston Hospital NHS Foundation Trust

Presenting author

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## **Introduction**

Transitional urology is in its inception as a subspecialty of Urology. Effective transitional care has been shown to improve clinical outcomes in type 1 diabetes and chronic kidney disease.

Adolescents present two main challenges: Firstly, they have unique medical and emotional demands. Secondly, many paediatric conditions have no equivalence in adult urology. There are no national guidelines regarding age or to whom adolescents should be referred. This study was designed to establish current UK practice and review other speciality practices on transitional care, to propose a model for management.

## **Methods**

Consultant Paediatric Urologists and adult Urologists present at the British Association of Paediatric Urology meeting were asked to complete a questionnaire on their transition practice.

## **Results**

Questionnaires were completed by 33 consultants across the UK (10 paediatric surgeons specialising in paediatric urology (PU) and 23 urologists who specialise in PU). 11(33%) thought children should be referred to an adolescent urologist (AU) at 16 but there was a wide range of opinions (0-17). 18(55%) refer locally. 24(73%) have a dedicated MDT and 24(73%) have formal transition programmes. Overall, 30(90%), 31(94%), 11(33%), 19(57.6%) 26(58%) and 2(82%) were happy to treat posterior urethral valves, hypospadias, bladder exstrophy, cloacal anomalies, detrusor sphincter anomalies and varicocele respectively. Urologists were less happy treating cloacal anomalies than paediatric surgeons (30% vs 73.9%;  $p=0.05$ ).

## **Conclusions**

There is a wide range of clinical practice of transitional urology in the UK. Bladder exstrophy and cloacal anomalies are best suited to regional and national referral centres. We propose that a single regional centre would be the most appropriate referral base for all patients transitioning into adulthood with congenital anomalies involving the urinary tract. Following initial assessment and instigation of long term management they could be referred to local centres with guidelines for re-referral.

# Presentation

## High intensity focused ultrasound as a salvage treatment for prostate cancer after external beam radiotherapy

Authors  
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Brighton and Sussex  
University Hospital NHS Trust

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### Introduction and method

Radiotherapy is a successful treatment for prostate cancer however, up to 63% of patients will develop prostate cancer recurrence. High intensity focused ultrasound (HIFU) has been used as a salvage treatment for these patients however there data on outcome are sparse.

We present our data on patients undergoing salvage HIFU between 2006 and 2014.

### Results

Fifty-three patients were identified with a median follow up of 36 months. One was excluded as salvage HIFU was not possible due a thick rectal wall of >6mm. The median age at initial diagnosis was 65 years (range 55-79) with a median age at HIFU treatment of 73 years (range 59-86). The median interval between radiotherapy and HIFU was 8 years (range 3-15). Thirty (58%) of patients had biochemical recurrence during their follow up period. A higher post-HIFU PSA nadir and a higher pre-HIFU PSA were both associated with biochemical recurrence (Mann-Whitney U  $p=0.0008$  and  $p=0.0095$ ).

### Conclusion

Our large series has shown a higher rate of biochemical recurrence in patients with a higher pre-HIFU PSA and a higher post-HIFU PSA nadir. The balance between disease control and side effects of treatment is key in the management of prostate cancer. Patients with a higher PSA may have a poorer disease response in salvage HIFU however, it may delay the commencement of androgen deprivation therapy. We welcome the commencement of the FORECAST trial to further investigate the role of salvage treatment in prostate cancer recurrence.

# Presentation

## **Extending indications in robotic partial nephrectomy: the development of the practice after 200 cases**

Authors

Wayne Lam, Faisal Al-Khalidi, James Dargan, Gideon Belcher, Rick Catterwell, Simon van Rij, Ben C hallacombe

Institution

Guy's and St Thomas' NHS Foundation Trust

Presenting author

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## **Introduction**

Robotic partial nephrectomy (RPN) is becoming the preferred surgical technique in management of small renal masses. Here we assess development of RPN within one centre over 5 years to assess quality outcomes and changes in case complexity.

## **Methods**

A prospective database of 200 elective cases from one institution was chronologically split into 4 groups of 50 patients: peri-, intra- and post-operative outcomes were compared. We compared length of stay, tumour size, warm ischaemic time (WIT), operative time and PADUA score.

## **Results**

181 cases were performed transperitoneally with 2 conversions to radical nephrectomy for tumour factors. There were no conversions to open surgery. Mean age was 55.8 years. Complications consisted of 1 transfusion, 5 positive margins and 3 Clavien IIIa/b complications.

In comparing groups 1 and 4, mean PADUA score increased from 7.11 to 7.63 ( $p=0.045$ ), mean length of stay decreased from 3.76 to 2.6 days ( $p<0.001$ ), mean WIT decreased from 18.3 to 16.4 minutes ( $p=0.0245$ ), mean operative time decreased from 180 to 162 minutes ( $p=0.012$ ). We also found a non-significant mean increase in tumour size of 2.8 to 3.32cm ( $p=0.06$ ). More patients with single kidneys and poor renal function were undertaken in group 4.

## **Conclusion**

We reported a large RPN series. We demonstrate that despite taking on more complex cases, we have reduced length of stay, WIT and operative times. With increased experience, it is possible to broaden the suitability of patients for RPN without compromising outcomes.

# Presentation

## **Assessment for early uretero-ileal anastomotic strictures with routine loopogram studies 3 months after cystectomy: diagnostic yield and lessons learnt.**

### Authors

Kawa Omar, Christine Gan,  
Rajesh Nair, Tim O'Brien,  
Ramesh Thurairaja,  
Muhammad Shamim Khan

### Institution

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Trust

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## **Abstract**

Assessment for early uretero-ileal anastomotic strictures with routine loopogram studies 3 months after cystectomy: diagnostic yield and lessons learnt.

## **Introduction**

Uretero-ileal anastomotic stricture is a serious complication of urinary diversion.

We studied the role of loopogram following cystectomy and urinary diversion in identifying early uretero-conduit stricture.

## **Materials and Method**

Routine loopogram 3months following cystectomy was included in the follow-up protocol after few adverse events in August 2010 and continued until December 2015. The findings were entered in a prospective database.

## **Results**

In total 250 patients (181male/69 female), average age of 68.32years (range38-83) had cystectomy and conduit urinary diversions. Surgical approaches included: open (n=129), robotic (n=111) and laparoscopic (n=10). 247(98.8%) had ileal conduit and 3(1.2%) had colonic conduit. 190 patients had loopogram and were followed up at median 18 months(range2-54). 167(67.2%) patients had routine loopogram 3 months following surgery and 7 had stricture. 23 patients had early (<3months) loopogram prompted by symptoms and 9 had strictures. The median time for early stricture development in both groups was 103 days. Five patients developed late strictures at a median of 22months(range5-36). The 7 patients diagnosed with strictures on routine logogram: 1 declined treatment, 1 had nephrectomy for non-functioning kidney, 4 had ureteric re-implantation, 1 had ureteric stent insertion. Thus routine loopogram benefitted 5/167(2.99%) patients.

## **Conclusion**

This study demonstrates that beingn uretero-conduit strictures can occur either very early or late. Routine loopogram at 3 months benefitted 5 of 167(2.99%) patients. Thus it is difficult to predict the time of strictures occurence. Therefore, a high index of suspicion in patients with conduit urinary diversion with deviation from smooth progress should prompt a loopogram study.

# Presentation

## The Effect of Clomiphene Therapy on Testosterone Levels

Authors

Rebecca Hilbert, Harry Naerger

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Frimley Park Foundation Trust

Presenting author

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### Introduction

Men suffering symptomatic hypogonadism who want to preserve their fertility are an interesting treatment paradigm. Exogenous testosterone cannot be used as it impairs spermatogenesis. Since 2013 men wanting to preserve their fertility and suffering from symptoms of hypogonadism have been prescribed clomiphene at Frimley Park Hospital. Indications for its use have included low libido, infertility, fatigue and erectile dysfunction. Clomiphene therapy is currently licenced to be prescribed to women for the treatment of oligomenorrhoea or secondary infertility. It inhibits the negative feedback of sex hormones on the hypothalamus thereby increasing gonadotropin release.

### Aim

To assess whether clomiphene therapy increases blood testosterone levels.

### Method

Blood results from 76 patients were assessed. The average age was 39 years, range 20-61. Their testosterone before commencing therapy was recorded. This was compared to a the testosterone level 2 months after starting clomiphene therapy, prescribed at 50mg once daily.

### Results

The normal range of testosterone is 8.4- 28.7. The average pre clomiphene testosterone level of patients in this study was 11.1. The range of results was 4.0- 28.6. The average level post clomiphene was 22.2, the range was 6.9- 47.9.

### Conclusion

This study shows there is, on average, a doubling in testosterone level after starting clomiphene therapy. In men, who are yet to complete their family, presenting with symptomatic hypogonadism clomiphene will increase the blood testosterone level.

# Presentation

## Is Hyperthermic Mitomycin an effective second line treatment in non-muscle invasive bladder cancer?

Authors

Maria Vedanayagam, Angela Elliott, Professor Sanjeev Madaan

Institution

Darent Valley Hospital

Presenting author

Maria Vedanayagam

Contact email address

maria.vedanayagam@nhs.net

### Abstract

Is Hyperthermic Mitomycin an effective second line treatment in non-muscle invasive bladder cancer?

### Introduction

There is no proven effective treatment for patients with non-muscle invasive bladder cancer with post-BCG tumour recurrence. Radiofrequency-Induced Thermo-Chemotherapy Effect (RITE) using MMC has been proposed as a treatment for post-BCG recurrence. Darent Valley Hospital serves as regional referral centre for this treatment post-BCG failure.

### Aims and Objectives

The aim of this study was to assess the efficacy of RITE + MMC in patients with recurrent NMIBC despite BCG treatment and patients intolerant of the toxic effects of BCG. The primary end point was to assess the recurrence free survival at 12 months.

### Method

A prospective database was maintained for all patients who received RITE from November 2011 to April 2015 with a minimum follow up period of 12 months.

### Results

25 patients received Synergo® RITE + MMC and were followed up for a minimum of 12 months. Following treatment, in 9/25 (36%) patients there was evidence of disease recurrence, however of these patients, 3 had recurrence of disease >12 months from commencing treatment. 16/25 (68%) remain recurrence free to date. This gives an overall 12-month survival free recurrence rate of 76%. We recognise that the rate of side effects causing cessation of treatment was above 50%. The mean recurrence free period was 19.5 months.

### Conclusion

These preliminary results show that RITE + MMC is a useful second line agent to consider in patients with recurrent NMIBC who are unfit or unwilling to have a cystectomy.

# Presentation

## Procedures for Penile Urethral Strictures: Options and Outcomes

Authors

I Rudd, D Evans, R Krishnan

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NHS Foundation Trust

Presenting author

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### Introduction

Penile urethral strictures can be treated by a variety of curative surgical procedures often in tertiary care centres. We present our experience of treating penile urethral strictures over an 8 year period.

### Patients & Methods

Between November 2008 and December 2015, 101 operations were performed by a single surgeon in seventy patients with penile urethral strictures. In twenty patients the stricture the bulbar urethra was also involved. The procedures consisted of two-stage urethroplasty with buccal mucosal graft (BMG) (49 first stage & 31 second stage), single-stage dorsal BMG urethroplasty (4), Orandi patch urethroplasty (5), first stage/marsupialisation (7) and perineal urethrostomy (5). Median age was 51.3 years and median stricture length was 5cm.

### Results

30% of penile strictures were iatrogenic, 30% were BXO related and 24% were failed hypospadias repairs. A successful outcome was seen in 90%. Four patients (5.7%) required minor revision prior to final reconstruction. Five patients (7%) suffered stricture recurrence after final reconstruction. Four of these patients had undergone a single stage reconstruction and one a perineal urethrostomy. Three patients (4.3%) developed a fistula.

### Conclusions

Single-stage penile urethroplasties have a high recurrence rate. Pan-urethral strictures in particular are best dealt with by a staged procedure. Strictures recurred either immediately proximal, distal or both proximal and distal to the graft. The grafted segment always remained of good calibre. A two-stage approach allows for revision of any stenosis prior to final reconstruction, improving the success rate.

# Presentation

## **Audit: the use of an algorithm in the follow-up of non-muscle invasive bladder cancer.**

Authors

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Institution

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Presenting author

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## **Introduction**

Over 10,000 people are diagnosed with bladder cancer annually in the UK. Of these, 75-80% are non-muscle invasive bladder cancers (NMIBC). The management and follow-up of NMIBC is dependent on risk stratification.

The aim of this audit was to observe the follow-up pattern in high risk NMIBC and assess the implementation of a local algorithm.

## **Methods**

Patients with newly diagnosed high risk NMIBC not for radical or palliative treatment between 2011–2012 were identified. The frequency of flexible cystoscopies, the frequency and mode of imaging performed and the use of urine cytology was reviewed. An algorithm was developed using NICE and EAU guidelines 2015 with local multidisciplinary consensus. The algorithm was implemented and its effect on follow-up of all NMIBC patients during January 2016 assessed.

## **Results**

In the initial audit of 36 patients, there was no discernable pattern to the timings of cystoscopies. Annual CT Urogram at year 3 follow-up was only performed in 13% with urinary cytology rarely requested. Following implementation of the algorithm, a re-audit showed that 72% (21/29) had flexible cystoscopies in line with local guidelines. Requesting of annual CT Urogram and urinary cytology were poor, 22% and nil respectively.

## **Conclusion**

The adoption of an algorithm for follow-up of NMIBC has led to an improvement in adherence to national guidelines. Follow-up of these patients is now more uniform and reproducible. The algorithm prevents inappropriate or prolonged follow-up of patients and reduces the risk of a missed window of progression of disease.

# Presentation

## Classification and management of buried penis

### Authors

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Nick Watkin

### Institution

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Trust

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## Introduction

Buried penis is an increasingly common urological problem due to the rise in obesity and lichen sclerosus (LS). It can lead to sexual dysfunction, urinary dysfunction and problems of body image. There are no clear guidelines for assessment and management and there is a need for a standardized classification guiding treatment.

## Methods

In our tertiary reconstructive centre we have retrospectively analysed over 100 cases referred with a tentative diagnosis of buried penis from 2001-15. Significant criteria for classification were recorded including, primary vs secondary phimosis, infrapubic fat pad, erect length < 12 cm, glans LS, meatal/urethral stricture, and loss of penile shaft skin.

## Results

With increasing complexity, the presence of identified criteria lead to a 6-stage classification. Type 1: primary phimosis, normal glans, consider conservative circumcision. Type 2: recurrent phimosis, erect length > 12 cm, normal glans, no shaft skin loss, consider redo circumcision. Type 3: active glans LS, and/or loss of shaft skin, consider interposition distal shaft skin graft. Type 4: as Type 3 with prominent fat pad and/or erect length < 12 cm, consider fat pad excision, graft and penile lengthening manoeuvres, Type 5: as Type 4 with severe glans LS consider glans resurfacing prior to type 4 procedures. Type 6; as Type 5 with urethral stricture, consider buccal graft urethroplasty or perineal urethrostomy. prior to penile surgeries.

## Conclusion

We defined a classification for buried penis with a reconstructive treatment ladder of increasing complexity to manage this challenging group of patients.

# Presentation

## **Risk Factors for UTI following bladder OnabotulinumtoxinA injections for refractory overactive bladder**

### Authors

Z Evans, M Van Hemelrijck,  
D Eldred-Evans, J Seth, S  
Malde, J Watkins, A Sahai

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Hospital

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## **Abstract**

Objectives: Although efficacious in treating refractory overactive bladder (OAB), OnabotulinumtoxinA injections into the bladder are associated with higher than expected rates of UTI. We set out to identify risk factors that lead to UTIs after bladder OnabotulinumtoxinA injections in this patient group.

## **Materials and Methods**

This was a single center retrospective study. Our prospective database on OnabotulinumtoxinA injections was analysed to identify patients who had developed UTI following treatment. The study population consisted of 159 patients with refractory OAB treated with their first OnabotulinumtoxinA (100-200U) in our designated botulinum toxin clinic. Patient information was collected using both electronic and paper notes. Literature review established current risk factors for UTI. Univariate and multivariate logistic regression assessed the association between risk factors and UTI adjusting for potential confounders.

## **Results**

25% of the population developed a UTI with no significant difference between males and females. 36.5% of the population had to perform clean intermittent self catheterization (CISC) with males being more likely ( $p=0.04$ ). Of the multiple parameters screened in the analysis higher OnabotulinumtoxinA doses (OR: 2.21; 95% CI: 0.94-5.19) and CISC use (OR: 4.17; 95%CI: 1.95-8.91) had greater odds of developing a UTI. UTI risk with higher doses was independent of CISC use. No other risk factors in our study were significant.

## **Conclusions**

Increasing number of bladder injections and CISC increase the likelihood of developing UTI in our series. This information can help counsel patients. Further research is required to understand the mechanism of the high UTI rate with bladder botulinum toxin injections.

# Presentation

## **An assessment of TURP set-up across the KSS region**

Authors

[Maria Vedanayagam](#),  
[Ian Dickinson](#)

Institution

[Darent Valley Hospital](#)

Presenting author

[Maria Vedanayagam](#)

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## **Abstract**

An assessment of TURP set-up across the KSS region.

## **Background**

For several decades, a transurethral resection of the prostate (TURP) has been the gold standard surgical intervention for benign prostatic hyperplasia. Since its introduction, there have been several advancements in the equipment used. This includes, video-TURP, continuous flow resectoscopes, and bipolar resecting instruments. These have reduced the morbidity associated with this procedure. To our knowledge, the ideal set-up for TURP has not been described in the literature.

## **Aim**

We have described what we consider to be the ideal set-up for a TURP. We aim to audit the current practice of TURP set-up in the trust within Kent Surrey and Sussex (KSS) and compare it to our practice.

## **Methods**

Questionnaires were sent to all trainees within the KSS Deanery to audit the practice used in their respective trusts.

## **Results**

12 questionnaires were sent out with a response rate of 92% (11/12). 100% used continuous irrigating resectoscopes. 45% (5/12) were using monopolar TURP only, 27% (3/12) had access to both bipolar and monopolar resection. 0% had access to an in-fluid warmer, and depended on a warming cabinet. Analysis of practical set up showed that 18% (2/11) did not have access to a TURP drape.

## **Conclusion**

We recognise that individual practice is determined by the local trust practice. We believe the TURP set-up described by our trust uses the best available equipment to optimise surgical performance especially in a training environment, and should be standardised across the region.

# Presentation

## How racist is prostate cancer in Britain?

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## Introduction

Literature on racial inequality of outcomes following radical prostatectomy suggests worse outcomes in Afro-Caribbeans. Our cohort study analyses Robotic-Assisted Radical Prostatectomy (RARP) oncological outcomes in a tertiary referral centre with high proportion of AC males with equal access to healthcare.

## Patients (or Materials) and Methods

A retrospective review of a prospectively held single-centre database of 500 RARPs performed between 01/07/08 and 30/04/15.

Three ethnic groups were defined: Afro-Caribbean (AC), Caucasian (CC) and South Asian (SA). Clinical, surgical and oncological variables were compared.

Biochemical-recurrence (BCR) was defined as PSA>0.1ng/mL. 434 men were eligible for analysis (AC n=117: CC n=258, SA: n=59).

## Results

AC patients were significantly younger; mean age 60 yrs vs. 63 (CC) and 64 yrs (SA). Mean console operating time in the AC group was significantly longer at 182 mins vs 160(CC) and 170(SA).

Asian men demonstrated more pathological upgrading than black and white men (p 0.05). Pre and post-surgical risk stratifications of these groups did not differ significantly.

Overall biochemical recurrence rates were not significantly different between the groups. Logistic regression analysis used pre and post surgical variables of age, ethnicity, PSA, date of surgery, biopsy and final Gleason score, clinical and pathological staging, pathological cancer volume and margin status.

Only pathological staging and margin status were significantly associated with BCR.

## Conclusions

Ethnicity does not affect the oncological outcomes of RARP unlike pathological staging and margin status. Equal access healthcare could improve RARP oncological outcomes in AC men through earlier detection and treatment.

# Presentation

## What Doses Are Our Patients Receiving? An Audit of Radiation Dose Associated with CT KUB, CT IVU, Ureteroscopy and PCNL

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## Introduction

All urologists are familiar with standard textbook reference doses for CT scans and quote these to our patients. However, what doses are patients actually receiving in reality and do they conform to radiation guidelines? The typical dose length product (DLP) for CT KUBs and CT IVUs in the UK is 355mGy-cm and 960mGy-cm respectively (Public Health England, 2011).

We audited our practice as well as analysing doses received during stone procedures.

## Methods

For CT data, patients were retrospectively identified from the Computerised Radiology Information System (CRIS®). All CT KUBs between September 2014 and April 2015 were analysed. A smaller cohort of CT IVU patients were analysed between November 2015 and December 2015. Data on consecutive patients undergoing ureteroscopy and PCNL was collected prospectively. Estimated radiation doses were calculated.

## Results

669, 70, 67 and 24 patients underwent CT KUB, CT IVU, ureteroscopy and PCNL respectively. The median DLP was 176.0mGy-cm and 639mGy-cm for CT KUB and CT IVU respectively. This corresponds to an estimated radiation dose of 2.3mSv and 8.3mSv. For ureteroscopy the dose-area product (DAP) was 158 $\mu$ Gym<sup>2</sup> giving an effective dose of 0.2mSv – although this falls to 0.09mSv for patients with BMA<30. For PCNL, the effective dose is 1.9mSv.

## Conclusions

Median doses of radiation from CT KUB and CT IVU at our institution compare favourably with average doses reported nationally. We are now able to give informed local data to our patients to reassure them regarding radiation safety for diagnostic procedures and therapeutic interventions.

# Presentation

## Ureterolysis in the Management of Ureteric Obstruction from Retroperitoneal Fibrosis (RPF)

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### Introduction

Controversy exists regarding the best long-term management of ureteric obstruction caused by retroperitoneal fibrosis (RPF). Stents and steroids have side effects and may not provide optimal relief from obstruction. Ureterolysis is a major undertaking; however, is it one worth taking?

### Methods

We prospectively evaluated 122 patients managed through our RPF service between January 2012 and December 2015. 48/122(39%) underwent open ureterolysis and omental wrap.

### Results

Median follow-up was 25 months (2-47). Indications included stent failure 26/48(55%), stent symptoms 17/48(35%) and nephrostomy dependence 3/48(6%). 11 additional procedures were performed including nephrectomy for non-function (7), ureteric reconstruction (3) and AAA repair (1). Median operative time and blood loss was 3.2 hours (2-4.5) and 390ml (20-1200) respectively. 4/48(8%) had Clavien III or IV complications.

Pre-operatively, 48/48(100%) patients had stents; post-operatively, 46/48(96%) remain stent-free. 44/48(92%) had improvement in GFR post-ureterolysis, with 29/48(60%) having  $\geq 15\%$  improvement. Pre-operatively, 32/48 (67%) patients were on steroids; post-ureterolysis, 28/32(88%) discontinued steroids. No ureters treated by ureterolysis have re-obstructed from RPF.

### Conclusions

Ureterolysis is challenging but appears to be successful in delivering optimal relief from obstruction, freedom from stents, and allowing confident cessation of steroids. In patients fit enough for major surgery, we advocate ureterolysis as the first-choice treatment in the management of ureteric obstruction from RPF.

# Presentation

## **Long term follow-up with the Memokath 051 stent in benign ureteric obstruction**

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## **Introduction**

The thermo-expandable nickel/titanium alloy Memokath 051 ureteric stent was first used for ureteric strictures in 1996. We report the long-term outcomes (up to 19 years follow-up) for the management of ureteric strictures of solely benign aetiology.

## **Patients**

From 1996 to present a single surgeon (RPK) has inserted 79 stents in 49 patients (26 male, 23 female) with a mean age of 58.4 years (range 11-87 years). 52 had a previous JJ stent. We encountered a wide range of aetiologies with the most common being post-radiotherapy and iatrogenic.

## **Results**

Mean stricture length 58mm (range 5-200mm) with the most common site of stricture being the distal ureter. The most commonly used stents were the 60mm and 100mm in length. The mean stent duration was 16.4 months (range 1-98 months) with the most common causes of failure being migration/distal obstruction, encrustation and infection. We found that strictures caused by impacted ureteric stones, abdominal aortic aneurysms and following trauma appeared to result in earlier Memokath failure.

## **Conclusion**

This study represents the largest cohort worldwide of Memokath 051 stents for benign ureteric strictures. The 051 is a useful addition available to the urologist managing this challenging patient group who, as opposed to malignant disease, may not have an affected life expectancy. If inserted we would advocate close surveillance comprising blood tests, functional imaging and ureteroscopic inspection.

# Presentation

## **The changing role of Trans-rectal Ultrasound guided prostate biopsies (TRUS) in the Era of Template biopsies and MRI imaging**

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## **Introduction**

Following the introduction of Multiparametric MRI prior to template biopsies, our biopsy practice has changed. We have studied the effect of this on biopsy outcomes.

## **Method**

Data was collected retrospectively on patients investigated for Prostate Cancer from 2010 to 2015. We've matched two cohorts of 100 patients undergoing TRUS or Template biopsy in 2010 and then in 2015.

## **Results**

Total biopsy rates have decreased between 2010 and 2015 with 425 and 355 biopsies respectively. There has been a significant decrease in the annual number of TRUS biopsies from 230 to 72. Total patients having pre-biopsy MRI has risen from 12,5% to 98,5% during the study period.

The number of benign TRUS biopsies has dropped from 40% to 13% and Gleason score 6 biopsies decreased from 30% to 7%, while Gleason score biopsies > 6 have risen from 30% to 80%. Template biopsy results had a large drop in Gleason score 6 percentage which shifted to Gleason score 7.

## **Conclusion**

Pre-biopsy MRI has led to better patient selection and improved biopsy outcomes. Therefore, we propose a new pathway including pre-biopsy MRI for appropriate biopsy technique selection.

# Presentation

## **Long Term Outcomes of Laparoscopic Nephro-ureterectomy with Transurethral Circumferential Excision of the Ureteric Orifice for Urothelial Carcinoma**

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## **Introduction**

When performing open or laparoscopic nephroureterectomy (LNU), the optimal way to excise the distal ureter remains controversial. There are concerns that primary endoscopic detachment of the intramural ureter is associated with adverse outcomes. We provide our institutions experience of this technique with a minimum of 5 years follow up.

## **Methods**

A ten year prospective study of 59 patients undergoing LNU. All patients underwent initial endoscopic circumferential release of the distal ureter and bladder cuff followed by retroperitoneal en bloc LNU.

## **Results**

Median age of 67 years. Median operative time was 180 minutes with blood loss 50ml. Median in-patient stay was 3 days. 46 patients had transitional cell carcinoma. 71% of patients had high grade disease (n=33) and 21% had distal ureteric disease (n=10). Recurrence occurred in 16 patients (Seven intra-vesical, nine metastases) with a median time to recurrence of 13 months. One patient required open excision of recurrence at the site of the excised ureteric orifice and remains disease free. 5 year cancer specific survival was 100% for patients with pta (n=7), pt1 (n=14) and pt2 (n=7) disease and 52% for patients with pT3 (n=18) disease.

## **Conclusions**

Transurethral resection of the ureteric orifice during LNU achieves acceptable long-term oncologic outcomes whilst minimising peri-operative morbidity and in-patient stay. This represents the largest single centre study of this technique to date.

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