



South Thames Regional Meeting: Abstracts

19th April 2018

Venue: Greenwood Lecture Theatre
(behind Guy's Hospital)

Address: 55 Weston Street, London, SE1 3RA

Programme

| | |
|-------------|--------------------------------------------------------|
| 10:00-12:00 | South Thames deanery meeting KSS deanery meeting |
| 12:30-13:30 | Lunch |
| 13:30-15:10 | Academic Session 1 - Oncology |
| 15:10-15:30 | Tea and coffee break |
| 15:30-16:40 | Academic Session 2 - Benign |
| 16:40-17:00 | Final remarks and close of meeting |
| 17:00–20:30 | Food and drinks will be served in the Gordon Museum |

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The Greenwood Theatre

Built and owned by the Charitable Foundation of Guy's Hospital following donations from Sir James Mantle Greenwood in 1975, the Greenwood Theatre is leased by King's College London for lectures, student productions and external client bookings.

The Gordon Museum

King's Gordon Museum of Pathology is the largest medical museum in the UK and contains some rare and unique artefacts including Lister's antiseptic spray and the original specimens of kidneys, adrenal glands and lymph nodes which led Richard Bright, Thomas Addison and Thomas Hodgkin to describe the medical conditions that bear their names.

The Museum's primary function has always been to help train medical, dental and biomedical students and professionals to diagnose disease and as such it provides a range of services and functions to The School of Medicine and to medical professionals. The Museum supports the studies of over 9,500 current healthcare students.

Housed in the Museum are also a number of important historic collections. The Joseph Towne anatomical and dermatological wax models, the Lam Qua pre-operative tumour paintings and the specimen and artefact collections of Hodgkin, Thomas Addison, Bright and Astley Cooper. All of these are on permanent display throughout the Gordon Museum.

Oncology session

1.30-3.10

| Timings | Title | Presenter |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| 1.30-1.40 | Surveillance algorithm for node positive squamous cell carcinoma of the penis | Michael Ager |
| 1.40-1.50 | Treatment satisfaction, decision regret and quality of life following Robot Assisted Radical Prostatectomy | J Lindsay |
| 1.50-2.00 | Searching for Metabolic Hot-Spots: A Review of PET Imaging of the Testes | A. Vicens-Morton |
| 2.00-2.10 | Evaluating the significance of bladder wall thickening reported on radiological examination | J. Lindsay |
| 2.10-2.20 | What Is The Negative Predictive Value of mpMRI in Excluding Significant Prostate Cancer at Biopsy? Results from a Regional Cancer Centre | N. Lobo |
| 2.20-2.30 | What is the impact of non-urothelial variant histology on mortality following radical cystectomy? | L. Stroman |
| 2.30-2.40 | Octagenarian Radical Cystectomy Analysis (ORCA©) | G. Litller |
| 2.40-2.50 | Nephron Sparing Surgery (NSS) in single kidneys: an audit of perioperative, functional and oncological outcomes | S Rintoul-Hoad |
| 2.50-3.00 | Audit of Detrusor Muscle Sampling in Trans-Urethral Resection of Bladder Tumour | J. Peacock |
| 3.00-3.10 | Can pre and intra-operative variables affect short-term postoperative outcomes following Robotic-Assisted Radical Prostatectomy (RARP)? | R. Saghir |

Benign session 3.30-4.40

| Timings | Title | Presenter |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------|------------------|
| 3.30-3.40 | Patient Led Trial Without Catheter (TWOC)- Is it feasible? | Li June Tay |
| 3.40-3.50 | Are poor response and adverse events predictable following Botulinum toxin-A injections for refractory idiopathic overactive bladder? | M. Muneeb Abrar |
| 3.50-4.00 | Buccal Mucosal Graft Urethroplasty in Patients after Renal Transplant | A. Vicens-Morton |
| 4.00-4.10 | Incidence and patterns of catheter associated UTIs (CAUTIs) post urethroplasties | H. lee |
| 4.10-4.20 | Contemporary management of ureteric stones in the post tamsulosin era. Experiences from the first UK virtual stone clinic. | O. Blach |
| 4.20-4.30 | Efficacy of extracorporeal shockwave lithotripsy for renal and ureteric calculi: is there a role in 2018? | A. Nagle |
| 4.30-4.40 | How accurate are ureteroscopic biopsies? | A. Nagle |
| 4.30-4.40 | Day case TURP in a stand-alone unit with no beds - is this feasible? prospective review of the first 100 cases. | O. Blach |

Title of presentation

Surveillance algorithm for node positive squamous cell carcinoma of the penis

Authors

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Abstract**Introduction & objectives**

Evidence for follow up of node positive SCC of the penis (SCCp) is scant. Our practice mirrors EAU guidelines; 3 monthly review CT (TAP) for 2 years and 6 monthly for years 3-5 (min. 16 scans). We aim to determine optimum frequency and duration of follow up CT TAP based on site and timing of first regional or distant recurrence.

Methods

A prospective database of all penile cancer patients treated at our centre from 2002-2017 was reviewed. We identified newly diagnosed pathologically node positive patients. Parameters assessed were nodal pathological stage, site and time of first recurrence. All pathology was re-reviewed and reclassified using TNM 7.

Results

Of 1019 patients with a new diagnosis of SCCp, 224 patients were node positive and suitable for analysis; pN1 (48), pN2 (33) and pN3 (143). Of the pN1 patients, 6 had recurrence, (range 1-11 months). 10 pN2 patients had recurrence (range 0 – 12 months). Of the pN3 group, 84 patients had disease recurrence (66 in year 1, 14 in year 2, 2 in years 3-5). Site of first recurrence was groin 21(21%), pelvis 28(28%), mediastinal 31(31%), 20(20%) other.

Conclusion

Regional and distant recurrence was not observed in pN1 and pN2 patients after 12 months surveillance. For pN3 patients, 97% did not relapse after 24 months. We confirmed that the sites of progression supports CT TAP surveillance. We propose a new CT TAP protocol of 2 years for pN1 and pN2 patients with 3 monthly scans for the first year and 6 monthly for the second and a further year for pN3.

Title of presentation

Treatment satisfaction, decision regret and quality of life following Robot Assisted Radical Prostatectomy

Authors

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Abstract**Introduction**

Information regarding treatment satisfaction and decision regret following robot assisted radical prostatectomy (RARP) in the UK is scarce. We aim to assess these parameters and correlate overall satisfaction, disease specific quality of life, sexual function and urinary incontinence at a high-volume centre.

Methods

Patients who had undergone RARP between June 2011 and January 2016 were invited to participate through mailed questionnaires. Patients who were suitable for active surveillance but chose to undergo robotic prostatectomy were included in the analysis. A total of 104 patients formed our cohort for this study. The questionnaires included EORTC QLQ30, the accompanying prostate cancer specific module (PR25), Sexual Health Inventory in Men (SHIM) score and a self-reported Likert scale for decision regret. Patients more than 18 months following radical prostatectomy were included to provide an appropriate assessment of their erectile function. A low threshold value of $\geq 15/100$ was used to define an outcome of decision regret.

Results

The mean patient age was 68 years and the mean duration of follow up was 22 months. Of the 104 patients, 49% (51/104) were fully satisfied with the decision to undergo robotic prostatectomy. Of the 53 patients who expressed regret, 66% (35/53) had scores $\geq 15/100$ which provided an outcome measure of decision regret as 34% (35/104). The mean value of regret was 20 (out of 100). The EORTC prostate specific symptom score was the only variable that showed a statistically significant association with decision regret (P 0.001).

Conclusion

Decision regret was observed in one third of our cohort of patients (35/104) and is associated with poor prostate specific quality of life. To minimise regret, extensive discussion regarding disease specific quality of life and complications should be included when counselling patients about their treatment options.

Title of presentation

Searching for Metabolic Hot-Spots: A Review of PET Imaging of the Testes

Authors

Mr Antoni Bochinski¹, Mr Andrew John Vicens-Morton¹, Miss Meghana Kulkarni², Mr Majid Shabbir², Dr Gilbert O Fruhwirth³, Dr Ewelina Kurtys³, Mr Tet Yep²

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Abstract

Introduction and objectives

Positron emission tomography (PET) has traditionally been used for the assessment of malignancy and its spread. However, as the technique has become more refined, there is greater interest in its use for the evaluation of benign conditions. PET imaging of the testis may reveal areas of active spermatogenesis and hormone production. The aim of this systematic review and meta-analysis was to evaluate the current results on the use of PET for imaging the testis for fertility, and develop a PET/CT protocol for a metabolic testicular imaging in an animal model that used for future clinical studies in infertile men.

Methods

A prospectively registered (PROSPERO) systematic literature review was performed in accordance to PRISMA guidelines to evaluate the use of PET for testicular fertility imaging in both humans. An assessment of the risk of bias was made and the key findings are described, including clinical practice relevance. Scanning protocol, methodology and the unit of measurement of metabolic activity was assessed. Data collection included SUVmean and SUVmax which are the mean tracer uptake into entire testicular volume and into point of maximal uptake respectively. From the initial data obtained, a functional imaging PET/CT protocol was developed for specifically imaging spermatozoa in Sprague-Dawley rat models.

Results

Ten studies were identified on PET/CT testes imaging. Three evaluated healthy adult patients (age range 30-89), one reviewed healthy paediatric patients (ages 9-17), one imaged patients following vasectomy and 5 with various forms of cancer including lymphoma as well as benign and malignant testicular tumours. 9 of the studies were retrospective in design and were single-centre evaluations. Study populations size varied between 8 and 320.

Despite the wide usage of SUVmean, SUVmax and testicular volume, there was no unified unit of measurement of testicular metabolism across all of the studies. Other more traditional parameters of reproductive function such as semen analysis and sex-hormonal levels were not routinely analysed alongside PET imaging for functional interpretation. A small pilot study of functional PET/MRI imaging in rat testis models, showed its potential feasibility in humans.

Conclusion

PET is potentially a ground-breaking tool in the metabolic evaluation of the testes for spermatogenesis and hormone production, and may be useful in predicting return to fertility in patients with cancer. Further work in the form of prospective studies which combine semen analysis, sex-hormone levels and functional imaging are needed to provide greater information on the causes and management of infertility. Our rat model pilot trials show that PET/MRI may be a feasible alternative to the radiation-heavy PET/CT.

Title of presentation

Evaluating the significance of bladder wall thickening reported on radiological examination

Authors

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Abstract**Introductions and Objectives**

An observational study to evaluate the significance of bladder wall thickening (BWT) reported on radiological examination through assessment of scan indication, BWT description and urological outcome.

Methods

A retrospective analysis was performed of all CT/US AP/KUB scan reports from PACS from July to December 2017 at RSCH. 16 828 reports were assessed for BWT which produced 74 results (61 CT, 13 US).

Results

The incidence of BWT on radiological examination was calculated at 0.44%.

60% (39/64) of patients who had BWT on radiological examination in the absence of a current diagnosis of bladder cancer had a flexible cystoscopy.

Of the 39 that had a flexible cystoscopy 10/39 (26%) went on to have a GA cystoscopy and Biopsy and 6/39 (15%) went onto have a diagnosis of bladder cancer at biopsy.

Of these six patients 4 patients were diagnosed with T2 disease (all of which had been reported as focal thickening on CT), one patient diagnosed with T1 disease and one patient with CIS.

3 of the patients diagnosed with T2 disease had BWT as well as hydronephrosis seen on CT.

21% (8/39) of patients who had flexible cystoscopy had no other urological indication (Haematuria, LUTS, recurrent UTIs). None of these patients went on to have positive findings at flexible cystoscopy. All 8 patients had had CT CAPs and 75% of the indications were to assess for undiagnosed malignancy.

Conclusion

Focal BWT and hydronephrosis on CT is highly suggestive of bladder cancer.

Bladder wall thickening on CT in the absence of other urological indications for flexible cystoscopy was not associated with diagnosis of bladder malignancy.

Title of presentation

What Is The Negative Predictive Value of mpMRI in Excluding Significant Prostate Cancer at Biopsy? Results from a Regional Cancer Centre

Authors

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Abstract**Introduction**

Pre-biopsy multiparametric MRI (mpMRI) is reported to have a negative predictive value of 89% in prostate cancer diagnosis. We aimed to determine the negative predictive value (NPV) of mpMRI for men undergoing 12-core systematic prostate biopsy at our Trust.

Methods

A retrospective audit of consecutive patients undergoing 1.5T or 3T mpMRI followed by prostate biopsy from June 2016 to January 2018. Men with negative pre-biopsy mpMRI undergoing 12-core systematic TRUS biopsy were identified. Clinical features, cancer detection rates and negative predictive values are summarized. Clinically significant cancer was defined as the presence of a single biopsy core indicating disease of Gleason score 3+4 or greater.

Results

416 mpMRIs were performed. Of these, 181 (43%) were PIRADS 1 or 2.

Overall, cancer was detected in 44/181 (24%) men with negative MRI. Clinically significant prostate cancer was detected in 26/181 (14%)

Gleason 3+3= 18/181 (9.9%)

Gleason 3+4= 20/181 (11.0%)

Gleason 4+3= 2/181 (1.1%)

Gleason 3+5= 3/181 (1.6%)

Gleason 4+5= 1/181 (0.5%)

The NPV for all cancers was 76% and for clinically significant prostate cancer was 86%.

Conclusion

At our Trust, a negative pre-biopsy mpMRI confers a NPV of 86% on 12-core biopsy for clinically significant prostate cancer defined as Gleason 3+4 or greater in 1 or more cores. This is similar to other published series. We are now able to inform our patients with locally audited data and suggest that all centres audit their own mpMRI use.

Title of presentation

What is the impact of non-urothelial variant histology on mortality following radical cystectomy?

Authors

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Abstract

Introduction

Non-urothelial variant histology (NUVH) is classified as high-risk bladder cancer. However, it is unclear whether the presence of NUVH affects mortality following radical cystectomy (RC), with varying results from previous studies. We investigate the effect of NUVH on cancer-specific and overall mortality following RC.

Methods

Review of a prospectively maintained database of all patients diagnosed with high-risk bladder cancer from 2007-2017 was performed. Following RC, mortality was determined for patients with NUVH (squamous differentiation, glandular, micropapillary, plasmacytoid, nested, microcystic, sarcomatoid, giant cell), and compared to urothelial carcinoma. Cancer specific and overall mortality was determined with Cox regression multivariate analysis and chi-squared analysis.

Results

430 patients underwent RC of which 73 (17%) displayed NUVH. The most frequent were squamous (n=41) and glandular (n=13). NUVH significantly increased overall (HR 4.55, CI 2.95-7.34) and cancer specific (HR 5.76, CI 3.26 – 7.90) mortality in univariate and multivariate analysis. Only squamous (HR 3.2, CI 1.84-5.55) and glandular (HR 11.2, CI 4.85-25.93) histological subtypes were associated with cancer specific and overall mortality in multivariate analysis. NUVH was associated with lymph node positivity in univariate (HR 2.47, CI 1.39 - 4.41) but not multivariate (HR 1.28, CI 0.59 – 2.75) analysis. NUVH was associated with increased tumour stage in chi-squared analysis ($p < 0.0001$).

Conclusions

The presence of NUVH is a poor prognostic marker and is associated with an increased risk of disease-specific mortality. Squamous and glandular subtypes were associated with worse outcomes but larger studies are needed to assess the effect of rare subtypes.

Title of presentation

Octagenarian Radical Cystectomy Analysis (ORCA©)

Authors

Gabriella Litler, Andrea Tay, DejiAkiboye, Ben Ayres, Babbin John, Sarah Hammond, Elaine Monahan, Hiten Patel, Rami Issa

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Abstract

Title: Octagenarian Radical Cystectomy Analysis (ORCA©)

Introduction: Historically, Radical Cystectomy (RC) is a major-complex surgery with considerable risks, thus, underutilized in Octogenarians. Modern RC practice has seen significant improvements such as centralization, super-specialization, enhanced recovery programs, personalized surgery and robotics.

Thus, in the current study, we performed ORCA© within a modern cohort of patients undergoing RC.

Aim: Is Octogenarian Radical Cystectomy (ORC), best avoided or a valid option?

Patients and methods: A prospectively populated RC database was used. The first 100 Robotic RC patients were excluded due to potential variables such as learning curve, non-enhanced recovery, varying anaesthesia protocols and other. The last 117 consecutive Robotic RC patients with a median follow up of 18 months were analyzed for multiple areas, comparing 26 patients ≥ 80 versus 91 patients < 80 years. Specific data comparison is calculated by Student's unpaired t-test, and summarized in the table of results.

Results: Both groups were similar for peri-operative and postoperative outcomes. Blood loss and length of stay were not significantly different. Ninety-day complications and mortality were not different, with no 90-day mortality in either group. Overall and disease-specific survival were also similar (see table).

Conclusions:

Our ORCA© was in a small group of patients, however, our study confirms that modern RC practice has a favorable risk profile and therefore should be offered routinely to octogenarians with reasonable fitness level when bladder removal is indicated.

Title of presentation

Nephron Sparing Surgery (NSS) in single kidneys: an audit of perioperative, functional and oncological outcomes

Authors

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Abstract

Introduction:

A mass in a single kidney is the classic imperative indication for NSS but questions remain as to how often the goals of long term cancer control and freedom from dialysis are achieved.

Methods:

Retrospective analysis of open NSS in single kidneys in a single centre (2000-2017). Outcomes addressed: technical success; dialysis and renal function; cancer recurrence and mortality. Median follow-up 3years.

Results:

89 patients. Median age 63years. Female 31%. Median pre-operative eGFR: 60 (26-108). Median tumour size: 50mm(15-110mm). Median PADUA score: 11 (6A-14A). 27% multiple tumours. 7% VHL.

Reason for single kidney: cancer nephrectomy 49/89 (55%); benign nephrectomy 17/89 (19%); congenital 23/89 (26%) including horseshoe (10) and transplant kidney (2).

NSS successful in 86/89 (96%). Complications \geq Clavien 3: 27/86 (31%); including secondary haemorrhage: 7 (8%); urine leak: 7 (8%).

Cancer specific survival 65/75 (80%) and overall survival 69/86 (80%)

75/86 (87%) malignant histology; 21/75 (28%) \geq T2.

6/75 developed local recurrence; 3/6 had positive margin

15/75 developed metastases. Of these: 5/15 had \geq T3 disease; 8/15 had multiple tumours, 7/15 had contralateral RCC nephrectomy <18 months previously. 10/15 died from metastatic RCC

80/86 (93%) patients are dialysis-free

12/86 dialysed post-op; Risk factors: PADUA>11; multiple tumours, >Clavien 3b complication; 1/12 remained dialysis dependent

5/86 required late dialysis; 4/5 anephric from treatment of recurrence.

Conclusion:

Open NSS for complex tumours i.e. PADUA>11, in single kidneys is challenging but worthwhile with high cancer-specific and dialysis-free survival. Analysing NSS in single kidneys allows unique insight into recovery of kidney function. The strongest risk factor for long-term dialysis is recurrence requiring treatment; and for metastatic disease is multiple tumours and recent contralateral cancer nephrectomy.

Title of presentation

Audit of Detrusor Muscle Sampling in Trans-Urethral Resection of Bladder Tumour

Authors

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Abstract

Introduction

Detrusor Muscle (DM) sampling during Transurethral Resection of Bladder Tumours (TURBT) is essential to allow accurate staging of disease. DM sampling is an accepted measure of the quality of tumour resection. Despite this, studies have shown the rate of absence of DM to be as high as 51%. Several factors are considered to be responsible for this, in particular surgical experience.

Aim

To assess the quality of TURBT at our Hospital with respect to the rate of DM sampling. To see whether the rate of DM sampling correlates with tumour histopathological grade or stage. To evaluate the association between the rate of DM sampling and the surgeon's experience level.

Method

A single loop audit of TURBTs performed between May 2017 and December 2017. 100 patients were included in this audit. Data was collected retrospectively, using electronic operative notes, patient letters and histopathology report as sources.

Results

75.9% of TURBT had DM present in the histological specimen, allowing for accurate staging. The most frequently noted histological staging in cases where DM was not sampled was pTa (37.2%). Those with high grade (G3) and T1 disease were more likely to have DM sampled. DM was present in 76.7% of cases performed by consultants, and 74.1% of non-consultants.

Conclusions

The rate of DM sampling suggests that this institution is performing good quality TURBT. It is important continue the close supervision of non-consultant surgeons. Additional care should be taken in the resection of superficial looking lesions to ensure DM sampling and precise staging.

Title of presentation

Can pre and intra-operative variables affect short-term postoperative outcomes following Robotic-Assisted Radical Prostatectomy (RARP)?

Authors

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Abstract**Introduction**

There is variability in outcomes after robotic-assisted radical prostatectomy (RARP) for localized prostate cancer. We evaluated peri-operative variables in men undergoing RARP and their relationship with short-term outcomes at a tertiary referral centre. These can inform surgical planning and intra-operative management to improve patient outcomes.

Methods

A retrospective analysis was performed on all RARPs over 16 months assessing PSA at 6 weeks, continence and erectile dysfunction (ED) at 6 months postoperatively.

Results

382 cases were performed between January 2016 and April 2017 (mean 24/month), by 5 experienced urologists, of which 331 were analysed. Mean preoperative PSA was 10.12(1.20-68.00)ng/ml. Bilateral nerve sparing was performed in 152(45.9%), unilateral in 109(32.9%) and no nerve sparing in 70(21.1%). Multivariate analysis showed at 6 weeks, preoperative PSA, Gleason grade, tumour stage, degree of nerve sparing, and presence of surgical margins significantly correlated with postoperative detectable PSA levels (all $p < 0.04$). At 6 months, 75.8% were either fully continent or requiring one-security pad. Continence was related to operating surgeon ($p < 0.001$). Erections were maintained spontaneously or with a PDE5-inhibitor in 35.2% patients. ED worsens with degree of nerve sparing, increasing age, presence and quantity of metastatic lymph nodes removed. (all $p < 0.03$). Tumor staging and margin rates were also significantly correlated ($p > 0.001$).

Conclusions

In this series, optimizing the balance between negative surgical margins and nerve sparing reduces the risk of incontinence and ED. At 6months, 75.8% are continent or ≤ 1 pad/day. Rates of ED are increased in non-nerve sparing, increased age and greater lymph node dissection cases.

Benign Session

3:30 – 4:40pm

Title of presentation

Patient Led Trial Without Catheter (TWOC)- Is it feasible?

Authors

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Abstract

Introduction

Our institution aims to perform Greenlight laser prostatectomy (PVP) with either TWOC the same day or on the first to third post-operative day. Patients with larger prostates, longer vaporisation times, or had pre-operatively been in urinary retention are discharged for a subsequent TWOC. In this study we test the feasibility of a patient-led TWOC.

Methods

We prospectively collected data between October 2017 and March 2018. Patients were taught to remove their catheter at home and instructed to do so on a designated day at 8am, and to attend urology Outpatients if they had difficulty voiding by 1pm. If they had concerns or changed their mind, a nurse-led TWOC was performed. Each patient was phoned to evaluate their progress.

Results

23 patients were suitable and agreed. Of these, 3 changed their mind and returned to outpatients, 2 were constipated and did not perform the TWOC, one patient's catheter fell out, two were uncontactable. Unsuitable patients included those admitted for social reasons, having an inpatient TWOC, and those requiring overnight irrigation. 91 % had PVP, 9% had TURBT or penile surgery. 15 patients removed their own catheter and 13 (87%) successfully voided. Two failed and returned to urology outpatients to be catheterised with a repeat TWOC; one in retention, one had incontinence. Both had successful TWOCs a week later. On follow-up, 11 patients were happy to remove their own catheter however three patients preferred a nurse-led TWOC.

Conclusion

Patient-led TWOCs are feasible. The majority of patients are satisfied and happy to remove their own catheter with a contingency plan should they fail to void.

Title of presentation

Are poor response and adverse events predictable following Botulinum toxin-A injections for refractory idiopathic overactive bladder?

Authors

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Abstract

Introduction: To ascertain whether a poor response, voiding dysfunction and UTI were predictable to first-time botulinum toxin-A (BTX-A; 100-200 U) injections in a patient cohort of idiopathic refractory overactive bladder (OAB).

Patient and Methods: A poor response was based on the UDI-6 questionnaire, filled in at baseline and 4-6 weeks post-injection. Data on patient demographics, urodynamic parameters as well as past medical and surgical history of each patient were also collected.

Results: 74 patients (50 females and 24 males) were analysed. Univariate logistic regression analysis suggested the only predictors of poor response were male gender (odds ratio (OR) 4.49, $p = 0.006$) and age (OR 1.05, $p = 0.027$). In terms of predicting UTIs, upon multivariate logistic regression lower PIP1 in females was shown to be significant (odds ratio 0.93, p -value= 0.050). Predictability of CISC, on multivariate logistic regression, suggested lower maximum urinary flow rates (OR = 0.91, $p = 0.023$) and male gender (OR = 5.14, $p = 0.013$) were significant. In addition, on univariate logistic regression in females, hysterectomy was associated with an increased risk of CISC (odds ratio= 4.55, p -value= 0.038). Finally, on multivariate logistic regression (accounting for age, gender, dosage and the urodynamic parameters), there was an association of CISC and having a UTI after injection (OR = 11.63, p -value= 0.037).

Conclusions: Male gender and age is associated with a poor response to BTX-A injections as well as increased risk of needing CISC. Lower detrusor contractility in women is also associated with an increased UTI risk. Females who have undergone hysterectomy are also at increased risk of CISC after BTX-A injections. Performing CISC also increases your risk of UTI in this cohort.

Title of presentation

Buccal Mucosal Graft Urethroplasty in Patients after Renal Transplant

Authors

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Abstract

Between 2013-2018, 101 patients underwent a buccal mucosal graft (BMG) urethroplasty for bulbar urethral strictures. 7 cases in this series were in renal transplant patients. Reports of urethroplasty outcomes in transplant patients are rare, with only one published series of 10 cases in the literature. 4/7 patients had normal urethras noted at the time of stent removal post-transplant, and developed their symptomatic stricture within 6months. Their mean stricture length was 5.6cm (4-8cm) compared to 4.6cm (2-8cm) in the non-transplant group (NS).

In the non-transplant group, 95% had a successful outcome (defined as normal flow rate, bell shaped curve and Qmax>15ml/s with no further intervention) after a median follow up of 23months. Complications included one wound infection (Clavien–Dindo I – 1%) and one case of erectile dysfunction requiring PDE5i(1%).

In the transplant group, only 71% had a successful outcome after a median follow up of 33months. 2 patients developed a flat top trace indicating stricture recurrence. However, on cystoscopy, both had complete patency of the reconstructed segment, and had developed strictures in a different region of the urethra. One has stabilized with endoscopic treatment, while the second stricture progressed across the entire penile urethra. One patient on steroids developed acute pancreatitis post op resulting in a protracted length of stay (Clavien-dindo II -10days). One patient had persistent recurrent UTI's despite a wide, patent urethra, excellent flow rate and no post-void residual. Two patients have developed erectile dysfunction (28%). One patient sadly passed away after developing a new jejunal cancer 3 yrs post urethroplasty.

While BMG Urethroplasty is a valid option in renal transplant patients, this subgroup presents a unique challenge, with a less predictable medium-long term outcome and a higher risk of complications. The nature of stricture development and behaviour may indicate a different natural history of urethral strictures in patients after transplant.

Title of presentation

Incidence and patterns of catheter associated UTIs (CAUTIs) post urethroplasties

Authors

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Abstract

There is little evidence reporting catheter associated urinary tract infections (CAUTIs) post urethroplasty. We analysed our cohort of patients to determine the incidence of CAUTI, and the types and sensitivities of pathogenic organisms in order to optimise peri-operative antibiotic usage.

Methodology:

Between January 2012 and July 2017, CSU specimens were routinely collected and cultured at catheter removal on patients undergoing urethroplasty in 3 of our 4 centres. Peri-operative antibiotics were standardised to intravenous gentamicin/co-amoxiclav on induction and 2 doses co-amoxiclav post-operatively. No antibiotics were routinely given at catheter removal. Data was prospectively collected and recorded electronically.

Results:

590 urethroplasties were performed in 478 patients, of which 280 were from the evaluable centres. 147 were penile and 133 bulbar, 84% had buccal mucosal grafts (BMG). In total 38 CAUTIs were recorded (13.6%); 17 (6.1%) in the penile group, 21 (7.5%) in the bulbar group. There were 13 penile wound infections (4.6%) and no perineal infections in the bulbar group. Organisms were E. coli (29%), Pseudomonas (29%), Enterococcus (10%), Staph Aureus (7%), ESBL E. Coli (5%), Candida (5%), Proteus (5%), Klebsiella (5%). Resistance patterns were Amoxicillin (80%), Trimethoprim (65%), Co-amoxiclav (65%), Cephalexin (46%), Nitrofurantoin (42%), Ciprofloxacin (15%) and Gentamicin (7.6%).

Conclusion

We have defined the incidence of CAUTI in our urethroplasty patients. The risk of CAUTI appears similar in penile and bulbar procedures. There was no evidence of oral organisms causing perineal wound infections. Gentamicin and Ciprofloxacin showed good sensitivity across most microbes.

Title of presentation

Contemporary management of ureteric stones in the post tamsulosin era. Experiences from the first UK virtual stone clinic.

Authors

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Abstract

Introduction

Since the release of SUSPEND trial, medical expulsion therapy (Tamsulosin) is no longer used at our institution. This change in practice coincided with the introduction of our new Virtual Stone Clinic (VSC). In this study, we evaluate the effectiveness and safety of contemporary expectant management of ureteric stones in the new VSC setting.

Patients & Methods

Patients with ureteric stones presenting via VSC in the first 52 weeks of its running were included. Data were collected prospectively on the management strategies employed, with emphasis on outcomes in patients managed expectantly without Tamsulosin. Passage rates were assessed on re-CT at ~6-12 weeks.

Results

Of the 412 patients with ureteric stones, 342 were managed expectantly, 62 with ESWL, and 8 surgically (Figure 1). Of those managed expectantly, 7 had PUJ, 63 proximal, 21 mid, 87 distal ureteric and 164 VUJ stones. 71 were excluded from analysis (DNA/moved/no rescan).

250 out of 271 stones passed spontaneously: 100% of 1–2mm, 98% of 3mm, 96% of 4mm, 82% of 5mm, 91% of 6mm, 82% of 7mm, 75% of 8mm and 50% of 9mm stones. Spontaneous passage rates as a function of stone location and size are summarised in Table 1.

6 patients (2.2%) managed expectantly required emergency surgical intervention (pain/sepsis/renal impairment).

Conclusions

Contemporary expectant management of ureteric stones can be delivered promptly and safely in a VSC setting providing easy access to focused re-CTs. Spontaneous passage rates vary with stone size and location, but seem to be higher than reported in the literature.

Title of presentation

Efficacy of extracorporeal shockwave lithotripsy for renal and ureteric calculi: is there a role in 2018?

Authors

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Abstract**Introduction**

Extracorporeal shockwave lithotripsy (ESWL) is an alternative option to endourological interventions for management of renal stones <2cm and ureteric stones of any size. The aim of this audit is to assess the short- and long-term outcomes and complications of ESWL performed for treatment of renal and ureteric calculi.

Patients and Methods

We analysed prospectively collected data between March and September 2017 for 111 consecutive patients undergoing ESWL. Stone clearance was assessed using plain x-ray, ultrasonography or computed tomography at 3 months following treatment and was defined as no residual stones or stones <2mm. All sessions were performed by a single radiographer using the Storz Medical Modulith SLX F2 lithotripter.

Results

The mean patient age was 47.3 (range: 23–72) years and 71% were male. In 80 (72%) patients the stone was located in the kidney, while in 31 (28%) the stone was located in the ureter. The mean stone size was 7.4mm (5–16mm) in the kidney and 7.2mm (5–13mm) in the ureter. The average number of ESWL sessions per patient was 1.5 (range:1-4). The overall complete stone-free rate at 3 months following treatment was 76% (65% for renal and 84% for ureteric calculi). In 8 (7.2%) patients, further surgical intervention was performed [percutaneous nephrolithotomy (n=1), primary ureteroscopy +/- stent insertion (n=6)]. Furthermore, 15 (13.5%) patients experienced colic post ESWL, of these patients 4 required hospital admission.

Conclusions

ESWL is a safe and effective option for management of small and medium sized ureteric and renal stones at any location. Alternative treatment and complication rates are low, supporting its use as first-line therapy.

Title of presentation

How accurate are ureteroscopic biopsies?

Authors

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Abstract**Introduction**

Recent interest in confocal microscopy has questioned the reliability of ureteroscopic biopsies in diagnosing urothelial malignancy. We set out to assess the accuracy in our unit.

Patients and Methods

We retrospectively reviewed ureteroscopic biopsies from Jan 2011 – Jan 2017. Patients were identified using the histopathology "SnoMed" database and included all urothelial histology specimens obtained via ureteroscopy. We excluded any non-endoscopic biopsies as well as transplant patients.

Results

We analysed the ureteroscopic biopsies of 105 patients with suspected upper tract TCC. Mean age 69 years (range 32-91); 54% male; 46% female. Overall 59(56%) of the biopsies were positive and 40(38%) negative with 6(6%) equivocal resulting in a sensitivity of 91% for the ureter (n=76) and 95% for the kidney (n=29) and a specificity of 100% for both the ureter and the kidney. It was found that 5(7%) ureteric and 1(3.4%) renal biopsy results were equivocal. 4 of these equivocal cases had repeat biopsies which were negative (with no subsequent malignancy was found); whilst 1 proceeded to surgical excision (based on visual endoscopic diagnosis and cross sectional imaging), which confirmed malignancy and in 1 case repeat investigation was not clinically indicated.

Conclusions

We have found ureteroscopic biopsies to be highly specific and sensitive in this study. Correlation in MDT setting is vital to interpret equivocal and negative biopsies. A number of cases were treated based on imaging and with current concerns about potential seeding into the bladder after biopsy, case selection as to who to biopsy remains crucial in managing upper tract TCC.

Title of presentation

Day case TURP in a stand-alone unit with no beds - is this feasible? Prospective review of the first 100 cases.

Authors

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Abstract

Introduction

Inpatient TURP remains the gold standard operation for BPH but advances in novel procedures increasingly allow for same day discharges. We have reviewed our new day-case TURis service in a stand-alone unit with no inpatient capacity.

Patients and Methods

100 consecutive patients under the care of a single consultant were prospectively reviewed. Standard Trust policy for day-case surgery and <80cc prostates were intended selection criteria. Larger prostates were partially resected (middle and 1 lateral lobe). Outpatient TWOCs were performed following surgery.

Results

53 patients underwent TURis for LUTS, 46 for retention (41 with pre-op catheter) and 2 for haematuria. Of the 63 patients who had measured prostate volumes, 17 had >80cc.

Average resection time was 38min (range 5-90min), with resected volume of 17.2g (range 1-40g). Button diathermy/ablation electrode was used in addition to the loop in 11 cases.

Only 1 patient required post-op ambulance transfer to the main hospital due to haematuria, and was discharged after overnight observation.

Within the first 30 days 4 patients were readmitted: 1 with urosepsis, 1 with acute retention post-TWOC, and 2 with haematuria, of which 1 required RBC transfusion following secondary haemorrhage. 18 patients attended A&E during that time: 17 with catheter-related issues and 1 with LUTS post-TWOC.

Average time to post-TURis TWOC was 5.8 days. 96 patients passed first TWOC, with 99 catheter-free at 30 days.

Conclusions

Day-case TURIS can be delivered safely and effectively in a stand-alone unit with very low rates of admission.