

ePoster Session 17 TUF-BAUS BEST OF REGIONS, Wednesday 18 June, 1130-1300, Charter 4

P17-1 On Cloud 9. Creating An FRCS Urology Question Bank Using The Cloud

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Background: The FRCS Urology examination is a Certificate of Completion of Training (CCT) requirement usually taken in the final two years of training in the UK and Ireland. At present the British Association of Urological Surgeons (BAUS) recommends several books and online resources to help pass the exam.

Unlike other Fellowship exams, there is no online question bank. There is evidence that online question banks improve exam performance for those sitting the exam as well as those writing content. We set out to create an online question bank for the FRCS Urology.

Methods: A server-side application was created using Python 3 and linked to a PostgreSQL database hosted on Heroku (The Cloud). Several tables were created to host data including questions, users as well as for individual question and quiz attempts.

A front-end application was developed in Bootstrap Studio. Test users and questions were inputted into the database. The application was hosted on Heroku.

Results: A website has been created which allows users to sign up and test themselves on Single Best Answer (SBA) questions (Image 1). The website collects and tracks users progress over time and in each category. Selected users can also upload questions to help with revision.

Conclusions: By using readily available resources, it's possible to create applications which present information to the end user, record their responses, and store this information in the cloud. This has been used to create a question bank, but could extend to patient questionnaires (IPSS, bladder diary) and consent forms.

A 62 year old male undergoes a CT urogram revealing a right proximal ureteric TCC invading into periureteric fat. There are 2, <2cm lymph nodes in the para aortic region. What best describes the staging?

T3,N2,M0

T2a,N2,M0

T3a,N2,M0

T2a,N1,M0

T3,N1,M0

Next

Invasion into periureteric fat = T3
Multiple lymph nodes = N2

TNM classification 2017 for upper tract urothelial cell carcinoma

Figure 1. A print screen of the website demonstrating a question and feedback.

P17-2 Do current consent processes for intimate examination under anaesthetic meet patient expectations and GMC requirements?

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Introduction: The General Medical Council (GMC) state patients must give explicit consent for all aspects of intimate examination under anaesthetic (EUA). However, in urological practice, this is not included in BAUS patient

information leaflets or many local consent templates, but has become a source of patient complaints and GMC referrals.

Methods: We conducted a snapshot survey of 31 UK consultant urologists specialising in functional urology to understand usual practice regarding consent in patients undergoing hydrodistension. Additionally we undertook a retrospective analysis of consecutive transurethral resections of bladder tumour (TURBT) and hydrodistension procedures to assess inclusion of EUA in these procedures, and whether specific written consent for EUA was obtained.

Results: 94% (29/31) of urologists surveyed perform an EUA as part of hydrodistension. 55% (17/31) routinely include EUA separately on written consent forms. Of 71 TURBTs performed at our centre, 73% (52/71) included an EUA but none had specific consent documented (59/71 performed in men, 83%). Of 25 hydrodistensions, 13 (52%) included EUA with 23% (3/25) having specific consent obtained (20/25 performed in women, 80%).

Conclusion: There is a disparity between some current urological practice and GMC expectations. Many patients would reasonably expect to be asked to give their consent specifically for an intimate examination, even in the context of an invasive urological procedure. Urological practice around consent, standard consent forms, and information leaflets, such as those produced by BAUS, should be updated to reflect the expectations of patients and to avoid adverse consequences of complaints for patients and healthcare professionals.

P17-3 Improving Documentation of Endoscopic Procedures for Urethral Stricture Disease – A Roadmap of the Urethra

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Introduction: Precise documentation in operative notes is vital for patients' safety and ensuring continuity of care. The first line of treatment is endoscopic dilation but with high recurrence rate. Adequate characterisation of USD would identify cases that would benefit from reconstruction earlier. This study assesses the impact of introducing a structured Op-note proforma on the quality of documentation for endoscopic USD procedures.

Methods: The study audited Op-notes for endoscopic USD procedures performed at our Institution. The first cycle retrospectively evaluated 50 free-text Op-notes from July 2021 to March 2022. Following a single awareness session and introduction of a structured endoscopic

USD proforma, the second cycle prospectively assessed 80 Op-notes from April 2022 to January 2023. Compliance was measured against the Royal College of Surgeons standards and local experts' recommendation.

Results: In the first cycle, 56% of Op-notes lacked critical USD details such as location (46%), length (44%), calibre (38%), and relation to a fixed point (56%). After education on reporting characteristics of USD and introduction of a USD op-note proforma, those that used the proforma (Group 2) exhibited significant improvements in documentation: EUA documentation increased by 73% (from 22% to 94.7%), USD length by 27% (from 62% to 89.5%), calibre by 39% (from 56% to 94.7%), and location by 46% (from 54% to 100%). All improvements were statistically significant (p -values <0.05).

Conclusion: This is the first time a USD proforma has been reported and shown to be effective at enhancing the documentation of endoscopic USD procedures.

P17-4 Audit of the Urodynamics Waiting List at Newham and Whipps Cross Hospitals, Barts Health NHS Trust

A snapshot of requests to January 2024

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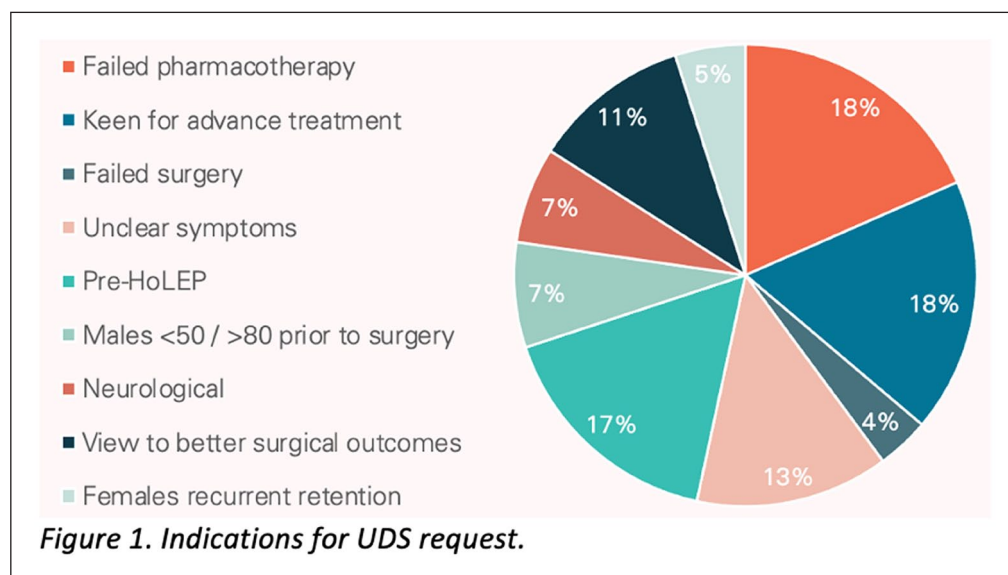
Introduction: Urodynamic studies are tests which investigate how well the bladder can store and release

urine. They involve retrograde filling of the bladder and recording internal pressures at different points. Newham and Whipps Cross Hospitals have significantly long waiting lists - 219 patients. There was concern that not all requests are indicated, and the waiting list may be able to be reduced in order to improve patient care and satisfaction.

Patients and Methods: Data was taken from the patient waiting list up until January 2024. Existing guidelines from the EAU, NICE and expert Consultant knowledge were combined to create a local standard. Time since request, requester role, prior investigations and indication were analysed.

Results: The average waiting time of patients from date of request was 235.5 days. 50% of requests were from Consultants, a further 40% from Registrars. 31% of patients were previously seen at Doctor/CNS LUTS clinic, and only 17% underwent a flow rate. Of the 219 patient requests, 56 (26%) were found to be not indicated according to our local guideline (Figure 1).

Conclusions: Requests were commonly not indicated due to being inappropriate reasons, direct CNS referral from TWOC clinic, premature requests due to knowledge of the long waiting list, and subjective decisions based on experience. Recommendations included: 1. Creating a flow chart for requesting UDS to ensure correct prior investigations and to reduce inappropriate referrals; 2. Consultants to re-review all current non-indicated and pre-HoLEP patients in clinic; 3. Re-audit in 6 months' time to monitor for improvements.



P17-5 Assessing the impact of clinical frailty on Urological unplanned admissions: a retrospective analysis

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Frailty is critical in emergency urology, affecting outcomes, treatment, and resources, although its impact remains undocumented. This study evaluated the Clinical Frailty Scale (CFS), correlation with the Hospital Frailty Risk Score (HFRS) and the impact of frailty on Urological unplanned admissions. Key outcomes assessed included prevalence, admission reasons, readmission rates, 1 year mortality, and length of hospital stay.

A 2-year retrospective analysis of hospital episode statistics was used to calculate HFRS, which was correlated documented CFS.

Results showed 54% of admission was aged 65+ (778/1443), with 33% being moderately or severely frail. CFS was poorly recorded (15/200) but showed a strong correlation with HFRS ($r=0.75$, $p<0.01$). Frailty significantly increased length of stay (6.8 vs. 2.5 days, $p<0.05$) and readmission rates (5.3% vs. 2.6%, $p<0.05$). One-year mortality was worse for frail patients ($p<0.01$, OR: 1.12, 95% CI: 1.08-1.16). Haematuria (76/262) and catheter complications (54/262) were leading admission causes, with frail patients suffering worse catheter-related outcomes.

Urological emergency care has a high frailty burden, leading to poor outcomes. Frailty is poorly recorded using

CFS, but an auto-populated HFRS correlates well to CFS and could provide valuable insights in departments with electronic patient records. Frailty is linked to increased mortality, longer hospital stays, and higher readmission rates, with worse outcomes in catheter-related complications and urosepsis. Routine frailty assessment in older urology patients is crucial for informed treatment decisions and care optimisation. Improved catheter care, innovation, and an understanding of frailty amongst urologist are essential to enhance patient outcomes, healthcare efficiency and service planning.

Statistics and calculations

Demographics

Patient Age	No. of patients
65 and under	665
65+	778
Grand Total	1443
46.08454608	
53.91545392	

	number	average age	% frail
Frail	262	80.5	32.83208
Not frail	536	77.2	67.16792
	798		

Length of stay analysis – t test

T Test: Two-Sample Assuming Unequal Variances		
	0	1
Mean	2.586916	6.873563
Variance	20.92829	164.3109
Observations	536	262
Hypothesized Mean Difference	0	
df	292	
t Stat	-5.24221	
P(T<=t) one-tail	1.52E-07	
t Critical one-tail	1.650089	
P(T<=t) two-tail	3.05E-07	
t Critical two-tail	1.968121	

1 year mortality logistic regression:

SUMMARY OUTPUT								
Regression Statistics								
Chi Square	93.32734							
Residual Dev.	782.6762							
# of iterations	5							
Observations	798							
	Coefficients	Standard Error	P-value	Odd Ratio	Lower 95%	Upper 95%	Lower 95%	Upper 95%
Intercept	-7.34091	1.002323	2.41E-13	0.000648	9.09E-05	0.004624	9.09E-05	0.004624
Age	0.070137	0.012491	1.96E-08	1.072655	1.046714	1.099239	1.046714	1.099239
HFRS	0.114452	0.018172	3.01E-10	1.121259	1.082026	1.161915	1.082026	1.161915

HFRS – CFS correlation calculation (pearson)

Coeff	0.781583266
N	200
T Statistic	17.63038639
DF	198
p value	-1.89593E-42

Chi-squared test for 1 year mortality

Chi square 1 year mortality					
	D	A	Totals	p	
F	87	175	262	x2	1.32E-05
NF	103	433	536		
	190	608	798		
expected	D	A	Totals		
F	62.38095238	199.619	262		
NF	127.6190476	408.381	536		
	190	608	798		

Chi-squared test for readmission rate

readmission (90 days)					
	R	NA	Totals	p	
F	26	236	262	x2	10.5412
NF	22	514	536		
	48	750	798		
expected	D	A	Totals		
F	15.7593985	246.2406	262		
NF	32.2406015	503.7594	536		
	48	750	798		

Chi-squared analysis on mortality in patients who are frail + catheter.

Catheter and frailty					
	D	A	Totals	p	
F	44	62	106	X2	4.8196
NF	50	124	174		
	94	186	280		
expected	D	A	Totals		
F	35.58571	70.41429	106		
NF	58.41429	115.5857	174		
	94	186	280		

P17-6 Antegrade Sclerotherapy for the Treatment of Varicoceles at Wrexham Maelor Hospital: an Effective Minimally-Invasive Procedure

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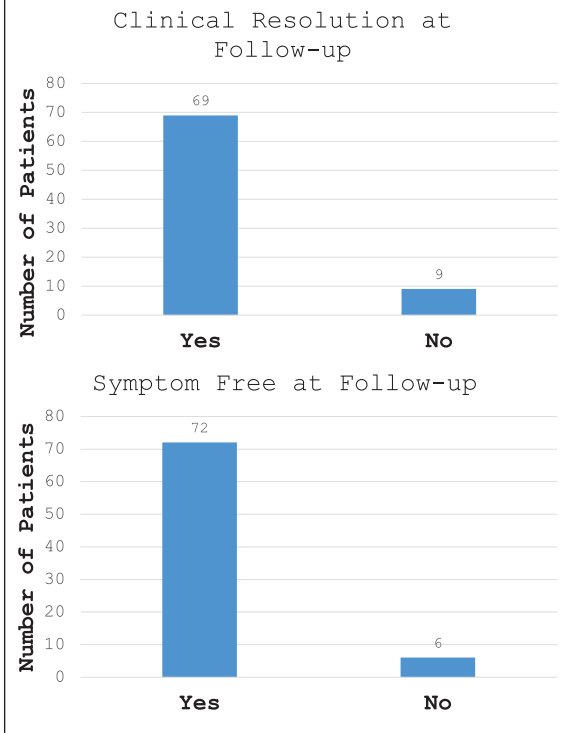
Introduction: Antegrade sclerotherapy is an established minimally invasive procedure used for the management of varicoceles. The aim of this study was to assess the efficacy and safety of antegrade sclerotherapy using 3% Aethoxsklerol in the treatment of varicoceles at a single centre in North Wales.

Patients and Methods: Medical records were retrospectively reviewed for all patients who underwent antegrade sclerotherapy for the treatment of varicoceles between 2005 – 2024 at Wrexham Maelor hospital. The primary outcomes were clinical resolution of varicocele at follow-up, presence of symptoms at follow-up, and incidence of post-operative complications. A secondary outcome was to assess intra-operative radiation exposure.

Results: Seventy eight patients with a median age of 29 (range 11 – 80 years) were included. The most common indication for intervention was pain/discomfort (71%) and almost all patients (77 out of 78) underwent left sided antegrade sclerotherapy. Sixty nine patients (88%) had no residual varicocele at follow-up and seventy two (92%) were symptom free. One case developed a wound infection and scrotal granuloma which resolved without procedural intervention. Median intra-operative radiation exposure was 76.8centigray/cm² (range 13.4 – 226centigray/cm²).

Conclusion: At our centre in North Wales, antegrade sclerotherapy showed a favourable outcome with 88% of cases demonstrating no residual varicocele and 92% of patients reporting resolution of symptoms at follow-up. No major complications were recorded and cases were associated with a low radiation dose. Antegrade sclerotherapy is a safe and effective treatment option for varicoceles.

Grade	Indication	Number
0	Subfertility/infertility	2
	Patient choice	1
1	Pain	0
	Swelling/lump	0
	Subfertility/infertility	0
2	Pain	30
	Swelling/lump	4
	Subfertility/infertility	7
3	Pain	25
	Swelling/lump	7
	Subfertility/infertility	2



P17-7 Does the 3-month renogram predict 24-month outcome after pyeloplasty?

Miss Amy Wombwell¹, Mr Thomas Walton¹

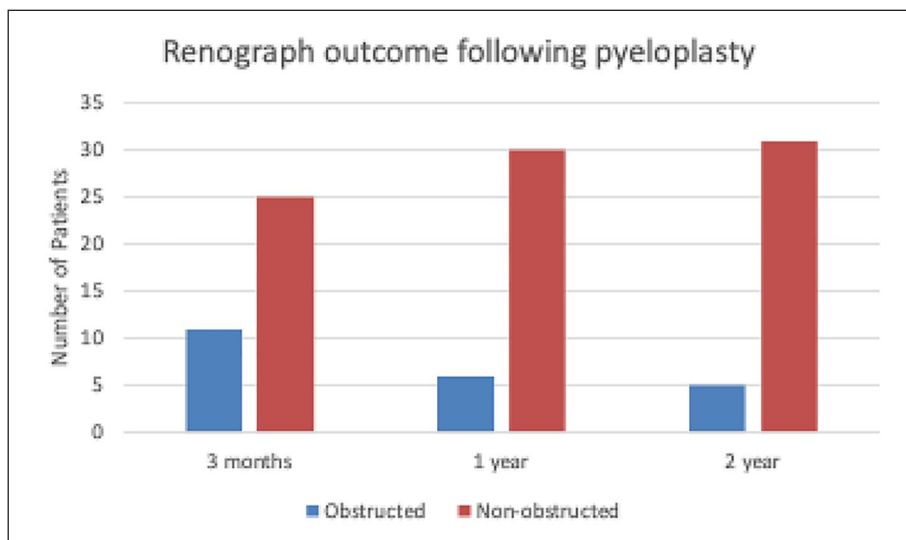
¹Nottingham City Hospital, Nottingham, United Kingdom

Background/Aims: Current literature does not provide robust guidance regarding the length of follow-up after pyeloplasty for pelviureteric junction obstruction (PUJO). We performed a single-surgeon retrospective audit of patients receiving pyeloplasty for PUJO, with the aim of assessing predictive ability of the initial 3-month postoperative renogram.

Methods: Patient demographics, operative data, and pre-operative renography results were collected for 62 patients receiving laparoscopic and robotic pyeloplasty from 2013 – 2021. Patients were excluded if they did not complete post-operative renographic follow-up at 3-months, 12 months and 24 months, leaving 36 evaluable patients.

Results: 25 patients were unobstructed at 3 months and 11 were obstructed at initial 3-month post-operative renography. 24/25 (96%) unobstructed patients remained unobstructed at 2 years. 1 patient (4%) developed a late stricture after 12 months; this patient re-presented with loin pain, and at redo pyeloplasty was found to have a migrated surgical clip causing mechanical obstruction. 6/11 (54%) obstructed patients were unobstructed at 2 years; of these 5/6 (83%) were unobstructed at 1 year.

Conclusions: Our study demonstrates that the initial 3-month post-operative renogram predicts outcome at 2 years. Patients with unobstructed renography at 3 months may therefore be safely discharged, provided they are advised to return if they develop recurrent symptoms. A significant proportion with obstruction at 3 months become unobstructed with extended follow-up. The reasons are not immediately clear, but may relate to resolving oedema following stent removal.



P17-8 Long term safety and benefits of an ambulatory pathway for patients with suspected acute pyelonephritis - the Suspected Acute Pyelonephritis Ambulatory (SAPA) pathway

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Introduction: The risks of unnecessary hospitalisations are well documented. The aim of this project is to demonstrate the safety and longevity of a suspected acute pyelonephritis ambulatory (SAPA) pathway.

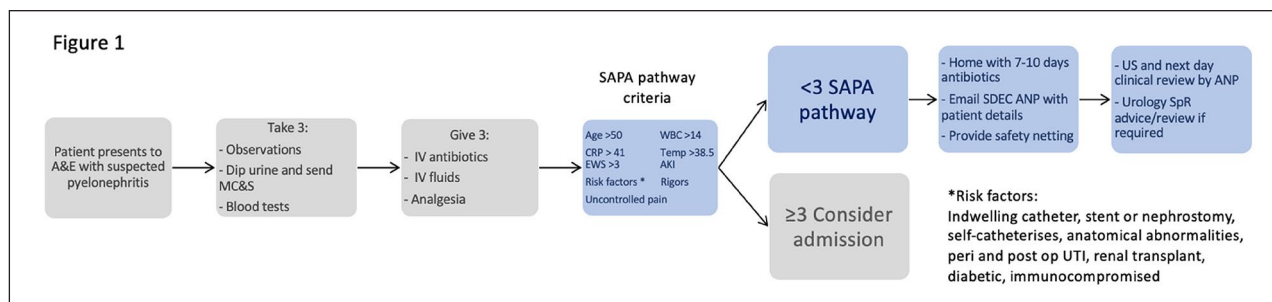
Methods: A baseline audit was performed to define pathway inclusion criteria (figure 1). The SAPA pathway was agreed at governance level and introduced in 2018. Patients who fulfilled the inclusion criteria were given a single dose of intravenous antibiotics and fluids and discharged with seven days of oral antibiotics. They returned for a renal

tract ultrasound and review the following day in surgical same day emergency care (SDEC) by advanced nurse practitioners (ANPs) with the support of the urology on call team. We performed an extended double closed loop audit with cycle one completed in 2019 and cycle two in 2024. Data included patient demographics, blood and ultrasound results and admission within 30 days with pyelonephritis. Cost-saving projections were performed using "The King's Fund" 2022 health economics projections.

Results: In 2018-2019, 73 patients were managed on the SAPA pathway over 52 weeks, and in 2023-2024 45 patients over 26-weeks (combined mean 1.5 patients per week). No patients required admission when reviewed the following day or within 30 days. This has led to an estimated cost saving of £35,500 per year.

Conclusion: We have demonstrated through two audit cycles that this pathway is safe, robust and beneficial. It frees up hospital inpatient beds and doctors' time, as well as reducing costs. These results should provide confidence for other units to adopt this pathway.

Figure 1



P17-9 Impact of Urology Area Network Formation on Day Case Surgery Rates: A Closed-Loop Audit

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Introduction: The establishment of Urology Area Networks (UANs) has been a key recommendation from the Getting It Right First Time (GIRFT) program to enhance the quality and efficiency of urological services and provide comprehensive coverage beyond existing networks across the UK. In 2020, Mid Yorkshire Teaching Trust (MYTT) and Barnsley Hospital NHS Foundation Trust (BHFT) formed a UAN. Initial GIRFT reports revealed notable disparities between the two Trusts: MYTT demonstrated excellent day case rates, particularly for TURBT and bladder outflow obstruction (BOO), while BHFT was significantly below national averages.

Aim: This closed-loop audit aimed to determine whether adopting practices from MYTT could improve day case rates for TURBT, BOO, and ureteroscopy (URS) at BHFT.

Methods: A retrospective audit was conducted (Dec 2022 – June 2023), followed by the implementation of targeted changes. A second prospective audit was then conducted (Aug 2023 – Feb 2024) to evaluate the outcomes.

Interventions: Key interventions included the introduction of HOLEP and bipolar TURP, collaboration with anaesthetics, revised peri-operative guidance for patients with obstructive sleep apnoea (OSA), Mitomycin instillation in theatre and clear postoperative recovery pathways.

Results: Day case surgery rates at BHFT improved significantly: TURBT increased from 44% to 64.4%, BOO from 4% to 23.3%, and URS from 77.5% to 83.3%.

Conclusion: The formation of the UAN facilitated significant improvements in day case rates at BHFT, demonstrating the benefits of collaborative networks in enhancing surgical outcomes in line with GIRFT guidance.

P17-10 Back to the future: Bringing the sewn bowel anastomosis into the 21st century with the robotic approach in radical cystectomy; improving costs and reducing environmental impact

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Introduction: Complete intracorporeal robotic reconstruction is increasingly performed following robotic-assisted radical cystectomy (RARC). While vesicourethral and ureteroileal anastomoses are routinely robot-sewn, bowel anastomoses are often completed using endostaplers, significantly adding to the cost of an already expensive procedure. This study aimed to establish a cost-effective robot-sewn ileoileal anastomosis technique during RARC and audit initial outcomes.

Methods: A prospective cohort study was conducted at a single center, involving two surgeons performing RARC, one of whom employed robot-sewn ileoileal anastomosis. Bowel segments were isolated using cold scissors for bowel dissection and hot scissors for mesentery division. The anastomosis was created using two semicircular single-layer Stratafix running sutures. After completing the anterior wall, the bowel was rotated 180° to facilitate posterior wall suturing. Outcomes were analyzed and reported.

Results: Between October 2023 and December 2024, 29 RARCs were performed, 25 of which included robot-sewn ileoileal anastomosis. The median time for the anastomosis was 40 minutes (IQR 36–48), with a median operative time of 5.5 hours (IQR 5–5.75). Blood loss was 100 mL (IQR 50–200), time to bowel movement was 6 days (IQR 5–6.25), and length of stay was 8 days (IQR 6–9). For stapled anastomoses, times were longer: 47.5 minutes (IQR 41.25–51.75) and 5.8 hours (IQR 5.6–6), respectively. No anastomotic leaks occurred, and the readmission rate was 16%.

Conclusion: This first UK series of robot-sewn ileoileal anastomosis during RARC demonstrated safety, efficacy, and significant cost savings (£8 vs. £1250). These outcomes align with European reports, warranting further studies to validate widespread adoption.

P17-11 Smooth Recovery – Rethinking Catheter Care After Robotic Prostatectomy

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Introduction and Objectives: Patients typically require at least one week of bladder catheterisation following robot assisted radical prostatectomy (RARP). Traditionally this was via the urethral approach. We have recently trialled suprapubic catheterisation (SPC) to improve patient experience following major cancer surgery. Our aim is to evaluate and compare Patient Reported Experience Measures (PREMs) on patient satisfaction with urethral catheterisation (UC) and SPC.

Materials and Methods: We developed a PREM questionnaire and asked all patients from January 2023 to March 2024 reporting on their experience with SPC care. Exclusions were those with intraoperative complications, leaks or salvage cases.

Patients were contacted at least 2 weeks after catheter removal. Data was collected on discomfort, care, pre and post operative information given and an objective score on a vas scale of 1 to 10 was given. Scores of 1 to 3 were categorised into very good, 4 to 7 as ok and 8 to 10 as very poor experiences. Questions regarding complications were also gathered.

Results: UC vs SPC discomfort - very good (37% vs 85%), ok (29% vs 14%), very poor (33% vs 1%)

UC vs SPC care - very good (64% vs 95%), ok (23% vs 5%), very poor (14% vs 0%)

P value <0.001

SPC complications – 2 required antibiotics

UC complications – 2 required antibiotics, 4 required A&E attendance for blocked urethral catheter

Conclusion: SPC is far superior to UC for patient experience in the recovery period following routine RARP and has become the standard in our local department.

P17-12 Treatment strategy does not alter oncological outcomes in older patients with small renal masses

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Introduction: Between November 2023-2024, 67% of patients seen in our Scottish renal surgical clinic between were aged ≥ 70 years. Improved access to healthcare and imaging has increased the diagnosis of incidental small

renal masses (SRMs), which are managed with active surveillance (AS), nephron-sparing surgery (NSS) or radical nephrectomy (RN).

Patients and Methods: The aim of this study was to analyse the differences in recurrence-free survival (RFS), cancer specific survival (CSS), overall survival (OS) and new chronic kidney disease (CKD) in patients aged ≥ 70 years, with a SRM (cT1aN0M0) diagnosed in Scotland between January 2012 and 2020 who were managed with AS, NSS or RN. This was a retrospective analysis of a prospectively maintained database from the Scottish Renal Cancer Consortium. All patients had at least two computed-tomography scans during follow-up.

Results: There were 247 patients included in the cohort (131 AS, 67 NSS and 49 RN). Patients in the AS group were older (median 79 years, $p < 0.05$) with a lower 5-year OS compared to NSS and RN groups, suggestive of selection bias. However, there was no significant difference in 5-year CSS ($p = 0.779$) or RFS ($p = 0.585$) between groups. New CKD was commoner in the RN group ($p < 0.05$) but there was no significant difference in 5-year OS between the NSS and RN groups ($p = 0.121$).

Conclusion: There is no significant difference in oncological outcomes between SRM management approaches in older patients in Scotland. Further work to understand patient treatment selection and predict tumour lethality is warranted to personalize management.

P17-13 Neobladder reconstruction after cystectomy: contemporary experience in a single-centre series

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Introduction: Some 80-100 patients require cystectomy each year in Ireland, but only a minority are suitable for neobladder reconstruction. Adequate physical dexterity and cognitive capacity are required to adhere to a strict post-operative neobladder care regimen. The aim of this study was to review our contemporary experience with this super-selected group of patients.

Methods: Consecutive patients undergoing cystectomy with neobladder reconstruction from 2005 to 2024 were retrospectively identified from a prospectively maintained cancer database. Clinicopathological characteristics, operative details, and outcomes were recorded.

Results: Fourteen patients were included, with mean age 54.6 years. All patients had bladder cancer, three with high-risk, non-muscle-invasive disease, and the remainder with $\geq T2$ disease. Ten Studer and 1 Mainz II pouch were formed for 11 male patients [1, 2]. Three female patients underwent Indiana pouch reconstruction [3]. Mean length of stay was 17 days. Mean follow-up was 62.8 months. Three

patients (21.4%) had a documented admission with urosepsis during this period. Three of 11 (27.3%) patients with Studer pouches self catheterise, with the remainder voiding voluntarily. No significant decrease in renal function over time was noted. One patient developed pancreatic cancer and died. Notably, all other patients remain alive and free of recurrence. This partially reflects their index fitness and favourable clinicopathologic characteristics.

Conclusion: Even when performed infrequently, this series demonstrates the long-term success of neobladder reconstruction. The favourable oncologic and functional outcomes in this cohort partially reflect the highly selected nature of the group. Neobladder reconstruction should remain an option for bladder cancer patients in Ireland.

P17-14 Adherence to acute testicular pain pathway and antimicrobial guidance for adult patients with suspected/confirmed epididymo-orchitis

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Introduction: Epididymo-orchitis requires appropriate antibiotic therapy based on clinical guidelines, including the suspicion of sexually transmitted infections (STIs) and patient age.

Aim: To assess if antibiotics prescribed for epididymo-orchitis align with trust and microbiology guidelines, specifically regarding age and STI suspicion.

Methods: Data from patients presenting with suspected epididymo-orchitis from 02/09/24 to 30/10/2024 were analyzed, focusing on antibiotic choice, sexual history documentation, and adherence to STI treatment guidelines. Follow-up care, including testicular ultrasound and outpatient urology referrals, was also assessed.

Results: Urine dipstick testing was conducted in 94% of patients and outpatient testicular ultrasound (USS) in 71%, with 21.4% of USS results confirming epididymo-orchitis. However, urine microbiological culture (MCS) was performed in only 18% of patients, and sexual history documentation was only 55%. Additionally, 31% of patients aged ≤ 35 years received the recommended ceftriaxone and doxycycline regimen. For those over 35 years, 39% ciprofloxacin was the popular choice.

Conclusion: Antibiotic guidelines for epididymo-orchitis should recommend IM Ceftriaxone and Doxycycline for sexually active males under 35, and revise options for patients over 35. To improve care, the frequency of urine MCS testing and documentation of sexual history should be increased with staff education and information dissemination.