

South Thames Urology Regional Meeting



Thursday 5th May
Education Centre
St George's Hospital

St George's Healthcare 
NHS Trust

Programme

0900 **STC Meeting (STC only)**

1230 **Lunch with sponsors (All)** – Education centre

1330 **Welcome and Introduction**

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

Novel ways of tunnelling extra-anatomical urinary diversion stents in obstructed kidneys in patients with advanced malignancy or complex benign ureteric disease

Ayres B, Edirsinghe K, Watson G
Eastbourne District General Hospital

Seven years of Robot-Assisted Radical Prostatectomy (RARP) at Guy's Hospital

Kumar P, Cahill D, Challacombe B, Popert R, Dasgupta P
Guy's and St Thomas' NHS Trust

MRI staging of prostate cancer: results from two District General Hospitals

Smith N, Bourghli I, Crundwell N, Plail R
Conquest Hospital & East Sussex Hospitals NHS Trust

Patient satisfaction following onabotulinumtoxinA treatment for refractory overactive bladder

Frasier O, Watkins J, Dowson C, Khan M, Dasgupta P, Sahai A
Guy's and St Thomas' NHS Trust

T3 renal cell carcinoma: has the TNM classification (7th version) got it right?

Sarkar S, Ghani KR, Mukhtar S, Nikolaou Thomas J, Corbishley C, Anderson CJ
St George's Healthcare NHS Trust

Tumour recurrence after open partial nephrectomy (OPN) for renal cancer (RCC) – lessons learnt from up to 11 years of follow up

Patel A, Ray E, Horsfield C, Chandra A, O'Brien T
Guy's and St Thomas' NHS Trust

Benefits of embarking on a robotic nephro-ureterectomy programme for surgeon and patient.

Zakri RH, Magrill D, Emaru A, Kommu S, Hindley R, Barber N
Frimley Park Hospital

1500 **Afternoon tea with sponsors**

1540 Presentations – 2nd Session

Incidental Renal Calculi in Potential Live Kidney Donors: Prevalence, Assessment and Role of Ex-Vivo Ureteroscopy

Wong K, Thomas K, Glass J, Smith N, Smith J, Rottenberg G, Hilton R, Olsburgh J
Guy's and St Thomas' NHS Trust

Prognostic significance of extracapsular spread (ECS) in inguinal nodes in penile cancer

Alnajjar HM, Tinwell B, Rajab R, Perry MJA, Corbishley CM, Watkin NA
St George's Healthcare NHS Trust

Is Routine Diuresis Renography Indicated After Pyeloplasty ?

Fernando AS, Ghani KR, Issa R, Le Roux PJ, Anderson CJ
St George's Healthcare NHS Trust

Holmium Laser Enucleation of the Prostate (HoLEP) in the octo- and nonagenarian: An evaluation of surgical outcome and quality of life

Nair R, Ahmed S, Cynk M
Maidstone and Tunbridge Wells NHS Trust

Measuring and Improving the Quality of TURBT

Nedas T, Mostafid H
North Hampshire Hospital

Outcome of treatment of high-risk non muscle-invasive bladder cancer with mitomycin hyperthermia with a minimum follow-up of two years.

Mukhtar S, Al-Najjar H, Durrant J, Connor A, Corbishley C, Bailey MJ
St George's Healthcare NHS Trust

Initial experience with a Randomised Controlled Trial of Open, Robotic, and Laparoscopic (CORAL) Radical Cystectomy: An interim report

Patel A, Ismail F, O'Brien TS, Rimington P, Dasgupta P, Khan MS
Guy's and St Thomas' NHS Trust, & Eastbourne District General Hospital

1700 Prize announcement and close

1730 Drinks –

1900 Dinner – Sree Krishna South Indian Restaurant, 192 Tooting High Street

Abstracts

Novel ways of tunnelling extra-anatomical urinary diversion stents in obstructed kidneys in patients with advanced malignancy or complex benign ureteric disease

Ayres B, Edirsinghe K, Watson G
Eastbourne District General Hospital

Introduction The management of obstructed kidneys in advanced malignancy and complex benign ureteric disease can prove challenging. We present our experience of extra-anatomical urinary diversion stents, including tunnelling them in a novel way to ileal conduits or to skin as a stoma.

Patients and Methods Since June 2010 thirteen silicone-PTFE-bonded DETOUR extra-anatomic stents (Mentor Porgès) were placed in ten patients who had failed nephrostomy / ureteric stent drainage. The causes of ureteric obstruction were advanced malignant disease in five, complicated ureteroileal strictures following bladder cancer treatment in four and complicated stricture disease in one patient.

Results Median age was 77 years (55-83) and median Charlson co-morbidity index was 6.5 (4-12). Two patients died of their metastatic disease 207 and 53 days following their procedures. The remaining eight patients are alive with functioning diversions at a median follow-up of 165 days (18-276) with stable or improved renal function. Median length of hospital stay was 9.5 days (1-18) and four patients suffered infective complications despite prophylactic antibiotics (2 Clavien II and 2 Clavien IV). Three DETOUR stents were tunnelled to the patient's bladder, four to ileal conduits and six (all bilateral) to skin as a stoma.

Conclusions Extra-anatomical urinary diversion stents are an alternative to ureteric stents and nephrostomies in patients with obstructed kidneys due to malignancy or complex benign disease unsuitable for reconstructive surgery. Infective complications were common despite antibiotic prophylaxis. In our experience they can be tunnelled to sites other than the bladder, although our follow-up is short.

Seven years of Robot-Assisted Radical Prostatectomy (RARP) at Guy's Hospital

Kumar P, Cahill D, Challacombe B, Popert R, Dasgupta P
Guy's and St Thomas' NHS Trust

Introduction The daVinci robotic system is playing an increasingly important role in radical prostatectomy worldwide. The number of UK systems has increased from 2 to 27 over seven years. We have performed RARP since 2004 at Guy's Hospital and present our experience to date with this approach.

Methods Data was collected both prospectively and retrospectively on all RARPs performed on NHS patients at Guy's Hospital between June 2004 and January 2011.

Results Data has been recorded on 540 consecutive RARPs carried out at Guy's. Average age is 61 years, presenting PSA 10ng/ml. Average operative time is 164 minutes, blood loss 324ml and prostate size 56g. 41% of patients are discharged to home after one night, 33% after two nights. Transfusion rate is 0.7% and incidence of Clavien III and IV complications rate at 60 days is 1.5% (including 2 rectal injuries). Bladder neck stenosis rate is 0.8% and continence at 1 year 95% (defined as single pad/day for security). 321 patients (59%) had pT2 disease on definitive pathology with a positive margin rate of 8%. 179 patients had extracapsular extension and 35 patients seminal vesicle invasion (pT3a–33% and pT3b–6% of all patients). Four patients had pT4 disease.

Conclusions RARP has evolved over seven years with surgeons striving to achieve improved outcomes for their patients. This series includes two open, one laparoscopic and one fellowship trained surgeon all of whom have successfully and safely made the transition to RARP. In addition six trainees have commenced independent practice in robotic surgery at other institutions.

MRI staging of prostate cancer: results from two District General Hospitals

Smith N, Bourghli I, Crundwell N, Plail R

Conquest Hospital & East Sussex Hospitals NHS Trust

Introduction: Magnetic resonance imaging (MRI) is commonly used to stage prostate cancer prior to radical prostatectomy in selected cases. Technological advancements and the introduction of multiparametric MRI have suggested a potential role in tumour detection, localisation and characterisation. We audited the accuracy of MRI staging, using 1/1.5 Tesla scanners, in patients undergoing radical prostatectomy at two District General Hospitals between March 1994 and August 2010.

Methods: Patients were identified using a prospective database. Contemporaneous electronic pathology and radiology reports were reviewed. SPSS was used for data analysis.

Results: Of 368 radical prostatectomy patients, 102 were eligible for inclusion. The study population characteristics were: median age 62 (44-71); median pre-operative Gleason score 6 (4-9); median DRE stage T1c (T1b-T3a). MRI staging results were: T1 25.5%; T2 50%; T3a 23.5% and T3b 1%. Radiologically significant nodes were identified in 1%. Pathological staging was compromised in 15.7% due to positive margins. Of the remaining specimens: 57% were pT2; 25.6% pT3a and 17.4% pT3b. No involved nodes were found at histological examination. MRI understaged the pathology in 51% of cases; overstaged pathology in 10% and was in agreement in 39%. In 34% the MRI accurately localised the prostate cancer. Patients in whom MRI overstaged pathology had a shorter period between prostate biopsy and MRI (not statistically significant).

Conclusions: The recent European Consensus Recommendations on MR imaging in prostate cancer suggest improved concordance with modern equipment and sequences. The 'minimum requirements' advocated by the authors provide a basis for discussion and improvement, particularly in institutions such as ours.

Patient satisfaction following onabotulinumtoxinA treatment for refractory overactive bladder

Frasier O, Watkins J, Dowson C, Khan M, Dasgupta P, Sahai A

Guy's and St Thomas' NHS Trust

Introduction OnabotulinumtoxinA treatment has proven to be a useful second line treatment option for refractory overactive bladder (OAB). Our aim was to evaluate all patients who had undergone onabotulinumtoxinA injections at our institution with a focus on patient satisfaction.

Patients and methods Data collection was retrospective and via telephone survey. Patients were asked specific questions devised by the clinical team about their current and future treatment options and the client satisfaction questionnaire (CSQ-8). The cohort consisted of patients with OAB symptoms and idiopathic detrusor overactivity refractory to anticholinergics. The majority of patients received 200 U onabotulinumtoxinA (Botox®) via flexible cystoscopy. Patients were re-injected when they reported a return of symptoms.

Results Complete data was available on 72 patients giving a response rate of 69%. Patients had received a varied number of injections. Of those contacted, 68% were continuing to have onabotulinumtoxinA injections. The overall CSQ-8 score was 28.3 out of a maximum 32. CSQ-8 scores in those who are currently continuing to receive onabotulinumtoxinA injections versus those who have stopped were 29.8 +/- 3.3 (SD) and 25.1 +/- 4.6 (SD), respectively ($p < 0.001$). For those not on onabotulinumtoxinA treatment the majority of patients were managing their bladder with either no treatment or anticholinergics and the minority with sacral neuromodulation. Only 1 patient that we are aware of has had clam ileocystoplasty.

Conclusion There appears to be very high satisfaction with onabotulinumtoxinA treatment for patients with OAB symptoms and refractory IDO.

T3 renal cell carcinoma: has the TNM classification (7th version) got it right?

Sarkar S, Ghani KR, Mukhtar S, Nikolaou Thomas J, Corbishley C, Anderson CJ
St George's Healthcare NHS Trust

Introduction: The classification of T3a and T3b has been subject of debate. The 7th version of TNM downstages renal vein involvement to T3a and upstages adrenal involvement to T4. Renal sinus involvement remains in T3a. We evaluated whether these changes correlated with our clinical experience.

Patients and Methods: From a prospective database we identified patients with T3a and T3b disease (TNM 6th version) over a ten-year period. We assessed median survival data to determine the variables that influence prognosis.

Results: The mean follow up period was 4.3 years (range 0.4 – 11 years). T3a/b disease was detected in 88 patients. Mean tumour size was 8.7 cm. Overall median survival was 22 months (9 lost to follow-up). Median survival for T3a (n=39) and T3b (n=40) were equivalent (22 vs. 22.9 months respectively). Renal sinus invasion conferred a poorer prognosis in patients with T3a or T3b compared to those without (15.5 vs. 42.1 months) ($p = 0.032$) and (18.7 vs. 61.7 months) ($p=0.03$). Capsular invasion in T3b disease conferred a poorer prognosis compared to T3b without capsular invasion (11.3 vs. 42.4 months). Overall, adrenal involvement conferred a poorer prognosis (11.2 months). Simultaneous renal sinus involvement led to an even worse survival.

Conclusion: These findings support the reclassification of adrenal involvement into T4 and renal vein involvement into T3a as per the 7th TNM version. Renal sinus conferred a poorer prognosis compared to other T3a variables. Its placement in this category is debatable and requires further evaluation.

Tumour recurrence after open partial nephrectomy (OPN) for renal cancer (RCC) – lessons learnt from up to 11 years of follow up

Patel A, Ray E, Horsfield C, Chandra A, O'Brien T
Guy's and St Thomas' NHS Trust

Introduction: OPN is now considered an effective treatment of localised RCC in elective and imperative settings. However it remains relatively underused in the treatment of RCC. Only with long-term follow-up will we be able to determine the true incidence of local and systemic recurrence. Furthermore, a benchmark is needed against which new technologies & surgical techniques can be judged.

Patients and Methods: We reviewed the results of 137 OPN's performed in a single institution by a single surgeon for suspected cancer between August 1999 and October 2010. 59/137 (43%) OPN's were for imperative indications (single kidney / renal impairment / bilateral tumours); 70/137(51%) OPN's were for elective indications (tumour <4cm & normal contralateral kidney); and 8 /137 (6%) for VHL. Median follow-up was 42 months (range 3 to129). Follow up comprised clinical review; imaging. Tumour recurrence was judged by imaging/biopsy.

Results: In 106/137 (77%) the final histological diagnosis was cancer. 23 non-VHL tumours were multifocal at presentation. Final histological stage was T1a=68; T1b=22; T2=3; T3a=5; and T3b=8. Positive margins were seen in 7 cases - all in imperative indications. Overall, cancer recurrence was seen in 8 patients (local recurrence only in 4; systemic recurrence only in 2, both local and systemic recurrence in 2). Recurrences were only seen after imperative OPN or VHL.

Conclusion: OPN with negative margins for T1 RCC in the elective setting can be considered curative. Follow up for recurrence should be concentrated on patients with multifocal tumours, bilateral tumours, T3 tumours, and VHL.

Benefits of embarking on a robotic nephro-ureterectomy programme for surgeon and patient.

Zakri RH, Magrill D, Emaru A, Kommu S, Hindley R, Barber N
Frimley Park Hospital

Introduction & Objective: Since the basic principles of virtual reality were introduced in the form of robotics during the 1980s, robot assisted operations have added a new dimension to the operative field. Having presented our technique, we aim to compare our initial experience of using the Da Vinci robot against standards set by laparoscopy for nephro-ureterectomies.

Materials & Methods: Since March 2010, 13 robot assisted nephro-ureterectomies have been performed at our centre. Data for this prospective, non-randomised study, compares this robot-assisted transperitoneal series to the most recent thirteen extraperitoneal laparoscopic procedures. Primary and secondary outcome measures were compared.

Results: Patient ages in both groups were 65.2 vs 64.8yrs. Mean operative time was longer with the robotic technique (221mins vs 188 mins). This did quickly improve however, to a constant range of 195 - 210 mins after the first 3 cases reflecting the published learning curves of the surgeon, assistant and theatre staff. Mean blood loss was 27 ml for robotic patients, with no conversions. This compares favorably with 215ml blood loss and one conversion in the laparoscopic series. Median post-operative length of stay was 2 days after robotic and 5 days after laparoscopic surgery.

Conclusion: Early data from our robotic series is encouraging, and compares favorably to our most contemporary comparable laparoscopic group. The patients suffered less blood loss, left hospital sooner and were catheter free much earlier. There would, therefore, appear to be benefits for patient, surgeon and hospital alike in developing the robot assisted nephro-ureterectomy programme further.

Incidental Renal Calculi in Potential Live Kidney Donors: Prevalence, Assessment and Role of Ex-Vivo Ureteroscopy

Wong K, Thomas K, Glass J, Smith N, Smith J, Rottenberg G, Hilton R, Olsburgh J
Guy's and St Thomas' NHS Trust

Introduction: We evaluated the incidence of incidental asymptomatic nephrolithiasis in our potential donor population and assessed the safety and success of ex-vivo ureteroscopy (ExURS) in removing stones from explanted donor kidneys.

Methods: A retrospective analysis of 377 CT angiograms for potential kidney donors was carried out to assess the incidence of asymptomatic renal stones. Potential kidney donors with stones were investigated with metabolic screening, EDTA GFR measurement and DMSA scan before proceeding to donation. For suitable donors, ExURS was performed with a flexible ureteroscope. Stones were removed with basket extraction or fragmented with Holmium laser. Donors were followed with yearly ultrasound scan of the remaining kidney.

Results: Review of 377 CT angiograms showed a 5% incidence of asymptomatic nephrolithiasis (n=19). 6 people were selected to proceed to donation with bench ExURS. In all but one case, ExURS was successful. In another case the kidney was found to be stone free. In three cases, laser lithotripsy was employed to clear the stones and in one case basket extraction was used. There was no post-operative allograft dysfunction or ureteric complications. At a mean follow-up of 26.8 months, there has been no recurrence of stone in either the donors' remaining kidney or the recipients' transplant kidney.

Conclusion: Asymptomatic renal calculi are present in 1 in 20 of our donors. Kidney donation should be considered in this group. ExURS can safely be used to render the kidney stone-free prior to transplantation.

Prognostic significance of extracapsular spread (ECS) in inguinal nodes in penile cancer

Alnajjar HM, Tinwell B, Rajab R, Perry MJA, Corbishley CM, Watkin NA
St George's Healthcare NHS Trust

Introduction: ECS in lymph nodes reflects the aggressiveness of a malignant disease, as reported in other cancers in the literature. ECS appears to have an important prognostic indicator in squamous cell carcinoma of the penis (SCCp). The objective of this study was to confirm ECS as an important prognostic indicator and measure 5-year cancer-specific survival of SCCp in a contemporary cohort based on ECS in inguinal nodes.

Materials & Methods: Prospective single centre cohort study from April 2000 to April 2010. Only primary SCCp with inguinal ECS were included in the study. Inguinal nodal basins with ECS were categorized into pN1 or pN2 groups. 5-year cancer-specific survival was calculated by Kaplan-Meier curves according to pN status with and without ECS, with statistical difference calculated by the Log-rank test.

Results: 40 SCCp cases with ECS of the inguinal nodes were identified from our prospective database over the 10 year period. 5-year cancer-specific survival in pN1 group with ECS is 25% vs. 100% without ECS and pN2 with ECS is 27% vs. 81.5% without ECS ($P < 0.0001$).

	pN1 (no ECS)	pN1 (ECS)	pN2 (no ECS)	pN2 (ECS)
N	26	12	16	28
Deaths	0	6	2	16
Median Survival	-	22 months	-	12 months

Conclusion Inguinal ECS is an independent prognostic indicator. Patients with inguinal ECS have significantly reduced survival rates and poorer outcomes. ECS group should be under close surveillance. Chemoradiotherapy for this group of patients should be considered at an early stage of their treatment.

Is Routine Diuresis Renography Indicated After Pyeloplasty ?

Fernando AS, Ghani KR, Issa R, Le Roux PJ, Anderson CJ
St George's Healthcare NHS Trust

Introduction Predicting improvement or failure after pyeloplasty using diuresis renography (MAG3) can be difficult. We assessed the reliability of renography in establishing outcomes after pyeloplasty.

Patients and Methods We retrospectively reviewed all patients who had a pyeloplasty performed by two surgeons since 2003. All had pre-operative and 3 month post-operative MAG3 scans, and at 12 months if necessary. Comparison was made between pre- and post-operative symptoms and MAG3 renogram results.

Results 64 patients had pyeloplasty (laparoscopic 52, robotic-assisted 8, open 4). Mean follow up was 22 months. Indications were pain in 60 (94%), remainder were UTI or stone. Pre-operatively, 61 (95%) were unequivocally obstructed on MAG3 renogram. Post pyeloplasty, 53 (83%) patients were asymptomatic. Of these, 44 (83%) had an improvement in their MAG3. Partial or unequivocal obstruction was detected in 9 (17%) of which 8 were asymptomatic and satisfied with their outcome, did not deteriorate on follow-up MAG3 and were discharged. Only 1 warranted further intervention. Of 11 (17%) patients that remained symptomatic, 9 had an improved renogram (unobstructed); 2 had an unchanged renogram with only 1 requiring further intervention. There was no statistical significance between MAG3 outcomes based on presence/absence of symptoms ($p=0.61$, Fisher Exact Test). MAG3 changed management in only 1 of 53 (2%) asymptomatic patients.

Conclusion MAG3 renogram is of arguable benefit in asymptomatic patients after pyeloplasty. In those that remain symptomatic the renogram is mainly of benefit in reassuring the clinician and patient. We propose that after pyeloplasty asymptomatic patients do not require routine renography.

Holmium Laser Enucleation of the Prostate (HoLEP) in the octo- and nonagenarian: An evaluation of surgical outcome and quality of life

Nair R, Ahmed S, Cynk M

Maidstone and Tunbridge Wells NHS Trust

Introduction Co-morbidity in the elderly makes transurethral surgery for obstructive prostatic disease a surgical and anaesthetic challenge. Although morbidity and outcome of HoLEP is well documented, there is need for critical evaluation of surgical and quality of life outcomes in the over 80-year-old undergoing this procedure.

Patients and Methods A prospective single-centre review of 340 HoLEPs was performed between February 2003 and December 2010. 52 cases were performed in patients over the age of 80 (range 80-93) and compared to 133 cases in patients aged 60-69. Co-morbidities were quantified using the Charlson Co-morbidity Index (CCI), and peri- and post-operative complications recorded. International Prostate Symptom Score (IPSS), urine flowmetry and catheter free survival was evaluated post-operatively.

Results The CCI for the over 80-year-old was significantly higher than the 60-69 age group. 52% underwent HoLEP for urinary retention in octo-and nonagenarians compared with 31% in those aged 60-69. Despite these adverse factors, there was no statistical difference in complications or length of stay, and no deaths were observed within 30 days of surgery. Significant flow rate and IPSS improvements were observed in both groups. Catheter free survival at 18 months (range 3-48) was 92% in the over 80-year-old and 97% in the 60-69 age group respectively.

Conclusion HoLEP is feasible, safe and effective in the over 80-year-old. This series demonstrates no difference in objective outcome between this age group and those aged 60-69. Catheter free survival is significant, and patients should not be denied surgery based on age alone.

Measuring and Improving the Quality of TURBT

Nedas T, Mostafid H

North Hampshire Hospital

Introduction TURBT is the most common urological operation performed to treat cancer and despite having been first described nearly 50 years ago outcomes and outcome measures remain widely variable and subject to debate. The aims of TURBT are to identify and remove completely all tumours from within the bladder, to provide adequate tissue for correct pathological staging and to detect areas of dysplasia or carcinoma in situ within the bladder.

Recent studies have described the 3 month recurrence rate, the presence of muscle in the specimen and understaging confirmed at re-TURBT as potential quality measures for TURBT. Furthermore photodynamic diagnosis and narrow band imaging are thought to offer an improved TURBT.

Materials and Methods Data concerning the primary TURBT for all patients under the care of a single consultant in a single institution was prospectively collected from 2001 to 2010. A single dose of intravesical mitomycin C instilled in theatre post resection was introduced in 2002. Photodynamic diagnosis (PDD) using hexaluminavanate was introduced in 2007.

Results 597 primary TURBT's were performed (265 with PDD). Recurrence at 3 months fell from 20% in 2001 to 6% in 2010 and similarly residual tumour at 4 weeks fell from 50% to 20%. Where muscle was present in T1 tumours understaging did not occur.

Conclusions Prospective audit of TURBT outcome is vital to allow improvement and to assess the impact of modifications to the procedure. Local data analysis can be used to alter department protocol (pathology reporting, list planning) to improve outcome.

Outcome of treatment of high-risk non muscle-invasive bladder cancer with mitomycin hyperthermia with a minimum follow-up of two years.

Mukhtar S, Al-Najjar H, Durrant J, Connor A, Corbishley C, Bailey MJ
St George's Healthcare NHS Trust

Introduction Mitomycin-hyperthermia (MMC-H) may be an alternative to cystectomy in patients with high-risk non muscle-invasive bladder cancer (HRNMIBC) who have failed other intravesical therapy. We present the results of treatment with MMC-H in patients with HRNMIBC who have a minimum of two years follow-up.

Methods Between 2006 and 2010, 51 patients have been treated with MMC-H at our institution. The treatment schedule has been described previously. All patients underwent regular cystoscopic follow-up. Only patients with a minimum complete follow-up of two years were included.

Results Data was available for 25 patients, of whom 18 are male. Median age was 71.5 years and median follow-up was 31.4 months. Three patients underwent cystectomy for recurrent disease (all still non-muscle invasive), one patient had radiotherapy for progression to T2 disease and one patient died from metastatic disease. Two patients developed disease outside the bladder (one upper tract, one urethral). Treatment failures occurred between 3 and 18 months after starting therapy. There were two deaths during this period from other causes. Disease specific survival was 96% with bladder preservation rate of 92%.

Conclusion In this very high risk group, MMC-H represents an alternative option to cystectomy. The durability of the procedure still requires longer term evaluation, but two year data is encouraging.

Initial experience with a Randomised Controlled Trial of Open, Robotic, and Laparoscopic (CORAL) Radical Cystectomy: An interim report

Patel A, Ismail F, O'Brien TS, Rimington P, Dasgupta P, Khan MS
Guy's and St Thomas' NHS Trust, & Eastbourne District General Hospital

Introduction Open radical cystectomy (ORC) is the gold standard for treatment of muscle invasive bladder cancer. Laparoscopic (LC) and robot-assisted (RALC) Radical cystectomy have now emerged as viable alternatives to ORC. There is limited evidence of the relative benefits of one technique over another. We report our experience in recruitment, and the interim results in terms of the complication rates, peri-operative and short term oncological outcomes.

Methods We have designed a single-centre prospective randomised trial to include all patients with high-risk bladder cancer, and fit for all approaches to RC with curative intent. 42 patients met the inclusion criteria, and 33(71%) agreed to be randomised. Of those who have undergone surgery 13 had ORC, 9 RALC and 11 LC. There were 2 conversions: 1 from RARC to ORC, and 1 from LRC to RARC. The primary endpoint is complication rates. Secondary endpoints include demographic characteristics, peri-operative and pathologic results.

Results Mean operating time was 283 for ORC, 376 for RALC and 308 minutes for LC. Estimated blood loss was 750mls for ORC, 456 mls for RALC and 465mls for LC. Mean hospital stay was 12.6 days (9-21) for ORC, 8.7days (5-17) RALC and 8.6 (5-14) days for LC. Mean Lymph node yield was, 21.9, 12.3 and 16 for ORC, RALC and LC respectively. Overall complication rate were 54, 33 and 27% for ORC, RALC and LC respectively.

Conclusion RALC and LC appear to be evenly matched in outcomes from surgery in terms of length of stay, complications rates and estimated blood loss. ORC has relatively greater lymph node yield and shorter operative time as compared to minimally invasive RC. However our interim results have not shown any statistically significant differences between the different surgical approaches as yet. Our study is on-going and hope to present further results in the future.

Directions

The postgraduate education centre is located at the rear of the hospital on the perimeter road. Please follow signs to Knightsbridge Wing / Buckland ward and exit the hospital. The education centre is sited directly opposite across the perimeter road.

By tube

From Central London, take the Northern Line south to Morden and get off at Tooting Broadway station which is a five minute walk from the hospital.

By bus

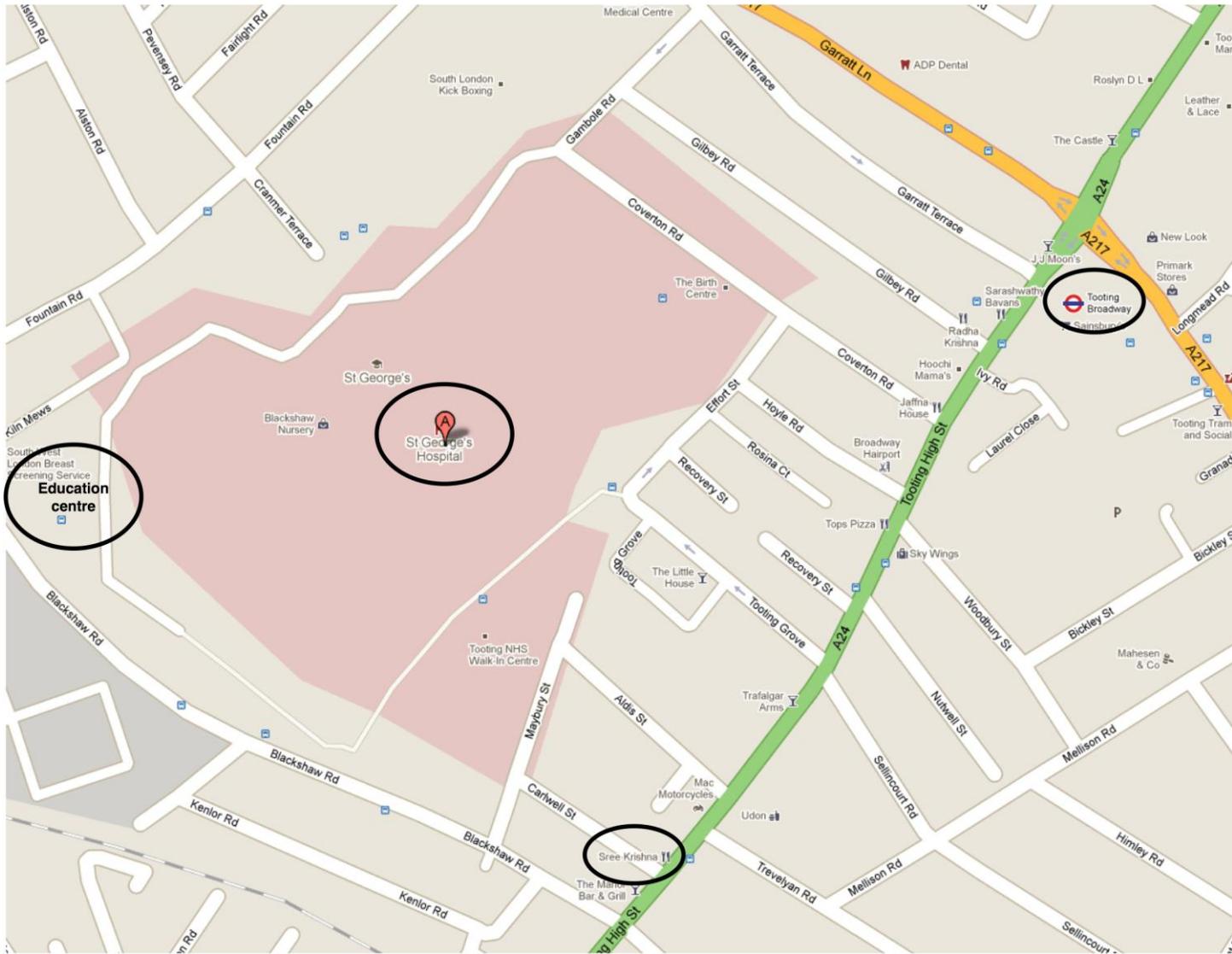
Buses to Tooting are: 44, 64, 77, 88, 155, 264, 270, 280, 355.

By train

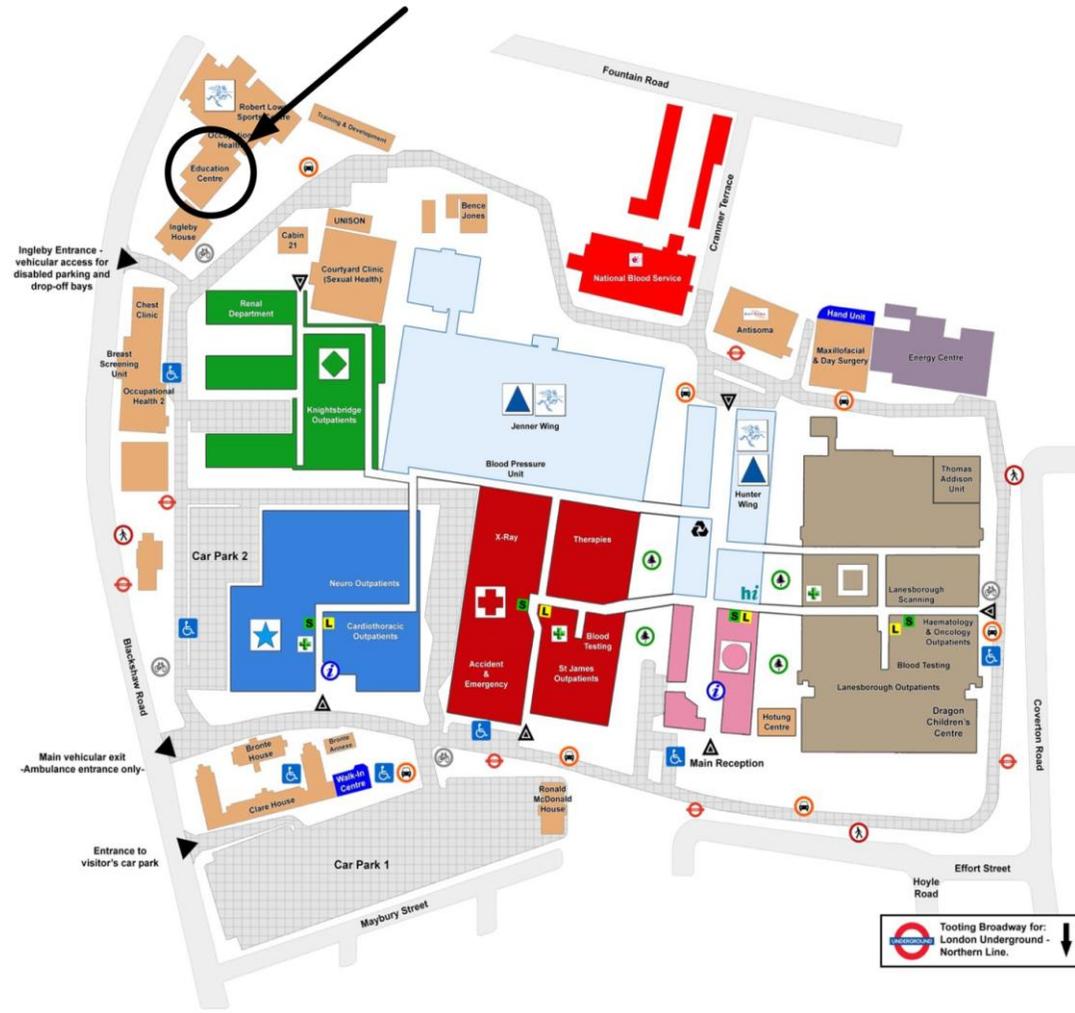
By rail to Wimbledon station then either hail a taxi or use the 57 bus to Tooting Broadway.

By car

Parking at St. George's is limited, there is no parking on site apart from the customer 'pay and display' car park and there are also pay and display meters on the public roads around the Hospital.



St. George's Hospital



- Atkinson Morley wing
 - St. James wing
 - Lanesborough wing
 - Knightsbridge wing
 - Grosvenor wing
 - Hunter wing
 - Jenner wing
 - St George's University of London
-
- Stairs
 - Lifts
 - Entrance to wing
 - Pharmacy
 - Information
 - Health Information
 - Natwest Bank/ATM
 - Disabled parking
 - Drop-off point
 - Cycle shelter
 - Pedestrian access
 - Bus stop
 - Garden
 - Perimeter road



Day buses including 24-hour services

Bus route	Stops	Bus stop
44	Stamford	Stamford
47	Stamford	Stamford
57	Stamford	Stamford
77	Stamford	Stamford
112	Stamford	Stamford
113	Stamford	Stamford
115	Stamford	Stamford
116	Stamford	Stamford
117	Stamford	Stamford
118	Stamford	Stamford
119	Stamford	Stamford
120	Stamford	Stamford
121	Stamford	Stamford
122	Stamford	Stamford
123	Stamford	Stamford
124	Stamford	Stamford
125	Stamford	Stamford
126	Stamford	Stamford
127	Stamford	Stamford
128	Stamford	Stamford
129	Stamford	Stamford
130	Stamford	Stamford
131	Stamford	Stamford
132	Stamford	Stamford
133	Stamford	Stamford
134	Stamford	Stamford
135	Stamford	Stamford
136	Stamford	Stamford
137	Stamford	Stamford
138	Stamford	Stamford
139	Stamford	Stamford
140	Stamford	Stamford
141	Stamford	Stamford
142	Stamford	Stamford
143	Stamford	Stamford
144	Stamford	Stamford
145	Stamford	Stamford
146	Stamford	Stamford
147	Stamford	Stamford
148	Stamford	Stamford
149	Stamford	Stamford
150	Stamford	Stamford
151	Stamford	Stamford
152	Stamford	Stamford
153	Stamford	Stamford
154	Stamford	Stamford
155	Stamford	Stamford
156	Stamford	Stamford
157	Stamford	Stamford
158	Stamford	Stamford
159	Stamford	Stamford
160	Stamford	Stamford
161	Stamford	Stamford
162	Stamford	Stamford
163	Stamford	Stamford
164	Stamford	Stamford
165	Stamford	Stamford
166	Stamford	Stamford
167	Stamford	Stamford
168	Stamford	Stamford
169	Stamford	Stamford
170	Stamford	Stamford
171	Stamford	Stamford
172	Stamford	Stamford
173	Stamford	Stamford
174	Stamford	Stamford
175	Stamford	Stamford
176	Stamford	Stamford
177	Stamford	Stamford
178	Stamford	Stamford
179	Stamford	Stamford
180	Stamford	Stamford
181	Stamford	Stamford
182	Stamford	Stamford
183	Stamford	Stamford
184	Stamford	Stamford
185	Stamford	Stamford
186	Stamford	Stamford
187	Stamford	Stamford
188	Stamford	Stamford
189	Stamford	Stamford
190	Stamford	Stamford
191	Stamford	Stamford
192	Stamford	Stamford
193	Stamford	Stamford
194	Stamford	Stamford
195	Stamford	Stamford
196	Stamford	Stamford
197	Stamford	Stamford
198	Stamford	Stamford
199	Stamford	Stamford
200	Stamford	Stamford

Night buses

Bus route	Stops	Bus stop
N44	Stamford	Stamford
N131	Stamford	Stamford
N155	Stamford	Stamford

Tooting Broadway for London Underground - Northern Line.