2023 SESAUA
ANNUAL MEETING
PROGRAM BOOK

AMELIA ISLAND

87th SESAUA 2023

Southeastern Section of the AUA, Inc.
87th Annual Meeting
March 15 – 18, 2023
The Ritz-Carlton Amelia Island
Amelia Island, Florida

2023 SESAUA
ANNUAL MEETING

S. Duke Herrell III, MD, FACS

2022 - 2023 President

Southeastern Section of the AUA, Inc.

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SCHEDULE AT A GLANCE

WEDNESDAY, MARCH 15

All sessions will be located in ***Talbot DE*** unless otherwise noted.

OVERVIEW

7:00 a.m. - 5:45 p.m.	**Registration/Information Desk Open**: *Talbot Pre-Function*
7:00 a.m. - 11:00 a.m.	**Board of Directors Meeting**: *Plaza Ballroom*
7:30 a.m. - 10:30 a.m.	**Spouse/Guest Hospitality Suite Open**: *Tidewater Grill*
10:30 a.m. - 5:45 p.m.	**Speaker Ready Room Open**: *Cumberland Room*
6:00 p.m. - 8:00 p.m.	**Welcome Reception**: *Salons 1-3*

GENERAL SESSION

11:00 a.m.	**Industry Sponsored Lunch Symposium:** *Talbot A-C*				
12:15 p.m.	**Opening Remarks**				
12:30 p.m.	**State-of-the-Art Lecture: An Update on GU Cancer Survivorship**				
1:00 p.m.	**Panel Discussion: Current Strategies in Testis Cancer**				
1:45 p.m.	**State-of-the-Art Lecture: The Role of the Microbiome in Bladder Cancer**				
2:15 p.m.	**Break:** *Talbot Pre-Function*				
2:30 p.m.	**State-of-the-Art Lecture: Prostate Biopsy in 2023: What Should I Know?**				
3:00 p.m.	**Panel Discussion: Treating Enlarged Prostates and LUTS in the Low Risk Prostate Cancer Patient**				
3:45 p.m.	**Montague Boyd Essay Contest: Finalist Presentations**				
4:15 p.m.	**Break:** *Talbot Pre-Function*				
4:30 p.m.	**Men's Health, Sexual Dysfunction and Infertility Podium Session** *Talbot A-C*	**Bladder Cancer Podium Session** *Talbot DE*	**Health Services Research and Socioeconomics Poster Session** *Plaza I*	**Prostate Cancer Poster Session** *Plaza II*	**Video Session I** *Talbot F-H*

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THURSDAY, MARCH 16

All sessions will be located in ***Talbot DE*** unless otherwise noted.

OVERVIEW

6:00 a.m. - 5:30 p.m.	**Registration/Information Desk Open**: *Talbot Pre-Function*
6:00 a.m. - 5:30 p.m.	**Speaker Ready Room Open**: *Cumberland Room*
7:30 a.m. - 10:30 a.m.	**Spouse/Guest Hospitality Suite Open**: *Tidewater Grill*
8:30 a.m. - 3:30 p.m.	**Exhibit Hall Open**: *Salons 1-3*

GENERAL SESSION

6:00 a.m.	**Industry Sponsored Breakfast Symposium:** *Talbot A-C*			
7:00 a.m.	**Men's Health and BPH Podium Session** *Talbot DE*	**Education and Simulation Podium Session** *Talbot F-H*	**Reconstructive Surgery, Voiding Dysfunction, and Female Pelvic Medicine Poster Session** *Plaza I*	**Kidney - Malignant and Benign Poster Session** *Plaza II*
8:30 a.m.	**Break/Visit Exhibits:** *Salons 1-3*			
9:00 a.m.	**AUA Course of Choice Lecture: Urological Trauma & Reconstruction**			
9:45 a.m.	**SESAUA Update**			
10:00 a.m.	**Break/Visit Exhibits:** *Salons 1-3*			
10:30 a.m.	**State-of-the-Art Lecture: Is There Value in Making Your Patient "Stone Free"?**			
11:00 a.m.	**Panel Discussion: Complex Urethral Reconstruction: Tips and Tricks**			
11:45 a.m.	**State-of-the-Art Lecture: Advanced Imaging for Prostate Cancer: What's Changed?**			
12:15 p.m.	**Industry Sponsored Lunch Symposium:** *Talbot F-H*		**Industry Sponsored Lunch Symposium:** *Talbot A-C*	
1:15 p.m.	**Break - Visit Exhibits:** *Salons 1-3*			
1:45 p.m.	**Ballenger Memorial Lecture: Lower Urinary Tract Symptoms following surgical treatment of BPE: how a better preoperative assessment can help avoid persistent LUTS**			
2:30 p.m.	**SESAUA History Lecture**			
2:45 p.m.	**Break/Visit Exhibits:** *Salons 1-3*			
3:15 p.m.	**Endourology Sub-Plenary Session** *Talbot DE*	**Pediatric Sub-Plenary Session** *Talbot F-H*	**Renal Tumors Sub-Plenary Session II** *Talbot A-C*	***3:15 p.m. - 4:15 p.m.*** **Men's Health, Sexual Dysfunction and Infertility Poster Session** *Plaza I* ***4:30 p.m. - 5:30 p.m.*** **Bladder Cancer Poster Session** *Plaza II*

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FRIDAY, MARCH 17

All sessions will be located in ***Talbot DE*** unless otherwise noted.

OVERVIEW

6:30 a.m. - 7:00 a.m.	**Breakfast:** *Salons 1-3*
6:30 a.m. - 1:15 p.m.	**Registration/Information Desk Open**: *Talbot Pre-Function*
6:00 a.m. - 1:15 p.m.	**Speaker Ready Room Open:** *Cumberland Room*
7:30 a.m. - 10:30 a.m.	**Spouse/Guest Hospitality Suite Open**: *Tidewater Grill*
7:30 a.m. - 11:30 a.m.	**Exhibit Hall Open**: *Salons 1-3*
6:30 p.m. - 10:00 p.m.	**Residents' Night Out**: *Ocean Front Lawn* *Sponsored by South Georgia Medical Center* *(Invite Only)*

GENERAL SESSION

7:00 a.m.	**Health Services Research Podium Session** *Talbot DE*	**Reconstructive Urology Podium Session** *Talbot F-H*	**Miscellaneous I Poster Session** *Plaza I*	**Pediatrics Poster Session** *Plaza II*
7:45 a.m.	**Break/Visit Exhibits:** *Salons 1-3*			
8:15 a.m.	**ABU Update**			
8:30 a.m.	**Gee-Dineen Health Policy Forum I:** **State-of-the-Art Lecture: Role of Private Equity in Medicine**			
9:00 a.m.	**Gee-Dineen Health Policy Forum I:** **Panel Discussion: The Next Generation of Urologists: What Will They Need to be Successful and How do we Need to Teach Them Now?**			
10:00 a.m.	**State-of-the-Art Lecture: Moving the Needle in Surgical Simulation: 3D Printing, Augmented Reality, and Artificial Intelligence**			
10:30 a.m.	**Break/Visit Exhibits:** *Salons 1-3*			
11:00 a.m.	**SESAUA Annual Business Meeting**			
11:45 a.m.	**AUA Update**			
12:00 p.m.	**AUA QIPS**			
12:15 p.m.	**Resident Quiz Bowl**			
1:15 p.m.	**Industry Sponsored Lunch Symposium:** *Talbot A-C*			

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SATURDAY, MARCH 18

All sessions will be located in ***Talbot DE*** unless otherwise noted.

OVERVIEW

6:30 a.m. - 5:00 p.m.	**Registration/Information Desk Open**: *Talbot Pre-Function*
6:30 a.m. - 5:00 p.m.	**Speaker Ready Room Open**: *Cumberland Room*
7:30 a.m. - 10:30 a.m.	**Spouse/Guest Hospitality Suite Open**: *Tidewater Grill*
6:00 p.m. - 8:00 p.m.	**SESAUA Closing Reception**: *Ocean Front Lawn*

GENERAL SESSION

6:30 a.m.	**Industry Sponsored Breakfast Symposium**: *Talbot A-C*			
7:30 a.m.	**Prostate Cancer Podium Session** *Talbot DE*	**Female Pelvic Medicine and Reconstructive Surgery Podium Session** *Talbot F-H*	**Miscellaneous Poster Session** *Plaza I*	**Video Session II** *Talbot F-H*
8:30 a.m.	**Break**: *Talbot Pre-Function*			
8:45 a.m.	**State-of-the-Art Lecture: Restorative Therapies in Erectile Dysfunction**			
9:15 a.m.	**Gee-Dineen Health Policy Forum II: Panel Discussion - The First Years in Practice: What Did I Have to Learn for Myself?**			
10:00 a.m.	**W. Bedford Waters Memorial Lecture: How Mentoring is Changing Urology**			
10:45 a.m.	**Break**: *Talbot Pre-Function*			
11:00 a.m.	**International Volunteerism Program**			
11:15 a.m.	**Gee-Dineen Health Policy Forum II: Ambrose Reed Lecture: Hospital Care at Home – New Models**			
12:00 p.m.	**Industry Sponsored Lunch Symposium**: *Talbot A-C*			
1:15 p.m.	**Presidential Lecture: What Have Our Patients Taught Us About Kidney Cancer in the Last 20 Years?**			
2:00 p.m.	**T. Leon Howard Imaging Competition**			
3:00 p.m.	**Break**: *Talbot Pre-Function*			
3:15 p.m.	**Hector Henry Memorial Lecture: What Military Medicine Taught Me**			
3:45 p.m.	**State-of-the-Art Lecture: Modern Management of GU Soft Tissue Sarcoma**			
4:15 p.m.	**State-of-the-Art Lecture: When Do I Convert Active Surveillance to Active Therapy in Prostate Cancer?**			
4:45 p.m.	**Best Abstracts Announcement and Awards Presentation**			

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MISSION STATEMENT

To be the professional organization in the southeastern United States that fosters the highest standards of urologic care through education, research and socioeconomic awareness. The Southeastern Section of the American Urological Association goals:

Support excellence in urologic care of patients

- Education of urologists
- Encourage research
- Forum for presentation of:
  - Clinical interest
  - Clinical and basic research
  - Support the AUA in healthcare policy and share ideas with the AUA, Inc.

CONTACT INFORMATION

To expedite the business of the SESAUA, inquiries should be referred to the SESAUA Secretary or the SESAUA office as follows:

SESAUA Secretary:
Chad W.M. Ritenour, MD
Emory University, Dept. of Urology
1365 Clifton Rd., NE
Suite #B1400
Atlanta, GA 30322

Phone: (404) 778-4615 Fax: (404) 778-4231 Email: criteno@emory.edu

- All inquiries and information regarding the scientific program of the annual meeting.

SESAUA Office:
Two Woodfield Lake
1100 E. Woodfield Road, Suite 350
Schaumburg, IL 60173-5121

Phone: (847) 969-0248 Fax: (847) 517-7229 Email: info@sesaua.org

Executive Director: Heather Swanson, M.A.Ed.

- Inquiries about or applications for membership in the SESAUA and the AUA
- Membership roster information *(changes/corrections to the present listing)*
- Any requests or information that one may wish to communicate
- All inquiries and reports regarding the standing and special committees of the SESAUA
- All matters needing the attention of or action by the Executive Committee

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CME INFORMATION

EDUCATIONAL NEEDS

Ongoing learning to mitigate practice gaps is important, and the SESAUA recognizes its duty to provide education to its members to improve overall knowledge. The Annual Meeting and the accompanying scientific program address the educational need for expert-led discussions regarding current topics in urology. Through a combination of lectures and question-and-answer formats, the planning committee has approved this program as a forum to provide state-of-the-art educational content relevant to its members and guests. Moreover, advancements in medical science and progress in management of various urologic diseases require basic and clinical research. Presentation and discussion of such peer-reviewed and peer-selected summaries and results of investigations provide "cutting edge" updates for practicing clinicians as well as essential feedback to researchers on the practical applications and translation of their investigations to clinical practice.

EDUCATIONAL OBJECTIVES

At the conclusion of the 87th Annual Meeting of the Southeastern Section of the AUA, attendees will be able to:

- Apply guidelines and best strategies in evaluation and management of urologic oncology patients, including those with prostate, bladder, kidney, and other cancers.
- Review issues related to care of men with benign prostatic hypertrophy.
- Apply latest guidelines in evaluation and management of patients with urologic trauma and reconstructive surgical needs.
- Discuss medical and surgical management for patients presenting with nephrolithiasis
- Identify strategies to employ in pediatric urologic patients presenting with common conditions.
- Describe new techniques for teaching and learning urology as well as recent socioeconomic changes impacting urologic care.
- Report up-to-date information for managing patients with urologic conditions in the outpatient setting.
- Integrate new technologies for surgical management of urologic patients.

FACULTY DISCLOSURE REPORT

View the disclosure report for this meeting at sesaua.org/disclosures.

AUA ACCREDITATION INFORMATION

Accreditation: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Urological Association (AUA) and the Southeastern Section of the AUA (SESAUA). The AUA is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation: The American Urological Association designates this live activity for a maximum of **24.00** *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Other Learners: The AUA is not accredited to offer credit to participants who are not MDs or DOs. However, the AUA will issue documentation of participation that states that the activity was certified for *AMA PRA Category 1 Credit™*.

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Evidence Based Content: It is the policy of the AUA to ensure that the content contained in this CME activity is valid, fair, balanced, scientifically rigorous, and free of commercial bias.

AUA Disclosure Policy: All persons in a position to control the content of an educational activity (i.e., activity planners, presenters, authors) are required to disclose to the provider all financial relationships with any commercial interest during the previous 24 months. The AUA must determine if the individual's relationships may influence the educational content and mitigate any conflicts of interest prior to the commencement of the educational activity. The intent of this disclosure is not to prevent individuals with relevant financial relationships from participating, but rather to provide learners information with which they can make their own judgments.

Mitigation of Identified Conflict of Interest: All disclosures will be reviewed by the AUA Conflict of Interest (COI) Review Work Group Chair and/or Vice Chair for identification of conflicts of interest. The AUA COI Review Work Group, working with Office of Education staff, will document the mechanism(s) for management and mitigation of the conflict of interest and final approval of the activity will be documented prior to implementation. Any of the mechanisms below can/will be used to mitigate conflict of interest:

Peer review for valid, evidence-based content by the AUA COI Review Work Group.

- Limit content to evidence with no recommendations
- Introduction of a debate format with an unbiased moderator (point-counterpoint)
- Inclusion of moderated panel discussion
- Publication of a parallel or rebuttal article for an article that is felt to be biased
- Limit equipment representatives to providing logistics and operation support only in procedural demonstrations
- Divestiture of the relationship by faculty
- Selection of alternative faculty for specific topic

Off-label or Unapproved Use of Drugs or Devices: The audience is advised that this continuing medical education activity may contain reference(s) to off-label or unapproved uses of drugs or devices. Please consult the prescribing information for full disclosure of approved uses.

AUA PARTICIPANT INFORMATION & POLICIES

Disclaimer: The opinions and recommendations expressed by faculty, authors and other experts whose input is included in this program are their own and do not necessarily represent the viewpoint of the AUA.

Consent to Use of Photographic Images: Attendance at or participation in AUA meetings and other activities constitutes an agreement by the registrant to AUA's use and distribution (both now and in the future) of the attendee's image or voice in photographs and electronic reproductions of such meetings and activities.

Audio, Video and Photographic Equipment: The use of audio, video and other photographic recording equipment by attendees is prohibited inside AUA meeting rooms.

Reproduction Permission: Reproduction of written materials developed for this AUA course is prohibited without the written permission from individual authors and the AUA.

Special Assistance/Dietary Needs: The AUA complies with the Americans with Disabilities Act §12112(a). If any participant is in need of special assistance or has any dietary restrictions, please see the registration desk.

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ONLINE CME SUBMISSION INSTRUCTIONS

The easiest and greenest way to collect CME submissions is through the online worksheet.

If you are eligible to receive CME credits from this meeting, the CME Certification Worksheet will open Saturday, March 18 at 7:30 a.m. Eastern Time and close on Sunday, April 9 at 11:59 p.m. Central Time.

1. **Record your attendance.** Attendees should claim only credit commensurate with the extent of their participation in the activity. When complete, click the "Submit CME Time Claimed" button.

   The CME submission form may be accessed via **sesaua.org/cme** or by scanning the QR code below.

2. **Complete Evaluation.** Approximately four weeks post-meeting, you will receive an email with a link to the CME Evaluation Survey. Follow the link to complete the survey online. The CME Evaluation will be open for 60 days.

3. **Access your Certificate.** Following your completion of the CME Evaluation Survey, you will be redirected to the AUA website where you will need to sign-in to have access to your certificate.

For physicians to officially receive *AMA PRA Category 1 Credit™* and for other healthcare providers to document their attendance, participants are required to complete both this attendance worksheet and the activity evaluation online.

Attendance and evaluations will be tracked.

If you have difficulties with the online CME submission, you may contact us via email at cmeinfo@wjweiser.com or via phone during regular business hours at (847) 969-0248.

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GENERAL MEETING INFORMATION

Scientific Program

SESAUA Secretary, Chad W.M. Ritenour, MD, has planned a dynamic program that is certain to provide practicing urologists cutting-edge information. Detailed information about the scientific program begins on page XX.

Registration/Information Desk Hours

Location: Talbot Pre-Function

Wednesday, March 15	7:00 a.m. – 5:00 p.m.
Thursday, March 16	6:00 a.m. – 5:15 p.m.
Friday, March 17	6:30 a.m. – 1:00 p.m.
Saturday, March 18	6:30 a.m. – 5:00 p.m.

Exhibit Hall Hours

Location: Salons 1-3

Wednesday, March 15	6:00 p.m. – 8:00 p.m.
Thursday, March 16	8:30 a.m. – 3:30 p.m.
Friday, March 17	7:30 a.m. – 11:30 a.m.

Speaker Ready Room

Location: Cumberland Room

Wednesday, March 15	7:00 a.m. – 5:45 p.m.
Thursday, March 16	6:00 a.m. – 5:15 p.m.
Friday, March 17	6:30 a.m. – 1:00 p.m.
Saturday, March 18	6:30 a.m. – 5:00 p.m.

Spouse/Guest Hospitality Suite Hours

Location: Tidewater Grill

Wednesday, March 15	7:30 a.m. – 10:30 a.m.
Thursday, March 16	7:30 a.m. – 10:30 a.m.
Friday, March 17	7:30 a.m. – 10:30 a.m.
Saturday, March 18	7:30 a.m. – 10:30 a.m.

Social Media

Tag your posts on social media with **#SESAUA23** to follow along and connect with other attendees at the 86th Annual Meeting. Follow SESAUA on Facebook at facebook.com/sesaua and Twitter at twitter.com/sesaua.

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BOARD OF DIRECTORS AND COMMITTEE MEETINGS

Executive Committee Lunch
Location: Boardroom

Tuesday, March 14 — 12:00 p.m.

Executive Committee Meeting
Location: Boardroom

Tuesday, March 14 — 1:00 p.m. – 5:00 p.m.

Board of Directors Meeting
Location: Plaza Ballroom

Wednesday, March 15 — 7:00 a.m. – 11:00 a.m.

Nominating Committee Meeting
Location: Magnolia Room

Thursday, March 16 — 7:00 a.m. – 8:00 a.m.

Breakfast will be served

Health Policy Council Meeting
Location: Magnolia Room

Thursday, March 16 — 12:00 p.m. – 1:15 p.m.

Lunch will be served

Residents Committee Meeting
Location: Magnolia Room

Friday, March 17 — 2:00 p.m. – 3:00 p.m.

Annual Business Meeting
The SESAUA Annual Business Meeting will be held on Friday, March 17 from 11:00 a.m. - 11:45 a.m. in *Talbot DE*. Only Members of SESAUA are able to attend. Please note that only active, senior members, and those Active and Senior members who are elected to Honorary Membership are eligible to vote. Members do not need to be registered for the scientific portion of the conference to attend the Annual Business Meeting.

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EVENING FUNCTIONS

One ticket to each evening function is included with attendee & guest registration fees.

Welcome Reception

Location: Salons 1-3
Attire: Business Casual

Wednesday, March 15 6:00 p.m. – 8:00 p.m.

Welcome to Amelia Island! Come enjoy a drink, wonderful cuisine, and entertainment while catching up with colleagues and meeting our exhibitors.

One ticket is included with registration, additional tickets are $150.00 for adults and complimentary for children.

Closing Reception

Location: Ocean Front Lawn
Attire: Resort Casual

Saturday, March 18 6:00 p.m. – 8:00 p.m.

The 2023 Closing Reception will be a night to remember. Attendees will enjoy cocktails and hors d'oeuvres while reflecting on the Annual Meeting.

One ticket is included with registration and additional tickets are $85.00.

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INDUSTRY SUPPORT

The SESAUA wishes to thank and recognize all of our 2023 industry partners.

PROMOTIONAL PARTNERS

Platinum Level

Astellas Pharma and Pfizer Oncology

Bayer HealthCare

Janssen Biotech, Inc.

Merck & Co., Inc.

Myovant/Pfizer

Pacific Edge Diagnostics USA Ltd

Urovant Sciences

Gold Level

Axonics, Inc.

Boston Scientific Corporation

Dendreon Pharmaceuticals LLC

MDxHealth

Medtronic

Silver Level

Blue Earth Diagnostics, Inc.

Cleveland Diagnostics, Inc.

Coloplast

Fujifilm Healthcare

HealthTronics, Inc.

Lantheus

LynxDx

MedArbor Diagnostics

PROCEPT BioRobotics

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EXHIBITORS

Alnylam Pharmaceuticals, Inc.

American Urological Association

Astellas Pharma and Pfizer Oncology

Axonics, Inc.

Ballad Health

Bayer HealthCare

Biobot Surgical U.S. Inc.

BioTE Medical, LLC

BK Medical

Blue Earth Diagnostics, Inc.

Boston Scientific Corporation

CirrusDx

Cleveland Diagnostics

Coloplast

Cook Medical

Decipher Urologic Cancers

Dendreon Pharmaceuticals

Dornier MedTech

Endo Pharmaceuticals

Evexias

Exosome Diagnostics

Fellow

Fujifilm Healthcare

GenPath Urology

Guerbet, LLC

HealthTronics, Inc.

HIFU Prostate Services

Imbrium Therapeutics LP

Janssen Biotech, Inc.

Karl STORZ

Lantheus

Levee Medical, Inc.

LynxDx

Mazon Sales Associates, LLC

MDxHealth

MedArbor Diagnostics

Medtronic

Merck & Co., Inc.

Myovant/Pfizer

Natera

NextMed, LLC

Olympus America Inc.

Pacific Edge Diagnostics USA Ltd

Photocure

Prisma Health

PROCEPT BioRobotics

Richard Wolf Medical Instruments Corporation

Siemens Healthineers

Solaris Health

Solv Wellness, LLC

Sonablate Corp.

South Georgia Medical Center

Southern Litho LLC

Teleflex Interventional Urology

Theralogix

UroGen Pharma

Urovant Sciences

Valencia Technologies

Verity Pharmaceuticals

Zida LLC

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INDUSTRY SYMPOSIUM EVENTS

Wednesday, March 15

11:00 a.m. - 12:00 p.m.

Industry Sponsored Lunch Symposium
Sponsored by: Janssen Biotech, Inc.
Location: Talbot A-C

"ERLEADA® (apalutamide)—For the Treatment of Patients With: Metastatic Castration-Sensitive Prostate Cancer (mCSPC)"

Judd Moul, MD & David Morris, MD

Thursday, March 16

6:00 a.m. - 7:00 a.m.

Industry Sponsored Breakfast Symposium
Sponsored by: Myovant/Pfizer
Location: Talbot A-C

"A GnRH Antagonist Treatment Option for Advanced Prostate Cancer"

Vahan S. Kassabian, MD

12:15 p.m. - 1:15 p.m.

Industry Sponsored Lunch Symposium
Sponsored by: Pacific Edge Diagnostics USA Ltd
Location: Talbot A-C

"Cxbladder® Detect and Monitor: Current Trends and Future Directions for Bladder Cancer Diagnostics"

Siamak Daneshmand, MD

12:15 p.m. - 1:15 p.m.

Industry Sponsored Lunch Symposium
Sponsored by: Urovant Sciences
Location: Talbot F-H

"Discover the Impact of GEMTESA: A Selective β3-Adrenergic Agonist for Effective OAB Treatment"

Alan J. Wein, MD, PhD(hon), FACS
Shenelle N. Wilson, MD

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Friday, March 17

1:15 p.m. - 2:15 p.m.

Industry Sponsored Lunch Symposium
Sponsored by: Bayer HealthCare
Location: Talbot A-C

"Nubeqa (darolutamide) efficacy and tolerability in mHSPC in combination with docetaxel and in nmCRPC"

Vahan S Kassabian, MD

Saturday, March 18

6:30 a.m. - 7:30 a.m.

Industry Sponsored Breakfast Symposium
Sponsored by: Merck & Co., Inc.
Location: Talbot A-C

"A Treatment Option for Certain Patients With RCC in the Adjuvant Setting"

Vahan S Kassabian, MD

12:00 p.m. - 1:15 p.m.

Industry Sponsored Lunch Symposium
Sponsored by: Astellas Pharma and Pfizer Oncology
Location: Talbot A-C

"Exploring Clinical Evidence of a Treatment Option for Metastatic Castration-Sensitive Prostate Cancer"

Scott Sellinger, MD

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NAMED LECTURES AND CONTESTS

The Ballenger Memorial Lecture
Dr. Edgar Ballenger was the Southeastern Section president in 1935 and president of the AUA in 1939. The Annual Ballenger Memorial Lectureship was established after his death in 1946 and serves as our major scientific presentation.

Gary Lemack, MD, is a Professor and Vice Chair of Education in the Department of Urology UT Southwestern Medical Center and is the holder of the Rose Mary Haggar and Helen J. and Robert S. Strauss Professorships. He and has a secondary appointment in the Department of Neurology. He is board certified in Urology and Female Pelvic Medicine and Reconstructive Surgery. He served as the Residency Program Director in the Department of Urology from 2006-2021 and was the Program Director for the Female Pelvic Medicine and Reconstructive Surgery Fellowship from 2014-2019.

His clinical specialties include urinary incontinence, pelvic organ prolapse, overactive bladder, and voiding dysfunction in the setting of neurologic disease. In particular, he cares for patients with bladder conditions stemming from spinal cord injury, multiple sclerosis, and movement disorders such as Parkinson's Disease. He performs complex urinary diversions for patients with severe bladder disorders due to congenital and advanced neurological diseases.

Dr. Lemack earned his medical degree from Cornell University and performed his residency at The New York Hospital – Cornell Medical Center. His fellowship training at UT Southwestern focused on incontinence, urodynamics, and neurourology. Dr. Lemack has been a faculty member at UT Southwestern since 1999.

Dr. Lemack's clinical research has focused on the use of urodynamic studies in patients with lower urinary tract dysfunction/incontinence, and on establishing best urological practices in the care of patients with multiple sclerosis, spinal cord injury, and other neurological conditions. He was one of the original nine sites for the NIDDK funded Urinary Incontinence Treatment Network.

Dr. Lemack is a Past President of the Society of Urodynamics, Female Pelvic Medicine, and Urogenital Reconstruction (SUFU). He has earned both the Paul Zimskind and Distinguished Service awards from SUFU, two of the highest honors that the Society bestows. He is President of The American Board of Urology and currently serves at the Chair of the Oral Examination Committee for the Board.

Dr. Lemack has been a co-author for three guidelines from the American Urological Association (Urodynamics, Stress Urinary Incontinence and Neurogenic Lower Urinary Tract Dysfunction). He also served as the lone American representative on The European Association of Urology Incontinence Guidelines. He has authored over 160 original articles and over 25 book chapters. He has been Visiting Professor at 25 locations throughout the United States, South and Central America and Australia.

The T. Leon Howard Imaging Conference
Dr. T. Leon Howard was president of the South Central Section in 1932. He was a founding trustee of the American Board of Urology in 1934 and AUA president in 1941. He became an honorary member of the Southeastern Section in 1947.

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The Gee-Dineen Health Policy Forum
The Gee-Dineen Health Policy Forum will examine the impact of government health policy, physician payment reform, and the interaction between quality patient care and the pressures of trying to practice medicine amid ever increasing government regulation. These sessions serve to honor Drs. William Gee and Martin Dineen, past presidents of the Section, for the major contributions they have made to the socioeconomic issues at both the section and national levels.

The Montague Boyd Prize Essay Contest
Dr. Montague Boyd was the founder of the Southeastern Section, and he served as president in 1933 and 1934. The prize was established in 1967 and is given to a resident, fellow, or urologist in private practice less than 10 years.


The Ambrose-Reed Lecture
Dr. Samuel Ambrose was the Southeastern Section president in 1975 and in 1981 became the first chairman of the AUA Public Relations Committee, later to be called the Socioeconomic Committee. Dr. Mason, who served as president, formed this committee, which later became the Health Policy Council.

Dr. Josiah Reed was the Southeastern Section president in 1992 and chairman of the AUA Socioeconomic Committee in 1986. This award honors these two pioneers in the field of health policy.

Michael J. Maniaci, MD is the Medical Director of Virtual Care in Mayo Clinic's Center for Digital Health, the enterprise physician lead for the Advanced Care at Home program, and the Medical Director of Mayo Clinic Hospital in Florida. Dr. Maniaci holds the academic rank of Associate Professor of Medicine in Mayo Clinic College of Medicine and Science.

Dr. Maniaci received his M.D. from Saint Louis University Medical School. He completed his residency training in internal medicine at Mayo Clinic School of Graduate Medical Education, where he then completed a one-year Chief Residency Program. Following completion of his training in 2007, he joined the Hospital Internal Medicine Practice at Mayo Clinic in Florida.

Dr. Maniaci has a passion for innovation and technology in the medical field. He is recognized as a leader in faculty development for the teaching of simulation medicine and has had several invited professorships to teach faculty development in simulation both in the United States and throughout Asia. His current focus is developing the Advanced Care at Home program and the Care Hotel program, Mayo Clinic's first expansion into the virtual home hospital and surgical aftercare realm.

Dr. Maniaci's previous leadership positions include the Chair of the Division of Hospital Internal Medicine in Florida, the Associate Chair of Inpatient Practice for the Department of Medicine in Florida, the Associate Program Director for the Internal Medicine Residency Program, the Associate Medical Director of the Mayo Clinic Multidisciplinary Simulation Center, and the Medical Director of Patient Experience in Florida.

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2023 Presidential Lecturer: Mohamad E. Allaf, MD
Dr. Mohamad Allaf is professor of urology and oncology at the Johns Hopkins University School of Medicine. He also serves as the Executive Vice Chairman of the Department of Urology and the MEA Endowed Director of Minimally Invasive and Robotic Urology.

Dr. Allaf is a world renowned surgeon-scientist having performed > 2,000 robotic procedures and published > 250 peer reviewed research papers in the field's best journals.

As one of the busiest robotic radical prostatectomy surgeons in the world, he aims to achieve the best outcome for his patients. Having trained with Dr. Patrick Walsh, Dr. Allaf has used Dr. Walsh's method of radical prostatectomy as the basis for his own anatomic method to this complex operation.

Dr. Allaf is also amongst the leaders in kidney cancer surgery having served on the American Urological Association Guideline Committee for Kidney Cancer. He also led a team who performed the rigorous analysis to help inform the most recent guidelines that was funded by the Agency for Healthcare Research and Quality (AHRQ). He is best known for his ability to save the kidney and remove the tumor in patients with kidney tumors.

Dr. Allaf runs a research endeavor aiming to decrease the morbidity associated with the treatment of cancer. He has mentored numerous leaders in academic urology and has an integral role in running the Brady Urological Institute alongside Dr. Alan Partin. Dr. Allaf is actively involved in fund raising for research and education and believes in expanding our knowledge base so that we can help generations to come avoid the diseases of today.

Hector Henry Memorial Lecture
Dr. Hector Henry was President of the Southeastern Section in 2001 and the Section's Historian from 2009 until his passing in 2013. The Annual Hector Henry Memorial Lectureship was established after Dr. Henry's death and is given by an active or retired member of the armed forces.

Dr. Gerard Henry graduated from medical school at UNC-Chapel Hill, then finished a urology residency at Duke University including a one-year basic science fellowship in ED at Duke University, and finishing basically a three-year fellowship with SK Wilson in surgical men's health.

Dr. Henry is currently in Bossier City/Shreveport, Louisiana, at ARKLATEX Urology performing about five implant cases a week for many years and writing dozens of peer-reviewed articles.

Dr. Thomas F. Stringer is Clinical Assistant Professor in the Department of Urology at the University of Florida in Gainesville, and assumed the full time role as Medical Director of the University of Florida Urology Clinic in 2011 after a career as managing partner of a large urology group practice and as an adjunct professor in the Department. Dr. Stringer currently serves as the Associate Chairman of the Department following his service as the interim Chairman of the Department from 2015 to 2016. Dr. Stringer received his undergraduate degree from the University of Michigan and his medical degree from Wayne State University in Detroit, Michigan. He went on to complete his residency in surgery and urology at the University of Florida College of Medicine in Gainesville, Florida.

Dr. Stringer is an active member of the AUA, and in 2010, he was awarded the AUA's prestigious Presidential Citation. He is past-president of the Southeastern Section of the AUA (2009 – 2010), where he also served as treasurer from 2004 – 2007. He has also served on the AUA's Finance, Bylaws and Investment Committees and is currently the Chairman of the AUA Compensation Committee. He has served as the Southeastern Section representative to the AUA board of directors since 2014. He is a contributing author to the AUA's Core Curriculum and was co-author of a 2015 textbook on the business of a successful medical practice. Dr. Stringer currently serves as president of the UroGators Alumni Society, and is past-president of the Florida Urological Society. He was an active foundation board member of Citrus Memorial Hospital and subsequently served as their inaugural chief medical officer. He writes and lectures nationally on the business of urology and serves as course director for an annual AUA post graduate course on physician employment contract negotiation. Dr. Stringer has been a member of the AUA since 1984.

W. Bedford Waters Lecture

Dr. W. Bedford Waters was a beloved member of the SESAUA and a national leader in Urology, including serving as the first African-American member and President of the ABU. He received the AUA Lifetime Achievement Award for his outstanding contributions as a urologic oncologist, mentor, and educator. Following his death in 2019, the lecture was established to honor his legacy and the importance of diversity, equity, and inclusion.

Dr. Cheryl Lee is Professor and Chair of the Department of Urology at The Ohio State University Wexner Medical Center where she holds the Dorothy M. Davis Endowed Chair in Cancer Research. She is also the Vice President of the OSU Physicians and Faculty Group Practice and The Chief Health Equity Officer for the OSU Wexner Medical Center. Her medical professional focus is dedicated to improving the care of bladder cancer patients through advocacy, education and research. She has served the Bladder Cancer Advocacy Network as the President of the Scientific Advisory Board, as a current member of its Board of Directors, and as a Past-Chairman of the Bladder Cancer Think Tank. She is a past-member of the SUO Board of Directors and currently serves as its liaison to the American Joint Committee on Cancer.

Dr. Lee is active in the education and certification of urologists. She has directed or been a faculty member of a postgraduate course at the annual meeting of the AUA for over a decade and has served on the ABU Oral Board Examination Committee, the AUA Education Council, the AUA Program Committee, the American Board of Urology /AUA Examination Committee, the Oncology Knowledge Assessment Test Committee of the Society of Urologic Oncology (SUO), and is an active member of the AUA Update Editorial Board. She is currently a Trustee of the American Board of Urology. Her current research is focused on faculty recruitment, retention and promotion.

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SCIENTIFIC PROGRAM

All sessions will be located in ***Talbot DE*** unless otherwise noted
Speakers and times are subject to change

WEDNESDAY, MARCH 15, 2023

OVERVIEW

7:00 a.m. - 5:45 p.m. — **Registration/Information Desk Open**
Location: Talbot Pre-Function

7:00 a.m. - 11:00 a.m. — **Board of Directors Meeting**
Location: Plaza Ballroom

7:30 a.m. - 10:30 a.m. — **Spouse/Guest Hospitality Suite Open**
Location: Tidewater Grill

10:30 a.m. - 5:45 p.m. — **Speaker Ready Room Open**
Location: Cumberland Room

6:00 p.m. - 8:00 p.m. — **Welcome Reception**
Location: Salons 1-3

GENERAL SESSION

11:00 a.m. - 12:00 p.m. — **Industry Sponsored Lunch Symposium**
Location: Talbot A-C

12:15 p.m. - 12:30 p.m. — **Opening Remarks**
President: S. Duke Herrell III, MD, FACS
Nashville, TN

12:30 p.m. - 1:00 p.m. — **State-of-the-Art Lecture: An Update on GU Cancer Survivorship**
Speaker: Andrew C. Peterson, MD, MPH, FACS
Durham, NC

1:00 p.m. - 1:45 p.m. — **Panel Discussion: Current Strategies in Testis Cancer**
Moderator: Kelvin A. Moses, MD, PhD, FACS
Nashville, TN
Panelists: Charles C. Peyton, MD
Birmingham, AL
Stephen B. Riggs, MD, MBA
Charlotte, NC

1:45 p.m. - 2:15 p.m. — **State-of-the-Art Lecture: The Role of the Microbiome in Bladder Cancer**
Speaker: Vikram M. Narayan, MD
Atlanta, GA

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2:15 p.m. - 2:30 p.m. **Break**
Location: Talbot Pre-Function

2:30 p.m. - 3:00 p.m. **State-of-the-Art Lecture: Prostate Biopsy in 2023: What Should I Know?**
Speaker: Kristen R. Scarpato, MD, MPH
Nashville, TN

3:00 p.m. - 3:45 p.m. **Panel Discussion: Treating Enlarged Prostates and LUTS in the Low Risk Prostate Cancer Patient**
Moderator: Gopal H. Badlani, MD
Winston-Salem, NC
Panelists: Victoria Y. Bird, MD
Gainesville, FL
Brendan M. Browne, MD
Atlanta, GA
Chandler D. Dora, MD
Jacksonville, FL

3:45 p.m. - 4:15 p.m. **Montague Boyd Essay Contest: Finalist Presentations**
Moderator: David D. Thiel, MD
Jacksonville, FL

3:45 p.m. - 3:52 p.m. **MT1, A NOVEL SMALL MOLECULAR BIVALENT BROMODOMAIN INHIBITOR, INHIBITS PROSTATE CANCER GROWTH**
Presenter: Allison H. Feibus, MD, MS
Jacksonville, FL

3:52 p.m. - 3:59 p.m. **PREOPERATIVE BLADDER MECHANICS FORECAST INDIVIDUALIZED ARTIFICIAL URINARY SPHINCTER LONGEVITY**
Presenter: Jordan Foreman, MD
Durham, NC

3:59 p.m. - 4:06 p.m. **DISPARITIES IN HEALTHCARE COVERAGE FOR CLEAN INTERMITTENT CATHETERIZATION - A NATIONWIDE ANALYSIS**
Presenter: Joey Bardot, MD
New Orleans, LA

4:06 p.m. - 4:15 p.m. **Q&A**

4:15 p.m. - 4:30 p.m. **Break**
Location: Talbot Pre-Function

CONCURRENT SESSIONS BEGIN

Concurrent Session 1 of 5

4:30 p.m. - 5:45 p.m. **Men's Health, Sexual Dysfunction and Infertility Podium Session**
Location: Talbot A-C
Moderators: Lawrence S. Hakim, MD, FACS
Weston, FL
Anand Shridharani, MD
Chattanooga, TN

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4:30 P.M. **#1**

PATIENT SATISFACTION WITH ORAL TESTOSTERONE UNDECANOATE (JATENZO) IN MEN WITH PREVIOUS TESTOSTERONE THERAPY: AN OPEN-LABEL, SINGLE-CENTER, PHASE IV CLINICAL TRIAL

Marco-Jose Rivero[1,2], Rohit Reddy[3], Akhil Muthigi[1], Ranjith Ramasamy[1]
[1]University of Miami Miller School of Medicine, Desai Sethi Urology Institute, Miami, FL, [2]Case Western Reserve University School of Medicine, Cleveland, OH, [3]University of Miami Miller School of Medicine, Miami, FL
Presented By: Marco-Jose Rivero

4:37 P.M. **#2**

COMMUNITY-BASED ASSESSMENT OF PREDICTORS OF NON-PRESCRIPTION PDE-5 INHIBITOR USE IN ADULT MEN

Jackson Cabo, MD, Niels Johnsen, MD MPH
Vanderbilt University Medical Center
Presented By: Jackson Cabo, MD

4:44 P.M. **#3**

SOCIOECONOMIC STATUS IS NOT ASSOCIATED WITH COMPLICATIONS OR PATIENT SATISFACTION FOLLOWING INFLATABLE PENILE PROSTHESIS SURGERY

Rohan Bhalla[1], Helen Gamrah[2], Jackson Cabo[1], George Koch[1], Tanya Marvi[1], Evan Watkins[2], Theresa Zwaschka[2], Melissa Kaufman[1], Douglas Milam[1], Niels Johnsen[1]
[1]Vanderbilt University Medical Center, [2]Vanderbilt University School of Medicine
Presented By: Rohan G. Bhalla, MD

4:51 P.M. **#4**

HYDROPHILIC INFLATABLE PENILE PROSTHESIS DISCS INOCULATED WITH BACTERIA AND FUNGAL SPECIES DIPPED IN 0.05% CHLORHEXIDINE GLUCONATE IRRIGATION SOLUTION AND IRRIGATED TO EVALUATE REAL WORLD SITUATIONS

Edward Karpman, MD[1], Carolyn Twomey[2], Gerard Henry, MD[3]
[1]Urological Surgeons of Northern California, [2]Irrimax Corporation, [3]WK Advanced Urology
Presented By: Gerard D. Henry, MD

4:58 P.M. **#5**

DELAYED CLOSED-SUCTION DRAIN REMOVAL FOLLOWING INFLATABLE PENILE PROSTHESIS: A MULTI-INSTITUTIONAL EXPERIENCE

Luke Shumaker[1], Nicholas Zulia[2], Jonathan Beilan[2], Emmett Kennady[3], Nicolas Ortiz[3], Adam Baumgarten[1]
[1]University of Alabama at Birmingham Department of Urology, [2]Advanced Urology Institute, [3]University of Virginia Department of Urology
Presented By: Luke A. Shumaker, MD

5:05 P.M. **#6**

IDENTIFICATION AND IN VITRO PROPAGATION OF UNDIFFERENTIATED SPERMATOGONIA FROM A 46, XX MALE

Mark Xu, MD[1,2], Aaron Bradshaw, MD[1,2], Harpreet Gosal, MBBS[1], Abinav Udaiyar, BS[1], Omar Abdelaal, MD[1,3], Kimberly Stogner-Underwood, MD[1,4], Stuart Howards, MD[4], Tamer Yalcinkaya, MD[5], Anthony Atala, MD[1,2], Hooman Sadri-Ardekani, MD[1,2,4]
[1]Wake Forest Institute for Regenerative Medicine, Winston-Salem, NC, USA, [2]Wake Forest School of Medicine, Department of Urology, Winston-Salem, NC, USA, [3]Department of Urology, Zagazig University, Egypt, [4]Wake Forest School of Medicine, Department of Pathology, Winston-Salem, NC, USA, [5]Carolinas Fertility Institute, Winston-Salem, NC, USA
Presented By: Mark Xu, MD

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5:12 P.M. **#7**

THE AVAILABILITY OF GONADOTROPIN THERAPY FROM FDA-APPROVED PHARMACIES FOR MEN WITH HYPOGONADISM AND INFERTILITY

Benjamin Borgert, MS[4], MPH[1], Michael Bacchus, MS[42], Alexandra Hernandez, MS[42], Shelby Potts, ARNP[3], Kevin Campbell, MD, MS[2]
[1]Florida State University College of Medicine, [2]University of Florida College of Medicine, [3]UF Health Shands, Department of Urology
Presented By: Benjamin Joseph Borgert, MPH

5:19 P.M. **#8**

COMBINATION OF MICRODISSECTION TESTICULAR SPERM EXTRACTION (MTESE) AND DENSITY GRADIENT PROCESSING TO OPTIMIZE SPERM RETRIEVAL AND PREGNANCY OUTCOMES IN MEN WITH NONOBSTRUCTIVE AZOOSPERMIA (NOA)

Nicholas Deebel, M.D.[1], Banafsheh Nikmehr, Ph.D[2,3], Janmejay Hingu, M.D.[1,3], Collette O'Connor, B.S.[4], Rachel Ruble[2], Yueqiang Song[2], Ayse Kose Vuruskan[2], Anuradha Devineni, M.D.[2], Cihan Halicigil, Ph.D[5], Stuart Howards, M.D.[1,3], Tamer Yalcinkaya, M.D.[2], Hooman Sadri-Ardekani, M.D., Ph.D[1,2,3]
[1]Department of Urology, Atrium Health Wake Forest Baptist, [2]Carolinas Fertility Institute, [3]Wake Forest Institute for Regenerative Medicine, [4]Wake Forest University School of Medicine, [5]Department of Obstetrics, Gynecology Reproductive Sciences, Yale School of Medicine
Presented By: Nicholas Deebel, MD

5:26 P.M. **#9**

A HEAD-TO-HEAD ERGONOMIC RISK ASSESSMENT OF THE 4K-3D EXOSCOPE VS. STANDARD OPERATING MICROSCOPE FOR MALE FERTILITY MICROSCURGERY

Nicholas Deebel, M.D.[1,2], Rohit Reddy, B.S.[1,3], Alexander Weber, B.S.[1,3], Kevin Chu, M.D.[1,3], Jesse Ory, M.D.[1,3], Ryan Terlecki, M.D.[1,2], Ranjith Ramasamy, M.D.[1,3]
[1]Department of Urology, [2]Atrium Health Wake Forest Baptist, [3]University of Miami
Presented By: Nicholas Deebel, MD

Concurrent Session 2 of 5

4:30 p.m. - 5:45 p.m.

Bladder Cancer Podium Session
Location: Talbot DE

Moderators: Spencer Krane, MD
Bethesda, MD
Amy N. Luckenbaugh, MD
Nashville, TN

4:30 P.M. **#10**

MULTI-FACETED GENOMIC, PATHOLOGIC, AND ARTIFICIAL INTELLIGENCE ANALYSIS ON LOW-GRADE NONINVASIVE BLADDER TUMORS REVEALS SIGNATURES TO PREDICT DOWNSTREAM TUMOR RECURRENCE

Kyle Rose, MD, MS[1], Aram Vosoughi, MD[1], Gustavo Borjas, BS, MS[1], Heather Huelster, MD[1], Shreyas Naidu, BS[1], Philippe Spiess, MD, FACS[1], Anders Berglund, PhD[1], Rohit Jain, MD[1], Daniel Grass, MD[1], David McConkey, MD[2], Seth Lerner, MD[3], Wade Sexton, MD[1], Anirudh Joshi[4], Nagi Kumar, PhD[1], Roger Li, MD[1]
[1]Moffitt Cancer Center, [2]Johns Hopkins, [3]Baylor College of Medicine, [4]Valar Labs, Inc.
Presented By: Kyle M. Rose, MD, MS

4:37 P.M. **#11**

CHRONIC EXPOSURE OF PHYSIOLOGICAL CONCENTRATION OF ARSENIC INDUCED BLADDER MALIGNANCY IN PRECLINICAL MODELS

Hangcheng Fu[1], Damodaran Chendil[2], Ankem Murali[1]
[1]University of Louisville Urology Department, [2]Texas AM Rangel College of Pharmacy
Presented By: Hangcheng Fu, MD

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4:44 P.M. **#12**

MENTAL HEALTH CHANGES IN PATIENTS UNDERGOING RADICAL CYSTECTOMY WITH URINARY DIVERSION

Pushan Prabhakar, MD[1], Hariharan Ganapathi, MD[2], Nikhil Kulkarni[3], Ahmed Eldefrawy, MD[1,3], Jorge Caso, MD[1,3], Murugesan Manoharan, MD[1,3]
[1]Miami Cancer Institute, Baptist Health South Florida, Miami, FL, [2]University of South Florida, Tampa, FL, [3]FIU Herbert Wertheim College of Medicine, Miami, FL
Presented By: Pushan Prabhakar

4:51 P.M. **#13**

CISPLATIN-INELIGIBLE MUSCLE-INVASIVE BLADDER CANCER DEMONSTRATES POOR LONG-TERM OUTCOMES FOLLOWING IMMEDIATE RADICAL CYSTECTOMY AND PRESENTS OPPORTUNITY FOR NEOADJUVANT PEMBROLIZUMAB

Kyle Rose, MD, MS[1], Adri Durant, MD[2], Marco Bandini, MD[3], Heather Huelster, MD[1], Megan Prunty, MD[4], Adnan Fazili, MD[5], Shreyas Naidu, BS[1], Stephen Bardot, MD[5], Laura Bukavina, MD[6], Seth Lerner, MD[7], Mark Tyson, MD[2], Andrea Necchi, MD[3], Roger Li, MD[1]
[1]Moffitt Cancer Center, [2]Mayo Clinic Arizona, [3]San Rafaele Hospital, [4]Case Western Reserve University, [5]Ochsner Medical Center, [6]Fox Chase Cancer Center, [7]Baylor College of Medicine
Presented By: Kyle M. Rose, MD, MS

4:58 P.M. **#14**

PATIENT-REPORTED TREATMENT BURDEN OF INTRAVESICAL THERAPY FOR BLADDER CANCER

Amanda A. Myers[1], Benjamin Ristau[2], Matthew Mossanen[3], Deborah Kaye[4], Mark D. Tyson[5], Stephanie Chisolm[6], Frank Sloan[7], Angela Smith[8], Timothy D. Lyon[1]
[1]Department of Urology, Mayo Clinic, Jacksonville, FL, [2]Division of Urology, UConn Health, Farmington, CT, [3]Division of Urologic Surgery, Brigham Women's Hospital, Dana Farber Cancer Institute, Boston, MA, [4]Division of Urology, Duke University Medical Center, Durham, NC, [5]Department of Urology, Mayo Clinic, Scottsdale, AZ, [6]Bladder Cancer Advocacy Network , Bethesda, MD, [7]Department of Economics, Duke University, Durham, NC, [8]Department of Urology, University of North Carolina, Chapel Hill, NC
Presented By: Amanda A. Myers, MD

5:05 P.M. **#15**

REMOVAL OF GABAPENTIN AND KETORALAC FROM ERAS PATHWAY INCREASES PERIOPERATIVE OPIOID USE: A FOLLOW-UP ANALYSIS

Rachel Locke, MD, Samuel Ivan, MD, Hailey Holck, BS, Peter Clark, MD, Justin Matulay, MD, Kris Gaston, MD, Stephen Riggs, MD
Department of Urology, Atrium Health Levine Cancer Institute, Charlotte, NC
Presented By: Rachel Locke

5:12 P.M. **#16**

STENT FREE RATES IN CUTANEOUS URETEROSTOMY URINARY DIVERSION AFTER RADICAL CYSTECTOMY

Parth Thakker, Justin Refugia, Corey Able, Randy Casals, Timothy O'Rourke, Matvey Tsivian
Atrium Health Wake Forest Baptist
Presented By: Parth Thakker, MD

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5:19 P.M. **#17**

ATTITUDES TOWARDS IN-HOME INTRAVESICAL THERAPY AMONG BLADDER CANCER PATIENTS

Amanda A. Myers[1], Benjamin Ristau[2], Matthew Mossanen[3], Deborah Kaye[4], Mark D. Tyson[5], Stephanie Chisolm[6], Frank Sloan[7], Colleen Ball[8], Angela Smith[9], Timothy D. Lyon[1]
[1]Department of Urology, Mayo Clinic, Jacksonville, FL, [2]Division of Urology, UConn Health, Farmington, CT, [3]Brigham Women's Hospital, Dana Farber Cancer Institute, Boston, MA, [4]Duke University Medical Center, Durham, NC, [5]Department of Urology, Mayo Clinic, Scottsdale, AZ, [6]Bladder Cancer Advocacy Network , Bethesda, MD, [7]Department of Economics, Duke University, Durham, NC, [8]Division of Clinical Trials and Biostatistics, Mayo Clinic, Jacksonville, FL, [9]Department of Urology, University of North Carolina, Chapel Hill, NC
Presented By: Amanda A. Myers, MD

5:26 P.M. **#18**

IDENTIFICATION OF T-CELL-FACTOR 7 EXPRESSION AS A POOR PROGNOSTIC INDICATOR AND POTENTIAL IMMUNOTHERAPY MARKER IN MUSCLE-INVASIVE BLADDER CANCER

Hangcheng Fu, Anne Geller, Ankem Murali
University of Louisville Urology Department
Presented By: Hangcheng Fu, MD

Concurrent Session 3 of 5

4:30 p.m. - 5:45 p.m.

Health Services Research and Socioeconomics Poster Session
Location: Plaza I

Moderators: Hans C. Arora, MD
Chapel Hill, NC
Ornob Roy, MD, MBA
Charlotte, NC

POSTER #1

ASSOCIATION OF DAY OF SURGERY WITH LENGTH OF STAY AND OUTCOMES IN PATIENTS UNDERGOING ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY IN A TERTIARY CENTER

Daniela Haehn, MD[1], Laura Geldmaker, BS[1], Bryce Baird, MD[1], Christian Ericson, MD[1], Collen Ball, MS[2], David Thiel, MD[1]
[1]Department of Urology, Mayo Clinic, Jacksonville, FL, [2]Division of Clinical Trials and Biostatistics, Mayo Clinic, Jacksonville, FL
Presented By: Daniela Andrea Haehn, MD

POSTER #2

AN UPDATE ON PROFESSIONAL BURNOUT AND CONFLICT-WORK FROM THE AUA WORKFORCE WORKGROUP

Seth Teplitsky, MD[1], Amanda North, MD[2], Raymond Fang, MSC, MASC[3], William Meeks[3], Kate Kraft, MD[4], Andrew Harris, MD[1]
[1]University of Kentucky, [2]Montefiore Medical Center, [3]AUA Data Management Statistical Analysis, [4]University of Michigan
Presented By: Seth Teplitsky, MD

POSTER #3

THE FINANCIAL TOXICITY OF UROLOGIC MALIGNANCIES

David Nelwan, MD[1], Ajay Varadhan[2], Zachary Connelly, PhD[3], Premsai Kumar[2], Kyle Michelson, MD[1], Trushar Patel, MD[1]
[1]Department of Urology, University of South Florida, [2]Morsani College of Medicine, University of South Florida, [3]LSU Health Shreveport
Presented By: David Nelwan, MD

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POSTER #4

NEIGHBORHOODS AND PENILE IMPLANTS: AN ANALYSIS OF SOCIOECONOMIC DISADVANTAGES AND THE RISK OF IPP REVISION

Nicholas Major, MD, John Williams, MD, Kelly Kossen, BS, Eric Laborde, MD
Ochsner Clinic Foundation, Department of Urology, New Orleans, LA
Presented By: Nicholas Major, MD

POSTER #5

ASSOCIATION BETWEEN MAYO ADHESIVE PROBABILITY (MAP) SCORE AND DURATION OF ROBOTIC-ASSISTED PARTIAL NEPHRECTOMIES

Laura Geldmaker, Amanda Myers, Daniela Haehn, Sarah Hampton, Colleen Ball, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

POSTER #6

A CALL TO CONTRACEPTION: OVERTURN OF ROE V. WADE CATALYZES RISE IN U.S. VASECTOMY CONSULTATIONS

Kevin Campbell, Department of Urology[1], John Lindsey II, Scott Department of Urology[2], Juan Torres-Anguiano, Scott Department of Urology[2], John Donato, Scott Department of Urology[2], Jordan Kassab, Scott Department of Urology[2], Lawrence Yeung, Department of Urology[1], Russell Terry, Department of Urology[1], Larry Lipshultz, Scott Department of Urology[2]
[1]University of Florida College of Medicine, [2]Baylor College of Medicine
Presented By: Kevin Campbell, MD, MS

POSTER #7

HIGH-RISK PROSTATE CANCER IN NORTH FLORIDA: DISPARITIES IN DIAGNOSTIC USE OF MRI VSSTANDARD PROSTATE BIOPSY

Leticia Rodriguez, B.S[1], Victoria Bird, MD[2]
[1]University of Florida, [2]Urologic Integrated Care
Presented By: Leticia Rodriguez, BS

POSTER #8

RURALITY IS ASSOCIATED WITH THE PRESENCE OF URINARY INCONTINENCE IN WOMEN

T. Anne Zwaschka, Stephanie Gleicher, Rosa Park, Roger Dmochowski, W. Stuart Reynolds, Elisabeth Sebesta
Vanderbilt University Medical Center, Nashville, TN
Presented By: Rosa Park, MD

POSTER #9

TRENDS IN COST ASSOCIATED WITH THE PHARMACOLOGIC MANAGEMENT OF OVERACTIVE BLADDER

Dhaval Jivanji, MD[1], Spencer Liem, MD[2], Jorge Pereira, MD, MPH[2]
[1]Herbert Wertheim College of Medicine at Florida International University, Miami, FL, [2]Columbia University Division of Urology, Mount Sinai Medical Center, Miami Beach, FL
Presented By: Dhaval Jivanji

POSTER #10

STANDARDIZATION OF CYSTOSCOPY OPERATING ROOM SET UP

Brittany Levy[1], Charles Campbell[1], Sherry Lantz[2], Wesley Wilt[1], Erik Ballert[2], Andrew Harris[2]
[1]University of Kentucky, [2]Lexington Veterans Affairs Medical Center
Presented By: Brittany Erin Levy, MD

POSTER #11

SOCIOECONOMIC STATUS AND POST-OPERATIVE OPIOID CONSUMPTION FOR CYSTECTOMY ERAS PATIENTS

Hailey Holck, Samuel Ivan, Ornob Roy, Stephen Riggs
Department of Urology, Levine Cancer Institute/Atrium Health
Presented By: Hailey Holck, BS

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POSTER #12

NEPHROLITHIASIS CARE BY PATIENT RACE: FROM A STATEWIDE QUALITY IMPROVEMENT COLLABORATIVE

Fumihiko Nakamura[1], Brandon Dodd[1], Ademilola Tejuoso[1], Sarah Johnson[1], Will Cranford[2], Eric Wahlstedt[2], Andrew Harris, MD[2,3], Kellen Choi, DO, FACOS[4]
[1]University of Louisville, School of Medicine, Louisville, KY, [2]University of Kentucky, College of Medicine, Lexington, KY, [3]Lexington VA Medical Center, [4]University of Louisville, Department of Urology, Louisville, KY
Presented By: Fumihiko Nakamura, MS

POSTER #13

TRANSFORMING PERIOPERATIVE PROCESSES: COLLABORATION, EVALUATION, AND IMPROVEMENT

Brittany Levy, Wesley Wilt, Julia Hay, Raymond Young, Emily Eichinger, Andrew Harris
University of Kentucky
Presented By: Brittany Erin Levy, MD

Concurrent Session 4 of 5

4:30 p.m. - 5:45 p.m.

Prostate Cancer Poster Session
Location: Plaza II

Moderators: Marc A. Bjurlin, DO, MSc
Chapel Hill, NC
David, Thiel, MD
Jacksonville, FL

POSTER #14

REFINEMENT AND EXTERNAL VALIDATION OF A NOVEL, NON-INVASIVE, MULTIPLEX URINE TEST FOR HIGH-GRADE PROSTATE CANCER

Jeffrey Tosoian[1], Yuping Zhang[2], Lanbo Xiao[2], Heng Zheng[2], Cassie Xie[3], Bruce Trock[4], Javed Siddiqui[2], Lakshmi Kunju[2], Zoey Chopra[2], Nathan Samora[1], Simpa Salami[2], Todd Morgan[5], Ganesh Palapattu[6], Yingye Zhang[3], John Wei[6], Arul Chinnaiyan[2]
[1]Department of Urology, Vanderbilt University Medical Center, [2]Michigan Center for Translational Pathology, University of Michigan, [3]Biostatistics Program, Public Health Sciences, Fred Hutchinson Cancer Research Center, [4]Brady Urological Institute, Johns Hopkins University, [5]Rogel Cancer Center, University of Michigan, [6]Department of Urology, University of Michigan
Presented By: Jeffrey J. Tosoian, MD, MPH

POSTER #15

OUTCOMES OF SALVAGE ROBOTIC-ASSISTED RADICAL PROSTATECTOMY COMPARING PATIENTS WITH PRIMARY FOCAL THERAPY AND WHOLE GLAND ABLATION: A MULTICENTRIC COLLABORATIVE STUDY.

Seetharam Bhat[1], Arjun Nathan[2], Marcio Covas Moschovas[1], Senthil Nathan[2], Vipul Patel[1]
[1]AdventHealth Global Robotics Institute, [2]University College London Hospital
Presented By: Marcio Covas Moschovas, MD

POSTER #16

LONG-TERM HEALTH RELATED QUALITY OF LIFE IN PROSTATE CANCER PATIENTS REQUIRING RADIOTHERAPY AFTER RADICAL PROSTATECTOMY

T. Anders Olsen, Atlanta, GA[1], Sagar Patel, Atlanta, GA[2], Dattatraya Patil, Atlanta, GA[2], Catrina Crociani, Atlanta, GA[3], Louis Alperti, Atlanta, GA[4], Peter Chang, Boston, MA[3], Martin Sanda, Atlanta, GA[5]
[1]Emory School of Medicine Department of Urology, [2]Emory Winship Cancer Institute, [3]Beth Israel Deaconess Medical Center Department of Urology, [4]Urology of St. Louis, [5]Emory Winship Cancer Institute and Department of Urology
Presented By: Timothy Anders Olsen, MD

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POSTER #18

HERNIA REPAIR WITH MESH PLACEMENT DOES NOT INCREASE COMPLICATIONS DURING ROBOTIC-ASSISTED RADICAL PROSTATECTOMY

Marcio Covas Moschovas[1], Abdel Jaber[1], Travis Rogers[1], Roshane Perera[1], Marco Sandri[2], Carlos Ortiz[1], Keila Morales[1], Vipul Patel[1]
[1]AdventHealth Global Robotics Institute, [2]Big Open Data, Italy
Presented By: Marcio Covas Moschovas, MD

POSTER #19

DIFFERENCES IN CANCER-SPECIFIC URINARY BIOMARKER EXPRESSION BASED ON SELF-REPORTED RACE

Nathan Samora[1], Michael Sessine[2], Scott Tomlins[3], Simpa Salami[4], Javed Siddiqui[5], John Wei[4], Todd Morgan[4], Arul Chinnaiyan[3], Jeffrey Tosoian[1]
[1]Vanderbilt Univ. Medical Center, Dept. of Urology, [2]Wayne State Univ. School of Medicine, Dept. or Urology, [3]Univ. of Michigan, Dept. of Pathology, [4]Univ. of Michigan, Dept. of Urology, [5]Univ. of Michigan, Center for Translational Pathology
Presented By: Nathan L. Samora, MD

POSTER #20

INFLUENCE OF VITAMIN D ON PROSTATE CANCER OUTCOMES

Merry Ma[1], Daye Park[1], Amelia Vu[1], Lin Gu[2], Amanda De Hoedt[2], Jessica Janes[2], Zachary Klaassen[1], Martha Terris[1]
[1]Augusta University, Augusta, GA, [2]Durham Veterans Affairs Health Care System, Durham, NC
Presented By: Merry Ma, MD, PHD

POSTER #21

UTILITY OF A URINARY EXOSOME BIOMARKER TO PREDICT CSPCA FOLLOWING NEGATIVE MRI

Elizabeth Kwenda[1], Brianna Nguyen[1], Rani Ashouri[1], Nickolas Davies[1], Padraic O'Malley[1], Li-MIng Su[1], Sanoj Punnen[2], Paul Crispen[1], Wayne Brisbane[1]
[1]University of Florida College of Medicine, Department of Urology, [2]University of Miami, Department of Urology
Presented By: Elizabeth Kwenda, MD

POSTER #22

THE IMPACT OF SOCIOECNOMIC STATUS ON THE SURVIVAL OF MEN WITH EARLY-ONSET PROSTATECANCER

Carlos Riveros, Victor Chalfant, Ahmed Elshafei, Allison Feibus, Mohammed Al-Toubat, K.C. Balaji
University of Florida College of Medicine - Jacksonville
Presented By: Allison H. Feibus, MD, MS

POSTER #23

REVIEW OF METASTATIC DISEASE DETECTION AND COST ANALYSIS OF NEXT GENERATION IMAGING USE IN INITIAL STAGING OF PROSTATE CANCER

Adonis Irons, MD, Christian Dewan, MD, William Fry, MD, Robert Wake, MD, Anthony Patterson, MD
University of Tennessee Health Science Center
Presented By: Adonis Paul Irons, MD

POSTER #24

FUNCTIONAL OUTCOMES OF FOCAL SALVAGE MRI FUSION GUIDED HIFU FOR LOCALIZED RECURRENT PROSTATE CANCER

Ali Kasraeian, MD, FACS[1], Miguel Alcantara[1], Kaitlyn Mola Alcantara[1], Stephen Scionti, MD[2]
[1]Kasraeian Urology, [2]Scionti Prostate Center
Presented By: Ali Kasraeian, MD, FACS

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POSTER #25

CLINICAL OUTCOMES OF PATIENTS WITH METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC) WITH PROSTATE-SPECIFIC ANTIGEN (PSA) DECLINE TO UNDETECTABLE LEVELS ON ENZALUTAMIDE: POST HOC ANALYSIS OF ARCHES

Neal D. Shore[1], Arnauld Villers[2], Taro Iguchi[3], Francisco Gomez-Veiga[4], Antonio Alcaraz[5], Arnulf Stenzl[6], Boris Alekseev[7], Arun A. Azad[8], Russell Z. Szmulewitz[9], Daniel P. Petrylak[10], Jeffrey Holzbeierlein[11], Brad Rosbrook[12], Fabian Zohren[12], Gabriel P. Haas[13], Georgia Gourgioti[14], Nader N. El-Chaar[13], Andrew J. Armstrong[15]

[1]Department of Urology, Carolina Urologic Research Center, Myrtle Beach, SC, USA, [2]Department of Urology, University Hospital Centre, Lille University, Lille, France, [3]Department of Urology, Kanazawa Medical University, Ishikawa, Japan, [4]Department of Urology, Salamanca University Hospital, Salamanca, Spain, [5]Department of Urology, Hospital Clinic de Barcelona, Barcelona, Spain, [6]Department of Urology, University Hospital, Eberhard Karls University of Tübingen, Tübingen, Germany, [7]Department of Oncology, Hertzen Moscow Cancer Research Institute, Moscow, Russia, [8]Department of Medical Oncology, Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia, [9]Department of Medicine, The University of Chicago, Chicago, IL, USA, [10]Department of Medical Oncology, Yale Cancer Center, New Haven, CT, USA, [11]Department of Urologic Oncology, The University of Kansas Medical Center, Kansas City, KS, USA, [12]Department of Global Biometrics and Data Management, Pfizer Inc., San Diego, CA, USA, [13]Global Medical Affairs, Astellas Pharma Inc., Northbrook, IL, USA, [14]Department of Biostatistics, Oncology, Astellas Pharma Inc., London, UK, [15]Divisions of Medical Oncology and Urology, Cancer Institute Center for Prostate Urologic Cancers, Durham, NC, USA

Presented By: Russell Z. Szmulewitz, MD

POSTER #26

PROSTATE BIOPSY SEPSIS PREVENTION: EXTERNAL VALIDATION OF AN ISOPROPYL ALCOHOL NEEDLE WASHING PROTOCOL

Anthony Hiffa, Michael Oberle, Matthew Simmons, Merry Chen, Faizan Boghani, William Reed, Sherita King, John Decaro, Martha Terris, Thomas Dykes

Augusta University, Division of Urology, Augusta, GA

Presented By: Anthony Hiffa, MD, MPH

POSTER #17 **WITHDRAWN**

Concurrent Session 5 of 5

4:30 p.m. - 5:45 p.m.

Video Session I

Location: Talbot F-H

Moderators: Niels V. Johnsen, MD, MPH
Nashville, TN
Soroush Rais-Bahrami, MD, MBA
Birmingham, AL

VIDEO #1

CUTANEOUS URETEROSTOMY URINARY DIVERSION: TECHNIQUE AND REVIEW OF SINGLE INSTITUTION EXPERIENCE

Liliya Velet, MD, Justin Refugia, MD, Matvey Tsivian, MD

Department of Urology, Atrium Health Wake Forest Baptist, Winston Salem, NC

Presented By: Liliya Velet, MD

VIDEO #2

ROBOTIC-ASSISTED RADICAL NEPHRECTOMY WITH CAVAL THROMBECTOMY

John R. Murfee, Resident Physician[1], W. Johnson Hardy, Resident Physician[1], Alec R. Holloway, Medical Student[2], Daniel McMahon, Assistant Professor[1], Christopher E. Keel, Associate Professor[3]
[1]University of South Alabama, Department of Surgery, Mobile, AL, [2]University of South Alabama College of Medicine, Mobile, AL, [3]University of South Alabama, Department of Urology, Mobile, AL
Presented By: Alec Holloway

VIDEO #3

ROBOTIC TECHNIQUE: ROBOTIC VESICOVAGINAL FISTULA REPAIR WITH A PERIVESICAL FLAP

Alex Hwang, MD, David Thompson, MD, Amar Singh, MD, Henry Okafor, MD
University of Tennessee College of Medicine Chattanooga, Erlanger Urology
Presented By: Alexander Jinhaa Hwang, MD

VIDEO #4

OFF-CLAMP ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY FOR ENDOPHYTIC RENAL TUMOR

Raju Thomas, William Hughes, Erik Castle
Tulane University
Presented By: William M. Hughes, MD, BS

VIDEO #5

ROBOTIC ASSISTED RE-DO PARTIAL NEPHRECTOMY FOR RECURRENT RENAL TUMOR

Sumit Saini, MD, Timothy O'Rourke, MD, Ashok Hemal, MD
Atrium Health Wake Forest Baptist, Winston-Salem, NC
Presented By: Sumit Saini, MD

VIDEO #6

MANAGEMENT OF A MATURE CYSTIC TERATOMA IN THE URINARY BLADDER

Spencer Kortum[1], Benjamin Behers[1], Karim Ghazli, MD[2], Robert Carey, MD, PhD[1,2]
[1]Florida State University College of Medicine, Tallahassee, FL, [2]Jellison Cancer Institute, Sarasota Memorial Hospital, Sarasota, FL
Presented By: Benjamin Behers

VIDEO #7

ROBOTIC-ASSISTED RENAL SPARING MANAGEMENT OF DISTAL URETERAL TUMOR

Sumit Saini, MD, Timothy O'Rourke, MD, Ashok Hemal, MD
Atrium Health Wake Forest Baptist, Winston-Salem, NC
Presented By: Sumit Saini, MD

VIDEO #8

NOVEL TECHNIQUE: PERIVESICAL FAT ROTATIONAL FLAP FOR RECTAL INTERPOSITION COVERAGE IN SALVAGE PROSTATECTOMY

Alex Hwang, MD, Matthew Watson, DO, Michael Tonzi, MD, Amar Singh, MD
University of Tennessee College of Medicine Chattanooga, Erlanger Urology
Presented By: Alexander Jinhaa Hwang, MD

VIDEO #9

ROBOT ASSISTED PARTIAL NEPHRECTOMY IN ECTOPIC PELVIC KIDNEY

Diana M Lopategui, MD, Nicole Matluck, MD, Akshay Bhandari, MD
Mount Sinai Medical Center, Miami Beach, FL
Presented By: Diana Maria Lopategui, MD

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VIDEO #10

IMPLEMENTATION AND TECHNICAL DETAILS OF HUGO RAS SYSTEM IN ROBOTIC-ASSISTED RADICAL PROSTATECTOMY
Claudia Alfano[1], Marcio Covas Moschovas[2], Vianette Montagne[1], Irela Soto[1], Ruben Ureña[1], Elias Boden[1]
[11]-Hospital Pacífica Salud, [2]AdventHealth Global Robotics Institute
Presented By: Marcio Covas Moschovas, MD

CONCURRENT SESSIONS END

6:00 p.m. - 8:00 p.m. **Welcome Reception**
Location: Salons 1-3

THURSDAY, MARCH 16, 2023

OVERVIEW

6:00 a.m. - 5:30 p.m. **Registration/Information Desk Open**
Location: Talbot Pre-Function

6:00 a.m. - 5:30 p.m. **Speaker Ready Room Open**
Location: Cumberland Room

7:30 a.m. - 10:30 a.m. **Spouse/Guest Hospitality Suite Open**
Location: Tidewater Grill

8:30 a.m. - 3:30 p.m. **Exhibit Hall Open**
Location: Salons 1-3

GENERAL SESSION

6:00 a.m. - 7:00 a.m. **Industry Sponsored Breakfast Symposium**
Location: Talbot A-C

CONCURRENT SESSIONS BEGIN

Concurrent Session 1 of 4

7:00 a.m. - 8:30 a.m. **Men's Health and BPH Podium Session**
Location: Talbot DE
Moderators: David F. Friedlander, MD, MPH
Chapel Hill, NC
Nicole L. Miller, MD, FACS
Nashville, TN

7:00 A.M. **#19**

ADHERANCE TO AUA GUIDELINES FOR WORK-UP, MEDICAL MANAGEMENT, SURGICAL EVALUATION AND TREATEMENT OF BPH: WORK FROM A QUALITY IMPROVEMENT COLLABORATIVE

John L. Graves Jr, M.D.[1], Eric Wahlstedt[2], Alison D'Alessandro[3], Will Cranford, M.S.[4], Nicholas A. Freidberg, M.D.[5], Amul Bhalodi, M.D.[6], John R. Bell, M.D.[1], Andrew James, M.D.[1], Jason Bylund, M.D.[1], Stephen E. Strup, M.D.[1], Andrew M. Harris, M.D.[1]
[1]University of Kentucky, Dept. of Urology, Lexington, KY, [2]University of Kentucky College of Medicine, Lexington, KY, [3]University of Kentucky, STEPS Service Center, Lexington, KY, [4]University of Kentucky College of Public Health, Dept. of Biostatistics, Lexington, KY, [5]Urology America, Urology Austin, Austin, TX, [6]Baptist Health Medical Group, Dept. of Gastroenterology and Urology, Lexington, KY
Presented By: John Lee Graves, Jr., MD

7:07 A.M. **#20**

AQUABLATION: A SINGLE INSTITUTION EXPERIENCE OF 100 PATIENTS

Dylan Dangerfield, MD[1], Yates Congleton, MD[1], Tanner Wright, MD[2], Wesley White, MD[1], Ryan Pickens, MD[1]
[1]University of Tennessee at Knoxville, Department of Urology, Knoxville, TN, [2]University of Tennessee at Knoxville, Department of Surgery, Knoxville, TN
Presented By: Ryan Baird Pickens, MD

7:14 A.M. **#21**

VALIDATION AND RELIABILITY OF THE HOLEP GLOBAL EVALUATION METRIC FOR RECORDED CASE VIDEOS

Gopal Narang[1], Kevin Wymer[2], Scott Cheney[2], Ahmed Ghazi[3], Mitchell Humphreys[2]
[1]University of North Carolina, [2]Mayo Clinic Arizona, [3]University of Rochester
Presented By: Gopal Narang

7:21 A.M. **#22**

PROSTATIC URETHRAL LIFT (PUL) PROVIDES DURABLE SYMPTOM RELIEF TO REAL-WORLD PATIENTS WITH PROSTATE CANCER

Manish Patel, MD[1], Gregg Eure, MD[2]
[1]Urology MD Consult, LLC, [2]Urology of Virginia
Presented By: Manish Patel

7:28 A.M. **#23**

THE MRI CASE FOR HOLEP VERSUS TURP: A SINGLE INSTITUTION RETROSPECTIVE COHORT STUDY

Christian Ericson[1], David Sella[1], David Mauler[2], Ram Pathak[1], Colleen Ball[1], Steven Lomax[3], Kevin Parikh[4], Kandace Bolan[1], Chandler Dora[1]
[1]Mayo Florida, [2]Mayo Arizona, [3]UT Health East Texas, [4]Urologic Specialists of Northwest Indiana
Presented By: Christian A. Ericson, MD, BS

7:35 A.M. **#24**

LOWER RATES OF CONTINUED AND DE NOVO BPH MEDICATION USE FOLLOWING PUL COMPARED TO PVP AND TURP IN US HEALTHCARE CLAIMS ANALYSIS

Gregg Eure, MD[1], Manish Patel, MD[2]
[1]Urology of Virginia, [2]Urology MD Consult, LLC
Presented By: Gregg R. Eure, MD

7:42 A.M. **#25**

IS ROUTINE FOLLOW-UP CYSTOSCOPY NECESSARY IN MEN UNDERGOING HOLEP FOR FAILED UROLIFT?

Giovanni Gonzalez Albo, Chief Resident, Bryce Baird, Resident, Christian Ericson, Resident, Jared Schommer, Resident, Chandler Dora, Assistant Professor
Mayo Clinic
Presented By: Giovanni Andre Gonzalez Albo, MD

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7:49 A.M. **#26**

COMPARISON OF DIFFERENT IMAGING MODALITIES FOR PREDICTING ENUCLEATED TISSUE YIELD DURING HOLEP: A COHORT STUDY FROM A TERTIARY CARE CENTER

C. Matthew Ellis, Cassandra Schuster, Hailey Holck, Mark Makhuli, Rebecca Gerber
Atrium Health Carolinas Medical Center, Charlotte, NC
Presented By: C. Matthew Ellis, MD

7:56 A.M. **#27**

CONSISTENT OUTCOMES OF PROSTATIC URETHRAL LIFT (PUL) ACROSS CONTROLLED TRIAL AND REAL-WORLD SETTINGS IN THE TREATMENT OF OBSTRUCTIVE MEDIAN LOBES

Gregg Eure, MD[1], Manish Patel, MD[2]
[1]Urology of Virginia, [2]Urology MD Consult, LLC
Presented By: Gregg R. Eure, MD

8:03 A.M. **#28**

INCIDENCE AND RISK FACTORS FOR POSTOPERATIVE URINARY INCONTINENCE AFTER VARIOUS PROSTATE ENUCLEATION PROCEDURES: SYSTEMIC REVIEW AND META-ANALYSIS OF PUBMED LITERATURE FROM 2000 TO 2021.

Presented By: João Gabriel Da Silva Porto

8:10 A.M. **#29**

SINGLE SURGEON EXPERIENCE WITH PROCEPT AQUABEAM AQUABLATION OF THE PROSTATE FOR MEN WITH BPH: FIRST 55 CASES (WITH 45-MONTH FOLLOW-UP)

Ali Kasraeian, MD, FACS[1], Miguel Alcantara[2], Kaitlyn Mola Alcantara[1], Ahmad Kasraeian, MD, FACS[1]
[1]Kasraeian Urology, [2]Karaeian Urology
Presented By: Ali Kasraeian, MD, FACS

Concurrent Session 2 of 4

7:00 a.m. - 8:30 a.m.

Education and Simulation Podium Session
Location: Talbot F-H

Moderators: Robert Marcovich, MD
Miami, FL
Trushar Patel, MD
Tampa, FL

7:00 A.M. **#30**

AUGMENTED REALITY-ASSISTED SURGERY (ARAS): A NOVEL SURGICAL TRAINING TOOL USING MICROSOFT HOLOLENS

David Nelwan, MD[1], Rafael Carrion Jr.[2], Jose Quesada-Olarte, MD[1], Raul Fernandez-Crespo, MD[1], Gerard Henry, MD, Jay Simhan, MD, Anand Shridharani, MD, Rafael Carrion, MD[1], Tariq Hakky, MD
[1]Department of Urology, University of South Florida, [2]University of South Florida
Presented By: David Nelwan, MD

7:07 A.M. **#31**

RESIDENT PARTICIPATION IN URETEROSCOPIC STONE EXTRACTION DOES NOT INCREASE OPERATIVE TIME OR COST AT A LARGE ACADEMIC TERTIARY REFERRAL CENTER

David L. Thompson, MD, S. Sunny Roy, MD, MSPH, Jessica N. Lange, MD
University of Tennessee College of Medicine Chattanooga, Department of Urology
Presented By: David Levi Thompson

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7:14 A.M. **#32**

VARIABILITY IN PARENTAL LEAVE POLICIES FOR UROLOGY RESIDENTS ACROSS UNITED STATES ACADEMIC MEDICAL INSTITUTIONS

Alice Chu, MD[1], Farah Abaza, BS[2], Simone Thavaseelan, MD[3], Lindsey Hartsell, MD[1], Akanksha Mehta, MD, MS[1]
[1]Department of Urology, Emory University School of Medicine, Atlanta, GA, [2]Morehouse School of Medicine, Atlanta, GA, [3]Department of Urology, Warren Alpert School of Medicine at Brown University, Providence, RI
Presented By: Alice Chu, MD

7:21 A.M. **#33**

A NEW BARRIER IN THE UROLOGY RESIDENCY APPLICATION PROCESS FOR STUDENTS: GROWTH OF U.S. MEDICAL SCHOOLS INCREASINGLY OUTPACES THE DEVELOPMENT OF UROLOGY PROGRAMS

David Nelwan, MD[1], Umberto Donato, BS[2], Trushar Patel, MD[1]
[1]Department of Urology, University of South Florida, [2]Morsani College of Medicine, University of South Florida
Presented By: David Nelwan, MD

7:28 A.M. **#34**

LONGITUDINAL RESIDENT CLINIC: INITIAL EXPERIENCE WITH A UNIQUE APPROACH TO OUTPATIENT UROLOGIC EDUCATION

Samuel J Ivan, Caroline D Lu, S Lee Guice, Manish N Patel, Alison C Keenan, Peter E Clark, Stephen B Riggs
Carolinas Medical Center Department of Urology
Presented By: Samuel Ivan, MD

7:35 A.M. **#35**

SURGICAL INTRAOPERATIVE HANDOFF INITIATIVE: STANDARDIZING OPERATING ROOM COMMUNICATION USING SHRIMPS

Wesley Wilt, MD, Brittany Levy, MD, Sherry Lantz, MSN, RN, Andrew Harris, MD
Lexington VA Medical Center
Presented By: Wesley Stephens Wilt, MD

7:42 A.M. **#36**

EFFECTIVE USE OF SOCIAL MEDIA TO ATTRACT UROLOGY RESIDENCY APPLICANTS

F Pearce Kudlata[1], Salil S Ghamande[1], William M Pearson[1], Luke G Scanlan[1], Brittany Ange[1], John J De Caro[2], Martha K Terris[1]
[1]Augusta University, [2]Charlie Norwood VA Medical Center
Presented By: Frederick Pearce Kudlata

7:49 A.M. **#37**

PERSONAL DRIVERS OF PREFERENCE SIGNALING IN THE 2022 UROLOGY RESIDENCY MATCH

Joon Kyung Kim, MD[1], Benjamin Morrison, BS[2], Jason Bylund, MD, MPH[1], Alison Rasper, MD[1], Benjamin Dropkin, MD[1]
[1]University of Kentucky Department of Urology, [2]University of Kentucky College of Medicine
Presented By: Joon Kyung Kim, MD

7:56 A.M. **#38**

AN ACTIVE LEARNING CURRICULUM FOR QUALITY EDUCATION IN SURGICAL RESIDENCY

Brittany Levy, MD, Jitesh Patel, MD, MBA, Sandra Beck, MD, Andrew Harris, MD
University of Kentucky
Presented By: Brittany Erin Levy, MD

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8:03 A.M. **#39**

COULD FINGER ASSIGNMENT AT THE ROBOTIC CONSOLE PLAY A ROLE IN SURGICAL PRECISION OR ANY ADVERSE OUTCOMES? A RANDOMIZED PROSPECTIVE BLINDED SIMULATION PILOT STUDY

Zachary M. Connelly[1], Matthew Moss[1], Tomas Paneque[1], Harrison Torres[1], Kevin Morgan[1], Alex Fuselier[1], Mohamed Ahmed[2], Nazih Khater[1]
[1]LSU Health Shreveport, [2]Mayo Clinic Rochester Department of Urology
Presented By: Nazih Khater, MD

8:10 A.M. **#40**

DEVELOPMENT AND OUTCOMES OF A FORMALIZED PALLIATIVE CARE CURRICULUM FOR UROLOGY RESIDENTS

Bryn Launer[1], Amy Luckenbaugh[1], Kelvin Moses[1], Sam Chang[1], Maie El-Sourady[2], Kristen Scarpato[1]
[1]Vanderbilt University Medical Center, Department of Urology, [2]Vanderbilt University Medical Center, Department of Internal Medicine
Presented By: Bryn Launer

Concurrent Session 3 of 4

7:00 a.m. - 8:30 a.m.

Reconstructive Surgery, Voiding Dysfunction, and Female Pelvic Medicine Poster Session
Location: Plaza I

Moderators: Michael J. Kennelly, MD, FACS
Charlotte, NC
Steven P. Petrou, MD
Jacksonville, FL

POSTER #27

LONG-TERM COST ANALYSIS OF THIRD-LINE TREATMENT OPTIONS FOR OVERACTIVE BLADDER

Mary Pelling, BSE[1], Dattatraya Patil, MBBS MPH[2], Jessica Hammett, MD[2]
[1]Emory University School of Medicine, [2]Emory Department of Urology
Presented By: Jessica Hammett, MD

POSTER #28

DE NOVO URGE INCONTINENCE AFTER ARTIFICIAL URINARY SPHINCTER PLACEMENT: IT'S MORE COMMON THAN YOU THINK

Dustin Whitaker, MD[1], Tanner Wright, MD[2], Wesley White, MD[1], John Lacy, MD[1]
[1]University of Tennessee at Knoxville Department of Urology, Knoxville, TN, [2]University of Tennessee at Knoxville Department of Surgery, Knoxville, TN
Presented By: Dustin L. Whitaker, MD

POSTER #29

ESTABLISHING A NEW GENDER AFFIRMINATION PROGRAM IN THE DEEP SOUTH: DISTRIBUTION OF PATIENT DEMOGRAPHICS, PAYER MIX, AND DISTANCE TRAVELED FOR CARE

Brian Ceballos[1], Ardy Sowe[1], Jean Paul Osula[2], J. Patrick Selph, Soroush Rais-Bahrami[1,3,4]
[1]University of Alabama at Birmingham, Department of Urology, [2]University of Alabama School of Medicine, [3]University of Alabama at Birmingham, Department of Radiology, [4]O'Neal Comprehensive Cancer Center
Presented By: Brian Ceballos, MD

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POSTER #30

QUALITATIVE ANALYSIS OF REASONS FOR DELAYING DEFINITIVE TREATMENT OF URETHRAL STRICTURE DISEASE

Abimbola Ayangbesan[1], George Koch[1], Chloe Dagostino[2], Jack Proctor[2], Kemberlee Bonnet[2], David Schlundt[2], Niels Johnsen[1], Rohan Bhalla[1]
[1]Department of Urology, Vanderbilt University Medical Center, Nashville, TN, [2]Department of Psychology, Vanderbilt University, Nashville, TN
Presented By: Rohan Bhalla, MD

POSTER #31

QUANTIFYING PUBOCERVICAL FIBROMUSCULARIS ELASTICITY UNDER NORMAL AND PROLAPSE CONDITIONS BY SHEAR WAVE ELASTOGRAPHY AND COMPARISION WITH URODYNAMICS FINDINGS

Sarah Abdelhameed[1], Allison Samudio[1], Anabelle Rosenthal[2], Hugo H Davila[1,3]
[1]Florida Healthcare Specialists and Florida Cancer Specialists Urology and Pelvic Floor Center, [2]Florida State University College of Medicine, [3]Cleveland Clinic Indian River Hospital
Presented By: Sarah Salem Abdelhameed

POSTER #32

ASSESSING THE READABILITY OF ONLINE PATIENT EDUCATION RESOURCES RELATED TO PHALLOPLASTY

Praneet Paidisetty[1], Sairandri Sathyanarayanan[1], Leonard Wang[2], Kristen Slaughter[1,3], Wendy Chen[1,3]
[1]McGovern Medical School at UTHealth, Houston, Texas, [2]John Sealy School of Medicine, The University of Texas Medical Branch, Galveston, Texas, [3]Department of Plastic and Reconstructive Surgery, UTHealth, Houston, Texas
Presented By: Praneet Paidisetty

POSTER #33

PULMONARY DISEASE INCREASES COMPLICATIONS AFTER ELECTIVE PERINEAL SURGERY IN MEN: DATA FOR QUALITY IMPROVEMENT

Rahul Dutta, Resident, Ryan Terlecki, Professor
Atrium Health Wake Forest Baptist
Presented By: Rahul Dutta, MD

POSTER #34

AGATSTON CALCIUM SCORE ASSESSMENT OF PLAQUE CALCIFICATION IN PEYRONIE'S DISEASE

Bryce Baird, Daniela Haehn, Laura Geldmaker, Christian Ericson, Gregory Broderick
Mayo Clinic Florida
Presented By: Daniela Andrea Haehn, MD

POSTER #35

URETHRAL LENGTH (UL) AS A PREDICTOR FOR INTRACORPORAL LENGTH (ICL) PRIOR TO INFLATABLE PENILE PROSTHESIS (IPP) PLACEMENT: IMPLICATIONS FOR OPERATING ROOM PROCEDURE

Nicholas Deebel, M.D.[1,2], Justin Refugia, M.D.[1,2], Collette O'Oconnor, B.S.[3], Raymond Xu, M.D.[1,2], Ryan Terlecki, M.D.[1,2]
[1]Department of Urology, [2]Atrium Health Wake Forest Baptist, [3]Wake Forest University School of Medicine
Presented By: Nicholas Deebel, MD

POSTER #36

SMALL FIBER POLYNEUROPATHY IS A SIGNIFICANT FEATURE OF THE SYSTEMIC PAIN SUBGROUP IN PATIENTS WITH INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME

Presented By: Wyatt Whitman, M.D., B.S.

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POSTER #37

THE EFFECTS OF A NON-DEPOLARIZING NEUROMUSCULAR BLOCKER ON SACRAL NEUROMODULATION AND PATIENT OUTCOMES: A PROSPECTIVE ANALYSIS

Mason Holtel, MD[1], Anastasia Couvaras, MD[1], Kelly Kossen[2], Courtney Nguyen[2], Colin Goudelocke, MD[1]
[1]Ochsner Health, Dept. of Urology, New Orleans, LA, [2]University of Queensland Medical School
Presented By: Mason S. Holtel, MD,BS

POSTER #38

LOW BLADDER CAPACITY HUNNER LESION NEGATIVE INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME PATIENTS COMPRISE A UNIQUE BLADDER-CENTRIC PHENOTYPE

Maxwell Sandberg, MD, MS[1], Wyatt Whitman, MD[1], Robert Evans, MD[1], Gopal Badlani, MD[1],[2], Catherine Matthews, MD[1], Stephen Walker, PhD[1],[2]
[1]Wake Forest University School of Medicine, [2]Wake Forest Institute for Regenerative Medicine
Presented By: Maxwell Sandberg, M.D., M.S.

POSTER #39

EVALUATION AND MANAGEMENT OF TRAUMATIC URETERAL INJURIES AT A HIGH VOLUME URBAN TRAUMA CENTER

Christine Callaway, Anthony Jeong, Christopher Ledbetter, Anthony Patterson, Robert Wake
University of Tennessee Health Science Center
Presented By: Christine M. Callaway, MD

POSTER #40

SHORT-TERM WORK, LONG-TERM EFFECTS: EXAMINING TOILETING BEHAVIORS AND BLADDER HEALTH IN GIG ECONOMY WORKERS

Leah Chisholm, MD, Rohan Bhalla, MD, Stephanie Gleicher, MD, MPH, Roger R. Dmochowski, MD, MMHC, W. Stuart Reynolds, MD, MPH, Elisabeth Sebesta, MD
Department of Urologic Surgery, Vanderbilt University Medical Center, Nashville, Tennessee
Presented By: Leah Chisholm, MD

POSTER #41

COMPARISON OF TRANSPERINEAL MRI GUIDED BIOPSY VS TRANSPERINEAL TEMPLATE BIOPSY IN DETECTION OF CLINICALLY SIGNIFICANT PROSTATE CANCER

Crystal Casado, B.S, Jackson Conlon, B.S, Jacob Greenberg, B.S, Christopher R. Koller, MD, Sydney Caputo, B.S, Spencer S. Krane, MD
Tulane University School of Medicine
Presented By: Crystal Casado

Concurrent Session 4 of 4

7:00 a.m. - 8:30 a.m.

Kidney - Malignant and Benign Poster Session
Location: Plaza II

Moderators: John Roger Bell, MD
Lexington, KY

Christopher E. Keel, DO, FACS
Mobile, AL

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POSTER #42

CORRELATION OF GLOMERULAR FILTRATION EQUATIONS WITH MEASURED 24 HOUR CREATININE CLEARANCE IN RENAL CELL CARCINOMA PATIENTS

Benjamin Schmeusser, MD, MS[1], Eric Midenberg, MD[2], Yash Shah, BS[3], Subir Goyal, PhD[4], Khushali Vashi, MPH[1], John Sheehy, BS[1], Manuel Armas-Phan, MD[1], Dattatraya Patil, MBBS, MPH[1], Kenneth Ogan, MD[1], Viraj Master, MD, PhD[1]
[1]Department of Urology, Emory University School of Medicine, Atlanta, GA, [2]Department of Urology, University of Louisville, Louisville, KY, [3]Sidney Kimmel Medical College, Thomas Jefferson University, Philadelphia, PA, [4]Biostatistics and Bioinformatics, Winship Cancer Institute of Emory University, Atlanta, GA
Presented By: Benjamin Nicholas Schmeusser, MD, MS

POSTER #43

THE USE OF HEMOSTATIC AGENTS IN PARTIAL NEPHRECTOMY OF LOCALIZED RENAL LESIONS: TRENDS AND OUTCOMES

Firaas Khan[1], Lachlan Shiver[1], Chen Wang[1], Katsiaryna Khatskevich[2], Claude Bassil[3], Michael Poch[3], Brandon Manley[3], Heather Huelster[3], Wade Sexton[3], Philippe Spiess[3]
[1]University of South Florida Morsani College of Medicine, Tampa, FL, [2]Department of Pathology and Laboratory Medicine, Medical University of South Carolina, Charleston, SC, [3]Department of Genitourinary Oncology, H. Lee Moffitt Cancer Center Research Institute, Tampa, FL
Presented By: Firaas Khan

POSTER #44

AN EXOSOMAL MICRORNA SIGNATURE CORRELATED WITH INCREASED PROLIFERATION AND METASTASIS IN TREATMENT RESISTANT RENAL CELL CARCINOMA

Jacob W. Greenberg, Hogyoung Kim, Joshua Pincus, Christopher R. Koller, Ahmed A. Moustafa, Asim B. Abdel-Mageed, L. Spencer Krane
Tulane University School of Medicine
Presented By: Christopher Koller, MD

POSTER #45

FEASIBILITY OF ABSTAINING FROM COMPUTERIZED TOMOGRAPHY WITH ARTERIOGRAPHY PRIOR TO EMBOLIZATION OF POST ROBOTIC PARTIAL NEPHRECTOMY PSEUDOANEURYSM

Christian Ericson, MD, Laura Geldmaker, Bryce Baird, MD, David Thiel, MD
Mayo Clinic
Presented By: Christian A. Ericson, MD, BS

POSTER #46

IMPACT OF PREOPERATIVE PROTEINURIA ON ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY (RAPN) OUTCOMES

Laura Geldmaker, Bryce Baird, Daniela Haehn, Mikolaj Wieczorek, Colleen Ball, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

POSTER #47

ASSOCIATION OF PRE-OPERATIVE GLUCOSE LEVELS WITH ROBOTIC ASSISTED PARTIAL NEPHRECTOMY (RAPN) PERI-OPERATIVE OUTCOMES

Laura Geldmaker, Daniela Haehn, Bryce Baird, Mikolaj Wieczorek, Colleen Ball, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

POSTER #48

ADOPTION OF THE MOSES 120W HOLMIUM LASER IS ASSOCIATED WITH SIGNIFICANTLY DECREASED OPERATIVE TIME DURING URETEROSCOPIC STONE EXTRACTION AT A LARGE TERTIARY REFERRAL CENTER

S. Sunny Roy, MSPH MD, David L. Thompson, MD, Jessica N. Lange, MD
University of Tennessee at Chattanooga College of Medicine – Erlanger Urology
Presented By: Samit Sunny Roy, MD

POSTER #49

URINARY STONE-RELATED FINANCIAL TOXICITY CLINIC: BASELINE FINANCIAL RESOURCES CORRELATE WITH FINANCIAL STRAIN

Jackson Cabo, MD, Sean Setia, MD, Ryan Hsi, MD
Vanderbilt University Medical Center
Presented By: Jackson Cabo, MD

POSTER #50

NOBODY LIKES BURNT POPCORN: THE MOST EFFICIENT POPCORNING SETTINGS IN A NOVEL 3D-KIDNEY MODEL THAT LIMITS THERMAL INJURY

Francois Soto Palou[1], Robert Medairos[1], Christian Tabib[1], Zachary Dionise[1], Sabrina Trans[2], Jodi Antonelli[1], Michael Lipkin[1], Glenn Preminger[1], Pei Zhong[2]
[1]Duke Urology, [2]Duke Engineering
Presented By: Francois Soto-Palou, MD

POSTER #51

PCR TECHNOLOGY TO IDENTIFY UROPATHOGENS IN PATIENTS UNDERGOING KIDNEY STONE SURGERY: PRELIMINARY RESULTS FROM A FEASIBILITY AND METHODS STUDY

Bristol B. Whiles, MD[1], WIllian Ito, MD[2], William Donelan, PhD[1], Vincent G. Bird, MD[1], Wilson Molina, MD[2], John M. DiBianco, MD[1], Benjamin K. Canales, MD[1], Russell S. Terry, MD[1]
[1]University of Florida, Dept. of Urology, Gainesville, FL, [2]University of Kansas, Dept. of Urology, Kansas City, KS
Presented By: Bristol B. Whiles, MD

POSTER #52

FACTORS ASSOCIATED WITH LIVING KIDNEY DONATION AMONG PATIENTS WITH KIDNEY STONE DISEASE

Tyler Compher[1], Kyle Wood, MD[1,2], Dean Assimos, MD[1,2], Shikha Mehta, MD[1,3,4], Vineeta Kumar, MD[1,3,4], Michael Hanaway, MD[1,4,5], Joseph Crivelli, MD[1,2]
[1]University of Alabama at Birmingham School of Medicine, Birmingham, Alabama, USA, [2]Department of Urology, University of Alabama at Birmingham, Birmingham, Alabama, USA, [3]Department of Medicine, University of Alabama at Birmingham, Birmingham, Alabama, USA, [4]Comprehensive Transplant Institute, University of Alabama at Birmingham, Birmingham, Alabama, USA, [5]Division of Transplantation, Department of Surgery, University of Alabama at Birmingham, Birmingham, Alabama, USA
Presented By: Tyler Reid Compher

POSTER #53

HIGH PREVALENCE OF OSTEOPOROSIS IN KIDNEY STONE FORMERS WITH CROHNS DISEASE

Elizabeth Kwenda, MD[1], Lucy Jiang, BS[1], Leticia Rodriguez, BS[1], Juan Varela, BS[1], Claisha Pruitt, BS[1], Sarah Glover, DO[2], Victoria Bird, MD[3]
[1]University of Florida, [2]University of Mississippi Medical Center, [3]National Med. Assoc. and Research Group
Presented By: Elizabeth Kwenda, MD

POSTER #54

IS THERE A SPECIFIC DURATION OF INDWELLING RETAINED URETERAL STENTS THAT WOULD PREDICT THE NECESSITY OF A PERCUTANEOUS NEPHROLITHOTOMY?

Zachary M. Connelly[1], Kevin Morgan[1], Tomas Paneque[1], Harrison Torres[1], Alex Fuselier[1], Mohamed Ahmed[2], Nazih Khater[1]
[1]LSU Health Shreveport, [2]Mayo Clinic Rochester
Presented By: Nazih Khater, MD

POSTER #55

SINGLE-INSTITUTION EXPERIENCE WITH PERCUTANEOUS NEPHROLITHOTOMY IN THE SOUTHEASTERN UNITED STATES

Benjamin Schmeusser, MD, MS[1], Henry Biermann, BS[1], Adil Ali, BS[1], Yash Shah, BS[2], Benjamin Herron, BA[1], Nikhil Vettikattu, BS, BA[1], Sriram Ambadi[1], Dattatraya Patil, MBBS, MPH[1], Eric Midenberg, MD[3], Reza Nabavizadeh, MD[4], John Pattaras, MD[1], Cara Cimmino, MD[1], Aaron Lay, MD[1], Viraj Master, MD[1], Kenneth Ogan, MD[1]
[1]Department of Urology, Emory University School of Medicine, Atlanta, GA, [2]Sidney Kimmel Medical College, Thomas Jefferson University, Philadelphia, PA, [3]Department of Urology, University of Louisville School of Medicine, Louisville, KY, [4]Department of Urology, Mayo Clinic, Rochester, MN
Presented By: Benjamin Nicholas Schmeusser, MD, MS

POSTER #56

SAFETY AND CLINICAL INSIGHTS OF RENAL PAPILLARY TIP BIOPSIES FOR THE STUDY OF LITHIASIS

Elizabeth Kwenda, Alexandra Hernandez, Elizabeth Di Valerio, Benjamin Canales
Department of Urology, University of Florida, Gainesville, FL
Presented By: Elizabeth Kwenda, MD

CONCURRENT SESSIONS END

8:30 a.m. - 9:00 a.m.

Break/Visit Exhibits
Location: Salons 1-3

9:00 a.m. - 9:45 a.m.

AUA Course of Choice Lecture: Urological Trauma & Reconstruction
AUA Course of Choice
Guest Speaker: Michael Coburn, MD, FACS
Houston, TX

9:45 a.m. - 10:00 a.m.

SESAUA Update
President: S. Duke Herrell III, MD, FACS
Nashville, TN

10:00 a.m. - 10:30 a.m.

Break/Visit Exhibits
Location: Salons 1-3

10:30 a.m. - 11:00 a.m.

State-of-the-Art Lecture: Is There Value in Making Your Patient "Stone Free"?
Guest Speaker: Mathew D. Sorensen, MD, MS, FACS
Seattle, WA

11:00 a.m. - 11:45 a.m.

Panel Discussion: Complex Urethral Reconstruction: Tips and Tricks
Moderator: Ryan P. Terlecki, MD, FACS
Winston-Salem, NC

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Rectourethral Fistula
Panelist: Niels V. Johnsen, MD, MPH
Nashville, TN

BXO
Panelist: Maxim J. McKibben, MD
Charlotte, NC

Female Reconstruction
Panelist: Melissa R. Kaufman, MD, PhD
Nashville, TN

11:45 a.m. - 12:15 p.m. **State-of-the-Art Lecture: Advanced Imaging for Prostate Cancer: What's Changed?**
Speaker: Julio M. Pow-Sang, MD
Tampa, FL

12:15 p.m. - 1:15 p.m. **Industry Sponsored Lunch Symposium**
Location: Talbot F-H

12:15 p.m. - 1:15 p.m. **Industry Sponsored Lunch Symposium**
Location: Talbot A-C

1:15 p.m. - 1:45 p.m. **Break - Visit Exhibits**
Location: Salons 1-3

1:45 p.m. - 2:30 p.m. **Ballenger Memorial Lecture: Lower Urinary Tract Symptoms Following Surgical Treatment of Benign Prostatic Enlargement: How a Better Preoperative Assessment Can Help Avoid Persistent LUTS**
Introducer: S. Duke Herrell III, MD, FACS
Nashville, TN
Guest Speaker: Gary E. Lemack, MD
Dallas, TX

2:30 p.m. - 2:45 p.m. **SESAUA History Lecture**
Speaker: Paul W. Coughlin, MD, FACS
High Point, NC

2:45 p.m. - 3:15 p.m. **Break/Visit Exhibits**
Location: Salons 1-3

CONCURRENT SESSIONS BEGIN

Concurrent Session 1 of 5

3:15 p.m. - 5:30 p.m. **Endourology Sub-Plenary Session**
Location: Talbot DE

3:15 p.m. - 4:00 p.m. **Nephrolithiasis Podium Session**
Location: Talbot DE
Moderators: Jodi Antonelli, MD
Durham, NC
Russell S. Terry, Jr., MD
Gainesville, FL

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3:15 P.M. **#41**

FACTORS ASSOCIATED WITH COMPLETING A 24-HOUR URINE IN LARGE COMMUNITY-BASED SAMPLE OF NEPHROLITHIASIS

Jackson Cabo, David Gelikman, Sean Setia, Ryan Hsi
Vanderbilt University Medical Center
Presented By: Jackson Cabo, MD

3:22 P.M. **#42**

COMPUTER VISION-MEDIATED ASSESSMENT OF SURGICAL SKILLS AND EXPERTISE FOR ENDOSCOPIC KIDNEY STONE REMOVAL SURGERY

Daiwei Lu[1], Chase Floyd[2], Zachary Stoebner[3], Ipek Oguz[1], Nicholas Kavoussi[4]
[1]Vanderbilt University, Electrical Engineering and Computer Science, Nashville, TN, [2]University of South Carolina School of Medicine, Dept. of Urology, Columbia, SC, [3]University of Texas at Austin, Electrical and Computer Engineering, Austin, TX, [4]Vanderbilt University Medical Center, Dept. of Urology, Nashville, TN
Presented By: Nicholas Kavoussi, MD

3:29 P.M. **#43**

EFFICACY AND SAFETY OF LUMASIRAN IN PATIENTS WITH PRIMARY HYPEROXALURIA TYPE 1: 24-MONTH ANALYSIS OF THE ILLUMINATE-A TRIAL

Kyle Wood, MD[1], John Lieske, MD[2], Jaap Groothoff, MD, PhD[3], Yaacov Frishberg, MD[4], Anne-Laure Sellier-Leclerc, MD[5], Hadas Shasha-Lavsky, MD[6], Jeffrey Saland, MD, MSCR[7], Wesley Hayes, MEng, MA, MBBChir, MRCPCH[8], Daniella Magen, MD[9], Shabbir Moochhala, MBChB, PhD[10], Martin Coenen, MD[11], Eva Simkova, MD[12], Taylor Ngo, MPH[13], John Gansner, MD, PhD[13], Sally-Anne Hulton, MD[14]
[1]University of Alabama at Birmingham, Department of Urology, Birmingham, AL, [2]Mayo Clinic, Division of Nephrology, Rochester, MN, [3]Emma Children's Hospital, University of Amsterdam, Department of Pediatric Nephrology, Amsterdam, The Netherlands, [4]Shaare Zedek Medical Center, Division of Pediatric Nephrology, Jerusalem, Israel, [5]Hospices Civils de Lyon, ERKnet, Pediatric Nephrology Unit, Bron, France, [6]Galilee Medical Center, Pediatric Nephrology Unit, Nahariya, Israel, [7]Mount Sinai Kravis Children's Hospital, Mount Sinai Health System, Jack and Lucy Clark Department of Pediatrics, New York, NY, [8]Great Ormond Street Hospital, Department of Paediatric Nephrology, London, UK, [9]Pediatric Nephrology Institute, Rambam Health Care Campus, Haifa, Israel, [10]Royal Free Hospital, Department of Renal Medicine, London, UK, [11]Clinical Study Core Unit, Institute of Clinical Chemistry and Clinical Pharmacology, University Hospital Bonn, Bonn, Germany, [12]Al Jalila Children's Hospital, Kidney Centre, Dubai, UAE, [13]Alnylam Pharmaceuticals, Cambridge, MA, [14]Birmingham Women's and Children's Hospital, Department of Nephrology, Birmingham, UK
Presented By: Kyle D. Wood, MD

3:36 P.M. **#44**

SPOT URINE OXALATE TESTING IN A CONTROLLED TRIAL OF FORCED HYDRATION AND SPINACH CONSUMPTION

William Donelan, PhD[1], Jason Joseph, MD[2], Bergen Lemack, BS[3], Paul Dominguez-Gutierrez, PhD[1], Vincent Bird, MD[1], Russell Terry, MD[1], Benjamin Canales, MD, MPH[1]
[1]University of Florida College of Medicine, Department of Urology, Gainesville, FL, [2]Urology of Virginia, Virginia Beach, VA, [3]University of Florida, Gainesville, FL
Presented By: Russell S. Terry, Jr., MD

3:43 P.M. **#45**

DUSTING EFFICIENCY FOR THULIUM FIBER LASER: WHEN IT COMES TO FREQUENCY, LESS IS MORE

Francois Soto Palou[1], Robert Medairos[1], Junqin Chen[2], Jodi Antonelli[1], Michael Lipkin[1], Glenn Preminger[1], Pei Zhong[2]
[1]Duke Urology, [2]Duke Engineering
Presented By: Francois Soto-Palou, MD

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3:50 P.M. **#46** **SHORT PULSE VS. LONG PULSE ABLATION WITH THE THULIUM FIBER LASER, AN IN VITRO STUDY**
Francois Soto Palou[1], Robert Medairos[1], Junqin Chen[2], Jodi Antonelli[1], Michael Lipkin[1], Glenn Preminger[1], Pei Zhong[2]
[1]Duke Urology, [2]Duke Engineering
Presented By: Francois Soto-Palou, MD

4:00 p.m. - 4:15 p.m. **Break**
Location: Talbot Pre-Function

4:15 p.m. - 4:45 p.m. **State-of-the-Art Lecture: Novel Therapies in the Management of Oxalate**
Location: Talbot DE
Speaker: Kyle D. Wood, MD
Birmingham, AL

4:45 p.m. - 5:30 p.m. **Panel Discussion: Stones in the Horseshoe Kidney**
Location: Talbot DE
Moderator: Kenneth Ogan, MD
Atlanta, GA
Panelists: Jason R. Bylund, MD, MPH
Lexington, KY
Nazih Paul Khater, MD, FACS
Shreveport, LA
Michael E. Lipkin, MD, MBA
Durham, NC

Concurrent Session 2 of 5

3:15 p.m. - 5:30 p.m. **Pediatric Sub-Plenary Session**
Location: Talbot F-H

3:15 p.m. - 4:00 p.m. **Pediatrics Panel Discussion - The Difficult Valve Patient: Management Through the Years**
Location: Talbot F-H
Moderator: Shuvro De, MD
Atlanta, GA
Panelists: Christopher Bayne, MD
Gainesville, FL
Campbell M. Grant, MD
Lexington, KY

4:00 p.m. - 4:30 p.m. **State-of-the-Art Lecture: SP Robot Use in Pediatrics**
Location: Talbot F-H
Speaker: Christopher Bayne, MD
Gainesville, FL

4:30 p.m. - 4:45 p.m. **Break**
Location: Talbot Pre-Function

4:45 p.m. - 5:30 p.m. **Pediatrics Podium Session**
Location: Talbot F-H
Moderators: John S. Wiener, MD
Durham, NC
Charlotte Wu, MD
Baltimore, MD

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4:45 P.M. **#47**

INFANTILE VERSUS CHILDHOOD POSTERIOR URETHRAL VALVE DIAGNOSIS: MANAGEMENT PATTERNS AND CLINICAL OUTCOMES AT OPPOSITE ENDS OF THE SPECTRUM

Andrew Gabrielson[1], Logan Galansky[1], Edwin Smith[2], Charlotte Wu[1]
[1]Johns Hopkins University School of Medicine, [2]Emory University School of Medicine
Presented By: Charlotte Wu, MD

4:52 P.M. **#48**

LOW RISK OF SECONDARY TREATMENT AFTER ENDOSCOPIC INJECTION OF VUR USING THE DOUBLE HIT METHOD: ANALYSIS OF 3059 PROCEDURES OVER 19 YEARS

Ricardo Arceo-Olaiz[1,2], Shuvro De[1,2], Andrew Kirsch[1,2]
[1]Emory University, [2]Children's Healthcare of Atlanta
Presented By: Ricardo Arceo Olaiz

4:59 P.M. **#49**

EFFECT OF SOCIAL DISPARITIES ON 10 YEAR SURVIVAL IN PEDIATRIC PATIENTS WITH WILMS' TUMOR

Victor Chalfant, BA[1], Carlos Riveros, MD[2], Andrew Stec, MD[3]
[1]Creighton University School of Medicine, Department of Urology, Omaha, NE, [2]University of Florida Health, Department of Urology, Jacksonville, FL, [3]Nemours Children's Health, Division of Urology, Jacksonville, FL
Presented By: Andrew Alexander Stec, MD

5:06 P.M. **#50**

GONADAL TUMORS IN PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT - A MULTI-SITE STUDY FROM THE PEDIATRIC UROLOGIC ONCOLOGY WORKING GROUP OF THE SOCIETIES FOR PEDIATRIC UROLOGY

Leslie Peard, MD[1], Jacqueline Morin, MD[2], Will Cranfod, MS[2], Viktor Flores, MD[1], Kyle Graham, MPH[1], Abby Taylor, MD, MPH[1], John Pope IV, MD[1], Valeska Halstead, MD, MPH[3], Nicholas Cost, MD[3], Evan Roberts, MBA[4], John Makari, MD, MHA, MA[4], Amanda Saltzman, MD[2]
[1]Vanderbilt University Medical Center, [2]University of Kentucky, [3]University of Colorado, [4]University of Nebraska Medical Center
Presented By: Leslie M. Peard, MD

5:13 P.M. **#51**

REPEAT CT IN ISOLATED INTRA-ABDOMINAL RENAL TRAUMA IS NOT ASSOCIATED WITH REDUCED COMPLICATIONS, READMISSIONS, OR DELAYED INTERVENTIONS

Viktor Flores[1], Benjamin Abelson[1], Shilin Zhao[1], Caroline Khanna[1], George Koch[1], Amber Greeno[1], Ching Man Carmen Tong[2], David Kitchens[2], Vinaya Bhatia[3], Jonathan Gerber[3], Christopher Long[4], Dana Weiss[4], Jacob Lucas[5], Albert Lee[6], Christina Ho[6], Jeffrey Ellis[5], Ming-Hsien Wang[3], Douglass Clayton[1]
[1]Vanderbilt University Medical Center, [2]Children's of Alabama, [3]Texas Children's Hospital at Baylor College of Medicine, [4]Children's Hospital of Philadelphia, [5]Einstein Healthcare Network, [6]Children's National Medical Center
Presented By: Viktor Xavier Flores

5:20 P.M. **#52**

PRELIMINARY RESULTS OF UMPIRE PROTOCOL DEVIATIONS AMONG INFANTS WITH SPINA BIFIDA

Jonathan Routh, MD, MPH[1], Jacqueline Mix, PhD, MPH[2], Tonya Williams, PhD, MS[2], Alexandra Borden, PA-C[1], David Chu, MD, MSCE[3], Kathryn Smith, RN, MN, DPH[4], Jennifer Ahn, MD, MS[5], Catharine Riley, PhD, MPH[2]
[1]Duke University, [2]CDC, [3]Lurie Children's Hospital, Northwestern University, [4]Children's Hospital Los Angeles, [5]Seattle Children's Hospital
Presented By: Jonathan C. Routh, MD, MPH

3:15 p.m. - 5:30 p.m. **Renal Tumors Sub-Plenary Session**
Location: Talbot A-C

3:15 p.m. - 3:45 p.m. **State-of-the-Art Lecture: Endoscopic Management of Upper Tract Urothelial Cancer**
Location: Talbot A-C
Speaker: John Roger Bell, MD
Lexington, KY

3:45 p.m. - 4:00 p.m. **Break**
Location: Talbot Pre-Function

4:00 p.m. - 4:45 p.m. **Kidney Cancer Podium Session**
Location: Talbot A-C
Moderators: Brant Inman, MD, MS
Durham, NC
Charles R. Pound, MD
Jackson, MS

4:00 P.M. **#53**
INFERIOR VENA CAVA LIGATION WITHOUT RECONSTRUCTION FOR RETROPERITONEAL TUMORS
Benjamin Schmeusser, MD, MS[1], Arnold Palacios, MD, MA[2], Eric Midenberg, MD[3], Dattatraya Patil, MBBS, MPH[1], Lillian Xie, MD[4], Kenneth Ogan, MD[1], Kenneth Cardona, MD[5], Shishir Maithel, MD[5], Viraj Master, MD, PhD[1]
[1]Department of Urology, Emory University School of Medicine, Atlanta, GA, [2]Department of Urology, Creighton University, Omaha, NE, [3]Department of Urology, University of Louisville, Louisville, KY, [4]Department of Urology, University of Washington, Seattle, WA, [5]Department of Surgery, Emory University School of Medicine, Atlanta, GA
Presented By: Arnold R. Palacios, MD, MA

4:07 P.M. **#54**
PD-L1 EXPRESSION AND RENAL CELL CARCINOMA: IS EXOGENOUS ESTROGEN DRIVING AGGRESSIVE TUMOR CHARACTERISTICS THROUGH INCREASED EXOSOME PRODUCTION?
Jacob W. Greenberg[1], Hogyoung Kim[1], Joshua Pincus[1], Ahmed A. Moustafa[1], Asim Abdel-Mageed[1], L. Spencer Krane[2]
[1]Tulane School of Medicine, [2]Southeast Louisiana Veterans Healthcare System
Presented By: Jacob Greenberg

4:14 P.M. **#55**
EPIDEMIOLOGY OF YOUNG ADULT RENAL CELL CARCINOMA IN KENTUCKY: INCIDENCE, CLINICOPATHOLOGIC FEATURES AND CANCER-SPECIFIC SURVIVAL
Jacob Elam, MD, Jason Bylund, MD
University of Kentucky, Department of Urology
Presented By: Jacob M. Elam, MD, BA

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4:21 P.M. **#56**

INABILITY OF MAYO ADHESIVE PROBABILITY SCORE TO PREDICT SURVIVAL OUTCOMES IN LOCALLY ADVANCED RENAL CELL CARCINOMA

Benjamin Schmeusser, MD, MS[1], Tad Manalo, MD[2], Yuan Liu, PhD[3], Yash Shah, BS[4], Dattatraya Patil, MBBS, MPH[1], Reza Nabavizadeh, MD[1,5], Kenneth Ogan, MD[1], Viraj Master, MD, PhD[1]
[1]Department of Urology, Emory University School of Medicine, Atlanta, GA, [2]Department of Urology, University of Colorado School of Medicine, Denver, CO, [3]Department of Biostatistics and Bioinformatics, Emory University School of Medicine, Atlanta, GA, [4]Sidney Kimmel Medical College, Thomas Jefferson University, Philadelphia, PA, [5]Department of Urology, Mayo Clinic, Rochester, MN
Presented By: Benjamin Nicholas Schmeusser, MD, MS

4:28 P.M. **#57**

PROGNOSTIC UTILITY OF LINEAR SEGMENTATION IN NONMETASTATIC RENAL CELL CARCINOMA: A CLINICALLY PRACTICAL TECHNIQUE SHOWING CORRELATION OF MUSCLE MASS AND OVERALL SURVIVAL

Benjamin Schmeusser, MD, MS[1], Eric Midenberg, MD[1,2], Arnold Palacios, MD, MA[3], Nikhil Vettikatu, BS, BA[4], Dattatraya Patil, MBBS, MPH[1], Alexandra Medline, MD[4], Michelle Higgins, MD[5], Sarah Psutka, MD, MS[6,7], Kenneth Ogan, MD[1], Viraj Master, MD, PhD[1]
[1]Emory University, Department of Urology, Atlanta, GA, [2]University of Louisville, Department of Urology, Louisville, KY, [3]Creighton University, Department of Urology, Omaha, NE, [4]Emory University School of Medicine, Atlanta, GA, [5]Johns Hopkins University, Department of Urology, Baltimore, MD, [6]Department of Urology, University of Washington, Seattle, WA, [7]Seattle Cancer Care Alliance
Presented By: Benjamin Nicholas Schmeusser, MD, MS

4:35 P.M. **#58**

IMPACT OF BASE SUTURE TYPE ON RATE OF POSTOPERATIVE RENAL ARTERY PSEUDOANEURYSM FOLLOWING ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY (RAPN)

Laura Geldmaker, Daniela Haehn, Amanda Myers, Mikolaj Wieczorek, Colleen Ball, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

4:45 p.m. - 5:30 p.m.

Panel Discussion: Role of Surgery With Metastatic RCC in 2023
Location: Talbot A-C

Moderator: Peter E. Clark, MD
Charlotte, NC

Panelists: Zachary Klaassen, MD, MSc
Augusta, GA

Jamie Messer, MD
Louisville, KY

Concurrent Session 4 of 5

3:15 p.m. - 4:15 p.m.

Men's Health, Sexual Dysfunction and Infertility Poster Session
Location: Plaza I

Moderators: Thomas A. Masterson III, MD
Miami, FL

Ashley H. Tapscott, DO
Huntersville, NC

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POSTER #57

DIRECT EFFECTS OF CANNABINOID ON DIFFERENT CELL TYPES OF HUMAN TESTIS: AN IN VITRO MODEL

Janmejay Hingu, MD[1,2], Salome Ambokadze[1], Bita Nickkholgh, MD, PhD[1], Allyn C. Howlett, PhD[3], Hooman Sadri-Ardekani, MD, PhD[1,2]
[1]Wake Forest University School of Medicine, Wake Forest Institute for Regenerative Medicine, Winston-Salem, NC, [2]Wake Forest University School of Medicine, Department of Urology, Winston-Salem, NC, [3]Wake Forest University School of Medicine, Department of Physiology and Pharmacology, Winston-Salem, NC
Presented By: Janmejay Hingu, MD

POSTER #58

EVALUATION OF THE EFFECTIVENESS OF MICROSURGICAL MANAGEMENT OF CHRONIC ORCHIALGIA

Caleb Natale, MD[1], Olivia Paulsen, BSc[2], Wayne JG Hellstrom, MD[1]
[1]Tulane University School of Medicine, New Orleans, LA, [2]Idaho College of Osteopathic Medicine, Meridian, ID
Presented By: Caleb Natale

POSTER #59

SEMEN MICROBIOME PROFILING IN MEN WITH NON-OBSTRUCTIVE AZOOSPERMIA: A NEXT-GENERATION SEQUENCING ANALYSIS

Farah Rahman[1], Katherine Campbell[1], Camila Suarez[1], Emad Ibrahim[1], Sabita Roy[1], Praveen Singh[1], Kajal Khodamoradi[1], Ranjith Ramasamy[1], Braian Ledesma[2]
[1]University of Miami, Desai Sethi Urology Institute, Miami, FL, [2]University of Miami, Desai Dethi Urology Instittue, Miami, FL
Presented By: Braian Rene Ledesma, MD

POSTER #60

COMPARISON OF HEMATOCRIT CHANGE IN TESTOSTERONE-DEFICIENT MEN TREATED WITH INTRANASAL TESTOSTERONE GEL VERSUS INTRAMUSCULAR TESTOSTERONE CYPIONATE: A SINGLE-CENTER RANDOMIZED CLINICAL TRIAL

Jesse Ory[1], Marco-Jose Rivero[2,3], Parris Diaz[2], Raul Clavijo[4], Nannan Thirumavalavan[5], Ruben Blachman-Braun[2], Justin Loloi[6], Ari Bernstein[7], Ranjith Ramasamy[2]
[1]Dalhousie University, Department of Urology, Halifax, NS, Canada, [2]University of Miami Miller School of Medicine, Desai Sethi Urology Institute, Miami, FL, [3]Case Western Reserve University School of Medicine, Cleveland, OH, [4]University of California Davis School of Medicine, Department of Urologic Surgery, Sacramento, CA, [5]University Hospitals Cleveland Medical Center, Urology Institute, Cleveland, OH, [6]Montefiore Medical Center, Department of Urology, New York, NY, [7]NYU Langone Health, Department of Urology, New York, NY
Presented By: Marco-Jose Rivero

POSTER #61

PRESENCE AND ETIOLOGY OF ERECTILE DYSFUNCTION IN PEYRONIE'S DISEASE AS DEMONSTRATED BY COLOR DOPPLER DUPLEX ULTRASOUND

Laura Geldmaker, BS[1], Daniela Haehn, MD[1], Christopher Walker[2], Colleen Ball, MS[3], Gregory Broderick, MD[1]
[1]Department of Urology, Mayo Clinic, Jacksonville, FL, [2]University of North Florida, Jacksonville, FL,, [3]Division of Clinical Trials and Biostatistics, Mayo Clinic, Jacksonville, FL
Presented By: Laura Elizabeth Geldmaker, B.S.

POSTER #62

HISTOLOGY APPEARS TO REVEAL GOOD SEALING OF THE HUMAN, PROCINE AND DOG VASECTOMY SPECIMENS USING THE VASECTOMY SEALING PROCEDURE

Gerard Henry, MD[1], Tariq Hakky, MD[2], Ryan Griggs, DO[1], Warren Nighan[3], Alex Fuselier[1], LeRoy Jones, MD[4]

[1]WK Advanced Urology, [2]Atlanta Cosmetic Urology, [3]Signati Medical Boston, [4]Urology San Antonio

Presented By: Alex Fuselier

POSTER #63

PATIENTS WITH ADULT-ACQUIRED BURIED PENIS AND THEIR SURGICAL MANAGEMENT: A SINGLE-CENTER STUDY

Melissa Wong, MD[1], Abigail Chaffin, MD[2], David Jansen, MD[2], Wayne JG Hellstrom, MD[1]

[1]Tulane University School of Medicine, Department of Urology, [2]Tulane University School of Medicine, Department of Plastic Surgery

Presented By: Melissa Wong, MD

POSTER #65

THE ROLE OF MICRO-ULTRASOUND FOR VASECTOMY REVERSAL. CAN WE IDENTIFY THE OBSTRUCTION?

Trisha Nguyen, MD, Miranda Eubank, MD, Wayne Brisbane, MD, Kevin Campbell, MD

University of Florida Department of Urology, Gainesville, FL

Presented By: Trisha Nguyen, MD

POSTER #66

SUPERFICIAL WOUND DEHISCENCE FOLLOWING PENOSCROTAL INFLATABLE PENILE PROSTHESIS PLACEMENT: A CAUSE FOR CONCERN?

John Williams, MD, Nicholas Major, MD, Eric Laborde, MD

Ochsner Clinic Foundation

Presented By: John Matthew Williams, MD, MS

POSTER #67

THALLIUM EXPOSURE TO 3D HUMAN TESTICULAR ORGANOIDS ALTERS MIRNA EXPRESSION BIOMARKERS.

Janmejay Hingu, MD[1,2], Adam Cohen, MD[1,2], Nima Pourhabibi Zarandi, MD[1,3], Anthony Atala, MD[1,2], Hooman Sadri-Ardekani, MD, PhD[1,2]

[1]Wake Forest University School of Medicine, Wake Forest Institute for Regenerative Medicine, Winston-Salem, NC, [2]Wake Forest University School of Medicine, Department of Urology, Winston-Salem, NC, [3]University of Pittsburgh Medical Central in Central Pa., Department of Internal Medicine, Harrisburg, PA

Presented By: Janmejay Hingu, MD

POSTER #64 **WITHDRAWN**

Concurrent Session 5 of 5

4:30 p.m. - 5:30 p.m.

Bladder Cancer Poster Session

Location: Plaza II

Moderators: Scott E. Delacroix Jr., MD
New Orleans, LA

Andrew C. James, MD
Lexington, KY

POSTER #68

POPULATION-BASED ASSESSMENT OF DETERMINING PREDICTORS FOR DISCHARGE DISPOSITION IN PATIENTS WITH BLADDER CANCER UNDERGOING RADICAL CYSTECTOMY

Raj Kumar, Kian Asanad, Gus Miranda, Jie Cai, Hooman Djalat, Mihir Desai, Inderbir Gill, Saum Ghodoussipour, Giovanni Cacciamani

Presented By: Raj Anirudh Kumar, BS

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POSTER #69

CONVERSION TO DISPOSABLE CYSTOSCOPES DECREASED POST-PROCEDURE INFECTIONS COMPARED TO REUSABLE CYSTOSCOPES

Bryce Baird, Laura Geldmaker, Eric Regele, Daniela Haehn, Colleen Ball, Gregory Broderick, Ram Pathak, Timothy Lyon, David Thiel
Mayo Clinic Florida
Presented By: Bryce Alden Baird, BS, MD

POSTER #70

ONCOLOGIC OUTCOMES: INTRAVESICAL GEMCITABINE/ DOCETAXEL IS A FEASIBLE ALTERNATIVE FOR MANAGEMENT OF HIGH-RISK NON-MUSCLE INVASIVE BLADDER CANCER

Emily Roebuck, BS[1], Justin Refugia, MD[2], Parth Thakker, MD[2], Taylor Peak, MD[2], Celeste Watts, PA[2], Ronald Davis, MD[2], Ashok Hemal, MD[2], Matvey Tsivian, MD[2]
[1]Wake Forest School of Medicine, Atrium Health Wake Forest Baptist, Winston-Salem, NC, [2]Department of Urology, Atrium Health Wake Forest Baptist, Winston-Salem, NC
Presented By: Emily H. Roebuck, BS

POSTER #71

PERIOPERATIVE AND NEW PERSISTENT OPIOID USE IN CYSTECTOMY PATIENTS

Hailey Holck[1], Samuel Ivan[1], Rachel Locke[1], Myra Robinson, MSPH[2], Peter Clark[1], Kris Gaston[1], Stephen Riggs[1]
[1]Department of Urology, Levine Cancer Institute/Atrium Health, [2]Department of Cancer Biostatistics, Levine Cancer Institute/ Atrium Health
Presented By: Hailey Holck, BS

POSTER #72

PATHOLOGIC OUTCOMES AFTER NEOADJUVANT CHEMOTHERAPY IN PRIMARY VERSUS SECONDARY MUSCLE INVASIVE BLADDER CANCER – A SINGLE INSTITUTION EXPERIENCE

Hiroko Miyagi, Padraic O'Malley, Paul Crispen
University of Florida, Department of Urology, Gainesville, FL
Presented By: Hiroko Miyagi, MD

POSTER #73

EFFICACY OF BCG FOR NON-MUSCLE INVASIVE BLADDER CANCER FOLLOWING NEPHROURETERECTOMY FOR UPPER TRACT UROTHELIAL CARCINOMA

Michael Massari, MD, Padraic O'Malley, MD, Paul Crispen, MD
University of Florida
Presented By: Michael Massari, MD

POSTER #74

THE ASSOCIATION BETWEEN PERIOPERATIVE SERUM BICARBONATE LEVELS AND COMPLICATION RATES AFTER RADICAL CYSTECTOMY

James Frisbie[1], Kathryn Gessner[1], Shivani Desai[2], Matthew Nielsen[1], Marc Bjurlin[1], Hung-Jui Tan[1], Angela Smith[1]
[1]UNC Department of Urology, [2]UNC School of Medicine
Presented By: James Frisbie, MD

POSTER #75

PREDICTORS OF TRAVEL DISTANCE FOR RADICAL CYSTECTOMY IN FLORIDA: IMPLICATIONS FOR ACCESS TO CARE

Jared Schommer, Shalmali Borkar, Emily Brennan, Andrew Zganjar, Dorin Colibaseanu, Aaron Spaulding, Timothy Lyon
Mayo Clinic Florida
Presented By: Jared Schommer, MD, PhD

POSTER #76

SUNRISE-1: TAR-200 PLUS CETRELIMAB, TAR-200 ALONE, OR CETRELIMAB ALONE IN HIGH-RISK NON-MUSCLE INVASIVE BLADDER CANCER IN BCG-UNRESPONSIVE PARTICIPANTS WHO ARE INELIGIBLE FOR/DECLINE RADICAL CYSTECTOMY

Joseph Jacob[1], Christopher Cutie[2], Shalaka Hampras[3], Shu Jin[2], Hui Tian[4], Katherine Stromberg[5], Xiang Li[5], Neil Beeharry[4], John Maffeo[2], Michiel S. van der Heijden[6], Peter Clark[7]
[1]Upstate Medical University, Department of Urology, Syracuse, NY, [2]Janssen Research Development, Clinical Oncology, Lexington, MA, USA, [3]Janssen Research Development, Clinical Oncology, Raritan, NJ, USA, [4]Janssen Research Development, Clinical Oncology, Spring House, PA, USA, [5]Janssen Research Development, Clinical Biostatistics, Raritan, NJ, USA, [6]Netherlands Cancer Institute, Department of Medical Oncology, Amsterdam, Netherlands, [7]HealthCare System Levine Cancer Institute
Presented By: Peter Clark, MD

POSTER #77

THE IMPACT OF A DEDICATED CLOSING TRAY ON SURGICAL SITE INFECTIONS: THE FIRST YEAR

Rand Wilcox Vanden Berg, Michael Abern
Division of Urology, Department of Surgery
Presented By: Rand N. Wilcox Vanden Berg, MD

POSTER #78

A CONTEMPORARY ANALYSIS OF TREATMENT OF MUSCLE INVASIVE BLADDER CANCER USING THE NATIONAL CANCER DATABASE: FACTORS ASSOCIATED WITH RECEIPT OF NON-AGGRESSIVE THERAPY.

Sol Moon[1], Vishruti Pandya[2], Andrew McDonald[3], Arnab Basu[4], Sejong Bae[2], James Ferguson[5]
[1]Department of Urology, University of Alabama Birmingham, [2]Department of Medicine, Division of Preventative Medicine, University of Alabama Birmingham, [3]Department of Radiation Oncology, University of Alabama Birmigham, [4]Department of Medicine, Division of Hematology-Oncology, University of Alabama Birmingham, [5]Department of Urology, University of Alabama Birmingham, Birmingham Veterans Affairs Medical Center
Presented By: Sol Moon, MD

CONCURRENT SESSIONS END

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FRIDAY, MARCH 17, 2023

OVERVIEW

6:00 a.m. - 7:00 a.m. **Breakfast in the Exhibit Hall**
Location: Salons 1-3

6:00 a.m. - 1:15 p.m. **Speaker Ready Room Open**
Location: Cumberland Room

6:30 a.m. - 1:15 p.m. **Registration/Information Desk Open**
Location: Talbot Pre-Function

7:30 a.m. - 10:30 a.m. **Spouse/Guest Hospitality Suite Open**
Location: Tidewater Grill

7:30 a.m. - 11:30 a.m. **Exhibit Hall Open**
Location: Salons 1-3

6:30 p.m. - 10:00 p.m. **Residents' Night Out**
Location: Ocean Front Lawn
Sponsored by South Georgia Medical Center
(Invite Only)

CONCURRENT SESSIONS BEGIN

Concurrent Session 1 of 4

7:00 a.m. - 7:45 a.m. **Health Services Research Podium Session**
Location: Talbot DE
Moderators: Brian F. Chapin, MD
Houston, TX
Ram A. Pathak, MD
Jacksonville, FL

7:00 A.M. **#59** **THE RELATIONSHIP BETWEEN SOCIAL DETERMINANTS OF HEALTH AND PERSISTENT POST OPERATIVE OPIOID UTILIZATION AFTER LAPARASCOPIC PARTIAL AND RADICAL NEPHRECTOMY**
Alexis Kentros, MD[1], J. Yates Congleton, MD[1], Aimee Pehrson, MPH, CHES[2], James Bienvenu, MD[1], Wesley White, MD[1], Jason Buehler, MD[3], Laura Sisk[2]
[1]University of Tennessee Medical Center, Dept. of Urology, [2]University of Tennessee Graduate School of Medicine, Dept. of Anesthesiology, [3]University of Tennessee Medical Center, Dept. of Anesthesiology
Presented By: Alexis Kentros, MD

7:07 A.M. **#60** **RURAL FOR-PROFIT HOSPITALS ARE ASSOCIATED WITH HIGHER PRICES FOR COMMON UROLOGIC PROCEDURES**
Alexandria Spellman, MD, MS[1], Ian Berger, MD, MS[1], Vishnukamal Golla, MD, MPH[1], Marcelo Cerullo, MD, MPH[1], Yuqi Zhang, MD, MHS[2], Michael Lipkin, MD, MBA[1], Gary Faerber, MD[1], Charles Scales, MD, MSHS[1], Deborah Kaye, MD, MS[1]
[1]Duke University, [2]Yale University
Presented By: Alexandria Alverdy Spellman, M.D., M.S.

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7:14 A.M. **#61**

IMPACT OF SOCIAL DISPARITIES ON 10 YEAR SURVIVAL RATES IN PEDIATRIC CANCERS

Victor Chalfant, BA[1], Carlos Riveros, MD[2], Scott Bradfield, MD[3], Andrew Stec, MD[4]
[1]Creighton University School of Medicine, Department of Urology, Omaha, NE, [2]University of Florida Health, Department of Urology, Jacksonville, FL, [3]Nemours Children's Health, Division of Hematology and Oncology, Jacksonville, FL, [4]Nemours Children's Health, Division of Urology, Jacksonville, FL
Presented By: Andrew Alexander Stec, MD

7:21 A.M. **#62**

POTENTIAL SAVINGS IN UROLOGY WITH USE OF COST PLUS PHARMACY

Van Schloegel, MD[1], David Bandy[2], Elijah Dawson, PharmD[3], Benjamin Dropkin, MD[1]
[1]University of Kentucky Department of Urology, [2]University of Kentucky School of Medicine, [3]University of Kentucky Pharmacy Services
Presented By: Van Schloegel

7:28 A.M. **#63**

DISPARITIES IN ACCESS TO HIGH VOLUME CENTERS AND IN PERIOPERATIVE OUTCOMES FOLLOWING RADICAL CYSTECTOMY

Bryce Baird[1], Ethan Wajswol[1], Tiara Taylor[1], Shalmali Borkar[1], Christian Ericson[1], Augustus Anderson[2], Stephen Boorjian[3], Andrew Zganjar[1], Aaron Spaulding, Dorin Colibaseanu[1], Timothy Lyon[1]
[1]Mayo Clinic Florida, [2]Tulane University College of Medicine, [3]Mayo Clinic Rochester
Presented By: Bryce Alden Baird, BS, MD

7:35 A.M. **#64**

THE IMPACT OF SOCIOECONOMIC STATUS ON PATIENT COMPLIANCE IN MANAGING RENAL MASSES

Hailey Holck[1], Alexander Sinks[2], Ornob Roy[1]
[1]Department of Urology, Levine Cancer Institute/Atrium Health, [2]Wake Forest School of Medicine
Presented By: Hailey Holck, BS

Concurrent Session 2 of 4

7:00 a.m. - 7:45 a.m.

Reconstructive Urology Podium Session
Location: Talbot F-H

Moderators: Lindsey M. Hartsell, MD
Atlanta, GA

Andrew C. Peterson, MD, MPH, FACS
Dunham, NC

7:00 A.M. **#65**

THE OPTILUME DRUG COATED BALLOON FOR RECURRENT ANTERIOR URETHRAL STRICTURES:ROBUST III STUDY 2-YEAR RESULTS

Jeffrey Dann, Daytona Beach, FL[1], Sean Elliott, Minneapolis, MN[2], Karl Coutinho, Millburn, NJ[3], Kaiser Robertson, Hanover, MD[4], Richard D'Anna, Little Rock, AR[5], Kent Chevli, Cheektowaga, NY[6], Serge Carrier, Montreal, Canada[7], Melanie Aube-Peterkin, Montreal, Canada[7], Christopher Cantrill, San Antonio, TX[8], Michael Ehlert, Woodbury, MN[9], Steven Brandes, New York, NY[10], Alexis Te, New York, NY[11], Jessica DeLong, Virginia Beach, VA[12], Billy Cordon[13]
[1]Advanced Urology Associates, [2]University of Minnesota, [3]New Jersey Urology, [4]Chesapeake Urology, [5]Arkansas Urology, [6]Western NY Urology Associates, [7]McGill University Health Center, [8]Urology San Antonio, [9]Metro Urology, [10]Columbia University, [11]Weil Cornell Medicine, [12]Urology of Virginia, [13]Mount Sinai Medical Center
Presented By: Jessica DeLong, MD

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7:07 A.M. **#66**

THE OPTILUME DRUG COATED BALLOON FOR RECURRENT ANTERIOR URETHRAL STRICTURES: THE ROBUST I STUDY 4-YEAR RESULTS

Jeffrey Dann, Daytona Beach, FL[1], Jessica DeLong, Virginia Beach, VA[2], Sean Elliott, Minneapolis, MN[3], Ramon Virasoro, Virginia Beach, VA[2], Rafael Estrella, Santiago de los Caballeros, DR[4], Merycarla Oichardo, Santo Domingo, DR[5], Ramon Lay, Panama City, Panama[6], Gustavo Espino, Panama City, Panama[7], Billy Cordon[8]

[1]Advanced Urology Institute, [2]Urology of Virginia, [3]University of Minnesota, [4]Clinica Union Medica, [5]URUS, [6]Urology Royal Center Panama City, [7]Centro Especializado, [8]Mount Sinai Medical Center

Presented By: Jessica DeLong, MD

7:14 A.M. **#67**

AREA DEPRIVATION INDEX (ADI) PREDICTIVE OF DELAYS TO URETHROPLASTY

Evan Watkins[1], Abimbola Ayangbesan[2], George Koch[2], Rohan Bhalla[2], Jackson Cabo[2], Helen Gambrah[1], Niels Johnsen[2]

[1]Vanderbilt University School of Medicine, Nashville, TN, [2]Vanderbilt University Medical Center, Department of Urology, Nashville, TN

Presented By: Evan Watkins

7:21 A.M. **#68**

PARTIAL COMPONENT EXCHANGE OF A NON-INFECTED INFLATABLE PENILE PROSTHESIS IS ASSOCIATED WITH A HIGHER COMPLICATION RATE

Austin J. Livingston[1], David W. Barham[2], Edward Choi[2], Muhammed Hammad[2], Daniel Swerdloff[3], Brittany D. Berk[4], Eric Chung[5], Jonathan Clavell-Hernandez[6], Martin S. Gross[7], Lawrence Jenkins[2], James M. Jones[7], Martin N. Kathrins[4], Aaron Lentz[1], Jay Simhan[4], J. Patrick Selph[8], Robert Welliver Jr.[9], Faysal Yafi[2]

[1]Division of Urology, Department of Surgery, Duke University, Durham, NC, USA, [2]Department of Urology, University of California, Irvine, Orange, CA, USA, [3]Department of Urology/ Urologic Oncology, Fox Chase Cancer Center, Philadelphia, PA, USA, [4]Division of Urology, Department of Surgery, Brigham and Women's Hospital, Boston, MA, USA, [5]Division of Urology, Department of Surgery, University of Queensland, Brisbane, QLD, Australia, [6]Clavell Urology, Houston, TX, USA, [7]Section of Urology, Dartmouth-Hitchcock Medical Center, Lebanon, NH, USA, [8]Department of Urology, University of Alabama at Birmingham, Birmingham, AL, USA, [9]Division of Urology, Albany Medical Center, Albany, NY, USA

Presented By: Austin Livingston

7:28 A.M. **#69**

INTERMITTENT SELF-CATHETERIZATION IS SAFE AND EFFECTIVE FOR THE SIMULTANEOUS MANAGEMENT OF STRESS URINARY INCONTINENCE AND POOR BLADDER EMPTYING AFTER BULBAR URETHRAL ARTIFICIAL URINARY SPHINCTER PLACEMENT

Austin Livingston[1], Kevin Krughoff[1], Brian Inouye[2], Andrew Peterson[1], Aaron Lentz[1]

[1]Division of Urology, Department of Surgery, Duke University Medical Center, Durham, NC, USA, [2]Division of Urology, Department of Surgery, Albany Medical College, Albany, NY, USA

Presented By: Austin Livingston

7:35 A.M. **#70**

CIRCUMCORPORAL ARTIFICIAL URINARY SPHINCTER (CC-AUS): A NOVEL SURGICAL APPROACH FOR THE TREATMENT OF COMPLEX MALE STRESS URINARY INCONTINENCE (SUI)

Jeff Brady, MD, FACS[1], Adam Procunier[1], Kevin Slagoski[1], Roshane Perera[1], Isabella Delbakhsh[1], Brandon Foley, MD[2]

[1]Advent Health Orlando, [2]University of Central Florida School of Medicine

Presented By: Jeffrey D. Brady, MD, FACS

7:00 a.m. - 7:45 a.m.

Miscellaneous I Poster Session
Location: Plaza I

Moderators: Benjamin M. Dropkin, MD
Lexington, KY

Adam B. Klein, MD
Birmingham, AL

POSTER #79

SURGEON-ADMINISTERED ULTRASOUND-GUIDED TRANSVERSUS ABDOMINIS PLANE BLOCKS DURING RADICAL CYSTECTOMY: DESCRIPTION OF TECHNIQUE AND PERIOPERATIVE OPIOID REQUIREMENT

Justin Refugia, MD[1], Hilary Brownstead, MD[2], Parth Thakker, MD[1], Randy Casals, MD[1], Corey Able, BS[3], Emily Roebuck, BS[4], Matvey Tsivian, MD[1]
[1]Department of Urology, Atrium Health Wake Forest Baptist, Winston-Salem, NC, [2]Department of Anesthesiology, Atrium Health Wake Forest Baptist, Winston-Salem, NC, [3]John Sealy School of Medicine, University of Texas Medical Branch, Galveston, TX, [4]Wake Forest School of Medicine, Atrium Health Wake Forest Baptist, Winston-Salem, NC
Presented By: Justin Refugia, MD

POSTER #80

LAWSUITS IN BENIGN PROSTATIC HYPERPLASIA PROCEDURES IN THE LAST 20 YEARS

João Porto[1], Maria Camila Suarez[1], Robin Schard[2], Timothy Loftus[2], Dimple Chanamolu[1], Hemendra Shah[1]
[1]Desai Sethi Urology Institute, University of Miami, Miller School of Medicine, Miami, FL, [2]School of Law, University of Miami, Miami, FL
Presented By: João Gabriel Da Silva Porto

POSTER #81

CONVERSION TO DISPOSABLE CYSTOSCOPES DECREASED 30-DAY POST-PROCEDURE ENCOUNTERS COMPARED TO REUSABLE CYSTOSCOPES

Laura Geldmaker, Bryce Baird, Eric Regele, Daniela Haehn, Colleen Ball, Gregory Broderick, Ram Pathak, Timothy Lyon, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

POSTER #82

ANALYSIS OF FIXED OPERATING ROOM (OR) TIMES IN UROLOGIC ROBOTIC SURGERY

Laura Geldmaker, Christopher Hasse, Bryce Baird, Daniela Haehn, Abena Anyane-Yeboah, Mikolaj Wieczorek, Colleen Ball, Chandler Dora, Timothy Lyon, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

POSTER #83

PATIENT PERCEPTIONS ON THE ROLE AND ACCEPTANCE OF UROLOGY RESIDENTS

Daniel Reich[1], Michael Maidaa[1,2], Trisha Nguyen[1,2], Kevin Campbell[1,2], Christopher Bayne[1,2], Louis Moy[1,2]
[1]University of Florida College of Medicine, Gainesville, FL, [2]University of Florida, Department of Urology, Gainesville, FL
Presented By: Daniel Reich, BA

POSTER #84

MATERNAL, NEONATAL, AND PREGNANCYOUTCOMES IN UROLOGY: HOW DO WE MEASURE UP?

Brittany Levy, Tessa London-Bounds, Alexandra Kejner, Nikita Gupta, Adam Dugan, Will Cranford, Amanda Saltzman
University of Kentucky
Presented By: Brittany Erin Levy, MD

POSTER #85

DEI IN GENITOURINARY CLINICAL TRIALS LEADING TO FDA NOVEL DRUG APPROVAL: AN ASSESSMENT OF THE FDA CENTER FOR DRUG EVALUATION AND RESEARCH DRUG TRIALS SNAPSHOT

Asia Matthew-Onabanjo, MD, PhD[1], Gabrielle Nortey[1], Richard Matulewicz, MD, MS[2], Ramsankar Basak, PhD[3], Donna Culton, MD, PhD[4], Kimberly Weaver, MD[5], Kristalyn Gallagher, DO[6], Hung-Jui Tan, MD, MSHPM[1], Tracy Rose, MD, MPH[7], Matthew Milowsky, MD[7], Marc Bjurlin, DO, MS[1]
[1]Department of Urology, University of North Carolina at Chapel Hill, North Carolina, [2]Department of Surgery, Urology Service, Memorial Sloan Kettering Cancer Center, New York, New York, [3]Department of Radiation Oncology, University of North Carolina, Chapel Hill, North Carolina, [4]Department of Dermatology, University of North Carolina at Chapel Hill, North Carolina, [5]Division of Gastroenterology Hepatology, University of North Carolina at Chapel Hill, North Carolina, [6]Division of Surgical Oncology, University of North Carolina at Chapel Hill, North Carolina, [7]Division of Oncology, University of North Carolina at Chapel Hill, North Carolina
Presented By: Asia Matthew-Onabanjo, MD

POSTER #86

PATIENT COMPLIANCE WITH POST-VASECTOMY SEMEN ANALYSIS: A 16.5 YEAR ASSESSMENT FROM AN INDEPENDENT, COMMUNITY PRACTICE PRIOR TO AND AFTER THE COVID-19 PANDEMIC

Hongyu Zhang[1], Ethan J. Ball[2], Adam J. Ball[3]
[1]Florida State University College of Medicine, Tallahassee, FL, [2]St. Edward's School, Vero Beach, FL, [3]Gulfstream Urology Associates, PA, Port St. Lucie, FL
Presented By: Hongyu Zhang

Concurrent Session 4 of 4

7:00 a.m. - 7:45 a.m.

Pediatrics Poster Session
Location: Plaza II

Moderators: Anthony J. Casale, MD
Lexington, KY
Pamela I. Ellsworth, MD
Orlando, FL

POSTER #87

POST-PUBERTAL DETRUSOR MYOGENIC FAILURE IS RARE AMONG A LARGE CONTEMPORARY COHORT OF PATIENTS WITH PERINATALLY-DIAGNOSED POSTERIOR URETHRAL VALVES

Andrew Gabrielson[1], Logan Galansky[1], Edwin Smith[2], Charlotte Wu[1]
[1]Johns Hopkins University School of Medicine, [2]Emory University School of Medicine
Presented By: Charlotte Wu, MD

POSTER #88

ARE THERE FACTORS THAT DETERMINE TESTICULAR VOLUME DISCREPANCY FLUCTUATIONS IN PEDIATRIC PATIENTS WITH VARICOCELE UNDER ACTIVE SURVEILLANCE?

Adele Raymo, BS[1], Maxwell Towe, MD[2], Maria Camila Suarez, MD[2], Christian Guevara, BS[1], Shimron Brown, BA[1], Samantha Isern, MD[1], Daniel E. Nassau, MD[1], Alireza Alam, MD[1]
[1]Nicklaus Children's Hospital, [2]University of Miami
Presented By: Adele Raymo

POSTER #89

EFFICACY AND SAFETY OF LUMASIRAN FOR INFANTS AND YOUNG CHILDREN WITH PRIMARY HYPEROXALURIA TYPE 1: 12-MONTH ANALYSIS OF THE PHASE 3 ILLUMINATE-B TRIAL

Kyle Wood, MD[1], Mini Michael, MD, FRACP, MMed[2], Wesley Hayes, MEng, MA, MBBChir, MRCPCH[3], David Sas, DO[4], Daniella Magen, MD[5], Hadas Shasha-Lavsky, MD[6], Anne-Laure Sellier-Leclerc, MD[7], Julien Hogan, MD, PhD[8], Taylor Ngo, MPH[9], Marianne Sweetser, MD, PhD[9], John Gansner, MD, PhD[9], Yaacov Frishberg, MD[10]

[1]University of Alabama at Birmingham, Department of Urology, Birmingham, AL, [2]Texas Children's Hospital/Baylor College of Medicine, Division of Nephrology, Department of Pediatrics, Houston, TX, [3]Great Ormond Street Hospital, Department of Paediatric Nephrology, London, UK, [4]Mayo Clinic, Division of Pediatric Nephrology and Hypertension, Rochester, MN, [5]Pediatric Nephrology Institute, Rambam Health Care Campus, Haifa, Israel, [6]Galilee Medical Center, Pediatric Nephrology Unit, Nahariya, Israel, [7]Hospices Civils de Lyon, ERKnet, Pediatric Nephrology Unit, Bron, France, [8]Hôpital Robert-Debré, APHP, Pediatric Nephrology Department, Paris, France, [9]Alnylam Pharmaceuticals, Cambridge, MA, [10]Shaare Zedek Medical Center, Division of Pediatric Nephrology, Jerusalem, Israel

Presented By: Kyle D. Wood, MD

POSTER #90

LONG-TERM OUTCOMES OF PATIENTS FOLLOWING RECTUS FASCIAL BLADDER NECK WRAP

Brian Wiseman, MD[1], Ashley Gordon, MD[2], Cynthia Sharadin, MD[3], Christopher Bayne, MD[1], Romano DeMarco, MD[1]

[1]University of Florida, Dept. of Urology, Gainesville, FL, [2]University of Miami Miller School of Medicine, Desai Seth Urology Institute, [3]University of Utah, Dept. of Urology, Salt Lake City, UT

Presented By: Brian Wiseman, MD

POSTER #91

A MULTI-INSTITUTIONAL STUDY OF PEDIATRIC NEPHROLITHIASIS IN THE STATE OF KENTUCKY

Hannah Jarvis, MD[1], Eric Wahlstedt[2], Alison D'Alessandro[3], William Cranford[4], Andrew Harris[1], Benjamin Morrison[5], Megan Sweeney, MD[6], Campbell Grant, MD[1]

[1]University of Kentucky, Department of Urology, [2]University of Kentucky College of Medicine, [3]Univeristy of Kentucky, [4]University of Kentucky, [5]University of Kentucky College of Medicine, [6]University of Kentucky, Department of Surgery

Presented By: Hannah Jarvis, MD

POSTER #92

PEDIATRIC UROTHELIAL CANCER SURVIVAL OUTCOMES: ANALYSIS OF THE NATIONAL CANCER DATABASE

Rafael Tua-Caraccia, MD[1], Leonid Aksenov, MD[1], Rebecca Fairchild, BS[1], Kristen Rhodin, MD[2], Harold J. Leraas, MD[2], Elisabeth T. Tracy, MD[2],[3], Jonathan C. Routh, MD,MPH[1]

[1]Division of Urology, Duke University School of Medicine, Durham, NC, [2]Department of General Surgery, Duke University School of Medicine, Durham, NC, [3]Division of Pediatric General Surgery, Duke University School of Medicine, Durham, NC

Presented By: Rafael Donato Tua-Caraccia, BA, MD

POSTER #93

PEDIATRIC URINARY MICROBIOME AT SPECIES-LEVEL RESOLUTION

Maryellen Kelly[1],[2], Tatyana Sysoeva[3], Lisa Karstens[4]

[1]Division of Healthcare of Women and Children, School of Nursing, Duke University, Durham, NC, [2]Division of Urology, Department of Surgery, Duke Health, Durham, NC, [3]Department of Biological Sciences, The University of Alabama in Huntsville, Huntsville, AL, [4]Division of Bioinformatics and Computational Biomedicine, Oregon Health Science University, Portland, OR

Presented By: Maryellen S. Kelly, DNP, CPNP, MHSc

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POSTER #94

LONG-TERM FOLLOW UP OF MYELOMENINGOCELE PATIENTS WITH HISTORY OF INTRADETRUSOR BOTULINUM TOXIN: WHERE ARE THEY NOW?
Leslie Peard, MD, Belinda Lee, MD, Abby Taylor, MD, Cyrus Adams, MD, John Thomas, MD, John Pope, IV, MD, Mark Adams, MD, John Brock, III, MD, Douglass Clayton, MD
Vanderbilt University Medical Center
Presented By: Leslie M. Peard, MD

CONCURRENT SESSIONS END

7:45 a.m. - 8:15 a.m.

Break/Visit Exhibits
Location: Salons 1-3

8:15 a.m. - 8:30 a.m.

ABU Update
Speaker: Gary E. Lemack, MD
Dallas, TX

8:30 a.m. - 10:00 a.m.

Gee-Dineen Health Policy Forum I

8:30 a.m. - 9:00 a.m.

State-of-the-Art Lecture: Role of Private Equity in Medicine
Speakers: Raymond W. Pak, MD, MBA
Jacksonville, FL
Wesley M. White, MD
Knoxville, TN

9:00 a.m. - 10:00 a.m.

Panel Discussion: The Next Generation of Urologists: What Will They Need to be Successful and How do we Need to Teach Them Now?
Moderator: Gary J. Faerber, MD
Durham, NC
Panelists: Mohamad E. Allaf, MD
Baltimore, MD
Gregory A. Broderick, MD
Jacksonville, FL
Akanksha Mehta, MD, MS
Atlanta, GA
Mathew D. Sorensen, MD, MS, FACS
Seattle, WA

10:00 a.m. - 10:30 a.m.

State-of-the-Art Lecture: Moving the Needle in Surgical Simulation: 3D Printing, Augmented Reality, and Artificial Intelligence
Guest Speaker: Ahmed Ghazi, MD, FEBU, MHPE
Rochester, NY

10:30 a.m. - 11:00 a.m.

Break/Visit Exhibits
Location: Salons 1-3

11:00 a.m. - 11:45 a.m.

SESAUA Annual Business Meeting

11:45 a.m. - 12:00 p.m.

AUA Update
AUA President: Randall B. Meacham, MD
Aurora, CO

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12:00 p.m. - 12:15 p.m. **AUA QIPS**
Speaker: Andrew M. Harris, MD
Lexington, KY

12:15 p.m. - 1:15 p.m. **Resident Quiz Bowl**
Moderators: Melissa R. Kaufman, MD, PhD
Nashville, TN
Akanksha Mehta, MD, MS
Atlanta, GA

1:15 p.m. - 2:15 p.m. **Industry Sponsored Lunch Symposium**
Location: Talbot A-C

6:30 p.m. - 10:00 p.m. **Residents' Night Out**
Location: Ocean Front Lawn
Sponsored by South Georgia Medical Center
(Invite Only)

SATURDAY, MARCH 18, 2023

OVERVIEW

6:30 a.m. - 5:00 p.m. **Registration/Information Desk Open**
Location: Talbot Pre-Function

6:30 a.m. - 5:00 p.m. **Speaker Ready Room Open**
Location: Cumberland Room

7:30 a.m. - 10:30 a.m. **Spouse/Guest Hospitality Suite Open**
Location: Tidewater Grill

6:00 p.m. - 8:00 p.m. **SESAUA Closing Reception**
Location: Ocean Front Lawn

GENERAL SESSION

6:30 a.m. - 7:30 a.m. **Industry Sponsored Breakfast Symposium**
Location: Talbot A-C

CONCURRENT SESSIONS BEGIN

Concurrent Session 1 of 4

7:30 a.m. - 8:30 a.m. **Prostate Cancer Podium Session**
Location: Talbot DE
Moderators: Michael R. Abern, MD
Durham, NC
Martin Sanda, MD
Atlanta, GA

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7:30 A.M. **#71**

ANNUAL MRI ACTIVE SURVEILLANCE PROTOCOL FOR GG1 PROSTATE CANCER: INCREASING PI-RADS OF THE SAME LESION CORRELATED WITH PATIENTS WHO HARBOR UNDERLYING CLINICALLY SIGNIFICANT DISEASE.

Jacob W. Greenberg[1], Joshua Pincus[1], Christopher Koller[1], Caleb Natale[1], Sydney Caputo[1], Crystal Casado[1], Garrett Brinkley[1], L. Spencer Krane[2]
[1]Tulane School of Medicine, [2]Southeast Louisiana Veterans Healthcare System
Presented By: Jacob Greenberg

7:37 A.M. **#72**

COMPLICATIONS OF OUTPATIENT ROBOTIC RADICAL PROSTATECTOMY: A COMPREHENSIVE ANALYSIS

Spencer Liem, MD[1], Timothy Demus, MD[1], Dhaval Jivanji, MD[2], Shuwei Peter Chang, BS[3], Shimron Brown, BS[4], Olga Lopez, BS[2], Akshay Bhandari, MD[1], Jorge Pereira, MD, MPH[1]
[1]Mount Sinai Medical Center, Dept of Urology, [2]Florida International University, [3]University of Florida, Dept of Biostatistics, [4]Flordia Atlantic University
Presented By: Spencer Liem, MD

7:44 A.M. **#73**

DISTINCT GENETIC VARIANTS OF EARLY AND LATE-ONSET PROSTATE CANCER

Victor Chalfant, BA[1], Allison Feibus, MD[2], Carlos Riveros, MD[2], Ahmed Elshafei, MD[2], K.C. Balaji, MD[2]
[1]Department of Urology, Creighton University, Omaha, NE, [2]Department of Urology, University of Florida, Jacksonville, FL,
Presented By: Allison H. Feibus, MD, MS

7:51 A.M. **#74**

BASELINE 4K SCORE PREDICTS PROGRESSION ON ACTIVE SURVEILLANCE IN PROSTATE CANCER INDEPENDENTLY OF CLINICAL INFORMATION AND PIRADS SCORE

Jamie Thomas, BS[1], Helen Hougen, MD[1], Isildinha Reis, PhD[2], Nachiketh Prakash, MBBS, MS[1], Ruben Blachman-Braun, MD[1], Chad Ritch, MD, MBA[1], Bruno Nahar, MD[1], Mark Gonzalgo, MD, PhD[1], Radka Stoyanova, PhD[3], Sandra Gaston, PhD[3], Oleksandr Kryvenko, MD[3], Brandon Mahal, MD[3], Matthew Abromowitz, MD[3], Alan Dal Pra, MD[3], Alan Pollack, MD, PhD[3], Dipen Parekh, MD[1], Sanoj Punnen, MD, MAS[1]
[1]Desai Sethi Urology Institute, Miami, FL, USA, [2]Biostatistics Shared Resources and Department of Public Health Sciences, Miami, FL, USA, [3]Department of Radiation Oncology, Miami, FL, USA
Presented By: Jamie Thomas, Bachelor of Science

7:58 A.M. **#75**

RADIOGRAPHIC PROGRESSION IN THE ABSENCE OF PROSTATE-SPECIFIC ANTIGEN (PSA) PROGRESSION IN PATIENTS WITH METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): POST HOC ANALYSIS OF ARCHES

Andrew J. Armstrong[1], Nicholas Mottet[2], Taro Iguchi[3], Russell Z. Szmulewitz[4], Jeffrey Holzbeierlein[5], Arnauld Villers[6], Antonio Alcaraz[7], Boris Alekseev[8], Neil D. Shore[9], Francisco Gomez-Veiga[10], Brad Rosbrook[11], Fabian Zohren[11], Ho-Jin Lee[12], Gabriel P. Haas[13], Arnulf Stenzl[14], Arun A. Azad[15]
[1]Divisions of Medical Oncology and Urology, Cancer Institute Center for Prostate Urologic Cancers, Durham, NC, USA, [2]Department of Urology, University Hospital, St. Etienne, France, [3]Department of Urology, Kanazawa Medical University, Ishikawa, Japan, [4]Department of Medicine, The University of Chicago, Chicago, IL, USA, [5]Department of Urologic Oncology, The University of Kansas Medical Center, Kansas City, KS, USA, [6]Department of Urology, University Hospital Centre, Lille University, Lille, France, [7]Department of Urology, Hospital Clinic de Barcelona, Barcelona, Spain, [8]Department of Oncology, Hertzen Moscow Cancer Research Institute, Moscow, Russia, [9]Department of Urology, Carolina Urologic Research Center, Myrtle Beach, SC, USA, [10]Department of Urology, Salamanca University Hospital, Salamanca, Spain, [11]Department of Global Biometrics and Data Management, Pfizer Inc., San Diego, CA, USA, [12]Department of Biostatistics, Astellas Pharma Inc., Northbrook, IL, USA, [13]Global Medical Affairs, Astellas Pharma Inc., Northbrook, IL, USA, [14]Department of Urology, University Hospital, Eberhard Karls University of Tübingen, Tübingen, Germany, [15]Medical Oncology, Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia
Presented By: Russell Z. Szmulewitz, MD

8:05 A.M. **#76**

NOVEL GENES MUTATIONS IN SMOKING-ASSOCIATED PROSTATE CANCER

Ahmed Elshafei, Allison Feibus, Mohammed Al-Toubat, K.C. Balaji
University of Florida College of Medicine - Jacksonville
Presented By: Mohammed Salah Al-Toubat

8:12 A.M. **#77**

COMPARING THE INCIDENCE OF INCISIONAL HERNIAS FOLLOWING SINGLE-PORT VERSUS MULTI-PORT ROBOTIC-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY

John Norton, MD, MPH[1], Tyler Compher[2], Zachary Burns, MD, PharmD[1], Jeffrey Nix, MD, MSHA[1,2,3], Abhisek Parmar, MD[4], Soroush Rais-Bahrami, MD, MBA[1,2,3,5]
[1]University of Alabama at Birmingham, Department of Urology, [2]University of Alabama at Birmingham, School of Medicine, [3]University of Alabama at Birmingham, O'Neal Comprehensive Cancer Center, [4]University of Alabama at Birmingham, Department of General Surgery, [5]University of Alabama at Birmingham, Department of Radiology
Presented By: John Corbin Norton, MD,MPH

Concurrent Session 2 of 4

7:30 a.m. - 8:30 a.m.

Female Pelvic Medicine and Reconstructive Surgery Podium Session
Location: Talbot F-H

Moderators: Katherine Amin, MD
Miami, FL
Elisabeth Sebesta, MD
Nashville, TN

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7:30 A.M. **#78**

ANESTHETIC BLADDER CAPACITY AS A BENCHMARK FOR THE BLADDER-CENTRIC PHENYTOPE IN INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME

Dylan T. Wolff[1], Gopal Badlani[1], Catherine A. Matthews[1], Robert J. Evans[1], Stephen J. Walker[1,2]
[1]Wake Forest School of Medicine, Urology. Winston-Salem, NC, [2]Wake Forest Institute for Regenerative Medicine
Presented By: Dylan Thomas Wolff, MD

7:37 A.M. **#79**

ENGINEERING OF VOLUMETRIC SKELETAL MUSCLE TISSUE FOR ACCELERATED RESTORATION OF PELVIC FLOOR MUSCLE FUNCTION

Ji Hyun Kim, In Kap Ko, Myung Jae Jeon, Ickhee Kim, John Jackson, Sang Jin Lee, Anthony Atala, James Yoo
Wake Forest School of Medicine, Wake Forest Institute for Regenerative Medicine, Winston Salem, NC
Presented By: John D. Jackson, PhD

7:44 A.M. **#80**

THE IMPACT OF WEIGHT GAIN OR LOSS ON SUCCESS AFTER MIDURETHRAL SLING SURGERY: A LONGITUDINAL ANALYSIS

Ann C. Stolzle, B.S.[1], Clifton F. Frilot II, Ph.D.[2], Alex Gomelsky, M.D.[3]
[1]LSU Health Shreveport School of Medicine, [2]LSU Health Shreveport School of Allied Health Professions, [3]LSU Health Shreveport Department of Urology
Presented By: Ann Stolzle, BS

7:51 A.M. **#81**

TRENDS IN VAGINAL NATIVE TISSUE VS ABDOMINAL MESH AUGMENTED REPAIR FOR APICAL PELVIC ORGAN PROLAPSE BETWEEN UROLOGISTS AND GYNECOLOGISTS OVER 10 YEARS

Rahul Dutta, Resident, Catherine Matthews, Professor
Atrium Health Wake Forest Baptist
Presented By: Rahul Dutta, MD

7:58 A.M. **#82**

SINGLE-INCISION MINISLINGS IN 2022: A META ANALYSIS

Ann C. Stolzle[1], Harrison Torres, M.D.[2], Clifton F. Frilot II, Ph.D.[3], Alex Gomelsky, M.D.[2]
[1]LSU Health Shreveport School of Medicine, [2]LSU Health Shreveport Department of Urology, [3]LSU Health Shreveport School of Allied Health Professions
Presented By: Ann Stolzle, BS

8:05 A.M. **#83**

VOIDING HABITS AND SOCIAL DETERMINANTS OF HEALTH AMONG INDIVIDUALS WITH RECURRENT URINARY TRACT INFECTIONS

Natalie Pace, MD, Rosa Park, MD, Stephanie Gleicher, MD, Melissa Kaufman, MD, Ph.D, Roger Dmochowski, MD, W. Stuart Reynolds, MD, Elizabeth Sebesta, MD
Department of Urology, Vanderbilt University Medical Center, Nashville, Tennessee
Presented By: Natalie M. Pace, MD, MSC

8:12 A.M. **#84**

NATIVE TISSUE ANTERIOR SACROSPINOUS HYSTEROPEXY IS AN EFFECTIVE AND SAFE APPROACH FOR PRIMARY UTEROVAGINAL PROLAPSE COMPARED TO MESH-AUGMENTED REPAIR.

Tyler Overholt, M.D.[1], Liliya Velet, M.D.[1], Hannah Mugford, B.S.[2], Rahul Dutta, M.D.[1], Catherine Matthews, M.D.[1,3]
[1]Department of Urology, Atrium Health Wake Forest Baptist, [2]School of Medicine, Wake Forest University, [3]Division of Female Pelvic Health, Atrium Health Wake Forest Baptist
Presented By: Tyler Lynne Overholt, MD, BS

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7:30 a.m. - 8:30 a.m.

Miscellaneous II Poster Session
Location: Plaza I

Moderators: Paula Domino, MD
Jackson, MS

Padraic O'Malley, MSc, MD, FRCSC
Gainesville, FL

POSTER #95

CONVERSION TO DISPOSABLE CYSTOSCOPY ELIMINATED POST-PROCEDURE ENCOUNTERS AND INFECTIONS COMPARED TO REUSABLE CYSTOSCOPES IN PATIENTS UNDERGOING RENAL TRANSPLANT STENT REMOVAL

Bryce Baird, Laura Geldmaker, Daniela Haehn, Colleen Ball, Ram Pathak, Gregory Broderick, Timothy Lyon, David Thiel, E. Mackenzie Gibbs
Mayo Clinic Florida
Presented By: E. Mackenzie Gibbs, MD

POSTER #96

URINARY MICROBIOME INVOLVEMENT WITH CATHETER ASSOCIATED URINARY TRACT INFECTIONS

Rajeev Subu, BS, Vikram Narayan, MD, Brendan Browne, MD
Emory University School of Medicine
Presented By: Rajeev P. Subu

POSTER #97

THE IMPACT OF SINGLE USE CYSTOSCOPES ON CLINICAL WORKFLOW IN AN OUTPATIENT SETTING

Robert Medairos, MD[1], Francois Soto-Palou, MD[1], Zachary Dionise, MD[1], Bailey Van Namen, BS[2], Rachel Locascio, MSN, RN[1], Jodi Antonelli, MD[1], Glenn Preminger, MD[1], Michael Lipkin, MD[1]
[1]Division of Urology, Duke University Medical Center, [2]Duke Health Performance Services
Presented By: Robert Medairos, MD

POSTER #98

A MORE GRANULAR EXAMINATION OF BURNOUT FROM THE AUA WORKFORCE WORKGROUP

Seth Teplitsky, MD[1], Amanda North, MD[2], Raymond Fang, MSC,MASC[3], William Meeks[3], Kate Kraft, MD[4], Andrew Harris, MD[1]
[1]University of Kentucky, [2]Montefiore Medical Center, [3]AUA Data Management Statistical Analysis, [4]University of Michigan
Presented By: Seth Teplitsky, MD

POSTER #99

CREATION OF A STANDARDIZED ANTIMICROBIAL PROPHYLAXIS ALGORITHM IN TRANSRECTAL PROSTATE BIOPSIES

Lawrence Bacudio[1], Jacob Khoury[1], Caleb Natale[2], Caitlin Martin Klinger[3], Kyle Widmer[3], L Spencer Krane[3]
[1]Tulane University School of Medicine, New Orleans, LA, [2]Tulane University School of Medicine, Department of Urology, New Orleans, LA, [3]Southeastern Louisiana Veterans Health Care System, New Orleans, LA
Presented By: Lawrence Bacudio

POSTER #100

ANGIOMYOLIPOMA GROWTH KINETICS IN TUBEROUS SCLEROSIS COMPLEX: THE EFFECTS OF MTOR INHIBITORS

Parth Thakker[1], Lauren Neal[2], Vanessa Lukas[2], Mary Silvia[1], Jane Boggs[1], Theodore Stem[1], Nicholas Mallet[1], Roy Strowd[1], Ram Pathak[3]
[1]Atrium Health Wake Forest Baptist, [2]Wake Forest School of Medicine, [3]Mayo Clinic, Jacksonville
Presented By: Parth Thakker, MD

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POSTER #101

VASECTOMY REFERRAL RATES BEFORE AND AFTER DOBBS: A SINGLE-INSTITUTION ANALYSIS

Scott Brimley, MD, Rohail Kazi, MD, Megan Sweeney, MD, Benjamin Dropkin, MD
University of Kentucky
Presented By: Scott Charles Brimley, MD,BS

POSTER #102

RPLND VERSUS PRIMARY CHEMOTHERAPY AFTER RADICAL ORCHIECTOMY IN STAGE IIA NON-SEMINOMA GERM CELL TUMOR TESTICULAR CANCER: A RETROSPECTIVE STUDY FROM NATIONAL SEER DATABASE

Hangcheng Fu[1], Sriharsha Talluri, Louisville[2], Roman Isakov, Louisville[2], Ankem Murali[1]
[1]University of Louisville Urology Department, [2]University of Louisville
Presented By: Hangcheng Fu, MD

POSTER #103

RESTORATION OF KIDNEY FUNCTION IN CHRONIC KIDNEY DISEASE (CKD) USING AUTOLOGOUS HUMAN RENAL CELLS

Sunil George, Jennifer Huling, Mehran Abolbashari, Tae Hyoung Kim, Tamer Aboushwareb, John Jackson, Anthony Atala, James Yoo
Wake Forest School of Medicine, Wake Forest Institute for Regenerative Medicine, Winston Salem, NC
Presented By: John D. Jackson, PhD

POSTER #104

REPUTATION RANKINGS, SOCIAL MEDIA ACTIVITY, AND APPLICATION RATES: ADVICE TO UROLOGY RESIDENCY APPLICANTS

William M Pearson[1], Luke G Scanlan[1], F Pearce Kudlata[1], Salil S Ghamande[1], Brittany Ange[1], John J De Caro[2], Martha K Terris[1]
[1]Augusta University, [2]Charlie Norwood VA Medical Center
Presented By: William Michael Pearson

POSTER #105

COMPARISON OF ROBOTIC ASSISTED RIGHT NEPHRECTOMY TO LAPAROSCOPIC LEFT NEPHRECTOMY IN PATIENTS UNDERGOING LIVING DONOR RENAL TRANSPLANT

Ryan Pickens, MD[1], Kevin Reed, MD[1], Winston Crute, MD[1], Dustin Whitaker, MD[1], Dylan Dangerfield, MD[1], Oscar Grandas, MD[2]
[1]University of Tennessee at Knoxville Department of Urology, Knoxville, TN, [2]University of Tennessee at Knoxville Department of Transplant Surgery, Knoxville, TN
Presented By: Dustin L. Whitaker, MD

POSTER #106

TOWARD GENDER EQUITY: AN EXAMINATION FROM THE AUA WORKFORCE WORKGROUP REGARDING AUA CENSUS DATA TO ESTABLISH KEY DIFFERENCES BETWEEN MALE AND FEMALE UROLOGISTS

Jacqueline Morin, M.D.[1], Andrew Harris, M.D.[2], Kate Kraft, M.D.[3]
[1]University of Kentucky School of Medicine, Lexington, KY, [2]Veterans Affairs Department of Urology, Lexington, KY, [3]University of Michigan School of Medicine, Ann Arbor, MI
Presented By: Jacqueline Morin, MD

Concurrent Session 4 of 4

7:30 a.m. - 8:30 a.m.

Video Session II
Location: Talbot A-C

Moderators: Andrew M. Harris, MD
Lexington, KY

Adam Lorentz, MD, FACS
Atlanta, GA

VIDEO #11

SINGLE-PORT ROBOTIC REMOVAL OF GIANT FIBROEPITHELIAL POLYPS
Michael Dineen, MD, Lucas Wiegand, MD
University of South Florida
Presented By: Michael D. Dineen, MD, MS

VIDEO #12

ROBOTIC REPAIR OF RECURRENT PROLAPSE AFTER INITIAL ATTEMPT SACROCOLPOPEXY FAILS
Spencer Kortum[1], Benjamin Behers[1], Karim Ghazli, MD[2], Robert Carey, MD, PhD[1,2]
[1]Florida State University College of Medicine, Tallahassee, FL, [2]Jellison Cancer Institute, Sarasota Memorial Hospital, Sarasota, FL
Presented By: Spencer Kortum

VIDEO #13

ROBOTIC-ASSISTED LAPAROSCOPIC REPAIR OF A PENETRATING BLADDER INJURY
Chase Griffin, MD, Winston Crute, MD, Wesley White, MD
University of Tennessee Medical Center - Knoxville, TN
Presented By: Chase Thomas Griffin, MD

VIDEO #14

ROBOTIC-ASSISTED LAPAROSCOPIC URETERAL RECONSTRUCTION FOR RETROCAVAL URETER
Emily Elliott, MS4, Austin Younger, MD, Christopher Keel, MD
University of South Alabama, Dept. of Urology
Presented By: Kimberly Waggener

VIDEO #15

ROBOTIC-ASSISTED EXCISION OF CYSTIC URINOMA WITHIN THE PSOAS MUSCLE
Emily Elliott, MS4, Austin Younger, MD, Christopher Keel, MD
University of South Alabama, Dept. of Urology
Presented By: Christian Manganti

VIDEO #16

TIP HYPOSPADIAS REPAIR USING THE ORBEYE EXOSCOPE
Rachel Locke, MD, Charles Ellis, MD, Mark Williams, MD
Department of Urology, Atrium Health, Charlotte, NC
Presented By: Rachel Locke

VIDEO #17

ROBOTIC ASSISTED LAPAROSCOPIC TRANSPLANT PYELOPLASTY USING A NATIVE URETER
Rohan Bhalla, Jacob Tallman, Nicholas Kavoussi, Niels Johnsen
Vanderbilt University Medical Center
Presented By: Rohan G. Bhalla, MD

VIDEO #18

INTESTINAL BOWEL SEGMENTS FOR ADVANCED ROBOTIC UPPER TRACT RECONSTRUCTIVE SURGERY
Raju Thomas, Ganesh Sanekommu, Erik Castle
Tulane University
Presented By: Ganesh Sanekommu, MD

VIDEO #19

ROBOTIC LEFT PYELOLITHOTOMY AND Y-V PYELOPLASTY
Raju Thomas, Ganesh Sanekommu, Melissa Wong
Tulane University
Presented By: Ganesh Sanekommu, MD

VIDEO #20

BILATERAL GROIN VASOVASOSTOMY USING SINGLE-PORT ROBOT ASSISTANCE WITH ICG FLUORESCENT VASOGRAPHY
Michael Maidaa, Marc Abboud, Kevin Campbell, Padraic O'Malley
University of Florida, Gainesville
Presented By: Michael Maidaa, MD

CONCURRENT SESSIONS END

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8:30 a.m. - 8:45 a.m.

Break
Location: Talbot Pre-Function

8:45 a.m. - 9:15 a.m.

State-of-the-Art Lecture: Restorative Therapies in Erectile Dysfunction

Speaker: Ranjith Ramasamy, MD
Miami, FL

9:15 a.m. - 10:00 a.m.

Gee-Dineen Health Policy Forum II
Panel Discussion: The First Years in Practice: What Did I Have to Learn for Myself?

Moderator: Stephen E. Strup, MD, FACS
Lexington, KY

Panelists: Sherita A. King, MD
Augusta, GA

John M. Lacy, MD
Knoxville, TN

Amy N. Luckenbaugh, MD
Nashville, TN

10:00 a.m. - 10:45 a.m.

W. Bedford Waters Memorial Lecture: Expanding the Future Impact of Urology Through Education and Mentorship

Introducer: S. Duke Herrell, III, MD, FACS
Nashville, TN

Guest Speaker: Cheryl T. Lee, MD
Columbus, OH

10:45 a.m. - 11:15 a.m.

Break
Location: Talbot Pre-Function

11:15 a.m. - 12:00 p.m.

Gee-Dineen Health Policy Forum II
Ambrose Reed Lecture: Hospital Care at Home – New Models

Introducer: S. Duke Herrell III, MD, FACS
Nashville, TN

Guest Speaker: Michael J. Maniaci, MD
Jacksonville, FL

12:00 p.m. - 1:15 p.m.

Industry Sponsored Lunch Symposium
Location: Talbot A-C

1:15 p.m. - 2:00 p.m.

Presidential Lecture: What Have Our Patients Taught Us About Kidney Cancer in the Last 20 Years?

Introducer: S. Duke Herrell, III, MD, FACS
Nashville, TN

Presidential
Guest Speaker: Mohamad E. Allaf, MD
Baltimore, MD

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2:00 p.m. - 3:00 p.m. **T. Leon Howard Imaging Competition**

Moderator: Wesley M. White, MD
Knoxville, TN

CASE #1 **A URETERAL STENT ANOMALY FOLLOWING NEOURETEROCYSTOTOMY**
Manuel Armas-Phan, MD, Ben Schmeusser, MD, Nick Eyrich, MD, Kenneth Ogan, MD
Emory
Presented By: Manuel Armas-Phan

CASE #2 **FEMALE INFANT IN URINARY RETENTION WITH ACUTE KIDNEY INJURY**
Daniel Reich[1], Christopher Bayne[1,2], Romano DeMarco[1,2]
[1]University of Florida College of Medicine, Gainesville, FL,
[2]University of Florida, Department of Urology, Gainesville, FL
Presented By: Daniel Reich, BA

CASE #3 **A NEONATE BORN WITH AN ABDOMINAL WALL DEFECT**
Jennifer Rosen, David Kitchens
University of Alabama at Birmingham
Presented By: Jennifer N. Rosen, MD

CASE #4 **A YOUNG MAN WITH ANURIA AFTER RENAL TRANSPLANT**
Robert Helm, MD, Paula Domino, MD
University of Mississippi Division of Urology
Presented By: Robert Helm, MD

CASE #5 **MIDDLE-AGED WOMAN WITH CHRONIC SEVERE ANEMIA AND WEIGHT LOSS**
Hangcheng Fu, Uzoma Anele
University of Louisville Urology Department
Presented By: Hangcheng Fu, MD

CASE #6 **ENLARGING RENAL MASS IN A TUBEROUS SCLEROSIS PATIENT**
Jacqueline Morin, MD, Seth Teplitsky, MD, Andrew James, MD
University of Kentucky School of Medicine
Presented By: Jacqueline Morin, MD

3:00 p.m. - 3:15 p.m. **Break**
Location: Talbot Pre-Function

3:15 p.m. - 3:45 p.m. **Hector Henry Memorial Lecture: The Importance of Volunteering, a Tribute to Martin Dineen**

Introducer: S. Duke Herrell, III, MD, FACS
Nashville, TN

Speakers: Gerard D. Henry, MD
Bossier City, LA

Thomas F. Stringer, MD, FACS
Gainesville, FL

3:45 p.m. - 4:15 p.m. **State-of-the-Art Lecture: Modern Management of GU Soft Tissue Sarcoma**

Speaker: Brant Inman, MD, MS
Durham, NC

4:15 p.m. - 4:45 p.m. **State-of-the-Art Lecture: When Do I Convert Active Surveillance to Active Therapy in Prostate Cancer?**

Speaker: L Spencer Krane, MD, FACS
New Orleans, LA

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4:45 p.m. - 5:00 p.m.	**Best Abstracts Announcement and Awards Presentation** Speaker: Chad W.M. Ritenour, MD *Atlanta, GA*
6:00 p.m. - 8:00 p.m.	**SESAUA Closing Reception** *Location: Ocean Front Lawn*

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OGAN, KENNETH
3/16/2023 4:45 p.m.

OLSEN, TIMOTHY
3/15/2023 4:30 p.m. Poster #16

O'MALLEY, PADRAIC
3/18/2023 7:30 a.m.

OVERHOLT, TYLER
3/18/2023 8:12 a.m. AB #84

PACE, NATALIE
3/18/2023 8:05 a.m. AB #83

PAIDISETTY, PRANEET
3/16/2023 7:00 a.m. Poster #32

PAK, RAYMOND
3/17/2023 8:30 a.m.

PALACIOS, ARNOLD
3/16/2023 4:00 p.m. AB #53

PARK, ROSA
3/15/2023 4:30 p.m. Poster #8

PATEL, MANISH
3/16/2023 7:21 a.m. AB #22

PATEL, TRUSHAR
3/16/2023 7:00 a.m.

PATHAK, RAM
3/17/2023 7:00 a.m.

PEARD, LESLIE
3/17/2023 7:00 a.m. Poster #94

PEARSON, WILLIAM
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PORTO, JOO
3/16/2023 8:03 a.m. AB #28
3/17/2023 7:00 a.m. Poster #80

POUND, CHARLES
3/16/2023 4:00 p.m.

POW-SANG, JULIO
3/16/2023 11:45 a.m.

PRABHAKAR, PUSHAN
3/15/2023 4:44 p.m. AB #12

RAIS-BAHRAMI, SOROUSH
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RAMASAMY, RANJITH
3/18/2023 8:45 a.m.

RAYMO, ADELE
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REICH, DANIEL
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RIGGS, STEPHEN
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RITENOUR, CHAD
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RIVERO, MARCO-JOSE
3/15/2023 4:30 p.m. AB #1
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ROEBUCK, EMILY
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ROSE, KYLE
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ROSEN, JENNIFER
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ROUTH, JONATHAN
3/16/2023 5:20 p.m. AB #52

ROY, ORNOB
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ROY, SAMIT
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SAMORA, NATHAN
3/15/2023 4:30 p.m. Poster #14
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SANDBERG, MAXWELL
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SCHLOEGEL, VAN
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SCHOMMER, JARED
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SHRIDHARANI, ANAND
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SHUMAKER, LUKE
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3/17/2023 9:00 a.m.

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STRUP, STEPHEN
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SUBU, RAJEEV
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SZMULEWITZ, RUSSELL
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TAPSCOTT, ASHLEY
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TEPLITSKY, SETH
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THAKKER, PARTH
3/15/2023 5:12 p.m. AB #16
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THIEL, DAVID
3/15/2023 3:45 p.m.
3/15/2023 4:30 p.m.

THOMAS, JAMIE
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THOMPSON, DAVID
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WHITAKER, DUSTIN
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WONG, MELISSA
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WOOD, KYLE
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ZHANG, HONGYU
3/17/2023 7:00 a.m. Poster #86

PODIUMS

Podium #1

PATIENT SATISFACTION WITH ORAL TESTOSTERONE UNDECANOATE (JATENZO) IN MEN WITH PREVIOUS TESTOSTERONE THERAPY: AN OPEN-LABEL, SINGLE-CENTER, PHASE IV CLINICAL TRIAL

Marco-Jose Rivero[1,2], Rohit Reddy[3], Akhil Muthigi[1], Ranjith Ramasamy[1]
[1]University of Miami Miller School of Medicine, Desai Sethi Urology Institute, Miami, FL, [2]Case Western Reserve University School of Medicine, Cleveland, OH, [3]University of Miami Miller School of Medicine, Miami, FL
Presented By: Marco-Jose Rivero

Introduction: Previously unavailable in the United States, oral testosterone therapy (TTh) formulations are convenient, easy to use, and avoid the problems of other forms of TTh. Jatenzo (testosterone undecanoate) is a novel US FDA-approved oral testosterone capsule that provides a uniform response in patients with testosterone deficiency (TD). In this study, we evaluated patient satisfaction with Jatenzo in men with a recent history of alternative TTh. We hypothesized that Jatenzo would have similar patient satisfaction relative to other forms of TTh.
Methods: Patients between 18 and 65 years of age with a diagnosis of TD were recruited. TD was defined as two measurements of serum total testosterone below 300 ng/dL combined with hypogonadal symptoms. Patients were required to have received previous TTh and completed an adequate washout period prior to starting Jatenzo. The primary outcomes were patient satisfaction, measured by the Treatment Satisfaction Questionnaire for Medication (TSQM-9); and changes in TD symptoms, measured by the quantitative Androgen Deficiency in Aging Males (qADAM) questionnaire at 3- and 6-month time points. Serum total testosterone, hematocrit, PSA, and estradiol were also evaluated at each time point.
Results: Of the 41 patients recruited into the study, 46% had previously received subdermal pellets, 41% intramuscular injections, and 12% intranasal gels. After the appropriate washout period, serum total testosterone levels increased from a baseline mean of 193 ng/dL to 748 ng/dL at 1 month, 520 ng/dL at 3 months, and 610 ng/dL at 6 months of treatment with Jatenzo. Mean patient global satisfaction measured by TSQM-9 progressed from 65.0% with previous TTh to 80.0% and 89.3% at the 3-month and 6-month time points, respectively. Mean hypogonadal symptom control as measured by qADAM progressed from 32.6 at baseline to 33.4 at 6 months of treatment with Jatenzo (on a scale of ten to fifty). No significant difference was noted in side effects such as polycythemia or changes in estradiol or PSA.
Conclusion: Jatenzo appears to provide similar patient satisfaction and similar improvement in hypogonadal symptoms relative to other forms of TTh. In addition, Jatenzo increases serum total serum testosterone to reference range (300 – 1000 ng/dL) in >90% of men without a difference in side effect profile.
Funding: Clarus Therapeutics

Podium #2

COMMUNITY-BASED ASSESSMENT OF PREDICTORS OF NON-PRESCRIPTION PDE-5 INHIBITOR USE IN ADULT MEN

Jackson Cabo, MD, Niels Johnsen, MD MPH
Vanderbilt University Medical Center
Presented By: Jackson Cabo, MD

Introduction: PDE-5 inhibitors are the mainstay of medical management for erectile dysfunction but do carry risk. Increased availability of these medicines from sources outside of a physician's office may present risks to patients due to incomplete counseling or medication reconciliation and may also expose individuals to counterfeit medication.

We sought to characterize associations of demographics, sexual function, and sexual orientation with PDE-5i obtained from non-prescription means.

Methods: Adult males were recruited through a national registry of volunteers (ResearchMatch) to participate in an online survey. We assessed PDE-5 inhibitor use and the medications' source of within the last year. Validated scores for erectile function (IIEF-5) and ejaculatory function (PEDT) were obtained in addition to demographic and sexual partner data. Logistic regression analyses were performed to identify associations with obtaining PDE-5 inhibitors from a non-prescription source.

Results: Of the 1033 men who completed the survey, 348 reported using PDE-5 inhibitors in the past year (Table 1). Of this cohort, 88 (25.1%) reported obtaining PDE-5 inhibitors from a non-prescription source. Men obtaining PDE-5i outside a physician's office tended to be younger (median age 51.5 vs. 62, p<0.001) than those obtaining it with a standard prescription. Sexual function characteristics including IIEF and PEDT scores were similar between groups. Men who have sex with men (MSM) were nearly twice as likely to have obtained PDE-5i from a non-prescription source (37.3 vs. 22.5%, P=0.018). Married men were less likely than single men to purchase PDE-5i from a non-prescription source (22.3 vs. 35.9%, P=0.017). On multivariable analysis, only younger age was associated with increased odds of obtaining PDE-5i from an online or non-prescription source (OR 0.97, 0.95-0.98, P<0.001; Table 2).

Conclusion: In this large, community-based study of adult men, we found that a quarter of PDE-5i users had obtained medication without seeing a physician. We found that younger men and men who have sex with men were more likely to obtain these medicines from alternative sources. While these medicines are typically well tolerated, medication obtained from unreliable sources is more likely to be counterfeit and may place individuals at higher risk for adverse events.

	Overall	Online or Non Prescription PDE-5 Inhibitor Use	Prescription PDE-5 Inhibitor Use	P-Value
		N=88	N=262	
Age	60 (46-68)	51.5 (35-63)	62 (50-69)	<0.001*
BHLS Score	15 (14-15)	15 (14-15)	15 (14-15)	0.52
EQ-5D Visual Analog Scale	79 (67-85)	79 (69-85)	78 (66-86)	0.94
Income				0.004*
$0-$24999	25	13 (52.0)	12 (48.0)	
$25K-$100K	178	37 (21.4)	136 (78.6)	
$100K and up	182	38 (20.9)	144 (79.1)	
Race	N=350			0.44
White	312	76 (24.4)	236 (75.6)	
Non-white	38	12 (31.6)	26 (68.4)	
Sexual Partner in Last Month	N=348			0.95
Yes	256	64 (25.0)	192 (75.0)	
No	92	24 (6.1)	68 (73.9)	
Sexual Partners				0.018*
Men Only or Both	45	25 (37.3)	42 (62.7)	
Women Only	283	63 (22.5)	220 (77.7)	
Relationship Status				0.017*
Single	78	28 (35.9)	50 (64.1)	
Married	193	43 (22.3)	150 (77.7)	
In a Relationship	58	17 (29.3)	41 (70.7)	
IIEF-5 (all) *median (IQR)*	14 (8-20)	14 (9-19)	14 (7-20)	0.70
PEDT (all) median (IQR)	9 (5-14)	8 (5-14)	9 (5-14)	0.93
Overall Satisfaction with Sex Life				0.92
Yes	87	24 (27.6)	63 (72.4)	
No	249	64 (25.8)	185 (74.2)	

Table 1. Demographic and sexual function characteristics according to prescription versus non-prescription PDE-5 inhibitor use.

	OR	95% CI	P-Value
Age	0.97	0.95-0.98	<0.001*
Sex Partners			0.16
Women only	**Ref**		
Men only or Men and Women	1.56	0.83-2.89	
Income			0.05
$0-$24999	**Ref**		
$25K-$100K	0.35	0.14-0.88	
$100K and up	0.53	0.21-1.39	
Relationship Status			0.24
Single	**Ref**		
Married	0.56	0.29-1.10	
In Relationship	0.69	0.31-1.53	

Table 2. Multivariable logistic regression for associations with online or non-prescription PDE-5i use in the past year.

Funding: N/A

Podium #3

SOCIOECONOMIC STATUS IS NOT ASSOCIATED WITH COMPLICATIONS OR PATIENT SATISFACTION FOLLOWING INFLATABLE PENILE PROSTHESIS SURGERY

Rohan Bhalla[1], Helen Gamrah[2], Jackson Cabo[1], George Koch[1], Tanya Marvi[1], Evan Watkins[2], Theresa Zwaschka[2], Melissa Kaufman[1], Douglas Milam[1], Niels Johnsen[1]
[1]Vanderbilt University Medical Center, [2]Vanderbilt University School of Medicine
Presented By: Rohan G. Bhalla, MD

Introduction: Socioeconomic background and neighborhood status have been previously associated with health care outcomes. The Area Deprivation Index (ADI), is a validated measurement evaluating the differences in socioeconomic status between neighborhoods. ADI incorporates patient income, education level, employment status, and housing quality. We aimed to understand how a patient's socioeconomic status affects surgical outcomes and satisfaction following inflatable penile prosthesis (IPP) placement.
Methods: We identified men that underwent IPP placement from 6/1/13 - 3/31/22. Using the Neighborhood Atlas National® (Madison, WI), national ADI percentiles (1-100) were calculated. Higher ADIs represent a more disadvantaged socioeconomic status while lower ADIs represent a more advantaged socioeconomic status. Complications were defined as mechanical failure, urethral erosion, infection, intractable pain, or other (ex. hematoma, herniated reservoir, pump revision). A patient satisfaction phone questionnaire was administered measuring overall satisfaction (Likert scale). To reduce recall bias and allow for adequate follow-up, the questionnaire was limited to men who underwent IPP placement between 2016-2020. Multivariable logistic regression and multivariable ordinal logistic regression were used to identify the association between ADI and surgical complications and patient satisfaction, respectively.
Results: The final cohort consisted of 430 men with 83% (n=355) Caucasian and a median age of 65 (IQR 58-69). The complication rate was 11.2% (n=48) with 5.1% (n=22) requiring surgical intervention. The median national ADI for patients with a complication was 57 (IQR 33-72) compared to 60 (IQR 42-76) in those without a complication (p=0.32). A total of 163 men completed the satisfaction questionnaire and 70% (n=114) of men stated that they were either very satisfied or satisfied with their IPP. The median ADI for patients who were satisfied was 64 (IQR 43-80) compared to 60 (IQR 42-76) in those who were not satisfied (p=0.45). On multivariable analysis, national ADI was not associated with postoperative complications (p=0.57) or patient satisfaction (p=0.39) (Table 1).
Conclusion: While living in a disadvantaged neighborhood has been associated with poor health outcomes, we found no association between a patient's socioeconomic status and complications or satisfaction following IPP placement. Regardless of geographic residence, patients pursuing an IPP can expect comparable outcomes and overall satisfaction rates suggesting that implant consideration should not be influenced by socioeconomic status.

Table 1a: Multivariable Logistic Regression for Complications

	Any Complication (n=48)		Operative Complication (n=22)	
	OR (95% CI)	p-value	OR (95% CI)	p-value
National ADI	0.99 (0.98-1.00)	0.43	0.99 (0.97-1.01)	0.27
Age	1.01 (0.98-1.05)	0.45	0.97 (0.92-1.02)	0.27
History of Radiation	0.96 (0.32-2.87)	0.94	1.21 (0.25-5.96)	0.81
DM	0.72 (0.33-1.56)	0.40	018 (0.04-0.79)	0.02
Modified Frailty Index	1.15 (0.90-1.48)	0.27	1.21 (0.82-1.78)	0.33

ADI = Area deprivation index, DM = Diabetes mellitus

Table 1b: Multivariable Ordinal Logistic Regression for Satisfaction Likert Scale

	OR (95% CI)	p-value
National ADI	1.00 (0.99-1.01)	0.69
Device Function	20.17 (5.08-80.02)	<0.01
Age	0.99 (0.97-1.03)	0.87
Marital Status	1.13 (0.74-1.72)	0.54
Preoperative SHIM	1.06 (0.99-1.15)	0.15

ADI = Area deprivation index, SHIM = Sexual health inventory for men

Funding: N/A

Podium #4

HYDROPHILIC INFLATABLE PENILE PROSTHESIS DISCS INOCULATED WITH BACTERIA AND FUNGAL SPECIES DIPPED IN 0.05% CHLORHEXIDINE GLUCONATE IRRIGATION SOLUTION AND IRRIGATED TO EVALUATE REAL WORLD SITUATIONS

Edward Karpman, MD[1], Carolyn Twomey[2], Gerard Henry, MD[3]
[1]*Urological Surgeons of Northern California,* [2]*Irrimax Corporation,* [3]*WK Advanced Urology*
Presented By: Gerard D. Henry, MD

Introduction: Hydrophilic-coated inflatable penile protheses (HC-IPP) have significantly decreased penile prosthesis infection (PPI) since their release in 2001. However, the microbial spectrum of PPI has significantly changed. Based on recent Next Generation Sequencing (NGS) literature, gram negative and fungal species are now included in the three most common organisms isolated. The Titan (Coloplast, Minneapolis, MN, USA) implant enables surgeons to choose a dipping solution. Irrisept (Irrimax, Lawrenceville, GA, USA) is 0.05% chlorhexidine gluconate (CHG) solution and has an extensive profile for microbial kill, including many bacterial and fungal species known to cause PPI.
Introduction: Evaluate microbial reduction on HC-IPP material dipped and irrigated with 0.05% CHG irrigation device using a validated microbiological study design: microbial contamination with microbial reduction counts following treatment.
Methods: An *In-Vitro* evaluation of the ability of an irrigation device to reduce transient bacterial contamination from a Test Substrate - pre-cut discs prepared from a HC-IPP material. Seven common PPI microorganisms - *Bacteroides fragilis* (A TCC #25285), *Candida albicans* (A TCC #10231), *Enterococcus faeca/is* (A TCC #29212), *Escherichia coli* (A TCC #25922), *Pseudomonas aeruginosa* (ATCC #27853), *Staphylococcus aureus*

(ATCC #29213) and *Staphylococcus epidermidis* (ATCC #12228) were used for this evaluation. For each challenge species, three discs of the implant material (i.e., carriers) were pre-conditioned by immersion in 0.9% Sodium Chloride Irrigation, USP (Baseline Controls), and six discs were pre-conditioned by immersion in the test irrigation solution, (Irrisept®; Test Carriers). Discs underwent three separate 150cc irrigations (one full bottle/disk with 0.05% CHG irrigation device. (Irrisept 450mL [Lot #21HDB982]).

Results: Table 1 presents the Initial population (CFU/mL), Mean Baseline Control Recovery (normal saline log10) and the mean Post-Exposure Recovery (0.05% CHG log10), and Mean Post-Exposure Reduction (0.05% CHG log10) following three separate 150cc irrigations (one full bottle/disk with 0.05% CHG irrigation device.(Irrisept 450mL [Lot #21HDB982]).

Conclusion: Dipped and irrigated HC-IPP material discs with the irrigation device containing 0.05% CHG results in clinically significant log10 reductions in tested microbial strains. All previous studies on this subject matter have used zone of inhibition (ZOI) testing only. This microbiological methodology is superior as it is quantitative not qualitative, and can evaluate bactericidal, virucidal and fungicial activity.

Table 1. An Evaluation of the Ability of An Irrigation Device to Remove Transient Bacterial Contamination from A Penile Implant Material

An Evaluation of the Ability of An Irrigation Device to Remove Transient Bacterial Contamination From A Penile Implant Material
Nelson Labs Boseman #2203163-250.01

Test Strain (ATCC #)	Initial Population (CFU/mL)	Mean Baseline Control Recovery Normal Saline With Bulb Syringe (log10; 3 replicates)	Mean Post Exposure Recovery Irrigation Device with 0.05% CHG (log10; 3 replicates)	Mean Post Exposure Reduction Irrigation Device with 0.05% CHG (Log10; 3 replicates)
Bacteroides fragilis ATCC #25285	2.70 x 10to the 9th	7.46	<1.0	6.46
Candida albicans ATCC #10231	1.74 x 10	7.21	<1.33	5.88
Enterococcus faecalis ATCC #29212	4.65 x 10	7.45	<4.47	2.98
Escherichia Coli ATCC #25922	1.24 x 10	6.96	<1.0	5.96*
Pseudomonas aeruginosa ATCC #27853	7.65 x 10	6.62	<1.0	5.52
Staphylococcus aureus ATCC #29213	1.95 x 10	7.16	<1.88	5.28
Staphylococcus epidermidis ATCC #12228	1.29 x 10	7.25	<1.72	5.53

* Reduction may be due, in small part, to incomplete neutralization of the wound irrigation fluid. (See section 13.3 of final report)

Funding: Irrimax Corporation

Podium #5

DELAYED CLOSED-SUCTION DRAIN REMOVAL FOLLOWING INFLATABLE PENILE PROSTHESIS: A MULTI-INSTITUTIONAL EXPERIENCE

Luke Shumaker[1], Nicholas Zulia[2], Jonathan Beilan[2], Emmett Kennady[3], Nicolas Ortiz[3], Adam Baumgarten[1]
[1]University of Alabama at Birmingham Department of Urology, [2]Advanced Urology Institute, [3]University of Virginia Department of Urology
Presented By: Luke A. Shumaker, MD

Introduction: There is little published data regarding percutaneous drain duration following inflatable penile prosthesis placement (IPP). The tissue dissection and dilation associated with IPP placement make scrotal hematomas relatively common in the first 72 hours. Maintaining a percutaneous drain represents a method to reduce scrotal hematoma formation and prevent hematoma sequela such as infection or incision tension. However, maintaining a percutaneous tract also represents a feasible path for seeding of a new prosthesis. Given the severe consequences of infection, establishing comparable outcomes for delayed drain removal patients is necessary. Here we detail rates of infection, hematoma, device explantation and other standard post IPP metrics in a multi-institutional cohort with delayed drain removal (48-hours or greater).

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Methods: Data was collected retrospectively for 224 patients undergoing virgin IPP placement with delayed percutaneous drain removal. Cases were performed by three surgeons at three high-volume centers between 01/01/2020 and 3/31/2022. It was the practice of these surgeons to leave percutaneous drains for an interval of 48 hours or greater. 15 patients had drains removed before 48 hours due to scheduling, patient preference, or inadvertent removal. These patients were excluded leaving 209 patients. R for Statistical Computing was used to generate descriptive statistics (Figure 1) and data visualization (Figure 2).

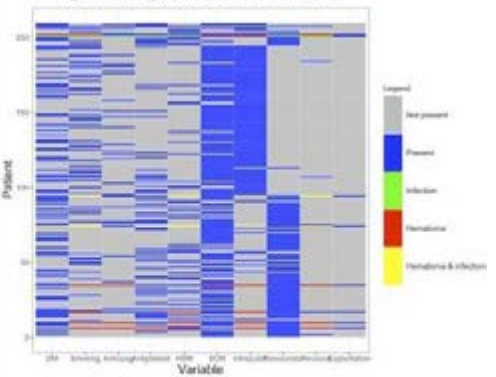
Results: Mean drain duration was 2.8 days. Mean follow-up interval was 170 days. 84 patients (40%) carried the diagnosis of diabetes mellitus with a mean hemoglobin A1c of 7.2. Penoscrotal and infrapubic approaches were employed (114 versus 95). Reservoir location was split between space of Retzius (SOR) and high submuscular (HSM) with SOR being more common (164 versus 45). 7 discrete hematomas were observed. Despite this small number, Fisher's exact testing demonstrated significant association between hematoma formation and both anticoagulation and antiplatelet therapy ($p<0.01$ in both cases). There were 3 device infections (1.4%). 9 patients (4.3%) required revision for non-infectious causes.

Conclusion: The rates of infection and explantation observed in virgin IPP implantation with delayed percutaneous drain removal are similar to rates in other modern virgin cohorts where percutaneous drains were not routinely employed. Additional prospective research would be useful to further characterize outcomes of percutaneous drain placement such as hematoma formation and postoperative pain.

Table 1. Population Characteristics and Outcomes

Total virgin IPP patients	**209**
Cohort characteristics	
Age (years)	64.5 (std dev 9.1)
Diabetes diagnosis	84 (40.2%)
Current smoker status	52 (24.9%)
Anticoagulation therapy	28 (13.4%)
Antiplatelet therapy	58 (27.8%)
Surgical approach	
Infrapubic	114 (54.5%)
Penoscrotal	95 (45.5%)
Device manufacturer	
Coloplast	132 (63.2%)
Boston Scientific	77 (36.8%)
Reservoir location	
Space of Retzius	164 (78.5%)
High submuscular	45 (21.5%)
Implant cylinder size (cm)	22.17 (std dev 2.4)
Follow up (days)	170 (std dev 78)
Outcomes	
Infection	3 (1.4%)
Erosion	1 (0.5%
Device malfunction	3 (1.4%)
Reservoir herniation	2 (1%)
Reintervention	
Revision	6 (2.9%)
Explantation (noninfectious)	3 (1.4%)

Figure 1. Categorical variable visualization



Funding: NA

Podium #6

IDENTIFICATION AND IN VITRO PROPAGATION OF UNDIFFERENTIATED SPERMATOGONIA FROM A 46, XX MALE

Mark Xu, MD[1,2], Aaron Bradshaw, MD[1,2], Harpreet Gosal, MBBS[1], Abinav Udaiyar, BS[1], Omar Abdelaal, MD[1,3], Kimberly Stogner-Underwood, MD[1,4], Stuart Howards, MD[4], Tamer Yalcinkaya, MD[5], Anthony Atala, MD[1,2], Hooman Sadri-Ardekani, MD[1,2,4]
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Presented By: Mark Xu, MD

Introduction: The SRY-positive 46, XX genotype is a testicular disorder of sex development found in 1/20,000 males. Patients are phenotypically male with small testes, variable hypogonadism, and azoospermia. Current literature has not yet documented spermatogonia in 46, XX male testes.
Methods: A 28-year-old Caucasian male was suspected of having Klinefelter Syndrome (XXY), but karyotype and FISH found a 46, XX genotype with a Y chromosome translocation of SRY onto the short distal arm of the X chromosome. He underwent experimental bilateral microscopic testicular biopsy and tissue preservation under IRB protocol. Fresh tissue was sent for histopathologic analysis using H&E staining and immunostaining of undifferentiated spermatogenic markers, including PGP 9.5/UCHL1 and ZBTB16. Biopsies from bilateral testes were used for RNA isolation/cDNA creation. Digital PCR and Real-time Quantitative (RT-Q) PCR were performed with ZBTB16 (undifferentiated spermatogonia), STAR (Leydig cell), CD34 (Peritubular cell), and SOX9 (Sertoli cell) target primers on testis samples from both sides. Isolated cells from the right testicular biopsy were cultured in StemPro medium for four weeks. RT-QPCR was performed with target primers for undifferentiated spermatogonia (ZBTB16, UCHL1, THY1, CD9, ITGA6, ITGB1), Sertoli (SOX9, GATA4, CYP19a1), Leydig (STAR, CALB2), and peritubular cells (CD34). Digital PCR was performed using ZBTB16 target primer to quantify undifferentiated spermatogonia. POLR2A was used for housekeeping. Flow cytometry on cultured cells was performed with CD9, CD49f, and HLA-ABC antibodies. Spermatogonial Stem Cells (SSCs) were identified as cells negative for HLA-ABC and positive for both CD9 and CD49f.
Results: Testes exhibited Leydig cell hyperplasia, seminiferous tubule hyalinization similar to Klinefelter Syndrome, and tubules filled mainly with Sertoli cells. Rare cells in seminiferous tubules were weakly positive for PGP9.5 and ZBTB16, representing undifferentiated spermatogonia. Digital and RT-QPCRs of testis tissue and cultured cells found evidence of all major types of testicular somatic cells and undifferentiated spermatogonia. Digital PCR for ZBTB16 identified 7.61% of cultured cells as undifferentiated spermatogonia and 0.71% as SSCs. Flow cytometry identified 2.52% of cultured cells as SSCs.
Conclusion: This is the first study suggesting the presence of SSCs in 46 XX male testes. Future work will further characterize cultured testicular cells and in vitro/in vivo differentiation of SSCs from 46, XX male testis.
Funding: N/A

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Podium #7

THE AVAILABILITY OF GONADOTROPIN THERAPY FROM FDA-APPROVED PHARMACIES FOR MEN WITH HYPOGONADISM AND INFERTILITY

Benjamin Borgert, MS4, MPH[1], Michael Bacchus, MS4[2], Alexandra Hernandez, MS4[2], Shelby Potts, ARNP[3], Kevin Campbell, MD, MS[2]
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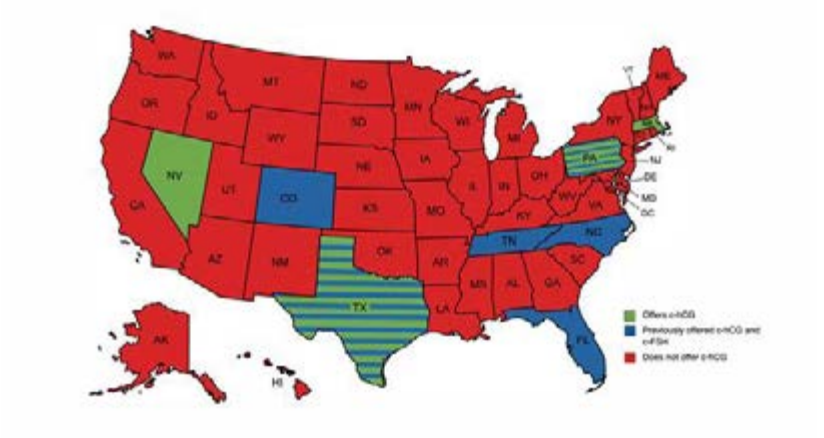
Presented By: Benjamin Joseph Borgert, MPH

Introduction: There are limited therapeutic options for hypogonadal men who desire future fertility. Additionally, the process of obtaining medications for hypogonadism can be challenging for a variety of reasons including insurance coverage. Men have previously utilized compounding pharmacies to acquire gonadotropins. However, recent changes to the Biologics Price Competition and Innovation Act of 2009 have created barriers to accessing therapy for men utilizing gonadotropins for hypogonadism and infertility.
Methods: A review of 503b compounding pharmacies was performed using the online published registry available from the FDA. Each pharmacy was contacted regarding their ability to provide gonadotropin therapy. Pharmacies were also queried regarding the impact of FDA-related legal changes and cost considerations.
Results: The eighty-one 503b compounding pharmacies approved by the FDA to produce hCG and FSH therapy were identified using the FDA registry. Seventy-five of the eighty-one pharmacies were contacted and responded to the survey (response rate = 92.6%). Of the approved pharmacies, five provided hCG (6.67%). Of the pharmacies offering compounded hCG, four offered FSH. No additional pharmacies offered compounded FSH. Eight pharmacies previously provided hCG and FSH (10.67%). Six of the eight pharmacies who stopped making hCG and FSH cited the 2020 FDA mandate as the reason for halting compounding services. Out of the 75 pharmacies who responded, only one pharmacy was able to provide the cost for FSH ($287) and three pharmacies were able to provide the cost for hCG ($50-83 per 10,000 IU vial).
Conclusion: There currently exists limited access to FDA-approved compounded gonadotropin therapies for hypogonadism and male infertility. These results demonstrate the barriers to hCG and FSH access and need for additional treatment options for this vulnerable patient population.



Funding: N/A

Podium #8

COMBINATION OF MICRODISSECTION TESTICULAR SPERM EXTRACTION (MTESE) AND DENSITY GRADIENT PROCESSING TO OPTIMIZE SPERM RETRIEVAL AND PREGNANCY OUTCOMES IN MEN WITH NONOBSTRUCTIVE AZOOSPERMIA (NOA)

Nicholas Deebel, M.D.[1], Banafsheh Nikmehr, Ph.D[2,3], Janmejay Hingu, M.D.[1,3], Collette O'Connor, B.S.[4], Rachel Ruble[2], Yueqiang Song[2], Ayse Kose Vuruskan[2], Anuradha Devineni, M.D.[2], Cihan Halicigil, Ph.D[5], Stuart Howards, M.D.[1,3], Tamer Yalcinkaya, M.D.[2], Hooman Sadri-Ardekani, M.D., Ph.D[1,2,3]

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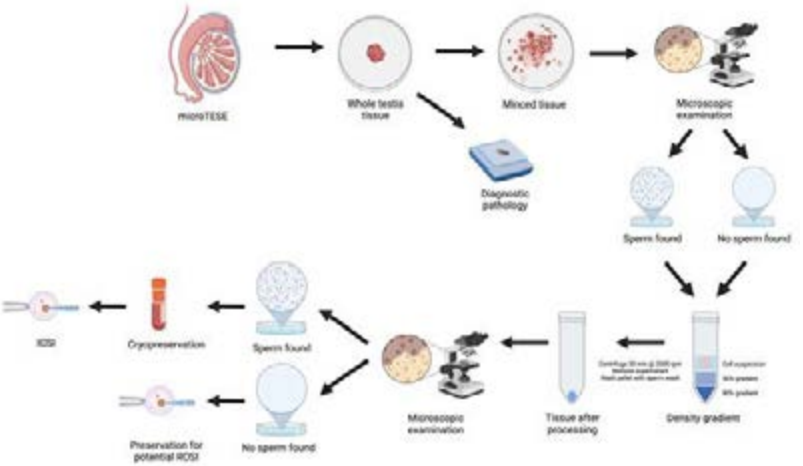
Presented By: Nicholas Deebel, MD

Introduction: mTESE with Intracytoplasmic sperm injection (ICSI) is the gold standard for treating infertile couples when NOA in the male is present. However, using conventional tissue processing techniques, many patients will remain negative for sperm on mTESE. Standard practice in assisted reproduction technology (ART) does not utilize the density gradient centrifugation process. We hypothesize that gradient utilization can enrich sperm retrieval following mTESE.

Methods: A cohort of patients with non-obstructive azoospermia underwent mTESE from 2019-2022 by a single surgeon. The biopsy specimens underwent mechanical dissection. Subsequent tissue processing and gradient wash were carried out through a gradient column including 90% and 50% gradient solution diluted in standard sperm wash medium. Upon verification of sperm, the post-gradient sperm and the remaining un-dissociated tissue were cryopreserved separately. On the day of ICSI, the frozen gradient sperm were first thawed to recover viable sperm. If needed, frozen tissue was thawed, subjected to mechanical dissociation, and a subsequent gradient to obtain enough viable sperm. Fertilization and embryo development were assessed morphologically with the Embryoscope and genetically with preimplantation genetic testing for aneuploidy (PGT-A). Following embryo transfer, biochemical (ß-HCG) and clinical (gestational sac) pregnancy were assessed.

Results: Overall, 24 male patients (36 ± 1.5 years old) with NOA underwent mTESE for an average operating time of 110.6 ± 6.9 minutes (range: 37-177). The primary sperm identification rate after the mechanical dissociation of tissue was 37.5% (n=9). The use of the density gradient led to an overall sperm retrieval rate of 70.8% (n=17) ($p < 0.05$) and secondary sperm retrieval rate (sperm identification in initially negative patients) of 53.3% (n=8). Retrieved sperm were cryopreserved to be used later for ICSI. Thirteen couples (average female age and AMH 32.1 ± 1.6 and 3.2 ± 0.8 ng/ml respectively) underwent ICSI using extracted sperm. The overall fertilization, per-cycle pregnancy, and per-transfer pregnancy rates were 66%, 76%, and 100% respectively. Amongst these couples, 6 underwent PGT-A, and 70.0% of tested blastocysts were euploid.

Conclusion: Utilization of mTESE with subsequent gradient technology may serve as a highly sensitive sperm detection and enrichment method for NOA patients in order to obtain superior ART outcomes.



Funding: N/A

Podium #9

A HEAD-TO-HEAD ERGONOMIC RISK ASSESSMENT OF THE 4K-3D EXOSCOPE VS. STANDARD OPERATING MICROSCOPE FOR MALE FERTILITY MICROSCURGERY

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Presented By: Nicholas Deebel, MD

Introduction: Surgery for male fertility is ergonomically demanding. The standard operating microscope (OM) places surgeons in uncomfortable positions predisposing microsurgeons to cervical strain and chronic pain. The 4K-3D exoscope lacks eyepieces allowing for a “heads up” posture. Given the standing position, surgeons may maintain a more “neutral” upper arm position. We aim to stratify ergonomic risk amongst infertility surgeons using the 4K-3D exoscope versus the OM with wearable technology.
Methods: The surgeon was calibrated with three wearable sensor inertial measurement units (IMUs) on the head and upper arms. Each IMU contains an accelerometer, magnetometer, and gyroscope. This allows for fluid measurement of the surgeon’s joint angle change. Microscopic surgical procedures for male fertility were included. The validated rapid upper limb assessment (RULA) was used to determine the proportion of time spent in ranges of risk. Categories 1-4 were assigned for the head and upper extremities (4 = highest ergonomic risk). A 5-point Likert scale questionnaire related to ergonomic, optical, and teaching metrics was administered. Chi-squared analysis was used to test for differences in proportions.
Results: A total of 500 and 479 microsurgical minutes from 4K-3D exoscope and OM guided surgeries were analyzed. Examination of the bilateral upper extremities showed that the 4K-3D exoscope significantly favored category 1 positioning compared to the OM (56.2% vs. 37.7%; $p < 0.0001$). The OM exposed the surgeon to higher category 3 positioning (14.6% vs. 1.6%; $p <0.0001$). More time was spent in the neck “extension” position using the 4K-3D exoscope compared to the OM (51.8% vs. 19.5%; $p < 0.0001$). During 4K-3D exoscope use, 67% of neck extension time was between 0-10 degrees (category 1). When considering both extension and flexion-based neck movements, more

time was spent in risk group 1 and 2 with the operating microscope ($p < 0.0001$). Likert scale survey assessment demonstrated surgeons favored the 4K-3D exoscope across all domains.

Conclusion: The 4K-3D exoscope offers favorable ergonomic positioning for the upper extremities which may reduce work stress related injury. More operative time was spent with the neck in mild extension with 4K-3D exoscope utilization. However, the operating microscope favored longer operative times in low-risk ergonomic positions for the neck.

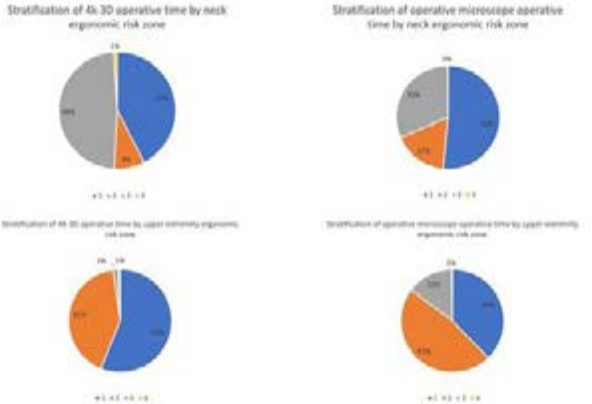

Figure 1. Pie charts demonstrating percentage of operative time spent per ergonomic risk category between the 4K-3D exoscope (left) and the operating microscope (right) for the neck (top row) and shoulders/upper extremities (bottom row). Ergonomic risk zones were defined as 1-4 with 1 representing minimal risk and 4 representing high risk.

Funding: N/A

Podium #10

MULTI-FACETED GENOMIC, PATHOLOGIC, AND ARTIFICIAL INTELLIGENCE ANALYSIS ON LOW-GRADE NONINVASIVE BLADDER TUMORS REVEALS SIGNATURES TO PREDICT DOWNSTREAM TUMOR RECURRENCE

Kyle Rose, MD, MS[1], Aram Vosoughi, MD[1], Gustavo Borjas, BS, MS[1], Heather Huelster, MD[1], Shreyas Naidu, BS[1], Philippe Spiess, MD, FACS[1], Anders Berglund, PhD[1], Rohit Jain, MD[1], Daniel Grass, MD[1], David McConkey, MD[2], Seth Lerner, MD[3], Wade Sexton, MD[1], Anirudh Joshi[4], Nagi Kumar, PhD[1], Roger Li, MD[1]
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Presented By: Kyle M. Rose, MD, MS

Introduction: Low-grade noninvasive (LGTa) bladder cancer is a heterogenous form of non-muscle invasive bladder cancer, characterized by downstream tumor recurrences in some which requires repeated resections and surveillance studies. We aimed to perform a multi-faceted analysis on index LGTa tumors including genomics, tumor microenvironment analysis, and artificial intelligence to identify predictors for later recurrences.

Methods: LGTa index tumors were stratified by those with no downstream recurrences (nonrecurrent) vs. those with later recurrences (recurrent). RNA sequencing was performed to identify differentially expressed genes (DEGs), then deconvoluted for cell-type using xCell. For validation, pathologic analysis was performed by a dedicated genitourinary pathologist and a deep-learning artificial intelligence (AI) platform. An artificial intelligence deep learning algorithm segmented nuclei from digital whole slide images of the tumor specimens to extract quantitative features. These features were then correlated to recurrence risk utilizing a multivariable Cox proportional hazards model, while recurrence free survival (RFS) was examined using Kaplan-Meier analysis and log-rank test.

Results: Thirty index bladder tumors/patients were identified, 18 (60%) had later recurrence with median 4 recurrences/patient at median 9 months after initial diagnosis (Table1). There were 238 DEGs recognized between groups. (Fig-1a). Recurrent tumors distinctly expressed signatures for epithelial mesenchymal transition, myogenesis, TNFα

signaling via NFκB, and angiogenesis (Fig-1b-c). Recurrent tumors also demonstrated a higher TME, stroma, and cancer-associated fibroblast score (Fig-1d). Pathologic TME analysis validated these findings, with recurrent tumors demonstrating a higher frequency of inverted growth pattern and a higher median stroma percentage ($p<0.01$) (Fig-1e). Finally, the AI-derived morphological signature was predictive of recurrence with an AUROC of 0.81, and risk-stratified the cohort robustly with a hazard ratio of 5.43 [95% CI 1.1-26.76] for predicting high and low risk of recurrence. Patients in the high risk group had a 87.5% recurrence rate while those in the low risk group had a 28.5% recurrence rate (Fig-1f).

Conclusion: Using a multi-disciplinary approach we identified key signatures of recurrent LGTa bladder cancer. Characterization of these factors is a critical first step in the risk-stratification of low-grade noninvasive tumors, and may allow urologists to risk-stratify surveillance protocols. Additionally, knowledge of these genomic pathways unique to recurrent tumors provides possible targets for chemoprevention trials.

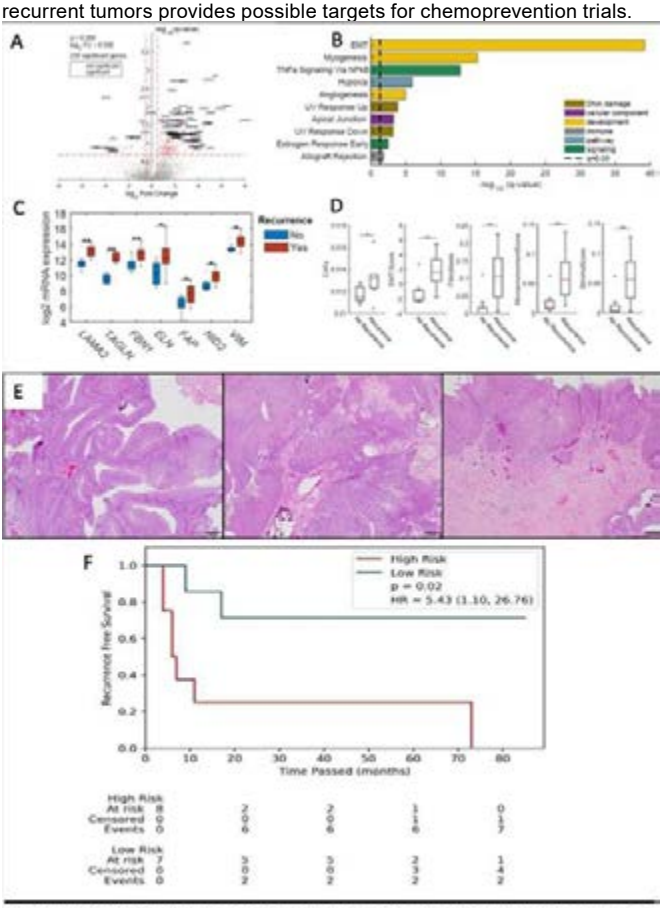

Figure 1. (A) Volcano plot demonstrating differentially expressed genes (DEGs) between recurrent and nonrecurrent LGTa bladder cancer. (B) Expression signatures upregulated in recurrent bladder tumors compared to nonrecurrent. (C) Critical genes involved in epithelial mesenchymal transition which are upregulated in recurrent LGTa tumors. (D) Boxplots demonstrating cancer-associated fibroblasts (CAFs), Epithelial Mesenchymal Transition Score (EMT), Fibroblasts, Microenvironment Score, Stoma Score. (E) From left to right: Histologic evaluation of non-invasive low grade urothelial carcinoma (H&E magnification 40x): common exophytic LGTa, inverted growth pattern of LGUC, stroma of lamina propria comprising a significant portion of resected tissue with LGTa tumor. (F) Kaplan Meier of recurrence free survival for patients categorized into high and low risk for recurrence via artificial intelligence deep-learning.

Funding: N/A

Podium #11

CHRONIC EXPOSURE OF PHYSIOLOGICAL CONCENTRATION OF ARSENIC INDUCED BLADDER MALIGNANCY IN PRECLINICAL MODELS

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Presented By: Hangcheng Fu, MD

Introduction: *Arsenic* is a naturally occurring metalloid classified as a group 1 carcinogen in humans. Chronic environmental exposure to inorganic arsenic has been frequently associated with different types of cancer, including squamous cell carcinoma of the skin and lung and bladder cancers. The bladder is one of the identified target tissues for arsenic toxicity as some of the toxic metabolites of arsenic excreted through urine have been detected in organs, particularly in the bladder. Hence, the study aims to understand how arsenic causes bladder carcinogenesis and dissect the molecular signaling responsible for transforming normal bladder epithelial cells.
Methods: To develop an *in vitro* model of arsenic (250 nM: 33 mg/L))-induced malignant transformation, we chronically exposed healthy bladder epithelial cells (HU-hTERT1) for over 12 months to a median physiological concentration of arsenic and the transformed (AST) cells like that observed in BCa patients. Cell proliferation, qRT-PCR, and Western blot analyses were used to assess the carcinogenicity effect of arsenic in TRT-HU1 cells. In vivo, xenotransplanted mice models were used to confirm the tumorigenicity potential of the transformed bladder epithelial cells. Computational Data and statistical analysis were performed.
Results: Our results demonstrate that arsenic levels in the urine of our bladder cancer patient's cohort are significantly higher (4–6 fold) than that observed in healthy controls. Arsenic-exposed cells began to form anchorage-dependent colonies and -independent spheroids after four months, and the number of colonies increased with exposure time. Our transcriptomic and RPPA analysis suggested stem cell activation may be responsible for arsenic-induced transformation in bladder epithelial cells. In addition, we found a robust induction of ALDH1A1 and CD44 transcript and protein expression correlating with stem cell enrichment in arsenic-mediated transformation. Silencing the stem cell activators (ALDH1A1 and CD44) abrogates arsenic-induced malignant transformation. Finally, the tumorgenicity potential of the transformed bladder epithelial cells was confirmed in xenografted mice models.
Conclusion: Our results suggested that stem cell activators may significantly facilitate the arsenic-exposed cells' survival advantage, enabling the healthy epithelial cells to reprogram into a cancer stem cell phenotype, leading to malignant transformation.
Funding: N/A

Podium #12

MENTAL HEALTH CHANGES IN PATIENTS UNDERGOING RADICAL CYSTECTOMY WITH URINARY DIVERSION

Pushan Prabhakar, MD[1], Hariharan Ganapathi, MD[2], Nikhil Kulkarni[3], Ahmed Eldefrawy, MD[1,3], Jorge Caso, MD[1,3], Murugesan Manoharan, MD[1,3]
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Presented By: Pushan Prabhakar

Introduction: Radical cystectomy (RC) with urinary diversion is the standard treatment for localized muscle-invasive bladder cancer (MIBC). RC adversely affects patient quality of life outcomes. Very few studies in the literature have focused on mental health outcomes such as depression in these patients. We aim to explore the depression score changes for patients undergoing RC with urinary diversion perioperatively.
Methods: A consecutive series of patients undergoing RC with urinary diversion for MIBC were screened using the Beck Depression Inventory-II (BDI-II). Responses were recorded pre-surgery, 6 weeks after surgery, 3 months after surgery, and 6 months after surgery. Based on guidelines, the BDI-II was scored as minimal range (0-13), mild depression (14-19), moderate depression (20-28), and severe depression (29-63).

Results: At the time of the analysis, 47 patients had completed the pre-surgery questionnaire with a mean age of 73.83 years. Of these patients, 34 were males and 13 were females with 45 patients undergoing an ileal conduit for urinary diversion.
6 weeks: 31 patients had minimal range, 1 patient each had mild, and moderate depression with a mean score 5.97 (range 0-22). From the baseline, 2 patients had no change, 14 scored lower, and 17 patients had an increased score. One patient had a significant migration between groups from minimal to moderate depression.
3 months: 27 patients scored in the minimal range category with a mean of 3.96 (0-13). The most notable finding was that 18 patients had a decrease in their score.
6 months: The mean score was 2.58 (0-5) with 6 patients showing no change, 4 showing a decrease, and only 1 patient having an increase.
Conclusion: The BDI-II scores predominantly increased over time from pre-surgery to 6 weeks after surgery. Following this, the trend in the scores showed a decrease over time or no significant change. This shows that the immediate post-operative period is when patients would require effective counseling and referrals to supportive services as needed. Educating the care provider team would be beneficial. This study is ongoing and objective evaluation of depression in postoperative cystectomy patients with a larger patient population would be beneficial.
Figure 1: BDI-II scores for patients undergoing radical cystectomy with urinary diversion.

	Pre-Surgery (n = 47)	6 Weeks after Surgery (n = 34)	3 Months after Surgery (n = 28)	6 Months after Surgery (n = 12)
BDI-II Score Category				
Minimal range, n (%)	43 (91.5)	32 (94.1)	28 (100)	12 (100)
Mild depression, n (%)	4 (8.5)	1 (2.9)	-	-
Moderate depression, n (%)	-	1 (2.9)	-	-
Mean (range)				
	5.36 (0-16)	5.97 (0-22)	3.96 (0-13)	2.58 (0-5)
Change in score				
No change, n (%)	-	2 (4.3)	4 (14.8)	7 (58.3)
Decrease, n (%)	-	15 (44.1)	18 (66.7)	4 (33.3)
Increase, n (%)	-	17 (50)	5 (18.5)	1 (8.3)

Funding: N/A

Podium #13

CISPLATIN-INELIGIBLE MUSCLE-INVASIVE BLADDER CANCER DEMONSTRATES POOR LONG-TERM OUTCOMES FOLLOWING IMMEDIATE RADICAL CYSTECTOMY AND PRESENTS OPPORTUNITY FOR NEOADJUVANT PEMBROLIZUMAB

Kyle Rose, MD, MS[1], Adri Durant, MD[2], Marco Bandini, MD[3], Heather Huelster, MD[1], Megan Prunty, MD[4], Adnan Fazili, MD[5], Shreyas Naidu, BS[1], Stephen Bardot, MD[5], Laura Bukavina, MD[6], Seth Lerner, MD[7], Mark Tyson, MD[2], Andrea Necchi, MD[3], Roger Li, MD[1]
[1]Moffitt Cancer Center, [2]Mayo Clinic Arizona, [3]San Rafaele Hospital, [4]Case Western Reserve University, [5]Ochsner Medical Center, [6]Fox Chase Cancer Center, [7]Baylor College of Medicine
Presented By: Kyle M. Rose, MD, MS

Introduction: Patients with muscle-invasive bladder cancer (MIBC) who are cisplatin-ineligible due to poor functional status and comorbidities have limited options apart from immediate radical cystectomy (IRC). Despite several ongoing clinical trials in this space, the expected survival after IRC remains undefined. We assessed overall survival in cis-ineligible MIBC patients undergoing IRC, and compare this to cis-ineligible patients undergoing neoadjuvant pembrolizumab.
Methods: Patients with cT2-4N0M0 MIBC who had undergone IRC were analyzed from four tertiary care centers. Criteria for cisplatin-ineligibility included Eastern Cooperative Oncology Group score >2, Glomerular Filtration Rate (GFR) <59, grade 2 hearing loss, grade 2 peripheral neuropathy, and New York Heart Association Class III heart failure. Overall survival (OS) analysis was performed using Kaplan-Meier method, and Cox-proportional hazards modelling. For comparison, IRC patients were matched using nearest neighbor propensity scoring technique against cisplatin-ineligible patients recorded from PURE-01 prospective clinical trial with neoadjuvant pembrolizumab (NAP). Patients were matched by pre-cystectomy ECOG status, GFR, age, sex, and pathologic T stage.
Results: 384 cis-ineligible MIBC patients underwent IRC, while 39 cisplatin-ineligible patients received NAP followed by radical cystectomy. In the IRC arm, 118 (31%) patients were down staged (pT0-pT1) from transurethral resection alone, 30 (8%) were pT0N0, and 82 (21%) patients were node-positive on final pathology. The median OS for IRC patients was 22.0 months (95% CI 16.0-28.0). Significantly worse OS occurred in patients with stage pT4N0-3 (HR=1.96, p=0.01), but no significant differences were seen in patients with pT0-3. When comparing cis-ineligible patients undergoing IRC vs. NAP in the propensity-matched analysis, patients receiving NAP experienced improved OS (HR=2.78, p<0.01) and higher complete response rate (pT0: 13.3% vs. 33%, p<0.01).
Conclusion: Cis-ineligible patients with MIBC undergoing IRC have poor long-term oncologic outcomes, likely exacerbated by diminished functional status and medical comorbidities. In this multi-institutional study, patients with pT4 disease or node-positivity on final pathology expectedly experienced the worst survival. Given the poor long-term outcomes, neoadjuvant immunotherapy shows promise in improving survival after radical cystectomy, and double-armed prospective studies are needed to solidify this finding.

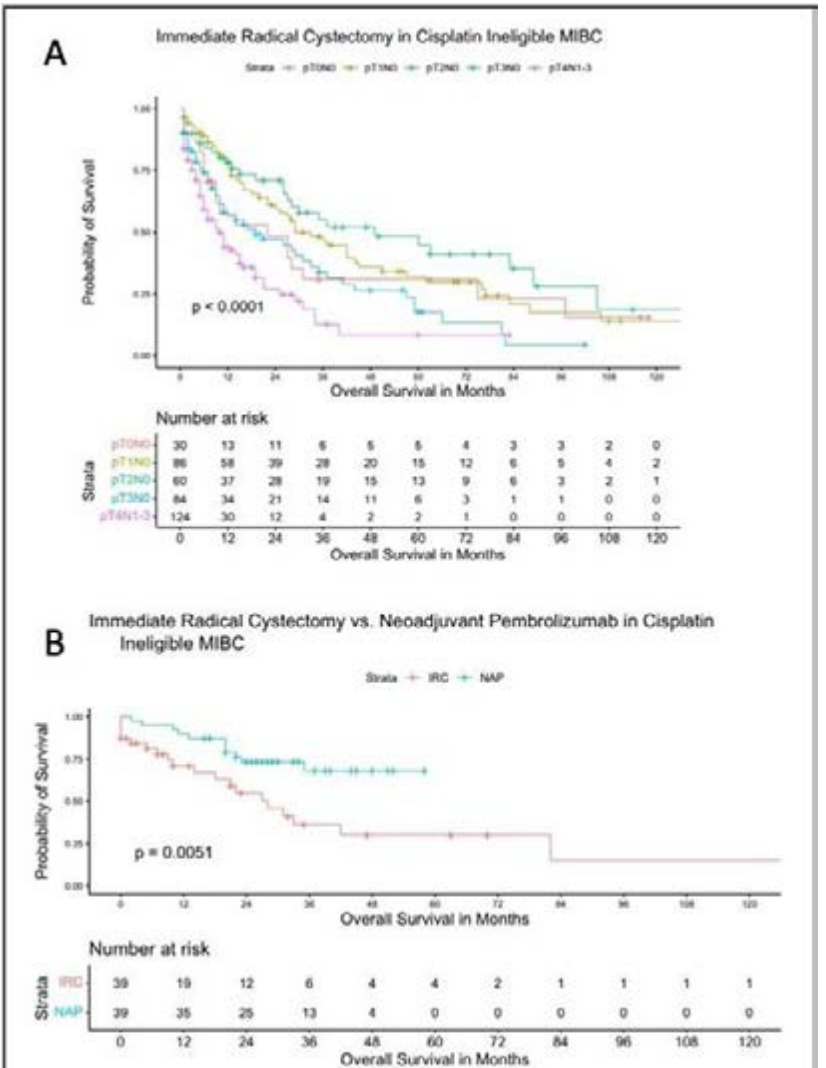

Figure 1. (A) Overall survival of patients with cisplatin-ineligible MIBC undergoing immediate radical cystectomy (IRC). (B) Overall survival of patients with cisplatin-ineligible MIBC undergoing IRC vs. neoadjuvant pembrolizumab followed by radical cystectomy

Funding: N/A

Podium #14

PATIENT-REPORTED TREATMENT BURDEN OF INTRAVESICAL THERAPY FOR BLADDER CANCER

Amanda A. Myers[1], Benjamin Ristau[2], Matthew Mossanen[3], Deborah Kaye[4], Mark D. Tyson[5], Stephanie Chisolm[6], Frank Sloan[7], Angela Smith[8], Timothy D. Lyon[1]
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Presented By: Amanda A. Myers, MD

Introduction: Intravesical therapy is the mainstay of treatment for non-muscle invasive bladder cancer (NMIBC). However, patients with NMIBC can face time, travel, and financial barriers to access intravesical therapy which may impact patient adherence to treatment. Therefore, we sought to quantify patient-reported treatment burden while receiving intravesical therapy for bladder cancer.
Methods: We conducted a cross-sectional survey of bladder cancer patients in the Bladder Cancer Advocacy Network (BCAN) Patient Survey Network to investigate patient-reported burden of intravesical therapy. Multiple choice survey questions were developed by investigators, then iteratively revised and improved by review from clinician and patient advocate stakeholders during the 2021 BCAN annual meeting. Eligible participants received at least one dose of intravesical therapy, including BCG and/or chemotherapy, delivered in an ambulatory setting. Survey was administered in November 2021 and was available for 1 month to respondents.
Results: A total of 233 patients responded to the survey (18% response rate), with a median age of 70 years (range 33-88). Respondents were 36% female and 97% white. A travel time >30 minutes to an intravesical treatment facility was reported by 55% (126/231) of patients, and 33% (77/231) reported personal out-of-pocket costs greater than $25 associated with each trip. Fifty-six percent (129/232) brought caregivers to their appointments. More than half of patients (56%, 129/232) reported spending more than 2 hours on each intravesical instillation, with 18% (42/232) spending more than 4 hours. Missing work for intravesical installations was reported by 36% (82/230) of patients, and of those who did, the majority (70%, 57/81) missed at least half a day of work (4 or more hours). Sixty-one respondents (26%) felt the process of receiving bladder instillations adversely affected their ability to perform regular daily activities. BCG shortages increased travel or wait time for intravesical therapy for 9% (20/229) of respondents.
Conclusion: Bladder cancer patients reported considerable travel distances, time requirements, out-of-pocket costs, and need for caregiver support in the process of receiving intravesical therapy. Innovative intravesical care delivery processes are needed to reduce the burden of care for our bladder cancer patients.
Funding: n/a

Podium #15

REMOVAL OF GABAPENTIN AND KETORALAC FROM ERAS PATHWAY INCREASES PERIOPERATIVE OPIOID USE: A FOLLOW-UP ANALYSIS

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Department of Urology, Atrium Health Levine Cancer Institute, Charlotte, NC
Presented By: Rachel Locke

Introduction: We previously identified poor compliance with the ketorolac and gabapentin components of our ERAS radical cystectomy post-operative analgesia protocol due to provider concerns of poor renal function, bleeding risk, confusion, and ataxia. To decrease complexity and improve both the patient and provider experience, we prospectively removed these two medications from our protocol to evaluate their effect on post-operative inpatient and post-discharge narcotic use.

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Methods: We retrospectively reviewed our IRB-approved, prospectively maintained radical cystectomy ERAS database. Pre-intervention cohort (3/3/2020-3/3/2021) included 84 radical cystectomy patients and post-intervention population (3/4/2021-12/31/2021) included 64 patients.
Our initial analgesia regimen included post-operative scheduled acetaminophen, ketorolac, and gabapentin. The post-intervention group received only scheduled acetaminophen. Narcotic pain medications were utilized as needed. The morphine milligram equivalent (MME) was then compared using Chi Squared, Fisher's Exact and Student's T tests as appropriate.
Results: Both pre- and post-implementation groups were similar in age, gender distribution, BMI, and ASA group. Surgical approach (robotic vs. open vs. laparoscopic; p=0.2656) and the patients receiving TAP block (p=0.8107) did not differ significantly between the two groups. There was no difference between cohorts in length of stay, complication rate, ICU stay, readmission, or time to bowel movement.
There was a significantly higher proportion of patients receiving opioids on post-operative day (POD) 1 and 2 in the post-intervention group. Concordantly, there was a significant increase in average MME on POD1 and POD2 and an increase in patient-reported pain scores. Though not statistically significant, there was a trend towards increased average MME and patient reported pain scores on POD3 (Table 1). After discharge, there was an increase in patients refilling opioid medications (p=0.0033) and the average number of opioid refills (p=0.0180).
Conclusion: Removal of ketorolac and gabapentin from our cystectomy ERAS post-operative pain regimen was associated with increased narcotic utilization on POD1 and POD2 and higher number of opioid refills. The average MME increase was approximately 14 MME, or 1 dose of 10mg oxycodone daily. The clinical significance of this increase must be weighed with the risks and benefits of ketorolac and/or gabapentin administration. We hope to continue discussion regarding the value and optimization of ERAS protocols with non-narcotic medications in radical cystectomy patients.

Opioid Utilization	Pre-Implementation (3/3/20-3/3/21)	Post-Implementation (3/4/21-12/31/22)	P-Value (p < .05)
Patients	84	64	
Average POD0 MME (SD)	8.8 (8.9)	11.9 (12.5)	.0943
Patients received Opioids POD0 (%)	64 (76.2)	56 (87.5)	.0818
Average Pain Score POD0 (SD)	3.63 (2.98)	4.12 (2.8)	.3092
Average POD1 MME (SD)	13.9 (20.1)	28.47 (28.6)	.0008*
Patients received Opioids POD1 (%)	46 (54.8)	54 (84.4)	.0001*
Average Pain Score POD1 (SD)	3.5 (2.8)	5.20 (1.9)	<.0001*
Average POD2 MME (SD)	13.2 (21.3)	26.59 (31.8)	.0048*
Patients received Opioids POD2 (%)	42 (50)	43 (67.2)	.0362*
Average Pain Score POD2 (SD)	3.1 (3.1)	4.6 (2.6)	.0016*
Average POD3 MME (SD)	12.1 (18.3)	20.38 (30.1)	.0574
Patients received Opioids POD3(%)	48 (57.1)	36 (56.2)	.9135
Average Pain Score POD3 (SD)	2.7 (3.0)	3.7 (2.92)	.0599
Average Discharge RX MME (SD)	66.8 (60.9)	67.5 (66.6)	.9437
Patients received Opioid RX (%)	55 (65.5)	42 (65.6)	.9849
Patients received refill on opioids (%)	4 (5)	13 (20.3)	.0033*
Average number of refills (SD)	1 (0)	1.4 (.5)	.0180*

Table 1: Postoperative opioid use before and after the removal of ketorolac and gabapentin from ERAS cystectomy analgesia protocol.
*Statistically significant

Funding: N/A

Podium #16

STENT FREE RATES IN CUTANEOUS URETEROSTOMY URINARY DIVERSION AFTER RADICAL CYSTECTOMY

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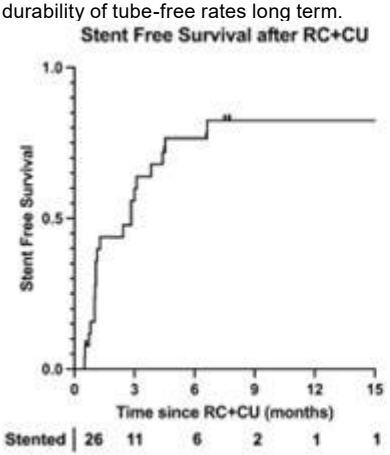
Atrium Health Wake Forest Baptist
Presented By: Parth Thakker, MD

Introduction: Cutaneous ureterostomy (CU) urinary diversion after radical cystectomy has historically been relegated to highly comorbid patients due to presumed rates of stenosis and subsequent drainage tube dependence. Historically, rates of stricture as high as 70% have been reported and many leave patients entirely stent dependent for fear of stenosis related complications. Though a variety of techniques have been developed to obviate need for prolonged stenting, CU remains an uncommonly performed method of urinary diversion. We believe that rates of tube dependence in single-stoma CU are lower than anticipated and thus presents a viable option for all patients undergoing radical cystectomy.
Methods: A retrospective review of patients having undergone radical cystectomy with single-stoma cutaneous ureterostomy from August 2020 to August 2022 by a single-surgeon, was performed. Demographic data and presence of stent, nephrostomy, or nephroureteral catheter was observed at last follow up. The primary outcome was “stent-free survival” incorporating all modalities of tube-dependent urinary drainage. Kaplan-Meier analysis was performed to determine stent-free survival at 6 and 12 months.
Results: A total of 26 patients underwent radical cystectomy with cutaneous ureterostomy during this time period with a median age of 73 years (IQR: 64-78). Median body mass index was 25.45 (IQR: 22.75-28.7). At 6 months 76.6% of patients were tubeless and at 12 months 82.4% of patients were free of urinary drainage tubes. Four (15.4%) patients had continued tube dependence due to disease progression rather than CU stenosis. One (3.8%) patient expressed a strong desire to keep their stents.
Conclusion: Single-stoma CU is a viable option for patients undergoing radical cystectomy with excellent tube-free rates at 1 year. Cutaneous ureterostomy should be considered a viable option for urinary diversion. Longer follow up is needed to assess durability of tube-free rates long term.



Funding: N/A

Podium #17

ATTITUDES TOWARDS IN-HOME INTRAVESICAL THERAPY AMONG BLADDER CANCER PATIENTS

Amanda A. Myers[1], Benjamin Ristau[2], Matthew Mossanen[3], Deborah Kaye[4], Mark D. Tyson[5], Stephanie Chisolm[6], Frank Sloan[7], Colleen Ball[8], Angela Smith[9], Timothy D. Lyon[1]
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Presented By: Amanda A. Myers, MD

Introduction: Patient adherence to recommended maintenance intravesical therapy for bladder cancer is known to decrease over time. Delivery of intravesical instillations in a patient's home may reduce the burden of care and improve treatment adherence, however, patient attitudes towards this approach have not been well studied. The objective of this study was to survey patient perspectives on in-home intravesical therapy.
Methods: We conducted a cross-sectional survey of bladder cancer patients in the Bladder Cancer Advocacy Network (BCAN) Patient Survey Network to investigate patient-reported openness to receiving intravesical instillations by a visiting nurse in their home. Multiple choice survey questions were developed by investigators, then iteratively revised and improved by review from clinician and patient advocate stakeholders during the 2021 BCAN annual meeting. Eligible participants had to have received at least one dose of intravesical therapy delivered in an ambulatory setting. The survey was administered in November 2021 and was available for 1 month to respondents.
Results: A total of 233 patients responded to the survey (18% response rate), with a median age of 70 years (range 33-88). Respondents were 36% female and 97% white. Of the 233 respondents, 168/232 (72%) reported openness to receive in-home intravesical instillations, including 103/232 (44%) who responded "Yes" and 65/232 (28%) who responded, "Maybe/Unsure." Among those surveyed, 157/231 (68%) reported that they would feel safe with medical personnel bringing bladder cancer medications into their home; 122/228 (54%) answered that in-home instillations would make the treatment process less disruptive to their lives; and 63/231 (27%) reported that in-home therapy would reduce their anxiety around intravesical instillations. Fifty-four of 230 patients (23%) indicated that they would be willing to pay an extra fee to receive in-home instillations, with a median of $50 (IQR $31-$94) per treatment proposed.
Conclusion: Nearly three-quarters of survey respondents reported openness to receive intravesical instillations in their home, with many reporting benefits to home over clinic-based therapy. Future work is needed to assess the feasibility and efficacy of in-home instillations.
Funding: n/a

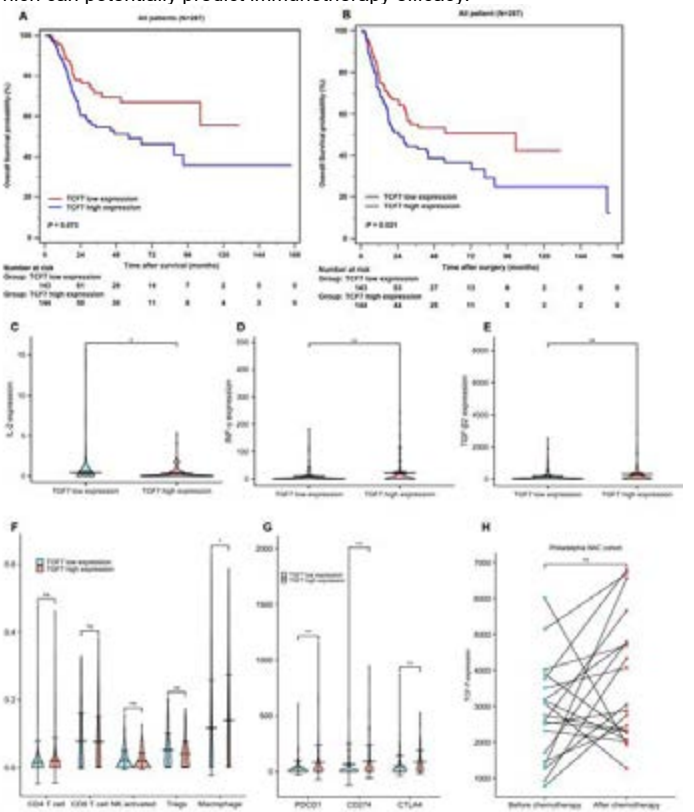
Podium #18

IDENTIFICATION OF T-CELL-FACTOR 7 EXPRESSION AS A POOR PROGNOSTIC INDICATOR AND POTENTIAL IMMUNOTHERAPY MARKER IN MUSCLE-INVASIVE BLADDER CANCER

Hangcheng Fu, Anne Geller, Ankem Murali
University of Louisville Urology Department
Presented By: Hangcheng Fu, MD

Purpose: We previously reported CD8 depleted stromal immunotype associated with worse postsurgical survival and decreased immune checkpoint expression in muscle-invasive bladder cancer (MIBC). T-cell-factor 7 (TCF7) contributes to CD8+ T cell exhaustion and was associated worse prognosis in cancer. This study aimed to reveal the prognostic value of TCF7 expression and its association with the cancer microenvironment in MIBC.

Method: We included in a total of 287 MIBC patients from the TCGA database in this study. Immune cell infiltration was evaluated by calculating the immune signature mRNA expression with CIBERSORT method. We used the median value to stratify the patients into the low TCF7 expression group and the high TCF expression group. Kaplan-Meier method with log-rank test was applied to compare survival curves. univariate and multivariate Cox regression models were employed to evaluate the prognostic value of TCF7 expression in overall survival (OS) and Disease-free survival (DFS).
Results: In patients with MIBC, TCF7 expression did not associate with age, gender, tumor T stage, N stage, or tumor grade. The high TCF7 expression subgroup was associated with unfavorable overall survival (5-year survival 49% vs. 66%, p=0.073). Similarly, high TCF7 expression was also correlated with worse disease-free survival (5-year survival 36% vs. 50%, p=0.021). In multivariable cox regression, TCF7, pT stage, and pN stage were independently associated with patient overall survival (p=0.013, p=0.046, and p=0.001, respectively). TCF7 expression was associated with lower expression of IL-2 and high expression of INF-γ and TGF-β. Also, high TCF7 expression is associated with more abundant infiltration of macrophages in tumor tissues. Importantly, TCF7 expression correlated with high expression of immune checkpoint marker including PD-L1, PD-1, and CTLA-4.
Conclusion: T-Cell-Factor 7 expression is an independent poor prognostic indicator for MIBC. It also correlated with immune exhaustion marker and immune checkpoint marker which can potentially predict immunotherapy efficacy.



Funding: N/A

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Podium #19

ADHERANCE TO AUA GUIDELINES FOR WORK-UP, MEDICAL MANAGEMENT, SURGICAL EVALUATION AND TREATEMENT OF BPH: WORK FROM A QUALITY IMPROVEMENT COLLABORATIVE

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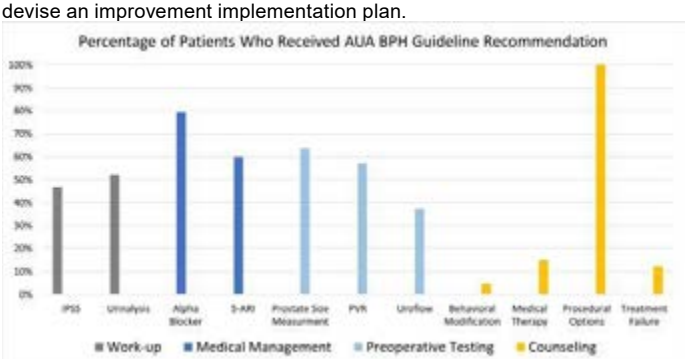
Presented By: John Lee Graves, Jr., MD

Introduction: The AUA has published guidelines for management of Benign Prostatic Hyperplasia. Regarding initial work-up, IPSS, urinalysis, and counseling about behavioral modifications, medical therapy, and procedural options were recommended. Regarding medical management, alpha blockers and 5-alpha reductase inhibitors were recommended. Regarding preoperative testing, prostate size assessment, post void residual, uroflowmetry, and counseling about treatment failure were recommended. We studied the rate of adherence to these guidelines using a quality improvement collaborative (QIC).
Methods: Data was collected as part of a statewide QIC. This initial stage included one academic institution. Medical records for patients undergoing CPT codes 52441, 52442, 52601, 52630, 52648, or 55821 from January 2020 to May 2022 were retrospectively reviewed for adherence to BPH guidelines.
Results: 107 men (M age = 68.5) underwent surgical treatment for BPH. This included twenty-eight Urolifts, seventy TURPS, eight greenlight prostate vaporizations, and one robotic simple prostatectomy. For their work-up, 53.3% of men completed an IPSS (M SS = 20.7, SD = 7.5 / M QOL = 4.3, SD = 1.4) and 52.3% had a urinalysis. 4.7% were counseled on behavioral modifications, 16% on medical therapy, and 100% on procedural options. For management, 79.4% were taking an alpha blocker and 59.8% were taking a 5-ARI. For evaluation, 57% had a PVR (M = 164.0cc, SD = 4.0), 63.6% had prostate size measurement (M = 53.3g), 37.4% had uroflowmetry (M peak = 10.1, SD = 4.0 / M avg. = 4.2, SD = 1.8), and 12.3% were counseled about treatment failure. Postoperatively, 51.6% completed an IPSS (M SS = 9.4, SD = 5.7 / M QOL = 2.0, SD = 1.6), 57% had a PVR (M = 70.7, SD 93.8%), 6.5% had uroflowmetry (M peak = 20.6, SD = 7.3 / M avg. = 10.4, SD = 3.0), 55.1% stopped their alpha blocker, and 80.0% stopped their 5-ARI.
Conclusion: There was moderate adherence to preoperative testing recommendations, but patient counseling was lacking in the initial workup and preoperative evaluation. This presents an ideal quality improvement target to enhance patient care. Next, we will convey the data to key stakeholders, expand data collection to other institutions in the QIC, and devise an improvement implementation plan.



Funding: Becton, Dickinson, and Company: Educational Grant

Podium #20

AQUABLATION: A SINGLE INSTITUTION EXPERIENCE OF 100 PATIENTS

Dylan Dangerfield, MD[1], Yates Congleton, MD[1], Tanner Wright, MD[2], Wesley White, MD[1], Ryan Pickens, MD[1]
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Presented By: Ryan Baird Pickens, MD

Introduction: Aquablation is a novel surgical approach for BPH that has shown noninferiority to TURP in the WATER I and WATER II trials while demonstrating lower risk of sexual dysfunction. Majority of published literature include smaller case series data. We report our initial data with 100 patients.
Methods: In this single-center, single surgeon study, 100 patients with moderate to severe LUTS related to BPH underwent Aquablation. Average age of men included was 71 years old.40 men had a history of urinary retention, 15 of whom required CIC preoperatively. Despite 87/100 (87%) of patients being on an alpha blocker, 5 alpha reductase inhibitor or combination therapy, average preop IPSS score documented as 28.8 with an average PVR of 327.3ml. Average prostate size was 123.6g (35-200g). IPSS and PVR were obtained at 6 weeks postoperatively and 6 months if available. Preoperative and 3 month postoperative PSA was also assessed.
Results: 100 men underwent Aquablation with average operative time (defined as TRUS insertion to foley catheter placement), average ablation time and transurethral resection times as noted in Figure 1. IPSS scores and PVR trends over time demonstrated in Figure 2. Average preoperative PSA recorded at 8 with average of 75% reduction noted 3 months postoperatively. Post-operative complications included 15 cases of urinary retention after initial foley catheter removal requiring CIC or replacement of indwelling foley catheter. Five patients required cystoscopy with clot evacuation and fulguration with 4 of the cases occurring in the first 40 cases before we adjusted our TUR technique. 10 of the 15 retention cases also occurred in the first 40 cases. No reports of de novo SUI or ED.
Conclusion: Early data appears to demonstrate Aquablation as an effective treatment for BPH with procedure duration less than 1 hour for large prostates while obtaining significant IPSS and PVR improvement similar to other BPH procedures. There does not appear to be a significant risk of sexual dysfunction associated.

	All Patients (n=100)
OR time (min)	50.4 (28-128)
Ablation time (min)	7.4 (1.5-20)
TURP time (min)	16.2 (5-57)

Figure 1. Average Aquablation Operative Times

	Pre-op	6 Weeks Post-op	6 Months Post-op
PVR (mL)	327.7 (0-1000)	82.1 (0-199)	32.8 (0-105)
IPSS	28.9 (7-35)	7.6 (1-11)	5.8 (1-11)

Figure 2. Average Postoperative PVR and IPSS Over Time

Funding: N/A

Podium #21

VALIDATION AND RELIABILITY OF THE HOLEP GLOBAL EVALUATION METRIC FOR RECORDED CASE VIDEOS

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Presented By: Gopal Narang

Introduction: Holmium laser enucleation of the prostate (HoLEP) is a size independent treatment for BPH with excellent durability and outcomes. HoLEP suffers from low adoption due to its steep learning curve. There is little in the way of formalized evaluation metrics to assess HoLEP proficiency. Here we describe the validation and reliability of the first HoLEP global evaluation metric in the assessment of recorded case videos.
Methods: The HoLEP global evaluation metric was developed using an accelerated 3-round Delphi process with the assistance of experts and learners. The metric evaluates 7 domains on a 1-5 Likert scale and has a correction factor for procedure difficulty. 18 HoLEP experts across the United States were asked to evaluate 10 recorded HoLEP cases (5 expert and 5 novice). Experts were blinded to the skill level of the surgeon and graded each video on 6/7 domains (the autonomy domain was excluded). Metric validation was assessed using linear mixed modeling to compare total and subdomain scores between expert and novice videos. Inter-rater reliability was assessed using Kendall's coefficient of concordance (*W*) for total and subdomain scores. Statistical significance of Kendall's coefficient was tested using an F-test.
Results: There were a total of 124 video-rater observations out of a possible 180 (18 raters x 10 videos). Mean total score between expert and novices was 25.0 (95% CI: 23.6 to 26.3) and 17.7 (95%CI: 16.3 to 19.0) (p=<0.001), respectively. For both total and each subdomain score, experts received statistically significantly higher scores on average than novices (p<.001 for each). *W* for the total score was 0.632 (p=<0.001), corresponding to substantial agreement between raters. When evaluation *W* for all subdomains, there was moderate to substantial agreement between raters, p <0.005 for each.
Conclusion: The HoLEP global evaluation metric can differentiate between experts and novices in blinded case videos. There is substantial agreement between raters when comparing both total and subdomain scores. This represents the first validation of a HoLEP global evaluation tool. Evaluation of case videos may help decrease the HoLEP learning curve by leveraging expert feedback without the need for in person mentorship.

Multi-rater agreement for total score and subdomains represented by Kendall's *W*

Domain	Kendall's *W*	Kendall's *W* 95% CI		F-test p-value
		Lower CI	Upper CI	
Total score	0.632	0.375	0.833	<.001
1: Plane identification	0.557	0.276	0.830	<.001
2: Scope handling	0.505	0.275	0.705	0.001
3: Blunt dissection	0.626	0.424	0.805	<.001
4: Laser dissection & hemostasis	0.460	0.275	0.686	0.005
5: Efficiency	0.705	0.415	0.884	<.001
6: Morcellation	0.670	0.351	0.845	<.001

Kendall's W Agreement: 0 - <0.20: Slight, 0.2 - <0.4: Fair, 0.4 - < 0.6: Moderate, 0.6 = <0.8: Substantial, >=0.8: Almost perfect

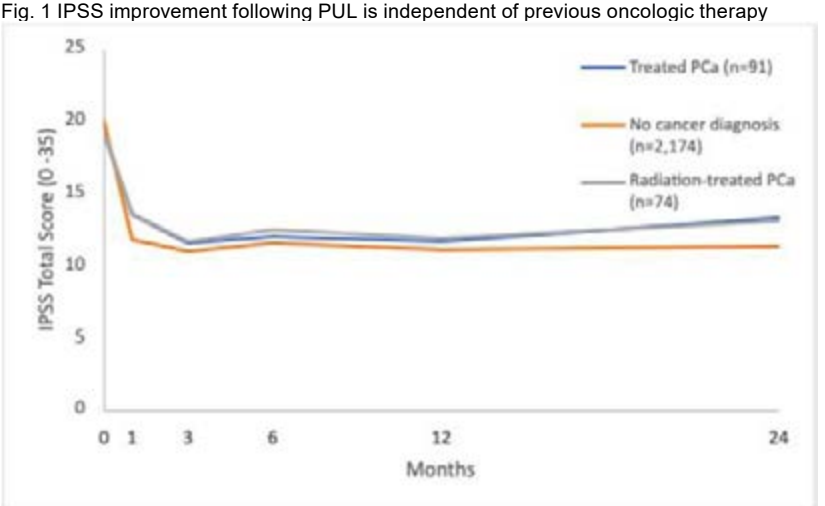
Funding: N/A

Podium #22

PROSTATIC URETHRAL LIFT (PUL) PROVIDES DURABLE SYMPTOM RELIEF TO REAL-WORLD PATIENTS WITH PROSTATE CANCER

Manish Patel, MD[1], Gregg Eure, MD[2]
[1]Urology MD Consult, LLC, [2]Urology of Virginia
Presented By: Manish Patel

Introduction: Patients with a history of treated prostate cancer experience increased rates of infection, bleeding, and incontinence when seeking surgical intervention for lower urinary tract symptoms secondary to BPH. In this analysis, we examine real-world outcomes of the minimally invasive Prostatic Urethral Lift (PUL) in patients with a diagnosis of prostate cancer.
Methods: The Real-world Retrospective (RWR) study includes 3,226 patients across 22 international centers treated with PUL after market clearance. Patients were stratified according to prostate cancer diagnosis (n=138), treated prostate cancer (n=91), and prostate cancer specifically treated with radiation (n=74). Outcomes through 24 months post-PUL were compared to patients in the RWR study without a diagnosis of prostate cancer (n=2,174).
Results: The average time from prostate cancer diagnosis to PUL procedure was 5.2 years. Patients with prostate cancer were older and had significantly higher base PSA levels compared to non-cancer patients. All studied cohorts demonstrated similar improvements in IPSS, Qmax, QoL, and PVR through 24 months post-procedure. Excluding standard-of-care catheterization, catheter independence rates were similar for non-cancer, treated cancer, and radiation-treated cancer groups. No differences in the rates of UTI, hematuria, and stricture were seen between groups, with most adverse events occurring within 3 months of the procedure. The incontinence rate in the cancer group was 7.8% within the first year after treatment, with the majority resolving after an average of 47 days.
Conclusion: This detailed, real-world analysis demonstrates that prostate cancer patients experience durable relief in lower urinary tracts symptoms secondary to BPH after treatment with PUL. Providing symptom relief while avoiding complications remains a priority in this population of men previously treated for oncologic disease.
Fig. 1 IPSS improvement following PUL is independent of previous oncologic therapy



Funding: Neotract, Inc. / Teleflex

Podium #23

THE MRI CASE FOR HOLEP VERSUS TURP: A SINGLE INSTITUTION RETROSPECTIVE COHORT STUDY

Christian Ericson[1], David Sella[1], David Mauler[2], Ram Pathak[1], Colleen Ball[1], Steven Lomax[3], Kevin Parikh[4], Kandace Bolan[1], Chandler Dora[1]
[1]Mayo Florida, [2]Mayo Arizona, [3]UT Health East Texas, [4]Urologic Specialists of Northwest Indiana
Presented By: Christian A. Ericson, MD, BS

Purpose: To correlate the magnetic resonance imaging (MRI)-determined preoperative transition zone (TZ) volume with postoperative specimen weight in two similar cohorts of men who underwent holmium laser enucleation of the prostate (HoLEP) and transurethral resection of the prostate (TURP).
Methods: In a single institution, 97 men who underwent HoLEP and 43 men who underwent TURP were analyzed. All had preoperative MRI and preoperative TZ volume measured using image analysis software. The specimen weight, prostate-specific antigen (PSA), and resection efficiency score were compared between the HoLEP and TURP cohorts using multivariable linear regression models and the nonparametric Spearman rank correlation coefficient.
Results: The age, preoperative PSA, and TZ volumes were similar between the HoLEP and TURP cohorts. The HoLEP cohort had a greater specimen weight (73.0 vs. 25.0 g, P <.001), resection efficiency score (0.98 vs. 0.39, P <.001), and PSA reduction (91.1 vs. 69.6%, P <.001). The HoLEP cohort had a lower postoperative PSA (0.7 vs. 3.20 ng/mL, P <.001). Eighteen patients were identified who underwent HoLEP and had both pre and postoperative MRI and the imaging characteristics and indications are presented as well.
Conclusion: Using MRI-determined TZ volume as a reliable and reproducible standard, HoLEP provides significantly greater removal of the transition zone as measured by specimen weight and PSA reduction compared to TURP. The correlation between preoperative TZ volume and specimen weight is significantly higher for HoLEP than TURP.

Table 1. Preop and postop characteristics

	HoLEP (N=97)	TURP (N=43)	P
Preop characteristics			
Age (years)	71 (66, 74)	71 (68, 76)	.48
Transition zone volume (cc)	73.2 (53.0, 116.8)	76.0 (52.0, 94.0)	.49
PSA (ng/mL)	7.90 (5.50, 11.62)	7.65 (5.12, 11.70)	.56
Postop characteristics			
Specimen weight (g)	73.0 (52.0, 101.0)	25.0 (17.3, 34.5)	<.001
PSA (ng/mL)	0.70 (0.40, 1.37)	3.20 (1.40, 4.20)	<.001
Resection efficiency	0.98 (0.86, 1.15)	0.39 (0.28, 0.52)	<.001
PSA reduction (%)	91.08 (81.27, 95.55)	69.57 (44.62, 84.47)	<.001

Data are shown as the sample median (25th percentile, 75th percentile). P values result from the Wilcoxon rank sum test.

Funding: NA

Podium #24

LOWER RATES OF CONTINUED AND DE NOVO BPH MEDICATION USE FOLLOWING PUL COMPARED TO PVP AND TURP IN US HEALTHCARE CLAIMS ANALYSIS

Gregg Eure, MD[1], Manish Patel, MD[2]
[1]*Urology of Virginia,* [2]*Urology MD Consult, LLC*
Presented By: Gregg R. Eure, MD

Introduction: Data regarding the use of medical therapy surrounding surgical therapies for BPH are limited. This real-world analysis examines pre-operative, post-operative, and continued BPH pharmacological treatment rates after prostatic urethral lift (PUL), photo-vaporization of the prostate (PVP), and TURP.

Methods: A representative sample of 40,267 Medicare and commercial claims patients who underwent PUL, PVP, or TURP for BPH from 2015-2020 were analyzed to calculate duration and rate of BPH medication use (I.e. alpha-blocker, 5-ARI, combination, PDE5 inhibitor, beta-3 agonist, anticholinergic). The likelihood of de novo and continued medication use relative to PUL was analyzed using odds ratios.

Results: For men with prior BPH medication usage who underwent surgical intervention, a higher percentage stop medication after PUL (66%) as compared to PVP (58%) and TURP (60%). De novo medication rates are also lower in PUL patients (13%) vs. PVP and TURP (20% and 19%, respectively). Odds ratios estimated a 51% and 65% increased likelihood of de novo medication use after PVP and TURP vs. PUL, and 39% and 58% increased likelihood of continued medication use after TURP and PVP as compared to PUL.

Conclusion: These results suggest that more patients initiate or continue BPH medications following procedures with greater expectations of symptomatic improvement (PVP/TURP) compared to PUL. More investigation is required to determine if these findings may represent an overperformance of PUL or an underperformance of PVP and TURP.

	PVP	TURP	PUL
Total patients that underwent procedure	11,158	22,021	7,088
- With medical records for BPH medication	3,162 (28.3%)	5,808 (26.4%)	1,497 (21.1%)
Prior Med Usage: *n of prior usage (% of patients with med records)*	2,533 (80.1%)	4730 (81.5%)	1,301 (86.9%)
	n (% prior meds users)	*n (% prior meds users)*	*n (% prior meds users)*
5-ARI	749 (29.6%)	1,306 (27.6%)	328 (25.2%)
α-blocker	2,230 (88.0%)	4,111 (86.9%)	1,115 (85.7%)
Combination	64 (2.5%)	100 (2.1%)	32 (2.5%)
Anti-cholinergic	389 (15.4%)	787 (16.6%)	221 (17.0%)
Beta-3 agonist	360 (14.2%)	572 (12.1%)	225 (15.6%)
PDE5-inhibitor	361 (14.3%)	653 (13.8%)	293 (22.5%)
- Stopped Upon Procedure: *n of stopped usage (% of prior med users)*	1,467 (57.9%)	2,860 (60.5%)	858 (65.9%)
Avg duration prior to procedure (first med record to procedure)	*68d*	*70d*	*127d*
- Continued After Surgery: *n of continued usage (% of prior med users)*	1,066 (42.1%)	1,870 (39.5%)	443 (34.1%)
Avg duration post procedure (procedure to final med record)	*260d*	*200d*	*222d*
	n (% continued meds users)	*n (% continued meds users)*	*n (% continued meds users)*
5-ARI	309 (29.0%)	504 (27.0%)	99 (22.3%)
α-blocker	790 (74.1%)	1,414 (75.6%)	306 (69.1%)
Combination	17 (1.6%)	27 (1.4%)	10 (2.3%)
Anti-cholinergic	246 (23.1%)	491 (26.3%)	122 (27.5%)
Beta-3 agonist	267 (25.0%)	395 (21.1%)	159 (35.9%)
PDE5-inhibitor	206 (19.3%)	346 (18.5%)	129 (29.1%)
Odds Ratio for Continued Usage (vs. PUL)	1.58	1.39	–
De Novo Med Usage: *n of de novo usage (% of patients with med records)*	629 (19.9%)	1,073 (18.5%)	196 (13.1%)
Avg time from procedure to first med record	*123d*	*94d*	*150d*
Avg duration of de novo usage	*51d*	*26d*	*20d*
	n (% de novo meds users)	*n (% de novo meds users)*	*n (% de novo meds users)*
5-ARI	110 (17.5%)	204 (19.0%)	23 (11.7%)
α-blocker	302 (48.0%)	501 (46.7%)	76 (38.8%)
Combination	3 (0.5%)	4 (0.4%)	0 (0.0%)
Anti-cholinergic	297 (47.2%)	674 (62.8%)	136 (69.4%)
Beta-3 agonist	348 (55.3%)	485 (45.2%)	139 (70.9%)
PDE5-inhibitor	160 (25.4%)	253 (23.6%)	58 (29.6%)
Odds Ratio (vs. PUL)	1.89	1.63	–

Funding: Neotract, Inc./Teleflex

Podium #25

IS ROUTINE FOLLOW-UP CYSTOSCOPY NECESSARY IN MEN UNDERGOING HOLEP FOR FAILED UROLIFT?

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Mayo Clinic
Presented By: Giovanni Andre Gonzalez Albo, MD

Aim: To determine the utility of routine postoperative cystoscopy in men who underwent HoLEP following failed Urolift.
Introduction: Due to the small size of the Urolift implant components, including the urethral end piece (UEP), and suboptimal visual conditions frequently occurring by the end of HoLEP we have routinely scheduled men who have had HoLEP following failed Urolift for office cystoscopy at their 3 month follow-up visit.
Methods: A prospective single surgeon HoLEP database was used to identify men underwent HoLEP following failed Urolift between 8/1/2018 and 4/28/2022. 27 of 845 men were identified and preoperative and postoperative characteristics were analyzed and reported.
Results: Follow-up was available in 26 of 27 patients. 17 of 27 consented to cystoscopy. The most common reason for refusal was lack of symptoms. 10 of 17 who underwent cystoscopy were asymptomatic. 7 of 17 were symptomatic (3 slow stream, 3 irritative symptoms, 1 urethral pain). Abnormalities were detected in 7 of 17 (2 bladder neck contracture, 3 strictures, 3 retained UEPs). 1 of 10 asymptomatic men who underwent cystoscopy had a retained UEP and follow-up surveillance cystoscopy was recommended in 2 years to monitor for encrustation.
Conclusion: Routine follow-up cystoscopy on asymptomatic men who underwent HoLEP following failed Urolift detected only one actionable item in 10 patients. We recommend for cause cystoscopy in this group of men with a low threshold for office cystoscopy at 3 month follow-up. Appropriate preoperative counselling should include the possibility of retained foreign bodies from Urolift due to the embedded nature of the capsular tab and polyethylene suture and the very small size of the UEP.
Funding: N/A

Podium #26

COMPARISON OF DIFFERENT IMAGING MODALITIES FOR PREDICTING ENUCLEATED TISSUE YIELD DURING HOLEP: A COHORT STUDY FROM A TERTIARY CARE CENTER

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Presented By: C. Matthew Ellis, MD

Introduction: HoLEP (Holmium Laser Enucleation of the Prostate) has become increasingly utilized as a size-independent procedure in the surgical management of benign prostatic hyperplasia (BPH) within the last decade. Preoperative imaging is often employed for surgical planning, a component of which is assessment of prostate volume. We sought to investigate the accuracy of various imaging modalities in estimating weight-based yield of prostatic tissue in HoLEP specimens.
Methods: A retrospective chart review was conducted for a prospectively-maintained database of individuals who underwent HoLEP between October 2021-August 2022 by two surgeons at a tertiary care center. Data was stratified based on three different preoperative imaging modalities utilized: Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Transrectal Ultrasound (TRUS). Statistical analysis employed T-tests, ANOVA, and post-Tukey Hoc testing as appropriate, wherein a $p<0.05$ was considered significant.
Results: A total of 101 individuals underwent HoLEP, with an average age of 68.6 years (47-85 years). The average weight measured from preoperative imaging was 112.1 grams. 30% (n=30) received a CT scan, 27% (n=28) received an MRI, and 42% (n=43) underwent TRUS prior to the operation. Percent yields, defined as the comparison between preoperative imaging weight estimations and weight obtained in the operating room,

differed significantly by imaging modality (p=0.0004). MRI percent yields were statistically significantly higher than CT (p=0.0002). Intraoperative prostatic tissue weights were also significantly different from the pathology-reported tissue weight (p<0.0001).
Conclusion: The number of individuals receiving HoLEPs continues to increase as a standard practice for treatment of BPH. Preoperative imaging can be a valuable tool by providing surgeons estimates of prostate size and shape. Overall, MRI is more accurate than CT in predicting weight-based yields for individuals undergoing HoLEP. Given these findings, further research should focus on determining if MRI and TRUS are equivalent in predicting percent yield as well as the correlation of enucleated yield and postoperative outcomes, such as improvement in symptoms, maximum flow rate, and percent decline in prostate specific antigen (PSA).

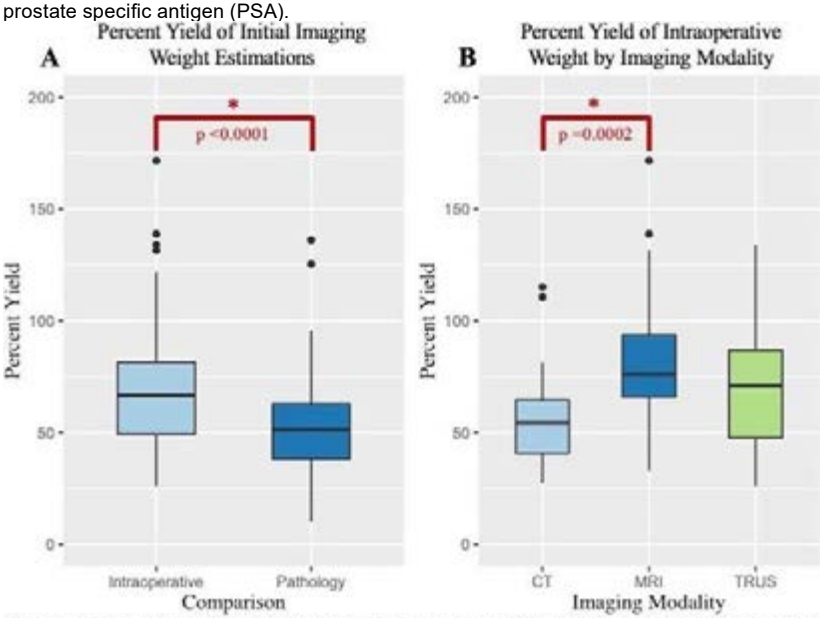

Figure 1. A) Percent tissue yield relative to preoperative imaging was significantly higher for intraoperatively weighed specimens compared to pathology-weighed specimens, p<0.0001. B) Comparison of intraoperative tissue percent yield relative to preoperative imaging modality, with MRI resulting in higher intraoperative percent yields than CT, p=0.0002.

Funding: N/A

Podium #27

CONSISTENT OUTCOMES OF PROSTATIC URETHRAL LIFT (PUL) ACROSS CONTROLLED TRIAL AND REAL-WORLD SETTINGS IN THE TREATMENT OF OBSTRUCTIVE MEDIAN LOBES

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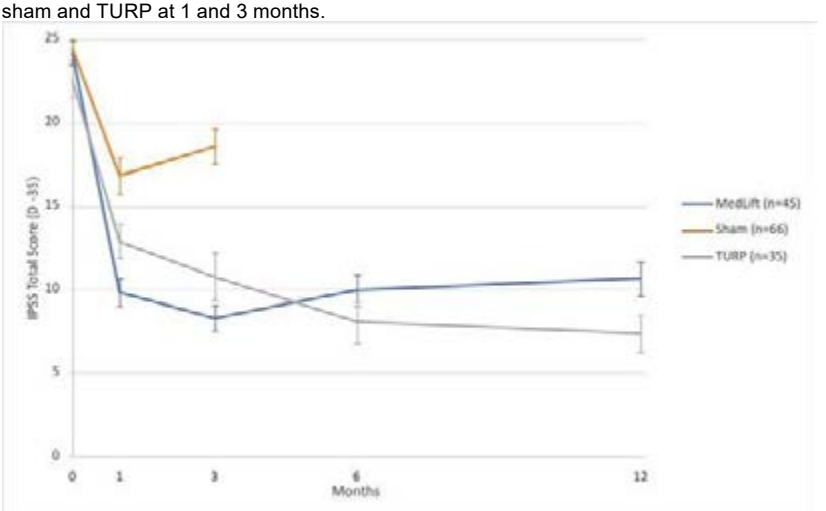
Presented By: Gregg R. Eure, MD

Introduction: Prostatic morphology can inform decision-making in the treatment of BPH as median lobe obstruction is associated with poor medication response and frequently necessitates surgical intervention. This analysis serves as the first detailed comparison of PUL outcomes in patients with obstructive median lobes (OML) in RCT, CCT, and real-world settings.
Methods: 66 men with lateral lobe obstruction in the L.I.F.T. pivotal RCT randomized to sham, 36 men from the BPH6 RCT randomized to TURP, and 45 men with OML from MedLift, the FDA-approved IDE extension of the L.I.F.T. trial were compared through 12 months post-PUL. 187 OML patients from the large real-world retrospective (RWR)

study filtered to approximate the MedLift population were further compared with MedLift outcomes.
Results: MedLift subjects experienced 170% greater IPSS improvement than sham at 3 months post-procedure; MedLift QoL, Qmax, and BPHII also improved significantly compared to sham. Compared to TURP, MedLift IPSS and QoL improved significantly at 1- and 3 months, with PUL demonstrating superior ejaculatory function scores at all timepoints. IPSS, QoL, Qmax, and PVR were equivalent between MedLift and RWR OML at 3-, 6-, and 12 months; overall adverse events were not elevated in RWR OML patients.
Conclusion: PUL is a safe and effective treatment for BPH-associated LUTS in real-world and controlled trial patients with median and lateral lobe obstruction.
Fig. 1 MedLift IPSS improvement following PUL procedure is significantly better than sham and TURP at 1 and 3 months.



Funding: Neotract, Inc./Teleflex

Podium #28

INCIDENCE AND RISK FACTORS FOR POSTOPERATIVE URINARY INCONTINENCE AFTER VARIOUS PROSTATE ENUCLEATION PROCEDURES: SYSTEMIC REVIEW AND META-ANALYSIS OF PUBMED LITERATURE FROM 2000 TO 2021.

Presented By: João Gabriel Da Silva Porto

Introduction: Benign Prostate Hyperplasia causing bladder outlet obstruction affects 80% of men older than 70 years. Prostate enucleation procedures (PEP) have recently become the preferred surgical approach for surgical management of BPH. The aim of this study is to evaluate and compare the risk of urinary incontinence (UI) after using different types of PEP.
Methods: PubMed was searched from January 2000 to July 2021 for studies investigating UI after PEP. The articles were divided into 5 subgroups: holmium, thulium, greenlight laser, electrocautery, and simple prostatectomy. Meta-analysis was performed to examine rate of stress (SUI), urge (UUI) or unspecified UI at short (< 3 month), intermediate (3-6 month), and long-term (> 6 month). The impact of age, prostate size, surgery time, laser time, postoperative nadir PSA level and technical modifications on UI was analyzed.
Results: Most (69.4%) of 49 articles included employed holmium laser. There was no significant difference in incidence of short, intermediate, and long-term UI, SUI and UUI between the 5 sub-groups and within different technical modifications. Although not statistically significant, the incidence of UI was higher (15%) at short-term with green-light and simple prostatectomy (95% CI: 9-23 & 1-84), and higher (4%) at intermediate-term with holmium laser (95% CI: 2-8). SUI was more prevalent at short-term with holmium

laser (4%; 95% CI: 2-5%), and at intermediate term with simple prostatectomy (3%; 95% CI: 1-14). UUI was higher in the thulium group (10%, 95% CI: 7-16). Increased age, surgery time, laser time and prostate size up to 80 cc were associated with higher UI. There was no correlation between postoperative PSA and UI.

Conclusion: There is no significant difference in incidence of UI, SUI and UUI after various PEP. Patients age, prostate size, surgery, and laser time are linearly associated with UI.

Table 1. Prevalence of urinary incontinence according to the various technical modifications of endoscopic enucleation of prostate.

Type of UI			Overall Urinary incontinence			Stress urinary incontinence			Urge urinary incontinence		
Technical modifications		Postoperative period (months)	S	N	Mean ± SD (%)	S	N	Mean ± SD (%)	S	N	Mean ± SD (%)
Enblor	Yes	0-3	6	1187	14 ± 1.7	NA	NA	NA	NA	NA	NA
		3-6	5	1032	2.3 ± 6.6	3	2541	1.4 ± 1.8	2	1253	0.8 ± 1.1
		>6	2	575	0.5 ± 0.7	NA	NA	NA	NA	NA	NA
	No	0-3	13	4916	12 ± 13	17	7001	6.2 ± 4.5	7	3512	12 ± 15
		3-6	10	3973	5.5 ± 8.7	14	5905	1.8 ± 1.6	4	3258	2.9 ± 2.9
		>6	6	1553	3.7 ± 6.5	3	1483	0.7 ± 0.3	NA	NA	NA
Early mucosal release	Yes	0-3	5	1223	3.3 ± 3.3	4	2051	5.8 ±8.1	NA	NA	NA
		3-6	4	953	0.2 ± 0.3	3	1991	1.1 ± 1.6	NA	NA	NA
		>6	NA	NA	NA	NA	NA	NA	NA	NA	NA
	No	0-3	16	5667	15 ± 11	13	6148	6.2 ± 3.6	7	3100	14 ± 14
		3-6	12	4561	5.6 ± 7.7	13	6365	1.9 ± 1.6	5	3911	2.6 ± 2.6
		>6	7	1514	3.3 ± 6.0	4	2548	1.0 ± 0.6	NA	NA	NA

S= number of studies reporting outcome; N= total number of patients in these studies; NA= no data available; No statistical significance was observed between en-bloc vs two/three-lobes technique or performing early mucosal release.

Funding: N/A

Podium #29

SINGLE SURGEON EXPERIENCE WITH PROCEPT AQUABEAM AQUABLATION OF THE PROSTATE FOR MEN WITH BPH: FIRST 55 CASES (WITH 45-MONTH FOLLOW-UP)

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[1]Kasraeian Urology, [2]Karaeian Urology

Presented By: Ali Kasraeian, MD, FACS

Introduction: Aquablation is a minimally invasive technology for management of BPH, regardless of prostate size or shape. The system uses a combination of robotic technology, real-time imaging, and (&) heat-free waterjet to precisely & accurately remove obstructive prostate tissue in men with BPH. We report our initial experience with our first 55 cases.

Methods: Between July 2018 & May 2019, 55 men underwent Aquablation. Evaluation included cystoscopy, urodynamics (UDS), & transrectal ultrasound (TRUS). Pre-operative (op), intra-op, post-op outcomes & data were prospectively collected & reported with 45-month follow-up.

Results: Pre-op mean prostate volume was 100 cc (27 to 252). Of our patients, 39 had prostates larger than 80cc (71%), 24 greater than 100cc (44%) & five (9%) greater than 150 cc. Median lobe was noted in 47 (85%). UDS demonstrated severe bladder outlet obstruction (BOO) in 51 (93%). Detrusor instability was noted in 31 men (56%) & 27 (49%) suffered from urinary retention with 17 (31%) requiring catheterization pre-operatively. Mean op time was 58 minutes (25-108). Thirty-five men were discharged on post-op day (POD) 1, with 13 discharged on POD 2. Two patients received transfusions, but due to pre-op anemia and hematuria associated with their enlarged prostate. One of two had also received transfusions pre-operatively.

Mean pre-op hemoglobin (Hgb) was 14 (8.6 to 16.7). Mean immediate post-op & day of discharge Hgb levels were 13 (9.3 to 16) & 11.8 (7.2 to 15.3), respectively. Of note, 47 of the 55 men reported erectile dysfunction at baseline. Post-operatively, a 17-point (2-29) mean decrease in AUA symptom score (AUASS) was noted from 22 (5 to 35), pre-operatively, to 5 (1-13), post-operatively. Post-op uroflow studies after 4-6 weeks demonstrated mean maximum flow rate (Qmax) of 21 ml/s (4.3 to 45), an increase of 13.3 points from 7.4 ml/s (1.9 to 15), pre-operatively. Erectile function was maintained post-operatively with mean SHIM score of 11.5 (range 1 to 25) versus 10.5 (1 to 25), pre-

operatively. All patients completed successful voiding trials post-operatively, & of those with baseline urinary retention, none currently require any form of catheterization.
Conclusion: Aquablation is an innovative technology that offers predictable, reproducible outcomes, independent of prostate size. Aquablation has a short learning curve & is easily reproduced regardless of prostate size or shape
Funding: N/A

Podium #30

AUGMENTED REALITY-ASSISTED SURGERY (ARAS): A NOVEL SURGICAL TRAINING TOOL USING MICROSOFT HOLOLENS

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Presented By: David Nelwan, MD

Introduction: Recent research with the Microsoft HoloLens mixed-reality HMD has found it to be a promising technology for surgical practice/education. The application of HoloLens in open urologic surgery has yet to be evaluated.
Objectives: To evaluate the feasibility of HoloLens as a useful training tool for penile surgery. Secondary objectives included identifying areas of improvement for software capabilities and overall user experience.
Methods: 2 male cadavers were used for this lab—one each for IPP implantation and male sling. 7 fellowship-trained Sexual Medicine urologists were recruited from our institution and SMSNA as study participants; 4 were present on-site to perform the procedures, and 3 were located out-of-state and joined the session virtually. All had previously been provided with a HoloLens 2 and had familiarized themselves with its functions/operation
Intraoperatively, 3D virtual renderings of a cylinder, pump, and reservoir were sized to their physical counterparts and placed “in” the cadaver, demonstrating where the physical components would be inserted (Figure 1). The male sling proceeded similarly, with a virtual video of the procedure placed next to the cadaver and intraoperative planning using 3D virtual renderings of the retractor and sling (Figure 2).
Immediately after the surgical simulation concluded, participants completed feedback surveys about the effectiveness and usefulness of HoloLens in this setting.
Results: On a 5-point scale, average educational usefulness of this technology rated 4.8; potential role in operating room 4.6; recommended implementation in residency training 4.4; recommended for remote surgical mentoring 4.6, likelihood to use in practice 4.6.
All 4 on-site participants agreed or strongly agreed that use of the HoloLens improved understanding of the procedure and anatomy. Feedback about ease of navigation, streaming and hologram quality, audio quality, voice command, and eye/hand tracking scored between 3.2-3.8. There was ubiquitous feedback about desired improvements in video/audio/hologram quality, tracking, and voice command.
Conclusion: This pilot study demonstrated feasibility of HoloLens as a surgical training tool, with strongly favorable feedback about its educational utility. However, the experience of remote participants was significantly hindered by technological issues. Though there is a distinct need for improved software integration and remote access interfacing, HoloLens is an exciting technology with immense potential for surgical education.

Funding: Coloplast

Podium #31

RESIDENT PARTICIPATION IN URETEROSCOPIC STONE EXTRACTION DOES NOT INCREASE OPERATIVE TIME OR COST AT A LARGE ACADEMIC TERTIARY REFERRAL CENTER

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Presented By: David Levi Thompson

Introduction: Surgical training must balance the needs of trainees with patient care. We sought to evaluate the effect of resident trainee participation on ureteroscopic stone extraction (USE) cases with regards to procedure time and cost in order to better understand the effect of surgical training on patient-centered outcomes.
Methods: Medical records for all USE procedures (CPT 52356) in patients >18 years of age at a single academic tertiary referral center performed by a single endourologist between 2019-2022 were collected. Cases in which additional procedures were performed concurrently were excluded. Demographic and perioperative data were abstracted from the medical record. Cost data as reported in the EMR as charges were also obtained. Data was analyzed using Stata statistical software v16 using chi-square, t-tests, Wilcoxon rank-sum tests, and multivariable linear regression where appropriate.
Results: A total of 238 USE cases were performed between 2019-2022. Of these 147 (61.8%) were cases involving residents from PGY1-PGY5. There was no difference in patient age (52 vs 53 years; p=0.72), patient sex (66 vs 60% female; p=0.35), BMI (30.6

vs 31.1; p=0.22), intraoperative stent placement (97 vs 94%; p=0.33), average Hounsfield units (915 vs 862; p=0.24), or maximum stone length (13 vs 13 mm; p=0.99).
Among cases performed with residents there was a significantly lower percentage of cases performed with a semirigid ureteroscope (89 vs 77%; p=0.019), higher percentage of pre-stented patients (46 vs 61% p=0.023), higher percentage of ureteral stones (25 vs 36%; p=0.047). There was no difference in supply cost ($1056 vs $1054; p=0.97), total cost ($16,454 vs $15,987; p=0.35), or procedure time (56 vs 50 min; p=0.083) in cases performed with resident participation. Using multivariable linear regression, resident participation was not significantly associated with total cost (p=-0.434) or procedure time (0.084). Both maximum stone length (p<0.001) and ureteral stone location (p<0.01) were associated with increased total cost and procedure time. Use of semirigid ureteroscope (p=0.032) was associated with increased procedure time after controlling for demographic and perioperative variables listed above.
Conclusion: Resident participation in USE cases was not significantly associated with increased cost or procedure time after controlling for demographic and perioperative variables.
Funding: N/A

Podium #32

VARIABILITY IN PARENTAL LEAVE POLICIES FOR UROLOGY RESIDENTS ACROSS UNITED STATES ACADEMIC MEDICAL INSTITUTIONS

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Presented By: Alice Chu, MD

Introduction: Parental leave is a significant consideration for resident physicians when considering family planning during their training. While the American College of Graduate Medical Education (ACGME) recently mandated a 6-week paid parental leave policy, there is currently no standardized parental leave policy across urology residency programs. This study sought to evaluate the availability and accessibility of parental leave for urology residents at academic medical institutions in the United States. We hypothesized that larger resident complement and higher proportion of female residents and/or faculty would be associated with more robust parental leave policies.
Methods: A non-validated 8-question survey was developed to capture the current status of parental leave policies (e.g. duration of leave, maternal vs paternal leave, birth vs adoptive children, compensation status). All ACGME-accredited urology residency programs were contacted via email. Data were collected via telephone/video interview, email, or online survey response. Program characteristics and demographic information were collected from the residency program website and Fellowship and Residency Electronic Interactive Database Access (FREIDA™). Fisher's exact test was used to determine association between program characteristics and favorable parental leave policies (i.e., >6 weeks).
Results: We successfully contacted 132 (93.6%) academic urology programs. A total of 35 (27%) programs responded. Maximum allowed weeks of parental leave ranged 3-18 weeks for birthing parents (median 6 weeks, mean 8.26 +/- 3.78 weeks) and 0-18 weeks for non-birthing parents (median 6 weeks, mean 7.06 +/- 3.83 weeks). Most institutions provided fully paid leave and did not require exhaustion of other time away from training (i.e., vacation, sick leave, continuing medical education; 74.3% and 71.4% respectively). Having >30% female faculty was associated with resident parental leave time >6 weeks (OR 10.3, p<0.05). Geographic region, program type (university- vs community-based), program size, number of program years, and resident gender complement were not associated with parental leave time.
Conclusion: There is large variability in the maximum amount of parental leave allowed and amount of paid leave among academic urology residency programs across the United

States. Standardization of these policies may increase equity across urology residencies in the U.S. and alleviate fears of financial burden and need to extend training.

Funding: N/A

Podium #33

A NEW BARRIER IN THE UROLOGY RESIDENCY APPLICATION PROCESS FOR STUDENTS: GROWTH OF U.S. MEDICAL SCHOOLS INCREASINGLY OUTPACES THE DEVELOPMENT OF UROLOGY PROGRAMS

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Presented By: David Nelwan, MD

Introduction: In 2006, the AAMC recommended that first-year medical school matriculation should increase by 30% to combat the increasing physician shortage in the U.S. Their goal was met in 2018, and as undergraduate medical education has since continued to expand, we wanted to examine the concomitant growth of urology training programs.
Methods: Data on the number of current MD and DO medical schools and urology residencies in the U.S., as well as their year of establishment, were ascertained via internet search, with sources including the AAMC, American Association of Colleges of Osteopathic Medicine, Doximity, and individual programs' websites. Data were tabulated and stratified by year of establishment (either <2000 or ≥2000).
Results: Before the year 2000, there were 142 medical schools (126 MD, 16 DO) and 113 accredited urology residencies. Since 2000, 76 new undergraduate medical training sites have been established (33 MD, 43 DO), as well as 35 new urology residency programs. In total, there are presently 218 undergraduate medical training sites (159 MD, 59 DO) and 148 urology residencies.
We calculated the percentages of undergraduate medical training sites with a urology residency, comparing pre-2000 to the present: <2000 = 79.6% (113/142); present = 67.9% (148/218). We also stratified by region, using AUA Sections (Table 1).
Conclusion: The growth rate of graduate medical education is lagging behind the increased rate of medical school matriculation. Prior to 2000, nearly 80% of medical schools had an associated urology residency; that number has fallen to 67.9% in the past two decades. The Western AUA Section region shows the greatest discrepancy between growth of medical schools and development of urology residencies. Overall, all AUA Sections have experienced a decrease in the percentage of medical training sites in their region with a urology residency, with the exception of the Mid-Atlantic and New England Sections.

Equity is one of the pillars of the AUA's DEI initiatives; however, students at 1/3rd of medical training sites lack local urologic mentorship. Given the importance of urology research to successfully matching, these students are potentially disadvantaged in their pursuit of a career in urology compared to students at institutions with a urology residency.

AUA section	<2000	≥2000	Now
Western	100.0%	22.2%	58.8%
South Central	68.2%	31.3%	52.6%
North Central	82.1%	66.7%	78.4%
Southeastern	56.7%	52.6%	55.1%
Mid-Atlantic	78.9%	100.0%	82.6%
Northeastern	83.3%	33.3%	66.7%
New York	118.2%	33.3%	88.2%
New England	90.0%	300.0%	109.1%
Total	79.6%	46.1%	67.9%

Table 1: Percentage of undergraduate medical training sites with a urology residency, stratified by AUA Section region and year of establishment, compared to the present.

Funding: N/A

Podium #34

LONGITUDINAL RESIDENT CLINIC: INITIAL EXPERIENCE WITH A UNIQUE APPROACH TO OUTPATIENT UROLOGIC EDUCATION

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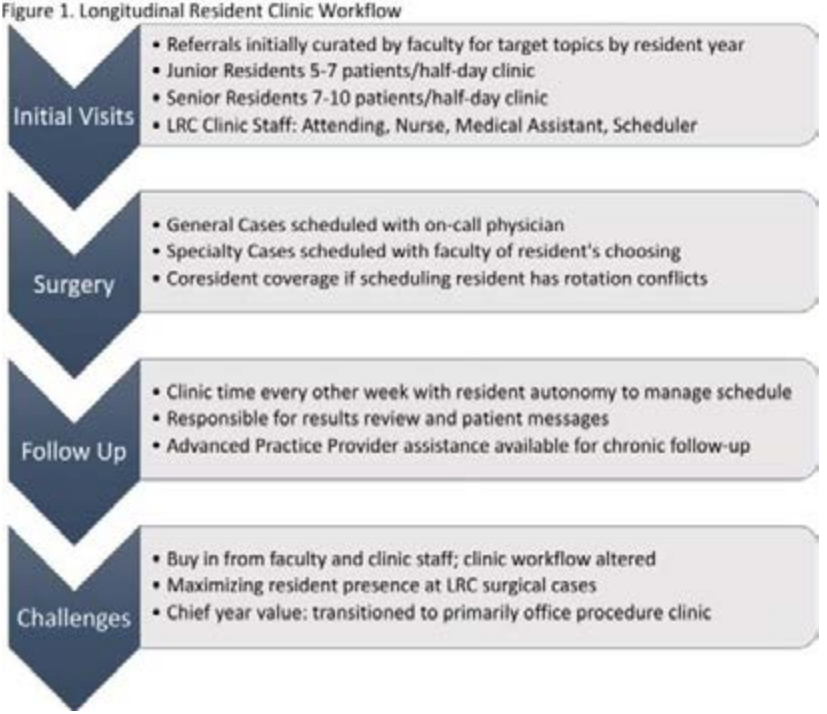
Carolinas Medical Center Department of Urology
Presented By: Samuel Ivan, MD

Introduction: Outpatient urological education is generally limited in follow-up by resident rotation length and may suffer in depth as a result. In contrast, the actual practice of urology requires management of patients over extended periods of time. The opportunity to mirror this reality and improve the preparation of urology residents for practice has led to the development of a Longitudinal Resident Clinic (LRC). We describe this new template for outpatient education which, to our knowledge, is the first of its kind within urological training.
Methods: In May 2021 we began piloting LRC. We describe the structure and implementation of this program and describe qualitative data from a survey of 5 participating residents. Survey questions included: 1) What are benefits of LRC? 2) What are hurdles to LRC?
Results: Patient referrals were initially screened and distributed by a faculty member. This allowed some selection by resident year, with junior residents focusing on topics including nephrolithiasis and benign prostatic hyperplasia and senior residents focusing on topics of increasing complexity such as renal mass and office-based procedures. Each resident had a half-day clinic every other week. A dedicated supervising faculty member, nurse, and medical assistant were assigned to LRC. Follow-up was designed to continue throughout post-graduate years 2-5 with the resident responsible for all aspects of patient care. Surgeries scheduled from LRC were performed with the on-call urologist or, if the case was more specialized, were scheduled with the resident's choice of faculty. Resident survey identified perceived educational benefits of managing billing/coding, clinic workflow, and a clinical team. Residents also reported an improved sense of autonomy, responsibility, and connection with patients. Additionally, there was felt to be patient benefit in decreased fragmentation of care compared to traditional resident-run clinics. Hurdles included initial education of office staff, referral distribution, integration of LRC surgical cases within established resident rotations, and maintaining educational value for chief year residents.

Conclusion: A longitudinal resident clinic presents possible benefits of increased resident autonomy, preparation for real life practice, and improved patient experience. Implementation requires buy-in from all faculty and clinic staff. Future research will seek to describe patient and resident experiences and determine the educational value of this model.

Figure 1. Longitudinal Resident Clinic Workflow



Funding: N/A

Podium #35

SURGICAL INTRAOPERATIVE HANDOFF INITIATIVE: STANDARDIZING OPERATING ROOM COMMUNICATION USING SHRIMPS

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Presented By: Wesley Stephens Wilt, MD

Introduction: Operating room (OR) staff changes can potentiate communication failures, potentially leading to adverse events and disruption of OR flow. OR handoffs are not universally standardized, though standardized sign outs have been proven to provide effective communication in other aspects of healthcare. We hypothesize creating a standardized handoff, with persistent auditing, will result in highly reliable, standardized communication between OR staff members.

Methods: An engaged frontline stakeholder approached our OR quality improvement (QI) team, led by a QI experienced urology faculty member, with concern regarding lack of information discussed during surgical technician handoffs during staff changes. Following, the Surgical Intraoperative Handoff Initiative commenced from 5/2022 through 9/2022. The OR QI team created an audit tool for preliminary data collection, and current handoffs were audited. The pilot cohort of audits was discussed with stakeholders, including intraoperative staff and OR leadership, to develop a standardized communication protocol. A finalized communication tool was created with domains regarding sponges, sharps, hidden items, replaced items, instruments, implants, medications, procedure overview,

and specimens. As a memory aid, an acronym of these domains, SHRIMPS, was affixed to each OR wall (Figure).

Results: 23 cases were observed both pre- and post-implementation. Handoffs occurred in 83% of cases pre-intervention, of which only 42% included communication with the surgeon, and the elements of the handoff varied. Sharps were discussed in 78%, instrument needs in 61%, medications in 65%, specimens requiring collection in 39%, and hidden items in 30% of handoff communications. In the initial Plan-Do-Study-Act (PDSA) cycle, piloted and audited in urology, general surgery, and neurosurgery after implementation of the standardized handoff, 100% of the 15 observed cases had a handoff performed, averaging 65 seconds per handoff. Additionally, 100% of cases announced a handoff to the surgeon, and all elements were addressed 99.6% of the time. PDSA cycle 2 involved implementation to all service lines, and of the 9 cases observed, 100% had a handoff performed at an average of 86 seconds per handoff, with 100% of elements addressed.

Conclusion: Little standardization of communication exists within the OR, especially regarding intraoperative staff changes. Implementation of a standardized handoff resulted in substantial improvement in critical communication during staff changes.

OR Technician Report Tool

S – Sharps, sponges, other countable items *on the field* (clips, vessel loops, shods, etc.)

H – Hidden or held items (dressings, extra suction tubing, etc. under basins or instrument trays; items in room, not yet opened)

R – Replaced, added, or changed countable items (suture, instruments, etc.)

I – Instruments & implants (anticipated instrument needs during break, what is on Mayo, are implants open)

M – Medications (injectables) (how much medication has been used, what is drawn up)

P – Procedure overview (point in the procedure, upcoming steps, do you need anatomy orientation?)

S – Specimens (specimen on field or if coming out during break)

Funding: N/A

Podium #36

EFFECTIVE USE OF SOCIAL MEDIA TO ATTRACT UROLOGY RESIDENCY APPLICANTS

F Pearce Kudlata[1], Salil S Ghamande[1], William M Pearson[1], Luke G Scanlan[1], Brittany Ange[1], John J De Caro[2], Martha K Terris[1]
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Presented By: Frederick Pearce Kudlata

Introduction: The role of social media has grown increasingly crucial for Urology residency programs as a mechanism of outreach to applicants. The purpose of this study is to determine how the presence and usage of different social media platforms correlate to residency application numbers. The goal is to provide Urology residency programs with evidence that specific social media use can increase exposure to applicants.
Methods: Accredited residency programs were obtained from the AUA. The social media presence of each program was identified by manual search, and social media usage analytics from 4/1/19-3/31/22 were determined using popsters.com. Program size and rankings of each program were acquired from Doximity, and city populations were acquired from US census data. Deidentified applicant data for 2019-2022 was obtained by the AUA/SAU. Statistics were calculated using Mann-Whitney-U tests, Fisher's Exact tests, and Spearman's rank correlations.
Results: Residency programs with a Twitter (90.7%), Facebook (28.6%), and YouTube (21.4%) presence had statistically significantly more applicants in 2022 than programs without a platform presence (p=0.0002, p=0.0133, p=0.0338, respectively). While there was no significant correlation between Instagram presence and application numbers (p=0.8994), as the number of accounts a program followed on Instagram increased, so did the mean number of applicants (Table 1). As the number of followers, following, and total posts increased for programs with Twitter, so did the mean number of applicants (Table 1). Furthermore, city population, number of residents, reputation ranking, and research ranking were all statistically significantly positively correlated with a higher number of applicants every year from 2019-2022 (p<0.0001).
Conclusion: There are many tangible ways Urology residency programs can use social media to expand their exposure and potentially increase their application numbers. Facebook and YouTube are relatively underutilized platforms that could be better employed by programs. Following and engaging with applicants on Instagram can strongly influence applicants' consideration of a program. Residency programs are encouraged to increase all aspects of their Twitter activity to optimize outreach. Finally, the content of programs' social media posts should emphasize their city population, program size, reputation, and research.

Table 1: Spearman's Rank Correlation Coefficients Between Social Media Metrics and Mean Number of Applicants

	Instagram N=66		Twitter N=119		YouTube N=27	
	Correlation Coeff.	p-value	Correlation Coeff.	p-value	Correlation Coeff.	p-value
# Followers Instagram	0.1227	0.3264				
# Following Instagram	0.2516	0.0416				
Total Posts Instagram	0.1147	0.3590				
# Followers Twitter			0.5748	<0.0001		
# Following Twitter			0.3353	0.0002		
Total Posts Twitter			0.4731	<0.0001		
# Subscribers YouTube					0.2062	0.3022
Total Posts YouTube					0.2136	0.2848

Funding: N/A

Podium #37

PERSONAL DRIVERS OF PREFERENCE SIGNALING IN THE 2022 UROLOGY RESIDENCY MATCH

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Presented By: Joon Kyung Kim, MD

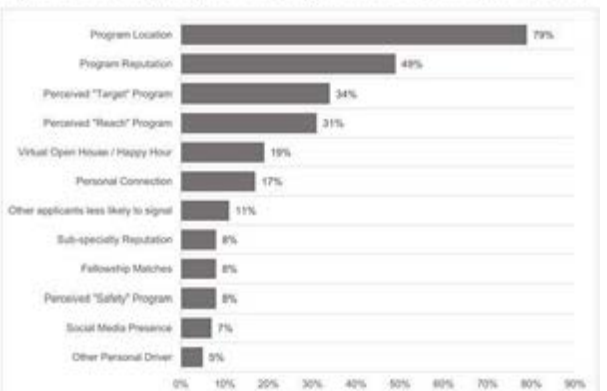
Introduction: For the 2022 AUA Match, there were a record 556 applicant rank lists submitted for 365 positions and a 23% increase in average applications received by programs, indicating the increased competition that urology applicants now face. This influx of applications makes it difficult for programs to delineate which applicants are truly interested and which are simply trying to maximize their chances of receiving interview invitations. Outside of away rotations, applicants have historically had limited opportunities to signal their interest to programs. In light of these challenges, Preference Signaling (PS) was implemented for the 2022 urology residency match, allowing applicants to "signal" their interest to up to 5 programs. Little is known about the urology PS process, particularly the motivations and factors that drive applicant's decisions about which programs to signal. We sought to evaluate personal drivers of PS among urology residency applicants for the 2022 AUA Match.

Methods: We emailed an anonymous, de-identified questionnaire survey to applicants to our institution for the 2022 AUA Match. The main question asked to applicants was "What factor(s) went into your decision to send 'Program X' a preference signal?" Certain questions allowed the selection of multiple options, and applicants were further asked to specify these by selecting a single most determinate option. Descriptive statistical analyses were conducted using IBM SPSS software.

Results: Out of 601 registrants to the AUA match, 324 individuals applied to our institution and therefore received a survey; 77 responded for a 24% response rate. A total of 383 PS were sent by the 77 applicants. The personal driver that most frequently factored into selection of PS was program location (79%), followed by program reputation (49%). More than one personal driver was considered in 73% of PS selections, with program location (45%) still considered the most important factor. In relation to applicant competitiveness, 35% of PS were sent to perceived "target" programs, 31% to "reach" programs, and 8% to "safety" programs.

Conclusion: Program location appears to be the most influential personal driver in sending a program a PS. Programs were also signaled based on applicant's perception of their own competitiveness.

Figure 1. Percentage of preference signals with a specific factor selected.



Funding: N/A

Podium #38

AN ACTIVE LEARNING CURRICULUM FOR QUALITY EDUCATION IN SURGICAL RESIDENCY

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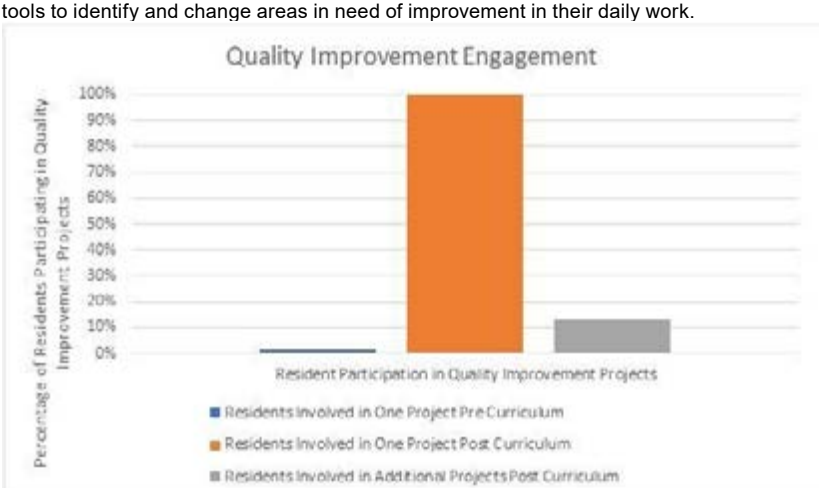
University of Kentucky
Presented By: Brittany Erin Levy, MD

Introduction: Formal resident education regarding quality improvement (QI) and process improvement (PI) is limited in surgery, nationwide. However, QI educational activities for mandated as a residency requirement by the ACGME. We developed and delivered an active learning QI curriculum to increase surgery resident education and participation in quality initiatives.
Methods: A QI curriculum was devised in concert with a QI experienced urology faculty member and a general surgery resident. Following, 60 surgery residents participated in monthly active-learning lecture and workshop sessions encompassing 8 forums over 6 months. Sessions progressed through the selection and completion of a PI project including scope, key stakeholder buy in, data collection, process mapping, implementation, standardization, and auditing. A focused framework based on an adapted LEAN methodology for healthcare QI was utilized. Currently this is ongoing in a urology specific process improvement initiative.
Results: Prior to curriculum development, no active QI learning was integrated into the educational curriculum and 1/60 residents were engaged in scholarly activity related to PI. Project ideas derived from resident workflow hardships contributing to burnout and resident dissatisfaction. Next, residents were divided into 4 implementation teams, each tasked with completing components of the project including preliminary data, stakeholder discussions, process mapping, and implementation. Monthly group sessions discussed completed tasks. Engagement in process improvement education yielded all residents participating in at least one QI project, and 13% of residents engaged in a second QI initiative. Overall residents initiated 6 QI projects across 2 institutions during the process of the QI curriculum (Figure). Furthermore, the group PI project was successful with an increase of 53% of the measured metric. Urology is currently in stage 2 of their project initiative with 100% resident involvement.
Conclusion: An active, ongoing learning curriculum model for QI education is an effective methodology for designing and engaging surgery residents in QI initiatives and satisfies the residency mandate. Additionally, this model provides residents with the necessary tools to identify and change areas in need of improvement in their daily work.



Funding: NA

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Podium #39

COULD FINGER ASSIGNMENT AT THE ROBOTIC CONSOLE PLAY A ROLE IN SURGICAL PRECISION OR ANY ADVERSE OUTCOMES? A RANDOMIZED PROSPECTIVE BLINDED SIMULATION PILOT STUDY

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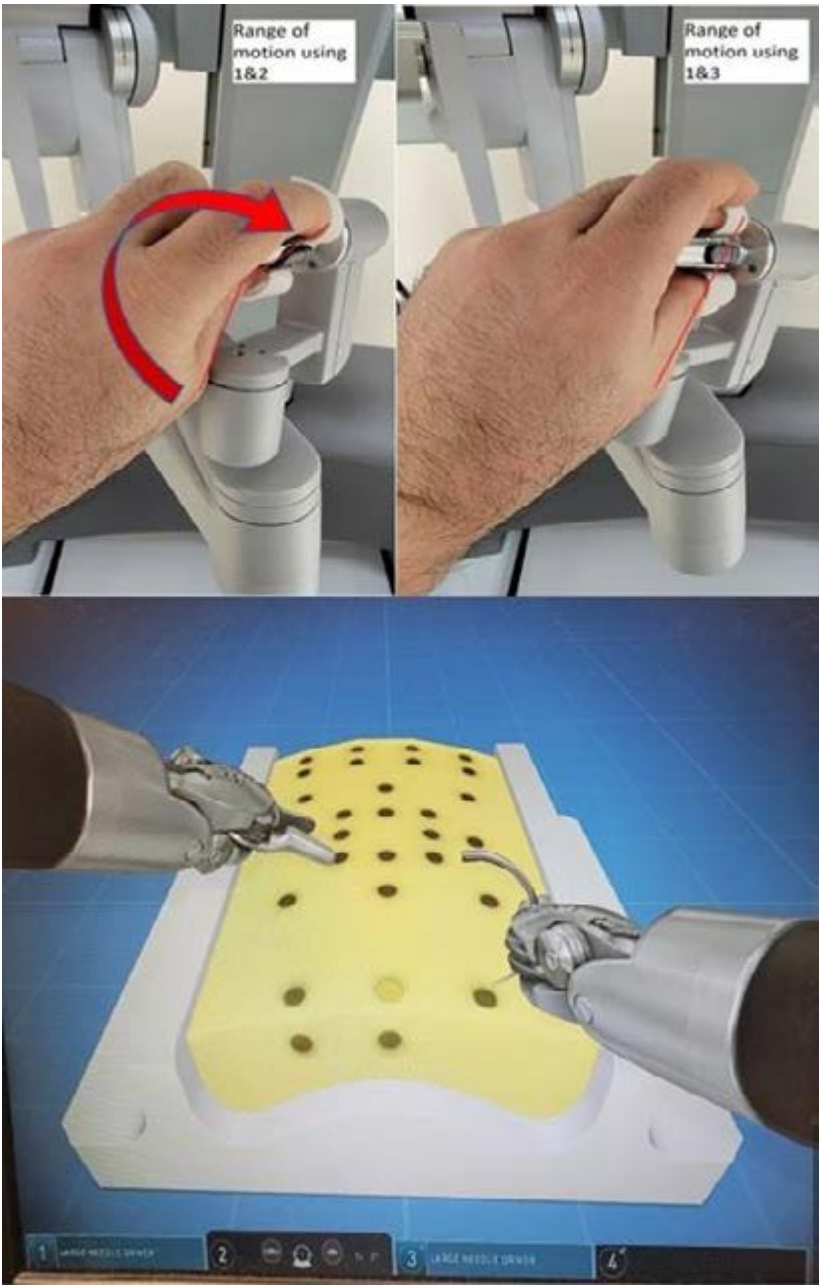
Presented By: Nazih Khater, MD

Introduction: Robotic surgery has become a standard approach in urology. Greater range of motion and efficiency may be attributed to the EndoWrist instruments that provide 7 degrees of freedom and an angle up to 90 degrees. This allows surgeons to gain precision and have fewer surgical complications. To our knowledge, no prior studies support one way to handle the controls at the surgical console. In our experience, volunteers report discomfort during wrist manipulation while using the thumb and middle finger (1&3). We hypothesize that using the thumb and index finger (1&2) will allow superior surgical proficiency via the Da Vinci Skills Simulator.
Methods: After IRB approval, we recruited 42 medical students across all 4 years in one university-based medical center. Each volunteer was given a standardized orientation. Students were then randomly assigned to start with their thumb and index finger (1&2) or (1&3). Two standardized modules were used with metrics calculated upon completion. These include: score, total time, economy of motion, efficiency score, collisions, inaccurate puncture, wound approximation, out of view, and penalty subtotal. Statistical analysis of the metrics was calculated using SPSS.
Results: Three were found to have statistically significant differences between the finger placement of 1&3compared to 1&2 (Figure 1). The number of collisions, wound approximation, and penalty score were all significant where 1&3 had a lower score in each. The number of collisions was 5.6 less in the 1&3 finger placement ($p= 0.017$). The wound approximation was 0.2 points smaller when using the 1&3 placement ($p = 0.001$). Lastly, the penalty assigned was 6.42 points lower when using 1&3 ($p= 0.023$). The overall score ($p= 0.615$), total time ($p= 0.385$), out of view ($p=0.462$), and economy of motion ($p= 0.184$) were not significant from one another.
Conclusion: Although finger placement did not affect the overall score of the completed simulation, instrument collisions and unnecessary wound complications may lead to adverse outcomes. This may be due to decreased comfort in hand position resulting in a more cautious surgical approach. Better understanding of how finger placement can lead to decreased ergonomics and increased complications may shape robotic training.



Funding: N/A

Podium #40

DEVELOPMENT AND OUTCOMES OF A FORMALIZED PALLIATIVE CARE CURRICULUM FOR UROLOGY RESIDENTS

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Presented By: Bryn Launer

Introduction: Palliative care (PC) is patient centered, coordinated care intended to improve quality of life through aggressive symptom management and expert communication. PC may be offered to patients at end of life or during treatment with curative intent, with myriad benefits to patients, families, and healthcare systems. We report our experience developing and implementing a novel PC curriculum within our urology residency training program.
Methods: In 2018, we incorporated PC into our resident training program with dedicated PC clinical days during PGY3. Pre- and post-rotation surveys were collected and analyzed. The curriculum was enhanced in 2020 with addition of the Palliative Care Education Curriculum, piloted across several specialties including urology at all training levels. Trainees completed a needs assessment followed by collaborative curriculum development by urology and PC faculty. The curriculum consists of monthly journal article distribution, biannual PC didactic training sessions, and a yearly PC interactive workshop with standardized patients.
Results: During the initial phase of our curriculum, a total of 14 residents spent 3 days each on the PC inpatient service, rounding with PC faculty, participating in goals of care discussions and assisting with management of palliative inpatients. Pre-curriculum surveys were completed by 12 trainees, 19 urology faculty, and 15 PC faculty. The majority of respondents agreed residents needed more training in all facets of PC. Interestingly, 100% of PC and urology faculty felt that residents needed more training in giving bad news, compared to only 58% of trainee respondents.
Of 12 pre-curriculum surveys, respondents rated skills including giving bad news (100%), discussing prognosis (91.7%), performing pain assessments (91.7%), and prescribing opioids (91.7%) as most important. Pre-post curriculum surveys were completed by 7 urology residents and 3 attendings. Trainees self-reported the highest proportion of increased skill in the PC facets of: giving bad news, discussing prognosis, and prescribing opioids.
Conclusion: Palliative care is a crucial component of patient-centered healthcare. There is a dearth of formalized PC programs in surgical residencies. We report improvement among trainees in PC skills such as giving bad news, discussing prognosis, and prescribing opioids. Future areas of development include standardization of PC education within urologic residencies and research on patient attitudes toward urology-provided PC.
Funding: N/A

Podium #41

FACTORS ASSOCIATED WITH COMPLETING A 24-HOUR URINE IN LARGE COMMUNITY-BASED SAMPLE OF NEPHROLITHIASIS

Jackson Cabo, David Gelikman, Sean Setia, Ryan Hsi
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Presented By: Jackson Cabo, MD

Introduction: Twenty-four-hour urine studies are a vital component of the metabolic workup of patients with kidney stones, particularly those with recurrent nephrolithiasis. Given the utility of this study in guiding medical therapy for patients with nephrolithiasis, we sought to better characterize barriers to completing obtaining a 24-hour urine study in a large, community-based survey.
Methods: Adults with nephrolithiasis were recruited through a national registry of volunteers (ResearchMatch). A computer-based survey queried stone event and management history, demographics, and an 11-item measure of stone-related financial

toxicity (COST-11 score). Multivariable logistic regression was performed to evaluate predictors of having completed a 24-hour urine study in one's lifetime.
Results: Overall, 942 responses have been obtained to date with 377 (39.4%) reporting having completed a 24-hour urine study in their lifetime. Of female respondents, 43% (N=253) had completed a 24-hour urine compared to 31.8% of males (N=118; P=0.01). 41% of those with private insurance (N=201) had completed a 24-hour urine compared to 27% (N=8) of those without insurance and 41% of Medicaid enrollees (P=0.46). Respondents who had completed 24-hour urine studies had worse stone-related financial toxicity by COST score (28 vs. 30,P=0.003). Multivariable logistic regression showed that those who had stone surgery in the past year were more than two times as likely to have completed a 24-hour urine (OR 2.36, 1.53-3.68,P=<0.001). Uninsured respondents were less likely to have completed a 24-hour urine compared to those with private insurance (OR 0.39, 0.16-0.90,P=0.034). Out of respondents with recurrent stone events in the past year (>1 passed) 106 (53%) had completed a 24-hour urine in their lifetime.
Conclusion: In this large, community-based survey of adults with nephrolithiasis, we found that those with private insurance and those who underwent stone surgery in the past year were more likely to have completed a 24-hour urine study in the past year. Importantly, only 53% of individuals with recurrent stones in the past year had ever completed a 24-hour urine, highlighting probable underuse of the study given its role in helping guide selective medical therapy.

Variable	OR	95% CI	P-Value
Age	0.99	0.98-1.00	0.066
Sex (ref: Male)			
Female	1.30	0.97-1.76	0.083
Insurance Status (ref: Private)			
Uninsured	0.39	0.16-0.90	0.034
Medicare	1.16	0.81-1.66	0.427
Medicaid	0.83	0.50-1.35	0.458
COST-11 Score	0.99	0.97-1.00	0.091
Stone Surgery in Past Year (Ref: No)			
Yes	2.36	1.53-3.68	<0.001

Table 1. Multivariable logistic regression for associations with completing a 24-hour urine study in one's lifetime.

Funding: N/A

Podium #42

COMPUTER VISION-MEDIATED ASSESSMENT OF SURGICAL SKILLS AND EXPERTISE FOR ENDOSCOPIC KIDNEY STONE REMOVAL SURGERY

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[2]*University of South Carolina School of Medicine, Dept. of Urology, Columbia, SC,*
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[4]*Vanderbilt University Medical Center, Dept. of Urology, Nashville, TN*
Presented By: Nicholas Kavoussi, MD

Introduction: The assessment of surgical skills is essential for clinical training and safety purposes. Though previous skills assessment tools have demonstrated success in evaluating surgical performance, there are no validated objective, real-time tools evaluating competency during retrograde intrarenal surgery (RIRS). We sought to apply our validated kidney stone segmentation software to evaluate automated metrics of RIRS skill level.
Methods: Forty-two separate videos of RIRS performed by four surgeons were prospectively recorded. Surgeons were categorized as 'expert' (n=2, i.e. fellowship trained endourologist performing >100 RIRS per year) or 'novice' (n=2, i.e. junior residents performing <100 RIRS per year), performing two identified tasks: stone localization, and

laser ablation. Each surgeon was randomly assigned to one of these tasks for each case. Stone localization was standardized for all cases with the systematic evaluation of the entire collecting system. For the second task, only the first 20 seconds of stone ablation (dusting, 0.3J and 60Hz) were analyzed. All videos were visually validated for quality and 30 frames per second (fps) were extracted. These frames were analyzed by our previously validated automated stone segmentation models. We performed a pixel based analysis, evaluating the percentage of each frame automatically identified as stone and compared differences between the novices and experts throughout each task.

Results: Of the 46 videos, 28 were evaluated for the localization task (14 novice, 14 expert) and 14 for the laser ablation task (7 novice, 7 expert). The number of frames without any identified stone was higher in the novice group for both the localization (novice: 25%, expert: 5%, $p<0.01$) and stone ablation (16% vs. 8%, $p<0.01$). Stones occupied more of each frame for novices in both the localization (18% vs. 11% , $p<0.01$) and stone ablation tasks (20% vs. 16%, $p<0.01$), suggesting closer stone visualization during RIRS by novice surgeons (Fig. 1). Additionally, there was greater variation in stone occupancy for novices during localization (2.9% vs 1.5%, $p<0.01$), suggesting less stability in novices.

Conclusion: Metrics automatically derived using computer vision show feasibility in discrimination of novice and expert surgeons performing RIRS for kidney stones.

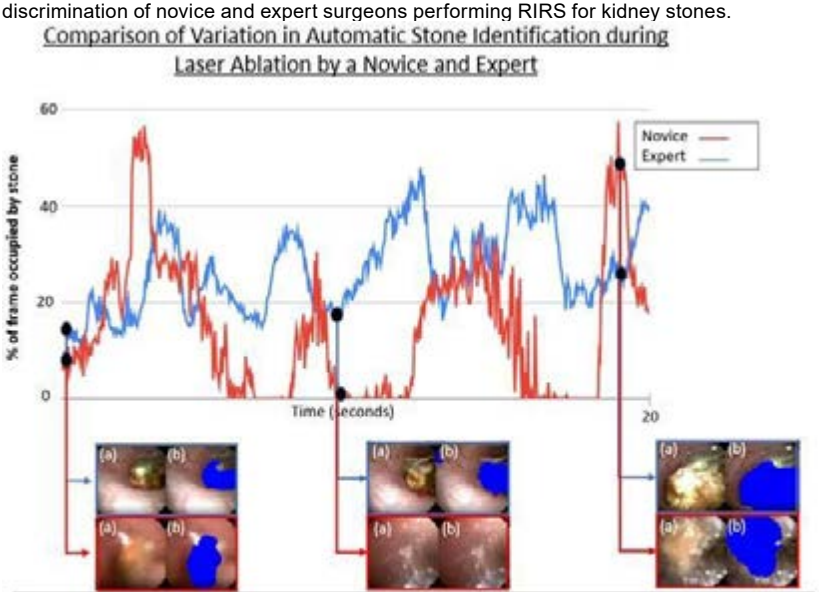

Figure 1: Example comparison of endoscopic videos during laser ablation of a stone by an expert (blue) and novice (red) showing: (a) original frames and (b) their corresponding automatic segmentations

Funding: N/A

Podium #43

EFFICACY AND SAFETY OF LUMASIRAN IN PATIENTS WITH PRIMARY HYPEROXALURIA TYPE 1: 24-MONTH ANALYSIS OF THE ILLUMINATE-A TRIAL

Kyle Wood, MD[1], John Lieske, MD[2], Jaap Groothoff, MD, PhD[3], Yaacov Frishberg, MD[4], Anne-Laure Sellier-Leclerc, MD[5], Hadas Shasha-Lavsky, MD[6], Jeffrey Saland, MD, MSCR[7], Wesley Hayes, MEng, MA, MBBChir, MRCPCH[8], Daniella Magen, MD[9], Shabbir Moochhala, MBChB, PhD[10], Martin Coenen, MD[11], Eva Simkova, MD[12], Taylor Ngo, MPH[13], John Gansner, MD, PhD[13], Sally-Anne Hulton, MD[14]

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Presented By: Kyle D. Wood, MD

Introduction: We report data from the 24-month analysis of ILLUMINATE-A, a Phase 3 trial of lumasiran, an RNA interference therapeutic designed to lower urinary oxalate (UOx) excretion in patients with primary hyperoxaluria type 1 (PH1).

Methods: ILLUMINATE-A is an ongoing, Phase 3, randomized, placebo-controlled trial in patients ≥6 years old with genetically confirmed PH1 and estimated glomerular filtration rate (eGFR) ≥30 mL/min/1.73m², with a 6-month primary analysis period followed by an extension period of up to 54 months where all patients receive lumasiran.

Results: Of 39 patients enrolled, 24/26 in the lumasiran/lumasiran group and 13/13 in the placebo/lumasiran group entered the extension period. Mean 24-hour UOx reduction at Month 24 relative to baseline was 58% in the lumasiran/lumasiran group and 49% in the placebo/lumasiran group. The proportion of patients achieving 24-hour UOx excretion ≤1.5×ULN at Month 24 was 83% in the lumasiran/lumasiran group and 62% in the placebo/lumasiran group; mean reductions from baseline in plasma oxalate at Month 24 were 56% and 61%, respectively. eGFR remained stable in both groups. Kidney stone event rates decreased from 3.19/person-year during the 12 months prior to consent to 0.80 in the lumasiran/lumasiran group and from 0.54/person-year to 0.28 in the placebo/lumasiran group. The most common lumasiran-related adverse events were mild, transient injection-site reactions.

Conclusion: Long-term lumasiran treatment resulted in a sustained reduction in UOx through Month 24 with acceptable safety in patients with PH1 and encouraging results on clinical outcomes.

Funding: Alnylam Pharmaceucticals

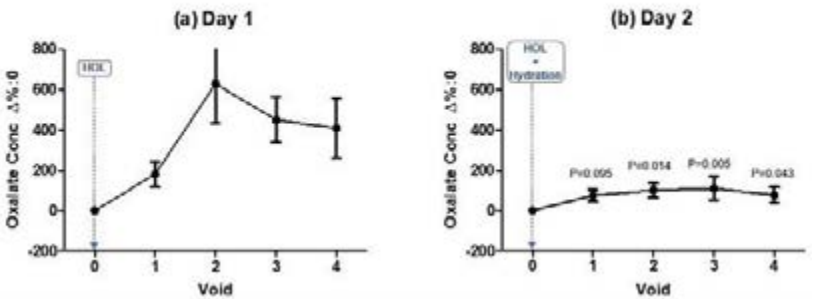
Podium #44

SPOT URINE OXALATE TESTING IN A CONTROLLED TRIAL OF FORCED HYDRATION AND SPINACH CONSUMPTION

William Donelan, PhD[1], Jason Joseph, MD[2], Bergen Lemack, BS[3], Paul Dominguez-Gutierrez, PhD[1], Vincent Bird, MD[1], Russell Terry, MD[1], Benjamin Canales, MD, MPH[1]
[1]*University of Florida College of Medicine, Department of Urology, Gainesville, FL,* [2]*Urology of Virginia, Virginia Beach, VA,* [3]*University of Florida, Gainesville, FL*
Presented By: Russell S. Terry, Jr., MD

Introduction: Spot measurements of the urinary mineral oxalate may uncover post-prandial spikes that increase kidney stone risk. Thus, we assessed the temporal pattern of urine oxalate excretion after high-oxalate load (HOL) and the impact of hydration on oxalate concentration.
Methods: Healthy non-stone formers (n=21) were prospectively enrolled and collected 48 hours of consecutive urine on low oxalate diet. At noon on both days, subjects consumed HOL (10 oz. spinach) and voided every 2 hours for an 8-hour post-HOL interval. On Day 2, subjects increased water intake (12 oz/2 hours) for the 8-hours post-HOL. Spot urine oxalates were measured by assay, and hyperoxaluric void (HOV) was defined as oxalate excretion >1.67 mg/hour or >40 mg/day.
Results: Mean urine oxalate excretion ranged from 17-97 mg/24 hours or roughly 2-12% gut oxalate absorption. Although individuals had a wide range of peak urinary oxalates, all but two (91%) had one or more HOV, reaching peak oxalate excretion ~7 hours following HOL. Spikes in urine oxalate concentration on Day 1 could be decreased up to 5-fold (p=0.014) by increased water intake on study Day 2. Individuals with hyperoxaluria had distinctive spot excretory oxalate patterns that allowed for categorization by either absorptive or endogenous type.
Conclusion: Following a spinach load in a controlled setting, total and peak urinary oxalate excretion varies greatly in non-stone formers. Increased water intake lowered urine concentration of oxalate regardless of the amount of oxalate excreted, confirming the importance of hydration in this study. Hyperoxaluric individuals had unique patterns of spot oxalate testing, suggesting a role for spot urinary oxalate monitoring in this particular population.

Mean relative change in urinary oxalate concentration from baseline after high oxalate load for Day 1 **(a)** and with hydration on Day 2 **(b)** for twenty participants*



Funding: N/A

Podium #45

DUSTING EFFICIENCY FOR THULIUM FIBER LASER: WHEN IT COMES TO FREQUENCY, LESS IS MORE

Francois Soto Palou[1], Robert Medairos[1], Junqin Chen[2], Jodi Antonelli[1], Michael Lipkin[1], Glenn Preminger[1], Pei Zhong[2]
[1]Duke Urology, [2]Duke Engineering
Presented By: Francois Soto-Palou, MD

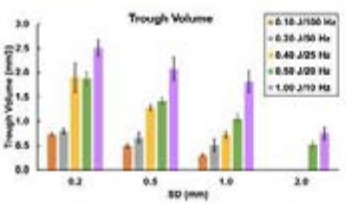
Introduction: Data from Holmium laser studies has taught us that optimal dusting generally require low energy and high frequency settings. In assessing thulium fiber laser (TFL) technology urologists have often relied on “traditional” dusting settings obtained from Holmium laser trials and experiments. However, these two platforms are fundamentally different in their pulse profile and energy (Ep) delivery. Clinical TFL platforms have an energy range of 0.025J-6J and a frequency (F) range of 1Hz-2400Hz. With the seemingly endless combination of settings and lack of scientific evidence to support one over the other, we aim to provide guidance to the practicing urologists and assess the efficiency of the TFL platform in an automated *in vitro* “dusting model”.
Methods: All tests were conducted using an IPG Photonics TLR-50W TFL system and a 200mm fiber on “soft” (5:2) Begostone phantoms. We selected the most popular dusting settings (Figure 1) among endourologist familiar with TFL[1] and tested each combination of Ep and F settings at four different standoff distances (SD) (0.2mm, 0.5mm 1mm, 2mm) and at clinically significant scanning speeds of 1mm/sec or 2mm/sec, under the same total laser energy delivered to the stone (i.e., 40 J). All pulses were adjusted to maximum peak power and the corresponding pulse duration. The laser fiber was scanned in a 15mm straight line with a 3D positioning system across a polished and submerged Begostone surface. Ablation volumes were quantified by optical coherence tomography (OCT).
Results: The maximum stone ablation was achieved at the combination of high energy and low frequency settings ($p<0.005$). Overall, the settings that produced the greatest ablation volume were 1J/10Hz (2.51mm3) and 1J/20Hz (2.55mm3). For the rectangular pulse profile typically used in TFL, as SD increased ablation volume decreased.
Conclusion: The most efficient dusting settings for dusting using the current TFL occur at high energy, low frequency, and at a short SD of 0.2mm. Further studies are warranted to compare dusting efficiency produced by these settings using human kidney stones.

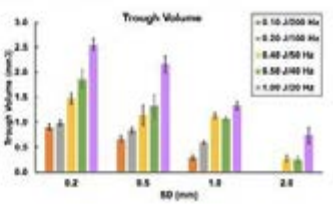
[1] Sierra A, Corrales M, Piñero A, Traxer O. Thulium fiber laser pre-settings during ureterorenoscopy: Twitter's experts' recommendations. *World J Urol*. 2022;40(6):1529-1535. doi:10.1007/s00345-022-03966-9

10 W (v_{fiber} = 1 mm/s) vs. 20 W (v_{fiber} = 2 mm/s) (40 J)

Power (W)	E_p (J) X F (Hz)	Fixed Peak Power (100%)	
		Pulse Duration (ms)	% Peak Power
10	0.05 x 200	0.20	45
	0.10 x 100	0.20	90
	0.20 x 50	0.35	100
	0.40 x 25	0.70	100
	0.50 x 20	0.87	100
	1.00 x 10	1.73	100

Power (W)	E_p (J) X F (Hz)	Fixed Peak Power (100%)	
		Pulse Duration (ms)	% Peak Power
20	0.05 x 400	0.20	45
	0.10 x 200	0.20	90
	0.20 x 100	0.35	100
	0.40 x 50	0.70	100
	0.50 x 40	0.87	100
	1.00 x 20	1.73	100





Funding: N/A

Podium #46

SHORT PULSE VS. LONG PULSE ABLATION WITH THE THULIUM FIBER LASER, AN IN VITRO STUDY

Francois Soto Palou[1], Robert Medairos[1], Junqin Chen[2], Jodi Antonelli[1], Michael Lipkin[1], Glenn Preminger[1], Pei Zhong[2]
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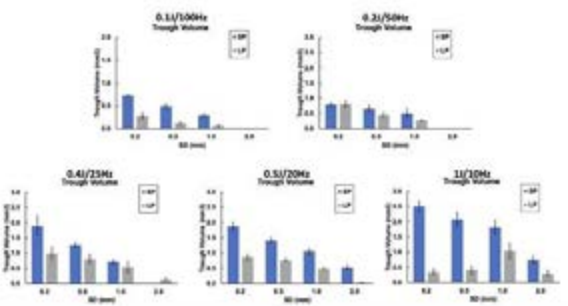
Presented By: Francois Soto-Palou, MD

Introduction: The Thulium fiber laser (TFL) is becoming of interest to Urologists due to its unique properties. The TFL pulse profile consists of rectangular pulses, designed for enhancing photothermal ablation. Energy for each pulse may be modified by altering pulse duration or peak power. Our aim for this study is to compare short pulse (SP) versus long pulse (LP) for common 10W dusting settings using the TFL platform.
Methods: All tests were conducted using an IPG Photonics TLR-50W TFL system and a 200mm fiber on "soft" (5:2) Begostone phantoms. The most popular 10W dusting settings (Figure 1) among endourologist familiar with TFL were evaluated.[1] Four different standoff distances (0.2mm, 0.5mm 1mm, 2mm), and a clinically significant scanning speed of 1mm/sec was used. The pulse profiles were altered for each energy setting to produce a short pulse (SP) and a long pulse (LP) design. The laser fiber was scanned in a 15mm straight line with a 3D positioning system across a polished and submerged Begostone surface. Ablation volumes were quantified by optical coherence tomography (OCT).
Results: Overall, SP provided greater ablation volume when compared to LP. The greatest difference observed between SP and LP was at 1J/10Hz and SD of 0.2mm (2.51mm3 vs. 0.35mm3) and this difference was statistically significant ($p<0.005$). Out of the 20 performed trials there were only two instances in which LP outperformed SP in terms of ablation volume: 0.4J/25Hz at SD of 2mm (0mm3 vs. 0.15mm3) and 0.2J/50Hz at SD of 0.2mm (0.79mm3 vs 0.81mm3). In the latter case, however, the difference was not found to be statistically significant ($p=0.7$).
Conclusion: TFL short pulse profile offers superior trough ablation volumes than long pulse during dusting under clinically relevant scanning speed of 1 mm/s with a time average power of 10 W.

[1] Sierra A, Corrales M, Piñero A, Traxer O. Thulium fiber laser pre-settings during ureterorenoscopy: Twitter's experts' recommendations. *World J Urol*. 2022;40(6):1529-1535. doi:10.1007/s00345-022-03966-9

Power (W)	E_p (J) X F (Hz)	SP		LP	
		Pulse Duration (ms)	% Peak Power	Pulse Duration (ms)	% Peak Power
10	0.10 x 100	0.20	90	0.87	20
	0.20 x 50	0.35	100	0.87	40
	0.40 x 25	0.69	100	1.38	50
	0.50 x 20	0.87	100	1.73	50
	1.00 x 10	1.73	100	3.46	50



Funding: N/A

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Podium #47

INFANTILE VERSUS CHILDHOOD POSTERIOR URETHRAL VALVE DIAGNOSIS: MANAGEMENT PATTERNS AND CLINICAL OUTCOMES AT OPPOSITE ENDS OF THE SPECTRUM

Andrew Gabrielson[1], Logan Galansky[1], Edwin Smith[2], Charlotte Wu[1]
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Presented By: Charlotte Wu, MD

Introduction: Management patterns and clinical outcomes are poorly defined in cases of late PUV diagnosis. Studies have debated whether a late diagnosis portends a favorable outcome due to milder obstructive uropathy or a worse outcome due to prolonged obstruction. We compare post-ablation management patterns and clinical outcomes of infantile (<1y) versus childhood (>5y) PUV diagnosis to gain insight into the pathologies at opposite ends of the PUV spectrum.
Methods: A retrospective cohort study was conducted using the TriNetX research network between 2006-2022. We defined two cohorts: 1) <1y arm had an index diagnosis of PUV and first cystoscopy with valve ablation within 1 year of life, 2) >5y arm had an index diagnosis of PUV and valve ablation after age 5. We report rates and time-to-first use of anticholinergic/B3 agonists, alpha-blockers, clean intermittent catheterization (CIC), bladder botox, enterocystoplasty/Mitrofanoff. Renal outcomes were rates and time-to-progression of CKD.
Results: We identified 534 patients (280 <1y; 254 >5y) for analysis. Median age at diagnosis was 1 month and 9 years for the <1y and >5y cohorts, respectively. Median follow-up was 8 and 10 years for the <1y and >5y cohorts, respectively. The <1y arm was significantly more likely to have persistent hydroureter or hydronephrosis (79.3% vs 35.4%) as well as any febrile UTI (10.4% vs 3.1%) with no difference in number of febrile UTI episodes (Table 1). Following ablation, patients in both arms were primarily managed with anticholinergic/B3 agonists, with no difference between groups (35.7% vs 41.7%). The >5y arm was significantly more likely to receive alpha-blockers (25.6% vs 12.1%) or bladder botox (6.7% vs 1.4%). The <1y arm was significantly more likely to be started on CIC, undergo enterocystoplasty/Mitrofanoff, or renal transplant. The <1y arm had significantly higher rates and shorter time-to-progression to CKD2+, CKD3+, and CKD4+. There were similar rates of ESRD (Table 1).
Conclusion: Patients with a late PUV diagnosis are disproportionately managed with conservative strategies (antispasmodics, bladder botox). Despite higher utilization of conservative strategies, the late diagnosis cohort had superior renal outcomes and low rates of progression to invasive treatments. The findings present compelling evidence that, with few exceptions, a late diagnosis reflects an overall milder disease process.

Table 1. Symptomatology, Medications, Diagnostics, and Interventions After Diagnosis and Primary Ablation of PUV

	Infantile / <1y (n = 280) (n, %)	Childhood / >5y (n = 254) (n, %)	P-value	
Clinical Sequela				
Any Febrile UTI	29 (10.4%)	8 (3.1%)	**0.004***	
Median Number of Episodes of Febrile UTI	2	1.5	0.10*	
Persistent Hydroureter or Hydronephrosis	222 (79.3%)	90 (35.4%)	**< 0.001***	
Medications and Diagnostics				
Oxybutynin or Mirabegron	100 (35.7%)	106 (41.7%)	0.15*	
Alpha-Blocker	34 (12.1%)	65 (25.6%)	**< 0.001***	
Post-Diagnosis VCUG	165 (58.9%)	67 (26.4%)	**< 0.001***	
Post-Diagnosis UDS	100 (35.7%)	166 (65.4%)	**< 0.001***	
Procedural Interventions				
CIC	39 (13.5%)	15 (5.9%)	**0.0021***	
Bladder Botulinum Toxin	4 (1.4%)	17 (6.7%)	**0.003****	
Enterocystoplasty, Mitrofanoff, Cutaneous Vesicostomy	28 (10%)	6 (2.4%)	**< 0.001****	
Renal Transplantation	13 (4.6%)	4 (1.6%)	**0.04****	
Renal Outcomes			**Risk Ratio**	**P-value**
Progression to CKD2+	90 (32.1%)	45 (17.7%)	1.8 (1.3, 2.5)	**< 0.001**
Progression to CKD3+	58 (20.7%)	34 (13.4%)	1.5 (1.1, 2.3)	**0.025**
Progression to CKD4+	37 (12.2%)	20 (7.9%)	1.7 (1.1, 2.8)	**0.045**
Progression to CKD5/ESRD	31 (11.1%)	19 (7.5%)	1.5 (0.8, 2.5)	0.16

*Calculated using two-sided T test
**Calculated using Fishers exact test

P-values < 0.05 were considered significant, indicated in bold

Funding: N/A

Podium #48

LOW RISK OF SECONDARY TREATMENT AFTER ENDOSCOPIC INJECTION OF VUR USING THE DOUBLE HIT METHOD: ANALYSIS OF 3059 PROCEDURES OVER 19 YEARS

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Presented By: Ricardo Arceo Olaiz

Introduction: Individuals with VUR have increased risk of recurrent febrile urinary tract infections, increasing the risk of renal scarring, and end stage renal disease. Endoscopic injection was first proposed in the 1980s as a means of curing VUR as a minimally invasive alternative to open ureteral reimplantation. Despite high success rates with reimplantation, it generally involves an open approach with associated risks and potentially painful recovery. Review of the contemporary double HIT method reaches success rates of 93%; however, the need for secondary procedures has not been evaluated. The objective of our study is to report our experience for additional Deflux injections after first injection failure.
Methods: We retrospectively reviewed our database of children who underwent Deflux (Dx/HA) from April 2003 to December 2021. We divided our population in 2 groups: Group A underwent Dx/HA injection from 2003 till 2012 represents historical method of endoscopic injection, and Group B underwent Dx/HA injection from 2013 till 2021 representing the double HIT method. We compared both groups to assess the need of additional injections.
Results: A total of 3059 Dx/HA injections were performed by 8 surgeons. We excluded patients > 18 years of age, leaving 3006 injections in this timeframe (2515 girls; 491 boys). In Group A, (from 2003 till 2012) 2168 injections were done and in Group B, (from 2013 till 2021) 838 patients were injected. A total of 285 secondary injections were performed during the whole period, representing only 9% of all procedures. In Group A, 221 additional injections were done (mean 22/year) compared to 64 in Group B (mean 7/year).

A statistically significant 71% of decrease in additional injections was seen in Group B, as well as a 32% decrease in mean injections per year.
Conclusion: Endoscopic injection of a bulking agent to correct VUR has a high success rate, comparable to ureteral reimplantation. In our experience, primary injection with the double HIT method has a low chance of secondary treatment and supports its use as a first line option for children with primary VUR.
Funding: N/A

Podium #49

EFFECT OF SOCIAL DISPARITIES ON 10 YEAR SURVIVAL IN PEDIATRIC PATIENTS WITH WILMS' TUMOR

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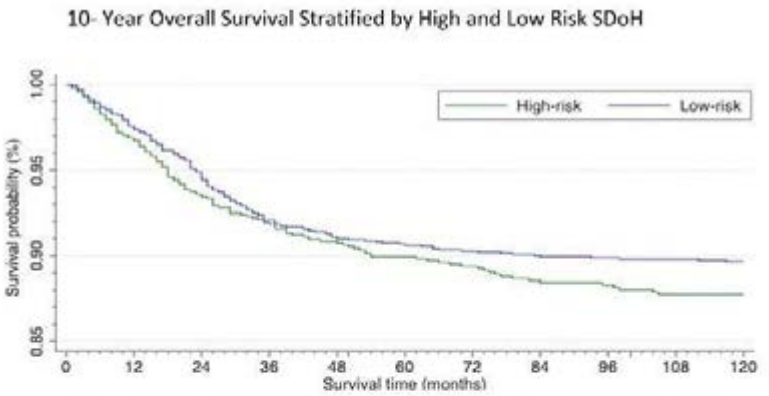
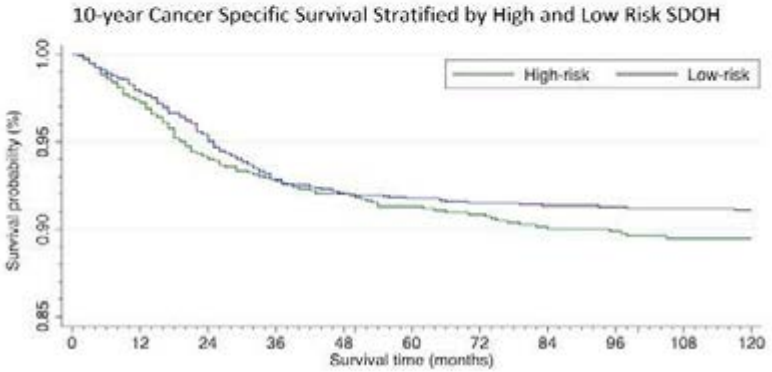
Presented By: Andrew Alexander Stec, MD

Introduction: Survival disparities exist across many areas of pediatric health care. Survival outcomes in a cohort of Wilms' Tumor patients were evaluated and stratified by degree of social disparities.
Methods: A retrospective cohort study was performed using the SEER oncology registry from 1975 to 2016 based on county-level data. Pediatric patients with a diagnosis of Wilms' tumor with confirmed histology codes were included. Social deprivation was based on the SDI, a tool that used to measure degree of socioeconomic disparities based on zip code and available census data. 10-year overall and cancer-specific survival were evaluated and compared by quintile.
Results: A total of 3,406 patients were included. Evaluating the survival curves, as they reach the 10-year mark, visually apparent differences become present between the quintiles. The 3 least deprived quintiles cluster and the 2 more deprived quintiles begin to cluster. The survival curves also begin to separate. Ooverall survival rates between Q1 (least deprived) and Q5 (most deprived) are 89.2% versus 86.6% respectively. A similar difference is seen in cancer-specific survival rates.
The patient population was divided into a high-risk (>60 percentile / more deprived) and low-risk (<60 percentile / less deprived) cohorts based on SDI scores. Patients in the high-risk group were 1.25 times significantly (p=0.035) more likely to experience mortality compared to the low-risk group. At 10-year follow-up, patients in the high-risk population had an overall survival of 87.3% compared to 89.3% in the low-risk population. (See Figure) Cancer-specific survival rates between the two groups were noticeably different but statistically non-significant (p=0.058). At 10-year follow-up, patients the high-risk population had a cancer-specific survival of 89.0% compared to 90.9% in the low-risk population.
Conclusion: 10-year overall and cancer-specific survival data for patients with Wilms' tumor stratify by socioeconomic lines. This represents an area that needs to be addressed in this pediatric oncologic population. Patients from more socially deprived areas have significantly worse 10-year overall survival rates and noticeably different 10-year cancer-specific survival rates. This study has process than could be readily applied across Urologic datasets to stratify outcomes of interest by SDoH.





Funding: N/A

Podium #50

GONADAL TUMORS IN PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT - A MULTI-SITE STUDY FROM THE PEDIATRIC UROLOGIC ONCOLOGY WORKING GROUP OF THE SOCIETIES FOR PEDIATRIC UROLOGY

Leslie Peard, MD[1], Jacqueline Morin, MD[2], Will Cranfod, MS[2], Viktor Flores, MD[1], Kyle Graham, MPH[1], Abby Taylor, MD, MPH[1], John Pope IV, MD[1], Valeska Halstead, MD, MPH[3], Nicholas Cost, MD[3], Evan Roberts, MBA[4], John Makari, MD, MHA, MA[4], Amanda Saltzman, MD[2]

[1]Vanderbilt University Medical Center, [2]University of Kentucky, [3]University of Colorado, [4]University of Nebraska Medical Center

Presented By: Leslie M. Peard, MD

Introduction: Disturbances in gonadal development lead to an increased risk of gonadal malignancy in some but not all patients with differences in sex development (DSD). The risk of malignancy in specific DSD conditions and long-term oncologic outcomes is clinically important, but current data are insufficient. The most ideal management would be to identify which patients need gonadectomy and when, allowing low risk patients' gonads to be retained to preserve gonadal function (hormonal and reproductive). The objective of this study was to describe the incidence of germ cell neoplasia in situ (GCNIS; including gonadoblastoma) and germ cell tumor (GCT) in a contemporary cohort of patients with DSD who undergo gonadal surgery and to provide long-term oncologic outcomes for these patients.

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Methods: Patients with a DSD diagnosis who underwent gonadal surgery (gonadectomy or gonadal biopsy) at any time were identified at four institutions. Clinical characteristics, pathology, and treatment details were obtained retrospectively. Patients were stratified into risk categories based on DSD diagnosis. Rate of having GCNIS/GCT was recorded. Oncologic treatment and outcomes were recorded. Descriptive statistics are reported using parametric methods.

Results: 83 patients were identified, with median age of 3y (0.03y-40y). Distribution of diagnosis is summarized in Table 1. Most patients underwent gonadectomy (83%) and 8/83 (9.6%) patients had GCNIS or GCT (7 GCNIS, 1 GCT). Median age of patients with GCNIS or GCT was 14y (0.25y-17.6y). 5 patients had bilateral GCNIS, 2 had unilateral GCNIS and 1 had GCT. All 8 patients had high or intermediate risk DSD diagnoses (4 mixed gonadal dysgenesis, 3 Turner with Y, 1 partial gonadal dysgenesis). 3/8 patients had follow-up imaging available (2 CT, 1 MRI). No patient received adjuvant chemotherapy or radiation, no patient had recurrence and all patients were living at the conclusion of the study. Mean follow up time was 6.4y.

Conclusion: In a contemporary cohort of patients with DSD undergoing gonadal surgery, the majority of patients do not have GCNIS or GCT on final pathology. All patients with malignant or premalignant pathology had a high or intermediate risk DSD diagnoses, and all patients with GCNIS or GCT were treated with surgery alone and survived without recurrence.

Risk Category	N	Surgery Type		Histologic Diagnosis		
		Gonadectomy	Biopsy	No GCNIS/GCT	GCNIS	GCT
High/Intermediate Risk	**54**	**46**	**8**	**47**	**7**	**1**
Mixed gonadal dysgenesis (46X/46XY and variants)	21	18	4	17	3	1
Turner with Y	16	16	0	13	3	0
46 XY PAIS	6	5	1	6	0	0
Denys-Drash (46XY), Frasier (46XX), predisposition syndrome (46XX)	5	3	1	5	0	0
46XY Partial gonadal dysgenesis	4	2	2	3	1	0
46XY Pure gonadal dysgenesis	2	2	0	2	0	0
Low Risk	**14**	**13**	**2**	**14**	**0**	**0**
46 XY CAIS	9	9	1	9	0	0
Ovotesticular DSD (46XY and variants)	2	1	1	2	0	0
Ovotesticular DSD (46XX)	1	1	0	1	0	0
Turner without Y	2	2	0	2	0	0
No Risk	**1**	**1**	**0**	**2**	**0**	**0**
5ARD	1	1	0	2	0	0
Unknown risk	**14**	**9**	**4**	**14**	**0**	**0**
XY gonadal regression	5	3	1	5	0	0
Klinefelter and variants	2	2	0	2	0	0
Persistent Mullerian duct syndrome	1	0	1	1	0	0
XX sex reversal	1	0	1	1	0	0
Defect in androgen action	1	0	1	1	0	0
Other not listed	4	4	0	4	0	0

Table 1. Presence of GCT/GCNIS and corresponding type of surgery, stratified by DSD risk classification and diagnosis.

Funding: N/A

Podium #51

REPEAT CT IN ISOLATED INTRA-ABDOMINAL RENAL TRAUMA IS NOT ASSOCIATED WITH REDUCED COMPLICATIONS, READMISSIONS, OR DELAYED INTERVENTIONS

Viktor Flores[1], Benjamin Abelson[1], Shilin Zhao[1], Caroline Khanna[1], George Koch[1], Amber Greeno[1], Ching Man Carmen Tong[2], David Kitchens[2], Vinaya Bhatia[3], Jonathan Gerber[3], Christopher Long[4], Dana Weiss[4], Jacob Lucas[5], Albert Lee[6], Christina Ho[6], Jeffrey Ellis[5], Ming-Hsien Wang[3], Douglass Clayton[1]

[1]Vanderbilt University Medical Center, [2]Children's of Alabama, [3]Texas Children's Hospital at Baylor College of Medicine, [4]Children's Hospital of Philadelphia, [5]Einstein Healthcare Network, [6]Children's National Medical Center

Presented By: Viktor Xavier Flores

Introduction: The 2020 AUA Urotrauma guidelines recommend repeat CT imaging in patients with high grade renal laceration (Grade IV or V based on AAST grading system) within 48-72hrs of injury. Little is known about the benefits of repeat CT imaging in pediatric patients with isolated renal trauma. We sought to determine if repeating a CT scan for the purposes of evaluating the evolution of a high-grade renal injury impacted inpatient complications, 90-day readmissions, or delayed intervention after discharge. We hypothesize that a repeat CT scan would identify concerns resulting in reduced complications, 90-day readmissions and delayed interventions.

Methods: Using the multi-institutional Traumatic Renal Injury Collaborative in Kids (TRICKs) consortium database, we retrospectively reviewed Grade IV and V renal traumas from 5 pediatric centers between 2007 to 2022. Inclusion criteria included patients less than 18 years of age with blunt injuries. Exclusion criteria included having concomitant bowel, hepatic, or splenic injury, or requiring an initial intervention (surgical or radiologic) after the first CT scan. We compared patients with repeat CT scan versus those without repeat CT imaging. The primary outcomes of interest were the incidence of inpatient complications, 90-day readmissions, and need for delayed intervention after discharge.

Results: 465 patients were included in the database but only 84 patients met criteria. Twenty patients had repeat imaging to assess the evolution of their renal injury (Group 1) and 64 patients did not have repeat CT imaging (Group 2). Of the 64 patients without repeat CT imaging, 23.4% had a renal ultrasound instead. There were no significant differences between Group 1 and Group 2 in complications (5% vs. 14%, p=0.275), 90-day readmissions (5% vs. 13%, 0.33), or delayed intervention after discharge (0% vs. 7.8%, p=0.236). When comparing the difference in subsequent intervention after repeat imaging, 20% of patients in Group 1 with CT imaging had a subsequent intervention versus 33% of the patients in Group 2 (p=0.372) with renal ultrasound (table 1).

Conclusion: Repeat CT imaging in pediatric patients with isolated renal trauma was not associated with reduced inpatient complications, 90-day readmissions, and delayed interventions. To our surprise, follow up renal ultrasound was equally likely to be associated with subsequent intervention.

Table 1: Intervention after Repeat Imaging in Group 1 vs. Subset of Patients in Group 2 with Repeat Imaging.

Variable	Odds Ratio	95% CI	p value
Complications	0.322	0.038 - 2.71	0.3
90 Day Readmission	0.36	0.042 - 3.03	0.34
Delayed Procedure	0.001	0.0 - 1.67	0.76

Funding: N/A

Podium #52

PRELIMINARY RESULTS OF UMPIRE PROTOCOL DEVIATIONS AMONG INFANTS WITH SPINA BIFIDA

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[1]Duke University, [2]CDC, [3]Lurie Children's Hospital, Northwestern University, [4]Children's Hospital Los Angeles, [5]Seattle Children's Hospital
Presented By: Jonathan C. Routh, MD, MPH

Introduction: The UMPIRE Protocol was designed to represent an expert-informed protocol hypothesized to lead to improved urologic outcomes. The quality improvement design allows for protocol deviations based on the assumption that deviation trends will reflect clinical realities not adequately captured by the protocol. Documenting and analyzing these deviations can inform which aspects of the protocol are working well and which merit revision. We explored the deviations to describe protocol adherence and patterns of deviations in anticipation that this information will lead to future protocol improvements.
Methods: We analyzed deviation data accrued between 2/2015 and 11/2020, by clinical domain (e.g., creatinine measurement, urodynamics, ultrasound completion). A committee of UMPIRE clinicians reviewed deviations to assess the clinics' categorization of "clinician-", "patient-", or "system-related" and, by group majority, to either concur or re-classify the deviation. The committee also evaluated the clinical narrative and further categorized deviations as justified, partially justified, or not justified. Descriptive statistics were used to quantify and describe trends.
Results: A total of 1,203 deviations were reviewed for 426 patients. The domains with the most common deviations were blood pressure (29%), creatinine (27%), urodynamics (20%), and renal ultrasound (8%). Additional clinically-significant deviations were noted to occur in patients with hostile bladder (1%) or vesicoureteral reflux (3%). The majority of deviations were not clinically justified (50-99% by domain), and were attributable to clinician decision (46-100% by domain).
Conclusion: The frequency and categorization of deviations (clinicians, systems, and patients) vary by clinical domain, and the majority of deviations were categorized as not justified. Further examination of these data is ongoing and will inform protocol revisions and improved adherence.
Funding: CDC U01-DD001278

Podium #53

INFERIOR VENA CAVA LIGATION WITHOUT RECONSTRUCTION FOR RETROPERITONEAL TUMORS

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Presented By: Arnold R. Palacios, MD, MA

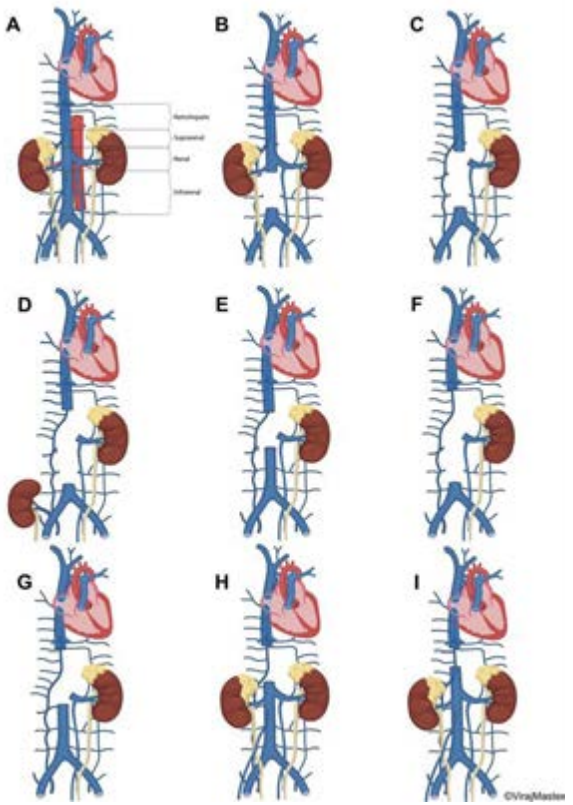
Introduction: Vascular resection of the inferior vena cava (IVC) is often necessary for retroperitoneal tumors, including renal cell carcinoma, to achieve complete tumor removal. Currently, there is no established consensus on whether IVC reconstruction or ligation is the preferred method following IVC resection. IVC reconstruction can increase operative times and has potential risk for deep venous thrombosis, graft thrombosis, or graft infection. IVC ligation without reconstruction necessitates venous collaterals established by prolonged tumor compression or invasion of the IVC. Additionally, there is postoperative concern for side effects that include decreased renal function, lymphedema,

and chylous ascites in IVC ligation. This study evaluates the safety and efficacy of IVC ligation without caval reconstruction.

Methods: A retrospective review of patients that underwent either IVC ligation (IVC-Ligation) or IVC resection with reconstruction (IVC-Reconstruction) at an academic referral center from 2004-2021 was conducted. Outcomes from the two surgical techniques were compared via univariate analysis using the Kruskal-Wallis test for continuous variables and Fisher's exact test for categorical variables.

Results: 49 IVC-Ligation and 6 IVC-Reconstruction surgeries were identified. A majority of the cases were renal cell carcinoma (n=33) with sarcomas (n=16) being the second most common. There were no differences in baseline demographics, tumor characteristics, overall 5-year survival, complication rates, and postoperative morbidity between the groups. IVC resection was performed at various IVC anatomic levels (Figure 1), with 16 cases (29%) requiring *en bloc* resection of the entire abdominal IVC. Patients undergoing IVC-Reconstruction were more likely to be admitted to the ICU (83% vs 33%; p=0.0257). Patients undergoing IVC-ligation presented more often with non-debilitating postoperative lymphedema (35% vs 0%; p=0.1615), though this was temporary and self-resolving.

Conclusion: IVC ligation without reconstruction is an acceptable surgical option for patients presenting with retroperitoneal tumors involving the IVC. Intraoperative evaluation of IVC for factors that may influence decision for ligation is important. For optimal outcomes, a multi-disciplinary team with expertise in various surgical fields is recommended.



Funding: We gratefully acknowledge support of the John Robinson Family Foundation, Christopher Churchill Foundation, and Cox Immunology Fund.

Podium #54

PD-L1 EXPRESSION AND RENAL CELL CARCINOMA: IS EXOGENOUS ESTROGEN DRIVING AGGRESSIVE TUMOR CHARACTERISTICS THROUGH INCREASED EXOSOME PRODUCTION?

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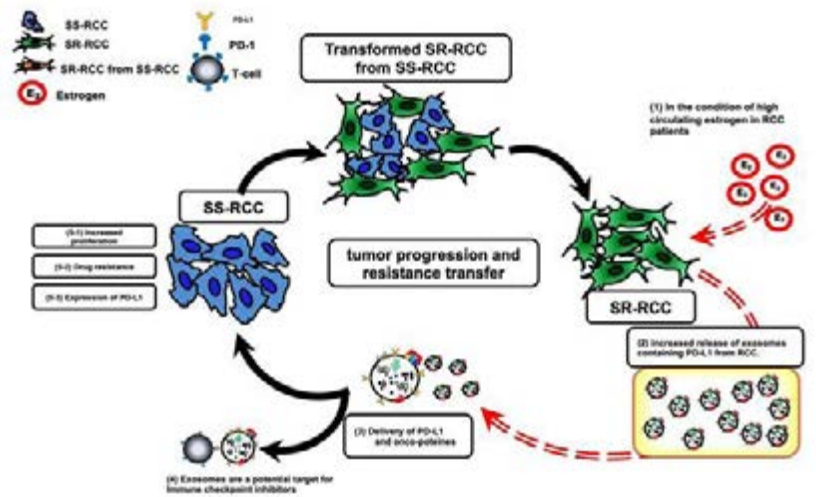
Presented By: Jacob Greenberg

Introduction: In 2022, SEER data projects 79,000 new cases renal cell carcinoma (RCC) with 15% of these presenting with progressed disease and distant metastasis. Prior publications have indicated that estrogen plays an important role by increasing RCC risk in female obese patients (Sun et al, EBioMedicine, 2018). However, the role of estrogen is still unknown in the setting of metastatic disease and treatment resistance. The aim of this study was to investigate whether estrogen's role in treatment resistance could be linked to exosomal transfer of this hormone.
Methods: Overall survival data was extracted and analyzed from the TCGA based on several gene expression profiles. 786-O, 786-O Suni Resistant (SR), A498, A498 SR, Caki-2, Caki-2 SR and 293-T cells were cultured, exosomes collected, and later isolated using differential ultracentrifugation. After exposure to estrogen, downstream analysis included western blot and qNano exosome quantification. Statistical analysis was performed using R computational language.
Results: TCGA database analysis revealed that upregulated ER-beta expression is associated with a 25% decrease in overall survival at 5 years. Increased ER-Beta was also linked to patients with increased stage and metastatic disease. After exposing our cell lines to estrogen for 24hr ER-beta, activated NF-kB, and PD-L1 expression increased in all 3 TKI-sensitive and resistant cell lines. However, when quantifying exosome concentrations after estrogen exposure our 3 TKI-sensitive lines displayed a decrease in exosome production. On the other hand, each of the TKI-resistant cells showed a 3-4 fold increased exosome concentrations. We then linked this discordance in exosome production with a similar pattern in EGFR expression.
Conclusion: In conclusion, estrogen is an important molecule present in many patients with RCC. This study's data shows that estrogen is a causative agent of increasing PD-L1 expression potentiated through exosome production. A graphical hypothesis based on this studies data of estrogen's role in the tumor microenvironment can be found in Figure 1.



Funding: U54 GM104940

Podium #55

EPIDEMIOLOGY OF YOUNG ADULT RENAL CELL CARCINOMA IN KENTUCKY: INCIDENCE, CLINICOPATHOLOGIC FEATURES AND CANCER-SPECIFIC SURVIVAL

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Presented By: Jacob M. Elam, MD, BA

Introduction: Renal cell carcinoma (RCC) is an important cause of morbidity and mortality in the United States. Recent epidemiologic data suggests increasing incidence in the developed world, particularly in Northern America and Western Europe. Kidney cancer is the sixth most common malignancy among men and tenth among women, and there are several studies suggesting an increasing incidence of RCC in young adults. This study analyzes the current epidemiology of RCC in the young adult population of Kentucky, specifically examining incidence rates, clinicopathologic features and cancer-specific survival for this population relative to an older, more typical RCC cohort.
Methods: Data analysis included the combined NPCR-SEER USCS public use database and the Kentucky Cancer Registry dataset with a date range from 2001-2014. Incidence rates and trends by age group and location were calculated and tested. Clinicopathologic features of disease among Kentucky cases were analyzed by age group. Cancer specific survival (CSS) analysis was performed, along with Cox proportional hazards regression to test for association of younger age with improved CSS.
Results: Data review revealed higher incidence of RCC in Kentucky compared to rest of the country, and a rising incidence rate, especially among younger adults. Annual percent change (APC) for patients in the 20-39 year-old age group was 8.5%, compared to 4.4% for the same age group nationally. APC among older patients in Kentucky was 5.4% for ages 40-49 and 1.8% for ages 50+. Younger adults in Kentucky were significantly more likely to be diagnosed with RCC of lower stage, lower grade, and more favorable histologic subtype of RCC. Survival curves by age group were similar when stratified by disease stage. Data analysis revealed a hazard ratio of 0.72 (95% CI 0.47-1.09) for the 19-39 age group and 0.61 (95% CI 0.49-0.76) for the 40-49 age group relative to the 50+ age group, adjusted for sex, stage, grade and subtype.
Conclusion: There is a rising incidence of RCC in young adults in Kentucky, however, they tend to have more favorable disease features compared to older adults. Further research is needed to determine potential causes and implications of accelerating incidence in this population, as well as to guide treatment decisions and post-treatment surveillance.
Funding: N/A

Podium #56

INABILITY OF MAYO ADHESIVE PROBABILITY SCORE TO PREDICT SURVIVAL OUTCOMES IN LOCALLY ADVANCED RENAL CELL CARCINOMA

Benjamin Schmeusser, MD, MS[1], Tad Manalo, MD[2], Yuan Liu, PhD[3], Yash Shah, BS[4], Dattatraya Patil, MBBS, MPH[1], Reza Nabavizadeh, MD[1,5], Kenneth Ogan, MD[1], Viraj Master, MD, PhD[1]
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Presented By: Benjamin Nicholas Schmeusser, MD, MS

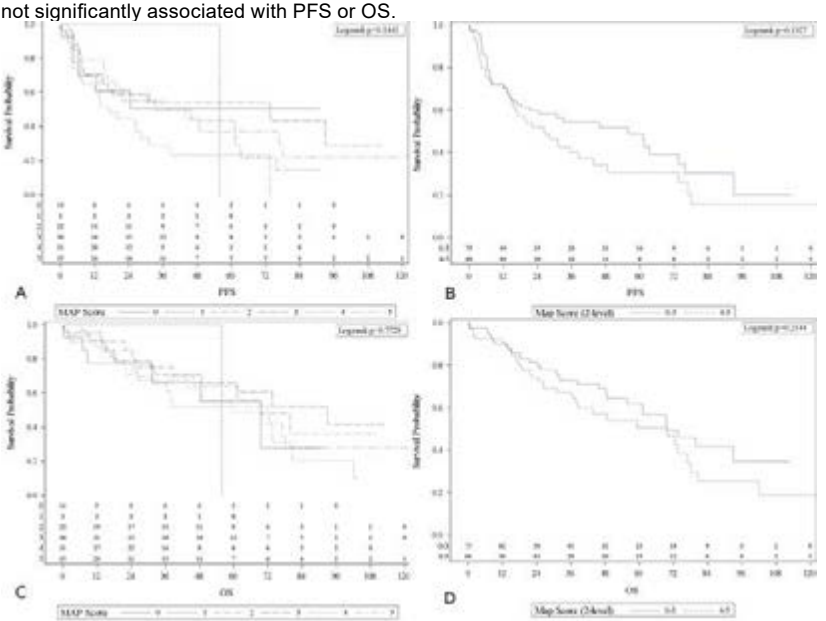
Introduction: Nephrectomy remains standard treatment for renal cell carcinoma (RCC). Interest remains in patient-specific preoperative risk stratification to assist clinical decision making. The Mayo Adhesive Probability (MAP) score is a radiographic feature that may offer insight into patient survival outcomes. As a simple measure of perinephric fat and stranding predictive of adherent perinephric fat and associated surgical complexity, MAP has additionally exhibited an ability to predict progression free survival (PFS), though

primarily reported in T1-T2 staged disease. In this study, we examined the ability of MAP scores to predict overall survival (OS) and PFS in locally advanced RCC.

Methods: We retrospectively analyzed patients that underwent radical nephrectomy from 2009-2016 at our institution. Patients with available computed tomography or magnetic resonance imaging of the abdomen/pelvis within 90 days preoperatively and T3/T4 renal cell carcinoma had MAP scores measured. Patient and tumor characteristics were additionally obtained. Survival analyses were conducted with MAP scores as individual (0-5) and dichotomized (0-3 vs 4-5) using the Kaplan-Meier method. Multivariable Cox proportional hazard regression models were built with backward elimination using alpha level of removal of 0.1. All statistical tests were two-sided with type I error set at 0.05.

Results: 141 patients were included. 134 (95%) had pT3 and 7 (5%) had pT4 disease. Most patients (76%) had clear cell histology, and nearly half (46.1%) had an inferior vena cava thrombus. Mean MAP score was 3.22±1.52, with 75 (53%) patients having a score between 0-3 and 66 (47%) having a score of 4-5. Both male gender (p=0.006) and clear cell histology (p=0.012) were significantly associated with increased MAP scores. No significant associations between continuous or dichotomized MAP scores and PFS or OS (Figure 1). On multivariable analysis, no significant associations were identified between MAP and PFS (HR=1.01, 95% CI 0.85-1.19, p=0.95) or OS (HR=1.01, 95% CI 0.84-1.21, p=0.917).

Conclusion: As the role of body composition, diagnostics, and patient-specific prognostication is further explored in RCC and other malignancies, comprehensive understanding of all potential tools, such as MAP, is important for informed decision making and patient counseling. In patients with locally advanced RCC, MAP scores were not significantly associated with PFS or OS.



Funding: We gratefully acknowledge support of the John Robinson Family Foundation, Christopher Churchill Foundation, and Cox Immunology Fund.

Podium #57

PROGNOSTIC UTILITY OF LINEAR SEGMENTATION IN NONMETASTATIC RENAL CELL CARCINOMA: A CLINICALLY PRACTICAL TECHNIQUE SHOWING CORRELATION OF MUSCLE MASS AND OVERALL SURVIVAL

Benjamin Schmeusser, MD, MS[1], Eric Midenberg, MD[1,2], Arnold Palacios, MD, MA[3], Nikhil Vettikatu, BS, BA[4], Dattatraya Patil, MBBS, MPH[1], Alexandra Medline, MD[4], Michelle Higgins, MD[5], Sarah Psutka, MD, MS[6,7], Kenneth Ogan, MD[1], Viraj Master, MD, PhD[1]
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Presented By: Benjamin Nicholas Schmeusser, MD, MS

Introduction: In renal cell carcinoma, as well as most other solid malignancies, sarcopenia has been associated with decreased survival and increased surgical complications. Traditional body composition analysis is an expensive and time extensive process. As a modifiable risk factor, more clinic friendly methods to identify patients with low muscle composition is of interest. Linear segmentation on routine imaging has been proposed as a fast, reliable and reproducible alternative. This study assesses the prognostic utility of linear segmentation in nonmetastatic renal cell carcinoma.
Methods: Patients that underwent nephrectomy for nonmetastatic RCC from 2005-2021 at an academic referral center were identified. Linear segmentation of the bilateral psoas/paraspinal muscles was completed on preoperative imaging obtained within 60 days of surgery. Cox proportional-hazards analysis was used to determine association between total muscle area and total muscle index and overall survival.
Results: 532 (388 clear cell) patients were analyzed and a median total muscle index was 28.6 (25.8-32.5) for women and 33.3 (29.1-36.9) for men. As a binary variable, lower total muscle index was significantly associated with decreased survival in both the full (HR=1.96, 95% CI 1.32-2.90, p<0.001) and clear cell only cohorts (HR=1.78, 95% CI 1.08-2.75, p=0.022) (Table 1). As a continuous variable, unit increases in total muscle index were significantly associated with improved survival in the full cohort (HR=0.95, 95% CI 0.92-0.99, p=0.006) and the clear cell only cohort (HR=0.95, 95% CI 0.92-0.99, p=0.016).
Conclusion: Assessment of muscle composition via linear segmentation on routinely obtained preoperative imaging is a clinically feasible technique with prognostic utility in patients with localized renal cell carcinoma. In this cohort of patients with nonmetastatic renal cell carcinoma, linear segmentation demonstrated significant associations with overall survival as a binary and continuous variable. This simplified technique may allow for routine inclusion of body composition into clinical decision making.

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Table 1: Multivariable Model Summary of COX Hazard Overall Survival for Binary Preoperative Linear Muscle Index

	Full Cohort		ccRCC	
Covariate	Hazard Ratio (95% CI)	HR P-value	Hazard Ratio (95% CI)	HR P-value
PreOp Total Muscle Index*				
Below Median	1.96 (1.32-2.90)	**<0.001**	1.72 (1.08-2.75)	**0.022**
Age 60+	1.59 (1.09-2.30)	**0.015**	1.62 (1.04-2.53)	**0.033**
Gender				
Male	1.13 (0.77-1.66)	0.54	1.19 (0.75-1.87)	0.459
Race				
Black	1.53 (1.00-2.36)	0.052	1.52 (0.87-2.63)	0.139
Obesity (≥ 30 kg/m2)	1.31 (0.91-1.89)	0.149	1.09 (0.71-1.68)	0.691
ECOG				
≥ 1	1.40 (0.93-2.10)	0.111	1.41 (0.85-2.34)	0.180
Nephrectomy Type				
Partial	0.65 (0.36-1.18)	0.155	0.56 (0.25-1.26)	0.159
pT-Stage				
T1	Ref	-	Ref	-
T2	0.92 (0.43-1.96)	0.824	0.78 (0.27-2.25)	0.650
T3	2.03 (1.07-3.86)	**0.03**	1.81 (0.85-3.86)	0.124
T4	2.71 (0.95-7.76)	0.063	2.91 (0.78-10.79)	0.110
Pathologic N-Stage				
N1	1.76 (0.97-3.21)	0.064	1.55 (0.68-3.53)	0.298
Fuhrman Grade				
G3-G4	1.14 (0.73-1.78)	0.554	0.90 (0.54-1.50)	0.675
ccRCC	0.98 (0.62-1.54)	0.928	-	-

*[TMA]/height (m2). Abbreviations: Clear Cell Renal Carcinoma (ccRCC), Stage, Size, Grade, Necrosis (SSIGN), Eastern Cooperative Oncology Group (ECOG)

Funding: We gratefully acknowledge support of the John Robinson Family Foundation, Christopher Churchill Foundation, and Cox Immunology Fund.

Podium #58

IMPACT OF BASE SUTURE TYPE ON RATE OF POSTOPERATIVE RENAL ARTERY PSEUDOANEURYSM FOLLOWING ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY (RAPN)

Laura Geldmaker, Daniela Haehn, Amanda Myers, Mikolaj Wieczorek, Colleen Ball, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Renal artery pseudoaneurysm is a reported postoperative complication following partial nephrectomy. We report the impact of resection base suture type on rate of pseudoaneurysm following robotic-assisted partial nephrectomy (RAPN).
Methods: 563 consecutive RAPNs performed by a single robotically trained surgeon were retrospectively reviewed. There were no exclusion criteria for our study. We evaluated the impact of renal suture type at resection base following RAPN on the rate of postoperative pseudoaneurysms. Patients were classified into 3 categories: 1) No base suture 2) 2-0 V-lock suture 3) 2-0 Vicryl suture. In our three-category analysis, suture at base of defect was classified into no suture versus suture versus V-lock suture. In a secondary analysis we evaluated suturing (including both Vicryl suture and V-lock suture) versus not suturing. P values < 0.05 were considered statistically significant.
Results: 563 RAPN were included in our analysis. 110 patients (19.5%) had V-lock suturing, 255 patients (45.3%) had Vicryl suturing, and 198 patients (35.2%) had no suturing. Patients had a median age of 62.8 years, a median BMI of 29.7 kg/m2, 338 (60.0%) had hypertension, 109 (19.4%) had diabetes, median preoperative eGFR was 78.2 ml/min/1.73m2, median MAP score was 2, and median RENAL score was 8. 449 (79.8%) patients had a histologically confirmed malignant mass removed. There was a considerable difference in median mass size between the three groups. Mass size from preoperative imaging was 3.0 cm for V-lock, 3.3 cm for Vicryl, and 2.0 cm for no suture (P<0.001). Overall, 21 patients (3.7%) developed a symptomatic postoperative pseudoaneurysm. There was not a significant difference in the rate of postoperative pseudoaneurysms in either analysis (P=1.00). In the primary analysis, the rate of pseudoaneurysm was 3.6% (4/110) (V-lock), 3.9% (10/255) (Vicryl), and 3.5% (7/198) (no suture) (P=1.00). In the secondary analysis, the rate of pseudoaneurysm was 3.5% (7/198) (no suture) and 3.8% (14/365) (suture) (P=1.00).
Conclusion: Use of resection base suture and/or type of suture used on the resection base during RAPN does not impact the rate of postoperative pseudoaneurysm in our large single surgeon series.
Funding: N/A

Podium #59

THE RELATIONSHIP BETWEEN SOCIAL DETERMINANTS OF HEALTH AND PERSISTENT POST OPERATIVE OPIOID UTILIZATION AFTER LAPARASCOPIC PARTIAL AND RADICAL NEPHRECTOMY

Alexis Kentros, MD[1], J. Yates Congleton, MD[1], Aimee Pehrson, MPH, CHES[2], James Bienvenu, MD[1], Wesley White, MD[1], Jason Buehler, MD[3], Laura Sisk[2]
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Presented By: Alexis Kentros, MD

Introduction: Post operative pain management is necessary for successful recovery and return to function. There is limited data evaluating the association between social need and persistent post operative opioid utilization (PPOU). This study aims to determine the association between SES and PPOU in patients who have undergone laparoscopic partial nephrectomy or radical nephrectomy at a tertiary academic medical center.
Methods: This retrospective, cross sectional study examines the role of social determinants of health (SDOH) in PPOU for patients undergoing laparoscopic partial and radical nephrectomies between January 1, 2020, to December 31, 2021 at a single tertiary academic center, (n=188). All patients included received a quadratus lumborum block

perioperatively. Opioid prescription data was obtained through patients' electronic health record. PPOU was defined as any opioid prescription filled 31-180 days post operatively. Dignity Health's Community Needs Index (CNI) score was used to stratify SDOH based on their address at time of surgery. CNI scores were categorized into lowest, mid, and highest need. Analysis was performed with non-parametric linear-by-linear association to examine significance ($p < 0.05$). Pearson chi-square test was used when measuring association between categorical variables.

Results: Overall, 50 patients (26.6%) were found to have PPOU. CNI scores were significantly associated with PPOU beyond 30 days ($p=0.046$). When comparing social needs categories, the highest need category had the largest percentage of PPOU, with 34 patients (30.9%), followed by mid at 14 (24.5%), and lowest at 2 (9.5%). Secondary outcomes included filling >1 opioid prescription within 30 days postoperatively. Of those, 52.9% had PPOU ($p<0.001$). Distribution by age, race, and sex was not significant.

Conclusion: Increasing CNI score, representing increased social need, was significantly associated with elevated risk of PPOU beyond 30 days. A PPOU rate of 26.6% was identified in this study, higher than 13% reported by NIH. This difference is attributed to the large distribution of patients in the highest need CNI category, further supporting the relationship of worse SDOH with PPOU. Patients who filled >1 opioid prescription within 30 days postoperatively had higher rates (52.9%) of PPOU, regardless of CNI category. This evidence supports consideration of targeted education and awareness for those with highest needs regarding their risk of PPOU.

Persistent Postoperative Opioid Utilization by CNI Scores

Opioid prescription, 31-180 days after surgery	Yes		No		Total
	n	%	*n*	%	
CNI score category					
Lowest	2	9.5%	19	90.5%	21
Mid	14	24.6%	43	75.4%	57
Highest	34	30.9%	138	69.1%	110
Total	50	26.6%	138	73.4%	188
Linear by linear association					0.046

Funding: N/A

Podium #60

RURAL FOR-PROFIT HOSPITALS ARE ASSOCIATED WITH HIGHER PRICES FOR COMMON UROLOGIC PROCEDURES

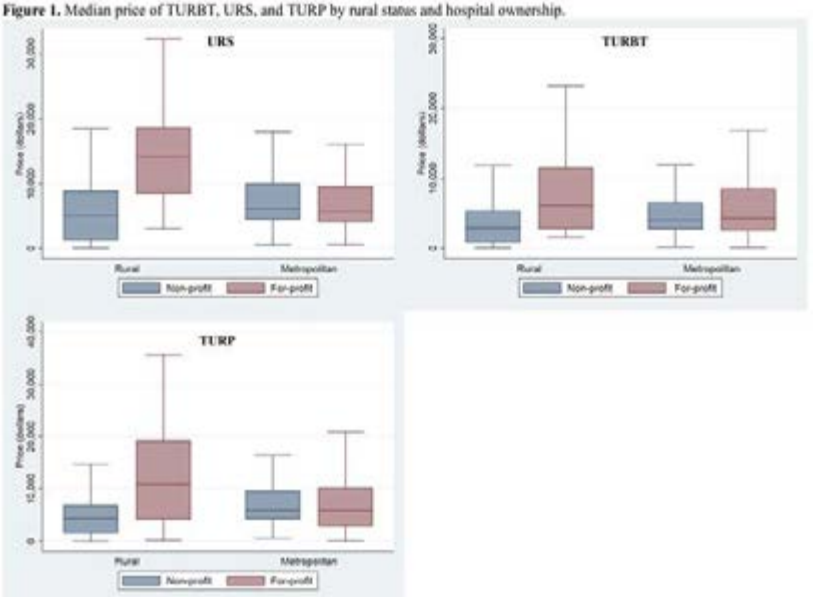
Alexandria Spellman, MD, MS[1], Ian Berger, MD, MS[1], Vishnukamal Golla, MD, MPH[1], Marcelo Cerullo, MD, MPH[1], Yuqi Zhang, MD, MHS[2], Michael Lipkin, MD, MBA[1], Gary Faerber, MD[1], Charles Scales, MD, MSHS[1], Deborah Kaye, MD, MS[1]
[1]Duke University, [2]Yale University
Presented By: Alexandria Alverdy Spellman, M.D., M.S.

Introduction: Options for urologic services and care are limited in rural settings. Patients in rural settings are often unable to avoid higher priced facilities, such as for-profit hospitals, given that they have fewer locations to receive care. This may dissuade underinsured patients from undergoing important urologic treatments and ultimately lead to delays in care and worse outcomes. Our study aims to describe cost differences of common urologic procedures in rural versus metropolitan and for-profit versus non-profit hospitals.

Methods: Publicly available prices for ureteroscopy and laser lithotripsy (URS), transurethral resection of bladder tumor (TURBT), and transurethral resection of prostate (TURP) were obtained from the Turquoise Health Transparency Database. Short-term acute care hospitals reporting a price for one urologic procedure were linked to the CMS Healthcare Cost Reporting Information System and Rural Urban Commuting Area codes to provide facility characteristics. A hospital price for each procedure was generated by averaging each hospitals insurer-specific prices. Generalized linear modelling with

gamma distribution and log link associated facility characteristics with price, including an interaction term for rural status and hospital ownership model (non-profit, for-profit).
Results: In total, 1,532 hospitals reported a price for at least one of the urologic procedures. Of these hospitals, 70% were metropolitan while 30% were rural. For-profit hospitals comprised 30% of metropolitan hospitals and 17% of rural hospitals. Prices for each procedure were higher at rural for-profit hospitals compared to rural non-profit and metropolitan for-profit hospitals (Figure 1). Accounting for facility characteristics, rural for-profit hospitals were associated with an additional 119% higher price for URS (Relative cost ratio (RCR) 2.19, 95% CI 1.66-2.89, p<0.001), 83% higher price for TURP (RCR 1.83, 95% CI 1.41-2.36, p<0.001, and 33% higher price for TURBT (RCR 1.33, 95% CI 1.02-1.73 p=0.037).
Conclusion: The median price for urologic procedures including URS, TURP, and TURBT was higher at rural-for profit hospitals than at rural non-profit and metropolitan for-profit hospitals. These price differences may contribute to disparities in healthcare for patients with urologic conditions.

Figure 1. Median price of TURBT, URS, and TURP by rural status and hospital ownership.



Funding: Bass Connections

Podium #61

IMPACT OF SOCIAL DISPARITIES ON 10 YEAR SURVIVAL RATES IN PEDIATRIC CANCERS

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Presented By: Andrew Alexander Stec, MD

Introduction: To examine the relationship between social determinants of health (SDoH), as measured by the social deprivation index (SDI) , and mortality in pediatric oncology patients in a population-based cancer registry.
Study Design: Cohort study of children across all pediatric cancers, survival rates were determined using the Surveillance, Epidemiology, and End Results (SEER) database from 1975 to 2016. Social deprivation was based on the SDI, a tool that used to measure

degree of socioeconomic disparities based on zip code and available census data. 10-year overall and cancer-specific survival were evaluated by quartile, race and presence of metastatic disease.

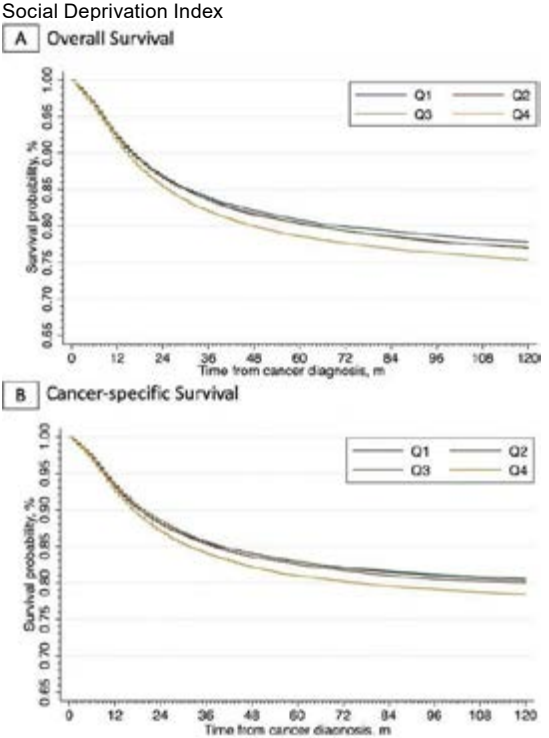
Results: The study cohort was composed of 99,542 patients with pediatric cancer. Patients had a median age of 10 years old with 46.3% of female sex. In the database, 80.4% of patients were identified as Caucasian while 10.9% were identified as African American. Patients from the more socially deprived areas had significantly higher risk of death overall for both non-metastatic [1.27 (95% CI: 1.19-1.36)] and metastatic presentations [1.09 (95% CI: 1.05-1.15)] compared to in most socioeconomically affluent areas.

10-year overall survival from the most deprived quarter of patients (Q4) was 73.8% compared to 76.7% from the most affluent 25% (Q1). (Fig 1A) Similarly, 10-year cancer-specific survival from SDI Q4 of 77.1% compared to SDI Q1 of 79.6%. (FIG 1B)

The most deprived Q4 population was further subdivided by race to evaluate the potential impact biology may have on this higher risk population. Overall 10-year survival in the Q4 black population was 67.6% compared to the non-black Q4 population at 75.2%. Cancer-specific survival in the black population at 71.5% survival compared to non-black at 78.2%.

Conclusion: SDoH are contributors to disparities in healthcare outcomes among pediatric oncology patients. Patients from the most socially deprived areas had significantly worse 10-year overall and cancer-specific survival rates across all pediatric cancers. To create more equitable outcomes, focus needs to be directed towards patients who are vulnerable and from socially deprived areas. This study has process than could be readily applied across Urologic datasets to stratify outcomes of interest by SDoH.

Figure 1: Kaplan-Meier Estimates for Overall and Cancer-specific Survival by Quartiles of Social Deprivation Index



Funding: N/A

Podium #62

POTENTIAL SAVINGS IN UROLOGY WITH USE OF COST PLUS PHARMACY

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Presented By: Van Schloegel

Introduction: With its stated goal "to end ridiculous drug prices," the Mark Cuban Cost Plus Drug Company (MCCPDC) launched in January 2022 with over 100 generic prescription drugs that could be mailed directly to patients. To promote drug cost transparency, all drugs are priced at the cost to manufacture the drug plus a 15% markup and a $3 pharmacist fee. MCCPDC is one of many mail-order pharmacies that have promised cheaper drug prices, but if, and how, these pharmacies deliver cost savings to the patient is unknown. Based on 2020 Medicare spending data, a recent analysis found that Medicare could have saved 9.3 billion dollars if they purchased all drugs available via MCCPDC. We sought to analyze the potential cost savings of urological drug prescriptions at MCCPDC compared with other available low-cost pharmacies.
Methods: Out of the approximately 100 generic drugs available on the MCCPDC website, we analyzed the 12 drugs that are primarily prescribed to treat urological diseases. To equally compare prices, we analyzed drug prices of 30-day prescriptions at the most common dose of each medication. Using the Good Rx prescription drug search engine, we compared the drug prices of the cheapest mail order and local in-person pharmacies near zip code 40508 (Lexington, Kentucky). We also pulled the Medicare 2020 spending data for the cost of a drug fill and our hospital retail pharmacy's average insurance co-pay for each drug for the year 2022 to date.
Results: MCCPDC offered the lower direct-to-consumer price on 10 of 12 drugs studied, with savings ranging from $0.50 to $200 per 30-day fill (Table 1). When comparing average Medicare co-pays with MCCPDC prices, the MCCPDC offered potential savings of $2 to $30 per 30-day fill for three drugs: sildenafil citrate, oxybutynin ER and oxybutynin.
Conclusion: MCCPDC can offer potentially significant cost savings to patients. Certain drugs, such as abiraterone, oxybutynin and PDE-5 inhibitors, have the most potential for cost savings. These findings have implications for urologists prescribing habits.

Comparison of 30-day Prescription Drug Prices by Pharmacy

Generic Drug (Brand Name)	Dose (mg)	MCCPDC Mail Order ($)	GoodRx Mail Order ($)	DiRx Mail Order ($)	Local Pharmacy* ($)
Abiraterone Acetate (Zytiga)	250	**39.6**	-	344	242
Alfusozin HCL ER (Uroxatral)	10	6.3	6.6	**6**	9.99
Doxazosin Mesylate (Cardura)	8	**6.9**	21	8	9
Finasteride (Proscar)	5	**4.5**	6	9	7.57
Oxybutynin Chloride (Ditropan)	5	**4.5**	12.9	6	7.13
Oxybutynin ER (Ditropan XL)	10	**5.7**	10.5	8	13.82
Sildenafil Citrate (Viagra)	20	**4.8**	9	17	8.05
Solifenacin Succinate (Vesicare)	5	**5.1**	14.1	15	17.99
Tadalafil (Cialis)	5	**4.5**	14.7	15	11.32
Tamsulosin (Flomax)	0.4	**4.5**	9	5	7.05
Tolterodine Tartrate (Detrol)	2	18	24.9	**17**	19.43
Tolterodine Tartrate ER (Detrol LA)	4	**25.8**	62	47	34.9

*Cheapest local pharmacy near zip code 40508 (Lexington, KY)

Funding: N/A

Podium #63

DISPARITIES IN ACCESS TO HIGH VOLUME CENTERS AND IN PERIOPERATIVE OUTCOMES FOLLOWING RADICAL CYSTECTOMY

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Presented By: Bryce Alden Baird, BS, MD

Introduction: Centralization of radical cystectomy (RC) has been shown to improve outcomes; however, it may also exacerbate existing disparities in access to and outcomes of care. Our objective was to define disparities in access to high-volume RC centers and in perioperative outcomes.
Methods: We identified RC patients in the Florida Inpatient Data File from 2013-2019. Hospital average annual cystectomy volume was categorized as low, medium, or high using data-derived 75th and 90th quantiles: <5, 5-13, and >13 RC/year. Outcomes included inpatient mortality, non-home discharge, in-hospital complications, length of stay and surgery in a low-volume hospital. Mixed-effects regression models accounting for clustering within centers were utilized.
Results: Among 4396 patients treated at 105 centers, RC at a high-volume center was associated with lower odds of mortality, non-home discharge, shorter length of stay and fewer complications (all $p \leq 0.001$). Characteristics associated with receiving care in a low-volume hospital included Black race (OR 1.67, 95% CI 1.14-2.39), Hispanic/Latino ethnicity (OR 1.74, 95% CI 1.32-2.00), and residing in northeast (OR 2.11, 95% CI 1.58-2.80) or west Florida (OR 1.34, 95% CI 1.05-1.71). Black patients had increased odds of

non-home discharge (OR 1.91, 95% CI 1.27-2.86) and longer length of stay (IRR 1.17, 95% CI 1.08-1.27), but no difference in the rate or number of postoperative complications (p>0.2).
Conclusion: In Florida, we observed racial and geographic disparities in likelihood of undergoing RC at a low-volume hospital and in postoperative disposition despite similar rates of complications. Efforts to increase access to high-value RC care for these vulnerable populations are needed.
Funding: N/A

Podium #64

THE IMPACT OF SOCIOECONOMIC STATUS ON PATIENT COMPLIANCE IN MANAGING RENAL MASSES

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Presented By: Hailey Holck, BS

Introduction: There are known socioeconomic and demographic disparities in the diagnosis, disease state, and survival outcomes for patients with renal cancers. Patient compliance is essential for the effective management of renal masses for patients undergoing active surveillance or post-treatment surveillance imaging. We aim to evaluate the impact of socioeconomic status (SES), as defined by the Area Deprivation Index (ADI) and estimated census income levels, on patient compliance and loss to follow-up.
Methods: This is an IRB-approved retrospective study of a prospectively maintained Kidney Tumor Program database with patients ranging from 2000-2020. ADI data was obtained from the University of Wisconsin School of Medicine. Income data was collected from the US Census Bureau. Compliance was defined as the completion of required appointments within six months of the initial follow-up visit date. Loss to follow-up was defined as patients who were required to follow up but never did.
Results: Each ADI quartile was similar in age, gender, tumor size, Charlson Comorbidity Index, treatment method, and renal mass biopsy rate. Notably, the quartiles differed significantly in BMI (p=0.006) and race/ethnicity (p<0.001). Patient compliance was similar across sex and primary treatment method but significantly differed with respect to race/ethnicity and biopsy result. After adjusting for race/ethnicity, patients with a high SES (Q1) had significantly higher rates of compliance in comparison to low SES patients (Q4) (p=0.025). Patients in Q1 were also less likely to be lost to follow-up than those in Q4 (p=0.043). Similarly, patients with a lower income were significantly less likely than those earning >120,000 to comply with management protocols (30,000-59,999, p<0.003) and more likely to be lost to follow-up (30,000-59,999, p=0.001; <30,000, p=0.025). Multivariate analysis indicates that a 30,000 increase in income correlates with a 24% increase in the rate of compliance (p<0.001) and a 25% decrease in loss to follow-up (p<0.001).
Conclusion: Both ADI and census income measurements indicate that lower SES is associated with decreased compliance and increased loss to follow-up in patients with renal masses. Our results suggest that SES could be an important consideration in the management of renal masses and an indication of future patient compliance and follow-up.

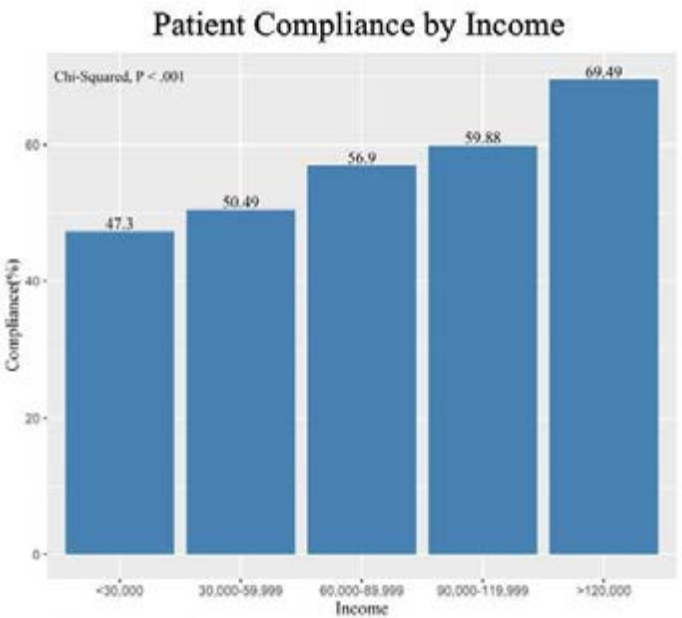

Figure 1. Compliance differed significantly with respect to income ($p<0.001$). Income also correlates with compliance ($p<0.001$; OR=1.24).

Funding: N/A

Podium #65

THE OPTILUME DRUG COATED BALLOON FOR RECURRENT ANTERIOR URETHRAL STRICTURES:ROBUST III STUDY 2-YEAR RESULTS

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Presented By: Jessica DeLong, MD

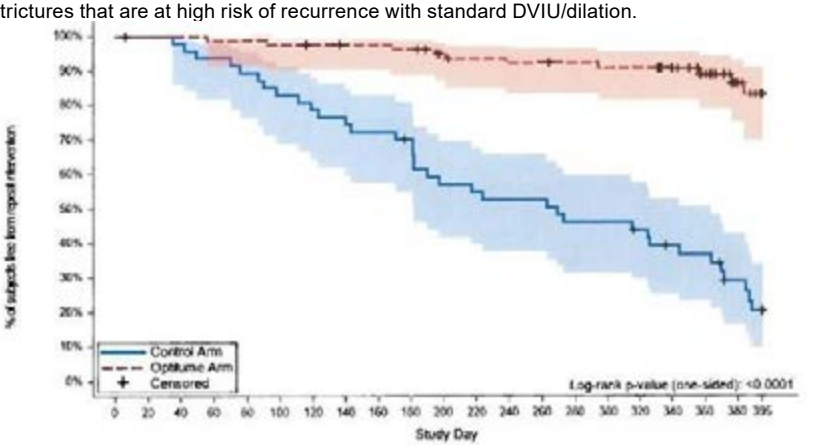
Introduction: The ROBUST III study is a randomized controlled trial comparing the Optilume® Drug Coated Balloon (DCB) against direct visual internal urethrotomy (DVIU) or dilation. One year outcomes have been previously published, and follow-up is planned through 5 years for subjects treated with the DCB. Outcomes after 2-year follow-up are presented here.

Methods: 127 subjects were randomized in a 2:1 fashion at 23 sites. Seventy-nine were treated with the DCB and 48 were treated with DVIU or dilation. Follow-up past 1 year was limited to those treated with the DCB. Eligibility criteria included adult males with anterior strictures with 2 prior treatments and stricture length ≤3cm. Long-term endpoints included freedom from repeat treatment, International Prostate Symptom Score (IPSS), and peak urinary flow rate (Qmax). Subjects randomized to DVIU/dilation were allowed to cross over to receive treatment with the DCB if stricture recurrence was confirmed by urethrogram

and symptom/flow deterioration. Follow-up for subjects after cross-over is complete through 1 year.

Results: Subjects randomized to receive the DCB had an average of 3.2 prior treatments and average stricture length of 1.6cm (46% ≥2cm), with 8/79 (10.1%) having penile strictures and 9/79 (11.4%) having prior pelvic radiation. IPSS significantly improved from 22.0 at baseline to 10.2 at 2 years (p<0.001). Qmax significantly improved from a baseline of 7.6 mL/sec to 13.9 mL/sec at 2 years (p<0.001). Freedom from repeat intervention for DCB subjects was 78%. No late-onset treatment related adverse events were observed. Crossover subjects showed significantly improved durability in symptom improvement, flow, and freedom from repeat intervention (72%) at 1 year after DCB when compared against outcomes after their original randomized treatment with DVIU/dilation.

Conclusion: The Optilume® DCB continues to achieve significant improvements in symptoms, flow, and reintervention rates through 2 years post treatment. Strong results in the crossover patient population demonstrate the effectiveness of the Optilume® DCB in strictures that are at high risk of recurrence with standard DVIU/dilation.



Characteristic	Standard of Care	OptilumeDCB	P value
Number patients	48	79	
Mean +-SD age (yrs)	60.6 +- 16.0	58.7 +- 15.5	0.500
Number prior treatments (median)	3.0	3.0	
Anatomical success at 6 months	74.6%	26.8%	<0.0001
IPSS at 1 year	19.8	9.0	
Qmax at 1 year	7.6	15.5	
Freedom from repeat intervention at 1 year	34%	89%	

Funding: Urotronic, Inc

Podium #66

THE OPTILUME DRUG COATED BALLOON FOR RECURRENT ANTERIOR URETHRAL STRICTURES: THE ROBUST I STUDY 4-YEAR RESULTS

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Presented By: Jessica DeLong, MD

Introduction: Although guidelines recommend urethroplasty over repeated mechanical dilation or direct visualization internal urethrotomy (DVIU), these procedures are common treatments for recurrent anterior urethral strictures. The ROBUST I study investigates the use of the Optilume® drug coated balloon (DCB) for recurrent anterior strictures, and here we present our 4-year follow up data.
Methods: Ethics committee approval was obtained from all sites. Men with strictures ≤ 2cm with 1-4 prior endoscopic interventions were treated with the Optilume® DCB. Follow-up was completed at 3 months, 6 months, and annually thereafter. The safety endpoint assessed serious urinary events. The effectiveness endpoint was the proportion of subjects with ≥ 50% improvement in International Prostate Symptom Score (IPSS). Secondary outcomes included quality of life, freedom from reintervention, erectile function, flow rate, and post-void residual volume. Subjects receiving secondary treatment were considered failures.
Results: A total of 53 subjects were included, 43% had ≥ 2 previous dilations, with a mean of 1.7 prior dilations. Forty-three subjects were evaluable at the four-year follow-up, including 11 that had received secondary treatment and 2 lost to follow-up with recurrent symptoms. There were no serious adverse events related to treatment through 4 years. IPSS success was achieved in 29/43 (67%), consistent with 2 and 3-year results. IPSS improved from a mean of 25.2 at baseline to 4.5 at 4 years ($p < 0.001$). Freedom from repeat intervention was 30/43 (70%}. Quality of life, flow rate, and post-void residual urine volumes improved significantly from baseline. There was no impact on erectile function.
Conclusion: Subjects with recurrent bulbar strictures treated with Optilume® paclitaxel-coated balloon exhibited significant improvement in symptomatic and functional outcomes through 4 years post treatment with demonstrably improved recurrence rates. There was no impact on erectile function and there were no serious adverse events.
Funding: Urotronic, Inc

Podium #67

AREA DEPRIVATION INDEX (ADI) PREDICTIVE OF DELAYS TO URETHROPLASTY

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Presented By: Evan Watkins

Introduction: Treatment of urethral stricture disease with multiple repeated endoscopic procedures has been shown to be both ineffective and costly. While many patient and provider factors are known to be associated with likelihood of undergoing multiple endoscopic procedures, little is known about non-clinical factors. The aim of this study was to assess if neighborhood factors are associated with delays to definitive care for urethral stricture disease.
Methods: This study identified patients treated by a single surgeon with urethroplasty between 9/4/2019 and 12/29/2021. Patients with a previous history of urethroplasty, under the age of 18, and those with insufficient follow-up data were excluded. Area deprivation index (ADI) is a composite comprised of 17 factors describing income, education, employment and housing quality based on subject 9-digit ZIP code and obtained from

the University of Wisconsin School of Medicine and Public Health Neighborhood Atlas®. Scores are normalized to a percentile from 0 to 100, with higher numbers representing higher levels of disadvantage. Patient addresses were geocoded and assigned a national ADI rank based on residential census block group. For this study, ADI rank was sub-grouped into least disadvantaged (lower 50%) and most disadvantaged (upper 50%). Multivariate logistic regression was performed to assess impact of ADI score on likelihood of receiving multiple endoscopic procedures prior to urethroplasty. Final model was assessed for multicollinearity and goodness of fit via Hosmer-Lemeshow goodness-of-fit test.

Results: 104 patients were included in the final analysis. 44% of patients had undergone multiple prior endoscopic procedures. Patients who had undergone ≥2 endoscopic procedures tended to be older, have higher ADI scores, and were more likely to be white. On multivariate analysis adjusting for age, ADI classification, and insurance status, patients in the more disadvantaged group were significantly more likely to have undergone multiple endoscopic procedures prior to urethroplasty (OR 2.79), as were older patients (OR 1.04).

Conclusion: Neighborhood disadvantage as assessed by the ADI provides an alternative methodology to identify disparities in health services utilization in patients with urethral stricture disease. These findings highlight needs to increase provision of resources and care to disadvantaged communities.

Table 2 – Multivariate logistic regression of likelihood of receiving multiple endoscopic procedures prior to urethroplasty, adjusted for age, insurance status and ADI classification.

	OR	95% CI	p-value
ADI Classification			0.02
Bottom 50% (less disadvantaged)	Ref	-	-
Upper 50% (more disadvantaged)	**2.79**	**1.16 – 7.00**	**0.02**
Age	**1.04**	**1.01 – 1.07**	**0.02**
Insurance status			0.72
Private	Ref	-	-
Medicare	0.75	0.24 – 2.22	0.60
Other	0.57	0.10 – 2.66	0.49

Funding: N/A

Podium #68

PARTIAL COMPONENT EXCHANGE OF A NON-INFECTED INFLATABLE PENILE PROSTHESIS IS ASSOCIATED WITH A HIGHER COMPLICATION RATE

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Presented By: Austin Livingston

Introduction: For a clinically non-infected IPP, partial component revision aims to decrease surgical costs and morbidity compared to complete replacement. We sought to

describe the infectious and non-infectious complications in men undergoing IPP revision with partial and complete component exchange.
Methods: We performed a multicenter retrospective cohort study of patients who underwent IPP revision. Men undergoing procedures for implant infection were excluded. Patients were divided into those who had complete exchange of the entire device or partial exchange of only one or two components. Infectious and non-infectious complications were compared between groups.
Results: 368 men had complete exchange of the entire device and 85 had partial component exchange. Men undergoing partial exchange had a significantly higher infection rate (7.1% vs 2.2%, p=0.031). The partial exchange group also was more likely to receive antifungals (51.8 vs 16.6%, p<0.001), have a modified salvage washout (77.4 vs 60.2%, p=0.004), and less likely to receive vancomycin and gentamicin (63.5 vs 83.7%, p<0.001). Time to revision was significantly shorter in the partial exchange group (44.9 vs 168.2 months, p<0.001). In multivariable analysis, partial exchange surgery, vancomycin and gentamicin prophylaxis, modified salvage washout, and antifungal prophylaxis were no longer associated with postoperative infections. The partial exchange group had greater rates of non-infectious complications (21.2% vs 9.5%, p=0.005) such as pump malfunction and tubing breakage.
Conclusion: Patients undergoing partial component revision had more infectious and non-infectious complications. These findings suggest that partial component exchange increases risks in men undergoing IPP revision.
Funding: N/A

Podium #69

INTERMITTENT SELF-CATHETERIZATION IS SAFE AND EFFECTIVE FOR THE SIMULTANEOUS MANAGEMENT OF STRESS URINARY INCONTINENCE AND POOR BLADDER EMPTYING AFTER BULBAR URETHRAL ARTIFICIAL URINARY SPHINCTER PLACEMENT

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Presented By: Austin Livingston

Introduction: Stress urinary incontinence (SUI) and poor bladder emptying are both possible sequelae of prostate surgery or radiation. For patients with both of these conditions, there is sparse data to guide management. The safety of intermittent catheterization (CIC) in men with an artificial urinary sphincter (AUS) at the bulbar urethra remains unclear. Our objective was to evaluate the functional and surgical outcomes of CIC protocols in men with a bulbar AUS cuff in place.
Methods: We performed a retrospective review of a quality improvement database containing bulbar urethral AUS procedures at our institution. Inclusion criteria were patients with a history of prostate cancer treatment, AUS placement for SUI, and a history of CIC before and/or after AUS placement. Records were divided into those who did or did not require CIC continuation after AUS placement. All eligible cases were reviewed. Surgical and continence outcomes were compared using chi-square, rank sum, or unpaired t-tests after assessment of data normality.
Results: 57 patients were identified with a history of CIC and AUS placement under the care of two surgeons. Eighteen continued to perform CIC or first initiated CIC after AUS placement and 39 discontinued CIC protocol prior to AUS placement. The incidence of erosion was no different amongst patients who continued or discontinued CIC after AUS placement (17.9% vs 22.2%, p = 0.79). There was no difference in future AUS removal or replacement (56.4% vs 44.4%, p = 0.41). Both groups experienced improvement in urinary incontinence after placement of an AUS.
Conclusion: Treatment dilemmas arise in men with concomitant SUI and poor bladder emptying as treatment of one condition often exacerbates the other. AUS placement in the setting of continuous intermittent catheterization is a viable option in patients with SUI and poor bladder emptying.

Table 1. Surgical and Continence Outcomes

	CIC Before AUS (n = 39)	CIC After AUS (n = 18)	
Urethra Size (cm)	Median 5 (4.5, 5.5)	Median 4.8 (4.5, 5.5)	p=0.84
Cuff Size (cm) – initial Cuff Size (cm) – second	4.37 ± 0.31 4.3 ± 0.27	4.39 ± 0.32 4.13 ± 0.44	p=0.85 p=0.44
Traumatic Catheter	2 (5.1%)	1 (5.6%)	p=0.94
Prolonged Foley (>3 days)	3 (7.7%) Mean Indwell (days) 12.6 ±10.9	5 (27.8%) Mean Indwell (days) 10.3 ±5.5	p=0.04
Pre-AUS Pad Count	Median 6 (5, 10)	Median 4 (3, 6)	p=0.02
Pre-AUS Pad Wt (grams)	Median 924 (362, 1190)	Median 681.5 (363, 1250)	p=0.72
Post-AUS Pad Count	Median 1 (0.5, 1)	Median 1 (0, 1.5)	p=0.95
AUS removed/replaced	22 (56.4%)	8 (44.4%)	p=0.41
Time until removal/replacement (days)	1081 (187, 2344)	1212 (566, 2041)	p=0.70
Erosion	7 (17.9%)	4 (22.2%)	p=0.79

Funding: N/A

Podium #70

CIRCUMCORPORAL ARTIFICIAL URINARY SPHINCTER (CC-AUS): A NOVEL SURGICAL APPROACH FOR THE TREATMENT OF COMPLEX MALE STRESS URINARY INCONTINENCE (SUI)

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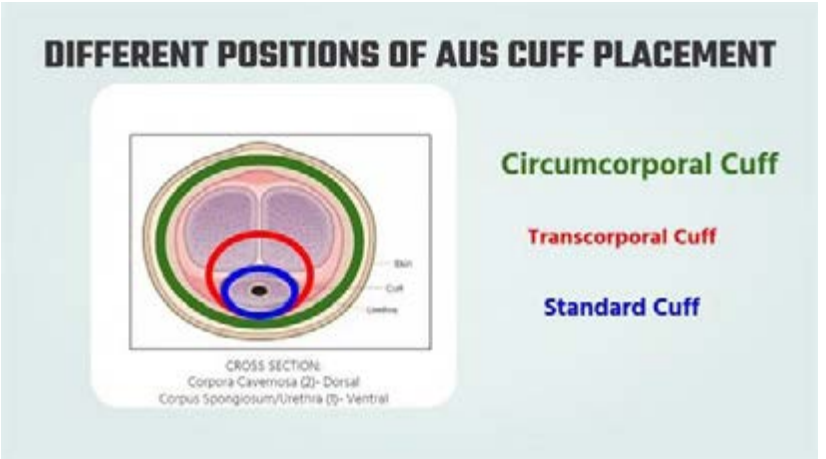
Presented By: Jeffrey D. Brady, MD, FACS

Introduction: The CIRCUMCORPORAL AUS (CC-AUS) is an innovative approach for patients with compromised urethras previously not candidates for replacement of an AUS. Men who have had prior AUS erosions, with simultaneously compromised corpora cavernosa, may no longer be AUS candidates for available techniques, such as the transcorporal AUS (TC-AUS). This is a single surgeon (JB) report reviewing the outcomes of the CIRCUMCORPORAL-AUS where the cuff is placed around all three corporal bodies.
Methods: This is a retrospective study on a database of AUS surgical outcomes. From 2000 to present, 603 AUS procedures were performed. Of these, 10 CC-AUS procedures were performed between Feb 2016 and Sept 2022. 9 have had sufficient follow up after AUS activation and are included in the analysis. Of the 6 patients with prostate cancer, all had radiation therapy (XRT). 5 had a radical prostatectomy with adjuvant XRT and 1 had XRT and salvage cryoablation. The average cuff size was 9.14 cm. Patients were surveyed pre- and post-operatively and scored the severity of their incontinence in pads/day, improvement vs pre-op SUI, comparison to their first AUS and if they would have the surgery again. Outcomes were analyzed using 2 tailed T-test.
Results: Mean follow up is 2.5 years (1.3 to 6.5 years). There was a decrease from 9.8 to 3.42 pads/day (p= 0.002). 100% of patients noted SUI improvement from pre-op (no AUS). When compared to the first AUS, 43% felt they were “more dry”, 14% were similar and 43% felt “less dry”. All patients would have surgery again or would recommend to a friend. No patients reported urinary retention, change in penile sensation, glans necrosis, infections, or AUS malfunction. 2 patients required downsizing of cuffs, and both had improvement. One patient had an erosion (ventral) of his CC-AUS with removal.
Conclusion: This is the first report of the CIRCUMCORPORAL AUS. It appears to be a safe and effective surgical option for SUI in complex cases with prior AUS erosions. It has been successful in patients following XRT and multiple prior erosions. There have been no sensory or penile vascular changes noted. Longer term follow up is required to determine if results are durable.



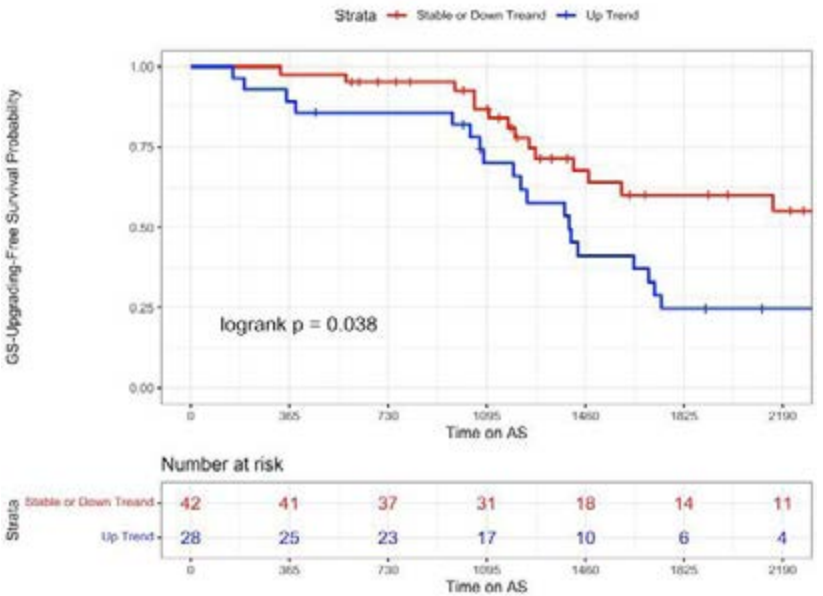
Funding: N/A

Podium #71

ANNUAL MRI ACTIVE SURVEILLANCE PROTOCOL FOR GG1 PROSTATE CANCER: INCREASING PI-RADS OF THE SAME LESION CORRELATED WITH PATIENTS WHO HARBOR UNDERLYING CLINICALLY SIGNIFICANT DISEASE.

Jacob W. Greenberg[1], Joshua Pincus[1], Christopher Koller[1], Caleb Natale[1], Sydney Caputo[1], Crystal Casado[1], Garrett Brinkley[1], L. Spencer Krane[2]
[1]Tulane School of Medicine, [2]Southeast Louisiana Veterans Healthcare System
Presented By: Jacob Greenberg

Introduction: While MRI targeting and biopsy are mainstay of active surveillance, recent advances in MRI identification of suspicious lesions have increased the use of annual imaging in these protocols. However, the current literature is vague on the clinical utility and predictive value of annual variation in PI-RADS scores for these regions of interest. The aim of this study was to investigate if an increasing trend in PI-RADS score was associated with patients who harbor underlying clinically significant disease.
Methods: From a prospectively maintained database, a total of >350 patients on AS for low-risk PCa spanning from 2013 to 2022, 208 underwent MRI imaging prior to initial diagnosis were entered into this study. Clinically significant PCa and AS failure was defined as biopsy with grade group (GG) ≥2 histology. To calculate the PI-RADS score trend, we used a linear-regression analysis.
Results: The median age of this cohort was 66 with a median follow-up of >5 years. On Kaplan-Meier curve patients who had a PI-RADS 4 lesion at the time of diagnosis, failed AS at higher rates than their counterparts (p=0.002). Interestingly enough, men with PI-RADS 5 lesions at the time of diagnosis had comparable AS failure probability to men with PI-RADS 1-3 lesions. In this cohort, 70 had 2 or more MRIs. Taking PI-RADS trend into account, men with up-trending scores in the same ROI had a poor probability of remaining on AS at 5 years when compared to those with stable or down trending PI-RADS (25% vs 66%, p=0.038). Using a logistic regression man with a PI-RADS 4 lesion at the time of AS initiation, were at higher odds of later having up-trending PI-RADS on sequential imaging.
Conclusion: This data displayed that men who initiate an AS protocol with a PI-RADS 4 lesion are at increasing odds of upgrading on MRI and later associated with harboring clinically significant disease. Based on current treatment paradigms, these patients should be counseled accordingly and are possible candidates for closer surveillance. On the opposite side of that coin, men with stable or decreasing PI-RADS on follow-up MRI were less likely to upgrade in this dataset and are early candidates for biopsy de-escalation protocols.



Funding: N/A

Podium #72

COMPLICATIONS OF OUTPATIENT ROBOTIC RADICAL PROSTATECTOMY: A COMPREHENSIVE ANALYSIS

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Presented By: Spencer Liem, MD

Introduction: Prostate cancer is one of the most common oncologic diseases. Robotic radical prostatectomy (RRP) is one of the treatment options available to patients with localized disease. Outpatient robotic radical prostatectomy is currently a topic of interest due to the ability to minimize costs while maintaining low complication rates. However, few studies have analyzed the possibility of performing outpatient RRP at a national level. As such, we compare the complication and readmission rates of inpatient versus outpatient RRP from a national database.
Methods: Using the National Surgical Quality Improvement Program Database (NSQIP), we extracted data from 2010-2020. We identify and report total number of RRP, intraoperative and post-operative complications and 30-day events such as readmission and mortality. We further divided RRP into inpatient and outpatient surgeries. The two groups were then compared regarding comorbidities, complications, and post-operative events. Trends in outpatient designation were also tabulated for each year.
Results: Between 2010-2020, a total of 79381 RRP were performed, 98.2% inpatient and 1.7% outpatient, with 6.2% of RRP designated as outpatient in 2020 alone. Average age of inpatient RRP was 63 ± 7 years while outpatient RRP was 62 ± 7 years, p<0.001. The mean operative time for inpatient RRP was 208.2 ± 73.5 minutes while outpatient RRP was 183.7 ± 67.9 minutes, p<0.001. Altogether, patients undergoing outpatient RRP were less likely to have active smoking history (9.0% vs. 11.4%, p=0.005), hypertension (47.5% vs. 52.3%, p<0.001), less transfusions (0.3% vs. 1.3%, p<0.001) and 30-day readmissions (2.6% vs. 4.2%, p=0.029) than patients undergoing inpatient RRP. Cardiopulmonary

complications, renal dysfunction, urinary tract infections, deep venous thrombosis, sepsis, and 30-day mortality rate were similar in both groups.

Conclusion: Outpatient RRP is associated with slightly lower patient age and shorter operative times. Patients undergoing outpatient RRP were less likely to have an active smoking history or a history of hypertension and had lower rates of intraoperative transfusions, as well as fewer unplanned readmissions. Other complications and 30-day events were similar in both groups.

Table 1: Characteristics, Comorbidities, and Complications of patients undergoing RRP*

All	Outpatient RRP	Inpatient RRP	P-value
N=79381	1325	78056	
Age (years)	62 ± 7	63 ± 7	**<0.001**
Operative time (min)	183.7 ± 67.9	208.2 ± 73.5	**<0.001**
American Indian or Alaska Native	3 (0.2%)	162 (0.2%)	0.881
Asian	50 (3.8%)	2138 (2.7%)	**0.023**
Black or African American	190 (14.3%)	9818 (12.6%)	0.055
Native Hawaiian or Pacific Islander	1 (0.1%)	190 (0.2%)	0.072
White	982 (74.1%)	57569 (73.8%)	0.768
Comorbidities			
Diabetes Insulin-Dependent	39 (2.9%)	2204 (2.8%)	0.794
Diabetes Non-Insulin Dependent	138 (10.4%)	8096 (10.4%)	0.399
Smoker	119 (9%)	8917 (11.4%)	**0.005**
Alcohol Use	3 (1.6%)	265 (1.2%)	0.602
Dyspnea - at rest	0 (0%)	49 (0.1%)	0.362
Dyspnea - at exertion	20 (1.5%)	1683 (2.2%)	0.145
Chronic Obstructive Pulmonary Disease	21 (1.6%)	1410 (1.8%)	0.603
Congestive Heart Failure	1 (0.1%)	101 (0.1%)	0.705
Hypertension	630 (47.5%)	40825 (52.3%)	**<0.001**
Malnourished	3 (0.2%)	123 (0.2%)	0.696
Bleeding Disorder	15 (1.1%)	820 (1.1%)	0.785
Metastatic Cancer (any)	7 (0.5%)	448 (0.6%)	0.868
ASA 1	38 (2.9%)	2065 (2.6%)	0.068
ASA 2	730 (55.1%)	44890 (57.5%)	
ASA 3	551 (41.6%)	30273 (38.8%)	
ASA 4	5 (0.4%)	682 (0.9%)	
Complications			
Cardiac Arrest	2 (0.2%)	79 (0.1%)	0.650
Reintubation	2 (0.2%)	160 (0.2%)	0.791
Transfusions	4 (0.3%)	1041 (1.3%)	**0.001**
Myocardial Infarction	3 (0.2%)	134 (0.2%)	0.748
Stroke	1 (0.1%)	59 (0.1%)	1.000
Deep Vein Thrombosis	4 (0.3%)	565 (0.7%)	0.071
Pulmonary Embolism	3 (0.2%)	414 (0.5%)	0.183
Pneumonia	1 (0.1%)	201 (0.3%)	0.267
Acute Renal Failure	2 (0.2%)	87 (0.1%)	0.682
Urinary Tract Infection	31 (2.3%)	1655 (2.1%)	0.629
Sepsis	6 (0.5%)	488 (0.6%)	0.506
Septic Shock	3 (0.2%)	97 (0.1%)	0.430
Superficial Incisional Infection	11 (0.8%)	366 (0.5%)	0.069
Deep Incisional Infection	0 (0%)	32 (0%)	0.069
Organ Infection	7 (0.5%)	650 (0.8%)	0.270
Wound Dehiscence	2 (0.2%)	109 (0.1%)	1.000
30-day Events			
Readmission	33 (2.6%)	3002 (4.2%)	**0.029**
Return to OR	9 (0.7%)	894 (1.1%)	0.122
Death	2 (0.2%)	97 (0.1%)	1.000

*RRP – Robotic Radical Prostatectomy

Funding: N/A

Podium #73

DISTINCT GENETIC VARIANTS OF EARLY AND LATE-ONSET PROSTATE CANCER

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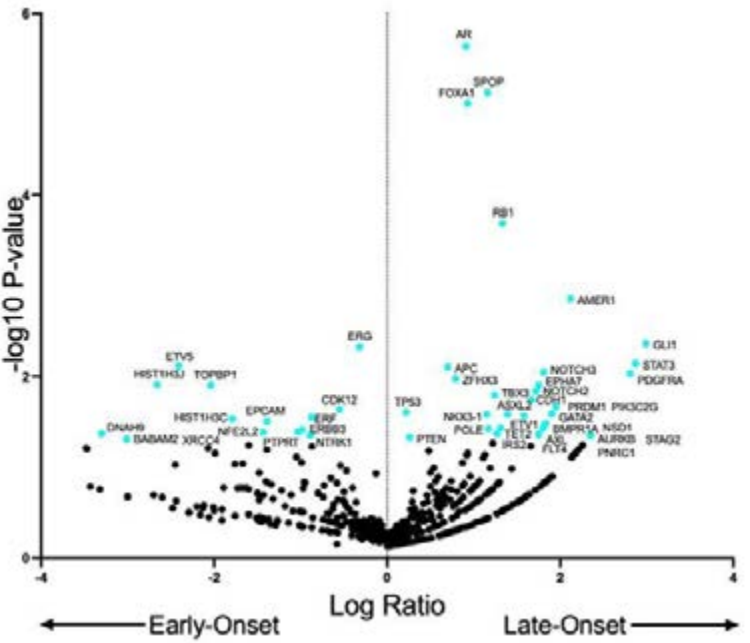
Presented By: Allison H. Feibus, MD, MS

Introduction: The incidence of patients diagnosed with early-onset (<55 years old) prostate cancer (PCa) has increased in the last two decades. Patients with early-onset PCa have lower 5-year relative survival rates compared to patients diagnosed later in life.
Methods: Patients with PCa were dichotomized into early (<55 years old) and late-onset PCa (>55 years old). Data is derived from the American Association for Cancer Research Project Genomics Evidence Neoplasia Information Exchange (GENIE) registry. The GENIE registry contains sequenced tumor samples and clinical data across many cancers. Adult men (>18 years old) with prostate adenocarcinoma in the GENIE database were included. Patterns in somatic gene tumor profiles were compared between early-onset and late-onset PCa using a chi-square test and logistic regression.
Results: A total of 452 (11.0%) patients had early-onset PCa while 3640 (89.0%) patients had late-onset PCa. Patients with early-onset PCa were more likely to be Black (12.2% vs 7.7%) and less likely to have metastatic disease (32.0% vs 45.0%). Figure 1 shows the somatic gene expression profile based on age of onset, with genes in blue denoting significance (p<0.05). After logistic regression, patients with early-onset PCa had higher odds of having a mutation in CDK12 [1.51 (95% CI: 1.04-2.22)] and ERF [1.81 (95% CI: 1.02-3.24)]. Patients with a CDK12 mutation were more likely to be Black [1.92 (95% CI: 1.28-2.86); p=0.002) and to have metastatic disease [1.53 (95% CI: 1.16-2.01); p=0.003).
Conclusion: Patients with early-onset PCa had distinct somatic gene tumor mutations in ERF and CDK12. Therapeutic targeting of genes associated with early-onset PCa can be potentially useful in future clinical studies.



Funding: N/A

Podium #74

BASELINE 4K SCORE PREDICTS PROGRESSION ON ACTIVE SURVEILLANCE IN PROSTATE CANCER INDEPENDENTLY OF CLINICAL INFORMATION AND PIRADS SCORE

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Presented By: Jamie Thomas, Bachelor of Science

Introduction: Active surveillance (AS) is the preferred management in low and select intermediate risk prostate cancer (PCa) patients. Currently, while the 4Kscore identifies men with grade-group-2+ (GG2+) disease in men with clinical suspicion of PCa, little is known about its utility in men undergoing AS. The MRI-Guided Active Selection for Treatment of Prostate Cancer (MAST) is a single-center, single-arm prospective study of men undergoing AS for low to intermediate risk PCa. In this study, we assessed the 4Kscore's ability to predict tumor progression when integrating clinical and MRI information from patients on AS.
Methods: Patients with biopsy-confirmed low to intermediate risk PCa who elected for AS were enrolled on the trial and underwent prostate MRI, targeted +/- systematic confirmatory biopsy, and 4Kscore within 1 year of diagnosis and then yearly for 3 years. The 4Kscore was categorized as low (=<7%), intermediate (7%-19%), and high (=>20%) risk. The primary outcome was progression as defined according to trial protocol. Cumulative incidence of progression rates were estimated by the Kaplan-Meier method and multivariable Cox analyses was used to assess the association between the 4Kscore and PCa progression.
Results: 4Kscore was collected from 166 men at the time of confirmatory biopsy. Over half had PIRADS 4 or 5 lesions and a 4K score of over 20%. Seventy-nine patients progressed over the trial, and they had higher baseline 4Kscores compared to patients who did not progress (31% IQR 15-59 vs. 14% IQR 8-35, p<0.001; Figure 1a). Patients with a 4Kscore above 20% had a significantly higher cumulative incidence of progression compared to patients with 4Kscores less than 20% (36 months rate 72.5% [95% CI 60.9-83.1%] vs. 41.0% [95% CI: 28.6-56.3%], p=0.0001, Figure 1b). In a multivariable Cox analysis, a 4Kscore above 20% was an independent predictor of progression (HR 1.73, 95% CI: 1.03, 2.88, p=0.037), even after adjustment for age, NCCN risk, MRI PIRADS score, and PSA density.
Conclusion: This study demonstrated that patients with a 4Kscore above 20% have a higher likelihood of progression despite their NCCN risk and MRI findings. This is the first study to prospectively evaluate the role of 4Kscore in AS within an MRI based protocol.

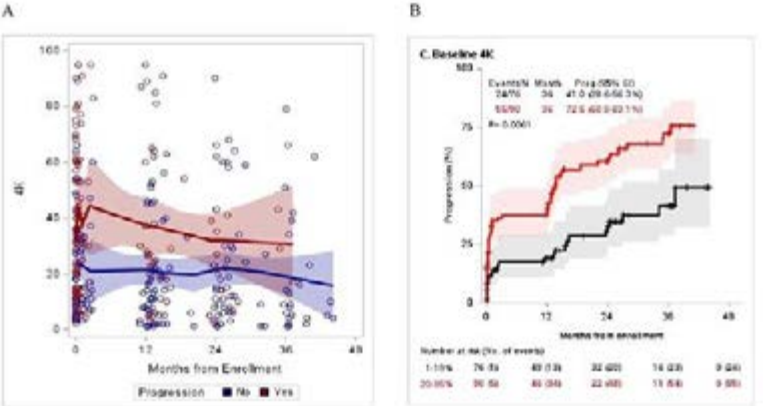

Figure 1. A: Scatterplot of 4K score of patients over study period by progression status and LOESS fitted local regression curves, via LOESS procedure, with corresponding 95% confidence intervals (shaded areas). Red circles indicate progressed over course of study, blue indicates did not progress. B: Cumulative incidence of progression rate by baseline 4K of 1-19% vs. =>20% estimated by Kaplan-Meier method.

Funding: N/A

Podium #75

RADIOGRAPHIC PROGRESSION IN THE ABSENCE OF PROSTATE-SPECIFIC ANTIGEN (PSA) PROGRESSION IN PATIENTS WITH METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): POST HOC ANALYSIS OF ARCHES

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Presented By: Russell Z. Szmulewitz, MD

Introduction: Enzalutamide (ENZA) + androgen deprivation therapy (ADT) significantly reduced the risk of radiographic progression and increased overall survival in men with mHSPC, regardless of baseline PSA levels (ARCHES; NCT02677896). This *post hoc* analysis investigated concordance between PSA progression and radiographic progression in patients with mHSPC.

Methods: Patients with mHSPC (n=1150) were randomized 1:1 to ENZA (160 mg/day) + ADT or placebo (PBO) + ADT. The concordance between radiographic progression

and PSA progression, as defined by Prostate Cancer Clinical Trials Working Group 2 (PCWG2) criteria, and between any rise in PSA above nadir, was assessed.
Results: In total, 267/1150 patients in ARCHES had radiographic progression (ENZA + ADT, n=79; PBO + ADT, n=188). At radiographic progression, the median (range) PSA for ENZA + ADT-treated patients was 2.25 ng/mL (0–1062.3 ng/mL) and 17.47 ng/mL (0–1779.5 ng/mL) for PBO + ADT-treated patients. Most patients (67%) treated with ENZA + ADT did not have PCWG2-defined PSA progression at radiographic progression, while 57% of those treated with PBO + ADT did have PSA progression at radiographic progression (Table). The median absolute and percentage rise in PSA from nadir to radiographic progression was 0.77 ng/mL and 200%, respectively, for ENZA + ADT compared with 12.23 ng/mL and 367%, respectively, for PBO + ADT.
Conclusion: In this *post hoc* analysis of ARCHES, we found frequent discordance between radiographic progression and PSA progression by PCWG2 criteria or any PSA rise over nadir in patients with mHSPC treated with ENZA + ADT. Thus, regular imaging is recommended to detect radiographic progression among patients treated with potent androgen receptor pathway inhibitors, such as ENZA + ADT, as serial PSA monitoring alone may not be sufficient to detect radiographic progression in many patients.

Table: Concordance of radiographic progression and increasing PSA

n (%)	ENZA + ADT (n=79)	PBO + ADT (n=188)
PSA progression[a] at time of radiographic progression[b]		
Yes	26 (32.9)	108 (57.4)
No	53 (67.1)	80 (42.6)
Any rise in PSA from nadir at time of radiographic progression[b]		
Yes	52 (65.8)	160 (85.1)
No	27 (34.2)	28 (14.9)

ADT=androgen deprivation therapy; ENZA=enzalutamide; PBO=placebo; PSA=prostate-specific antigen.

[a]PSA progression is defined as a ≥25% increase and an absolute increase of ≥2 ng/mL above the nadir, confirmed by a second consecutive value at least 3 weeks later; [b]Radiographic progression was assessed by independent central review or death (defined as death from any cause within 24 weeks from study drug discontinuation), whichever occurred first.

Funding: Pfizer and Astellas Pharma, the co-developers of enzalutamide.
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Podium #76

NOVEL GENES MUTATIONS IN SMOKING-ASSOCIATED PROSTATE CANCER

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Presented By: Mohammed Salah Al-Toubat

Introduction: Tobacco smoking has been established as a risk factor for various cancers, representing one of the most important modifiable risk factor. However, association between smoking and prostate cancer (PCa) remains unclear. We compared gene mutations using a next generation sequencing (NGS) database of smokers and non-smokers with prostate cancer.
Methods: Data is derived from the American Association for Cancer Research Project Genomics Evidence Neoplasia Information Exchange (GENIE) registry. The GENIE registry contains sequenced tumor samples and clinical data across many cancers. We included 1832 men with PCa in our cohort , categorized as smokers and non/never smokers and compared the frequency of mutations (point mutations, copy number variations and structural variants) of 47 number genes between the two categories. We also studied the association of the novel gene mutations with overall survival. We used univariate and multivariate logistic regression analysis to identify factors associated with mortality.
Results: A majority of men in the cohort,1007 (55%) patients were non-smokers and the remaining 825 (45%) were smokers. Patients with a smoking history had a higher percentage of somatic mutations in PREX2 ($p = 0.018$), PTEN ($p = 0.02$), AGO2 ($p = 0.03$), and KMT2C ($p = 0.04$) compared to non-smokers. In contrast, non-smokers had a higher percentage of somatic mutations in APC ($p = 0.02$) and KMT2A ($p = 0.04$) compared to smokers. The mortality rate was significantly higher among the smoker population ($p = 0.006$). The presence of metastatic disease at the time of diagnosis (OR 2.26,$p < 0.001$), smoking history (OR 1.32, $p = 0.02$), and PTEN somatic gene mutation (OR 1.89,$p < 0.001$) were independent predictors of mortality among patients diagnosed with PCa. (Table1)
Conclusion: PCa patients with a tobacco smoking history had significantly higher somatic mutations of PREX2, KMT2C, AGO2, and PTEN genes. Moreover, PTEN somatic gene mutation is linked to mortality among patients with PCa. The data could be used in future studies for biomarker development and novel therapeutics.

Table1. Independent predictors of mortality in PCa patients

Variable	OR. (95% CI)	p value
Age at time of diagnosis (years)	1.0 (0.99-1.02)	0.34
PSA (ng/mL)	1.0 (0.99-1.0)	0.65
Metastatic disease	2.26 (1.78-2.89)	<0.001
Smoking history	1.32 (1.05-1.65)	0.012
PTEN	1.89 (1.46-2.45)	<0.001

Funding: N/A

Podium #77

COMPARING THE INCIDENCE OF INCISIONAL HERNIAS FOLLOWING SINGLE-PORT VERSUS MULTI-PORT ROBOTIC-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY

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Presented By: John Corbin Norton, MD,MPH

Introduction: Prostate cancer is the second most common cause of cancer death of men in the United States. Radical prostatectomy is a common curable treatment for localized prostate cancer. Incisional hernias from extraction sites are a recognized potential complication of multi-port robotic-assisted radical prostatectomy (MP-RALP). Regarding single-port RALP (SP-RALP), the occurrence of incisional hernias has not been well described. The aim of this study was to compare the rate of incisional hernias among patients who recently underwent SP-RALP vs MP-RALP and to describe patient demographic and surgical factors that may contribute to developing this complication.
Methods: Retrospective, single-institution review of 397 RALP procedures from January 2019 to April 2022. Of these, a total of 365 patients (301 SP-RALP and 64 MP-RALP) underwent primary RALP via a trans-peritoneal approach were included for analysis. Patient demographics, surgical parameters such as operating room time, estimated blood loss, and postoperative outcomes as well as pathology and tumor characteristics were recorded. Statistical analysis was performed via t-test, Man-Whitney U, Fisher Exact, and Chi-Square.
Results: The majority of patients were Caucasian (n=239, 65.5%) and between 60-69 years of age (n=185, 50.7%). The overall incidence rate of incisional hernias was 6.58% (n=24). No significant difference in the rate of incisional hernias (6.98% vs 4.69%) between SP-RALP and MP-RALP was observed (p=0.502). There was no major difference in age (p=0.379), BMI (p=0.450), prostate size (p=0.772), pathologic grade (p=0.769), T-stage (p=0.161), or lymph node involvement (p=0.617) between SP-RALP vs MP-RALP patients. The MP-RALP cohort had higher estimated blood loss (p<0.001), longer operating room time (p<0.001), and longer length of stay (p<0.001) than patients who underwent SP-RALP. Within the SP-RALP cohort, men who developed incisional hernias had higher average BMIs than those who did not (32.36 vs 29.77), though not significant (p=0.027).
Conclusion: This study represents one of the largest high-volume, single-institution analyses of SP-RALP to date with a total of 301 patients. The overall rate of incisional hernias following RALP was 6.58% but there was no major difference in the rate of incisional hernias when comparing the SP-RALP (6.97%) to the MP-RALP (4.69%). Patients with higher BMIs were associated with an increased incidence of developing post-operative incisional hernias.

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Table 1: Single-Port vs Multi-Port Robotic Assisted Laparoscopic Prostatectomy Summary Statistics

	Single-Port (n=301)	Multi-port (n=64)	P-Value
Ethnicity	N (%)	N (%)	**0.006**
Caucasian	206 (0.68)	33 (0.52)	
African American	87 (0.29)	31 (0.48)	
Unk	8 (0.03)	0 (0.00)	
Incisional Hernia	N (%)	N (%)	0.502
Yes	21 (0.07)	3 (0.05)	
No	280 (0.93)	61 (0.95)	
Pathologic Grade	N (%)	N (%)	0.769
GG1	13 (0.04)	3 (0.05)	
GG2	168 (0.56)	41 (0.64)	
GG3	72 (0.24)	12 (0.19)	
GG4	9 (0.03)	1 (0.02)	
GG5	39 (0.13)	7 (0.11)	
Pathologic T-stage	N (%)	N (%)	0.161
pT2	115 (0.38)	32 (0.50)	
pT3a	146 (0.49)	23 (0.36)	
pT3b	40 (0.13)	9 (0.14)	
Pathologic N-stage	N (%)	N (%)	0.617
N0	216 (0.72)	42 (0.66)	
N1	16 (0.05)	4 (0.06)	
Nx	69 (0.23)	18 (0.28)	
Length of Stay	N (%)	N (%)	**<0.001**
Same-day Discharge	45 (0.15)	1 (0.02)	
POD1	233 (0.77)	47 (0.73)	
POD2+	23 (0.08)	16 (0.25)	
	Mean (S.D)	Mean (S.D)	
BMI (kg/m^2)	29.95 ±5.19	30.5 ±5.72	0.450
Age (yr)	64.48 ±7.38	63.97 ±5.87	0.604
EBL (mL)	148.29 ±103.59	216.95 ±155.33	**<0.001**
OR Time (min)	241.39 ±52.12	293.83 ±61.34	**<0.001**
Lymph Node Yield†	13.02 ±6.71	15.63 ±7.97	**0.020**
Prostate Weight (g)	55.14 ±20.26	55.96 ±21.90	0.772

Abbreviations: Number (N), Standard Deviation (S.D.), Body Mass Index (BMI), Estimated Blood Loss (EBL), Operating Room Time (OR Time), Grade Group (GGx), Post-op Day (POD)

†Total of 278 patients of 365 (76.2%) underwent pelvic lymph node dissection. Of which 232 patients within the single-port cohort (77.1%) and 46 within multi-port cohort (71.9%) had lymph node data to analyze.

Funding: N/A

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Podium #78

ANESTHETIC BLADDER CAPACITY AS A BENCHMARK FOR THE BLADDER-CENTRIC PHENYTOPE IN INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME

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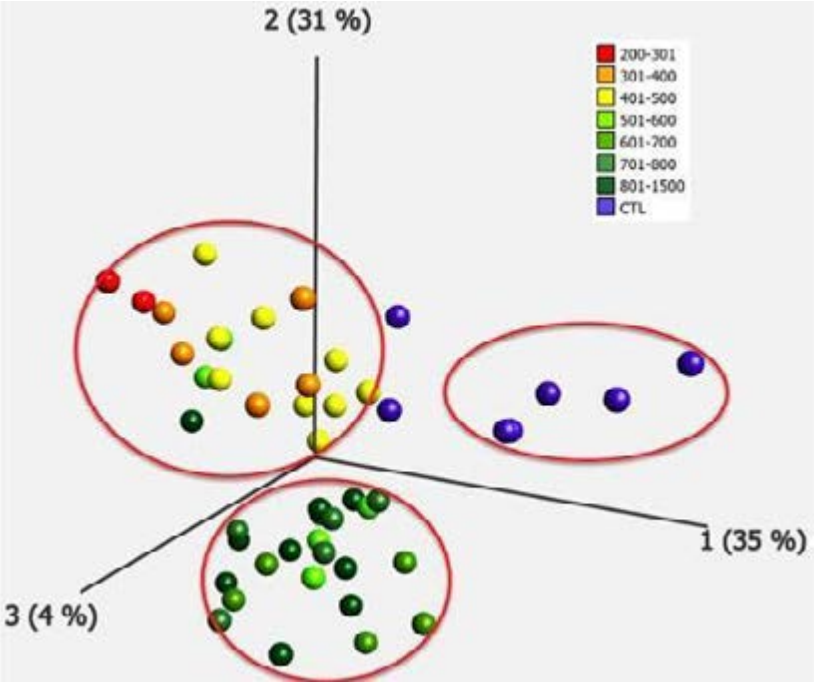
Presented By: Dylan Thomas Wolff, MD

Introduction: Interstitial cystitis/bladder pain syndrome (IC/BPS) is a chronic condition that is difficult to diagnose and treat. The highly heterogeneous symptom profile, together with the lack of clear understanding regarding disease etiology, contribute to these challenges. In our ongoing efforts to stratify patients into clinically meaningful subgroups we had previously suggested, based on a modest amount of molecular data, that patients with an anesthetic bladder capacity (BC) ≤ 400cc represent a bladder-centric IC/BPS phenotypic subgroup. In this study we revisit this hypothesis by leveraging data from a significantly larger patient cohort.
Methods: IC/BPS patients undergoing therapeutic hydrodistention were prospectively recruited for this IRB-approved study. Mucosal biopsies and clinical/demographic data including BC, HL status, scores on validated IC/BPS symptom scores (IC Symptom & Problem Indices [ICSI/ICPI], and Pain & Urgency/Frequency [PUF]), and data on common non-urologic associated symptoms (NUAS) were collected for each patient. Whole genome gene expression data from 48 mucosal biopsy samples (41 IC/BPS; 7 controls) were used to identify patient subgroups. Next, clinical data from an additional 491 patients in our patient registry were analyzed in the context of the newly generated molecular data to further refine the bladder-centric phenotype.
Results: Unsupervised clustering and principal component analysis (PCA) of 48 transcriptomic profiles identified three individual clusters: (1) IC/BPS with BC 200-500cc, (2) IC/BPS with BC 501-1500cc, and (3) controls (no IC/BPS) (Figure 1). Combining these 48 with data from 491 registry patients, we found those with a BC ≤ 500cc (i.e., low BC) were older, more likely to be HL+, had higher symptom scores, and had a shorter length of diagnosis than those with a BC > 500mL (i.e., non-low BC) ($p<0.05$). Patients in the low BC group also had a lower average number of NUAS, including lower rates of endometriosis, pelvic floor muscle dysfunction, irritable bowel syndrome (IBS), chronic fatigue syndrome (CFS), fibromyalgia, migraines, depression, panic disorder, insomnia, and asthma.
Conclusion: Analysis of this combined molecular and clinical data set provide a rational basis for the designation of bladder-centric and non-bladder centric subgroups within the IC/BPS patient population, and we conclude that an anesthetic BC ≤ 500cc suggests a bladder-centric phenotype



Funding: NIDDK 1R01DK124599-01

Podium #79

ENGINEERING OF VOLUMETRIC SKELETAL MUSCLE TISSUE FOR ACCELERATED RESTORATION OF PELVIC FLOOR MUSCLE FUNCTION

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Presented By: John D. Jackson, PhD

Introduction: Damages in the pelvic floor muscles often cause dysfunction of the entire pelvic urogenital system. Current treatments for the injury include physical therapy, autologous muscle flap transfer, and surgical interventions using synthetic and biological materials. However, none entirely addresses the problems associated with long-term restoration of normal anatomy and function in the injured pelvic floor muscle system. The engineering of functional muscle tissue constructs may provide a solution to this unmet medical need. However, the current muscle engineering techniques are limited by the ability to build sizable constructs with timely innervation for successful graft survival. To this end, this study aims to fabricate and optimize volumetric 3-D bioprinted skeletal muscle constructs with innervation capability for repairing pelvic floor muscle injuries.
Methods: Bioprinted skeletal muscle constructs that mimic native skeletal muscle organization were fabricated using a 'bioink' formulation consisting of fibrin-based hydrogel containing human muscle progenitor cells. Agrin was treated to the bioprinted muscle construct to pre-form acetylcholine receptor (AChR) clusters on the muscle cells. Muscle tissue formation, accelerating innervation, and histological and functional restoration were investigated in a pelvic floor muscle injury in rats.
Results: 3-D bioprinted muscle constructs showed high cell viability with aligned muscle fiber formation and AChR clusters pre-formation during *in vitro* culture. In a rat model of pelvic floor muscle injury, implantation of skeletal muscle constructs containing the

pre-formed AChR clusters resulted in functional muscle reconstruction with accelerated construct innervation.
Conclusion: This approach may provide a therapeutic solution to the many challenges associated with pelvic floor reconstruction resulting from the lack of suitable bioengineered tissue for efficient innervation and muscle function restoration.
Funding: DoD AFIRM II

Podium #80

THE IMPACT OF WEIGHT GAIN OR LOSS ON SUCCESS AFTER MIDURETHRAL SLING SURGERY: A LONGITUDINAL ANALYSIS

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Presented By: Ann Stolzle, BS

Introduction: While weight loss is an effective modifier for women with stress incontinence (SUI), the impact of weight gain or loss on sustained stress continence after definitive midurethral sling (MUS) has not been evaluated. We aim to assess the effects of postoperative weight change on SUI cure after retropubic (RP) and transobturator (TO) MUS.
Methods: We performed an IRB-approved, retrospective chart review of women who underwent MUS at our institution. Inclusion criteria included body-mass index (BMI) at preoperative assessment and at last follow-up and a 12-month minimum follow-up. Pelvic exam and quality of life assessment was conducted at each visit. SUI resolution was defined as absence of subjective or objective SUI and no additional procedures for SUI.
Results: We included 1500 women in our analysis (1063 RP, 437 TO). Mean age at surgery was 52.1 years and mean follow-up was 44 months. Of the entire cohort, 1092 (72.8%) achieved resolution of SUI. Over the follow-up period, 1065 (71%) either maintained or lost weight. For the entire cohort, those with SUI resolution had a mean reduction in BMI from 29.5 to 29.2 during follow-up (-0.3), while those with persistent/recurrent SUI had a mean increase from 30.3 to 30.6 (+0.3; $p<0.01$). This relationship between SUI resolution and ΔBMI was consistent for both RP and TO groups, as well as when BMI was stratified into classes (Table). In the obese cohort (BMI>30), there was a significant association between greater weight loss during follow-up (negative ΔBMI) and maintaining stress continence, for both RP and TO slings.
Conclusion: Weight loss during follow-up may be associated with maintenance of stress continence while weight gain may be associated with persistent or recurrent SUI after either RP or TO MUS surgery. While it is unclear whether the amount of actual weight lost or gained was clinically significant in either the obese or non-obese groups, women undergoing MUS should be counseled that postoperative weight maintenance or loss may confer a beneficial effect on eventual stress continence.

		Initial BMI					
MUS	SUI Resolution	<25	25-29.9	30-34.9	35-39.9	≥40	All
All	No (n)	84	133	104	54	33	408
	ΔBMI	+0.28	+0.30	+0.32	+0.11	0.66	+0.31
	Yes (n)	267	371	257	130	67	1092
	ΔBMI	-0.10	-0.27	-0.45	-0.50	-0.76	-0.33
RP	No (n)	54	101	80	39	26	300
	ΔBMI	+0.33	+0.30	+0.31	+0.20	+0.39	+0.30
	Yes (n)	195	251	186	90	41	763
	ΔBMI	-0.06	-0.15	-0.40	-0.52	-0.79	-0.27
TO	No (n)	30	32	24	15	7	108
	ΔBMI	+0.19	+0.30	+0.33	-0.11	+1.67	+0.31
	Yes (n)	72	120	71	40	26	329
	ΔBMI	-0.19	-0.50	-0.60	-0.47	-0.72	-0.47

Key: BMI, body mass index; MUS, midurethral sling; ΔBMI, net change in BMI; RP, retropubic; TO, transobturator

Funding: N/A

Podium #81

TRENDS IN VAGINAL NATIVE TISSUE VS ABDOMINAL MESH AUGMENTED REPAIR FOR APICAL PELVIC ORGAN PROLAPSE BETWEEN UROLOGISTS AND GYNECOLOGISTS OVER 10 YEARS

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Presented By: Rahul Dutta, MD

Introduction: Apical pelvic organ prolapse (APOP) is treated surgically by both urologists and gynecologists from both abdominal mesh-augmented sacrocolpopexy (ASCP) and apical vaginal native tissue repair (AVNTR) approaches. Given the differences in surgical training between the two specialties, we hypothesized that their approaches to management of APOP would differ.
Methods: The prospectively maintained National Surgical Quality Improvement Program (NSQIP) database was queried for both ASCP (CPT 57280, 57425) and AVNTR (CPT 57265, 57268, 57282, 57283) performed by both urologists and gynecologists. Vaginal mesh-based repairs were excluded given the FDA ban. Demographics and operative details were retrieved. Trends in repair type utilization between the specialties were analyzed.
Results: A total of 15,736 cases of APOP repair (53% AVNTR, 47% ASCP) from 2010-2019 were included, 12% of which were done by urologists. Urologists tended to operate on older (66 vs 63 years) patients with higher ASA score (33% vs 25% ASA III) ($p<0.0001$ for both). Mean BMI was 28 and did not vary by specialty. Urologists performed significantly more ASCP relative to AVNTR (72% vs 43%, $p<0.0001$) and both specialties tended to perform them laparoscopically (84% urology 78% gynecology) ($p<0.0001$). There was no significant change over the 10-year timeframe in the relative utilization of ASCP vs VNTR for gynecologists ($p>0.05$), while urologists have been performing more ASCP ($p=0.0311$). Urologists were less likely to perform any concomitant vaginal native tissue repair during ASCP (17% vs 38%, $p<0.0001$) and had a similar likelihood of placing a concomitant urethral sling (29% vs 30%, $p>0.05$) to gynecologists. Laparoscopic ASCP is being more frequently performed over time for both specialties relative to open

(p<0.0001). There has been a significant trend towards more concurrent VNTR during ASCP amongst gynecologists (p=0.0005) but not urologists (p>0.05). Midurethral sling placement during APOP repair has not varied significantly over time (p>0.05).
Conclusion: Urologists perform a minority of APOP repairs and tend to favor abdominal sacrocolpopexy over vaginal native tissue repair. Urologists are less likely to perform concurrent vaginal repairs during abdominal sacrocolpopexy than gynecologists. Laparoscopic sacrocolpopexy is being more frequently utilized for all specialties treating APOP.
Funding: N/A

Podium #82

SINGLE-INCISION MINISLINGS IN 2022: A META ANALYSIS

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Presented By: Ann Stolzle, BS

Introduction: The TVT-Secur, which comprised many of the randomized controlled trials (RCTs) in the 2017 Cochrane Review of single-incision minislings (SIMS), has since been withdrawn from the market. Our purpose is to review the emerging RCTs in which SIMS comprises at least one of the trial arms.
Methods: A comprehensive PubMed search was performed, and several reviewers independently assessed the quality of the studies and extracted data. Study exclusion criteria included: abstract only, non-English language publication, minimum follow-up <6 months, and TVT-Secur as the sole other trial arm. A meta-analysis of surgical outcomes and adverse postoperative sequelae was performed.
Results: Literature search yielded 31 unique data sets (research groups) and 43 RCTs. SIMS comprising at least one arm included: Ajust, Altis, Contasure Needleless, EFA, MiniArc, Ophira, TFS, and TVT-Abbrevo. While all studies were randomized, there was significant variation in study design, allocation concealment, blinding of outcome assessment, and handling of incomplete data sets. There was also significant variation in inclusion/exclusion criteria, outcome criteria, and adverse event reporting. In all, 2844 women had a SIMS in at least one study arm. Six studies either had a combination of two SIMS or two MUS in a trial arm, or two separate SIMS individually compared to one MUS. Objective and subjective outcomes stratified by length of follow-up and comparison device are summarized in the Table. Only one study reported outcomes at >48 months. Most of the comparisons were SIMS vs. transobturator midurethral slings (MUS), with only four data sets comparing SIMS and retropubic MUS. Overall, SIMS were non inferior to other MUS procedures and no one SIMS was associated with significantly better outcomes. Rates of *de novo* urgency and urgency incontinence, long-term pain, vaginal mesh exposure, and repeat surgery were low and were not significantly different between groups.
Conclusion: Short- and medium-term results from RCTs suggest that SIMS are safe and non-inferior to other MUS. The majority of the comparisons are between SIMS and transobturator MUS and significant variations in study design make grouping of outcomes challenging.

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Follow-Up	Success	SIMS vs. SIMS		SIMS vs. TO MUS		SIMS vs. RP MUS		Total	
		SIMS (1)	SIMS (2)	SIMS	TO MUS	SIMS	RP MUS	SIMS	MUS
<12m	Objective	2 Studies		19 Studies		4 Studies (*)		25 Studies	
		116/131 88.5%	171/177 96.6%	1079/1246 86.6%	1036/1171 88.5%	259/288 89.9%	269/279 95.7%	1454/1665 87.3%	1476/1627 90.7%
	Subjective	2 Studies		17 Studies		4 Studies		23 Studies	
		103/131 78.6%	152/177 85.9%	1012/1199 84.4%	988/1140 86.7%	185/284 64.4%	199/274 72.6%	1298/1614 80.4%	1339/1591 84.2%
12-48 m	Objective	2 Studies		6 Studies		1 Study		9 Studies	
		66/72 91.7%	107/116 92.2%	399/493 80.9%	386/460 83.9%	75/87 86.2%	64/79 81%	540/652 82.8%	557/655 85%
	Subjective	3 Studies		6 Studies		3 Studies		12 Studies	
		91/112 81.3%	138/156 88.5%	404/480 84.2%	386/450 85.6%	250/383 65.3%	237/366 64.8%	745/975 76.4%	761/972 78.3%
Total	Objective	4 Studies		25 Studies		5 Studies		34 Studies	
		182/203 89.7%	278/293 94.9%	1478/1739 83.3%	1422/1631 87.2%	334/375 89.1%	333/358 93%	1994/2317 86.1%	2033/2282 89.1%
	Subjective	5 Studies		23 Studies		7 Studies		35 Studies	
		194/243 79.8%	290/333 87.1%	1404/1679 84.3%	1374/1590 86.4%	433/667 64.9%	436/640 68.1%	1043/1589 78.9%	1590/1963 81.9%

*: Includes one study comparing SIMS to rectus fascia sling

Funding: N/A

Podium #83

VOIDING HABITS AND SOCIAL DETERMINANTS OF HEALTH AMONG INDIVIDUALS WITH RECURRENT URINARY TRACT INFECTIONS

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Presented By: Natalie M. Pace, MD, MSC

Introduction: Recurrent urinary tract infections (rUTIs) produce significant personal and economic burdens such as absenteeism from work and social events. Known risk factors include female gender, age, urinary procedures and catheterization. Some data suggest that infrequent voiding is another risk factor, however the data supporting this mostly comes from the pediatric literature (1). We aimed to evaluate sociodemographic characteristics, social determinants of health and voiding habits among adults with rUTIs to determine risk factors.

Methods:
3,907 people living in the U.S. were electronically recruited with ResearchMatch to answer questionnaires on unmet social needs and urinary symptoms (LURN S-10). Respondents were excluded if they were currently pregnant, had a history of cystectomy, reported bladder catheterization or any known neurogenic bladder dysfunction. Respondents self-reported a history of rUTIs defined as 3 or more symptomatic UTIs in one year requiring antibiotic treatment. Infrequent voiding was defined as voiding less than 3 times a day. Sociodemographic characteristics, social determinants of health, voiding habits and urinary symptoms were compared between those with and without a history of rUTIs. Multivariable logistic regression was performed to determine possible risks factors for rUTIs.

Results: Among respondents, 283 (7.2%) reported history of rUTIs. Patients with rUTIs were younger (mean 46.3 years, p=0.01), female, identified as white, non-Hispanic, had lower educational attrition, lived below the US poverty line, more often on disability and using Medicare or Medicaid (Table). Additionally, participants with rUTIs reported more unmet social needs than those without. Those with rUTIs reported more severe urinary symptoms on LURN SI-10, however, there was no association with infrequent voiding. On multivariable regression after adjusting for confounders, female gender and a cumulative effect of increasing unmet social needs remained significant. Infrequent voiding was not significantly associated with rUTIs.

Conclusion: Infrequent voiding was not associated with rUTI in this study, however there is a strong association with social determinants of health. Our findings suggests that clinicians should address unmet social needs when treating patients with rUTIs.

References:
1. Jagtap, S. *et al.* Comprehensive assessment of holding urine as a behavioral risk factor for UTI in women and reasons for delayed voiding. *BMC Infect Dis* **22**, 521 (2022).

Table		Univariate				Multivariate	
		Total	rUTI	No rUTI	p-value	aOR	p-value
Participants (%)		3907	283 (7.2)	3624 (92.8)			
Mean age, years (SD)		48.8 (17.4)	46.3 (15.5)	49.0 (17.5)	0.01	0.99 (0.98-1.01)	0.3
Mean BMI (SD)		27.6 (6.7)	27.7 (6.9)	27.6 (6.7)	0.9	0.99 (0.97-1.01)	0.4
Gender (%)					<0.001		
	Male	816 (20.9)	16 (5.7)	800 (22.1)		0.20 (0.12-0.34)	<0.001
	Female	2990 (76.5)	259 (91.5)	2731 (75.4)		Ref	
	Transgender/non-binary	93 (2.4)	8 (2.8)	85 (2.4)		0.61 (0.28-1.33)	0.2
	Unspecified	8 (0.2)	0 (0)	8 (0.2)		N/A	
Race, ethnicity (%)					0.006		
	White, Non-Hispanic	3273 (83.8)	234 (82.7)	3039 (83.9)		Ref	
	Black, non-Hispanic	201 (5.1)	9 (3.2)	192 (5.3)		0.48 (0.24-0.98)	0.04
	Hispanic	144 (3.7)	11 (3.9)	133 (3.7)		0.93 (0.48-1.79)	0.8
	Asian	132 (3.4)	6 (2.1)	126 (3.5)		0.62 (0.26-1.47)	0.3
	Multiracial	87 (2.2)	13 (4.6)	74 (2.0)		1.91 (1.02-3.61)	0.04
	Other	48 (1.2)	8 (2.8)	40 (1.1)		2.40 (1.05-5.50	0.04
	Unspecified	22 (0.6)	2 (0.7)	20 (0.6)		1.10 (0.24-5.10)	0.9
Education (%)					<0.001		
	High school diploma or less	659 (16.9)	70 (24.7)	589 (16.3)		Ref	
	Associates or Bachelor's degree	1722 (44.1)	130 (45.9)	1592 (43.9)		0.83 (0.59-1.16)	0.3
	Graduate or professional degree	1526 (39.1)	83 (29.3)	1433 (39.8)		0.69 (0.47-1.00)	0.05
Below 2021 poverty guideline (%)		209 (5.4)	32 (11.3)	177 (4.9)	<0.001	1.42 (0.88-2.30)	0.1
Health Insurance (%)					0.001		
	Uninsured	256 (6.6)	13 (4.6)	243 (6.7)		Ref	
	Medicaid	266 (6.8)	35 (12.4)	231 (6.4)		2.05 (1.02-4.14)	0.04
	Medicare	477 (12.2)	40 (14.1)	437 (12.1)		2.94 (1.39-6.19)	0.004
	Private	477 (12.2)	40 (14.1)	2039 (56.3)		1.47 (0.79-2.73)	0.2
	Government† + Private	378 (9.7)	24 (8.5)	354 (9.8)		2.53 (1.16-5.52)	0.02
	Military	59 (1.5)	7 (2.5)	52 (1.4)		3.40 (1.24-9.34)	0.02
	Other	295 (7.6)	27 (9.5)	268 (7.4)		2.29 (1.07-4.83)	0.03
Number unmet social needs					<0.001		
	None	2581 (66.1)	133 (47)	2448 (67.6)		Ref	
	1	706 (18.1)	60 (21.2)	646 (17.8)		1.56 (1.12-2.16)	0.008
	2	263 (6.7)	24 (8.5)	239 (6.6)		1.55 (0.97-2.50)	0.07
	3+	357 (9.1)	66 (23.3)	291 (8.0)		3.36 (2.29-4.94)	<0.001
Median LURN score (IQR)		5.1 (2.5, 7.6)	8.9 (5.1, 11.4)	5.1 (2.5, 7.6)	<0.001		
Infrequent voiders (%)		509 (13.0)	43 (15.2)	466 (12.9)	0.3	11.1 (0.78, 1.60)	0.6

†Medicaid/Medicare and Private

Funding: UL1 TR000445 from NCATS/NIH

Podium #84

NATIVE TISSUE ANTERIOR SACROSPINOUS HYSTEROPEXY IS AN EFFECTIVE AND SAFE APPROACH FOR PRIMARY UTEROVAGINAL PROLAPSE COMPARED TO MESH-AUGMENTED REPAIR.

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Presented By: Tyler Lynne Overholt, MD, BS

Introduction: An anterior approach to sacrospinous hysteropexy was popularized by transvaginal mesh kits. Following mesh kit market withdrawal, we hypothesized similar efficacy could be achieved through native tissue reattachment of the pubocervical fascia to the cervix with fixation of the anterior cervix to the sacrospinous ligament. Few comparative analyses exist for the efficacy of anterior sacrospinous hysteropexy using native tissue versus mesh-augmented repair.
Methods: A retrospective cohort analysis of women who underwent transvaginal sacrospinous hysteropexy at a tertiary center between 01/01/2016-12/31/2021 was performed. Women underwent mesh-augmented repair using the Uphold Lite Vaginal

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Support SystemTM or a native tissue anterior sacrospinous hysteropexy. Demographics, clinical/urogynecological history, and intra/post-operative data were reviewed. Composite success was defined as: no subjective bulge symptoms, no prolapse retreatment, and no recurrent prolapse beyond the hymen with apex non-descended > 1/3 the total vaginal length. Descriptive and bivariate statistics were performed as indicated.

Results: Ninety-seven women (40 mesh-augmented; 57 native-tissue) met inclusion criteria and were compared. There were no differences in age (0.095), BMI (0.347), or vaginal delivery history (0.711) between groups. The median pre-operative POP-Q was stage III for all women. Those in the mesh-augmented group were more likely to have undergone a prior prolapse (p=0.003) or intra-abdominal (p=0.015) surgery. There were no differences in surgical times (p=0.211) or ASA classification (p=0.211) between groups (Table 1). The median post-procedure follow-up time was 8.2 months. The composite success rate was 95% for all women (Table 1). Anatomic success was demonstrated in 100% of patients. Vaginal bulge symptoms were reported by 2 women in the mesh-augmented group compared to 3 in the native tissue group (p=0.999). One woman in the mesh-augmented group underwent re-treatment (pessary) compared to 3 women in the native tissue group (2 pessary, 1 surgery; p=0.639). There were no differences in intra-operative (p=0.999) or 30-day post-operative (p=0.775) complication rates between groups (Table 1).

Conclusion: Ninety-five percent of women who underwent an anterior approach sacrospinous hysteropexy achieved surgical success and the use of mesh-augmentation did not confer any added benefit in terms of efficacy or complications when compared to native tissue only. Further long-term data is needed to continue our assessment of native tissue anterior sacrospinous hysteropexy.

Table 1. Operative, complication, and follow up data for patients who underwent mesh-augmented versus native tissue anterior sacrospinous hysteropexy. P-value < 0.05 determined statistical significance.

	Mesh-augmented N=40	Native tissue N=57	P-Value
Intra-operative data			
Concomitant Anterior Repair	40 (100%)	54 (94.7%)	0.266
Concomitant Posterior Repair	35 (87.5%)	45 (78.9%)	0.416
Concomitant Sling Placement	22 (55.0%)	24 (42.1%)	0.211
Intra-operative Complications	0	Urethral injury: 1 Blood transfusion: 1 Ureteral injury: 1	0.999
ASA Score	1: 1 2: 18 3: 21 4: 0 5: 0	1: 0 2: 35 3: 22 4: 0 5: 0	0.325
Surgery Time (minutes)	102.4 ± 31.4	109.8 ± 19.6	0.124
Follow Up Data			
Thirty Day Complications	Urinary tract infection: 1 Non-UTI Infection: 1 Hematoma: 2 Blood transfusion: 1 Emergency Visit: 1 Re-operation: 0 Sepsis: 0	Urinary tract infection: 1 Non-UTI Infection: 3 Hematoma: 3 Blood transfusion: 1 Emergency Visit: 0 Re-operation: 1 Sepsis: 2	0.775
Subjective Success (No bulge symptoms)	38 (95.0%)	54 (94.7%)	0.999
Post-operative POP-Q Stage	Stage 0: 35 Stage I: 15 Stage II: 7 Stage III: 0 Stage IV: 0	Stage 0: 23 Stage I: 13 Stage II: 4 Stage III: 0 Stage IV: 0	0.349
Anatomic success	40 (100.0%)	57 (100.0%)	1
Re-treatment for Prolapse	Pessary: 1 Repeat Surgery: 0	Pessary: 2 Repeat Surgery: 1	0.639

Funding: N/A

POSTERS

Poster #1

ASSOCIATION OF DAY OF SURGERY WITH LENGTH OF STAY AND OUTCOMES IN PATIENTS UNDERGOING ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY IN A TERTIARY CENTER

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Presented By: Daniela Andrea Haehn, MD

Introduction: To analyze the association between days of the week that surgery was performed with prolonged length of stay (LOS) after robotic-assisted partial nephrectomy (RAPN) in a tertiary care center.
Methods: We analyzed 536 patients who underwent RAPN at our institution. Data was obtained from a database of RAPN performed at our institution. Comparisons were made based on the day of surgery Monday-Wednesday, and Thursday/Friday. For this analysis, we collected the following demographic data and perioperative information: age, sex, race, BMI (Body Mass Index), preoperative and postoperative GFR (Glomerular Filtration Rate), day of the week when surgery was performed, and date of discharge. LOS was defined as ≥3 days in the hospital. Wilcoxon rank sum test for continuous characteristics and Fisher's exact test for categorical characteristics were used for statistical analysis.
Results: Out of five hundred and sixty-three patients, 380 (67%) patients had the procedure performed between Monday-Wednesday, and 183 (33%) had a RAPN performed on Thursday/ Friday. When compared patients who underwent RAPN on Monday-Wednesday with those who underwent RAPN on Thursday/Friday, there was no difference in age (63.3 years old vs. 61.2 years old, p=0.399), race, sex, and or comorbidities such as BMI (30.1 vs. 28.7), hypertension [228 (60%) vs.110 (60%)], diabetes [72 (19%) vs. 3 (20%)], cardiovascular disease [261 (69%) vs.114 (63%)], and GFR [Median (IQR); 4.0 (12-126) vs. 78 (15-132)], all P>0,05. However, patients who underwent surgery on Thursday/Friday were more likely to have a prolonged LOS [81 (44%) vs. 133 (35%), p 0.004] due to medical reasons [48 (59%) vs. 71 (53%), p<0.001]. There was no evidence of a difference in 30-day readmission, p=0.994.
Conclusion: Day of the week impacts patients' LOS after RAPN. This could be explained by the lack of support personnel in different services during the weekend. Further studies are required to better evaluate this.
Funding: N/A

Poster #2

AN UPDATE ON PROFESSIONAL BURNOUT AND CONFLICT-WORK FROM THE AUA WORKFORCE WORKGROUP

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Presented By: Seth Teplitsky, MD

Introduction: Urologists are experiencing burnout at an alarming rate. With this, the American urologic Association (AUA) has continued to collect various pertinent workforce metrics in the annual census. Here the AUA Workforce Workgroup compares the latest data collected in the census related to burnout, comparing these metrics over time.
Methods: The AUA Workforce Workgroup examined the annual census results since 2016. The AUA sends out an annual census to all practicing urologists. The census works to collect demographic and geographic data, in addition to collecting answers to other pertinent questions from practicing urologists. Particular to this study, burnout related

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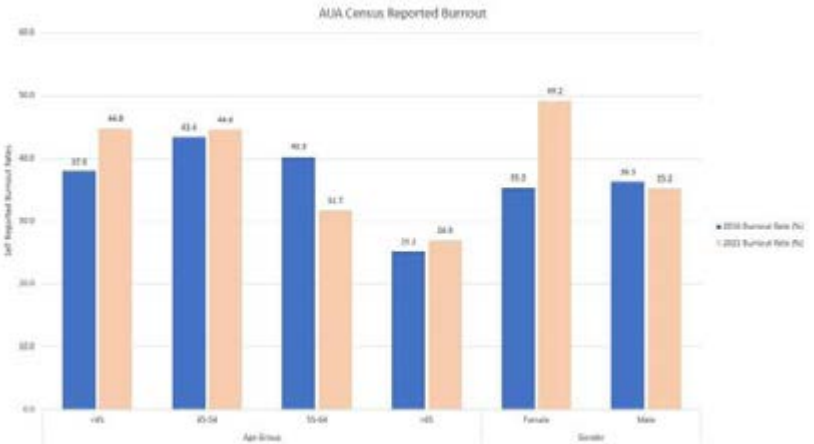
data was examined from the past 5 years. Examined metrics included burnout assess across age and gender, effect of COVID on burnout, work-personal life conflict across demographic groups.

Results: In 2021, 36.7% of urologists report burnout compared to 36.2% in 2016. When assessing by gender, burnout in men decreased from 36.3% to 35.2%, but increased in women from 35.3% to 49.2%. When examined by age, the largest increases in burnout were seen in the <45 years old group, increasing from 37.9% to 44.8%, followed by 45-54 years old, 43.4% to 44.6%. Those over age 55 either had a decrease or stable burnout. When asked about the effect of COVID-19 on burnout, 54% of urologists didn't feel COVID-19 impacted burnout. When considering work-life conflicts, 25.0% of men and 4.6% of women reported no conflict between work and personal responsibilities, while 25.7% of men and 44.7% of women resolved conflicts in favor of work or were unable to resolve them. Respondents were then asked how satisfied they were with work-life balance, where 22.5% of men, and 37.1% of women responded dissatisfied. Similarly, 33.6% of males reported their work schedule does not leave enough time for personal/family life, compared to 57.5% of females.

Conclusion: Overall, urologists have higher burnout now when compared to 2016. The gender discrepancy has vastly widened with women experiencing burnout at an increased rate compared to 2016, while burnout in men decreased. Burnout has increased the most in younger urologists, with the highest increase seen in those <45 years old. Further action is needed to substantiate the causes of burnout.



Funding: N/A

Poster #3

THE FINANCIAL TOXICITY OF UROLOGIC MALIGNANCIES

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Presented By: David Nelwan, MD

Introduction: Financial toxicity (FT) is a significant patient-reported outcome in cancer patients, but there is a paucity of data in GU cancer patients. We aim to determine the extent of FT in patients with urologic malignancies at our institution, as well as investigating potential risk factors for increased FT in these patients.

Methods: After institutional IRB approval, all patients with a history of urologic malignancy were eligible for inclusion. Participation was voluntary and without incentives/compensation. Financial toxicity was measured using the COmprehensive Score for financial Toxicity (COST) measure. Patient and cancer demographic data, including health

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insurance status, were also collected. Our statistical analysis focused on 5 questions that were most directly related to cancer/treatment (Figure 1).
A student's t-test was used for the gender analysis; ANOVA was used to analyze cancer type and insurance type. Statistical significance was considered to be $p<0.05$. Statistical analyses conducted using SPSS 27.0.1.0.
Results: A total of 104 patients were recruited to participate in the study—85 males and 19 females. Table 1 shows stratification by cancer type and insurance type, with mean Likert score per question. There was no significant difference between sexes. Differences in answers were found to be statistically significant between cancer types for Questions 1 (p=0.030) and 2 (p=0.016) but not for Questions 3 (p=0.055), 10 (p=0.279), and 12 (p=0.096). Differences in answers were found to be statistically significant between insurance types for Questions 1 (p=0.028), 2 (p=0.018), and 3 (p=0.003), but not for Questions 10 (p=0.394), and 12 (p=0.291).
Conclusion: Compared to bladder/kidney cancer, patients with prostate cancer feel more secure in their ability to cover costs of treatment, have less unexpected total out-of-pocket expenses, and have less financial worry resulting from their cancer/treatment.
The analysis indicates that those with Commercial health insurance feel the most secure in their ability to cover costs of treatment. However, they seem to have more unexpected total out-of-pocket expenses, compared to patients with Medicare and Medicare with supplemental coverage ("Medicare+"). Those with ACA/Medicaid appear to have the most financial worry related to their cancer/treatment, followed by Medicare+, Commercial, and lastly Medicare patients.

Q1	I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment
Q2	My out-of-pocket medical expenses are more than I thought they would be
Q3	I worry about the financial problems I will have in the future as a result of my illness or treatment
Q10	My cancer or treatment has reduced my satisfaction with my present financial situation
Q12	My illness has been a financial hardship to my family and me

Figure 1: The 5 questions used for this analysis, answered on a 5-point Likert scale from 0 ("not at all") to 4 ("very much")

	#	Q1	Q2	Q3	Q10	Q12
male	85	2.30	1.13	1.48	0.90	0.85
female	19	1.70	1.55	1.90	1.15	0.95
prostate	38	2.81	0.58	1.05	0.68	0.61
bladder	25	2.08	1.32	1.72	1.16	1.20
kidney	26	1.92	1.42	1.88	0.69	0.54
ureter	6	1.50	1.33	2.50	2.17	1.67
penis	0					
testis	1	4.00	2.00	0.00	0.00	0.00
2+	8	2.25	1.75	1.38	0.63	0.88
Medicare	26	2.37	0.71	0.75	0.63	0.56
Medicare+	32	1.97	1.06	1.94	0.81	0.88
Commercial	34	2.49	1.63	1.74	1.11	0.77
ACA/Medicaid	8	0.88	2.00	2.50	1.25	1.50
Tricare	3	4.00	0.00	0.00	0.00	0.00
Self-pay	1	0.00	0.00	1.00	1.00	1.00

Table 1: Stratification by cancer type and insurance type, with mean Likert score per question

Funding: N/A

Poster #4

NEIGHBORHOODS AND PENILE IMPLANTS: AN ANALYSIS OF SOCIOECONOMIC DISADVANTAGES AND THE RISK OF IPP REVISION

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Presented By: Nicholas Major, MD

Introduction: Health disparities are largely impacted by a patient's socioeconomic status. Individuals living in disadvantaged neighborhoods are at increased risk for developing certain diseases and comorbidities. However, there is still much uncertainty in how a patient's neighborhood can influence their chance of requiring a revision surgery following initial placement of an inflatable penile prosthesis (IPP).
Methods: Data was retrospectively reviewed on all patients who underwent placement of a three-piece IPP at a single institution from 1/2019 to 6/2022. Patient demographics, comorbidities, and surgical history were recorded. Geographical data was analyzed from the U.S. Census Bureau. The University of Wisconsin's Neighborhood Atlas was employed to provide each patient with an Area Deprivation Index (ADI) based on rankings of their neighborhoods on the national level by socioeconomic status. Univariate analyses and Student's T-Tests were performed to analyze the data.
Results: A total of 116 patients were included. Surgeries were performed by a single surgeon. Of the 116 patients who underwent surgery, 23.3% (n=27) underwent IPP revision surgery due to mechanical failure, 5.2% (n=6) underwent revision surgery due to IPP infection, while 71.5% (n=83) did not undergo any revision surgery. For those undergoing revision surgery due to mechanical failure, the mean time to failure was 58.5 months. The average age of patients undergoing all revision surgeries was 67.8 years, compared to 65.2 years for those who did not. The mechanical failure revision group had an average ADI percentile of 69.4 compared to a percentile of 41.3 in the non-revision group ($P<0.001$). Those who underwent revision surgery due to infection had an average ADI percentile of 66.3 ($p<0.05$).
Conclusion: Those who underwent revision IPP surgery were seen to have a significantly higher average ADI percentile compared to those who did not, indicating the potential weight of socioeconomic disadvantage and worse socioeconomic status on healthcare outcomes. This study illuminates the impact that a patient's neighborhood can have on their overall health disparities, even their risk of IPP revision surgery. Therefore, assessing these social factors and appropriately counseling vulnerable patients on their increased risks in the pre-operative arena can potentially prevent the need for reoperation following IPP implantation and work to combat certain healthcare inequalities.
Funding: n/a

Poster #5

ASSOCIATION BETWEEN MAYO ADHESIVE PROBABILITY (MAP) SCORE AND DURATION OF ROBOTIC-ASSISTED PARTIAL NEPHRECTOMIES

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Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Our objective was to evaluate the impact of a high Mayo Adhesive Probability (MAP) score on the duration of robotic-assisted partial nephrectomy (RAPN) surgical times.
Methods: A retrospective review of RAPNs performed from February 2008 through November 2021 by a single, fellowship trained urologist was performed. For patients with multiple RAPN, only their first procedure was included. MAP scores of the tumor kidney were classified as either high (MAP 4-5) or low (MAP 0-3). Outcomes included dissection time, total operative time (OT), and warm ischemia time (WIT). OT was defined as WIT plus dissection time. Multivariable linear regression models adjusting for preoperative characteristics were used to estimate the difference in mean RAPN surgical times between patients with a high MAP score and patients with low MAP score; 95% confidence intervals (CIs) for the difference in means were reported.

Results: Our analysis included 548 RAPN patients with a median age of 63 y (IQR 55-70 y), 338 (61.7%) were male, a median BMI of 29.7 kg/m2 (IQR 25.9-33.3 kg/m2), a median Charlson Comorbidity Index of 4 (IQR 3-5), a median preoperative eGFR of 78.2 ml/kg/1.73m2 (IQR 66.1-91.4 ml/kg/1.73m2), and a median MAP score of 3 (IQR 2-5). MAP score was classified as high (N=174) or low (N=374) where a high MAP score represents a higher risk of "sticky fat". Preoperative factors associated with a high MAP score included older age, male sex, higher BMI, lower eGFR, and a higher Charlson comorbidity index. The unadjusted mean±SD surgical times for high MAP vs. low MAP scores were 218±52 vs. 198±45 minutes for OT, 199±51 vs. 181±43 minutes for dissection time, and 19±7 vs. 18±8 minutes for WIT. After adjusting for preoperative characteristics, patients with a high MAP 4-5 score had a mean OT 13 minutes (95% CI 3-22 minutes) longer than those with low MAP score. This difference was largely due to longer dissection time (11 minutes, 95% CI 2-21 minutes), with minimal difference in mean WIT (1 minute, 95% CI -1-2 minutes).
Conclusion: High MAP score was associated with longer total operative time and longer dissection time, but no evidence of longer warm ischemia time.
Funding: N/A

Poster #6

A CALL TO CONTRACEPTION: OVERTURN OF ROE V. WADE CATALYZES RISE IN U.S. VASECTOMY CONSULTATIONS

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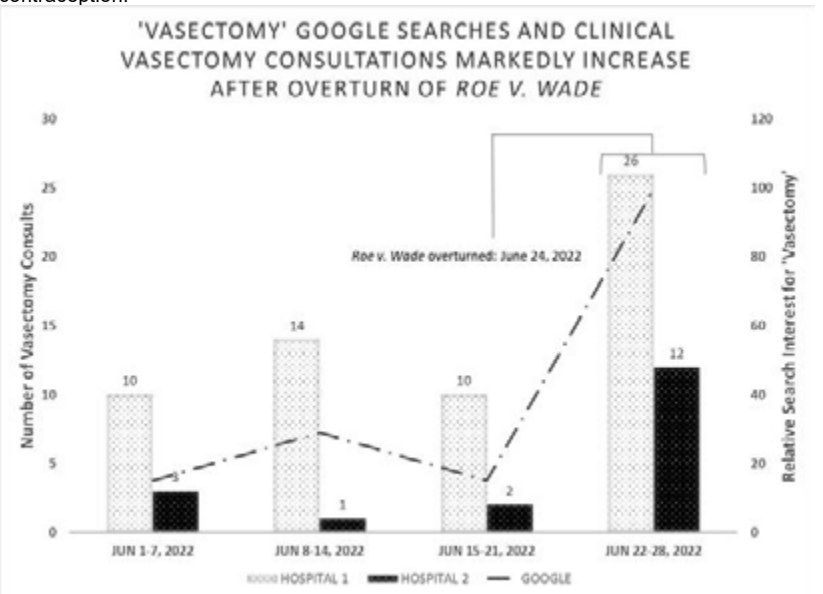
Presented By: Kevin Campbell, MD, MS

Introduction: On June 24, 2022, the U.S. Supreme Court's landmark decision on *Dobbs v. Jackson Women's Health Organization* leaves abortion rights or restrictions to be defined at the state level. The following week several news outlets reported that urologists across the country are experiencing significant increases in clinical encounters for individuals interested in undergoing a vasectomy.
OBJECTIVE
To explore the impact of changes to federal protection of abortion rights on the number of individuals seeking vasectomies at two high-impact academic centers and their correlation with Google Web searches.
Methods: A cross-sectional analysis of Google web searches from 1/1/2004 -6/30/2022 was performed for the key term 'vasectomy' utilizing Google Trends®. One primary outcome was relative search interest in the key term 'vasectomy' prior and after the overturn of *Roe v. Wade*. We calculated the coefficients of determination for the linear search trend of this term. In parallel, cross-sectional analyses were performed utilizing databases from the electronic medical records of two high-impact university hospitals ('Hospital-1' and 'Hospital-2') in the U.S. focusing on patient encounters for vasectomy consultation coded as 'vasectomy / vasectomy consult / vasectomy planning/ vasectomy education.' The observation interval included 06/01/2022 - 06/30/2022. Correlation coefficients were calculated using SPSS.
Results: Web searches for the term 'vasectomy' increased 3.6 times the average number of searches for 'vasectomy' during the week following the U.S. Supreme Court's decision on abortion, and it marked the most the term had ever been searched since Google began tracking its searches in 2004. Similarly, office visits for vasectomy consultations for Hospital-1 and Hospital-2 increased by factors of 2.4 and 6.0, respectively. Internet searches for 'vasectomy' and the number of clinic vasectomy consultations demonstrated correlation values of r = 0.96 and r = 0.89 for Hospital-1 and and Hospital-2, respectively.
Conclusion: Online search interest as well as clinical encounters for vasectomy consultation have increased over the past 30 days coincidentally with - and perhaps as a consequence of - the overturn of *Roe v. Wade*. Our study has demonstrated marked correlation between the increase in Google searches and office visits for vasectomy

consultation. This may mark a watershed moment in the adoption of vasectomy for male contraception.



Funding: N/A

Poster #7

HIGH-RISK PROSTATE CANCER IN NORTH FLORIDA: DISPARITIES IN DIAGNOSTIC USE OF MRI VS STANDARD PROSTATE BIOPSY

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Presented By: Leticia Rodriguez, BS

Introduction: Prostate cancer remains the leading diagnosed cancer and the second leading cause of cancer-related death in the US. Early diagnosis plays a vital role in patient survival. Diagnostic MRI gives an advantage to the urologist to identify and target tumors visualized in MRI vs standard biopsies, which are systematic but blind biopsies with no specific identified tumor targets; thus, having an MRI may confer an advantage to early diagnosis and improve survival. Obtaining MRIs depend on patients' insurance, socioeconomic status, and access to imaging modality. We aim to identify diagnostic disparities among patients with high-risk prostate cancer.
Methods: Our study cohort includes patients who underwent MRI and Standard prostate biopsies. Only patients with MRI PIRADS 3-5 were selected. Cancer patients were stratified into three categories: low, intermediate, and high-risk. Only patients with high-risk prostate cancer were included in this analysis. We identified the rate of high-risk PCa in these populations as well as corresponding zip codes. We examine zip code patterns for poverty levels.
Results: From 2019 to 2022, 115 biopsies were done, 45% were MRI-fusion and 55% were standard, 63% of the cancers were found in MRIs and 53.2% of the cancer was found in the standard. Patients who had high-risk prostate cancer were 19.2 % and 11.2% in MRI vs standard groups. Patients that had MRIs lived in different zip-codes than patients that did not have MRIs for diagnostics. Mapping of zip codes demonstrated high-risk prostate cancer prominently in 32694, 32615, and 32071 for non-MRI patients vs. 32686, 32606, 32080, 32055, 32608, and 32605 for MRI patients. The greatest disparities were seen when comparing the income of zip-codes 32071 and 32605 ($25,000 vs.

$70,000 respectively). Patients with certain insurances were more common among patients who did not have MRI compared to patients with MRI, 67% vs. 55% respectively.
Conclusion: Early diagnosis of high-risk prostate cancer is improved with the use of MRI. We identified areas in our community that have barriers to this diagnostic modality that overlap with higher poverty levels. Further large-scale population studies are needed to allocate efforts to improve diagnostic-modalities in areas in need.
Funding: N/A

Poster #8

RURALITY IS ASSOCIATED WITH THE PRESENCE OF URINARY INCONTINENCE IN WOMEN

T. Anne Zwaschka, Stephanie Gleicher, Rosa Park, Roger Dmochowski, W. Stuart Reynolds, Elisabeth Sebesta
Vanderbilt University Medical Center, Nashville, TN
Presented By: Rosa Park, MD

Introduction: Urinary incontinence (UI) affects over half of all adult women in the United States, posing a significant public health burden. There is a growing appreciation of how social determinants of health (SDOH) may help us understand healthcare disparities and the impact on health outcomes, including urinary conditions. Rurality has been associated with SDOH and poorer health outcomes. This study's aim was to examine social risk factors and unmet social needs in rural women, and how they may impact the rate and severity of UI in a large, community-based sample.
Methods: This secondary analysis of a sample of 3,226 cis-gendered women living in the U.S. was electronically recruited via ResearchMatch for a study investigating unmet social needs and urinary symptoms. Respondents were excluded if they were currently pregnant or had a history of cystectomy. Sociodemographics, urinary symptoms and severity of incontinence (ICIQ UI-SF), unmet social needs, and incontinence product usage was compared between women living in rural versus non-rural communities.
Results: Of the study cohort, 384 (12%) reported living in a rural community. Rural participants were older ($p<0.001$) and more often identified as white, non-Hispanic ($p<0.001$). Additionally, rural women had less education ($p<0.001$), were more often unemployed, retired, or on disability ($p<0.001$), and more often uninsured or using Medicaid/Medicare ($p<0.001$) over non-rural women. Women in rural communities had a higher rate of UI (66% vs. 60%, $p=0.02$) and trended towards more severe UI as assessed by ICIQ UI-SF score. Rural women also reported higher daily UI product usage ($p=0.01$) in addition to higher costs of UI products weekly, although this was not significant. Finally, women in rural communities reported a greater number of unmet social needs, with 16% reporting 3 or more needs ($p<0.001$).
Conclusion: This study demonstrates that women living in rural communities have more social risk factors and unmet social needs that may affect UI. In our cohort, rural women had a higher rate of UI and a greater UI product burden, with a trend towards increased UI severity. This information will guide further research into the unmet social needs that affect women with UI in rural communities, with the goal of providing more comprehensive care.

Table 1: Demographics

	Rural (%)	Non-rural (%)	p-value
Total (%)	384 (11.9)	2,842 (88.1)	
Mean age (yrs, st dev)	51.7 (14.2)	47.4 (17.1)	<0.001
Median age (yrs, IQR)	53 (40.5, 64)	46 (32, 62)	
Mean BMI (yrs)	28.5 (7.4)	27.5 (6.9)	0.01
Race/ethnicity (%)			<0.001
White, non-Hispanic	350 (91.2)	2,363 (83.2)	
Black, non-Hispanic	7 (1.8)	159 (5.6)	
All Hispanic	8 (2.1)	111 (3.9)	
Asian	3 (0.8)	99 (3.5)	
Multiracial	9 (2.3)	64 (2.3)	
Other	7 (1.8)	27 (0.9)	
Unknown	0 (0)	19 (0.7)	
Smokers (%)	76 (19.8)	410 (14.4)	<0.001
History of pelvic surgery (%)			
Incontinence surgery	22 (5.7)	89 (3.1)	<0.001
Prolapse surgery	23 (6.0)	80 (2.8)	<0.001
Hysterectomy	110 (28.7)	445 (15.7)	<0.001
Parity (%)			<0.001
0	103 (26.8)	1,215 (42.8)	
1	56 (14.6)	381 (13.4)	
2	92 (24.0)	517 (18.2)	
3+	133 (34.6)	729 (25.6)	
Number of unmet social needs (%)			<0.001
No needs	230 (59.9)	1,867 (65.7)	
1	62 (16.2)	527 (18.5)	
2	31 (8.1)	198 (7.0)	
3+	61 (15.9)	250 (8.8)	
Incontinence (%)	255 (66.4)	1,703 (59.9)	0.02
Incontinence severity by ICIQ UI-SF (%)			0.09
None	129 (33.7)	1,139 (40.1)	
Slight	116 (30.3)	853 (30.1)	
Moderate	114 (29.8)	705 (24.8)	
Severe	22 (5.7)	130 (4.6)	
Very severe	2 (0.5)	11 (0.4)	
Mean incontinence product usage per day (st dev)	0.7 (1.8)	0.5 (1.4)	0.01
Mean cost of products per week ($, st dev)	1.96 (5.47)	1.45 (5.55)	0.09

Funding: N/A

Poster #9

TRENDS IN COST ASSOCIATED WITH THE PHARMACOLOGIC MANAGEMENT OF OVERACTIVE BLADDER

Dhaval Jivanji, MD[1], Spencer Liem, MD[2], Jorge Pereira, MD, MPH[2]
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Presented By: Dhaval Jivanji

Introduction: Overactive bladder (OAB) is a common urologic condition that is estimated to have an overall prevalence of around 16% in the United States. Outside of behavioral modifications and bladder training, pharmacotherapy is the mainstay of treatment for OAB. With symptoms often being chronic, patients may remain on therapy for several years, which can be costly. The objective of this study is to highlight the trends in costs associated with the medical management of OAB.

Methods: Using the Medicare Provider Utilization and Payment Data: Part D, we gathered and analyzed the changes in total claims and associated cost of medications used for the treatment of OAB between 2013-2019. The seven most common medications for OAB were analyzed and information was gathered regarding total claims, total cost, and patient-associated costs. Medications were only included if total claims were >40,000 or the total cost was >$1,000,000.
Results: Mirabegron was the most prescribed drug for the management of OAB with 2,773,084 claims in 2019. The overall cost to the Medicare system was $1445M of which patients paid $126M. Since 2013, Mirabegron has seen a 1291% increase in claims and a 2577% increase in total cost. Oxybutynin and Trospium had similar increases in claims (19%); however, Trospium saw a significant decline in total cost (-22%). Other anticholinergics, such as Tolterodine, Solifenacin, Fesoterodine, and Darifenacin all saw a decline in favor of other medications (-35%, -50%, -30%, -83%, respectively); however, in 2019, they still contributed significantly to overall patient cost ($21M, $36M, $15M, $2M, respectively).
Conclusion: There are significant costs related to the pharmacologic management of OAB. Mirabegron is the most prescribed medication and is associated with the greatest financial cost to patients.

Table 1 – Trends in Total Claims and Total Cost for Common OAB Medication

Drug Name (Generic/Brand Name)	Total Claims		Change over time (%)	Total Cost		Change over time (%)	Total cost to patients in 2019
	2013	2019		2013	2019		
Mirabegron/Myrbetriq	199,332	2,773,084	1291%	$54M	$1445M	2577%	$126M
Oxybutynin/Ditropan	4,907,055	5,849,996	19%	$241M	$247M	2%	$71M
Trospium/Sanctura	287,650	341,273	19%	$51M	$40M	-22%	$6M
Tolterodine/Detrol	1,445,749	936,296	-35%	$345M	$151M	-56%	$21M
Solifenacin/Vesicare	2,202,398	1,105,077	-50%	$554M	$444M	-20%	$36M
Fesoterodine/Toviaz	504,465	351,449	-30%	$105M	$168M	61%	$15M
Darifenacin/Enablex	354,233	59,203	-83%	$76M	$18M	-77%	$2M

Funding: N/A

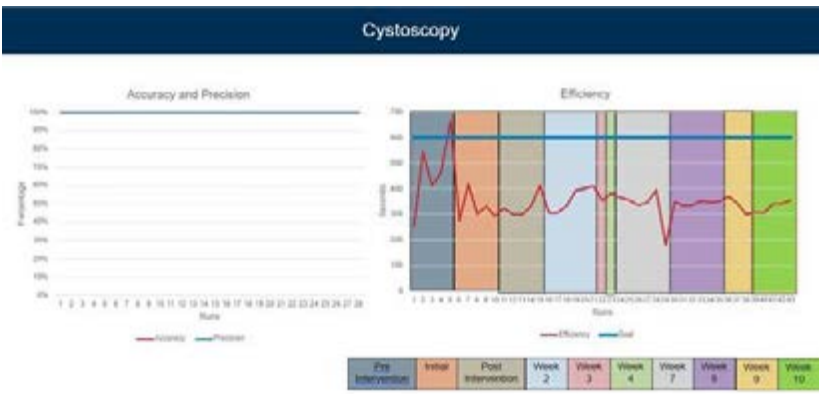
Poster #10

STANDARDIZATION OF CYSTOSCOPY OPERATING ROOM SET UP

Brittany Levy[1], Charles Campbell[1], Sherry Lantz[2], Wesley Wilt[1], Erik Ballert[2], Andrew Harris[2]
[1]University of Kentucky, [2]Lexington Veterans Affairs Medical Center
Presented By: Brittany Erin Levy, MD

Introduction: Reproducible results rely on standardized processes to reduce points of variation. The operating room (OR) is a source of significant variation, leading to varied turnover times, room set up times, and patient outcomes. We hypothesize standardizing sterile back table set up for high volume procedures, for high volume procedures, will lead to improved accuracy of instrumentation available and enhanced set up efficiency.
Methods: Nine surgical subspecialty teams comprised of scrub technicians, circulating nurses, and the OR nurse manager identified high volume operative procedures. Cystoscopy was chosen for standardization by the urology team. The back table sterile set up was completed by 5 different scrub technicians. Time to set up and location of each item was recorded and photos were taken of each set up to document variation. Subsequently, a standardized set up (SSU) was devised by the subspecialty team. A photograph of the SSU was displayed in the OR and 5 test set ups were conducted to determine a time benchmark. The longest repeatable time was used as a goal metric,

in addition to 80% accuracy and 80% precision of instrument placement. Accuracy was defined as if the instrument was open on the table. Precision was defined as if the instrument was in the correct quadrant of the table compared to the SSU photograph. SSUs were then audited for the next several months.
Results: Prior to standardization, no standardized set up was present, with substantial variance in precision of instrument placement. Additionally, set up times varied by technicians, set up times for cystoscopy set up ranging from 254s to 665s with a mean of 467s. Whereby, following standardization, accuracy and precision improved to 100% irrespective of start time or room staff. Additionally, set up times saw reduced variation, and reduced average set up time to 341s. Sustainability of this project has persisted over 2.5 months without drift from the standardized process. Similar results are observed across all 9 surgical subspecialty high volume procedures.
Conclusion: SSU are an effective way to reduce variation in the operating room, conferring improved safety and efficiency metrics.



Funding: N/A

Poster #11

SOCIOECONOMIC STATUS AND POST-OPERATIVE OPIOID CONSUMPTION FOR CYSTECTOMY ERAS PATIENTS

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Presented By: Hailey Holck, BS

Introduction: The increasing severity of the opioid epidemic necessitates continued investigation of opioid consumption and prescription patterns. Major surgery, postoperative opioid consumption, and low socioeconomic status (SES) are considered risk factors for future opiate use. While enhanced recovery after surgery protocols (ERAS) have been shown to decrease postoperative opioid consumption, current literature is conflicting concerning the associations between SES and postoperative opioid consumption. We aim to investigate whether SES status is associated with immediate postoperative opioid consumption, discharge prescription, or refills within our ERAS cystectomy patient cohort.
Methods: This was an IRB-approved retrospective study of a prospectively maintained RedCap database. Our patient cohort included consecutive patients undergoing radical cystectomy between 2017 and 2022. Area Deprivation Index (ADI) data was obtained from the University of Wisconsin School of Medicine. We excluded patients with a documented history of chronic pain, opioid use, or recreational drug use. Statistical analysis employed chi-squared and ANOVA tests when appropriate.
Results: Each ADI quartile (socioeconomic group) was similar in age, sex, race/ethnicity, primary length of stay, diabetes prevalence, ASA group, procedure type, surgical approach, length of readmission, and complication rate. Postoperative day (POD) 0, 1,

2, and 3 each had similar morphine milligram equivalent (MME) consumption across SES. Additionally, there was no statistical difference in the number of patients consuming opioids while in the hospital. MME at discharge was also similar across ADI quartile (p=0.118). Likewise, there was no significant difference in the number of refills (p=0.526) and MME of refills (p=0.422) between SES.

Conclusion: Our results indicate that there was no significant difference between SES and MME consumption postoperatively amongst patients undergoing cystectomy on an ERAS protocol. Further investigation is warranted to elucidate the individual risk for postoperative opioid consumption and whether ERAS protocols can have a mitigating effect.

Table 1. ADI Quartile and Opioid MME Consumption

	Total	Q1 (Highest SES)	Q2	Q3	Q4 (Lowest SES)	p Value
Patients	**304**	**37**	**104**	**109**	**51**	
POD 0						
POD0 MME (SD)	11.4 (12.9)	13.2 (11.1)	11.2 (14.8)	11.1 (10.9)	11.3 (14.2)	0.852†
Opioid users (%)	175 (57.6)	23 (62.2)	58 (55.8)	66 (60.6)	28 (54.9)	0.810*
Average pain score (SD)	4.0 (2.8)	4.4 (2.7)	4.3 (2.7)	3.4 (2.8)	4.4 (2.9)	0.069†
POD 1						
POD1 MME (SD)	18.8 (23.5)	19.4 (21)	21 (26.4)	18.4 (23.0)	14.9 (19.8)	0.502†
Opioid users (%)	130 (42.8)	16 (43.2)	37 (35.6)	55 (50.5)	22 (43.1)	0.187*
Average pain score (SD)	3.9 (2.6)	3.9 (2.4)	4.2 (2.7)	3.8 (2.5)	3.9 (2.7)	0.788†
POD 2						
POD2 MME (SD)	16.2 (22.5)	12.9 (18.2)	18.1 (24.3)	16.9 (23.6)	12.9 (19)	0.432†
Opioid users (%)	124 (40.8)	17 (46)	38 (36.5)	47 (43.1)	22 (43.1)	0.677*
Average pain score (SD)	3.7 (2.8)	3.45(3.1)	3.6 (2.7)	3.6 (2.8)	4.2 (3.0)	0.61†
POD 3						
POD3 MME (SD)	13.4 (20)	9.9 (14.6)	14 (21.1)	13.6 (18.8)	14.1 (23.5)	0.733†
Opioid users (%)	127 (41.8)	12 (32.4)	38 (36.5)	51 (46.8)	26 (51)	0.147*
Average pain score (SD)	3.3 (2.8)	2.5 (2.7)	3.0 (2.8)	3.5 (2.8)	3.8 (2.8)	0.127†
Discharge						
MME at discharge (SD)	122.32 (110.9)	90.9 (99.7)	126.6 (109.7)	136.3 (121.8)	106.6 (91.13)	0.118†
Received opioid at discharge (%)	219 (72.0)	22 (59.5)	77(74.0)	83 (76.1)	37 (72.5)	0.259*
Refills						
Received opioid refill (%)	36 (11.8)	3 (8.1)	14 (13.5)	15 (13.8)	5 (9.8)	0.743*
Number of refills (SD)	1.4 (0.667)	1(0)	1.6 (0.8)	1.4 (0.7)	1.2 (0.4)	0.526†
Refill MME of those who got refills (SD)	263.3 (323.2)	58.33 (14.4)	235 (185)	357.5 (460.4)	183 (105.7)	0.422†

*Chi-Squared

†ANOVA

Funding: N/A

Poster #12

NEPHROLITHIASIS CARE BY PATIENT RACE: FROM A STATEWIDE QUALITY IMPROVEMENT COLLABORATIVE

Fumihiko Nakamura[1], Brandon Dodd[1], Ademilola Tejuoso[1], Sarah Johnson[1], Will Cranford[2], Eric Wahlstedt[2], Andrew Harris, MD[2,3], Kellen Choi, DO, FACOS[4]

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Presented By: Fumihiko Nakamura, MS

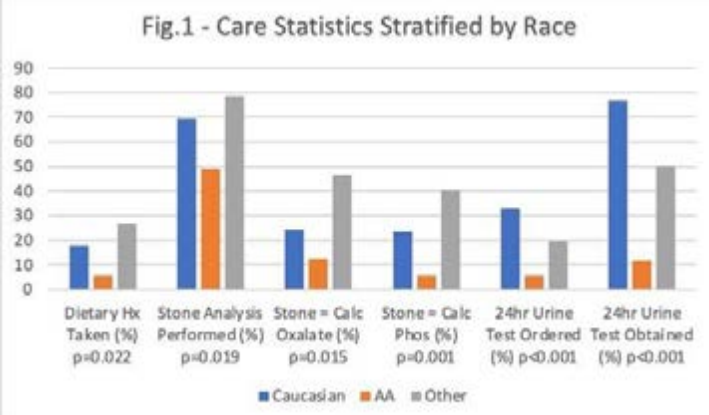
Introduction: In the United States, the “Kidney Stone Belt” refers to a collection of states in the South and Southeast where prevalence of renal calculi is highest. As a member of this region, our state should analyze its role in the quality of nephrolithiasis care. To this end, our study, a collaborative effort between the two largest academic medical

institutions in our state, aims to elucidate practice patterns and discuss options to improve care for our patients.

Methods: A retrospective chart review of 429 nephrolithiasis patients, receiving care from 7 different urologists at two institutions, between 01/2017 and 02/2022 was performed. A database was generated, collecting 105 datapoints from each patient, based on conditions during and after care, as well as documentation of actions performed in-line with standard practice for nephrolithiasis workup and management, with input from AUA guidelines. Datapoints include patient discharge with narcotics, initial admission via the Emergency Department, orders for post-lithotripsy stone analysis and 24hr urine tests, and counseling regarding recurrence prevention. This data was then analyzed and stratified by race. Chi-squared test was used for analysis, with statistical significance set by convention at $p < 0.05$.

Results: The racial breakdown of our 429 patients included 359 Caucasian, 55 African American (AA), and 15 Other. In analyzing documentation of guideline-directed best practices, statistically significant differences were noted by race. AA patients were less likely to have a stone analysis compared to Caucasians (49% vs 69%) and orders for 24hr urine tests (6% vs 33%). A difference was also seen in rates of dietary histories being taken upon initial evaluation (5.5% vs 18%). Though not statistically significant, it is worth noting that, in our patient population, we found minimal documentation of physician-led counseling on preventative measures to decrease stone recurrence across all races. Overall findings are illustrated in more detail in fig1.

Conclusion: Nephrolithiasis care in our state remains a multifactorial and challenging endeavor, for both patients and clinicians. In our study comparing nephrolithiasis care in two of our state's largest academic medical institutions, our data suggests several areas in which patients could benefit from improved documentation of adherence to guideline-directed practices and counseling on preventative metabolic stone management.



Funding: N/A

Poster #13

TRANSFORMING PERIOPERATIVE PROCESSES: COLLABORATION, EVALUATION, AND IMPROVEMENT

Brittany Levy, Wesley Wilt, Julia Hay, Raymond Young, Emily Eichinger, Andrew Harris
University of Kentucky
Presented By: Brittany Erin Levy, MD

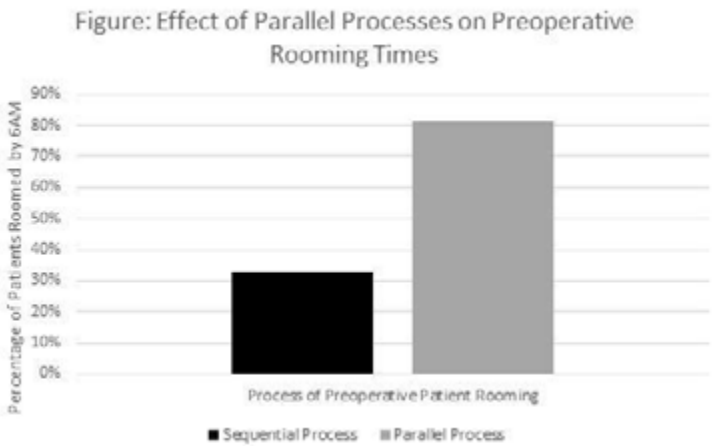
Introduction: On-time first case starts (FCS) is a nationally recognized indicator for operating room efficiency. While much attention is given to the minutes surrounding in-room time, opportunities for efficiency start from the moment the patient arrives in the hospital. Therefore, initial processes surrounding patient registration and rooming play an important role in achieving an on-time operating room (OR) start. LEAN methodology is commonly used within healthcare to improve processes efficiency by employing

tactics of standardization, sequential processes, and process mapping. We hypothesize LEAN methodology process improvement could enhance perioperative efficiency and standardization.

Methods: The Parallel Process Quality Improvement Initiative was conducted from 7/2022-9/2022 in the main OR of a tertiary care academic center. 844 visits pre-implementation and 244 visits post-implementation were audited over the study period. The QI initiatives were developed in concert with a QI experienced urology faculty member. Both leadership and frontline stakeholders were engaged, including perioperative leadership, perioperative staff, and administrative staff to identify current workflows and potential interventions targeting outpatient elective procedures. Process mapping outlined current rooming workflows. Benchmarks were developed through stakeholder team collaboration, and outcomes based on these benchmarks were obtained.

Results: Preliminary data revealed 844 patients who underwent elective FCS outpatient surgeries over a 2-month time period. Pre-implementation, patients were roomed by a mean time of 6:06AM. However, after collaboration with the multidisciplinary team, 6AM was chosen as the benchmark for FCS rooming. Overall, pre-implementation, 33% of FCS patients were roomed by 6AM. Process mapping revealed a sequential process, which was converted to a parallel process. Implementation of the parallel process rendered an improved 6AM rooming rate to 81% of FCS patients (Figure). Additionally, the parallel process reduced downtime for perioperative staff, by an average of 9 minutes (IQR=0, 13min).

Conclusion: Using LEAN methodology of process improvement and multidisciplinary collaboration, perioperative processes can be evaluated and improved. Benchmarking, process evaluation, and auditing are needed for sustainable improvement. Standardized, parallel processes support enhanced efficiency in the perioperative process.



Funding: N/A

Poster #14

REFINEMENT AND EXTERNAL VALIDATION OF A NOVEL, NON-INVASIVE, MULTIPLEX URINE TEST FOR HIGH-GRADE PROSTATE CANCER

Jeffrey Tosoian[1], Yuping Zhang[2], Lanbo Xiao[2], Heng Zheng[2], Cassie Xie[3], Bruce Trock[4], Javed Siddiqui[2], Lakshmi Kunju[2], Zoey Chopra[2], Nathan Samora[1], Simpa Salami[2], Todd Morgan[5], Ganesh Palapattu[6], Yingye Zhang[3], John Wei[6], Arul Chinnaiyan[2]

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Hopkins University, [5]Rogel Cancer Center, University of Michigan, [6]Department of Urology, University of Michigan
Presented By: Jeffrey J. Tosoian, MD, MPH

Introduction: The MyProstateScore (MPS) test employs the long non-coding RNA PCA3 and the TMPRSS2-ERG (T2-ERG) gene fusion to detect clinically-significant (Grade Group[GG]≥2) prostate cancer (PCa). To build upon MPS, we analyzed RNA-seq data from a PCa compendium to identify novel high-grade cancer-specific transcripts. The current study sought to develop and validate a novel non-invasive urinary test for improved detection of GG≥2 PCa.
Methods: Fifty-five candidate markers were assessed by *glmnet* modeling in a development cohort undergoing prostate biopsy at the University of Michigan, yielding 17 markers independently contributing to model accuracy. Three novel *MPS2* models were developed for use based on availability of clinical data (c) and prostate volume (v): i) markers-only (*MPS2*), ii) markers and clinical data (*MPS2+c*), and iii) markers, clinical data, and prostate volume (*MPS2+cv*). The existing MPS test and locked *MPS2* models were applied to a blinded, external NCI-EDRN validation cohort, and performance measures were assessed.
Results: In total, 55 transcripts were measured by multiplex qPCR in 1504 urine specimens. Model development included 761 men with PSA 3-10 ng/ml, including 293 (39%) with GG≥2 cancer on biopsy. The existing MPS test provided an area under the receiver operating characteristic curve (AUC) of 0.732, while the *MPS2, MPS2+c,* and *MPS2+cv* models yielded cross-validated AUC values of 0.784, 0.802 and 0.820, respectively. In the validation cohort of 743 men with PSA 3-10 ng/ml, 151 (20%) were found to have GG≥2 cancer on biopsy. The existing MPS test yielded an AUC of 0.731, while *MPS2* models yielded AUC values of 0.751, 0.801, and 0.819, respectively. At test thresholds yielding 95% sensitivity, MPS provided 25% specificity, while *MPS2+cv* provided 38% specificity. At 90% sensitivity, MPS provided 37% specificity, and *MPS2+cv* provided 52% specificity.
Conclusion: Incorporating novel transcripts of high-grade cancer, we validated a 17-marker urinary panel for detection of GG≥2 PCa. Compared to the clinically-available MPS test, the *MPS2+cv* model improved diagnostic accuracy (AUC) by 9% and increased specificity by 13-15% across highly-sensitive thresholds. Enhanced performance was maintained across the development and validation cohorts, supporting external generalizability. These findings suggest that the novel *MPS2* test meaningfully improves detection of GG≥2 PCa relative to currently-available diagnostic tests.
Funding: This work was funded by the Prostate Cancer Foundation Young Investigator Award (20YOUN11), the Early Detection Research Network (U01CA214170, U2CCA271854), the NCI Prostate SPORE (P50CA186786), and an NCI Outstanding Investigator Award (R35CA231996).

Poster #15

OUTCOMES OF SALVAGE ROBOTIC-ASSISTED RADICAL PROSTATECTOMY COMPARING PATIENTS WITH PRIMARY FOCAL THERAPY AND WHOLE GLAND ABLATION: A MULTICENTRIC COLLABORATIVE STUDY.

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Presented By: Marcio Covas Moschovas, MD

Introduction: With increasing experience, surgeons worldwide have increasingly used Salvage Robotic-assisted Radical Prostatectomy (SRARP) as a tool to treat patients who failed previous non-surgical treatment for prostate cancer. Our study compared the outcomes of salvage radical prostatectomy from two high-volume centers from the US and UK in patients who failed prior treatment with whole gland ablation (wg-SRARP) and focal therapy (f-SRARP).
Methods: The study assessed 339 patients compared in two groups: 145 patients who had primary focal therapy and 194 patients who had primary whole gland treatment. SRARP was performed in all cases using a standardized technique developed at

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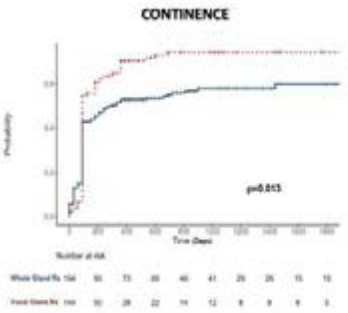
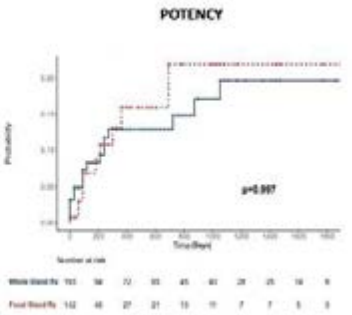
respective institutes with the da Vinci Xi Surgical System. Our primary endpoint was the comparison of the functional and oncological outcomes between the groups.
Results: The median total operative time for f-SRARP was 18 mins higher than wg-SRARP (P <0.001). Significantly higher rates of nerve-sparing were performed in f-SRARP (focal vs whole gland; bilateral – 15.2% vs 9.3%; unilateral 49% vs 28.4%; p <0.001).Wg-SRARP had higher rates of ISUP 5 (26.3% vs 19.3%; p <0.001) and deferred ISUP score due to altered pathology (14.8% vs 0.7; p <0.001) while f-SRSRP had higher rates of ISUP 4 (11.7% vs 10.7%; p<0.001) and ≥ pT3a (64.8% vs 51.6%; p <0.001). Also, f-SRARP had higher rates of positive surgical margins (26.2% vs 10.3%; p <0.001). Functional outcomes were poor in both groups. However, postoperative continence was higher and faster in patients who had f-SPARP compared to wg-SRARP (69% vs. 54.6% ; p=0.013). [MMM2] We could not identify statistically significant difference in postoperative potency recovery and biochemical recurrence.
Conclusion: Salvage robotic-assisted radical prostatectomy is challenging wherein patients have adverse pathological features irrespective of primary treatment. Focal therapy group had higher rates of nerve-sparing with increased positive surgical margins. However, both groups had poor functional outcomes regardless of nerve-sparing degree, indicating significant collateral and contralateral damage to tissues surrounding the prostate. We believe that this analysis is crucial for counseling patients regarding expected outcomes before performing a salvage treatment following ablative therapies failure.





Funding: N/A

Poster #16

LONG-TERM HEALTH RELATED QUALITY OF LIFE IN PROSTATE CANCER PATIENTS REQUIRING RADIOTHERAPY AFTER RADICAL PROSTATECTOMY

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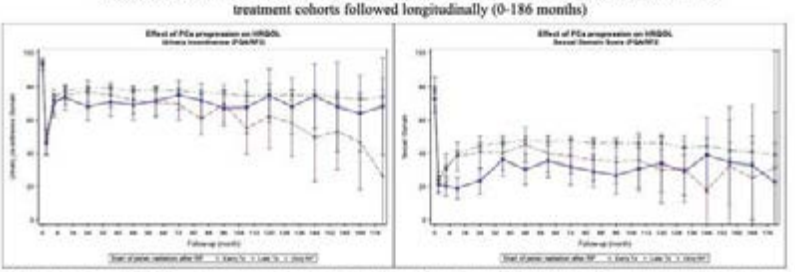
Presented By: Timothy Anders Olsen, MD

Introduction: The optimal timing of radiotherapy (XRT) after radical prostatectomy (RP) is controversial, and the impact of early versus late post-RP XRT on patient-reported health related quality of life (HRQOL) is unclear.
Methods: In our study, 1,203 men with localized prostate cancer were prospectively enrolled in the PROSTQA (2003-2006) and RP2 (2010-2014) consortiums. They were treated with RP and 121 subjects received post-RP XRT. The exposure of interest was receipt and timing of post-RP XRT, leading to three treatment cohorts: 1) RP only (n=1,082), 2) RP + early XRT (n=57), and 3) RP + late XRT (n=64). Given the inclusion criteria was localized prostate cancer, most patients did not receive XRT after RP. Early versus late XRT was defined as ≤12 months and >12 months post-RP, respectively.

The primary outcome was HRQOL via the Expanded Prostate Cancer Index Composite (EPIC-26) sexual, urinary incontinence and urinary irritation/obstruction scores, measured at pre-treatment and annually thereafter. Treatment groups were compared using multivariable GEE models of change in longitudinal HRQOL domain scores. Urinary incontinence pad usage was also evaluated before and after post-RP XRT.
Results: Median follow-up for the entire cohort was 85.6 months (IQR 35.8-117.2). Compared to RP alone, subjects undergoing post-RP XRT had significantly worse longitudinal changes in sexual, urinary incontinence and urinary irritation/obstruction HRQOL (p-values: 0.03, 0.004, <0.001, respectively). We were unable to detect HRQOL differences between late and early XRT longitudinally, due possibly to the size of the XRT cohorts (n=121 total). Longitudinal differences between the three cohorts can be appreciated in Figure 1. Post-RP recovery for urinary control was noted for early XRT, as 49% of subjects were pad-free before XRT, and 70% were pad free at their next HRQOL evaluation. At five years after XRT (n=40), 69% of early XRT subjects and 47% of late XRT subjects endorsed no pad usage.
Conclusion: This prospective cohort study with long-term follow up confirms the detrimental impact of XRT on post-RP HRQOL. Distinguishing differences between late and early XRT after RP was not detectible, limited by the size of our post-RP XRT cohorts. Further study is needed to assess the differential impact of treatments and prostate cancer recurrence/progression on HRQOL.

Figure 1. Differential EPIC-26 Urinary Incontinence and Sexual Domain Scores for patients in three treatment cohorts followed longitudinally (0-186 months)



Note: Early (blue, circles) and late (red, plusses) cohorts correspond to patients who received early or late radiotherapy (XRT) in addition to radical prostatectomy (RP). The patients who received RP therapy alone are also included in this figure (green, x's).

Funding: NCT01325506: (PROSTQA- RP2)5RC1EB011001-02 Effectiveness of Robotic Compared to Standard Prostatectomy for Prostate Cancer

Poster #18

HERNIA REPAIR WITH MESH PLACEMENT DOES NOT INCREASE COMPLICATIONS DURING ROBOTIC-ASSISTED RADICAL PROSTATECTOMY

Marcio Covas Moschovas[1], Abdel Jaber[1], Travis Rogers[1], Roshane Perera[1], Marco Sandri[2], Carlos Ortiz[1], Keila Morales[1], Vipul Patel[1]
[1]AdventHealth Global Robotics Institute, [2]Big Open Data, Italy
Presented By: Marcio Covas Moschovas, MD

Introduction: Robotic-assisted radical prostatectomy (RARP) is known as the gold-standard treatment for localized prostate cancer in the USA. However, performing RARP along with a concomitant hernia repair with mesh is debatable because the current literature supports no sufficient and well-designed studies. Some argue that this procedure may result in mesh infections due to possible contact with urine. This study reports our experience with simultaneous hernia repair with mesh placement in patients who underwent radical prostatectomy
Methods: From August 2008 to August 2021, we prospectively collected the data of 244 patients who underwent RARP with concomitant hernia repair (inguinal, umbilical, and ventral) with mesh placement. After a propensity score match (PS), these patients were retrospectively compared with with 244 patients from 6275 RARPs operated on the same period without hernia repair. We report the preoperative demography and perioperative outcomes up to 90 days after the surgery.

Results: Median follow-up was 36.6 months for the control and hernia groups respectively (p= 0.81). Eighty-three patients had unilateral inguinal hernia repair, 22 had a bilateral inguinal hernia repair, 95 had a ventral hernia repair, and 44 had an umbilical hernia repair. The median operative time was 112 min for the control group and 160 min for hernia groups (p<0.001). Estimated median blood loss was 100mL and 50mL for the control and hernia groups, respectively (p= 0.41). We did not find statistically significant differences in minor complications (Clavien ≤ 2). Although the postoperative readmissions in 90-days were higher in the hernia group (18 vs.7, p=0.038), none was associated with mesh complications.

Conclusion: Robotic-assisted radical prostatectomy with concomitant hernia repair and mesh placement is safe and does not increase complications related to the mesh. In our experience, hernia repair increases the operative time, usually due to initial peritoneal flap dissection and final suturing. Therefore, we believe that hernia repair with mesh during RARP is safe and spares patients the additional impacts related to an additional surgical procedure.

Parameters	Control (n=244)	Hernia Repair with Mesh (n=244)	P
Type of surgery n, %			
Unilateral IHR	-	83 (34)	-
Bilateral IHR	-	22 (9)	-
Ventral HR	-	95 (39)	-
Umbilical HR	-	44 (18)	
Estimated Blood Loss (mL)	100 (50-100)	50 (50-150)	0.41
Unilateral IHR	-	100 (50-100)	1
Bilateral IHR	-	100 (50-100)	1
Umbilical HR	-	100 (50-150)	1
Ventral HR	-	100 (100-150)	1
Total Operative Time (minutes)	112 (101-125)	160 (132- 180)	**<0.001**
Unilateral IHR	-	162 (149-180)	**<0.001**
Bilateral IHR	-	171 (163-188)	**<0.001**
Umbilical HR	-	132 (110-152)	**0.001**
Ventral HR	-	159 (131-188)	**<0.001**
Intraoperative Complications	None	None	-
Postoperative Complications (Clavien- Dindo) n, % Clavien ≤ 2	42 (17)	51 (20)	0.35
Postoperative readmissions in 90 days n, %	7 (3)	18 (8)	**0.038**
Infected lymphocele with IR drainage n, %	2 (0.8)	5 (2.5)	
DVT n, %	1 (0.4)	None	
Urinary retention n, %	1 (0.4)	1 (0.4)	
Ileus n, %	2 (0.8)	9 (4)	
Nausea n, %	1 (0.4)	None	
UTI n, %	None	1 (0.4)	
Wound infection (cellulitis) n, %	None	1 (0.4)	
Congestive heart failure n, %	None	1 (0.4)	
Mesh infection and removal	-	None	

Funding: N/A

Poster #19

DIFFERENCES IN CANCER-SPECIFIC URINARY BIOMARKER EXPRESSION BASED ON SELF-REPORTED RACE

Nathan Samora[1], Michael Sessine[2], Scott Tomlins[3], Simpa Salami[4], Javed Siddiqui[5], John Wei[4], Todd Morgan[4], Arul Chinnaiyan[3], Jeffrey Tosoian[1]
[1]Vanderbilt Univ. Medical Center, Dept. of Urology, [2]Wayne State Univ. School of Medicine, Dept. or Urology, [3]Univ. of Michigan, Dept. of Pathology, [4]Univ. of Michigan, Dept. of Urology, [5]Univ. of Michigan, Center for Translational Pathology
Presented By: Nathan L. Samora, MD

Introduction: African American (AA) men are more likely to develop and die from prostate cancer (PCa) than white men (CA). Racism and other social factors contribute to disparities, while race-based variation in PCa molecular subtypes is also reported in the literature and provides a biologic rationale for variability in biomarker test performance by race. We compared the association of urinary PCA3 and T2:ERG levels and MyProstateScore (MPS) test results with the detection of Grade Group (GG) ≥2 PCa in AA and CA men undergoing prostate biopsy.
Methods: Men participating in a multisite biomarker validation study from 2007-2011 were included. The AA cohort was supplemented with eligible AA men who underwent prostate biopsy from 2008-2018 at the University of Michigan. All men provided post-DRE urine under a standardized protocol before TRUS-guided systematic biopsy. Urinary PCA3 and T2:ERG mRNA levels were quantified by transcription-mediated amplification. MPS scores were calculated using the locked model for GG≥2 PCa. Clinicodemographic and biomarker data were retrospectively compared in CA and AA men.
Results: Supplementation increased the study population from 152 to 327 AA men, preserving inclusion of 1762 CA men (Table 1). After stratification (negative/GG1 vs GG≥2), biomarker data were compared (Table 2). In men without GG≥2 PCa, PCA3 score was significantly higher in AA men. In men with GG≥2 PCa, PCA3 score did not differ significantly by race. In men without GG≥2 PCa, urinary T2:ERG score did not differ significantly by race, while AA had significantly lower T2:ERG scores among men with GG≥2 PCa. In men without GG≥2 PCa, MPS scores were significantly higher in AA than CA men. Applying the validated MPS threshold to both populations resulted in 94-100% GG≥2 PCa sensitivity, while 16% of AA men would have avoided unnecessary biopsies vs 36% of CA men.
Conclusion: We performed a retrospective, exploratory analysis of the association between PCa biomarkers and GG≥2 PCa in CA and AA men. Population heterogeneity due to a supplemented AA sample is a study limitation. Nonetheless, our findings corroborate tissue-based molecular data demonstrating ERG is less overexpressed in AA men's tumors. These data underscore the importance of considering race in the development of PCa biomarkers.

Table 1 – Baseline demographic and clinical data. Values are median or N(%).

	CA men (N=1762)	AA men (N=327)
Age (years)	64	63
PSA (ng/ml)	4.8	5.8
Abnormal DRE	352 (20%)	49 (15%)
Previous negative biopsy	388 (22%)	92 (28%)
Positive family history	370 (21%)	82 (25%)
GG≥2 cancer on biopsy	370 (21%)	116 (36%)

Table 2: Median PCA3 score, T2:ERG score, and MPS by race in men with negative/GG1 versus GG≥2 cancer on biopsy. Bold text represents significant difference (p<0.05).

	Negative/GG1 cancer		GG≥2 cancer	
	CA men	AA men	CA men	AA men
N	1397	206	365	116
PCA3 score	**19**	**32**	47	47
T2:ERG score	**4**	0.6	**27**	**9**
MPS	**15.7**	**28**	40	42

Funding: N/A

Poster #20

INFLUENCE OF VITAMIN D ON PROSTATE CANCER OUTCOMES

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Presented By: Merry Ma, MD, PHD

Introduction: Vitamin D (VitD) has been implicated in regulating a variety of physiological processes, including the prevention and treatment of cancers. Recently, VitD has become a nutrient of interest as its hormonally active form has been shown to have an effect on prostate cancer (PCa) cell proliferation and possibly reduce the incidence of PCa. However, the role of VitD in PCa outcomes, such as overall survival and development of metastases are still unclear.
Methods: A retrospective cohort analysis was performed amongst patients who had VitD values available prior to undergoing radical prostatectomy who were in the Shared Equal Access Regional Cancer Hospital (SEARCH) database. Baseline characteristics, such as age, race, and pathological features were compared against VitD levels. A Cox regression model was used to identify any associations between VitD levels and overall survival from PCa, as well as development of biochemical recurrence (BCR) and metastases.
Results: A total of 170 patients within the SEARCH database met the inclusion criteria. 45 of 170 patients were VitD deficient (VitDdef) at time of surgery. African Americans were more likely to be VitDdef compared to Caucasians (58% vs 33%, p=0.009). VitDdef patients had overall higher pre-op PSAs (8.5 vs 5.6, p=<0.001) and were more likely to have seminal vesical invasion (24% vs 12%, p=0.047), positive surgical margins (58% vs 34%, p=0.005), and lymph node involvement (9% vs 2%, p=0.047). VitDdef showed possible trend towards increased likelihood of developing BCR (HR 1.55, 95% CI 0.081-2.94, p=0.182), however the trend was not seen when adjusting for above variables. No significant differences were identified in overall PCa survival and risk of developing metastases.
Conclusion: Within the SEARCH cohort of patients undergoing radical prostatectomy for PCa, VitDdef is seen more often in African Americans and is also associated with higher rate of seminal vesical invasion, positive surgical margins, and lymph node involvement. No significant differences were seen in overall PCa survival or risk of BCR or metastases. As VitDdef is more prevalent in the African American population, a group that has also been associated more aggressive PCa, further studies in larger populations are necessary to elucidate the independent role of VitD in PCa outcomes.
Funding: N/A

Poster #21

UTILITY OF A URINARY EXOSOME BIOMARKER TO PREDICT CSPCA FOLLOWING NEGATIVE MRI

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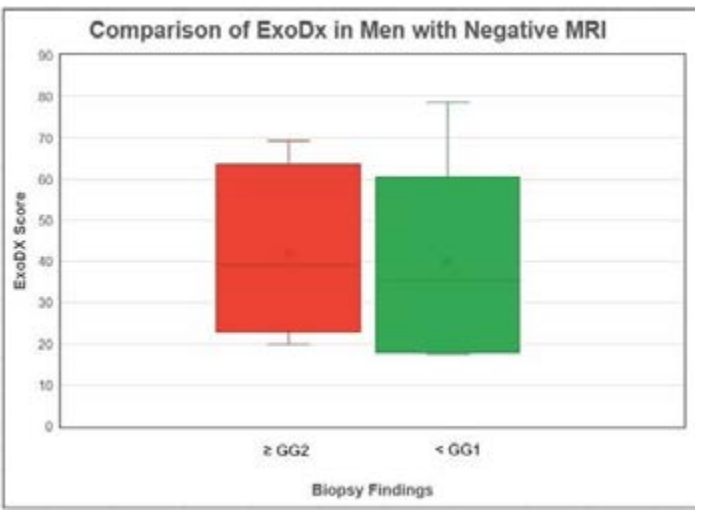
Presented By: Elizabeth Kwenda, MD

Introduction: In the setting of an elevate PSA, the NCCN, AUA and EUA guidelines recommend obtaining an MRI prior to biopsy. The guidelines are unclear as to if biopsy can be avoided in the setting of negative MRI. In PROMIS, Ahmed et al., demonstrated that the false negative rate for MRI can be as high 20-30% indicating a need for further risk stratification if biopsy is to be avoided.1 ExoDx (Exosome Dx, Waltham MA) is a urine based exosome-gene expression assay that provides a risk score to discriminate the presence of csPCA. Prior work has demonstrated that a negative MRI + negative ExoDx (score < 15.6) excludes 92% of prostate cancer.2 However, it is unclear of the significance of scores > 15.6 in the setting of a negative MRI. We hypothesized that an ExoDx score >30 would be predict clinically significant prostate cancer (csPCa) in the setting of a negative MRI.

Methods: We performed a retrospective analysis of men undergoing transperineal prostate biopsy at the University of Florida between 9/2021 - 4/2022 (IRB 202200022). Our cohort included men with clinical concern for prostate cancer, with pre-biopsy MRI. Men with ≥PI-RADS 3 lesion on MRI underwent biopsy. Men with a negative MRI, were counseled on biopsy, or additional biomarker testing with ExoDx. Men with an ExoDx score > 15.6 underwent biopsy. The primary endpoint was presence of csPCa at biopsy. Statistical tests were performed using Pandas 1.0.3.
Results: Within our cohort of 51 men undergoing biopsy, 24% had a had a negative MRI. Among these men, ExoDx >15.6 in 10 men with a median score of 39.1. Greater than GG2 prostate cancer was identified in 40% of the cohort. There was not a significant difference in the ExoDx score between the two groups, median 39.1; 35.5 and IQR = 23.8;34.2 respectively; p = 0.90010 (figure 1).
Conclusion: ExoDx was historically validated in an imaging naïve cohort.3 Prior retrospective evaluation of double negative MRI + ExoDx virtually excludes csPCa.2 Within our data, there was no identified ExoDx score useful for delineating prostate cancer vs no prostate cancer.



Funding: N/A

Poster #22

THE IMPACT OF SOCIOECNOMIC STATUS ON THE SURVIVAL OF MEN WITH EARLY-ONSET PROSTATE CANCER

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Presented By: Allison H. Feibus, MD, MS

Introduction: Prostate cancer (PCa) is generally considered a disease of older men; however, about 10% of new diagnoses in the US occur in men ≤ 55 years old. Socioeconomic status (SES) has been shown to influence survival in patients with PCa; however, the impact of SES on men with early-onset PCa remains undescribed.
Methods: Using the National Cancer Database, we identified adult men ≤ 55 years of age with a diagnosis of prostatic adenocarcinoma between 2004-2018. Descriptive statistics were used to characterize differences among different SES groups. Kaplan-Meier (KM) and Cox regression analyses were used to assess the effect of SES on overall survival (OS). To establish the impact of SES, the quartile assignments of median income and education level were combined to create a composite SES measure. Income and education level, were determined by matching each patient's ZIP code at the time

of diagnosis with data derived from the 2016 American Community Survey on median household income and the percentage of people aged ≥ 25 years old who had not earned a high school diploma, respectively.The quartile assignments (Q1, Q2, Q3, Q4) of the income and education measures were added together to form four composite SES categories: 2-3=Low SES; 4-5=Mid-Low SES; 6-7=Mid-High SES; and 8=High SES.
Results: A total of 112,563 young patients with PCa with a median follow-up of 79.0 months were identified. Compared to high SES patients, low SES patients were more likely to be African American (42.4% vs. 8.6%; p<0.001), Hispanic (9.5% vs. 2.7%; p<0.001), and uninsured (5.2% vs. 1.1%; p<0.001); they were also more likely to live in a rural area (3.2% vs 0.1%; p<0.001) and have stage IV disease (5.5% vs. 3.1%; p<0.001). KM analysis showed that a decreasing SES was directly associated with lower rates of OS (log- rank test p<0.001). On multivariable analysis, SES was found to have a negative effect on OS (low SES vs. high SES; hazard ratio [HR] 1.54; 95% confidence interval [CI] 1.41-1.68; p<0.001). (fig1)
Conclusion: In patients with early-onset PCa, Socioeconomic status was associated with overall survival. SES may be considered when implementing programs to improve the management of patients with early-onset PCa.

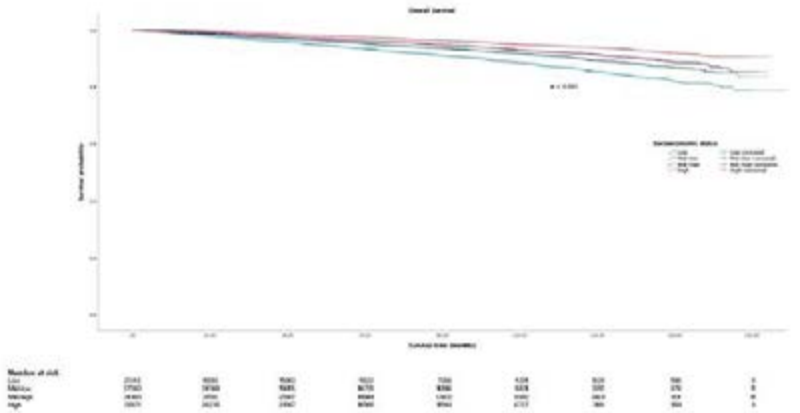

Figure 1 – Kaplan-Meier curve for overall survival stratified by socioeconomic status

Funding: N/A

Poster #23

REVIEW OF METASTATIC DISEASE DETECTION AND COST ANALYSIS OF NEXT GENERATION IMAGING USE IN INITIAL STAGING OF PROSTATE CANCER

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Presented By: Adonis Paul Irons, MD

Introduction: Next generation imaging (NGI), such as Fluciclovine F18 (Axumin) and Gallium-68 prostate-specific membrane antigen (PSMA) use in positron emission tomography (PET), has had an increasing role in prostate cancer (PCa) staging given growing evidence of increased detection of metastases. However, there is discrepancy in guidelines for offering this with the AUA still recommending prerequisite bone scan, and CT or MRI in high-risk disease staging despite noted increased sensitivity/specificity of NGI. Missed metastases affects both patient outcomes and financial aspects of management. To add to the understanding of NGI's impact, we evaluated staging outcomes and imaging costs between NGI and conventional imaging at a local healthcare level.

Methods: Charts of patients diagnosed with unfavorable intermediate-risk or higher PCa were retrospectively reviewed to compare findings of metastatic disease on staging imaging. Patients were included if they had 1) either Axumin or PSMA PET and 2) at least one form of conventional imaging (CT abdomen/pelvis with contrast and/or bone scan) within <12 months of NGI. Charged costs from imaging centers for each modality were used to calculate relative costs of the study population. Average cost of NGI was compared to the assumed costs of each patient having a complete conventional work up per AUA guidelines.
Results: Analysis included 6 men with high-risk disease and 22 with unfavorable intermediate-risk. 21.4% had NGI positive for metastases with negative conventional imaging, with half of those upstaged having high-risk disease. Lowest PSA level for an upstaged patient was 8.17. Average cost of the two NGI types totaled $11,705, although PSMA cost ($9,409) was slightly lower than combined cost of CT/bone scan ($9,825). Relative costs of all imaging if CT, bone scan, and NGI were completed totaled $602,840, or $21,530 per patient. Estimated cost of upfront NGI staging totaled $327,740, with projected savings of $275,100 for this study population.
Conclusion: We reported metastatic disease detection similar to that of current literature with comparable costs on small-scale analysis to highlight benefits of NGI. Although further research is needed to assess long-term disease outcomes and fiscal impacts on the healthcare system, this adds to a foundation of evidence showing the benefits of phasing out conventional imaging and utilizing NGI.
Funding: N/A

Poster #24

FUNCTIONAL OUTCOMES OF FOCAL SALVAGE MRI FUSION GUIDED HIFU FOR LOCALIZED RECURRENT PROSTATE CANCER

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Presented By: Ali Kasraeian, MD, FACS

Introduction: Only two percent of men in the United States with localized radiation recurrence are offered local salvage therapy, often due to the high morbidity associated with whole gland salvage therapy for their recurrent prostate cancer. If, however, the recurrent tumor can be identified with advanced diagnostic techniques, such as MRI/US Fusion biopsy, and focally targeted, treatment morbidity can possibly be reduced. We discuss our experience with Focal Salvage MRI Fusion Guided HIFU with dose escalation (FS-mfHIFU). Functional outcomes and data were prospectively collected, analyzed, and reported.
Methods: Between December 2015 and October 2019, 14 patients underwent FS-mfHIFU. Median age was 65 years of age. Gleason Scores ranged from 6 to 10, with one low risk, 7 intermediate risk, and 6 high risk patients undergoing salvage focal therapy. Seven patients underwent focal HIFU of the MRI target with margin, four were treated with hemiablation, and three using a subtotal (urethral sparing) technique.
Results: A Foley catheter was used in all 14 patients who underwent FS-msHIFU. Mean catheterization time was 7.25 days. Only 2 patients required catheter replacement due to urinary retention (14%). Only 2 (14%) required endoscopic intervention (due to urethral stricture). No rectal fistulae were noted in our series. Twelve of the 14 men treated reported pad-free urinary continence (86%).
Functional outcomes included mean serial IPSS measurements of 8.6 (pre-treatment), 9.78 (3 months), 7.4 (12 months). IIEF measures of mean erectile function demonstrated scores of 11.7 (pre-treatment), 9.2 (3 months), and 7 (12 months). Additionally, mean PSA was 4 (pre-treatment), 0.59 (3 months), 0.74 (6 months), and 0.67 (12 months).
Conclusion: With careful selection, advanced diagnostic techniques, and appropriate and honest counseling, focal salvage HIFU can offer men with localized radiation recurrence disease control with better preservation of their urinary and bowel function than whole gland salvage therapies for recurrent prostate cancer.
Funding: N/A

Poster #25

CLINICAL OUTCOMES OF PATIENTS WITH METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC) WITH PROSTATE-SPECIFIC ANTIGEN (PSA) DECLINE TO UNDETECTABLE LEVELS ON ENZALUTAMIDE: POST HOC ANALYSIS OF ARCHES

Neal D. Shore[1], Arnauld Villers[2], Taro Iguchi[3], Francisco Gomez-Veiga[4], Antonio Alcaraz[5], Arnulf Stenzl[6], Boris Alekseev[7], Arun A. Azad[8], Russell Z. Szmulewitz[9], Daniel P. Petrylak[10], Jeffrey Holzbeierlein[11], Brad Rosbrook[12], Fabian Zohren[12], Gabriel P. Haas[13], Georgia Gourgioti[14], Nader N. El-Chaar[13], Andrew J. Armstrong[15]

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Presented By: Russell Z. Szmulewitz, MD

Introduction: In the previously reported ARCHES trial (NCT02677896), enzalutamide (ENZA) + androgen deprivation therapy (ADT) vs placebo (PBO) + ADT improved overall survival (OS) and clinical outcomes in men with mHSPC. This *post hoc* analysis assessed clinical endpoints in men with mHSPC who reached undetectable PSA levels on ENZA+ADT or PBO+ADT and investigated predictors of such a PSA decline.

Methods: Men with mHSPC were randomized 1:1 to ENZA (160 mg/day) + ADT or PBO+ADT, stratified by disease volume and prior docetaxel. *Post hoc* analyses were based on reaching undetectable (<0.2 ng/mL) or detectable (≥0.2 ng/mL) PSA levels during study treatment and included men with both detectable baseline PSA (≥0.2 ng/mL) and post-baseline PSA measurements (ENZA+ADT, n=507; PBO+ADT, n=504). Stepwise multivariate analysis was conducted on variables from a univariate logistic regression model to identify clinical factors that significantly correlated with PSA decline to undetectable levels.

Results: PSA undetectable groups had fewer men with high-volume disease, Gleason scores ≥8, and *de novo* mHSPC; both ENZA+ADT groups had more men with these clinical factors. Men who reached undetectable PSA levels had improved clinical outcomes, e.g. delayed radiographic progression and improved OS (Table). Men on ENZA+ADT (n=348 [68.6%]) were almost four times more likely to reach undetectable PSA than men on PBO+ADT (n=89 [17.7%]). Predictors of reaching undetectable PSA on ENZA+ADT were the absence of *de novo* disease (M0 vs M1: odds ratio [OR] 4.3; p=0.001) and baseline PSA levels (below median vs above median: OR 3.3; p<0.0001). Men who reached undetectable PSA on ENZA+ADT had more treatment-emergent adverse events (TEAEs) but fewer serious and grade 3–4 TEAEs vs those with detectable PSA levels. Safety across treatment arms was similar to prior findings.

Conclusion: Men with mHSPC in ARCHES who reached undetectable PSA levels had improved clinical outcomes and less severe AEs. Men were more likely to reach undetectable PSA on ENZA+ADT vs PBO+ADT. The absence of *de novo* disease and baseline PSA may help identify men who reach undetectable PSA on ENZA+ADT.

This abstract was accepted and previously presented at the 2022 EAU Annual Congress.

Table: Clinical outcomes based on PSA decline to undetectable PSA levels[a]

Subgroup, n (%)	ENZA+ADT (n=507)		PBO+ADT (n=504)	
	Undetectable PSA (n=348 [68.6])	Detectable PSA (n=159 [31.4])	Undetectable PSA (n=89 [17.7])	Detectable PSA (n=415 [82.3])
Median OS, months (95% CI)	NR (54.21, NR)	36.44 (29.73, 48.46)	NR (50.33, NR)	47.70 (42.35, NR)
HR (95% CI)	0.24 (0.17, 0.34)		0.35 (0.22, 0.57)	
Median time to rPFS, months (95% CI)	NR (NR, NR)	14.00 (12.39, NR)	NR (NR, NR)	13.86 (12.35, 16.76)
HR (95% CI)	0.14 (0.09, 0.23)		0.24 (0.13, 0.43)	
Median time to PSA progression, months (95% CI)	NR (NR, NR)	NR (16.72, NR)	NR (NR, NR)	13.73 (11.07, 14.00)
HR (95% CI)	0.05 (0.02, 0.12)		0.07 (0.02, 0.17)	
Median time to new antineoplastic therapy, months (95% CI)	NR (NR, NR)	30.19 (20.04, 30.19)	NR (NR, NR)	21.06 (17.22, NR)
HR (95% CI)	0.13 (0.06, 0.26)		0.12 (0.05, 0.33)	
Median time to castration resistance, months (95% CI)	NR (NR, NR)	16.72 (13.83, NR)	NR (NR, NR)	11.01 (8.71, 11.20)
HR (95% CI)	0.16 (0.10, 0.25)		0.16 (0.09, 0.29)	
ORR, % (IQR)[b]	88.7 (80.6–94.2)	79.2 (68.0–87.8)	73.7 (48.8–90.9)	64.7 (56.6–72.3)

ADT=androgen deprivation therapy; CI=confidence interval; ENZA=enzalutamide; HR=hazard ratio; IQR=interquartile range; NR=not reached; ORR=objective response rate; OS=overall survival; PBO=placebo; PSA=prostate-specific antigen; rPFS=radiographic progression-free survival.

[a]The number of patients who achieved undetectable PSA levels (<0.2 ng/mL); [b]This analysis was conducted on patients who had measurable soft tissue disease at baseline (ENZA+ADT [undetectable PSA], n=97; ENZA+ADT [detectable PSA], n=72; PBO+ADT [undetectable PSA], n=19; PBO+ADT [detectable PSA], n=153).

Funding: Pfizer and Astellas Pharma, the co-developers of enzalutamide.
Acknowledgments: Medical writing assistance funded by the sponsors was provided by Terrance Ku, MSc and Jane Beck, MA (Hons) from Complete HealthVizion, and Kirstie Anderson of Onyx, a Prime Global agency.

Poster #26

PROSTATE BIOPSY SEPSIS PREVENTION: EXTERNAL VALIDATION OF AN ISOPROPYL ALCOHOL NEEDLE WASHING PROTOCOL

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Presented By: Anthony Hiffa, MD, MPH

Introduction: A recent study described a “pop-driven” isopropyl alcohol needle washing protocol (POP) that significantly decreased post-biopsy sepsis (PBS) rates after prostate biopsy. We examined efficacy of POP in our clinic population.
Methods: Data were reviewed for 1132 consecutive patients undergoing TRUS-guided prostate biopsy at the Charlie Norwood VA Medical Center from January 2017 to July 2022. Complications events were recorded over the time period. Student’s T test and chi-squared tests were employed to assess significant differences among study groups.

Results: There were 912 and 211 patients in pre-POP and post-POP groups, respectively. Groups had equivalent demographic features. Standard 12 core biopsies were done in 83% and 80% of pre-POP and post-POP groups, respectively (p=0.424). Total complication rates were 4% and 3.2% in pre-POP and post-POP groups, respectively (p=0.13). There were 13 sepsis events in the pre-POP group (1.5%) and none in the post-POP group (p=0.042). 63% and 86% of complications were Clavien-Dindo Grade I-II in pre-POP and post-POP groups, respectively (p=0.13). The pre-POP group contained a higher percentage of patients who received PO fluoroquinolone prophylaxis only (14% vs. 0%, P<0.001), and a lower number of patients who received IV antibiotics (5% vs. 14%, P<0.001). Subset analysis limited to patients who received standard prophylaxis with PO fluoroquinolone and IM gentamicin confirmed a significant difference in sepsis rates (1.5% vs 0%; p=0.034).
Conclusion: Adoption of POP was associated with a significant decrease in PBS. The study externally validates the initial report of POP, and data supports its clinical use.

Table 1. Prostate Biopsy Complications Data

	Total	Pre-POP	Post-POP	P Value*
N	1132	912	221	
Total (%)	45 (4%)	38 (4%)	7 (3.2%)	0.130
Post-Bx Sepsis	13 (1%)	13 (1.4%)	0	0.042
Non-sepsis Comps (%)	32 (2.8%)	25 (2.7%)	7 (3.2%)	0.362
Clavien-Dindo Scores (%)				
I	10 (0.8%)	8 (0.8%)	3 (1.4%)	0.259
II	20 (1.6%)	17 (1.9%)	3 (1.4%)	0.301
III	1 (<0.1%)	0	1 (0.5%)	0.021
IV	13 (1.1%)	13 (1.4%)	0	0.037
V	1 (<0.1%)	1 (0.1%)	0	0.311

*Chi-Squared; Significant when p<0.05

Funding: N/A

Poster #27

LONG-TERM COST ANALYSIS OF THIRD-LINE TREATMENT OPTIONS FOR OVERACTIVE BLADDER

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Presented By: Jessica Hammett, MD

Introduction: Overactive bladder (OAB) causes a frequent and sudden urge to urinate that may be difficult to control and can greatly affect patient's quality of life. When first- and second-line therapies including conservative management and antimuscarinic or beta-3 agonist medications fail to improve symptoms, third line options such as injections of botulinum A (BTX), sacral nerve stimulation (SNS), and percutaneous tibial nerve stimulation (PTNS) may be employed as possible treatment options. Our aim was to analyze long-term cost of these third-line treatments.
Methods: This insurance claims review analyzed 2015-2020 MarketScan (MKS) claims dataset subjects with age 18 or more, a diagnosis of OAB using ICD-9 / ICD-10 codes and receipt of treatment for PTNS, SNS, and BTX using CPT codes after diagnosis. Information on age, gender, treatment types, and costs for treatment were extracted from the database along with treatment with anti-cholinergic medications from pharmacy claims. Treatment costs were aggregated at the level of patient and treatment type for total payment and patient contribution by combining co-pay, co-insurance, and deductible. We used the Wilcoxon rank-sum test for continuous and chi-square test for categorical variables. SAS v9.4 was used for all analyses. Significant was set at p<0.05.
Results: We identified 17,755 patients from the commercial claims MKS and 10,912 patients from the Medicare supplemental (MDC) database with mean age 50.7±11.1 and 75.5 ±7.6, respectively, who underwent ≥1 third line OAB treatment. Patients receiving third-line treatment were predominantly female (84.9%, MKS, 74.8%, MDC). Long-term costs over a 15-year period were estimated. PTNS is the most expensive in terms of total

net payment ($105,337.50MKS, $94,102.50 MDC) and patient contribution ($9,177.60 MKS, $3,921.00 MDC). Total net payment for BTX was $67,968 (MSK), $54,261 (MDC) and patient contribution cost was $2,850 (MSK), $1,110 (MDC). The most cost-effective option was SNS in terms of both total net payment ($5,179.10 MKS, $6.099.00 MDC) and patient contribution ($59.10 MKS, $60.00 MDC).
Conclusion: SNS was the most cost effective third line treatment for OAB looking over a 15-year period in terms of both total net payment and patient contribution. PTNS over a long-term period was shown to be significantly more expensive.
Funding: N/A

Poster #28

DE NOVO URGE INCONTINENCE AFTER ARTIFICIAL URINARY SPHINCTER PLACEMENT: IT'S MORE COMMON THAN YOU THINK

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Presented By: Dustin L. Whitaker, MD

Introduction: We aim to investigate the incidence of de novo overactive bladder (OAB) or urge urinary incontinence (UUI) following artificial urinary sphincter (AUS) placement in men with no prior history of these symptoms.
Methods: A retrospective review examining Current Procedural Terminology (CPT) codes 53444-53449 billed from 2016-2022 by a single surgeon at a single institution was conducted. Pre-operative and post-operative OAB/UUI symptoms were assessed. Need for post-operative OAB/UUI treatment and history of radiation therapy were evaluated.
Results: 87 patient encounters were identified. 68 patients met inclusion criteria of primary AUS placement with no history of AUS explantation procedure or incomplete follow up. One patient developed stress urinary incontinence after TURP and radiation, with the remainder having a history of radical prostatectomy. 51 men (75%) undergoing AUS placement denied pre-operative OAB/UUI and 17 men (25%) endorsed preoperative OAB/UUI. In the group with no preoperative symptoms, 9 patients (18%) developed de novo OAB/UUI after AUS placement. Of these patients, 2 (22%) elected observation, 4 (44%) remained on OAB medications and 3 (33%) required third line surgical therapies for OAB/UUI refractory to medical management. History of radiation therapy was noted in 8 patients (47%) with preoperative OAB/UUI and 4 patients (44%) who developed de novo OAB/UUI. Among the 10 patients who required third line surgical therapies, 4 (40%) had a history of radiation and 6 (60%) did not. Mean time from radiation was 9.5 years.
Conclusion: In our cohort, a significant number of patients report de novo OAB or UUI symptoms following AUS placement. Clinicians should conduct thorough screening prior to AUS placement and counsel patients regarding the possibility of subclinical or de novo OAB/UUI. Identification and diagnosis of persistent incontinence or bothersome lower urinary tract symptoms following AUS placement is crucial, as these patients may require medical or surgical therapies for OAB/UUI rather than AUS revision.
Funding: N/A

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Poster #29

ESTABLISHING A NEW GENDER AFFIRMINATION PROGRAM IN THE DEEP SOUTH: DISTRIBUTION OF PATIENT DEMOGRAPHICS, PAYER MIX, AND DISTANCE TRAVELED FOR CARE

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Presented By: Brian Ceballos, MD

Introduction: As an integral part of resolving gender dysphoria, the establishment of a new gender affirming surgical program has introduced a riveting opportunity for patients with gender dysphoria in the Deep South. The objective of this study is to evaluate the demographics and surgical parameters around a new transgender surgical program at our institution.
Methods: A retrospective chart review was conducted over a 21-month time frame between June 2020 and March 2022.
Results: 112 patients were included in our transgender database. Of the 112 patients, our current investigation focused on 99. The average age and BMI were 37.9 and 28.4, respectively. Most of the patients were Caucasian (83 patients, 83.8 %) and were covered by private insurance (87 patients, 87.9%). All patients were followed by an endocrinologist. World Professional Association for Transgender Health (WPATH) Criteria for transgender surgery was not met by most patients by time of initial consultation (86 pts, 87%), with the most common missing component being two supporting letters from other providers. While most patients had not had previous gender affirming surgery prior to surgical consultation at our institution (75 pts, 76%), nearly half of the patients who saw us ultimately underwent gender affirming surgery (either vaginoplasty or vulvoplasty) at our institution (48 pts, 48.5%), with the average patient traveling 177.1 miles.
Conclusion: Establishment of a new gender affirming surgery program in the deep south revealed a robust referral program. All patients had been seen by endocrinologists, while many others had seen a variety of other specialties prior to presentation to our transgender surgery program. Approximately half of patients had undergone surgery with our program, and patients traveled on average over 170 miles. Further investigations about distance from other programs and multi-disciplinary institutions should be conducted to compare different regions of the country that serve different populations.

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Table 1: Demographics and Perioperative Characteristics of Patients who were seen in our Gender Affirming Surgical program

Age (year)	37.94 ± 14.46
Race	
Caucasian	83 (83.8%)
Black/African American	11 (11.1%)
Hispanic	1 (1%)
Unknown	4 (4%)
BMI (kg/m^2)	28.41 ± 6.68
Average distance traveled (miles)	177.12 ± 225.32
Providers seen	
Endocrinology	99 (100%)
Mental Health Specialist	87 (87.9%)
Plastic Surgery	19 (19.2%)
Urology	9 (9.1%)
Social Worker	3 (3.03%)
Smoking history	
Cigarettes	12 (12.1%)
Vape	2 (2%)
None	85 (85.9%)
Permanent Hair Removal	
Yes	55 (55.6%)
No	44 (44.4%)
Covered by private insurance	
Yes	87 (87.9%)
No	12 (12.1%)
Prior Gender Affirming Surgeries	
Yes	22 (22.2%)
No	77 (77.8%)
Underwent Gender Affirming Surgery at our institution	
Yes	48 (48.5%)
No	51 (51.5%)
WPATH Criteria met at time of initial consultation	
Yes	13 (13.13%)
No	86 (86.9%)
If WPATH Criteria not met, missing component	
2+ letters from providers	81 (81.8%)
<12 months hormone therapy	1 (1.01%)
Both letters/<12-month hormones	4 (4.04%)

Abbreviation(s):

*WPATH: World Professional Association for Transgender health

Funding: N/A

Poster #30

QUALITATIVE ANALYSIS OF REASONS FOR DELAYING DEFINITIVE TREATMENT OF URETHRAL STRICTURE DISEASE

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Presented By: Rohan Bhalla, MD

Introduction: Urethroplasty (UPL) for urethral stricture disease (USD) has high success and satisfaction rates. Despite this many patients undergo repeat endoscopic management with either dilation or urethrotomy. Our primary goal was to obtain a more comprehensive understanding of patient decision making to undergo UPL in patients who had undergone multiple prior endoscopic procedures.
Methods: We conducted 20 semi-structured interviews with patients who underwent UPL and had previously undergone 2 or more endoscopic procedures. Interviews were audio recorded and transcribed. A hierarchical coding system was developed using the interview guide and preliminary review of transcripts. Transcripts were coded by experienced qualitative researchers. The coded transcripts were analyzed using an iterative inductive-deductive approach.
Results: Most patients experienced similar clinical trajectories following symptom onset characterized by growing concern, seeking and receiving a USD diagnosis, and then undergoing endoscopic procedures such as dilations to relieve symptoms. Despite experiencing temporary relief, most patients expressed dissatisfaction with endoscopic procedures and reported that they failed to improve their quality of life (QoL). QoL appraisals were an interaction between clinical trajectory and psychological factors such as emotional response, control beliefs, and internal comparisons. Participants described feelings of shame and embarrassment, limited control, and adverse comparisons of their current reality to “what they used to do”. Declining QoL and intensifying symptoms led patients to reach a “turning point” where they sought urethroplasty surgery as their only hope. Additionally, patients had concerns about the surgery including cost, transportation, distance, caregiver support, comorbidities, and recovery times. Patients’ perception of their surgeons also played a critical role in their surgery decisions. Patients who trusted their surgeons, reported high quality of communication, and a shared decision-making process were eager to have urethroplasty if recommended by the surgeon. Mistrust and negative communication experiences were associated with a fear and reluctance towards surgery.
Conclusion: QoL, psychological responses, logistical factors, and relationships with surgeons all influenced the decision to seek urethroplasty, with a trajectory of worsening symptoms and declining QoL being the most important factor.
Funding: N/A

Poster #31

QUANTIFYING PUBOCERVICAL FIBROMUSCULARIS ELASTICITY UNDER NORMAL AND PROLAPSE CONDITIONS BY SHEAR WAVE ELASTOGRAPHY AND COMPARISION WITH URODYNAMICS FINDINGS

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Presented By: Sarah Salem Abdelhameed

Introduction: To determine whether elasticity quantification of the pubocervical fibromuscularis in patients with anterior pelvic organ prolapse correlates with urodynamics findings of stress urinary incontinence.
Methods: This study was a single-center prospective observational study, including no-prolapse (n= 114) and anterior pelvic organ prolapse patients a) stage II (n= 101), b) stage III (n= 41) and c) stage IV (n= 7) women. Data collection included baseline characteristics, physical examination data, Pelvic Floor Impact Questionnaire, and pelvic

floor ultrasonography with elastography measurements. The elastography measurements (E/B Ratio) were taken between the anterior vaginal wall and bladder floor. The Valsalva leak point pressure (VLPP) determination series was repeated two times in each subject. The patients were classified into three groups according to VLPP; 1) VLPP≤60 cm H2O, 2) 6090 cm H2O.
Results: A total of 263 subjects were enrolled in this study, with a total of 269 pelvic floor ultrasounds. The cohort's mean age was 67.4 years, the mean body mass index (BMI) was 29.2, and 78.4% were of Caucasian ethnicity. The group of patients with pelvic organ prolapse ≥ stage II were older with a mean age of 69.1, and had more vaginal deliveries, with a mean 2.5 deliveries. Comparing the VLPP prolapse groups and elastography measurements on the pubocervical fibromuscularis: stage II (69 cm H20), stage III (59 cm H2O) and E/B ratio stage II (6 +/-2) and stage III (9 +/-1) (p=<0.05)
Conclusion: Patients with VLPP <60 cm H2O correlated with ultrasonography E/B ratio elastography measurements of 9 +/-1 and these patients had an anterior pelvic organ prolapse stage III. This may open new indications for pelvic floor ultrasound.
Funding: N/A

Poster #32

ASSESSING THE READABILITY OF ONLINE PATIENT EDUCATION RESOURCES RELATED TO PHALLOPLASTY

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Presented By: Praneet Paidisetty

Introduction: Despite the National Institutes of Health recommending patient education materials (PEMs) be written at the 6th-7th grade readability level, online PEMs are often difficult to read. On average, transmasculine persons are more likely to be below the poverty line and less likely to be college educated than biological males, negatively influencing health literacy. PEMs with advanced readability can further negatively affect transmasculine patients' health literacy and understanding of treatment plans, increasing barriers to care and worsening health outcomes and patient satisfaction. This study assessed the readability of online phalloplasty PEMs.
Methods: The English and Spanish terms "phalloplasty" and "faloplastia" were queried on Google and the first fifty Uniform Resource Locators (URLs) for each search term were selected. Included resources were non-video, free articles. Each URL was categorized into institutional (government, medical school, teaching hospital), non-institutional (private practice, news channel, blog, etc.), and academic (journal article, book chapter) groups. Readability scores were generated using the Simple Measure of Gobbledygook (SMOG) and the Spanish SMOG scales for collected URLs.
Results: Overall, online phalloplasty PEMs surpassed recommended reading levels in both English ($\bar{x}$ = 13.9, university sophomore) and Spanish ($\bar{x}$ = 10.8, high school junior). The lowest reading level observed in either language was 8th grade. For English materials, non-institutional PEMs were more difficult to read than institutional PEMs ($p < 0.05$). Conversely, for Spanish PEMs, there was no significant difference in readability between institutional and non-institutional PEMs. English PEMs were harder to read than Spanish PEMs overall ($p < 0.001$) and when comparing across the three categories between the two languages ($p < 0.001$).
Conclusion: Our results show that the readability of English and Spanish materials for phalloplasty exceeds recommended levels. An estimated 3% of transmasculine persons undergo phalloplasty, an irreversible surgery with the highest rate of complications among gender-affirming procedures. Thus, it is vital that these patients are provided with educational material appropriate to their literacy level in order for them to truly give informed consent. Online information for phalloplasty should be revised and/or standardized materials should be created by trans-affirming healthcare providers and

national organizations in order to more fully educate the public and prospective patients prior to intervention.
Funding: N/A

Poster #33

PULMONARY DISEASE INCREASES COMPLICATIONS AFTER ELECTIVE PERINEAL SURGERY IN MEN: DATA FOR QUALITY IMPROVEMENT

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Presented By: Rahul Dutta, MD

Introduction: Elective perineal surgery in men is performed for incontinence, urethral stricture, or prostate cancer. Given the small operative field, proximity to the anus, and tissue stress from ambulation, potential complications include bleeding, infection, and wound separation. The incidence and risk factors for complications specific to these cases have not been thoroughly examined and was the purpose of this investigation.
Methods: We queried the prospectively maintained National Surgical Quality Improvement Program (NSQIP) database from 2015-2019 for cases of male perineal surgery including placement of male sling or artificial urinary sphincter (prosthetics; PR), perineal prostatectomy (PP), posterior urethroplasty (URP), and perineal urethrostomy (PU). Patient demographics, operative details, and 30-day complications data were analyzed.
Results: A total of 3,967 cases met search criteria, with most (65%) being PR. Mean age was 66 years and mean body mass index (BMI) was 29 kg/m2. Mean length of stay (LOS) was 1.5 days. Transfusions within 30 days were rare (1.3%), but significantly more likely after PP (5.9%; $p<0.0001$). Wound infections and separations were also low (1.2 and 0.6%, respectively), and did not vary by operation ($p>0.05$); wound separation, however, was more likely with preoperative steroid usage (2.9% vs 0.5%, $p=0.0016$). Elevated BMI was associated with wound infection ($p=0.0375$). Urinary tract infection (UTI) was seen in 2.2% of cases, but significantly more after URP (3.8%) and PP (4.1%) than for PR (1.2%) and PU (2.7%) ($p<0.0001$). 30-day readmissions occurred most after PU (11%) and least after PR (3.4%; $p<0.0001$). Mean LOS was longer for PP than all other surgeries (3.2 days, $p<0.0001$). Chronic obstructive pulmonary disease (COPD) was associated with both wound separation (2.3% vs 0.5%, $p=0.0087$) and need for transfusion (4.6% vs 1.2%, $p=0.0008$). Diabetes was not significantly associated with complications ($p>0.05$).
Conclusion: Despite the challenge of surgery and postoperative wound care within the perineum, cases of transfusion, infection, and wound separation are low. However, wound and bleeding complications were significantly higher among patients with COPD. This may be related to oxygenation, chronic coughing, or variables unaccounted for by NSQIP. Men planned for perineal surgery should be queried for COPD for preoperative counseling, and future work should evaluate the role for pulmonary prehabilitation.
Funding: N/A

Poster #34

AGATSTON CALCIUM SCORE ASSESSMENT OF PLAQUE CALCIFICATION IN PEYRONIE'S DISEASE

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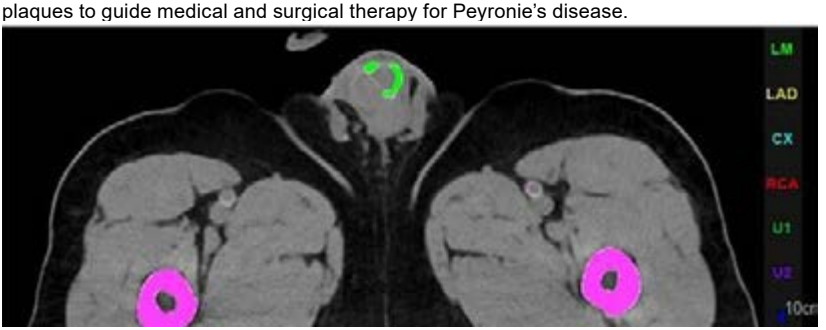
Presented By: Daniela Andrea Haehn, MD

Introduction: Fibrosis and plaque formation are often part of Peyronie's Disease (PD) pathophysiology. Calcified plaques can alter treatment planning, as patients are excluded from receiving collagenase injection therapy and can require more extensive surgery (plaque excision and grafting, inflatable penile prosthesis placement or plaque incision and grafting). Penile ultrasound with Doppler (PUS) is used to exclude erectile dysfunction and identify plaques. However, plaque extent and distribution can be obscured by acoustic shadowing, limiting complete plaque characterization. Non-contrast pelvis computed tomography (CT) provides a noninvasive method to identify plaques in 3 dimensions

and quantify plaque Calcium (Ca) burden. Agatston Ca scoring has potential to measure Ca burden more consistently as 3 plane plaque measurement can be affected by penile curvature or positioning. This study aims to utilize CT scans with Agatston Ca score to quantifiy calcium levels in PD plaques.
Methods/Materals: A retrospective database from 1/1/2017 and 6/30/2021 identified 25 men with calcified plaques on CT after PUS performed by a single urologist. Two abdominal radiologists CT reviewed in consensus to measure calcified plaque size and distribution on Visage PACS. Semiautomated Agatston Ca scoring values were obtained with Syngo.via. Total Ca volume/mm3, total Ca score were correlated with hourglass deformity on clinical exam, plaque complexity on CT (>2 discrete calcified plaques, circumferential corpus cavernosum involvement, septal involvement), and surgical management using descriptive statistics and t-test.
Results: Mean Ca volume 1417 mm3 (range 1.4-5425.7, standard deviation (SD) 1570); mean Ca score 1691 (range 1.6-6048; SD 1862) with significantly higher Ca volume in patients with complex plaques (265 mm3 vs 472 mm3, $p<0.05$), and significantly longer plaque dimension for longest plaque dimension measured by CT vs US (31 vs 23, $p<0.05$). There was no significant difference in Ca volume for nonsurgical vs surgical (1791 vs 893, $p=0.06$) or for no hourglass vs hourglass deformity (1173 vs 1904, $p=0.19$).
Conclusion: CT scan and calcium scoring are useful tools in the assessment of PD. Semiautomated Ca scoring may help noninvasively identify complex calcified penile plaques to guide medical and surgical therapy for Peyronie's disease.



Funding: N/A

Poster #35

URETHRAL LENGTH (UL) AS A PREDICTOR FOR INTRACORPORAL LENGTH (ICL) PRIOR TO INFLATABLE PENILE PROSTHESIS (IPP) PLACEMENT: IMPLICATIONS FOR OPERATING ROOM PROCEDURE

Nicholas Deebel, M.D.[1,2], Justin Refugia, M.D.[1,2], Collette O'Oconnor, B.S.[3], Raymond Xu, M.D.[1,2], Ryan Terlecki, M.D.[1,2]
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Presented By: Nicholas Deebel, MD

Introduction: Measurement of ICL dictates IPP size with reservoir sizing determined by cylinder length and/or surgeon preference. Stretched penile length helps set expectations for postoperative penile appearance but does not adequately predict total ICL. No prior research has determined if UL correlates to ICL.
Methods:
Our IRB-approved database was reviewed for cases of IPP (penoscrotal) with urethral assessment. Initially, a 14 French silicone Foley catheter was placed with 10 mL in the balloon. Exposed catheter length (ECL) was measured (cm) with penis on stretch as distance between urethral meatus and catheter hub. This reflects UL given a fixed catheter length between hub and balloon.
Results: 116 patients (mean age 64.7 +/- 0.8 years) were included. History of intracavernosal injection or Peyronie's disease did not impact ECL ($p > 0.05$). Mean ECL were calculated per IPP size range: 16-19.9, 20-22.9, 23-26 cm; 8.8 +/- 0.3, 7.0 +/- 0.3, 3.8

+/- 0.5 cm, respectively (p < 0.0001). Exclusion of patients with prior radical prostatectomy RALP (n = 34) were similar: 8.1+/- 0.3, 6.3 +/- 0.3, 3.0 +/- 0.4 cm respectively (p < 0.0001). ECL negatively correlated with total IPP size (R2= 0.48; slope -0.53). Exclusion of RALP patients yielded a stronger correlation (R2= 0.66; slope -0.67). After excluding RALP patients and significant simple linear regression, multivariate linear regression with BMI and ECL maintained a significance for ECL (R2= 0.66; slope -0.65; p < 0.0001). When stratified by race (African American, AA) mean ECL was less in AA men (4.4 +/-0.6 vs. 6.4 +/- 0.3 cm)(p < 0.05).
ECL was examined as a predictive factor for 100cc reservoir size. A threshold of ≤ 7cm carried a sensitivity of 81.1% for all patients and 92.1% for those without RALP. When stratified by race, a threshold of ≤ 7 and ≤ 5.5 cm carried a sensitivity of 93.3% and 80% respectively for AA men and 90.5% and 60% respectively for Caucasian men.
Conclusion: ECL, a surrogate for UL, may predict ICL and dimensions of IPP components, especially in patients with intact prostates. This may allow for preemptive device preparation, increased operating room efficiency, and offer insight into adequacy of corporal dilation.

A.

	African American	Caucasian	p value
Exposed catheter length (ECL) (cm)	4.4 ± 0.6	6.4 ± 0.3	< 0.05
Total device length (cm)	22.7 ± 1.6	20.7 ± 0.2	< 0.05
Rear tip extension length (cm)	1.3 ± 0.4	1.8 ± 0.2	> 0.05

B.

	African American	Caucasian	p value
ECL vs total length (slope, R^2)	-0.56, 0.63	-0.64, 0.80	> 0.05
ECL vs. cylinder/total length ratio (slope, R^2)	-0.01, 0.1	-0.01, 0.04	> 0.05

Table 1. Stratification of IPP recipients without history of RALP by race. 1A depicts comparison of means for ECL, total device length and rear tip extension length (cm). 1B depicts the relationship between ECL and total length as well as ECL versus the ratio of cylinder (Total length – rear tip extension) to total length.

Funding: N/A

Poster #36

SMALL FIBER POLYNEUROPATHY IS A SIGNIFICANT FEATURE OF THE SYSTEMIC PAIN SUBGROUP IN PATIENTS WITH INTERSTITIAL CYSTITIS/ BLADDER PAIN SYNDROME

Presented By: Wyatt Whitman, M.D., B.S.

Introduction: In addition to a variety of co-occurring urological and non-urological symptoms and syndromes, we have found that ~30% of patients with a diagnosis of interstitial cystitis/bladder pain syndrome (IC/BPS) also have small fiber polyneuropathy (SFPN). The objective of this study was to determine the association between SFPN and co-occurring symptoms and syndromes in IC/BPS patients.
Methods: Skin biopsies were taken from the distal calf of IC/BPS patients who were undergoing therapeutic hydrodistension (HOD). SFPN status (+ or -) was determined by counting intraepidermal nerve fibers (IENF) in a stained section from the biopsy and comparing the IENF density to normative reference values. Patient characteristics such as anesthetic bladder capacity (BC), Hunner lesion (HL) status, and glomerulations were determined at the time of hydrodistension under direct cystoscopy. Information regarding demographics, co-occurring medical conditions, and symptomatology was obtained via patient reports and review of medical records. To test for an association of SFPN+ with demographic and clinical characteristics, a logistic regression model was calculated. Since diabetes is a known cause of SFPN, all subsequent analyses were adjusted accordingly. A logistic regression model was developed using stepwise methods (backward regression) with statistical significance considered at p ≤ 0.05. Standard logistic regression diagnostics were utilized to ensure the model fit to the data.
Results: Between October 2019 and April 2022 133 participants were enrolled; 117 females and 16 males. Mean age was 50.1 (± 15.5). Overall, one third were SFPN+ (43/133; 32.33%). There was a statistically significant difference in the following adjusted odds ratios (OR, [95% CI]) between the SFPN+ and SFPN- groups: thyroid disease (5.47, [1.099, 27.204]), chronic pelvic pain (4.74, [1.51, 14.91]), chronic fatigue syndrome (17.60,

[2.91, 106.69]), migraines (0.071, [0.014, 0.354]), allergies (0.192, [0.056, 0.659]), and diabetes mellitus (4.71, [1.27, 17.51]) (Table 1).
Conclusion: Small fiber polyneuropathy is common in patients with IC/BPS and this study has identified a significant positive correlation between SFPN and a concomitant diagnosis of CFS, CPPS, or DM in these patients. These findings align with the concept that a large subset of IC/BPS patients have a systemic pain disorder that may be amenable to a more targeted therapeutic approach.

Table 1. Logistic regression analysis to identify associations between clinical features in IC/BPS patients with and without SFPN.

			95% CI		
	S.E.	OR	Lower	Upper	p-value
Thyroid Disease	0.819	5.467	1.099	27.204	0.038
Chronic Pelvic Pain Syndrome (CPPS)	0.584	4.744	1.51	14.907	0.008
Chronic Fatigue Syndrome (CFS)	0.919	17.604	2.905	106.689	0.002
Migraines	0.82	0.071	0.014	0.354	0.001
Allergies	0.63	0.192	0.056	0.659	0.009
Diabetes Mellitus (DM)	0.67	4.707	1.265	17.506	0.021
Constant	0.42	0.353			0.013

Variables in the model: Age, Gender, Race, BMI, Hx/Current Smoker, HOD BC, HL status, any Glomerulations, ICSI, ICPI, PUF, thyroid Dz, Vitamin B12 Deficiency, any autoimmune, Endometriosis, Irritable Bowel Syndrome (IBS), Chronic Pelvic Pain (CPP), chronic fatigue syndrome (CFS), Fibromyalgia, Migraines, Depression, Panic Disorder, Allergies, Asthma, Vulvodynia, non-low BC, Diabetes Mellitus (DM). S.E. = standard error; OR = odds ratio

Funding: R01 DK124599

Poster #37

THE EFFECTS OF A NON-DEPOLARIZING NEUROMUSCULAR BLOCKER ON SACRAL NEUROMODULATION AND PATIENT OUTCOMES: A PROSPECTIVE ANALYSIS

Mason Holtel, MD[1], Anastasia Couvaras, MD[1], Kelly Kossen[2], Courtney Nguyen[2], Colin Goudelocke, MD[1]
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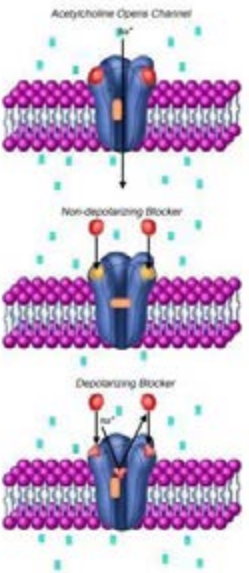
Presented By: Mason S. Holtel, MD,BS

Introduction: Succinylcholine is a common anesthetic induction agent used in the outpatient surgery setting due to its short half-life. Rocuronium, a non-depolarizing muscle relaxer, can be given alongside succinylcholine in low doses with the intention of reducing postoperative myalgias, a common side effect of succinylcholine. This use, although incompletely studied, is often practiced by anesthesiologists who theorize that these defasciculating doses minimally affect the neuromuscular synapse thereby having a negligible effect on motor response during sacral neuromodulation (SNM) testing.
Methods: Twenty-six patients underwent staged SNM testing by a single surgeon at the study institution from 10/2021 to 08/2022. A defasciculating dose of rocuronium (≤10 mg) was used in 16/26 patients. Prospective analysis was performed to assess opening thresholds during stage 1 testing as well as rates of stage 2 implantation. Symptom surveys were obtained within 14 days of stage I testing to assess for postoperative myalgia. Statistical analysis was performed using T-test for bellows and toe threshold means, chi-square analysis was used to compare implantation rates between the two groups, and Fischer's Exact test was applied to survey answers to compare postoperative myalgia rates.
Results: Mean opening threshold for bellow response was 0.67±0.24 mA in the control group and 0.72±0.41 mA for those that received rocuronium (p=0.27). Mean opening threshold for toe response between the non-rocuronium group versus rocuronium pretreated was 0.99±0.71 mA and 0.73±0.19 mA respectively (p=0.31). 8/10 patients that did not receive rocuronium proceeded with generator implantation versus 15/16 of the

treatment group (p=0.54). 0/10 patients without rocuronium reported postoperative pain outside of the surgical site versus 3/16 in the treatment group (p=.26).
Conclusion: There was no statistically significant difference between opening thresholds for bellows or toe when comparing rocuronium and non-rocuronium groups. No statistically significant difference was observed in rates of generator implantation between the groups. The use of rocuronium does not significantly affect the rate of reported muscle pain after stage I SNM. This study suggests that defasciculating rocuronium doses can safely be administered without altering SNM lead placement, but its role in reducing postoperative myalgia may need further investigation.

Figure 1: Demonstration of mechanism of acetylcholine, non-depolarizing neuromuscular blockers, and depolarizing neuromuscular blockers.



Funding: N/A

Poster #38

LOW BLADDER CAPACITY HUNNER LESION NEGATIVE INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME PATIENTS COMPRISE A UNIQUE BLADDER-CENTRIC PHENOTYPE

Maxwell Sandberg, MD, MS[1], Wyatt Whitman, MD[1], Robert Evans, MD[1], Gopal Badlani, MD[1,2], Catherine Matthews, MD[1], Stephen Walker, PhD[1,2]
[1]Wake Forest University School of Medicine, [2]Wake Forest Institute for Regenerative Medicine
Presented By: Maxwell Sandberg, M.D., M.S.

Introduction: Interstitial cystitis/bladder pain syndrome (IC/BPS) patients constitute a heterogeneous population both in terms of molecular and clinical characteristics, falling broadly into two phenotypic subgroups: bladder-centric and non-bladder centric. Bladder-centric patients are typically older, with higher symptom scores and fewer non-urological symptoms, and represent 15-20% of all IC/BPS patients. Whereas the presence of Hunner lesion (HL) is widely considered a hallmark of the bladder-centric phenotype, we have found that >50% of bladder-centric IC/BPS patients with low bladder capacity (low BC) are HL-. The objective of this study was to determine if there are unique

molecular characteristics that can distinguish the HL+ and HL- bladder-centric phenotypic subgroups.

Methods: Samples from 19 female IC/BPS patients (7 HL+; 12 HL-) with a low anesthetic BC (≤ 500cc) were selected from our tissue bank (IRB00018552) for gene expression profiling. Patients had previously undergone therapeutic bladder hydrodistention (per the NIDDK guidelines) at which time BC and HL status were recorded and mucosal biopsies were collected from the posterior bladder wall. Total RNA was isolated from the biopsies per standard protocols and assayed on whole genome microarrays (Illumina HT v4 BeadArray). Results were analyzed using Qlucore Omics Explorer and Ingenuity® Pathway Analysis software.

Results: In the comparison between samples from HL+ and HL- patients, 427 differentially expressed transcripts (DETs) were identified as significant ($q \leq 0.05$). DETs were enriched in a variety of biological pathways, notably the macrophage classical activation signaling (MCAS) pathway and the PD-1/PD-L1 (programmed cell death) cancer immunotherapy pathway. The MCAS pathway was upregulated in HL+ samples (p=6.29e-21); activation leads to upregulation of M1 macrophages, which produce inflammation, and inhibition of M2 macrophages, which are responsible for blocking inflammation. Activation of this pathway also upregulates CXCL9/10/11, potential biomarkers in IC/BPS. The PD-1/PD-L1 pathway, which inhibits T-cell function, was downregulated in HL+ samples (p=2.59e-16) and may signal an attenuation of the immune response in HL- low BC patients (Figure 1).

Conclusion: This initial comparison of differential gene expression in bladder mucosal biopsies from low BC IC/BPS patients with and without HL provides support for the concept of a bladder-centric HL- IC/BPS phenotypic subgroup that is distinct from the established HL+ phenotype.

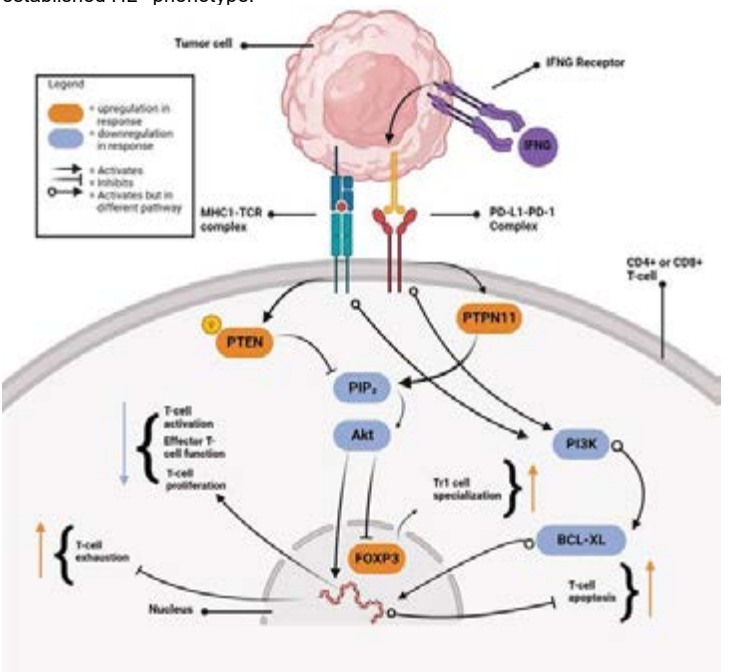


Figure 1. PD-1/PD-L1 Cancer Immunotherapy Pathway. This pathway is activated in T-cells through the interaction of ligand PD-L1 on PD-1 receptors. Activating this pathway inhibits T-cell function and proliferation and can promote apoptosis. This pathway was upregulated in low BC HL- samples relative to low BC HL+, indicating a downgraded immune response in this patient population. This supports the idea that low BC HL- patients should be treated as a distinct phenotype, potentially driven by immune suppression.

Funding: R01 DK124599

Poster #39

EVALUATION AND MANAGEMENT OF TRAUMATIC URETERAL INJURIES AT A HIGH VOLUME URBAN TRAUMA CENTER

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University of Tennessee Health Science Center
Presented By: Christine M. Callaway, MD

Introduction: Traumatic ureteral injuries are a rare entity, accounting for 1% of urologic trauma. Traumatic ureteral injury typically occurs in the setting of significant trauma and is almost always associated with concomitant injuries to other abdominal structures. We aim to review pre-operative evaluation and management of patients presenting with traumatic ureteral injury.
Methods: A retrospective analysis of adult patients with traumatic ureteral injuries presenting to a single level I trauma center from 2018-2021 was performed.
Results: A total of 13 patients, with 14 ureteral injuries were identified for analysis. Most patients were young (mean age 32.7 years) males (76.9%, N=10). The mechanism of injury was gun-shot wound in 92.9% (N=13) and iatrogenic in 7.7% (N=1). Gross hematuria was present in only 30.8% of patients (N=4); of these patients, 3 had associated bladder injuries. Most patients, 61.5% (N=8), were taken to the operating room, due to critical condition, without pre-operative cross-sectional imaging. Of those with pre-operative imaging, none were diagnostic. Diagnosis was made by laparotomy in 71.4% of injuries (N=10) and by retrograde ureterogram in 28.6% (N=4). Using the American Association for the Surgery of Trauma – Organ Injury Score classification of ureteral injuries, Grade 4 injuries were most common (57.1%), followed by Grade 1 (14.3%), Grade 2 (14.3%), Grade 3 (7.1%), and Grade 5 (7.1%). Distal ureteral injuries were most common (71.4%, N=10) followed by mid and proximal injuries, which occurred with equal frequency (14.3%, N=2, for each). Concomitant abdominal injuries were present in 92.9% of all patients (N=13) and in 100% of patients presenting with penetrating trauma. Ureteral injuries were treated by ureteral reimplantation (57.1%, N=8), ureteroureterostomy (28.6%, N=4), stent placement (7.1%, N=1), and percutaneous nephrostomy placement (7.1%, N=1).
Conclusion: Traumatic ureteral injury is rare, and these patients often present in critical condition. In this series, GSW is the predominant mechanism of ureteral injury. Providers should have a low threshold to proceed with surgical evaluation as physical examination and pre-operative imaging findings were non-diagnostic. Prompt management of ureteral injuries should be performed with ureteral stent placement or debridement of devascularized tissue with a tension-free, water-tight, mucosa-to-mucosa anastomosis.
Funding: N/A

Poster #40

SHORT-TERM WORK, LONG-TERM EFFECTS: EXAMINING TOILETING BEHAVIORS AND BLADDER HEALTH IN GIG ECONOMY WORKERS

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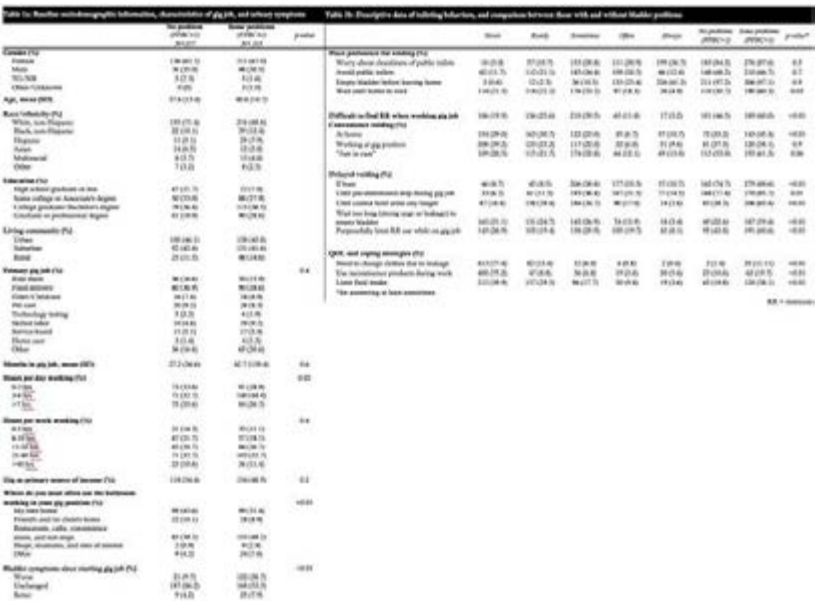
Presented By: Leah Chisholm, MD

Introduction: An increasing percentage of the population participates in the “gig economy” – short-term work through online applications. This work often requires continuous travel without reliable restroom access. We aimed to assess toileting behaviors and bladder health in community-dwelling gig economy workers.
Methods: Adult gig workers were electronically recruited using ResearchMatch. Participants completed validated questionnaires assessing bladder health, toileting behaviors, and information about working in the gig economy. The Patient Perception of Bladder Condition (PPBC) was used to assess their perception of their bladder health, with responses >1 (“My bladder condition causes me…” at least “some very minor problems”) considered positive for bladder problems. Toileting behaviors, coping

strategies, and aspects of their work were compared between those with and without self-perceived bladder problems.

Results: Of the 532 gig workers who participated, 59% reported self-perceived bladder issues (PPBC>1). Demographics and type of gig work were similar between groups. Most participants identified as middle-aged, college-educated, white, non-Hispanic females living in urban or suburban areas. The most common type of gig employment was food delivery services, and about half reported their gig work as their primary source of income. While at work, those with at least some bladder issues based on PPBC reported using public restrooms more often (49%), and were more likely to have difficulties finding restrooms (60%), engage in delayed voiding (85%), and use bladder coping behaviors such as limiting restroom use (60%) and fluid intake (38%). Lastly, workers with perceived bladder issues reported longer employment in gig economy (42 mo. vs 27 mo.), and 39% felt that their bladder symptoms worsened since starting their gig job.

Conclusion: Both gig workers with and without perceived bladder issues report their job in the gig economy effects their bladder behaviors. Gig workers with perceived bladder problems are more likely to demonstrate unhealthy toileting behaviors and coping strategies while at work. Limitations in reliable restroom access for gig workers may contribute to these poor toileting habits which may further exacerbate underlying bladder conditions. Further research is needed to better understand the long-term associations between of bladder health and employment in the gig economy.



Funding: N/A

Poster #41

COMPARISON OF TRANSPERINEAL MRI GUIDED BIOPSY VS TRANSPERINEAL TEMPLATE BIOPSY IN DETECTION OF CLINICALLY SIGNIFICANT PROSTATE CANCER

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Presented By: Crystal Casado

Introduction: Magnetic resonance (MRI) imaging has risen to popularity for targeting areas of the prostate at high risk for cancer during MRI prostate guided biopsies. The PERCISION trial was the first to evaluate the efficacy of MRI guided biopsies however, historically these have been completed through the transrectal (TR) approach. While targeted biopsies are widely used for transrectal biopsies, the published literature is still vague on its utility using the transperineal (TP) approach. The aim of this retrospective study is to compare the rate of accuracy in detecting clinically significant prostate cancer among various zones between transperineal targeted vs template prostate biopsies.
Methods: Data was gathered from 95 men with MRI identified lesions suspicious for prostate cancer who underwent transperineal MRI target biopsies followed by transperineal template guided biopsies. Clinical significance was defined using Gleason score 3+4 or greater. Fisher test was used to calculate for statistical significance.
Results: Mean patient age was 65 years. Median prostate specific antigen prior to biopsy was 6.41 ng/ml (IQR 5.1–10.0). Clinically significant cancer was detected by MRI targeted biopsy and template guided prostate biopsy in 41% and 6% of men (p=0.0797) in the Peripheral Lateral zone, 38% and 15% in the Peripheral Mid Zone (p=.0397), 14% and 14% (p=0.99) in the Transitional Lateral Zone, and 0% and 29% in the Transitional Mid Zone (p=.462).
Conclusion: The use of magnetic resonance imaging for targeted biopsies of suspicious lesions in men with risk of clinically significant prostate cancer has been shown to be a superior method when compared to transrectal TRUS guided biopsies. Our study demonstrates that TP targeted biopsies were significantly superior to TP template biopsies in detecting significant prostate cancer in the peripheral zone mid area however was comparable in other areas of the prostate.

Figure 1. Rate of clinically significant prostate cancer in MRI Targeted Biopsy vs Transperineal Template Prostate Biopsy

Location	Targeted Biopsy	Template Biopsy
PZ Lateral Right	20%	0%
PZ Lateral Left	40%	20%
PZ Mid Right	35%	20%
PZ Mid Left	42%	11%
TZ Lateral Right	29%	14%
TZ Lateral Left	0%	14%
TZ Mid Right	0%	50%
TZ Mid Left	0%	20%

Funding: N/A

Poster #42

CORRELATION OF GLOMERULAR FILTRATION EQUATIONS WITH MEASURED 24 HOUR CREATININE CLEARANCE IN RENAL CELL CARCINOMA PATIENTS

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Presented By: Benjamin Nicholas Schmeusser, MD, MS

Introduction: Estimated glomerular filtration rate (eGFR) is an important consideration in management for patients with renal masses. Guidelines recommend nephron sparing surgery in patients with a baseline eGFR<60mL/min/1.73m2 or estimated postoperative eGFR<45mL/min/1.73m2. However, eGFR significantly varies depending on the equation used. Currently, there is no consensus on the optimal eGFR equation for patients undergoing nephrectomy. This study evaluates the performance of common eGFR equations compared to a measured glomerular filtration rate (mGFR) from pre-nephrectomy 24-hour urine collection.
Methods: Patients undergoing preoperative workup for renal masses at a tertiary referral center from February 2021 to July 2022 were offered to complete a 24-hour urine collection. Preoperative serum creatinine (SCr) and cystatin-C (Cys-C) levels were obtained for eGFR calculation, in addition to patient demographics, laboratory values, and comorbidities. The following eGFR equations were examined: Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) SCr equations with race (CKD-EPI-Cr-2009) and without race (CKD-EPI-Cr-2021); CKD-EPI SCr-Cys-C equations with (CKD-EPI-Cr-Cys-C-2012) and without race (CKD-EPI-Cr-Cys-C-2021); the CKD-EPI Cys-C equation (CKD-EPI-Cys-C-2012); the Modification of Diet in Renal Disease (MDRD) equation with (MDRD-Race) and without race (MDRD-WithoutRace); and Cockcroft-Gault. Accuracy of 24h urine collection was determined using urine creatinine-weight ratios. Concordance correlation coefficients were calculated and Bland-Altman plots were constructed between mGFR and eGFR values.
Results: 104 patients were identified. 63 (60.6%) were male. 59 (56.7%) and 21 (20.2%) were White and Black, respectively. 91 patients completed 24-hour collection. 33 (32.4%) had an accurate collection, with 12 (11.8%) having greater and 46 (45.1%) having lower than expected urine creatinine. Mean mGFR was 79.21±35.90mL/min/1.73m2. Concordance between mGFR and eGFR varied depending on eGFR formula (Table 1). Inclusion of Cys-C and SCr together greatly improved eGFR/mGFR correlation. Race adjustment had variable effects.
Conclusion: Estimated renal function has implications on decision-making and counseling for patients with renal masses. Our data identifies variance in eGFR depending on the equation used, with increased correlation to mGFR when using a combination of SCr and Cys-C. Future directions include further data collection and subgroup analyses to determine optimal, patient-specific eGFR equation selection in patients undergoing nephrectomy.

Renal Function Calculation		Inclusion of Race	Mean±SD (mL/min/1.73m^2)	Correlation	95% CI
mGFR		N/A	79.21±35.90	*Reference*	
eGFR	CKD-EPI-Cr-Cys-C-2021	No	76.81±23.77	0.672	0.562-0.759
	Cockcroft-Gault	No	67.87±32.00	0.671	0.547-0.766
	CKD-EPI-Cr-Cys-C-2012	Yes	73.49±23.31	0.667	0.559-0.753
	MDRD-Race	Yes	72.18±28.49	0.660	0.535-0.756
	CKD-EPI-Cr-2009	Yes	73.93±23.29	0.643	0.530-0.734
	MDRD-WithoutRace	No	69.58±27.96	0.635	0.507-0.735
	CKD-EPI-Cys-C-2012	No	88.60±14.45	0.413	0.304-0.512
	CKD-EPI-Cr-2021	No	82.28±30.65	0.237	0.037-0.419

Funding: We gratefully acknowledge the support of the John Robinson Family Foundation and the Chris Churchill Family Foundation.

Poster #43

THE USE OF HEMOSTATIC AGENTS IN PARTIAL NEPHRECTOMY OF LOCALIZED RENAL LESIONS: TRENDS AND OUTCOMES

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Presented By: Firaas Khan

Introduction: Hemostatic agents (HA) have become increasingly popular as adjuvants to suturing in Partial Nephrectomies (PN) due to the inferred advantage of limiting hemorrhagic events. We sought to assess the impact of HA use on postoperative bleeding events, perioperative complications, and hospital readmission after PNs in a large institutional cohort. Additionally, we explored the experience of surgeons performing PNs and how their utilization of HAs during PNs changed over time.
Methods: A retrospective analysis of 971 PNs at a single center from 2009 to 2017 was performed. The number and type of HAs used and the presence of postoperative complications, including hospital readmission, blood transfusion, renal embolization, urine leak, and perinephric abscess formation, within 30 days for each PN were quantified using chart review. The relationship between the number of HAs utilized and postoperative complications was analyzed using the Independent Samples Mann-Whitney U Test. ANOVA was used to evaluate the change in HA use over time by surgeons performing greater than 20 PNs annually from 2009 to 2020.
Results: Of 971 PNs, 658 (68%) were performed using an open technique and 313 (32%) were minimally-invasive, with an open technique utilized for significantly larger mean tumor size diameters ($p < 0.001$). A mean 2.8 HAs were utilized per PN, and the most common agents used were Surgicel, Floseal, Surgifoam and Bioglue. 10% of patients undergoing PN~~s~~ received a blood transfusion intraoperatively or postoperatively. Fewer HAs were utilized in surgeries that resulted in the patient receiving a blood transfusion (2.6 vs 2.9, $p = 0.04$, Table 1). 2% experienced a bleeding event resulting in renal embolization. Fewer HAs were also used intraoperatively in patients that required an embolization (1.9 vs 2.9, $p < 0.001$). Hospital readmission, urine leak, and perinephric abscess rates were not associated with a difference in HA use. Additionally, the average number of HAs used by high-volume surgeons decreased over time with increasing experience.
Conclusion: Increasing numbers of hemostatic agents used during PN are associated with a lower rate of bleeding complications. Additionally, high-volume surgeons performing PN relied less on the intraoperative use of HA over time with increasing experience.

Table 1: Comparison of the Average Number of Hemostatic Agents Used and the Presence of Post-Operative Complications within 30 Days

Variable	Level	N (971)	Mean # of HA Used	p-value
Blood Transfusion	Yes	97 (10%)	2.6	0.04*
	No	874 (90%)	2.9	
Embolization	Yes	23 (2%)	1.5	<0.001*
	No	948 (98%)	2.9	
Urine Leak	Yes	25 (3%)	3.1	0.3
	No	946 (97%)	2.8	
Perinephric Abscess	Yes	4 (0.4%)	2.50	0.4
	No	967 (99.6%)	2.8	
Readmission	Yes	59 (6%)	2.8	0.8
	No	912 (94%)	2.9	

*Significant p-value
The significance level is .05

Funding: N/A

Poster #44

AN EXOSOMAL MICRORNA SIGNATURE CORRELATED WITH INCREASED PROLIFERATION AND METASTASIS IN TREATMENT RESISTANT RENAL CELL CARCINOMA

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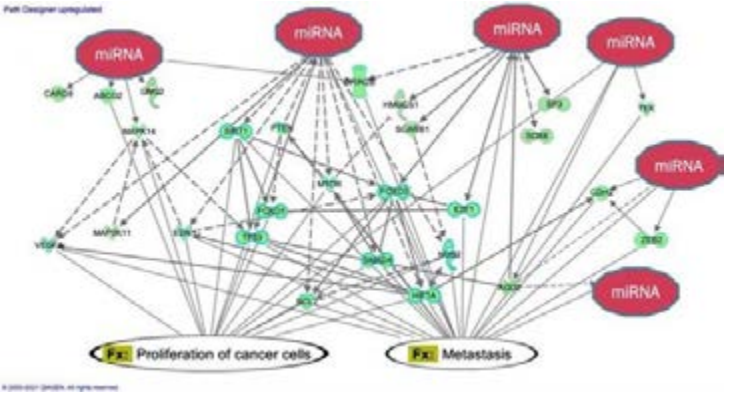
Presented By: Christopher Koller, MD

Introduction: RCC is the 8 most common cancer with incident rates increasing 1% each year. ~15% of RCC patients present with metastatic disease and guidelines suggest immune checkpoint inhibitor in combination with a TKI. However, all patients placed on TKI therapy ultimately become resistant at a median of 14 months of therapy. RCC TKI-resistance has been linked to several types of RNAs which can be transferred between cells through exosomes. However, this exosomal link between resistance and specifically to miRNAs is still yet under-investigated. This study aimed to identify miRNAs which had a correlation to drug resistance.
Methods: Perioperative blood was drawn from patients with pT1 and pT3 RCC. Exosomes were then isolated and purified from whole blood patient samples using differential ultracentrifugation. Sunitinib resistance (SR) was induced in cell lines by treating sensitive cells with increasing dosages of sunitinib over a 6-month period then maintained by 5 μM suni with each subsequent passage. Cells were then cultured for 48hr and their conditioned medial (CM) collected and exosomes isolated with ultracentrifugation. Isolated exosomes from patient blood and cell culture were sent for miRNA sequencing in triplicates and compared for differential expression.
Results: After comparing expression within the exosomes of TKI-resistant vs -sensitive cells, a total of 31 deferentially expressed miRNAs were identified with a fold change >1 and $p<0.05$. 6 of 31 differently expressed miRNAs were upregulated (mir-218, 150, 576, 1185, 223, 199a) and then subjected to pathway analysis. These 6 upregulated miRNAs were found to alter common oncologic pathways including HIF1a, PTEN, MTOR, VEGF, TP53, and BCL2, among many others (Figure2). Patient blood exosome miRNA profiles were compared between pT1 and pT3 patients. 25 differently expressed miRNAs were identified among patient samples, 3 of which were correlated with cell culture exosomes (100-5p, 21, 30).

Conclusion: Of note, the majorly of miRNAs identified from patient and cell cultures exosomes favored downward expression. Exosomes isolated from SR cell lines demonstrate unique oncogenic cargo. miRNAs associated with TKI-resistance alter common oncologic pathways. Interestingly enough, the majority of the differently expressed miRNAs were downwardly expressed showing a return towards a wildtype profile. Further validation of these miRNA to confirm differential expression is ongoing in our lab.



Funding: U54 GM104940

Poster #45

FEASIBILITY OF ABSTAINING FROM COMPUTERIZED TOMOGRAPHY WITH ARTERIOGRAPHY PRIOR TO EMBOLIZATION OF POST ROBOTIC PARTIAL NEPHRECTOMY PSEUDOANEURYSM

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Mayo Clinic
Presented By: Christian A. Ericson, MD, BS

Introduction: To assess the feasibility and safety of proceeding to Interventional Radiology (IR) for Arteriographic Embolization (AE) without pre-procedural Computerized Tomography with Arteriography (CTA) when pseudoaneurysm is highly suspected after Robotic Assisted Partial Nephrectomy (RAPN).
Methods: We retrospectively reviewed all patients who both underwent RAPN by a single surgeon at a high-volume academic institution from February 15, 2008, through September 6, 2022 and who were subsequently presented with marked gross hematuria within 3 months of surgery and treated for post-operative pseudoaneurysm with AE by IR. The rate of preprocedural CTA, embolization failure, time from surgery to embolization, CTA impression, and AE impressions were recorded and descriptively compared. Patient demographics and surgical pathology were all maintained in an intuitional database.
Results: Retrospective review identified 20 of 633 (3.16%) patients who underwent RAPN and subsequently were successfully treated for pseudoaneurysm via AE. 4 of 20 (20%) of AE underwent a preprocedural CTA for evaluation of pseudoaneurysm. Median time from surgery to AE was 11 days (IQR 8-17 days). 20 of 20 (100%) positively identified pseudoaneurysm on IR AE irrespective of presence of preprocedural CTA. 2 of 20 (10%) of AE failed and required repeat AE.
Conclusion: CTA is a test often requested for diagnosis of pseudoaneurysm after RAPN even in the setting of marked gross hematuria. Our series documents successful AE by an experienced IR department without the need for preprocedural CTA thus decreasing medical costs, contrast exposure, and possibly time from diagnosis to treatment.
Funding: NA

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Poster #46

IMPACT OF PREOPERATIVE PROTEINURIA ON ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY (RAPN) OUTCOMES

Laura Geldmaker, Bryce Baird, Daniela Haehn, Mikolaj Wieczorek, Colleen Ball, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Urinalysis (UA) is routine preoperative test performed before all surgical procedures at our institution. Our objective was to evaluate the impact of preoperative proteinuria on surgical outcomes following robotic-assisted partial nephrectomy (RAPN).
Methods: All RAPNs performed from February 2008 through November 2021 by a single, fellowship trained urologist at our institution were retrospectively reviewed. All patients undergoing RAPN at our institution completed dipstick UA preoperatively. Proteinuria was defined as any trace of protein present in the urine. In the primary analysis we compared surgical outcomes for patients who had preoperative proteinuria versus patients who did not have any trace of protein detected. To compare groups for categorical variables the Fisher exact test was utilized and to compare groups for continuous variables the Wilcoxon rank sum test was utilized. Two-sided *P* values less than 0.05 were statistically significant. Results are shown as median (interquartile range) or n (percent). eGFR units = ml/min/1.73m2.
Results: This analysis included 546 RAPN in total. Median age was 63 years, median BMI was 29.7 kg/m2, 331 (60.6%) patients had hypertension, 367 (67.5%) patients had cardiovascular disease, median MAP score was 2, and median RENAL score was 8. 117 (21.4%) patients had preoperative proteinuria. Compared to patients without preoperative proteinuria, patients with preoperative proteinuria had lower eGFR preoperatively [73.5 (58.5, 86.5) vs. 78.7 (67.5, 92.8), P=0.002] and at 1-month postoperatively [63.8 (49.7, 74.6) vs. 69.7 (56.8, 86.3), P=0.001], however there was no evidence of a difference 6-months postoperatively [68.8 (52.2, 82.8) vs. 68.1 (56.9, 81.2), P=0.50]. We did not observe clinically meaningful difference in length of stay [2 days (2, 3) vs. 2 days (2, 3), P=0.003] based on presence of preoperative proteinuria nor did we find evidence of differences in readmission within 30 days [9 (7.7%) vs. 37 (8.6%), P=0.85] or postoperative complications grade 3 or higher [7 (6.0%) vs. 21 (4.9%), P=0.64] according to presence of preoperative proteinuria.
Conclusion: Patients with preoperative proteinuria have a significantly lower median eGFR preoperatively and at 1-month post-RAPN than patients without preoperative proteinuria. At 6-months post-RAPN this substantial difference in eGFR levels does not exist.
Funding: N/A

Poster #47

ASSOCIATION OF PRE-OPERATIVE GLUCOSE LEVELS WITH ROBOTIC ASSISTED PARTIAL NEPHRECTOMY (RAPN) PERI-OPERATIVE OUTCOMES

Laura Geldmaker, Daniela Haehn, Bryce Baird, Mikolaj Wieczorek, Colleen Ball, David Thiel
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Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Our objective was to evaluate the impact of preoperative serum glucose levels on peri-operative outcomes in a cohort of robotic-assisted partial nephrectomy (RAPN) patients.
Methods: RAPNs performed by a single, fellowship trained urologist from February 2008 through November 2021 at our institution were retrospectively reviewed. All patients undergoing RAPN at our institution had preoperative blood work including a complete blood count and basic metabolic panel. Preoperative serum glucose was categorized as > 100 mg/dL or ≤ 100 mg/dL for analysis. Propensity score (PS) methods were used to control for potentially confounding characteristics. Potential imbalance in preoperative characteristics were evaluated using standardized mean differences (SMDs). Relative risks (RRs) of perioperative outcomes and 95% confidence intervals (CIs) were estimated

from a modified Poisson regression model using PS matching weights. PS is defined here as the conditional probability a patient will have a preoperative glucose > 100 mg/dL given their preoperative characteristics (age, sex, race, ethnicity, body mass index [BMI], Charlson comorbidity index (CCI), hypertension, cardiovascular disease (CVD), Mayo Adhesive Probability (MAP) score, RENAL score, and preoperative eGFR).
Results: 529 RAPN were included in our analysis. 269 (50.9%) patients had a serum glucose ≤ 100 mg/dL and 260 (49.1%) patients had a serum glucose > 100 mg/dL. Before PS-weighted analysis, factors associated with glucose > 100 mg/dL were male sex, older age, higher BMI, higher CCI, hypertension, CVD, a higher MAP score, and lower preoperative eGFR (SMDs > 0.20). After PS weighting, all SMDs were negligible (<0.10). After PS weighting, there was no evidence of serum glucose > 100 mg/dL increasing the risk of Clavien Dindo postoperative complications grade 3 or higher (RR 1.05, 95% CI 0.48-2.31, P=.90), length of stay (LOS) ≥ 3 days (RR 0.97, 95% CI 0.77-1.21, P=0.76), or 1-month eGFR less than 90% of preoperative levels (RR 1.03, 95% CI 0.86-1.23, P=.77). Before PS weighting, 30-day readmissions were higher in patients with serum glucose>100 mg/dL (11.9% vs. 5.2%), however this was not statistically significant after PS-weighting (RR 1.73, 95% CI 0.90-3.31, P=0.10).
Conclusion: We did not find evidence of an association of preoperative serum glucose levels with complications, extended LOS, 1-month eGFR<90% of preoperative levels, or 30-day readmission.
Funding: N/A

Poster #48

ADOPTION OF THE MOSES 120W HOLMIUM LASER IS ASSOCIATED WITH SIGNIFICANTLY DECREASED OPERATIVE TIME DURING URETEROSCOPIC STONE EXTRACTION AT A LARGE TERTIARY REFERRAL CENTER

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Presented By: Samit Sunny Roy, MD

Introduction: As technologic advancement continues to improve in urology it is critical to evaluate objective outcomes after adoption to ensure appropriate value added to patients and clinicians. There are few studies examining the real-world results of adoption of the MOSES 120-watt holmium laser compared to prior laser models for ureteroscopic stone extraction (USE) with regards to operative time. We hypothesized that there would be a significant decrease in operative time for USE regardless of demographics or perioperative variables when using MOSES laser compared to prior models.
Methods: Medical records for all USE procedures (CPT 52356) in patients >18 years of age at a single academic tertiary referral center performed by a single endourologist between 2019-2022 were collected. Cases during which other procedures were performed concurrently were excluded. Demographic and perioperative data were abstracted from the medical record. Data was analyzed using Stata statistical software v16 using chi-square, t-tests, Wilcoxon rank-sum tests, and multivariable linear regression where appropriate.
Results: A total of 238 USE cases were performed between 2019-2022. Of these, 53 (22.3%) were performed prior to adoption of the MOSES laser at our institution using 120W laser. There were no differences in patient sex (54 vs 64% female; p=0.14), BMI (31.0 vs 31.7; p=0.61), pre-stented patients (51% vs 57%; p=0.45), intraoperative stent placement (96 vs 95%; p=0.63), average Hounsfield units (911 vs 873; =0.47), maximum stone length (12 vs 13 mm; p=0.33), use of semirigid ureteroscope (89% vs 79%; p=0.13), or stone location (58% vs 46% renal; p=0.29). After adoption of MOSES laser there was a increase in average patient age (49 vs 54 years; p=0.030) as well as a decrease in average procedure time (60.3 vs 49.6 min; p=0.003). Multivariable linear regression modeling was performed to determine significant predictors of procedure time after controlling for relevant factors. Use of the MOSES laser (p=0.004), stone volume (p<0.001), and ureteral stone location (p=0.011) were the only significant predictors of procedure time after controlling for above listed variables.

Conclusion: There was a significant decrease in procedure time after adoption of the MOSES laser system even after controlling for demographic and perioperative factors.
Funding: N/A

Poster #49

URINARY STONE-RELATED FINANCIAL TOXICITY CLINIC: BASELINE FINANCIAL RESOURCES CORRELATE WITH FINANCIAL STRAIN

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Presented By: Jackson Cabo, MD

Introduction: We sought to characterize stone-related financial burden among adults with a history of nephrolithiasis through validated questionnaires for financial toxicity (COST-11 score). We further assessed for demographic and disease-related predictors of financial toxicity.
Methods: We performed a cross-sectional survey of adults with a history of nephrolithiasis through convenience sampling at an outpatient clinic. The survey contained an 11-item measure of stone-related financial toxicity (COST score), and assessed demographics, stone event history, and burden of overall, ancillary, preventative, and insurance costs related to nephrolithiasis. We classified those with high financial toxicity as those with COST score ≤ 21. Multivariate logistic regression to evaluate whether financial toxicity was associated with demographic variables and stone event history.
Results: Overall, 100 patients completed the survey with a median age of 57 years (IQR 48 – 64). The median COST score was 30 (IQR 23-37), and 19 (19%) reported high financial toxicity. Insurance status, household income, stone surgeries during lifetime and within the last 3 years were each significantly associated with financial toxicity of nephrolithiasis care on univariate analysis ($p < 0.05$). All questions related to burden of nephrolithiasis care including overall costs, insurance, ancillary, and preventative costs were significantly different between groups indicating higher burden within the high financial toxicity cohort (each $p < 0.05$). On stepwise multivariate logistic regression, patient income > $75,000 remained significant (OR 0.22, 95% CI 0.05 – 0.77, $p = 0.02$, Table 1). When asked whether their provider should be mindful of their financial situation when making recommendations, 18.2% reported "very much" (median response = 3 of 5).
Conclusion: In this cohort, 1 in 5 patients seeking care for nephrolithiasis meet criteria for high financial toxicity. Financial toxicity was associated with household income, insurance status, education level, as well as frequency of stone events. A subset of patients feel that providers should keep their financial situation in mind when making recommendations.

Table 1: Multivariable logistic regression	OR	95% CI	P-Value
Age	0.99	0.95 - 1.04	0.982
Race			
White	Ref		
Non-white	<0.001	NA	0.991
Sex			
Male	Ref		
Female	1.28	0.41 - 4.14	0.675
Insurance			
Private	Ref		
Non-private or uninsured	1.09	0.33 - 3.88	0.879
Household income			
< $75,000	Ref		
> $75,000	0.18	0.04 – 0.67	0.014*
Education level			
Did not finish college	Ref		
Finished college	0.36	0.10 - 1.19	0.099

Table 1. Multivariable logistic regression for associations with high financial toxicity according to COST-11 score. Variables selected included demographic variables, insurance/education history, and annual family income.

Funding: N/A

Poster #50

NOBODY LIKES BURNT POPCORN: THE MOST EFFICIENT POPCORNING SETTINGS IN A NOVEL 3D-KIDNEY MODEL THAT LIMITS THERMAL INJURY

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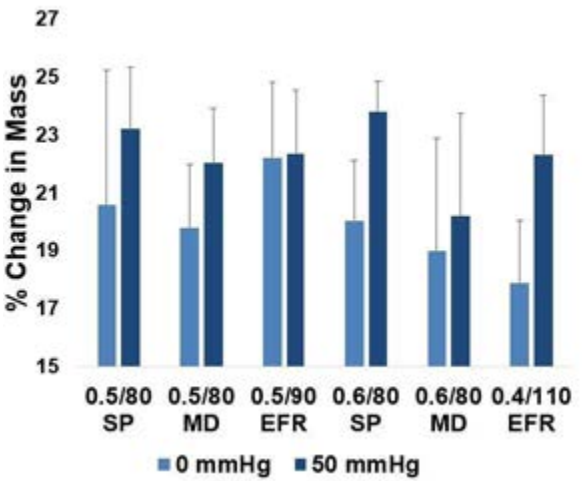
Presented By: Francois Soto-Palou, MD

Introduction: When stone popcorning, the use of higher energy with little to no irrigation is preferred. However, this combination of high power with low flow can lead to increased risk of thermal damage with longer laser firing times. Using predetermined lasering and irrigation 'cool down' durations within a novel, anatomically accurate 3D kidney model, our aim was to identify the laser settings that produce the most efficient popcorning without reaching thermal dose (*t43*) that causes tissue damage.
Methods: Hard Begostone phantoms, mimicking calcium oxalate monohydrate stones, were crushed and sieved to 2-4mm fragments. Fragments were then separated by size measuring 2-2.8mm, 2.8-3.35mm, and 3.35-4mm and mixed by mass at a ratio of 2:2:1, respectively. Approximately 0.5g of fragments were placed in the upper pole of our anatomical 3D-printed kidney model. Each triplicate trial consisted of iterative laser/irrigation cooling cycles for two minutes using a MosesTM 120H 2.0 laser (Table). Laser firing and cooling times were determined by measuring *t43* with each laser setting, allowing for maximal laser to cooling ratio that would not exceed tissue injury threshold (*t43* 70 min). After treatment, stones were dried and sieved into < 1mm, 1-2mm, 2-2.8mm, 2.8-3.35, and 3.35-4mm fragments, which were then weighed. Ablation efficiency was calculated as post-treatment mass < 1mm with comparisons by ANOVA and Tukey post-hoc tests.
Results: Overall, the most efficient setting was 0.5J/90Hz with no irrigation; while the most efficient setting using low irrigation were 0.4J/110Hz and 0.6/J/80Hz SP (Figure). Even with shorter laser times, popcorning was more efficient with no irrigation, especially at high powers (all $p< 0.05$).
Conclusion: When accounting for thermal dose, 0.5J/90Hz without irrigation provides the most efficient popcorning, despite shorter laser times. When thermal injury is of special concern and the surgeon prefers low flow, 0.4J/110Hz appears most efficient. Last, if extended frequency is unavailable, 0.6J/80Hz without irrigation should be used.



Funding: N/A

Poster #51

PCR TECHNOLOGY TO IDENTIFY UROPATHOGENS IN PATIENTS UNDERGOING KIDNEY STONE SURGERY: PRELIMINARY RESULTS FROM A FEASIBILITY AND METHODS STUDY

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Presented By: Bristol B. Whiles, MD

Introduction: Accurate pathogen identification is critical for patients undergoing nephrolithiasis treatment. Although >100-year-old traditional culture methodology is used, newer technology such as polymerase chain reaction (PCR) has emerged with improved sensitivity and specificity. However, little has been published regarding the use of PCR for pathogen identification in urogenital foreign bodies, such as kidney stones and urinary drainage tubes (i.e. ureteral stents). We therefore developed a feasibility and methods study to evaluate the use of PCR in our surgical stone population.
Methods: Following IRB approval, we prospectively enrolled patients undergoing stone surgery (URS or PCNL) who had an indwelling urinary drainage tube (ureteral stent, nephrostomy, or nephroureteral tube) and a urine culture within 3 months. Crushed kidney stone fragments and the tube's renal pelvis curl were collected, placed in sterile containers with phosphate buffer solution, and shipped overnight for PCR testing at a molecular laboratory. The Uropathogen PCR panel screened for 14 singular microbes and 13 different antibiotic resistance genes. PCR results were compared to pre-operative urine and intra-operative stone culture. Feasibility was determined by PCR result availability on these novel specimens.
Results: A total of 10 patients, 9 URS and 1 PCNL, were enrolled. Mean age was 59.4 ± 14.5 years, and 8 (80%) patients were female. PCR testing was able to be performed on all specimens collected (Table 1). PCR detected polymicrobial growth in 3 of 6 (50.0%) positive stone specimens and 2 of 7 (28.6%) positive tube specimens. PCR detection level for all specimens was <10,000 cells/mL, therefore antibiotic sensitivity testing could not be performed. Antibiotic resistance genes were detected in 6 (30%) of the 20 total PCR specimens. Stone culture and PCR results were discordant in 6 (66.7%) patients, with microbes only detected by stone PCR. Stone PCR and tube PCR were discordant in 7 (70%) patients.
Conclusion: PCR technology is feasible for stone and tube microbe identification. Based on our preliminary data, there is a high discordance rate, with PCR being more sensitive than traditional stone culture. Further study is required to evaluate PCR utility in clinical practice and to understand if improved uropathogen detection with PCR or its potential for quicker turn-around-time alters patient outcomes.
Funding: PCR testing was provided by molecular laboratory Genus 3, LLC

Poster #52

FACTORS ASSOCIATED WITH LIVING KIDNEY DONATION AMONG PATIENTS WITH KIDNEY STONE DISEASE

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Presented By: Tyler Reid Compher

Introduction: While a history or presence of kidney stones was once a contraindication for donor nephrectomy, select kidney stone formers are now considered as candidates. There is a lack of evidence-based guidelines for donor nephrectomy in those with a

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history or presence of kidney stones. We performed a retrospective analysis of kidney donor candidates with either a history or presence of kidney stones on imaging who underwent 24-hour urine testing at our institution. We aimed to determine the drivers influencing the decision to proceed with donation.

Methods: All patients were evaluated with history and physical examination, abdominal/pelvic CT imaging, standard urine and blood tests, and 24-hour urine stone risk assessments. Urologists were not directly involved in the donor selection process. All decisions regarding eligibility candidacy were made by a multi-disciplinary living donor team. We compared sociodemographic and stone-related characteristics of patients approved for donation versus those not approved for donation using chi square tests for categorical variables, independent t-tests for continuous variables, and nonparametric tests when appropriate.

Results: A total of 111 kidney donor candidates with radiologic evidence or history of kidney stones collected 213 primary 24-hour urine specimens from 2012 to 2022. Fifty-seven (51%) patients were approved for donor nephrectomy. Fifty-four (49%) patients were rejected for donation; of these, 19 (17%) were rejected for stone-related reasons. Candidates approved for donation had a lower relative supersaturation of calcium oxalate (RSS CaOx) compared to those not approved (p=0.002). When comparing patients approved for donation and those rejected for stone reasons (Table 1), patients approved for donation had lower urinary calcium, urinary oxalate, and RSS CaOx. They also had fewer urinary abnormalities and fewer stones on CT.

Conclusion: This study represents a high-volume, single-institution analysis of stone-related factors associated with the decision to proceed with donor nephrectomy in those with a history of kidney stones or kidney stones found on imaging. Urinary calcium, urinary oxalate, RSS CaOx, and stone burden appeared to be the major driving factors.

Characteristic	Approved for donation (n=57)	Rejected for donation for stone reasons (n=19)	*p*-value
Demographic/anthropometric			
Age (years)	47 ± 11	45 ± 12	0.7
Sex			
Male	21 (36)	10 (53)	0.2
Female	36 (63)	9 (47)	
Race/ethnicity			
White	45 (79)	15 (79)	
Black	11 (19)	1 (5)	0.08
Hispanic	0 (0)	1 (5)	
Other or refused	1 (2)	1 (5)	
Body mass index (kg/m^2)	27 ± 4	27 ± 3	0.8
Urinary parameters			
Volume (L/d)	2.3 ± 1.0	2.3 ± 1.4	0.4
Calcium (mg/d)	174 ± 83	249 ± 95	**0.003**
Oxalate (mg/d)	31 ± 11	40 ± 19	**0.02**
Citrate (mg/d)	703 ± 269	648 ± 339	0.4
Sodium (mmol/d)	175 ± 61	195 ± 73	0.4
RSS CaOx	4.3 ± 2.3	7.2 ± 3.2	**<0.001**
Urinary abnormalities			
Low urine volume	31 (54)	11 (58)	0.8
Hypercalciuria	15 (26)	8 (42)	0.2
Hyperoxaluria	7 (12)	5 (26)	0.2
Hypocitraturia	18 (32)	6 (32)	1.0
High urine sodium	34 (60)	14 (74)	0.3
Elevated RSS CaOx	1 (2)	3 (16)	**0.03**
Number of abnormalities	2.0 ± 1.0	2.8 ± 1.3	**0.003**
CT findings			
Number of stones	1.0 ± 0.6	1.5 ± 1.0	**0.03**
Total stone size (mm)	2.5 ± 2.0	4.2 ± 3.6	0.10

Table 1. Characteristics of patients approved for donation vs. rejected for donation for stone reasons; n (%) is shown for categorical variables and mean ± standard deviation for continuous variables.

Funding: N/A

Poster #53

HIGH PREVALENCE OF OSTEOPOROSIS IN KIDNEY STONE FORMERS WITH CROHNS DISEASE

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Presented By: Elizabeth Kwenda, MD

Introduction: The aim of the study is to explore the prevalence of osteoporosis (OP) in patients with Crohn's disease (CD) and kidney stones (KS).
Methods: A retrospective large-scale bioinformatics database, Information for Integrated Biology and Bedside depository data (i2b2) of the UF Health System was used to analyze the prevalence of osteoporosis in CD patients with KS and the general population from November 2011 to September 2017. The i2b2 repository database runs systematic query searches based on ICD and CPT codes that are used for institutional billing. Statistical analysis was performed using the SAS v.9.4 software.
Results: The total population was 1,002,357; ages 18-95 years old were 832,910. Males 18-95 years were 44.7%. In the general population, the prevalence of osteoporosis was 0.19%, 0.27%, 0.44%, 0.68%, 0.86%, 1.06%, 1.67% in males and 0.20%, 0.39%,0.93%, 2.55%, 5.11%, 6.70%, 9.16% females in the age groups 18-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above respectively. In the Crohn's disease with kidney stones cohort, the prevalence of osteoporosis was 11.1%, 0%, 0%, 27.8%, 10.6%, 15.4%, 0% in males and 13.6%, 0%, 24%, 26.2%, 41.7%, 44.4%, 0% in females in the age groups 18-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above respectively. The 0% of patients indicated no evidence of osteoporosis in the group study. Remarkably, the prevalence of osteoporosis in the CD with KS cohort was higher in the 18-35-year-old group compared to the 85-95-year-old general population in males: 11.1% vs. 1.67% ($p < 0.001$) and females: 13.6% vs. 9.16% ($p < 0.001$).
Conclusion: The rate of OP in patients with CD and KS is significantly higher than the general population, most remarkable in the population under 35 years of age. This finding suggests a devastating premature aging process and the effects of the bowel on the kidney-bone axis. Further research on this subject is needed to identify the other variables that play a role in these findings.
Funding: N/A

Poster #54

IS THERE A SPECIFIC DURATION OF INDWELLING RETAINED URETERAL STENTS THAT WOULD PREDICT THE NECESSITY OF A PERCUTANEOUS NEPHROLITHOTOMY?

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Presented By: Nazih Khater, MD

Introduction: Retained ureteral stents may represent a complex situation. With prolonged indwelling time, there is an increased difficulty in stent removal, leading to potential morbidity and mortality. The purpose of this study is to evaluate our patients who had retained stents, to analyze the indication of a multimodal endourological approach and to identify if there would be a certain duration after which a percutaneous nephrolithotomy (PCNL) becomes required.
Methods: After IRB approval, we retrospectively reviewed data of patients who underwent multimodal endourological procedures for the removal of their retained ureteral stents from 2010 to 2018. The primary outcomes analyzed were patients' characteristics, potential etiologies for stent encrustation, and outcomes of multimodal endourological approaches.
Results: We included 38 patients with 41 ureteral stents. Indications for stents included malignancy, urolithiasis, ureteropelvic junction obstruction and trauma. All patients had encrustation on fluoroscopy and failed stent removal. The median (IQR) age was 43.5 (19-

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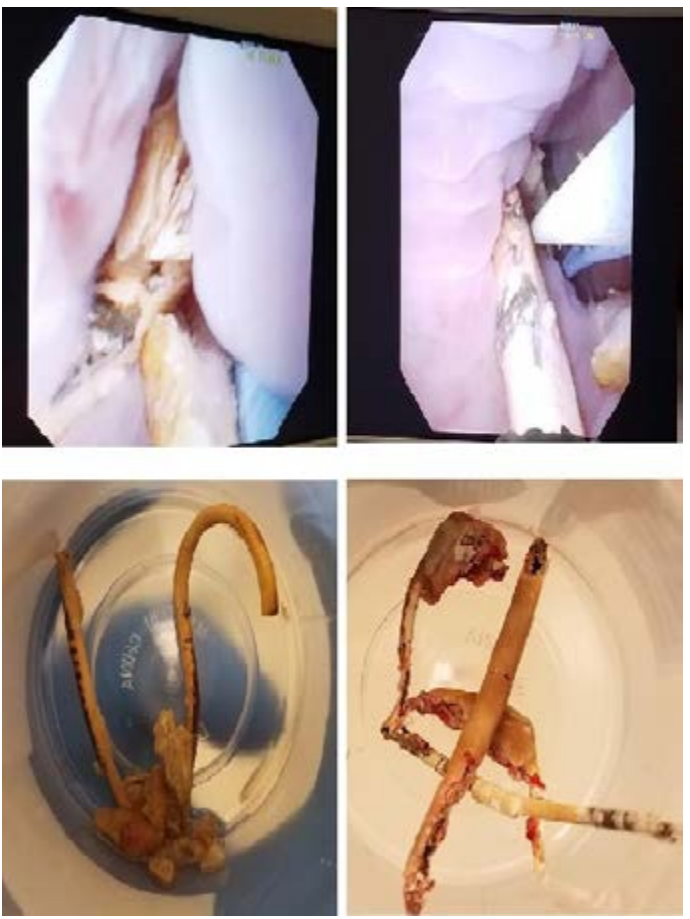
77) years; 60% were females. Patients traveled a median of 144 miles (12- 180) for care. Only 31% of patients had financial support for medical care. Stents were indwelling for a median of 10 months (2- 264). Encrustations were visible on the upper coils only (4), lower coils only (12), or both (22). Reasons for delayed stent removal included transportation (22); prolonged management (14); and pregnancy (2). Successful stent removal required shock wave lithotripsy (SWL) in 22 patients, combined SWL and cystolitholapaxy (CLL) in 16, CLL in 13, ureteroscopy (URS) in 5, PCNL in 5, and robotic ureterolithotomy in one. Median operative time was 102.5 minutes. Among those, was a 22-year-old retained stent, one of the oldest reported in the literature. It was removed at our institution with a combination of SWL, CLL, URS and PCNL. No intraoperative complications were encountered. Postoperatively, one patient developed a myocardial infarction, another had a pleural effusion.

Conclusion: Ureteral stent encrustation should be avoided. Female patients may be at higher risk. Socioeconomic factors and transportation issues play a major role. A multimodality surgical approach including PCNL was often needed in our patients, when both coils were encrusted or when stents were bilateral or have been retained for more than at least 10 months.



Funding: N/A

Poster #55

SINGLE-INSTITUTION EXPERIENCE WITH PERCUTANEOUS NEPHROLITHOTOMY IN THE SOUTHEASTERN UNITED STATES

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Presented By: Benjamin Nicholas Schmeusser, MD, MS

Introduction: Urolithiasis affects more than 12% of individuals, nearly tripling in prevalence since the 1980s. Patients in the Southeastern United States are especially inflicted by kidney stones, earning its label as the “Stone Belt.” Percutaneous nephrolithotomy (PCNL) is commonly performed for stone management, with modern day advances improving its associated outcomes. Herein, we review PCNL cases performed at a single institution in the Southeastern United States.

Methods: Retrospective review was completed on patients that underwent PCNL from 2005-2022 at our academic, tertiary center. Patient demographics, comorbidities, as well as laboratory and stone analysis information were collected. Available perioperative imaging was utilized to calculate stone risk scores (Guy’s Score and Size, Tract, Obstruction, Number of calyces, and essence [S.T.O.N.E] score) and muscle composition. Details such as operative time, blood loss, length of stay, reoperation within 90 days, and 30 day complications were also reviewed. Data was described as median (interquartile range) and mean (standard deviation).

Results: 319 patients with no missing demographic or preoperative information were analyzed. The average patient age was 56, with 55.8% being female. 62.1%, 27.3%, 5.6%, 3.1%, and 1.8% were white, black, asian, hispanic/latino, and other, respectively. Most patients had an ASA score of 2 (34.8%) or 3 (55.2), and an average Charlson Comorbidity Index of 2.35 (± 2.2). 61.1% of patients had a STONE score of 5-8, with 38.9% having a score of 9-12. 56.4% and 43.6% of patients had a Guy’s score of 1-2 and 3-4, respectively. Most patients underwent a left-sided PCNL (55.2%). 30% of patients required a secondary same-side operation within 90 days. Nearly a quarter of patients had infected preoperative urine culture, with 5 (1.6%) instances of postoperative urosepsis. The most common primary stone compositions (>50% composition) were calcium oxalate monohydrate (39.3%) and calcium phosphate (30.7%). Overall complication incidence was 31.0%, with 11.6% being major and 5.9% being pneumo- or hydrothorax.

Conclusion: This data describes the experience of a diverse cohort undergoing PCNL at a Southeastern academic institution.

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Table 1: **Descriptive summary of percutaneous nephrolithotomy cohort (n=319).**

	n (%)
Age*	56 (44-65)
Gender	
Female	178 (55.8)
Race	
White	198 (62.1)
Black	87 (27.3)
Asian	18 (5.6)
Hispanic/Latino	10 (3.1)
Unknown/Other	6 (1.8)
Body Mass Index (Kg/m²)*	28.5 (23.9-33.7)
ASA Score	
I	14 (4.4)
II	111 (34.8)
III	176 (55.2)
IV	18 (5.6)
Preoperative Creatinine (mg/dL) *	0.95 (0.79-1.21)
Charlson Comorbidity Index**	2.35 (+/- 2.2)
Muscle Imaging	
Days from PCNL**	9 (+/- 16)
Total Linear Muscle Area (cm²) *	82.2 (69.8-97.6)
Total Muscle Index (cm²/m²) *	29.0 (25.4-32.8)
STONE Score	
5-8	195 (61.1)
9-12	124 (38.9)
Guy's Score	
1-2	180 (56.4)
3-4	139 (43.6)
PCNL Side	
Left	176 (55.2)
Right	134 (42.0)
Bilateral	9 (2.8)
Preoperative Urine Culture (missing=11)	
Days from PCNL*	8 (4-22)
Infected	73 (23.7)
Primary Stone Composition (missing=26)	
Calcium Oxalate Monohydrate	115 (39.3)
Calcium phosphate	90 (30.7)
Uric acid	28 (9.6)
Magnesium Ammonium Phosphate	21 (7.2)
Calcium Oxalate Dihydrate	14 (4.8)
Calcium monohydrogen phosphate dihydrate	13 (4.4)
Cystine	7 (2.4)
Ammonium Acid Urate	5 (1.7)
Operative Time (minutes)*	135 (103-183)
Estimated Blood Loss (mL)*	50 (25-100)
Length of Stay (Days)*	1 (1-2)
Secondary Operation (0-90 days)	94 (29.5)
Complications	
Any Complication	99 (31.0)
Major Complication	37 (11.6)
Lung Related Injury	19 (5.9)
Transfusion	12 (3.7)
Any Infectious	43 (13.5)
Urosepsis	5 (1.6)
Any Complication (Excluding Infection)	66 (20.1)

*Median (IQR). **Mean (Std). Abbreviations: American Society of Anesthesiology (ASA)

Funding: N/A

Poster #56

SAFETY AND CLINICAL INSIGHTS OF RENAL PAPILLARY TIP BIOPSIES FOR THE STUDY OF LITHIASIS

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Presented By: Elizabeth Kwenda, MD

Introduction: Alexander Randall first published renal papillary tip findings from stone formers in 1937, paving the way for modern endoscopic assessment and biopsy studies exploring kidney stone pathogenesis. We performed an exhaustive literature search to evaluate the safety of papillary tip biopsy and the clinical insights gained from modern renal papillary investigations.
Methods: A MEDLINE search was performed on the topic of renal papillary biopsy, providing an overview of Randall's plaques (RP), an analysis of current classification systems for renal papillary grading, and a summary of procedure type, complications, and outcomes. When study populations overlapped, duplicates were removed. The procedure was assumed to be safe if no biopsy complication was reported by study authors.
Results: We identified 26 published manuscripts. Within these, 660 individuals underwent renal papillary tip biopsy percutaneously (n=562), endoscopically (n = 37), or unspecified (n=23). Post-operative changes in blood counts were similar to controls, and only one individual (1/562; 0.2%) had fever >38°C reported. In two studies, long-term mean serum creatinine post-biopsy (n=32) was unchanged. In a controlled series reporting times, biopsies during URS and PCNL added roughly 20-30 minutes of procedure time over non-biopsy cases. Compared to controls, papillary plaque-containing tissue had upregulation in pro-inflammatory genes, immune cells, and cellular apoptosis with over-expression of inflammatory cytokines. Urinary calcium and papillary plaque coverage were found to differ between RP stone formers and non-RP stone formers, suggesting that inflammation promotes plaque and stone formation with differing underlying pathophysiology for these groups. Two separate renal papillary scoring systems have been externally validated and are used to classify stone formers based on stone type and papillary characteristics.
Conclusion: Our review showed that renal papillary biopsies are safe and effective with excellent potential for further research. Newer tissue analysis and animal models will allow further exploration of plaque pathogenesis and identification of target therapies for stone prevention which, along with the systematic adaption of papillary grading scales, can help individualize the care of patients with nephrolithiasis.
Funding: N/A

Poster #57

DIRECT EFFECTS OF CANNABINOID ON DIFFERENT CELL TYPES OF HUMAN TESTIS: AN IN VITRO MODEL

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Presented By: Janmejay Hingu, MD

Introduction: The endocannabinoid system (ECS) is a well-regulated network of endogenous cannabinoids (eCB), transporter, and metabolic enzymes involved in various organ systems, including male reproduction. The pharmacological properties of eCBs are mediated by their binding to CB1 and CB2 cannabinoid receptors. This study aims to assess the effect of selective CB1 and CB2 agonism and inverse agonism on human testicular cell cultures to study the *in vitro* effects on cellular profile and modulation of male reproductive function.
Methods: Human adult testicular biopsy specimens for cell culture were cryopreserved in 8% dimethyl sulfoxide and 20% fetal calf serum in minimum essential medium and stored at –196°C. Cells were isolated and cultured at 24,000 cells/cm2 in StemPro-34 medium at 37°C supplemented with growth factors. After reaching at least 80% confluency, six

experimental conditions were applied to the cells: (1) CP55,940 (cannabinoid agonist, 100nM, 2 hours), (2) SR141716 (CB1 inverse agonist, 100nM, 2 hours), (3) SR144528 (CB2 inverse agonist, 100nM, 2 hours), (4) initially SR141716 (100nM, 5 min), followed by CP55,940 (100nM, 2 hours), (5) initially SR144528 (100nM, 5 min), followed by CP55,940 (100nM, 2 hours), and (6) no treatment as control. RNA was isolated using the RNeasy Kit (Qiagen), and cDNA was synthesized using the high-capacity cDNA inverse transcription kit (Applied Biosystems). RT-qPCR determined relative gene expression for cellular markers of undifferentiated spermatogonial cells (ZBTB16, UCHL1, THY1), Sertoli cells (SOX9, Clusterin), Leydig cells (STAR, TSPO), and peritubular cells (ACTA2, CD34), as well as FAAH (a target gene involved in spermatogenesis regulation) using TaqMan gene expression assay with technical triplicates.
Results: RT-qPCR Ct values were normalized to control using POLR2A housekeeping gene as the endogenous control. ANOVA showed a significant difference between conditions for FAAH *(p=0.0488)*, Clusterin *(p=0.0444)*, and TSPO *(p<0.0001)*.
TSPO expression showed a significant difference for SR141716, SR144528, CP55,940+SR141716, and CP55,940+SR144528 when compared to control (*p<0.0001)*.
Conclusion: FAAH and Clusterin expressions appear to be downregulated with cannabinoid agonist, CP55,940. TSPO expression was significantly upregulated for all treatment groups except CP55,940. Spermatogonial and peritubular markers did not show any significant changes for evaluated markers. To verify comparable gene expression data, more biological replicants, varying cannabinoid concentrations, and different exposure durations are needed.
Funding: N/A

Poster #58

EVALUATION OF THE EFFECTIVENESS OF MICROSURGICAL MANAGEMENT OF CHRONIC ORCHIALGIA

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Presented By: Caleb Natale

Introduction: Chronic orchialgia, defined as chronic/intermittent testicular pain for ≥ 3 months, is a challenging condition to treat, as management is not well standardized, and the pain is frequently idiopathic. Urologists typically utilize a variety of conservative measures prior to surgical management strategies. Microsurgical denervation of the spermatic cord has proven to be a less invasive surgical technique, its effectiveness partially predicted by response to a spermatic cord block. Simple orchiectomy is generally considered to be a surgical treatment of last resort.
Methods: We reviewed all patients undergoing surgical management for chronic orchialgia at our institution from August 2020 through August 2022. The primary endpoint was reduction of pain following surgery. We also reviewed the number of conservative therapies employed prior to surgical management as well as the common etiologies of pain.
Results: Twenty-two patients underwent surgical management of orchialgia. Seven reported previous vasectomies. The average age of patients was 48.5 years (range: 20-73), and the average follow-up was 12.1 months (1-40). Three patients described symptoms consistent with nociceptive pain (e.g., dull, aching), while all patients described symptoms consistent with neuropathic pain (e.g., burning, hyperesthesia, radiation to scrotal skin). Twelve patients reported bilateral pain, and 10 patients reported unilateral pain. All patients had testicular ultrasounds performed to eliminate other identifiable issues. All patients failed treatment with at least two conservative modalities prior to surgical management, with the average patient undergoing 4.5 conservative strategies. All patients undergoing microsurgical denervation of the spermatic cord were first treated with spermatic cord block, and all patients demonstrated pain relief following the block. Twenty patients underwent microsurgical denervation of unilateral or bilateral spermatic cord. Three patients underwent concurrent granuloma removal. One patient underwent unilateral simple orchiectomy, and one patient underwent neurolysis with ethanol. Six

patients (27%) found no relief, three (14%) showed minimal reduction in pain, and seven (32%) reported significant relief. Reduction of most pain and cure of all pain were reported in three patients (14%).
Conclusion: Chronic orchialgia remains a challenging condition to manage. Judicious use of invasive surgical treatments is appropriate following trials of conservative treatment options, but patients should be counseled, as many will continue to experience chronic pain despite surgery.
Funding: N/A

Poster #59

SEMEN MICROBIOME PROFILING IN MEN WITH NON-OBSTRUCTIVE AZOOSPERMIA: A NEXT-GENERATION SEQUENCING ANALYSIS

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Presented By: Braian Rene Ledesma, MD

Introduction: Detection of a microbiome profile coupled with advanced genetic sequencing has opened a new research frontier. We hypothesized that the semen microbiome profile in men with non-obstructive azoospermia (NOA) would differ from the semen microbiome of fertile controls (FC).
Methods: NOA was diagnosed using semen analysis and clinical phenotype (ex. small testis volume, FSH >10 IU/mL). FC were identified as men undergoing vasectomy after fathering at least one child. We used Next Generation Sequencing (NGS) including quantitative PCR and 16s rRNA V1/V2 region comprehensive sequencing using Illumina MiSeq technology on semen samples. Analysis included alpha diversity via overall richness, Shannon diversity, and Hill1 diversity. We analyzed beta diversity via Bray-Curtis difference. Differential abundance was evaluated with ANCOMBC procedure. Variables were assessed for significance.
Results: 21 men with NOA and 36 FC were enrolled during the study period. Demographic data collected was similar between both groups. Alpha diversity was not observed based on all three parameters which suggests that the groups were similar in species type and evenness. Beta diversity was also insignificant based on Bray-Curtis, suggesting that within group variation was as high as between group variation. 24 species varied significantly in abundance between men with NOA as compared to FC (q rounded to 0) as shown in Table 1, and two genera varied significantly with higher *Aerococcus* in NOA, and higher *Burkholderia* in FC.
Conclusion: Our study showed no difference in seminal microbiome diversity between men with NOA and FC. However, there was abundant difference at the species and genus levels. This finding prompts the need to further study the possibility of commensalism between the human body and bacteria in the realm of fertility. Future studies in this field may explore the dimension of harnessing the microbiome through probiotics to impact fertility.

Most Differential Species Per Group	
NOA	FC
C. pilbarense	*C. trachomatis*
P. catoniae	*P. melaninogenica*
D. propionicifaciens	*B. cepacia*
S. rhizogenes	*T. aromaticivorans*

Funding: microgendx

Poster #60

COMPARISON OF HEMATOCRIT CHANGE IN TESTOSTERONE-DEFICIENT MEN TREATED WITH INTRANASAL TESTOSTERONE GEL VERSUS INTRAMUSCULAR TESTOSTERONE CYPIONATE: A SINGLE-CENTER RANDOMIZED CLINICAL TRIAL

Jesse Ory[1], Marco-Jose Rivero[2,3], Parris Diaz[2], Raul Clavijo[4], Nannan Thirumavalavan[5], Ruben Blachman-Braun[2], Justin Loloi[6], Ari Bernstein[7], Ranjith Ramasamy[2]
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Presented By: Marco-Jose Rivero

Introduction: Testosterone therapy is associated with increased hematocrit (HCT) and subsequent risk of thrombotic events. Recent evidence has shown that the modality and half-life of each formulation may affect the incidence of these side effects. We hypothesized that treatment with intramuscular testosterone cypionate (TC) would result in a larger increase in HCT relative to intranasal testosterone gel (NT).
Methods: This randomized clinical trial was performed on 46 men with TD, defined as hypogonadal symptoms in combination with at least two serum total testosterone (T) levels below 300 ng/dL. Men were randomized (1:1) to receive either NT (5.5 mg per nostril) three times a day or TC (200 mg intramuscularly) once every two weeks. The primary outcomes were changes in HCT and T before and after four months of treatment. Secondary outcomes were changes in estradiol (E), prostate-specific antigen (PSA), and 17-hydroxyprogesterone (17-OHP). Data analysis was performed using two-sample t-tests (Microsoft Excel v.16.60).
Results: 46 men with TD were randomized to receive either NT (n=19) or TC (n=27). The median participant age was 46.5 years with a mean T of 242.1 ng/dL and mean HCT of 43.2. The prevalence of participants who screened positive for obstructive sleep apnea on STOP-BANG questionnaire was 68% for the NT group and 74% for the TC group. Compared to their respective baselines, men in both groups experienced significantly increased T levels ($p<0.001$), although a larger increase was seen in the TC group. There was an increase in the mean HCT of the TC group from 42.4 to 46.0 at four-month follow-up ($p=0.004$), while the NT group experienced no such changes ($p=0.73$). The TC group experienced significant increases in E ($p<0.001$) and decreases in 17-OHP ($p<0.001$) at follow-up, while the NT group experienced no such changes. Neither regimen significantly affected PSA levels on four-month follow-up.
Conclusion: Both NT and TC regimens are effective in treating men with TD. However, NT does not appear to significantly affect HCT levels, especially when compared to TC. Those who are at increased risk of developing polycythemia or those who wish to avoid changes in E or 17-OHP levels may benefit from short-acting testosterone formulations such as NT.
Funding: Acerus Pharmaceuticals

Poster #61

PRESENCE AND ETIOLOGY OF ERECTILE DYSFUNCTION IN PEYRONIE'S DISEASE AS DEMONSTRATED BY COLOR DOPPLER DUPLEX ULTRASOUND

Laura Geldmaker, BS[1], Daniela Haehn, MD[1], Christopher Walker[2], Colleen Ball, MS[3], Gregory Broderick, MD[1]
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Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Peyronie's Disease (PD) can coexist with erectile dysfunction (ED). International guidelines recommend that management of PD include an assessment of each patient's ability to initiate and sustain erection. PD can cause significant stress to the patient and his partner. This distress may limit the patient's ability to assess adequacy of penile rigidity. Our objective was to assess vascular erectile integrity non-invasively in the setting of PD.
Methods: Consecutive patients who underwent intracavernous injection (ICI) followed by Color Doppler Duplex Ultrasound (CDDU) at our institution from August 2004 through June 2022 were retrospectively reviewed. CDDU findings were recorded following injection of low dose alprostadil (10-20 mcg) and again after a period of privacy and visual sexual stimulation. CDDU findings including peak systolic velocities, and resistive indices were recorded. Among patients diagnosed with PD, comparisons of patient characteristics between those with and without a diagnosis of ED were made using a Wilcoxon rank sum test (continuous characteristics) or Fisher's exact test (categorical characteristics).
Results: Our assessment of 1853 men using CDDU found 1239 were diagnosed with PD by CDDU. Among those with PD, 353 (28.5%) were diagnosed with PD only (vascular normal) and 886 (71.5%) were diagnosed with PD and ED. Patients with a CDDU diagnosis of PD only were younger [median: 57 (49, 62) vs. 61 (55, 67) years, $P < 0.001$], less likely to have hypertension [119/349 (34.1%) vs. 424/885 (47.9%), $P < 0.001$], less likely to have used PDE-5 inhibitor [243/348 (69.8%) vs. 692/882 (78.5%), $P = 0.002$], and less likely to have failed to a PDE-5 inhibitor [150/243 (61.7%) vs. 531/691 (76.8%, $P < 0.001$] compared to men with PD and ED. SHIM scores were higher among those with PD only compared to PD and ED [median (interquartile range): 14 (8–20) vs. 10 (6–18) , $P < 0.001$]. CDDU diagnoses for men with PD and ED were: AI 284/886 (32.1%), CVOD 371/886 (41.9%), mixed vascular ED 231/886 (26.1%). **Conclusion:** In our cohort of men, Doppler analysis found that 71.5% of PD patients have some form of vascular ED. We recommend an evidence-based assessment of vascular erectile integrity before any patient is triaged to surgical intervention.
Funding: NA

Poster #62

HISTOLOGY APPEARS TO REVEAL GOOD SEALING OF THE HUMAN, PROCINE AND DOG VASECTOMY SPECIMENS USING THE VASECTOMY SEALING PROCEDURE

Gerard Henry, MD[1], Tariq Hakky, MD[2], Ryan Griggs, DO[1], Warren Nighan[3], Alex Fuselier[1], LeRoy Jones, MD[4]
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Presented By: Alex Fuselier

Introduction: The Sealed Vasectomy Procedure (SVP) is a new bipolar radiofrequency sealing tool for transdermal vasectomy in hopes of making the procedure a faster, simpler, and safer office procedure. Testing has been successful in rabbits with excellent wound healing, complete vas occlusion on histology, and no sperm in post procedural semen analysis. The study data was presented last year as a video submission and subsequently won the AUA 2022's "Best Video" of the andrology / infertility / sexual dysfunction session. Further studies in larger animals were indicated and FDA-approval are needed before its application in humans. The issue of "does the SVP effectively seal the vas deferens in animals larger than a rabbit and in humans?" is a critical one for treating physicians.

Aim: Evaluate the effectiveness of the SVP in sealing the vas deferens in animals larger than a rabbit and in humans.
Methods: Animal (rabbit) studies have been previously described. We preformed microscopic evaluation of the vas deferens tissues from canines treated with the SVP at either 40 or 60 watts, euthanized at 14 days post-treatment under the conditions of this study. Human vas deferens specimens after removal from the patient were then immediately treated with SVP tool on benchtop. Porcine vas deferens samples were procured and underwent benchtop testing. Specimens were sent for pathologic evaluation by a third-party professional vendor [Crisp County Regional Medical Center in Cordele, Georgia].
Results: 4 canine, 6 human, and 26 porcine vas deferens were included in SVP testing. Human, porcine, and canine specimens demonstrated tissue coagulation and fibrosis [CK1] in the treated vasa deferentia. (See Figure 1 Human and 2 Canine)
Conclusion: SVP is a potentially exciting novel vasectomy procedure that appears to provide good sealing of the vas deferens in the canine animal model and on benchtop for the human and porcine vas deferens. FDA-approval is still needed before use in humans.
Funding: Signati

Poster #63

PATIENTS WITH ADULT-ACQUIRED BURIED PENIS AND THEIR SURGICAL MANAGEMENT: A SINGLE-CENTER STUDY

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Presented By: Melissa Wong, MD

Introduction: Adult-acquired buried penis (AABP) is a condition where the penis is concealed by suprapubic scar and fat (escutcheon). AABP etiologies include obesity, pelvic lymphedema, lichen sclerosis, and scar contraction following a circumcision. Patients suffer with hygiene and infection issues, urinary and sexual disorders, and psychological problems such as depression, diminished self-esteem, and poor quality of life. After weight reduction, successful management of AABP involves surgical correction. The goal of surgical repair is to extract the telescoped penis from the escutcheon. In our experience, this has been successful with a urologist/plastic surgeon team.
Methods: Cases of surgical repair for AABP performed from 2012 to 2022 were retrospectively reviewed. Fourteen patients were identified. Surgeries were performed at a single medical center. Patient characteristics were reviewed as well as the updated surgical techniques.
Results: Patients' ages ranged from 40 to 74 years old. Their BMIs ranged from 32.1 to 62.4 (mean 43.31). All patients were obese; eight patients were severely obese. Five patients had a history of adult circumcision, five had a prior diagnosis of lichen sclerosis, and three had genital lymphedema.
The initial procedures were routine with some variation. Panniculectomy was performed in 11 patients. A meshed split-thickness skin graft (STSG) was used for penile shaft coverage, with the graft being harvested from the excised pannus or the anterior thigh. The most common complication was wound dehiscence. Two complications required return to the OR; one for closure of an infected wound and the other for resection and a new STSG for lymphedema. All patients eventually did well, clinically.
Conclusion: AABP has several etiologies, with obesity as the leading cause; other predisposing conditions include lichen sclerosis and adult circumcision. The surgical techniques included panniculectomy/escutcheonectomy, penile degloving, removal of nonfunctional fibrotic tissues, incision of the suspensory ligament, and use of meshed STSG for penile shaft skin coverage.

Table 1: Preoperative Demographics

Patients, *n*	14
Age, mean in years (SD)	57.86 (+/- 10.73)
40-59, *n*	8 (57%)
60+, *n*	6 (43%)
BMI, mean (SD)	43.31 (+/- 8.78)
30-39, *n* (%)	6 (43%)
40+, *n* (%)	8 (57%)
Predisposing factors	
Obesity, *n* (%)	14 (100%)
Lichen sclerosis, *n* (%)	5 (36%)
Adult circumcision, *n* (%)	5 (36%)
Genital lymphedema, *n* (%)	3 (21%)

Funding: N/A

Poster #65

THE ROLE OF MICRO-ULTRASOUND FOR VASECTOMY REVERSAL. CAN WE IDENTIFY THE OBSTRUCTION?

Trisha Nguyen, MD, Miranda Eubank, MD, Wayne Brisbane, MD, Kevin Campbell, MD
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Presented By: Trisha Nguyen, MD

Introduction: High-resolution micro-ultrasound (MUS) is a contemporary imaging technology that operates at 29 MHz compared to the standard ultrasound frequency of 5-9 MHz. MUS delivers a resolution of up to 70 microns and has notably been studied as a modality for prostate imaging with reported results comparable to multiparametric MRI. Evaluation of the seminal tract with MUS has not been previously described. Here we describe the utility of epididymal MUS as a preoperative imaging modality prior to vasectomy reversal.
Methods: Two men with history of iatrogenic infertility from prior vasectomy presented to a tertiary referral center for vasectomy reversal. Vasectomy obstruction interval (VOI) was greater than 20 years for both men. Preoperative evaluation with MUS was performed to assess the patency and caliber of the vasa deferentia and to assess the epididymes for obstruction proximal to the site of vasectomy. MUS imaging was correlated with intra-operative findings to determine whether micro-ultrasound successfully identified the level of obstruction in the vas deferens.
Results: Patient 1 had a VOI of 21 years and prior unsuccessful vasectomy reversal at another institution. Preoperative MUS revealed normal caliber proximal vasa deferentia. Intraoperative evaluation demonstrated left vasal occlusion at a mid-high vasal site with sperm noted and subsequent vasovasostomy performed. A right epididymovasostomy was performed with epidydimal occlusion to the level of the corpus epididymis.
Patient 2 similarly had a VOI of 20 years followed by a failed vasectomy reversal. Preoperative MUS revealed normal caliber proximal vasa deferentia. Intraoperative findings demonstrated proximal vasal obstruction without sperm in the vasal fluid. Bilateral epididymovasostomies were performed at the cauda epididymis, correlating to MUS findings. Additionally, bilateral abdominal vas deferens were noted to have an atretic lumen, correlating to decreased diameter measurements on MUS.
Conclusion: MUS offers a high-resolution imaging modality that may assist in preoperative planning and counseling in men undergoing vasectomy reversal.

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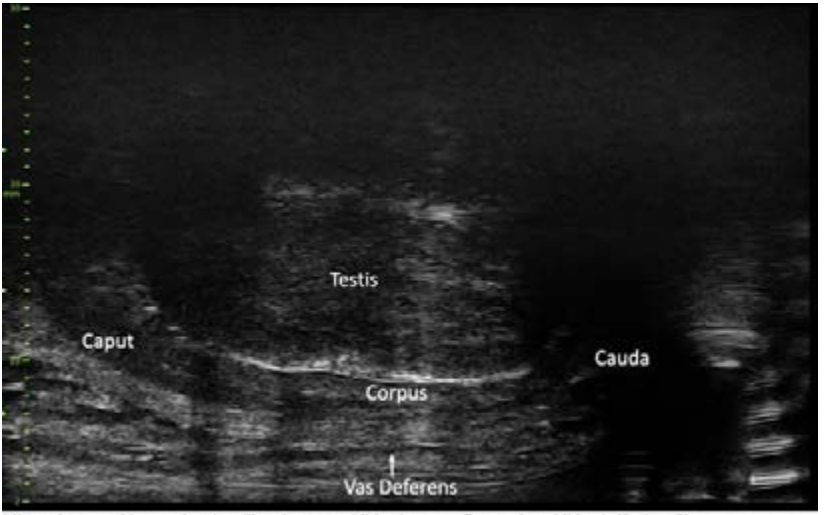

Micro-ultrasound image showing dilated caput epididymis versus flat cauda epididymis (Patient 2)

Funding: N/A

Poster #66

SUPERFICIAL WOUND DEHISCENCE FOLLOWING PENOSCROTAL INFLATABLE PENILE PROSTHESIS PLACEMENT: A CAUSE FOR CONCERN?

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Ochsner Clinic Foundation
Presented By: John Matthew Williams, MD, MS

Introduction: Complete wound dehiscence following inflatable penile prosthesis (IPP) placement is a feared complication. Device exposure necessitates a washout with either an attempted salvage or explant. On the contrary, superficial wound dehiscence with an intact dartos is managed expectantly at our institution if there are no signs of implant infection. However, due to limited discussion in the literature, uncertainty exists regarding the risk superficial wound dehiscence poses for implant infection. We sought to investigate factors associated with development of superficial wound dehiscence and its association with implant infection risk.
Methods: Data was retrospectively reviewed on all patients who underwent three-piece IPP placement at a single institution from 1/2019 to 6/2022. Patient demographics, clinical characteristics, comorbidities, and presence of post-operative superficial wound dehiscence were recorded. We used chi-square tests for categorical and Welch's t-tests for continuous variables.
Results: A total of 117 patients were included in this study. All surgeries were performed via penoscrotal approach by a single surgeon. The mean age of our cohort was 66 years (range: 42-79 years) and 43% (n = 50) had a BMI of 30 kg/m² or greater. Twelve patients (10%) were current smokers and 38% (n = 44) were diabetic. 21% (n = 24) were revision procedures due to mechanical device malfunction. Twenty-one patients (18%) developed superficial wound dehiscence, and all healed via secondary intention. There were no instances of complete wound dehiscence with device exposure. Two patients (9.5%) who experienced superficial wound dehiscence and four (4.2%) who did not ultimately developed a device infection ($p = 0.31$). Further, two patients (9.5%) who experienced superficial wound dehiscence had surrounding cellulitis, none of whom experienced a device infection. Additionally, 12 patients (57%) who experienced superficial wound dehiscence and 32 (33%) who did not were diabetic ($p = 0.041$). There was not a statistically significant relationship between age, obesity, smoking, immunosuppression, or revision surgery and the development of superficial wound dehiscence.

Conclusion: We observed that diabetics were at greater risk for superficial wound dehiscence. Although, in our cohort, post-operative superficial wound dehiscence was not associated with an increased risk of IPP infection. Our study sheds light on risk factors and outcomes for this often-overlooked occurrence.
Funding: N/A

Poster #67

THALLIUM EXPOSURE TO 3D HUMAN TESTICULAR ORGANOIDS ALTERS MIRNA EXPRESSION BIOMARKERS.

Janmejay Hingu, MD[1,2], Adam Cohen, MD[1,2], Nima Pourhabibi Zarandi, MD[1,3], Anthony Atala, MD[1,2], Hooman Sadri-Ardekani, MD, PhD[1,2]
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Presented By: Janmejay Hingu, MD

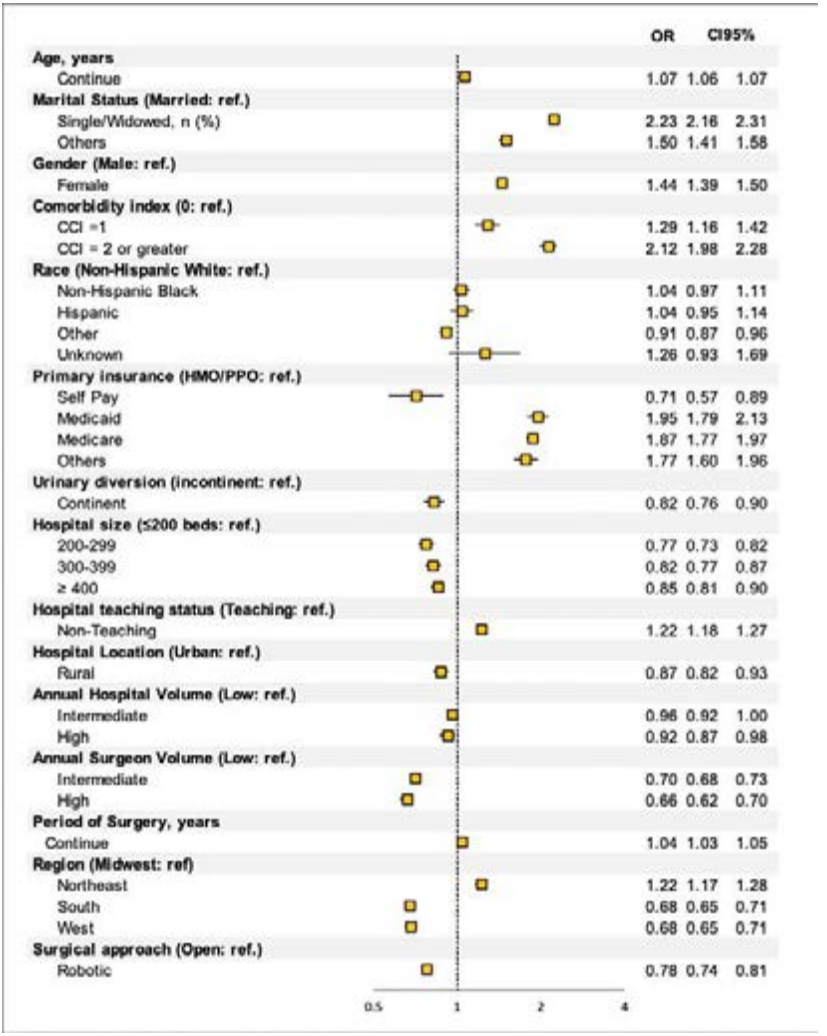
Introduction: Previous studies have demonstrated that heavy metal exposure can negatively impact male infertility and testicular carcinogenesis due to increased oxidative stress. This can lead to molecular dysfunction, part of which is mediated by small molecules of non-coding RNA known as miRNA. An increasing role for miRNAs is developing as they may serve as potential biomarkers for disease. We present a miRNA analysis following thallium exposure to three-dimensional human testicular organoids (HTOs).
Methods: 3D HTOs were created from 2D testicular cell cultures derived from three brain-dead adult patients. After determining IC50 values, HTOs were exposed to either thallium or ultrapure water and harvested for miRNA analyses. The miRNA analysis was performed for all replicates using the Nanostring nCounter Human v3b miRNA panel, with probes representing 827 unique miRNAs. Target normalization was executed with the geometric mean of the top 100 miRNAs detected, followed by background subtraction of 57 counts, which was the average of exogenous negative controls in the panel plus two standard deviations. All miRNAs with average counts of <5 within a sample group were excluded to ensure robust expression within the sample. The miRNA analysis results were normalized and analyzed with nSolver 4.0 (Nanostring).
Results: 9 miRNAs were uniquely expressed within the thallium HTOs compared to 3 in control HTOs. Of the 107 miRNAs expressed in both, 7 were significantly differentially expressed (miR-574-3p, miR-374a-5p, miR-423-5p, miR-106a-5p+miR-17-5p, miR-29b-3p, and miR-26b-5p were upregulated; miR-145-5p was downregulated). However, none survived the application of the false discovery rate.
Conclusion: Expression of 7 miRNAs following thallium exposure in HTOs was significantly altered compared to the control group. Of these, miR-145-5p and miR-574-3p have previously been linked to play a role in male infertility. Additionally, miR-423-5p has been associated with asthenozoospermia, and miR-26b-5p may serve as a biomarker of idiopathic male infertility. Testicular diffuse large B-cell lymphoma has been shown to express miR-17-5p. Although only 4 of these miRNAs have been previously implicated in male infertility and testicular cancer, further studies may demonstrate an increased role for more miRNAs. Future work using a combination of the HTO model and single-cell RNA sequencing may reveal the cell-specific effects of thallium on human testes.
Funding: N/A

Poster #68

POPULATION-BASED ASSESSMENT OF DETERMINING PREDICTORS FOR DISCHARGE DISPOSITION IN PATIENTS WITH BLADDER CANCER UNDERGOING RADICAL CYSTECTOMY

Raj Kumar, Kian Asanad, Gus Miranda, Jie Cai, Hooman Djalat, Mihir Desai, Inderbir Gill, Saum Ghodoussipour, Giovanni Cacciamani
Presented By: Raj Anirudh Kumar, BS

Introduction: Radical cystectomy (RC) remains the mainstay of treatment for muscle-invasive bladder cancer. Discharge disposition (DD) following RC - either home or to a continued rehabilitation facility (CRF) – is a clinical decision based on several clinical measures. Given that DD can have a dramatic impact on patient expense and recovery, the purpose of this study is to assess predictors of DD after undergoing RC for bladder cancer in the United States.
Methods: This study is a retrospective, cohort study. Patients were divided into two cohorts: those discharged home and those discharged to CRF. We examined patient, surgical, and hospital characteristics. Multivariable logistic regression models were used to control for selected variables. All statistical tests were two-sided. Patients were derived from the Premier Healthcare Database. International classification of disease (ICD)-9 (<2014), ICD-10 (≥ 2015), and Current Procedural Terminology (CPT) codes were used to identify patient diagnoses and encounters. The population consisted of 138,151 patients who underwent RC for bladder cancer between January 1, 2000 and December 31, 2019.
Results: A total of 24,922 (18.0%) of patients were admitted to CRFs. Multivariate analysis revealed that older age [Odds Ratio (OR):1.066, 95% Confidence Interval (CI): 1.063-1.068], single/widowed marital status [OR:2.232, 95%CI:2.160-2.307], female gender [OR:1.444, 95%CI:1.392-1.497], increased Charlson Comorbidity Index (CCI) [CCI=1 OR:1.285, 95%CI:1.162-1.421] [CCI≥2 OR:2.123, 95%CI:1.976-2.281], Medicaid [OR:1.949, 95%CI:1.785-2.129], and Medicare insurance [OR:1.870, 95%CI:1.774-2.129] are associated with CRF discharge. Rural hospital location [OR:0.873, 95%CI:0.824-0.925], self-pay status [OR:0.710, 95%CI:0.565-0.891], increased annual surgeon case [OR:0.660, 95%CI:0.624-0.697], and robotic surgical approach [OR:0.777, 95%CI:0.744-0.811] are associated with home discharge.
Conclusion: Several specific patient, surgical, and facility characteristics were identified that may significantly impact DD after RC for bladder cancer. This new information should help with preoperative counseling and shared decision-making.



Funding: N/A

Poster #69

CONVERSION TO DISPOSABLE CYSTOSCOPES DECREASED POST-PROCEDURE INFECTIONS COMPARED TO REUSABLE CYSTOSCOPES

Bryce Baird, Laura Geldmaker, Eric Regele, Daniela Haehn, Colleen Ball, Gregory Broderick, Ram Pathak, Timothy Lyon, David Thiel
Mayo Clinic Florida
Presented By: Bryce Alden Baird, BS, MD

Introduction: Given the current challenges in the sterile processing of surgical equipment, our Urology practice converted to single-use cystoscopes. Our objective was to evaluate differences in post-procedure encounters and infections following disposable and reusable cystoscopy.

Methods: Cystoscopies performed from June 2020 through August 2020 and February 2021 through April 2021 were retrospectively reviewed. Cystoscopies performed in 2020 were done with reusable cystoscopes while cystoscopies done in 2021 were performed with disposable cystoscopes (Ambu Inc., Columbia, MD, USA). Our primary analysis compared post-procedural infections seen after reusable and disposable cystoscopy within 30 days of the procedure.
Results: 1,051 cystoscopies were included in our four-month retrospective analysis. 533 cystoscopies utilized disposable cystoscopes and 518 utilized reusable cystoscopes.
In the disposable scope group, 380 (71.3%) patients were male and 153 (28.7%) were female. In the reusable scope group, 356 (68.7%) patients were male and 162 (31.3%) were female. Median age was 71 years for both groups [range: 20-97 (disposable), 23-98 (reusable)]. The most common indication for cystoscopy in both groups was suspicion of bladder cancer [disposable: 152 (28.5%) and reusable: 144 (27.8%)].
The reusable cystoscope group had a higher percentage of post-procedural urine cultures [83 (16.0%) vs. 4 (0.8%), P<0.001], positive urine cultures [23 (4.4%) vs. 2 (0.4%), P<0.001], and hospitalizations for urinary tract infection [3 (0.6%) vs. 1 (0.2%), P=0.367] when compared to the disposable scope group.
Conclusion: The use of disposable cystoscopes decreased the number of post-procedural urine cultures performed, positive urine cultures, and urinary tract infection-related hospitalizations in the 30 days following outpatient cystoscopy in our clinic.
Funding: N/A

Poster #70

ONCOLOGIC OUTCOMES: INTRAVESICAL GEMCITABINE/DOCETAXEL IS A FEASIBLE ALTERNATIVE FOR MANAGEMENT OF HIGH-RISK NON-MUSCLE INVASIVE BLADDER CANCER

Emily Roebuck, BS[1], Justin Refugia, MD[2], Parth Thakker, MD[2], Taylor Peak, MD[2], Celeste Watts, PA[2], Ronald Davis, MD[2], Ashok Hemal, MD[2], Matvey Tsivian, MD[2]
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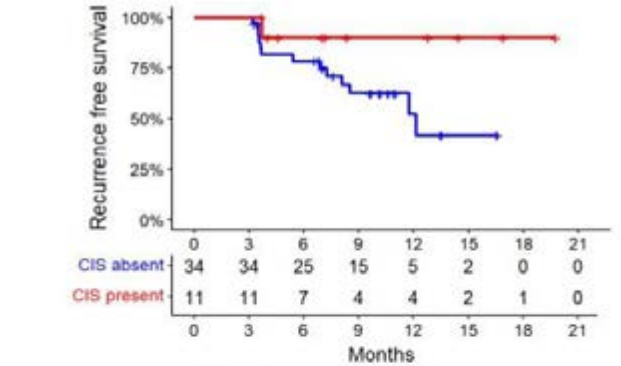
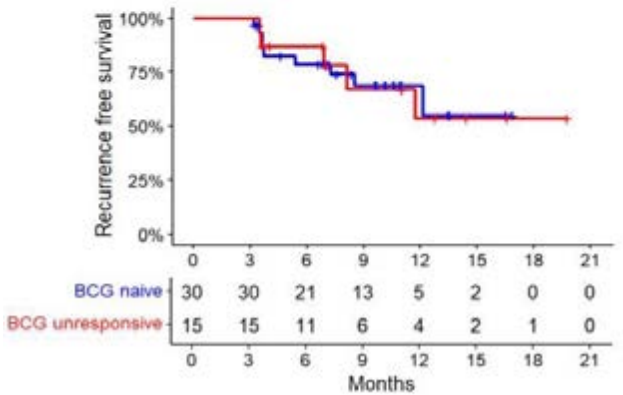
Presented By: Emily H. Roebuck, BS

Introduction: There continues to be an international shortage of intravesical Bacillus Calmette-Guérin (BCG), the first-line therapy for high-risk non-muscle invasive bladder cancer (HR NMIBC). No alternative treatments have yet been approved. In response to this, our institution employed sequential intravesical (IV) chemotherapy of gemcitabine and docetaxel (Gem-Doce). Here, we aim to define oncologic outcomes in patients receiving IV Gem-Doce to evaluate the efficacy in management of HR NMIBC.
Methods: We conducted a retrospective cohort study of patients with HR NMIBC that received IV Gem-Doce as first-line or salvage therapy. Metrics included prior BCG status, tumor pathology, and recurrence status. BCG-unresponsive was defined per FDA definition of adequate BCG. The primary outcome was recurrence-free survival (RFS). Groups compared: BCG-naïve versus BCG-unresponsive patients, patients with CIS present versus no CIS, and patients with multifocal versus non-multifocal disease. We performed a Kaplan-Meier survival analysis to determine RFS at 6, 12, and 18-months.
Results: We identified 45 patients for analysis between 2020 and 2022. Pretreatment pathology was high-grade (HG) Ta (71%), CIS (24%) or HG T1(20%). The patients were either BCG-naïve (67%) or BCG-unresponsive (33%) and a majority had multifocal disease (58%). Progression occurred in three patients (6.7%) and one patient died. Overall RFS at 6-, 12-, and 18-month was 81%, 61%, and 55% respectively. 12-month RFS was high in the BCG-naïve group at 69% (95% CI 0.52-0.90) compared to BCG-unresponsive group at 54% (95% CI 0.29-1.0, p = 0.97). Additionally, 12-month was a higher for patients with CIS at 89% (95% CI 0.70-1.0) compared to without CIS at 53% (95% CI 0.34-0.84, p = 0.086). Lastly, 12-month RFS was higher for the non-multifocal group at 74% (95% CI 0.54-1.0) comapred to multifocal group at 37% (95% CI 0.16-0.84, p = 0.082).
Conclusion: Our data suggest that IV Gem-Doce is a feasible alternative to BCG for patients with HR NMIBC in the setting of BCG shortage. Additional studies are needed

to evaluate predictors of response to IV Gem-Doce based on clinical and pathologic characteristics.





Funding: N/A

Poster #71

PERIOPERATIVE AND NEW PERSISTENT OPIOID USE IN CYSTECTOMY PATIENTS

Hailey Holck[1], Samuel Ivan[1], Rachel Locke[1], Myra Robinson, MSPH[2], Peter Clark[1], Kris Gaston[1], Stephen Riggs[1]
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Presented By: Hailey Holck, BS

Introduction: In large database studies, major surgery has been associated with new persistent opioid use in up to 10% of patients. Cancer patients are also at an increased risk for continued postoperative opioid use. However, there is limited data describing new persistent opioid use in radical cystectomy patients. We describe the use of a novel clinical opioid misuse and diversion identification tool to assess pre and postoperative opioid use patterns in an updated cohort of radical cystectomy patients.
Methods: We retrospectively queried our prospectively maintained, IRB-approved radical cystectomy database using patients spanning from 1/1/2017 to 1/1/2021. We employed Prescription Reporting with Immediate Medication Utilization Mapping (PRIMUM)—a clinical decision support intervention tool that identifies risk factors for misuse, abuse, and diversion of controlled substances. We assessed opioid prescriptions for nine months prior to surgery. New persistent use was defined as an opioid prescription between 91 and

365 days postoperatively in patients without preoperative prescriptions. McNemar tests for agreement compared the opioid usage pre versus post cystectomy.
Results: Our patient cohort included 258 patients, consisting of 76.4% male with an average age of 71 years. Surgery was performed by open approach in 34.1% and robotic approach in 65.9%. In the nine months preceding surgery, 137 (53.1%) patients had zero narcotic prescriptions, 66 (25.6%) had one, and 55 (21.3%) had two or more prescriptions. Postoperatively, 20 patients (14.6%) demonstrated new persistent opioid use. There was a significant difference between the postoperative narcotic prescriptions and pre-operative opioid use (p<0.001).
Conclusion: Postoperative opioid use varies significantly with preoperative opioid use in patients undergoing radical cystectomies. Radical cystectomy is also associated with a new persistent opioid use rate of 14% in our cohort. Additionally, 23.6% of patients undergoing cystectomy demonstrated persistent opioid use. This underscores the continued importance of investigating opioid use in ERAS cystectomy patients to mitigate the risk of unnecessary opioid use. Future studies will explore patterns of opioid use in cystectomy patients and whether ERAS can mitigate or moderate persistent use.

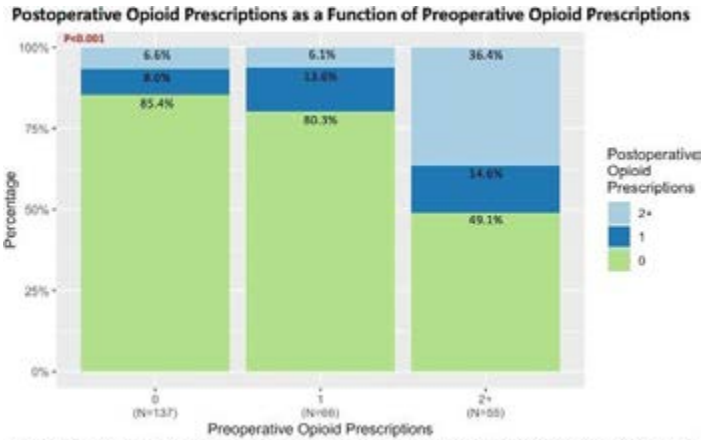

Figure 1. Postoperative opioid prescriptions varied significantly with respect to preoperative opioid prescriptions (p<0.001, McNemar Test)

Funding: N/A

Poster #72

PATHOLOGIC OUTCOMES AFTER NEOADJUVANT CHEMOTHERAPY IN PRIMARY VERSUS SECONDARY MUSCLE INVASIVE BLADDER CANCER – A SINGLE INSTITUTION EXPERIENCE

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Presented By: Hiroko Miyagi, MD

Introduction: Neoadjuvant chemotherapy (NAC) followed by radical cystectomy (RC) is the standard of care for muscle invasive bladder cancer (MIBC). Retrospective studies have demonstrated that patients with non-muscle invasive bladder cancer (NMIBC) progressing to MIBC (secondary MIBC) have worse clinical outcomes than similarly treated patients with primary MIBC. However, it is unknown whether pathologic response rates differ between primary and secondary MIBC patients undergoing NAC and RC. The objective of this study was to investigate the pathologic response rates of patients with primary versus secondary muscle invasive bladder cancer treated with neoadjuvant chemotherapy.
Methods: A retrospective review of RC patients at the University of Florida from 2011 to 2021 was performed to identify patients treated with NAC and RC. Patients with a history of intravesical therapy who progressed to MIBC were defined as secondary MIBC. Those presenting with MIBC at time of cancer diagnosis were defined as primary MIBC.

Oncologic outcomes were compared for 172 patients with primary MIBC with 33 patients with secondary MIBC who underwent NAC and RC. Specifically, rates of complete response rate (pT0) and downstaging (<pT2) were investigated.
Results: A total of 205 patients who received NAC and RC and were included in the analysis. The complete pathologic response (pT0) rate and pathologic downstaging (<pT2) of all patients was 19% (38/205) and 38% (77/205), respectively. There was no difference in complete pathologic response (pT0) between primary and secondary MIBC patients (primary MIBC: 17% vs. secondary MIBC: 27%, p=0.177). There was no difference in pathologic downstaging (<pT2) between primary and secondary MIBC patients (primary MIBC: 37% vs. secondary MIBC: 39%, p=0.813).
Conclusion: In our patient population, there was no difference in pathologic response rates to NAC between primary MIBC and secondary MIBC patients. NAC should be recommended for all cT2-4N0 MIBC regardless of tumor status as our results suggest that secondary MIBC patients are as likely to have a pathologic response in comparison to primary MIBC patients.
Funding: n/a

Poster #73

EFFICACY OF BCG FOR NON-MUSCLE INVASIVE BLADDER CANCER FOLLOWING NEPHROURETERECTOMY FOR UPPER TRACT UROTHELIAL CARCINOMA

Michael Massari, MD, Padraic O'Malley, MD, Paul Crispen, MD
University of Florida
Presented By: Michael Massari, MD

Introduction: While histologically similar, urothelial carcinomas developing in the upper urinary tract and the bladder differ from one another based on tumor genomics. This may lead to a difference in response to intravesical therapy for non-muscle invasive tumors developing in the bladder following nephroureterectomy for upper tract disease. Here we evaluate recurrence rates following BCG therapy in patients with non-muscle invasive bladder cancer following nephroureterectomy for upper tract urothelial cell carcinoma.
Methods: A single institution retrospective review of patients who underwent nephroureterectomy for upper tract urothelial cell carcinoma from 2009 to 2021 was performed. Patients included those who developed non-muscle invasive disease and subsequently received BCG. Patients were evaluated for rates of disease recurrence and progression.
Results: 25 patients were identified between April 2009 – February 2021 which met our inclusion criteria. Median time of follow-up after bladder tumor recurrence was 22 months. Stage of bladder tumor recurrence prior to BCG induction was LG Ta (3/25), CIS (6/25), HG Ta (9/25), HG T1 (7/25). Recurrence after complete transurethral resection and induction BCG was noted to be 52% (13/25). Median time to recurrence or progression was 5.7 months following resection of the recurrent bladder tumor. 23% (3/13) progressed to cystectomy. Progression to metastatic disease noted in 30% (4/13). Of the 48% (12/25) patients with a durable response to BCG, median follow-up was 27 (11.7-108) months.
Conclusion: The efficacy of BCG to prevent superficial bladder cancer recurrence and progression appears to be worse in patients with a history of nephroureterectomy for upper tract urothelial cell carcinoma relative to the established recurrence rates in similar patients without a history of upper tract disease. Patients in this population should be counseled accordingly and more aggressive treatments for bladder tumor recurrence should be considered.
No Funding

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Poster #74

THE ASSOCIATION BETWEEN PERIOPERATIVE SERUM BICARBONATE LEVELS AND COMPLICATION RATES AFTER RADICAL CYSTECTOMY

James Frisbie[1], Kathryn Gessner[1], Shivani Desai[2], Matthew Nielsen[1], Marc Bjurlin[1], Hung-Jui Tan[1], Angela Smith[1]
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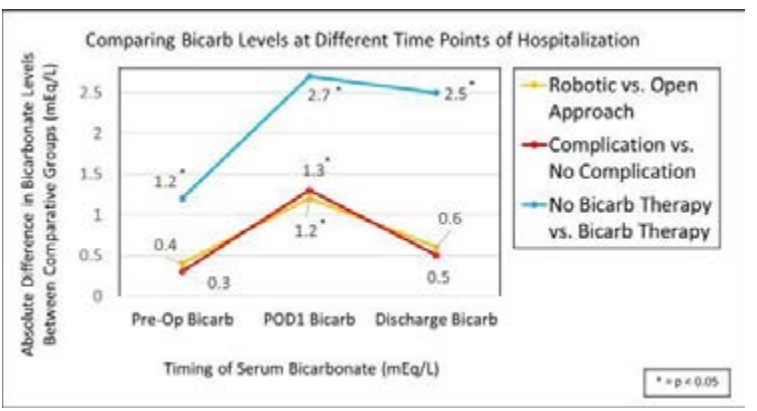
Presented By: James Frisbie, MD

Introduction: Metabolic acidosis is a recognized complication following urinary diversion. However, knowledge is limited regarding patient and surgical factors associated with perioperative bicarbonate levels and whether bicarbonate levels predict post-operative complications. Additionally, there is a paucity of data on when to start and which patients should receive bicarbonate replacement therapy. Our study evaluates the association between serum bicarbonate level, bicarbonate replacement, and patient and surgical factors with post-operative complication rates following radical cystectomy.
Methods: We conducted a retrospective study evaluating patients undergoing radical cystectomy with urinary diversion for bladder cancer between the years of 2014 and 2019 at our institution. We obtained demographic characteristics as well as treatment-related data such as surgical approach, complication rates, and bicarbonate levels at time of pre-op, post-operative day 1 (POD1), and day of discharge (DOD). We also evaluated whether patients were started on supplemental bicarbonate therapy within 90 days of surgery. Univariable and bivariable statistical analyses were performed with a significance level of < 0.05 deemed statistically significant.
Results: Among 291 patients identified in this study, mean age was 68 years, and 85% of patients were male. 175 (59%) patients underwent robotic surgery. A total of 130 (45%) of patients had a complication within 30 days. Bivariable analysis demonstrated both female patients and an open surgical approach had significantly lower POD1 bicarbonate levels, compared to male patients ($p=0.04$) and patients undergoing a robotic approach ($p=0.001$), respectively. Patients who were started on supplemental bicarbonate therapy within 30 days of surgery had significantly lower bicarbonate levels pre-operatively ($p=0.018$), POD1 ($p<0.001$), and DOD ($p=0.005$) compared to patients who were not started on supplemental bicarbonate. Additionally, patients who experienced a complication within 30 days of surgery demonstrated lower POD1 bicarbonate levels compared to those without complication (22.87 vs 24.17, $p < 0.001$) and were more likely to be on supplemental bicarbonate therapy ($p < 0.001$).
Conclusion: Lower serum bicarbonate levels on POD1 and taking supplemental bicarbonate therapy are associated with a higher rate of 30 day complications following radical cystectomy with urinary diversion. Future studies are necessary to determine the clinical utility of bicarbonate therapy in helping prevent metabolic acidosis and subsequent complications in the post-operative period.



Funding: N/A

Poster #75

PREDICTORS OF TRAVEL DISTANCE FOR RADICAL CYSTECTOMY IN FLORIDA: IMPLICATIONS FOR ACCESS TO CARE

Jared Schommer, Shalmali Borkar, Emily Brennan, Andrew Zganjar, Dorin Colibaseanu, Aaron Spaulding, Timothy Lyon
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Presented By: Jared Schommer, MD, PhD

Introduction: Travel distance to a center performing radical cystectomy (RC) is a well-established risk factor for impaired access to care and care fragmentation. However, the characteristics associated with increased travel for RC remain incompletely defined but are needed to inform efforts to bridge these gaps in care. The objective of this study was to assess features associated with travel distance for RC in a statewide dataset.
Methods: The Florida Inpatient Discharge Database was used to identify RC patients from 2013-2019. Travel distance was estimated using zip code centroids and modeled as < 25 miles, 25-50 miles, or > 50 miles. The primary outcome was travel >50 miles for RC. Secondary outcomes included inpatient mortality, discharge to a non-home facility, inpatient complications, and characteristics of hospitals that were bypassed by those traveling. U.S. County Health Rankings were included as model covariates and analyzed by tertile. Mixed effects logistic regression models accounting for clustering within hospitals were utilized.
Results: We identified 4209 patients, of whom 2284 (54%) traveled <25 miles, 654 (16%) traveled 25-50 miles, and 1271 (30%) traveled >50 miles. Travel distance >50 miles was associated with treatment at a high-volume center and significantly lower risks of inpatient mortality, non-home discharge, and postoperative complications (all $P<0.02$). Bypassed hospitals were less likely to be teaching facilities (56% vs. 96%, $P<0.001$) and more likely to perform ≤5 RC/year (75% vs. 25%, $P<0.001$). Following multivariable adjustment, patients who traveled >50 miles were significantly younger (OR 0.98, 95% CI 0.97-1.00), less likely to be Hispanic/Latino (OR 0.35, 95% CI 0.23-0.51), and more likely to reside in a county with the lowest health behavior ranking (OR 6.48, 95% 3.81-11.2) and lowest social economic ranking (OR 7.63, 95% CI 5.30-11.1) compared to those who traveled <25 miles (all $P<0.01$). Patients who traveled >50 miles primarily lived in central, southeast, or southwest Florida.
Conclusion: In Florida, digital outreach aimed to improve care coordination for RC patients would be best targeted in counties with low health behavior and social economic rankings in central and southern Florida. Further work is needed to understand why Hispanic/Latino patients were least likely to travel outside of their local community for RC.
Funding: N/A

Poster #76

SUNRISE-1: TAR-200 PLUS CETRELIMAB, TAR-200 ALONE, OR CETRELIMAB ALONE IN HIGH-RISK NON-MUSCLE INVASIVE BLADDER CANCER IN BCG-UNRESPONSIVE PARTICIPANTS WHO ARE INELIGIBLE FOR/DECLINE RADICAL CYSTECTOMY

Joseph Jacob[1], Christopher Cutie[2], Shalaka Hampras[3], Shu Jin[2], Hui Tian[4], Katherine Stromberg[5], Xiang Li[5], Neil Beeharry[4], John Maffeo[2], Michiel S. van der Heijden[6], Peter Clark[7]
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Presented By: Peter Clark, MD

Introduction: Treatment options are limited for patients with high-risk non-muscle-invasive bladder cancer (HR NMIBC) unresponsive to intravesical bacillus Calmette–Guérin (BCG). TAR-200 is an intravesical drug delivery system that provides local

continuous release of gemcitabine within the bladder. This study is assessing rate of complete response (CR) upon treatment with TAR-200 + systemic CET (anti–PD-1 antibody), TAR-200 alone, and CET alone in BCG-unresponsive patients with HR NMIBC who are ineligible for or decline radical cystectomy.
Methods: SunRISe-1 (NCT04640623) is an open-label, parallel-group, multicenter phase 2b study designed to assess efficacy and safety of TAR-200 + CET, TAR-200 alone, and CET alone in patients with BCG-unresponsive HR NMIBC. Eligible patients are aged ≥18 years with ECOG PS 0-2 and histologically confirmed carcinoma in situ, with or without papillary disease (T1, high-grade Ta), and within 12 months of completing adequate BCG. Patients (N=200) are randomized 2:1:1 to TAR-200 + CET (Cohort 1, n=100), TAR-200 (Cohort 2, n=50), or CET (Cohort 3, n=50). In Cohorts 1 and 2, TAR-200 is dosed every 3 weeks (Q3W) through Week 24, and Q12W thereafter until Week 96. Cystoscopy and centrally read urine cytology occur at baseline, Q12W through Year 2, then Q24W until end of Year 3, with additional disease assessments in Year 4 and Year 5 in accordance with institutional standards of care. Centrally assessed tumor biopsy is conducted at Weeks 24 and 48. CT/MRI is conducted at baseline and Q24W through end of Year 3. The primary end point is overall CR rate at any time point. Secondary end points include duration of response (time from first CR to recurrence, progression, or death), overall survival, pharmacokinetics, safety/tolerability, and patient-reported outcomes. Enrollment initiated in January 2021 and is ongoing.
Results: As of September 1, 2022, 69 patients have been randomized, from the US, Europe, and Australia. Several patients have reached disease assessment milestones at Months 3 and 6, as study enrollment continues.
Conclusion: This phase 2b study is assessing the efficacy and safety of TAR-200 + CET, TAR-200, and CET in BCG-unresponsive patients with HR NMIBC who are ineligible for or decline RC.
Funding: Janssen Research Development

Poster #77

THE IMPACT OF A DEDICATED CLOSING TRAY ON SURGICAL SITE INFECTIONS: THE FIRST YEAR

Rand Wilcox Vanden Berg, Michael Abern
Division of Urology, Department of Surgery
Presented By: Rand N. Wilcox Vanden Berg, MD

Introduction: Radical cystectomy remains an operation with a significant number of post-operative complications, one of which remains surgical site infections. Colorectal surgeons have used dedicated closing trays to decrease infections. We implemented the use of a closing tray for all urologic surgeries involving a urinary diversion and report the impact on surgical site infections.
Methods: Data for urologic surgeries undergoing a urinary diversion were collected from institutional data and stratified usage of a dedicated closing tray. Baseline demographics, surgical and perioperative variables, and post-operative infectious complications and outcomes were analyzed.
Descriptive statistics were calculated using the Wilcoxon rank sum test, Pearson's Chi-squared test, and Fisher's exact test where appropriate. Univariate and multivariate logistic and linear regression models were used to determine factors associated with log length of stay, any major complications, and wound infection. P values of 0.05 were considered statistically significant. All analyses were performed using R statistical programming version 3.5.3 (Vienna, Austria).
Results: A total of 268 surgeries were identified of which 39 were performed with a dedicated closing tray. Baseline characteristics between the two groups, including comorbidities, were not significantly different. The distribution of surgery types did not differ.
The median (IQR) duration of surgery differed between groups (372 [298-455] with closing tray vs. 314 [263-373] min, p = 0.001). On univariate and multivariate analysis, no closing tray was not associated with a significantly higher odds of wound infection (OR 2.74 [95% CI 0.38-20.05], aOR 3.45 [95% CI 0.51-88.8], respectively). No closing tray was also not

associated with a significantly higher odds of a high-grade complication (OR 0.37 [95% CI 0.14-1.02], aOR 0.39 [95% CI 0.12-1.0], respectively). No use of a closing tray was further not associated with log(length of stay) on multivariable analysis (aOR 0.96 [95% CI 0.82-1.14).
Conclusion: In the first year after implementing a dedicated closing tray, we did not see a significant reduction on the risk of a surgical site infection. We did, however, find an increase in operative duration. These data suggest that more studies are needed to quantify the effect, both financial and medical, of using a dedicated closing tray during urologic surgeries with a urinary diversion.
Funding: N/A

Poster #78

A CONTEMPORARY ANALYSIS OF TREATMENT OF MUSCLE INVASIVE BLADDER CANCER USING THE NATIONAL CANCER DATABASE: FACTORS ASSOCIATED WITH RECEIPT OF NON-AGGRESSIVE THERAPY.

Sol Moon[1], Vishruti Pandya[2], Andrew McDonald[3], Arnab Basu[4], Sejong Bae[2], James Ferguson[5]
[1]Department of Urology, University of Alabama Birmingham, [2]Department of Medicine, Division of Preventative Medicine, University of Alabama Birmingham, [3]Department of Radiation Oncology, University of Alabama Birmigham, [4]Department of Medicine, Division of Hematology-Oncology, University of Alabama Birmingham, [5]Department of Urology, University of Alabama Birmingham, Birmingham Veterans Affairs Medical Center
Presented By: Sol Moon, MD

Introduction: Patients with muscle-invasive bladder cancer (MIBC) face a potentially lethal disease, yet often do not receive potentially curative therapies. This study aims to characterize the treatments received by patients with MIBC, analyze their use according to sociodemographic, clinical, pathologic, and facility measures, and to identify possibilities for improvement in care for patients with MIBC.
Methods: Using the NCDB, we analyzed 102,119 patients with stage II-IV muscle invasive bladder cancer who were diagnosed between 2009-2018, excluding patients with cT4b or distant metastases. Treatments included cystectomy, with or without perioperative chemotherapy; chemoradiation; radiation alone; chemotherapy, or observation after diagnosis. Aggressive therapy (AT) was defined as cystectomy or radiotherapy >50 Gy. A multivariable generalized estimating equation model was used to assess the relationship of independent variables with receiving AT. Statistical analysis was conducted using SAS version 9.4.
Results: The median age was 73 years, with 72.9% male, 84.3% White, and 7.1% Black. Stage distribution included 59.4% stage II, 23.0% (III), and 17.6% (IV). Overall, 55.2% of patients received AT, while 41.1% did not, with 26.6% receiving observation alone. 45.4% of patients received cystectomy, 9.8% underwent definitive radiotherapy, and 12.8% underwent chemotherapy as primary treatment. Notably, over 30% of patients between ages of 50 and 70 did not receive aggressive therapy (Fig 1). On multivariate analysis, factors associated with lack of aggressive therapy included age >70 (OR <0.79, p<0.0001), Black race (OR 0.70, p<0.0001), Medicaid and underinsured status (OR 0.62-0.75, p<0.0001), Charlson score >/= 2 (OR 0.88-0.74, p<0.0001), and low volume (OR 0.72 p<0.0001), non-academic cancer program (OR 0.54-0.71 p<0.0001). Trends over time included increased utilization of perioperative chemotherapy (15.5% in 2009 to 24.7% in 2018), and chemoradiotherapy (5.4% in 2009 to 8.8% in 2018).
Conclusion: Over a third of patients do not receive aggressive therapy for MIBC, with many of these patients seemingly eligible by age and comorbidity status. While increased utilization of perioperative chemotherapy and chemoradiotherapy over time are favorable indicators, more granular research is needed to determine exactly why these patients do not receive aggressive therapy. A better understanding of patient vs access to care vs provider factors would help to focus efforts to improve care for patients with MIBC.

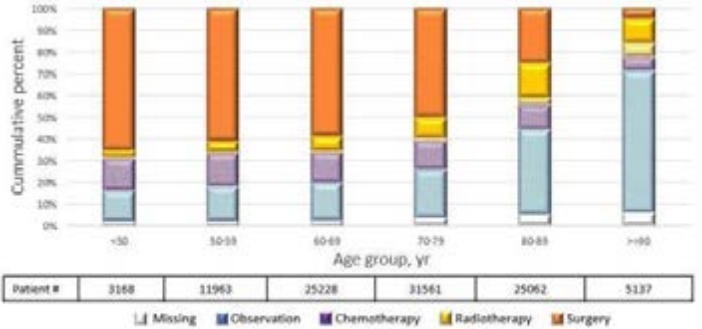

Fig. 1 – Distribution of primary therapies received by patients with muscle-invasive bladder cancer by age group. Aggressive therapies are shown in solid colors, nonaggressive therapies are shown in striped colors.

Funding: VA Research Development Award

Poster #79

SURGEON-ADMINISTERED ULTRASOUND-GUIDED TRANSVERSUS ABDOMINIS PLANE BLOCKS DURING RADICAL CYSTECTOMY: DESCRIPTION OF TECHNIQUE AND PERIOPERATIVE OPIOID REQUIREMENT

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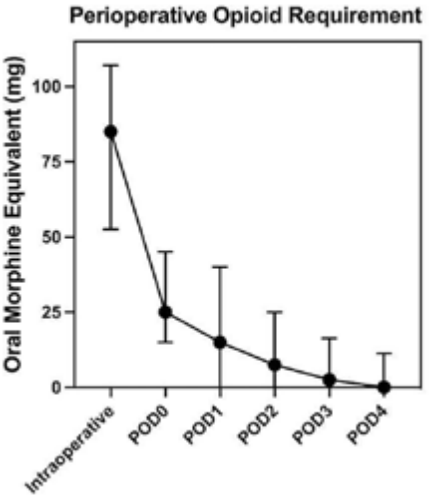
Presented By: Justin Refugia, MD

Introduction: Implementation of standardized analgesic regimens is paramount to developing enhanced recovery after surgery (ERAS) protocols for radical cystectomy (RC). Transversus abdominis plane (TAP) blocks have demonstrated decreased length of stay (LOS) and perioperative opioid requirement in current literature. To date, no studies have reported on ultrasound (US) guided TAP blocks performed by the surgeon in this setting. In this study, we present our technique for surgeon-administered, US-guided TAP (sUTAP) blocks and review postoperative opioid requirements.
Methods: We retrospectively reviewed patients that received sUTAP blocks just prior to incision for RC. The blocks were performed with US-guidance to advance the needle into the transversus abdominis plane at the anterior axillary line between the subcostal margin and iliac crest. Next, 25-cc of an anesthetic solution was instilled into this plane and the procedure was repeated on contralateral side (total of two injection sites). The primary objective was overall perioperative opioid requirement. Due to protocol changes, we also compared two groups of patients that received a 50-cc mixture of: 0.25% bupivacaine mixed with liposomal-bupivacaine (LB) or 0.25% bupivacaine only. Analyses were performed on patient demographics, surgical and anesthetic details, and perioperative medications.
Results: Between 2020 and 2022, we identified 47 patients that received sUTAP blocks during RC. The men (79%) had a median age of 70 years (IQR 61-75), and women (21%) had a median age 77 years (IQR 67-80). RC approach was open (81%) or robotic (19%). Urinary diversion was with ileal conduit (53%) or cutaneous ureterostomy (47%). Overall median perioperative MMEs (IQR): intraoperative – 85 (53-107), POD0 – 25 (15-45), POD1 – 15 (0-40), POD2 – 7.5 (0-25), POD3 – 2.5 (0-16), and POD4 – 0 (0-11). The overall median length of stay was 4 days (IQR 3-6). LB was included for 14 patients (30%) and was associated with higher intraoperative/POD1 MMEs than the 33 patients (70%) that received bupivacaine only ($p < 0.05$).

Conclusion: Our results suggest that addition of sUTAP blocks may reduce postoperative opioid requirements. Learning our technique should be considered by surgeons that are developing ERAS protocols for RC. Further comparative studies between anesthesia-administered TAP blocks and other peri-operative regional pain management modalities may clarify efficacy of sUTAP.



Funding: N/A

Poster #80

LAWSUITS IN BENIGN PROSTATIC HYPERPLASIA PROCEDURES IN THE LAST 20 YEARS

João Porto[1], Maria Camila Suarez[1], Robin Schard[2], Timothy Loftus[2], Dimple Chanamolu[1], Hemendra Shah[1]
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Presented By: João Gabriel Da Silva Porto

Introduction: Lawsuits related to medical malpractice are a known occupational hazard of practicing medicine. Over last few decades United States (US) is experiencing the medical malpractice crisis. In a survey of AUA members in 2006, 69% of urologist reported being named in medical malpractice lawsuits a mean of 2.1 times. Surgery for benign prostatic hyperplasia (BPH) is one of the commonest urological procedures reportedly performed by 95% of practicing urologist in US. In this study we aim to understand the characteristics of lawsuits related to BPH surgeries. This might assist urologist to minimize future complications due to their medical action.
Methods: Our data was collected from Westlaw database using key words: BPH, enlarged prostate, surgery and malpractice from 1/1/2000 to 12/31/2021 to look for all cases from entire US. Extracted from the cases were details related to type of procedure, plaintiff, nature of allegation, alleged complication, defendant, verdict, and compensation amount.
Results: After removing unrelated and duplicate files, Westlaw's search resulted in 17 cases that fit this study. The most common procedure was transurethral resection of the prostate (23%), and inadequate postoperative care was the main nature of the claim in the lawsuits (41%). The most processed professionals were urologists as well as other nonurological providers (60%). The most common clinical outcome was urinary incontinence and erectile dysfunction (29%). Interestingly, most patients were from the prison system (70%). Finally, the plaintiffs had a final favorable verdict in only two cases

(12%) that involved complication of colon perforation after interstitial laser coagulation with Indigo laser and recto-urethral fistula after TUMT.
Conclusion: The present study demonstrates that although most lawsuits were related to postoperative urinary incontinence and erectile dysfunction, the verdict was in favor of defendant. Urologist should be aware of the growing activation of the justice system by the prison population. We came across only two cases in which the plaintiff had a favorable verdict for presenting an unexpected clinical outcome with grave consequences.
Funding: N/A

Poster #81

CONVERSION TO DISPOSABLE CYSTOSCOPES DECREASED 30-DAY POST-PROCEDURE ENCOUNTERS COMPARED TO REUSABLE CYSTOSCOPES

Laura Geldmaker, Bryce Baird, Eric Regele, Daniela Haehn, Colleen Ball, Gregory Broderick, Ram Pathak, Timothy Lyon, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Given the current challenges in the sterile processing of surgical equipment, our Urology practice converted to single-use cystoscopes. Our objective was to evaluate differences in post-procedure 30-day encounters following disposable and reusable cystoscopy.
Methods: Cystoscopies performed from June 2020 through August 2020 and February 2021 through April 2021 were retrospectively reviewed. Cystoscopies performed in 2020 were done with reusable cystoscopes while cystoscopies done in 2021 were performed with disposable cystoscopes (Ambu Inc., Columbia, MD, USA). Our primary analysis compared post-procedural encounters and infections for reusable and disposable cystoscopes. Encounters were defined as all phone calls, Emergency department visits, or clinic appointments related to post-procedural complications such as pain, hematuria, or fever within 30 days of the cystoscopy.
Results: 1,051 cystoscopies were included in our four-month retrospective analysis. 533 cystoscopies utilized disposable cystoscopes and 518 utilized reusable cystoscopes. In the disposable scope group, 380 (71.3%) patients were male and 153 (28.7%) were female. In the reusable scope group, 356 (68.7%) patients were male and 162 (31.3%) were female. Overall median age was 71 years for both groups [range: 20-97 (disposable), 23-98 (reusable)]. The most common indication for cystoscopy in both groups was suspicion of bladder cancer [disposable: 152 (28.5%) and reusable: 144 (27.8%)]. The reusable cystoscope group had a higher percent of encounters [87 (16.8%) vs. 12 (2.3%), $P<0.001$], urine cultures [83 (16.0%) vs. 4 (0.8%), $P<0.001$], positive urine cultures [23 (4.4%) vs. 2 (0.4%), $P<0.001$], and hospitalizations [3 (0.6%) vs. 1 (0.2%), $P=0.367$] when compared to the disposable scope group.
Conclusion: The use of disposable cystoscopes decreased the number of post-procedural encounters and hospitalizations in the 30 days following office cystoscopy.
Funding: N/A

Poster #82

ANALYSIS OF FIXED OPERATING ROOM (OR) TIMES IN UROLOGIC ROBOTIC SURGERY

Laura Geldmaker, Christopher Hasse, Bryce Baird, Daniela Haehn, Abena Anyane-Yeboah, Mikolaj Wieczorek, Colleen Ball, Chandler Dora, Timothy Lyon, David Thiel
Mayo Clinic Florida
Presented By: Laura Elizabeth Geldmaker, B.S.

Introduction: Current evaluations of robotic OR efficiency focus on surgical console time. We broke procedures into fixed and variable time points. Our objective was to evaluate fixed OR times for three common robotic urologic procedures.
Methods: Over a 24-month period, we prospectively collected intraoperative data for 635-consecutive robotic-assisted surgeries. Fixed OR times were evaluated for robotic-assisted partial nephrectomy (RAPN) (n=146), robotic-assisted radical cystectomy

(RARC) (n=77), and robotic-assisted radical prostatectomy (RARP) (n=412). Fixed OR times were defined as nonprocedural time in the OR, including: in room time to anesthesia release time (IRAT), anesthesia release to cut time (ARCT), in room time to cut time (IRCT; IRAT + ARCT), and close time to wheels out time (CTWO). The effects of surgery time of day and the number of anesthesia personnel (AP) present in surgery on fixed OR times were also analyzed. Comparisons between groups were performed using the Fisher exact test for categorical variables and the Kruskal Wallis test for continuous variables. P values less than 0.05 were considered statistically significant.
Results: Fixed OR times occupied 15% (range: 9%-49%) (RARC), 27% (7%-41%) (RAPN), and 20% (9%-40%) (RARP) of total OR time. Time of day did not have a negative effect on fixed OR times for robotic urologic surgeries. Median AP count was highest for RARC (median: 3, range: 1-7). We did not find any association between AP count and fixed OR times for any of the procedures evaluated ($P \geq 0.19$).
Conclusion: Fixed OR times made up a significant percentage of total OR time for robotic-assisted procedures and should be incorporated into OR efficiency analyses. The number of AP per case and time of day of surgery did not negatively impact fixed OR times in urologic robotic surgeries.
Funding: N/A

Poster #83

PATIENT PERCEPTIONS ON THE ROLE AND ACCEPTANCE OF UROLOGY RESIDENTS

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Presented By: Daniel Reich, BA

Introduction: Medical education involves a complex hierarchy of providers including medical students, residents, fellows, and attending physicians. Although this system is advantageous for medical training purposes, it often convolutes the patient's understanding of each role. Previous literature in different medical specialties has demonstrated a noticeable knowledge gap in their patient populations. Our objective was to identify both the patient understanding of urology residents and their comfort working with such training physicians.
Methods: A prospective survey was distributed to patients prior to outpatient clinic visit at a single academic institution between 9/19/2022 and 9/29/2022. Survey included 16 questions assessing the patient's demographics, knowledge about residents, and opinion of residents. A score accounting for patient knowledge about residents (KAR) was calculated by combining correct responses for five questions (max score = 5). Another score evaluating patient opinion of residents (OOR) was calculated based on Likert scale questions (score 3-19) denoting patient outlook on residents being involved in clinical care.
Results: 50 surveys were distributed. The average patient age was 66.1 +/- 12.3 years. Most of the patients were white (n=39, 78%) or African American (n=8, 16%) and identified as males (n=36, 72%). The average reported length of urology residency was 3.8 +/- 1.9 years. Patients that reported they had been seen at an academic medical institution at least once (n=26) reported a higher average OOR of 13.8 versus those that reported they have never been to such as institution or were unsure (n=21) with average OOR of 12.7. Patients that had completed some college or more (n=31) had higher KAR scores with average of 3.4 versus those with less baseline formal education (n=15) who scored 2.4.
Conclusion: Current patient understanding of the role of a urology resident is suboptimal. Specifically, we found that patients with lower baseline education level and lack of exposure to academic medicine experienced the most uncertainty of urology resident role and capabilities. We plan to generate education modules to help our patients better understand urology resident training and capabilities. We hope to improve participant's positive perception of residents, comfortability, and receptiveness to receiving care from clinicians at all training levels.

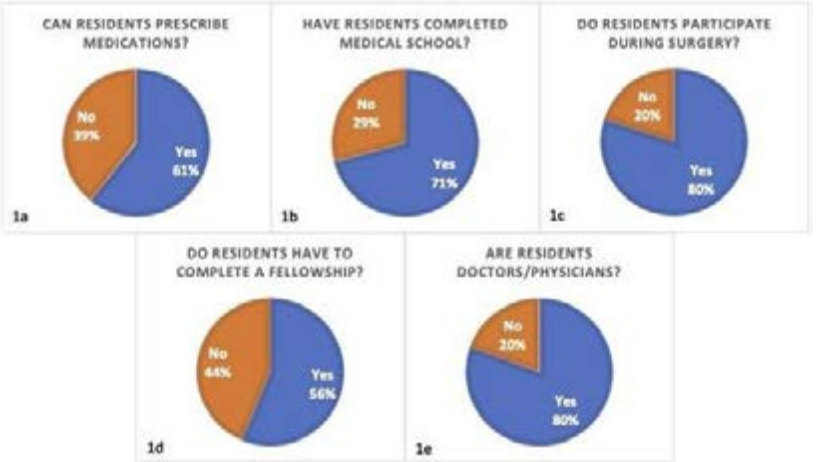

Figure 1a-e. Patient survey response breakdown for questions assessing knowledge about residents (KAR).

Funding: N/A

Poster #84

MATERNAL, NEONATAL, AND PREGNANCYOUTCOMES IN UROLOGY: HOW DO WE MEASURE UP?

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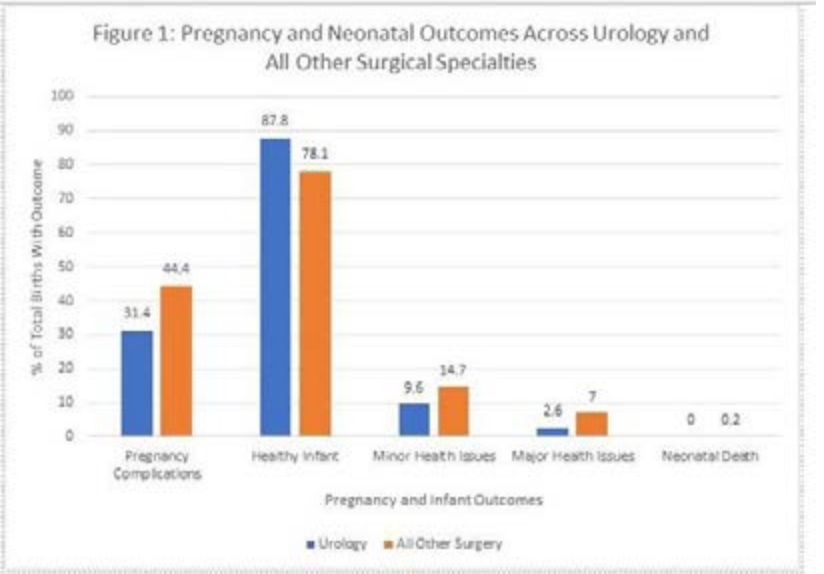
University of Kentucky
Presented By: Brittany Erin Levy, MD

Introduction: Physicians and especially surgeons, are higher risk for pregnancy complications leading to poor pregnancy, neonatal and health outcomes. However, across surgical specialties, pregnancy and neonatal outcomes have not been delineated. The objective of this survey study was to evaluate maternal, neonatal and pregnancy outcomes compared to other surgical specialties.
Methods: A survey was distributed to practicing surgeons across specialties including general surgery, urology, otolaryngology, and associated subspecialities. Survey questions regarding demographics, career stage, pregnancy/delivery, neonatal complications, maternity leave, breast feeding goals, and barriers to meeting these goals were asked. Responses were analyzed comparing urology/urologic subspecialties to other surgical specialties.
Results: 1162 births across surgical specialties were obtained, 159 of which were to urologic surgeons. Of these births, 454 were to trainees, while 694 children were birthed to attendings. Similarities across surgical subspecialties included gestational age at delivery (p=0.161). Those in urology/urology subspecialties were less likely to have pregnancy complications compared to other surgical specialties (31.4% vs 44.4%, p=0.003). Additionally, children born to urologists were more frequently healthy (87.8% vs 78.1%, p=0.031) without major or minor neonatal health issues. Figure 1.
Conclusion: Overall, urologists have improved pregnancy and infant health outcomes compared to other surgical specialties. Further research is needed to identify specific etiologies to enable directed quality improvement measures for all child bearing surgeons.



Funding: N/A

Poster #85

DEI IN GENITOURINARY CLINICAL TRIALS LEADING TO FDA NOVEL DRUG APPROVAL: AN ASSESSMENT OF THE FDA CENTER FOR DRUG EVALUATION AND RESEARCH DRUG TRIALS SNAPSHOT

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Presented By: Asia Matthew-Onabanjo, MD

Introduction: Diversity in urologic research participation is essential for ensuring that new interventions benefit all populations. However, under-representation of minorities in urologic clinical trials has not been well studied. We determined the distribution of race and ethnicity among genitourinary oncology trial participants leading to FDA approval of novel molecular entities/biologics. Additionally, we evaluated whether the proportion of Black participants in clinical trials increased over time.

Methods: A retrospective review of the FDA Center for Drug Evaluation and Research Drug Trials Snapshot (DTS) was conducted from 2015-2022. DTS was searched for urologic oncology clinical trials leading to FDA approval of novel drugs. Enrollment data was stratified by race and ethnicity. Cochran-Armitage Trend tests were used to examine changes in Black patient participation over years.

Results: Nine clinical trials were identified that led to FDA approval of 5 novel molecular entities for prostate and 4 molecular entities for urothelial carcinoma treatment. Trials for prostate cancer included 5,202 participants of which 69.8% were White, 4.0% Black,

11.0% Asian, 2.5% Hispanic, <1% American Indian/Alaska Native or Native Hawaiian/Pacific Islander, 3% other (8% race/ethnicity data missing). Trials in urothelial carcinoma had 704 participants of which 75.1% were male, 80.8% White, 2.3% Black, 8.2% Hispanic, <1% American Indian/Alaska Native or Native Hawaiian/Pacific Islander, 5% other (3.3% race/ethnicity data missing). Cancers combined revealed no difference in Black patient participation rates over years (*P*=0.28). Prostate cancer trends among Black patient participation rates declined in recent years (*P*=0.03)
Conclusion: Participants in genitourinary clinical trials leading to FDA approval of novel drugs are overwhelmingly white despite associations of worse outcomes in Black patients who desperately need better treatment options. Involving stakeholders who represent the needs and interests of underrepresented populations in the design and implementation of clinical trials of novel agents may be a strategy to increase diversity, equity, and inclusion among genitourinary clinical trials.
Funding: N/A

Poster #86

PATIENT COMPLIANCE WITH POST-VASECTOMY SEMEN ANALYSIS: A 16.5 YEAR ASSESSMENT FROM AN INDEPENDENT, COMMUNITY PRACTICE PRIOR TO AND AFTER THE COVID-19 PANDEMIC

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Presented By: Hongyu Zhang

Introduction: Urologic literature has suggested poor compliance with post-vasectomy semen analysis (PVSA). We sought to assess patient adherence to the American Urological Association (AUA) Guideline recommendations prior to and after the COVID-19 pandemic.
Methods: A retrospective chart review was performed from an independent, community practice of men who had undergone a vasectomy from August 2005 - February 2022. Patients were advised on completion of a PVSA at least 3 times (initial consultation, procedure, and post-operative visit). A 4th reminder phone call was provided to those patients who initially did not complete a PVSA. Patients were divided into 2 cohorts: vasectomy performed pre-COVID-19 (Group 1) and post-COVID-19 (Group 2) pandemic outbreak. Data was collected, including patient demographics, vasectomy procedure, complications, PVSA results, and follow-up.
Results: A total of 691 consecutive patients were reviewed, including 523 (75.6%) in Group 1 and 168 (24.4%) in Group 2. Mean age was 37.5 years (SD± 6.8). A total of 600 (86.8%) men were married and 91 (13.2%) men were single/other. Vasectomy location was in the office (631) or in the OR (60). In Group 1 (pre-COVID-19), 300 (57.4%) men completed a PVSA, whereas 223 (42.6%) did not complete a PVSA. In Group 2 (post-COVID-19), 76 (45.2%) men completed a PVSA whereas 92 (54.8%) did not complete a PVSA (p=0.006). Thus, 54.4% of all patients completed at least 1 PVSA as recommended on at least 3 occasions. In patients who did not initially complete a PVSA, the average days post-vasectomy follow-up phone call was 206 (SD± 98.5) in Group 1 and 214.2 (SD± 63.1) in Group 2. Only 5 patients (2.2%) in Group 1 and 4 patients (4.3%) in Group 2 completed a PVSA after the 4th phone call reminder (p=0.278). Early complications (<30 days) occurred in 31 patients in Group 1 (5.9%) and in 4 patients in Group 2 (2.3%) (p=0.068), with mild hematoma (24) the most common.
Conclusion: Despite our dedicated efforts to ensure compliance with AUA Guideline recommendations, only 54.4% actually completed a PVSA. A surprising number of patients in the post-COVID-19 era were more likely to remain non-compliant. Long-term follow-up contact efforts to encourage PVSA in those men initially non-compliant remained futile.

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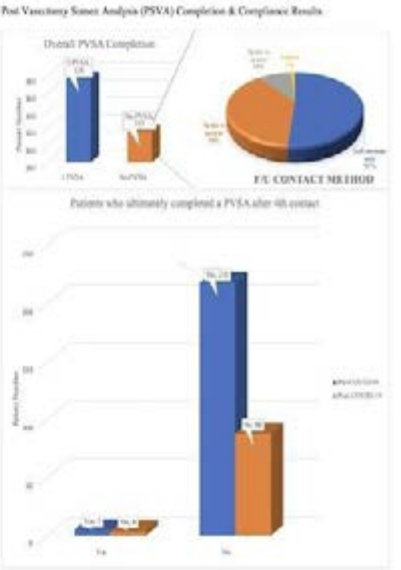
Table 1: Characteristics of patient demographics in Pre- and Post-COVID groups

Characteristics	Pre-COVID No. (%)	Post-COVID No. (%)
Total (N=491)	323 (75.6)	168 (24.4)
Age - yrs		
≥ 35	344 (65.8)	97 (57.7)
< 35	179 (34.2)	71 (42.3)
Mean ± std	38.0 ± 7.1	35.9 ± 5.8
Race		
White	428 (79.9)	117 (69.6)
Hispanic	98 (8.8)	33 (19.6)
Black	48 (9.7)	16 (9.5)
Asian	3 (0.6)	2 (1.2)
Other/unspecified	8 (1.5)	0 (0)
Occupation		
First responder/ Law Enforcement	73 (14.0)	28 (16.7)
Construction/Utilities	66 (12.6)	24 (14.3)
Retail/Service Industry	150 (28.7)	56 (33.3)
Healthcare	26 (5.0)	10 (6.0)
Professional/Real Estate	24 (4.6)	13 (7.7)
IT/Engineering	30 (5.7)	13 (7.7)
Education	19 (3.6)	3 (1.8)
Other	66 (12.6)	14 (8.3)
Unknown	69 (13.2)	7 (4.2)
Marital Status		
Married	475 (87.0)	145 (86.3)
Single/All others	48 (13.0)	23 (13.7)
Number of children		
0	26 (5.0)	9 (5.3)
1	94 (16.3)	25 (14.9)
2	244 (46.7)	72 (42.9)
3	132 (25.2)	38 (22.6)
4	46 (8.8)	22 (13.1)
5+	21 (4.0)	2 (1.2)
Financial		
Insurance	498 (95.2)	145 (86.3)
Self-pay	25 (4.8)	23 (13.7)
Contraception methods		
Coitus interruptus	197 (36.7)	46 (16.3)
Condoms	108 (20.8)	43 (25.6)
OCPs	85 (16.1)	27 (16.1)
IUD	30 (5.7)	16 (9.5)
BTL	2 (0.4)	2 (1.2)
Abstain	7 (1.3)	4 (2.4)
No prophylaxis	68 (13.0)	7 (4.2)
Unknown	31 (5.9)	3 (1.8)



Funding: N/A

Poster #87

POST-PUBERTAL DETRUSOR MYOGENIC FAILURE IS RARE AMONG A LARGE CONTEMPORARY COHORT OF PATIENTS WITH PERINATALLY-DIAGNOSED POSTERIOR URETHRAL VALVES

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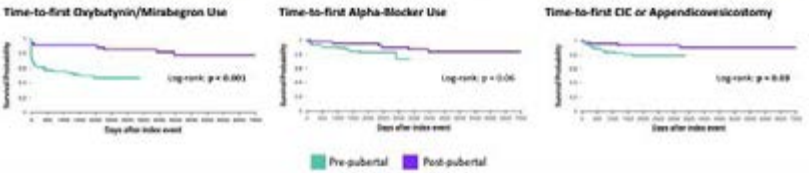
Presented By: Charlotte Wu, MD

Introduction: Several historical papers have posited that patients with Posterior urethral valves (PUV) have a pattern of detrusor overactivity with poor compliance in early childhood that evolves to detrusor hypocontractility with myogenic failure after puberty. However, the basis and prevalence of this phenomenon have not been established. If myogenic failure is a common outcome, we hypothesize differential utilization of antispasmodic medications and rates of clean intermittent catheterization (CIC) between pre-pubertal and post-pubertal males.
Methods: A retrospective cohort study was conducted using TriNetX research network, a claims database of 110 million patient encounters between 2006-2022. Patients with a diagnosis of congenital PUV and cystoscopy with primary valve ablation within the first year of life were stratified into pre-pubertal (< 9 years old) and post-pubertal (>13 years old) arms based on current age. Rates of antispasmodic and alpha-blocker use, rates and time-to-first use of CIC or cutaneous appendicovesicostomy, and detrusor underactivity or atony on urodynamics (UDS) were queried using ICD10, CPT, LOINC and VA class codes.
Results: A total of 237 patients (180 pre-pubertal, 57 post-pubertal with median age 5 and 17 years) were included. Rates of detrusor underactivity or atony on UDS were low and comparable between groups (1.7% vs 0%, p=0.44). There was no difference in the utilization of CIC or appendicovesicostomy between groups (15.0% vs 7.0%, p=0.18). Patients in the pre-pubertal group were significantly more likely to be prescribed

antispasmodic medication and at an earlier age than patients in the post-pubertal group (44.4% vs 15.8%, p<0.001; log-rank p<0.001). There was no difference in rates or time-to-first use of alpha-blockers between groups (12.2% vs 10.5%, p=0.31) (Figure 1).
Conclusion: In this contemporary cohort of PUV patients, we saw no significant increase in the use of CIC or appendicovesicostomy in adolescence. Overall, more pre-pubertal patients are managed with antispasmodic medications, which may reflect a greater incidence of detrusor overactivity in young children or a shift in practice patterns favoring earlier aggressive medical treatment. These data overall suggest that a pattern of evolution to true myogenic failure is low, contrary to historical reports.

Figure 1. Comparison of Rates and Time-to-first Use of Bladder Management Strategies Among Pre- vs. Post-Pubertal Males with PUV

	Pre-Pubertal (<9y) n = 180	Post-Pubertal (>13y) n = 57	P-value
Oxybutynin/Mirabegron Use	80 (44.4%)	9 (15.8%)	**< 0.001**
Alpha-Blocker Use	12 (12.2%)	6 (10.5%)	0.31
CIC or Appendicovesicostomy	27 (15%)	4 (7.0%)	0.18
Detrusor Underactivity/Atony on UDS	3 (1.7%)	0 (0%)	0.44



Funding: N/A

Poster #88

ARE THERE FACTORS THAT DETERMINE TESTICULAR VOLUME DISCREPANCY FLUCTUATIONS IN PEDIATRIC PATIENTS WITH VARICOCELE UNDER ACTIVE SURVEILLANCE?

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Presented By: Adele Raymo

Introduction: In the pediatric population, testicular asymmetry is thought to be a predictive marker for relative testicular function. Testicular volume differential (TVD) >20% is commonly used as a determinant for varicocele repair as it is linked to poor semen parameters in adulthood. However, testicular asymmetry can fluctuate as males progress through puberty. We aimed to identify factors that influence fluctuations in TVD in children and adolescents with varicoceles under active surveillance.
Methods: From 2004 to 2022, we retrospectively identified boys diagnosed with left varicocele. Inclusion criteria were having a minimum of 2 scrotal ultrasounds (US) at least 12 months apart and being under active surveillance. Exclusion criteria were not having fluctuations in TVD during the study period, incomplete records or bilateral varicocele. The absolute value of the difference between the TVD at the first US (US1) and the TVD at the last US (US2) was calculated. The population was divided into 2 groups: absolute change in TVD 20% (n=25), and absolute change in TVD <20% (n=82). Comparison among groups was assessed by independent measures t-test and chi-squared test. Significance was assessed at p-value of <0.05.
Results: From a single institution cohort of boys with varicocele, 107 met the inclusion criteria. There was a significant difference in mean age between two groups at the time of US1 (p=0.011) and also at the time of US2 (p=0.014). The mean testicular size per side at US1 was 6.62 ± 4.40 cc for the right and 5.93 ± 4.02 cc for the left, and at US2 was 11.84 ± 4.69 cc for the right and 10.87 ± 4.59 cc for the left. Mean time between US1 and US2,

varicocele grade, and tanner stage were not significantly different between the 2 groups (Table 1).

Conclusion: In this cohort of boys under active surveillance for varicocele, the largest fluctuations in TVD occurred in boys who had an US performed at a younger age. Our data suggest that when considering varicocelectomy, TVD should be evaluated in the context of other indications for surgery as this factor alone can vary greatly especially in younger populations. Therefore, it may be prudent to reassess TVD postpuberty prior to considering varicocelectomy.

Table 1. **Variables Associated with Changes in TVD**

Variables	Absolute Change in TVD ≥20% n=25	Absolute Change in TVD <20% n=82	p-value
Varicocele Grade			
1	2 (8%)	3 (4%)	
2	4 (16%)	26 (32%)	
3	19 (76%)	50 (61%)	0.22
Mean Time between US1 and US2	39.6 ± 19.6 months	34.9 ± 19.9 months	0.30
Tanner Stage at US1			
1	6 (24%)	11 (13%)	
2	2 (8%)	8 (10%)	
3	5 (20%)	12 (15%)	
4	1 (4%)	17 (21%)	
5	3 (12%)	6 (7%)	0.25
Tanner Stage at US2			
1	1 (4%)	1 (1%)	
2	0 (0%)	2 (2%)	
3	1 (4%)	4 (5%)	
4	7 (28%)	16 (20%)	
5	14 (56%)	46 (56%)	0.76
Varicocelectomy	3 (12%)	19 (23%)	0.23
Age at US1 (years)	11.85 ± 2.3	13.08 ± 2.5	0.01
Age at US2 (years)	15.2 ± 2.0	16.0 ± 2.1	0.01

Funding: N/A

Poster #89

EFFICACY AND SAFETY OF LUMASIRAN FOR INFANTS AND YOUNG CHILDREN WITH PRIMARY HYPEROXALURIA TYPE 1: 12-MONTH ANALYSIS OF THE PHASE 3 ILLUMINATE-B TRIAL

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Presented By: Kyle D. Wood, MD

Introduction: Primary hyperoxaluria type 1 (PH1) is a rare genetic disorder characterized by hepatic overproduction of oxalate. Excretion of oxalate by the kidneys leads to recurrent kidney stones, nephrocalcinosis, progressive kidney disease, and multiorgan damage from systemic oxalosis. Lumasiran, a liver-directed RNA interference therapeutic designed to reduce oxalate production, demonstrated efficacy and an acceptable safety profile when given for 6 months (M) to infants and children age <6 years with PH1 in the primary analysis of the ILLUMINATE-B trial. Outcomes of 12M lumasiran treatment in ILLUMINATE-B are presented here.
Methods: ILLUMINATE-B is an ongoing, Phase 3, multinational, open-label, single-arm study (ClinicalTrials.gov: NCT03905694). The 6M primary analysis period is followed by an extension period of up to 54M. Key inclusion criteria are confirmed PH1 diagnosis, age <6 years old, eGFR >45 mL/min/1.73m² if ≥12M or normal serum creatinine for age if <12M. Patients received weight-based dosing of subcutaneous lumasiran. Results are summarized with descriptive statistics.
Results: All 18 patients enrolled in ILLUMINATE-B entered the extension period and completed ≥12M of treatment (median [range] exposure, 17.8M [12.7–20.5M]). The mean reduction from baseline in spot urinary oxalate:creatinine was 72% at M6 and was maintained at 72% at M12. Mean M12 reductions in prespecified weight subgroups were 89%, 68%, and 71% for patients <10 kg, 10 to <20 kg, and ≥20 kg, respectively. Mean reductions from baseline in plasma oxalate were 32% at M6 and 47% at M12. eGFR remained stable through M12. Among 14 patients with nephrocalcinosis at baseline, nephrocalcinosis grade improved in 79% (11/14) at M12, and no patient worsened; of 4 with no baseline nephrocalcinosis, 3 remained stable and 1 had unavailable data at M12. Kidney stone event rates remained low. The most common lumasiran-related adverse events were mild, transient injection-site reactions (3 patients [17%]).
Conclusion: Lumasiran treatment resulted in sustained reductions in urinary and plasma oxalate through M12, with acceptable safety in infants and young children with PH1. Given the causal role of urinary oxalate in kidney damage, it is encouraging that patients maintained stable kidney function and low rates of kidney stone events and that most patients had improvement in nephrocalcinosis grade.
Funding: Alnylam Pharmaceuticals

Poster #90

LONG-TERM OUTCOMES OF PATIENTS FOLLOWING RECTUS FASCIAL BLADDER NECK WRAP

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Presented By: Brian Wiseman, MD

Introduction: The rectus fascial wrap procedure was designed as a method to provide 360 degrees of compression at the bladder neck while allowing urethral catheterization of patients with urinary incontinence. Patients with refractory incontinence who had Valsalva leak point pressure of <40 cm of water on urodynamics or an open bladder neck on cystography or cystoscopy were candidates for this surgery. Early results of this technique were promising and prompted a long-term and historic evaluation of this procedure.
Methods: We performed an IRB approved retrospective analysis of patients at our institution who had undergone a rectus fascial bladder neck wrap and had at least 1 year of follow-up.
Results: A total of 16 patients (9 female) with an average age of 11.4 years at time of surgery were identified. Bladder neck wrap was performed with autologous fascia in 14 patients, 13 requiring bladder neck repair to accommodate the graft. Concomitant procedures included bladder augmentation in 13 and creation of a continent catheterizable channel in 4. The average length of follow-up was 9.8 years. All patients required catheterization following surgery. At last follow-up, 9 patients (56%) were dry. Two of these patients required secondary procedures (collagen injection and repeat bladder neck surgery) to become continent. Four (25%) had improved continence, while 3 (19%) had no improvement. One patient died 9 years following surgery at 17 years of age due to urosepsis. Nine patients (56%) required repeat urologic surgery following bladder neck wrap. One patient at 30 years of age (20 years following bladder neck wrap) required cystectomy and colon conduit due to incontinence and inability to catheterize her continent stoma secondary to her body habitus. Two patients (13%) had surgery for lithiasis, 1 had PCNL with ureteroscopy, 1 had an open cystolithotomy. Four patients (25%) continue to leak after multiple urologic procedures for persistent incontinence.
Conclusion: The rectus fascial bladder neck wrap was a novel technique described over two decades ago which provided 360 degrees of bladder outlet compression. This procedure is safe and durable and has provided good long-term continence results. Subsequent modifications of this technique have led to greater rates of continence in children with low bladder outlet resistance.
Funding: N/A

Poster #91

A MULTI-INSTITUTIONAL STUDY OF PEDIATRIC NEPHROLITHIASIS IN THE STATE OF KENTUCKY

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Presented By: Hannah Jarvis, MD

Introduction: Over the past few decades, an increase in incidence of kidney stones has been observed among pediatric patients. The aim of this study was to collect data from two institutions regarding the incidence of stone events and the pre- and post-operative care of these patients to identify areas where we could collaborate to improve care.
Methods: Data was collected as part of a statewide Quality Improvement Collaborative (QIC). Two academic institutions were included. A stone database was developed through a grant funded, multi-institutional collaboration. Charts were selected by CPT code 52356 and retrospectively reviewed. Qualitative data regarding patient and stone characteristics

as well as pre- and post-operative care was collected from January 2020 through May 2022.
Results: The majority of patients were white race, non-Hispanic ethnicity (93%). Pre-operatively, the majority of patients underwent CT imaging (74.4%). When evaluating stone characteristics, the laterality ratio was equivocal (51.2 right, 48.8 left). Evidence of obstruction on initial imaging was seen in 60.5% of patients. Regarding pre-operative care, nearly 2/3 of patients did not receive medical expulsive therapy (MET) in the form of alpha blockers (60.5%), compared to post-operatively where 57.5% of patients were discharged with alpha blockers. Comparatively, 16.3% of patients were discharged home with narcotic pain medication. Not quite half of patients received post-operative imaging within 90 days of the initial procedure (48.8%), but the majority followed-up in clinic within 90 days (69.8%). Nearly half of patients had an unplanned ER visit, most commonly due to flank pain. Only 23.3% completed PTH testing post-operatively. A 24-hour urine study was ordered on 13 (30.2%) of post-operative patients of whom only 6 (66.7%) completed the study.
Conclusion: From this data we can garner insight into the diagnosis, pre-operative care, and post-operative management of pediatric kidney stone patients in Kentucky. This highlights a high use of ionizing radiation pre-operatively, and a lack of MET therapy pre-operatively despite a majority of patients receiving it post-operatively. This data calls into question how we can better manage patients' pain and prevent unplanned ER visits. Furthermore, the data suggests room for improvement in appropriate follow up including imaging and metabolic testing as a tool for stone prevention.
Funding: n/a

Poster #92

PEDIATRIC UROTHELIAL CANCER SURVIVAL OUTCOMES: ANALYSIS OF THE NATIONAL CANCER DATABASE

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Presented By: Rafael Donato Tua-Caraccia, BA, MD

Introduction: Urothelial cancer is a rare malignancy among children and adolescents. Studies examining outcomes in this condition suggest low rate of recurrence or death compared to adults. We therefore assessed pediatric urothelial cancer outcomes, which we hypothesize to be favorable.
Methods: We analyzed the 2004-2016 National Cancer DataBase (NCDB). The population of interest was pediatric patients (0-18yrs) with a diagnosis of urothelial cancer of bladder. Those with rhabdomyosarcoma were excluded. Variables of interest included TNM staging, pathology, tumor size, surgical procedures, and post-operative re-admission. Overall survival was defined as months since diagnosis as of last follow-up. Descriptive statistics were used to represent sample demographics, histology, and staging. Categorical variables were presented as frequencies; continuous variables as means with standard deviations.
Results: Of the 140 cases of predominantly papillary urothelial neoplasm of low malignant potential reported to NCDB between 2004-2016, 75.7% (N=106) were Stage 0 at time of diagnosis, 6.4% (N=9) were stage I, 2.9% (N=4) were Stage II and 3.6% (N=5) were Stage IV while 11.4% cases (N=16) were unknown. From available mortality data on 121 of 140 patient records, 30-day mortality was zero; no patients died after definitive surgical resection of the primary site or date of first surgical procedure. Only 1 of 121 patient was reported as dead at 90 days, although cause of death is unknown. Most (96.7%) were alive at 90 days and 3 (2.5%) were lost to follow-up.
Conclusion: We report reassuring short term outcomes among children and adolescents diagnosed with non-rhabdomyosarcoma bladder tumors while illuminating the need for further data to characterize long-term outcomes, specifically recurrence and quality of life. This informs patient counseling and questions whether adult protocols for low-risk,

non-muscle-invasive, bladder cancer surveillance are appropriate in children, particularly given the need for general anesthesia for cystoscopic surveillance. We suggest that such surveillance techniques may not best serve the long-term outcomes of these patients, and simple monitoring with renal/bladder ultrasound may be a more effective and efficient surveillance option.
Funding: N/A

Poster #93

PEDIATRIC URINARY MICROBIOME AT SPECIES-LEVEL RESOLUTION

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Presented By: Maryellen S. Kelly, DNP, CPNP, MHSc

Introduction: Studies in adults report associations between urinary health and the composition of the urinary microbiome (urobiome). There is a lack of knowledge about development of the urobiome in children. We tested the feasibility of a novel sequencing approach to establish the species-level composition of the pediatric urobiome.
Methods: We obtained catheterized urine samples from fifty children ages 0-60 months who underwent voiding cystourethrograms at a single institution. Variables collected were sex, age, UTI history, antibiotic use history and current use. Urine biomass was collected via filtration and total DNA was extracted using modified QIAamp Fast DNA Stool Mini Kit. 16S rRNA gene sequencing for samples and controls was done by synthetic long-read technology in triplicate. Sequences were processed with Dada2 and taxonomy was assigned using the Silva database. The alpha diversity measures were compared between groups using non-parametric Wilcoxon rank-sum.
Results: Preliminary analysis shows that bacterial DNA can be robustly detected in young children of both sexes as early as 3 months, with 33 of 50 urine samples providing analyzable sequencing data (“sequence-positive”). Technical sequencing triplicates demonstrated consistency in the relative abundance of bacteria. No significant associations between demographics or clinical variables from individuals whose samples were sequence-positive versus sequence-negative were identified. While both males and females have a polymicrobial urobiome composed of several bacteria, there were significant differences by sex in alpha diversity assessed by the Inverse Simpson and Shannon indices ($p = 0.05$ and 0.04, respectively). Overall, age was significantly associated with alpha diversity as measured by the observed number of species ($p = 0.007$) and Shannon index ($p = 0.02$).
Conclusion: We present species-level analysis of the pediatric urobiome showing that this microbiome can be characterized using combination of filtering and synthetic long-read sequencing. It also suggests that differences in the urobiome exists between sexes at an early age.
Funding: U01 DD001082 CAIRIBU Collaboration Award

Poster #94

LONG-TERM FOLLOW UP OF MYELOMENINGOCELE PATIENTS WITH HISTORY OF INTRADETRUSOR BOTULINUM TOXIN: WHERE ARE THEY NOW?

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Presented By: Leslie M. Peard, MD

Introduction: The urologic management of children with myelomeningocele requires a multi-pronged approach prioritizing upper-tract preservation and prevention of urinary tract infections while minimizing morbidity from anatomy-altering operations and optimizing quality of life. Intradetrusor onobotulinum toxin A (Botox) injection has become

a common tool in bladder management of these patients. However, it remains unclear whether repeat Botox injections are a viable option for long-term management or part of a stepwise approach aiming to delay bladder augmentation. We sought to characterize the current bladder management in patients with long-term follow up after Botox injection. We hypothesized that a significant portion of patients will have discontinued Botox and progressed to reconstructive surgery.

Methods: Patients with myelomeningocele who underwent Botox between 2013-2015 were retrospectively identified. Demographic information and clinical characteristics were recorded. Date of last follow-up and details of current bladder management were recorded. Descriptive statistics are reported using parametric methods.

Results: 23 patients were identified. Median age at first Botox was 9.6 years (y) (IQR 5.8-14.8). Median follow-up from time of first Botox was 7.4y (IQR 6.7-8.5). Figure 1 summarizes bladder management at most recent follow up. For patients who progressed to reconstructive surgery, 7/9 had elevated bladder pressures on urodynamics. Median time to surgery after first Botox was 0.9y (IQR 0.2-2.7). 5/8 patients still getting Botox also remained on scheduled anticholinergic medications. No patients had evidence of worsening upper tract function on last follow-up.

Conclusion: Most patients who have had intradetrusor Botox injections for management of neurogenic bladder associated with myelomeningocele are no longer undergoing Botox at long-term follow up. However, only a portion of these patients required anatomy-altering reconstructive operations. Additionally, in the proportion that have continued Botox injections, transition to injection without anesthesia appears feasible. Although these data are limited by small patient numbers and retrospective nature, more information regarding the long-term course of myelomeningocele patients receiving intradetrusor Botox injections can help us understand the appropriate use of Botox in this population.

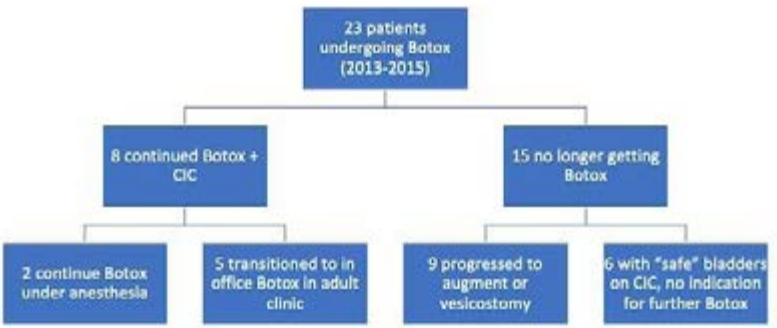

Figure 1. Most current recorded bladder management of patients who received intradetrusor Botox injections between 2013-2015.

Funding: N/A

Poster #95

CONVERSION TO DISPOSABLE CYSTOSCOPY ELIMINATED POST-PROCEDURE ENCOUNTERS AND INFECTIONS COMPARED TO REUSABLE CYSTOSCOPES IN PATIENTS UNDERGOING RENAL TRANSPLANT STENT REMOVAL

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Mayo Clinic Florida
Presented By: E. Mackenzie Gibbs, MD

Introduction: Given current challenges in the sterile processing of surgical equipment, our Urology practice converted to single-use cystoscopes with particular attention to the renal transplant population. Our objective was to evaluate differences in post-procedural infections and encounters in the 30 days following disposable and reusable cystoscopy performed for renal transplant stent removal.
Methods: Cystoscopies performed for transplant stent removal from June 2020 through August 2020 and February 2021 through April 2021 were retrospectively reviewed. Cystoscopies performed in 2020 were done with reusable cystoscopes while cystoscopies done in 2021 were performed with disposable cystoscopes (Ambu Inc., Columbia, MD, USA). Our primary analysis compared post-procedural encounters and infections in the renal transplant stent population. Encounters were defined as all phone calls, emergency department visits, or clinic appointments related to post-procedural complications such as pain, hematuria, or fever within 30 days of the cystoscopy. Additionally, hospitalizations were tracked separately.
Results: A total of 51 cystoscopies were included in our four-month retrospective analysis of patients undergoing renal transplant stent removal. There was no difference in the number of cystoscopies performed between disposable (n = 27) and reusable (n = 24) cystoscopy groups. In the disposable scope group, 13 (48.1%) patients were male and 14 (51.9%) were female. In the reusable scope group, 13 (54.2%) patients were male and 11 (45.8%) were female. Overall, median age was 59 years for both groups [range: 27-77 (disposable), 27-77 (reusable)].
The reusable cystoscope group had a higher percent of encounters [8 (33.3%) vs. 0 (0.0%), p<0.001], urine cultures [14 (58.3%) vs. 0 (0.0%), p<0.001], positive urine cultures [5 (20.8%) vs. 0 (0.0%), p=0.018], and hospitalizations [2 (8.3%) vs. (0.0%), p=0.216] when compared to the disposable scope group.
Conclusion: The use of disposable cystoscopes eliminated post-procedural encounters, urine cultures performed, positive urine cultures, and hospitalizations when compared to reusable cystoscopy in the 30 days post-procedure.
Funding: N/A

Poster #96

URINARY MICROBIOME INVOLVEMENT WITH CATHETER ASSOCIATED URINARY TRACT INFECTIONS

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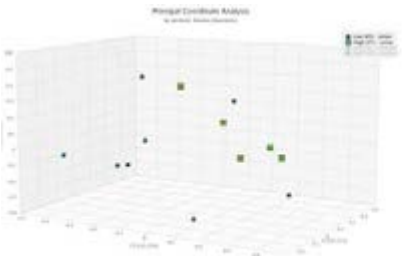
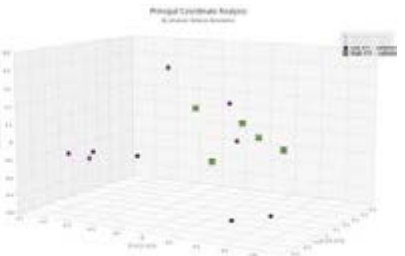
Emory University School of Medicine
Presented By: Rajeev P. Subu

Introduction: The urinary microbiome and its relationship with catheter-associated urinary tract infections (CAUTI) remain largely uncharacterized. Chronic catheters certainly influence the urinary microbiome and allow easy access for external bacteria into the bladder, but not all patients with chronic catheters have a high burden of symptomatic UTI.
Methods: This project is a pilot study that evaluated the taxonomic differences in urine and catheter biofilms for chronically catheterized patients with high-frequency UTIs (N=5) compared with patients with low frequency of UTIs (N=11). At the time of catheter change, the catheter tip, as well as urine through a fresh catheter, were collected and microbial diversity was evaluated with shotgun metagenomics.
Results: For the low-burden UTI group, the predominant phyla in the urine and biofilm were Proteobacteria, Actinobacteria, Firmicutes, and Bacteriodetes, and predominant

species included *Proteus mirabilis*, *Klebsiella pneumonia*, and *Bifidobacterium breve*. The urine and biofilm of the high burden UTI group demonstrated a higher proportion of Proteobacteria and a lower proportion of Actinobacteria, Firmicutes, and Bacteriodetes, with predominant species including *Enterobacter cloacae and Enterococcus faecalis*. The urobiome of the low UTI cohort displayed higher alpha diversity than the high UTI cohort, but the small sample size did not reach statistical significance. Beta diversity evaluation showed that high UTI patients were more closely related than low UTI patients which had a wider variety of microbes.
Conclusion: A clearer understanding of the urinary microbiome in CAUTI opens a new paradigm regarding infections in chronically catheterized patients with opportunities for therapeutic and prophylactic interventions.



Beta Diversity – Urine



Beta Diversity – Catheter Biofilm

Funding: N/A

Poster #97

THE IMPACT OF SINGLE USE CYSTOSCOPES ON CLINICAL WORKFLOW IN AN OUTPATIENT SETTING

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Presented By: Robert Medairos, MD

Introduction: Outpatient Urology procedures are historically performed with reusable equipment, which requires dedicated time from clinical staff to perform cleaning and sterilization related tasks. The single-use cystoscope recently developed by Ambu (Ballerup, Denmark) could optimize clinical staff encounter time in a high-volume outpatient setting. No studies exist evaluating the potential clinical time benefit of a single-use cystoscope, which may improve the ancillary staff workflow and overall clinical productivity. Our aim was to evaluate the change in overall clinical encounter time and clinical capacity after transitioning to single-use cystoscopes in an outpatient clinic setting.
Methods: A single-institution prospective study on two full days of outpatient Urological clinical procedure encounters was performed. Two procedure rooms were staffed by two nurses and one provider for an entire clinic day, where cystoscopy procedures were completed. Encounter times for each portion of nursing care responsibilities were observed and divided into discrete categories, and time spent during each portion of the clinical encounter was recorded. Clinical procedures transitioned from reusable to single-use cystoscope clinical encounters in 03/2022, and a single clinic day was observed for reusable and single-use cystoscopy clinics. The differences in overall clinical encounter time and capacity (patient visits per day) before and after the transition to single use cystoscopy procedure clinics were compared.
Results: A total number of 24 outpatient Urology procedures were performed, producing the same number of cystoscopy procedures on both the reusable and single-use cystoscopy clinic days (n=12). Preliminary cystoscope cleaning and transportation tasks by nursing staff were eliminated when utilizing single-use cystoscopes, which accounted

for a significant reduction in clinical encounter time (Table 1). The average total encounter time decreased from 66 minutes to 44 minutes, resulting in a 34% reduction in clinical encounter time after transitioning from reusable to single-use cystoscopes. As a result, overall clinical patient capacity with single-use cystoscopy clinics has since improved from 12 to 21 patients per provider clinic day.
Conclusion: Transition to a completely single-use cystoscopy outpatient procedure clinic improved clinical efficiency, which increased the overall clinical patient volume.

Table 1. Average Clinical Encounter Time for Each Workflow Category

Encounter Workflow Category	Reusable Cystoscope (min.)	Single-Use Cystoscope (min.)
Preparation of cystoscope tray	4	0
Transportation of cystoscope tray	1	0
Setup of cystoscope	5	5
Prepare sterile processing	5	0
Prepare patient for consent	5	5
Intake and provider consent	17	17
Lidocaine instillation	10	10
Procedure length	3	3
Cystoscope breakdown	2	2
Cystoscope preliminary cleaning	10	0
Alert transportation of cystoscope	2	0
Room turnover	2	2
Total	66	44

Funding: N/A

Poster #98

A MORE GRANULAR EXAMINATION OF BURNOUT FROM THE AUA WORKFORCE WORKGROUP

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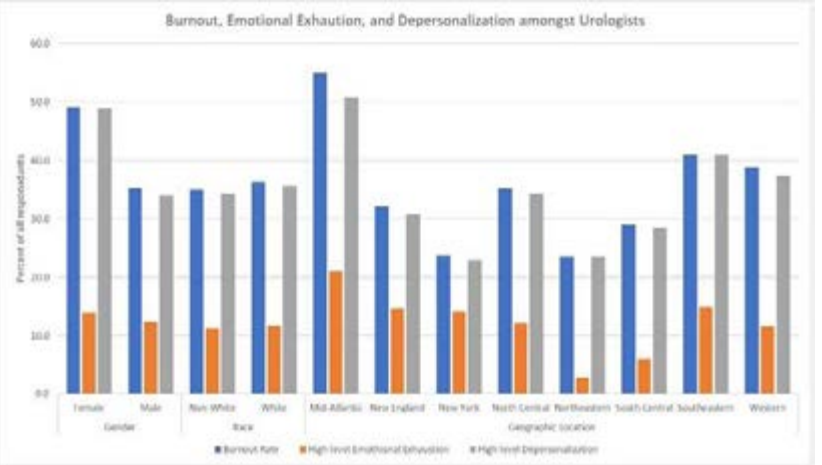
Presented By: Seth Teplitsky, MD

Introduction: Burnout continues to be a substantial issue among urologists. Burnout has been associated with depression, and poor patient outcomes. While this has been examined across our specialty, the AUA workforce workgroup sought to provide more granularity to enhance understanding.
Methods: The 2021 AUA census included the Maslach Burnout Inventory to further elucidate burnout among practicing urologists. The AUA data team provided statistical support. Data was collected regarding burnout, components of burnout including emotional exhaustion (EE) and depersonalization (D), and work-life balance questions. These results were then examined by race, gender, and AUA section. Statistical significance was set as $p < 0.05$.
Results: Statistically significant differences are reported. Urologists in private practice reported higher burnout rates compared to those in academia, 39% vs 34%. Urologists subspecializing in urologic oncology reported higher burnout when compared to pediatrics and others (46% vs 25% vs 39%). Regarding EE, non-white members were more likely to experience low levels (67 vs 63%) while white members were more likely to experience moderate EE (25% vs 22%). Females were more likely to experience moderate to high-level EE than males. Non-white members were more likely to experience moderate D (26% vs 20%) than white members. The Mid-Atlantic section was more likely than others to report high-level D (51%), with the next closest being the Southeastern section (41%). Female members were more likely to experience high-level D (49% vs 34%). Regarding work-life balance, females were more likely to be dissatisfied (37% vs 23%). Females were more likely to feel their schedule had enough personal/family time (58% vs 34 % for males). No differences in race or geographic region were seen regarding enough personal/family time.
Conclusion: Specific demographic differences are seen across burnout variables. Racial, gender, and regional variability should be further examined. Widespread variability, as

seen in gender across multiple variables, is of considerable importance. An individualistic approach and local leadership engagement is prudent. The AUA workforce workgroup will continue to aid in understanding these issues among our members.



Funding: N/A

Poster #99

CREATION OF A STANDARDIZED ANTIMICROBIAL PROPHYLAXIS ALGORITHM IN TRANSRECTAL PROSTATE BIOPSIES

Lawrence Bacudio[1], Jacob Khoury[1], Caleb Natale[2], Caitlin Martin Klinger[3], Kyle Widmer[3], L Spencer Krane[3]
[1]Tulane University School of Medicine, New Orleans, LA, [2]Tulane University School of Medicine, Department of Urology, New Orleans, LA, [3]Southeastern Louisiana Veterans Health Care System, New Orleans, LA
Presented By: Lawrence Bacudio

Introduction: Transrectal ultrasound-guided prostate needle biopsies (TRUSBx) are associated with bacterial infection, within the urinary tract and systemically following the procedure. AUA recommendations for TRUSBx antibiotic coverage encourage a single dosage for class-3 wound coverage to cover gram-negative rods and anaerobic coverage. Due to inconsistencies in provider practice, patient adherence and biopsy timing, there's concern that the optimal treatment isn't consistently being provided. Using a team-approach and incorporation of infectious disease consultants, we aimed to study current antibiotic usage and, following assessment of current trends, implement a standardized antimicrobial prophylaxis at the Southeastern Louisiana Veterans Health Care System.
Methods: All consecutive male patients undergoing TRUSBx at the outpatient clinic from July 1, 2021 to June 30, 2022 were included for this study. Meticulous review of all prescribed and administered antibiotics before, during and following the procedure were reviewed for 102 patients in 2021 and 121 patients in 2022. No changes to provider practice were implemented in July 2021. Beginning January 1, 2022, a standardized prophylaxis technique based on institutional antibiotic nomogram was implemented. This consisted of a single dose of 1gm ceftriaxone (pending patient allergies) intramuscularly more than 1hr prior to prostate biopsy, with an emphasis on no at home oral antimicrobial therapy.
Results: Baseline assessment of antibiotic prescribing demonstrated wide variability in quantity, medication, and prescription duration (Table 1). We only identified one patient to have an infectious related complication, which was a fever 48 hours following TRUS bx prior to protocol initiation. Following protocol implantation, we found usage of more than one antibiotic decreased from 81% to 16% ($p<0.0001$), with the majority of those being

the 1st 2 months after implementation (Table 2). Importantly, the use of PO antibiotics decreased from 99% to 15%. Duration of antibiotic therapy for greater than 1 day decreased from 93% to 16%.

Conclusion: Implementation of a standardized antimicrobial prophylaxis was successful and substantially decreased both duration and quantity of antibiotic utilization. Infectious complications remained low in both cohorts. These results suggest that it is possible to reduce the number of antibiotics without a change in complication risk. Our findings can potentially optimize prescribing practices, reduce improper antibiotic use, and improve patient safety.

		Before standardized prophylaxis	After Standardized prophylaxis
IM Antibiotics	Ceftriaxone 1gm	72	115
	Gentamicin 80mg	7	4
	Gentamicin 240mg	0	1
	Gentamicin 320mg	0	1
PO Antibiotics	Cefdinir 300mg x1	1	0
	Levofloxacin 250mg PO x1	1	0
	Levofloxacin 250mg PO x2	3	0
	Levofloxacin 500mg x1	2	0
	Levofloxacin 500mg x2	38	6
	Levofloxacin 500mg x3	6	2
	Levofloxacin 750mg x1	2	0
	Levofloxacin 750mg x2	45	11
	Levofloxacin 750mg x3	3	0
	Sulfamethoxazole 800/Trimethroprim 160mg x1	1	0

Table 1. IM and PO antibiotics used for antimicrobial prophylaxis in TRUSBx at SLVHCS before and after standardized prophylaxis.

	1 antibiotic	>1 antibiotic	Total
After Standardized Prophylaxis	102	19	121
Before Standardized Prophylaxis	19	83	102
Total	121	102	223

Table 2. Number of patients using only 1 antibiotic and >1 antibiotic before and after standardized prophylaxis. There was a significant association between standardized prophylaxis and number of antibiotics used (two-tailed $p<0.0001$).

Funding: N/A

Poster #100

ANGIOMYOLIPOMA GROWTH KINETICS IN TUBEROUS SCLEROSIS COMPLEX: THE EFFECTS OF MTOR INHIBITORS

Parth Thakker[1], Lauren Neal[2], Vanessa Lukas[2], Mary Silvia[1], Jane Boggs[1], Theodore Stem[1], Nicholas Mallet[1], Roy Strowd[1], Ram Pathak[3]

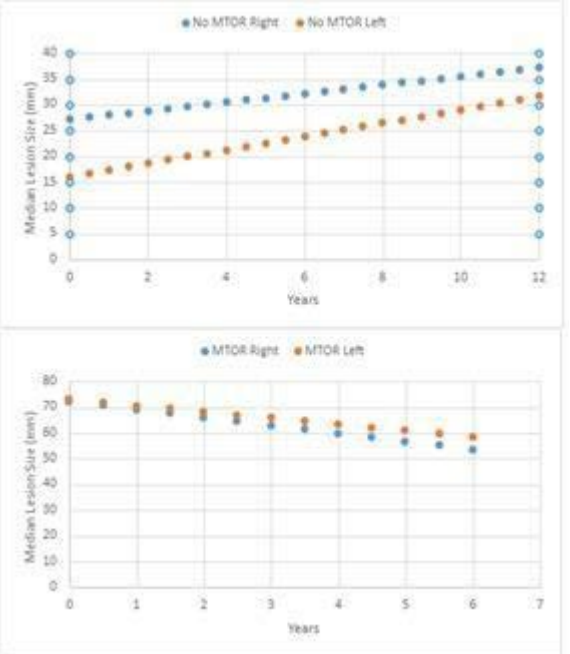
[1]Atrium Health Wake Forest Baptist, [2]Wake Forest School of Medicine, [3]Mayo Clinic, Jacksonville

Presented By: Parth Thakker, MD

Introduction: Tuberous Sclerosis Complex (TSC) is a multi-system disorder involving the nervous, integumentary, pulmonary, and urinary systems, among others. Of relevance to urologists is the formation of TSC related angiomyolipomas (AMLs). Historically, AMLs > 4 cm required surgical treatment however this paradigm has shifted to medical management for patients with high-risk AMLs with mTOR inhibitors. It remains unclear what effect mTOR inhibitor have on AML size and growth rates in those undergoing observation. The primary aim was to examine growth kinetics of TSC-associated AMLs and define rates of catastrophic complications in this cohort.

Methods: A retrospective analysis of patients diagnosed with TSC-related AMLs was performed. Patient demographics, AML size and growth, mTOR status, and AML related hemorrhage was collected. Surveillance strategies were predominantly based on cross-sectional imaging. Imaging of the dominant lesion was followed from initial imaging to most recent imaging and the dominant lesion size was recorded at each cross-sectional

imaging date. Growth kinetics was defined as change in maximum dimension of the dominant lesion over a 6 month period between imaging.
Results: Complete data was available for 44 patients with mean age 35.6 years±13.8 (61% female, 18% rural). Eighty percent (80%) of patients had renal involvement and 77% of patients had >10 AMLs at baseline imaging. The number of AMLs did not change significantly over the median follow-up of 38 months. There was a median increase of 4mm for the dominant lesion over this time period. Patients with TSC related AMLs on surveillance had growth rates of 0.84mm (right) and 0.95mm (left) every 6 months whereas patients on or had previously taken mTOR inhibitors had AML shrinkage rates of 3.1mm (right) and 3.0mm (left). Catastrophic events related to AMLs in these patients were uncommon (1 case of AML hemorrhage) and resulted in ipsilateral nephrectomy. This patient is alive to date.
Conclusion: In this cohort of patients with TSC related AMLs, those undergoing surveillance saw an average increase in close to 1mm every 6 months while those having ever taken mTOR inhibitors exhibited a 3mm size decrease over 6 months. AML hemorrhage occurred in 1 patient over a median follow-up of 38 months



Funding: Institutional Grant

Poster #101

VASECTOMY REFERRAL RATES BEFORE AND AFTER DOBBS: A SINGLE-INSTITUTION ANALYSIS

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University of Kentucky
Presented By: Scott Charles Brimley, MD,BS

Introduction: There has been an increased interest in vasectomy procedures since the outcome of the Dobbs v Jackson supreme court case was leaked in May 2022. This decision eliminated federal abortion protections. While this has been the topic of national discussion as well as increased interest according to recent google search trends, it is unclear if this will result in a real-world uptick in the number of vasectomies performed.

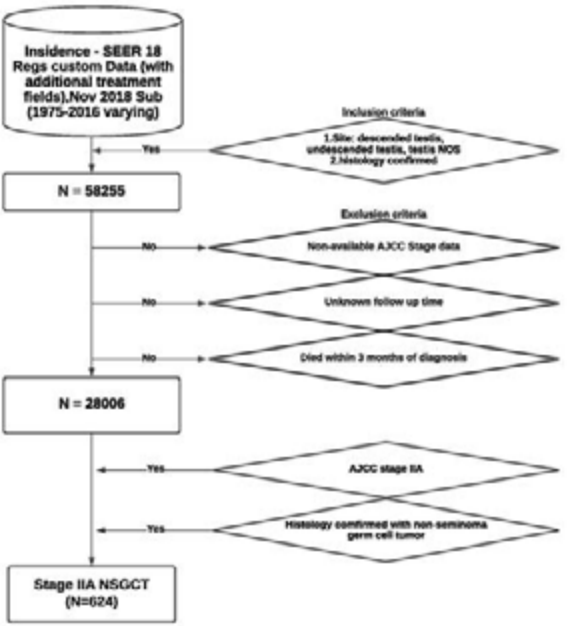
Methods: We queried our institutional database for vasectomy referrals. Patients are initially evaluated by a Urologist or an advanced practice provider (APP) to discuss the vasectomy procedure and alternatives. Patients then return to the clinic to undergo the procedure at a later date. The data presented here represents referrals received by the Urology clinic for patients interested in sterilization.
Results: The average monthly Vasectomy referral rate was 13.7 at our institution prior to May 2022. Since the leak of the recent supreme court case regarding abortion, the rate of vasectomy referrals has increased to 22 referrals per month, an increase of 61%. The data presented shows that the three months following the Supreme Court decision resulted in the highest vasectomy referral rate recorded at our institution during the study period.
Conclusion: Some have speculated that a consequence of Dobbs would be an increase in the desire of men to pursue sterilization through vasectomy. Indeed, Urologists across the country have also noticed a growing interest in the procedure since May of this year. Our institution's vasectomy referral rate has increased substantially during this time and is now at a five-year high. This suggests a real-world increase in the number of men pursuing vasectomy in the state of Kentucky. More research will be needed on this topic to elucidate the long-term trend.
Funding: N/A

Poster #102

RPLND VERSUS PRIMARY CHEMOTHERAPY AFTER RADICAL ORCHIECTOMY IN STAGE IIA NON-SEMINOMA GERM CELL TUMOR TESTICULAR CANCER: A RETROSPECTIVE STUDY FROM NATIONAL SEER DATABASE

Hangcheng Fu[1], Sriharsha Talluri, Louisville[2], Roman Isakov, Louisville[2], Ankem Murali[1]
[1]University of Louisville Urology Department, [2]University of Louisville
Presented By: Hangcheng Fu, MD

Introduction: Patients with Stage IIA Non-seminoma germ cell tumor testicular cancer (NSGCT) often required either primary chemotherapy or nerve-sparing retroperitoneal lymph node dissection (RPLND) according to the guideline. We proposed using the SEER database, which has the largest cohort of Stage IIA NSGCT patients to investigate if there is actually a difference between primary chemotherapy.
Methods: From the national SEER database (1975-2016), 624 Stage IIA NSGCT patients were selected from 58,255 patients with testicular cancer. The median follow-up tie in our cohort is 76 months. Primary end point is overall survival which is calculated from the time of diagnosis testicular cancer to time of death. Treatment modalities include RPLND, chemotherapy, or both.
Results: In our cohort, we identified 28 patients who did not receive RPLND or chemotherapy after radical orchiectomy. 114 patients only received RPLND, 287 patients only received chemotherapy, and 195 patients received both chemotherapy and RPLND. The oldest patient that received RPLND was 58, while the oldest patient that received chemotherapy was 71-year-olds. The most common histology types in Stage IIA NSGCTs were mixed germ cell tumor (56.0%), embryonal carcinoma (26.4%), and malignant teratoma (6.1%). 71% of patients diagnosed with malignant teratoma in our cohort received only RPLND. The 10-year survival rate of the cohort is 96.1%. Using Kaplan-Meier survival analysis, we found that Stage IIA NSGCT patients who did not receive either chemotherapy or RPLND has no difference in overall survival as compared to the patients that received either chemotherapy or RPLND. Our results also shows that there was no difference in overall survival between those that received both chemotherapy and RPLND compared to those that only received chemotherapy or RPLND.
Conclusion: Our results showed that there is no overall survival difference in Stage IIA NSGCT patients that received no treatment compared to those that did receive treatment.



Funding: N/A

Poster #103

RESTORATION OF KIDNEY FUNCTION IN CHRONIC KIDNEY DISEASE (CKD) USING AUTOLOGOUS HUMAN RENAL CELLS

Sunil George, Jennifer Huling, Mehran Abolbashari, Tae Hyoung Kim, Tamer Aboushwareb, John Jackson, Anthony Atala, James Yoo
Wake Forest School of Medicine, Wake Forest Institute for Regenerative Medicine, Winston Salem, NC
Presented By: John D. Jackson, PhD

Introduction: Chronic Kidney Disease (CKD) is a major medical problem that leads to progressive loss of kidney function in approximately 37 million adults in the United States. Currently, kidney transplantation is the only treatment that restores renal function; however, a shortage of donor kidneys for transplantation remains a problem. Cell-based therapy may provide an alternative approach to augment and restore kidney function. We hypothesized that human primary renal cells derived from CKD kidneys could reduce CKD progression. This study examined the functional and structural effects of CKD primary cells injected in a rat model of CKD. We evaluated whether CKD cells are as effective as NK cells for cell therapy in animals with renal failure.
Methods: CKD was induced using an established model of ischemia-reperfusion. Male Nude (Nu) Rats were anesthetized, and the renal pedicle was obstructed bilaterally for 60 minutes, then released to induce the ischemia-reperfusion injury. Two weeks post-surgery, Gentamycin (100 mg/kg) was injected subcutaneously for five days. Serum creatinine & BUN levels were measured to determine the levels of renal impairment. After inhalational anesthesia, a single dose of Normal Kidney (NK) and (CKD) cells (5x106) suspended in PBS were injected into the upper and lower poles of both kidneys. Controls were injected with 0.05 ml of saline. Renal function was assessed by measuring serum creatinine (sCr), and blood urea nitrogen (BUN), glomerular filtration rate (GFR) until 12 weeks after cell injection. Histological analyses were applied to evaluate structural damage and regeneration of the chronic kidney.

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Results: Our results demonstrated that intrarenal injection of NK and CKD cells significantly improved sCr, BUN, and GFR levels throughout the 12-week post-ischemic insult period ($p<0.001$). Treatment with CKD cells showed a similar improvement in glomerular damage, tubular damage, cell migration, and cell engraftment as the NK cell treatment.
Conclusion: These findings demonstrate that culture-expanded renal cells from diseased human kidneys could provide a cell source for an effective cell-based therapy for CKD treatment. Further studies are needed to optimize the cell numbers, the number of injections, and molecular mechanisms of renal protection to develop a clinical therapy for CKD.
Funding: This study was supported in part by Tengion Inc.

Poster #104

REPUTATION RANKINGS, SOCIAL MEDIA ACTIVITY, AND APPLICATION RATES: ADVICE TO UROLOGY RESIDENCY APPLICANTS

William M Pearson[1], Luke G Scanlan[1], F Pearce Kudlata[1], Salil S Ghamande[1], Brittany Ange[1], John J De Caro[2], Martha K Terris[1]
[1]Augusta University, [2]Charlie Norwood VA Medical Center
Presented By: William Michael Pearson

Introduction: Interest in Urology has risen sharply in recent years. Higher application rates coupled with only a modest increase in residency positions creates a highly competitive environment. While applicants may be able to complete some visiting rotations, virtual interviews prevent in-person assessment of the majority of programs. The goal of this project was to shed light on the factors that influence application rates.
Methods: A list of programs and de-identified applicant data was obtained from the AUA/SAU. Social media accounts were identified. Resident number and reputation rankings were recorded from Doximity. Population was obtained from US census data, and city QOL data was retrieved from Niche. Kruskal-Wallis tests were calculated. Multiple comparisons were assessed using Dwass, Steel, and Critchlow-Fligner multiple comparison tests.
Results: Data was collected from 2018-2022 and programs divided into quintiles based upon Doximity reputation ranking. The total number of Urology applicants increased in all quintiles over the four years observed. In all four years observed, as a program's quintile rank increases, so does the number of applications they receive ($p<.0001$). There was a significant correlation between the number of residents in a program and the quintile into which that program falls ($p<.0001$). Finally, the higher quintile programs were more active on Twitter, but there was no such correlation for Instagram and Youtube ($p<.0001$, $p<.0032$, $p<.0001$ for Twitter number of followers, number of following, and number of posts respectively).
Conclusion: The data presented here suggests that it would be wise as an applicant to spread your applications to schools outside of the top quintiles. The schools in the higher quintiles receive more applications and therefore applying to lower quintile schools (lower Doximity reputation rankings) may increase one's match rate. In accordance with this strategy, spreading preference signals across a greater range of rankings may be effective and a point for further research. Additionally, this data suggests that Twitter is the most accurate reflection of a program and there is a significant correlation between Twitter activity and their reputation ranking. Therefore, as an applicant, being an active user of Urology Twitter may help pair down one's program decision process.

Table 1: Comparisons across Doximity reputation quintiles.

Variable	Quintile										p-value
	N	1 Rank 1-28 Total N=28	N	2 Rank 29-57 Total N=26	N	3 Rank 58-87 Total N=26	N	4 Rank 88-117 Total N=27	N	5 Rank 118-146 Total N=22	
# applicants 2019 – Mean (SD) *3 missing (No)	28	277.0 (39.1)	26	253.7 (1.7)	26	233.1 (48.5)	27	208.9 (55.1)	22	162.0 (44.0)	<.0001
# applicants 2020 – Mean (SD)	26	304.4 (51.9)	25	293.8 (41.9)	26	255.8 (53.8)	27	233.5 (57.2)	22	162.1 (41.4)	<.0001
# applicants 2021 – Mean (SD) *1 missing (no)	28	343.7 (48.6)	26	317.0 (45.9)	26	294.7 (50.4)	26	262.3 (68.0)	21	204.0 (44.2)	<.0001
# applicants 2022 – Mean (SD)	28	400.5 (62.1)	25	390.6 (46.9)	26	368.5 (57.7)	27	334.9 (64.0)	22	254.7 (56.8)	<.0001
City QOL Numerical – Mean (SD)	28	2.6 (1.5)	26	3.0 (1.7)	26	3.7 (1.9)	27	3.3 (1.4)	22	3.7 (1.9)	0.0841
# Residents – Mean (SD)	28	18.5 (4.3)	26	15.5 (3.0)	26	12.8 (3.2)	27	11.5 (2.7)	22	10.0 (3.1)	<.0001
# followers Instagram	15	865.7 (643.0)	16	679.5 (372.3)	13	503.5 (298.6)	13	607.5 (398.6)	9	445.0 (252.3)	0.2056
# following Instagram	15	220.2 (386.5)	16	254.6 (271.0)	13	153.3 (134.6)	13	203.2 (377.3)	9	72.7 (52.3)	0.1691
Total Posts IG	15	108.4 (259.8)	16	118.1 (151.6)	13	42.8 (28.6)	13	197.8 (471.6)	9	51.7 (52.5)	0.3887
# followers Twitter	28	2574.8 (1470.5)	25	1686.6 (686.7)	25	1181.7 (799.5)	25	1155.2 (922.2)	16	618.1 (375.4)	<.0001
# following Twitter	28	899.2 (949.7)	25	668.4 (684.9)	25	386.4 (316.4)	25	546.3 (923.0)	161	242.8 (191.5)	0.0032
Total Posts Twitter	28	1873.6 (2333.9)	25	781.1 (682.0)	25	552.0 (845.9)	25	342.4 (542.2)	6	139.6 (201.3)	<.0001
# subscribers YouTube	9	980.6 (1421.3)	7	145.6 (261.0)	5	257.2 (369.8)	3	400.7 (666.4)	3	5.7 (8.1)	0.2389
Total Posts YouTube	9	54.9 (64.4)	7	49.4 (66.9)	5	32.2 (46.6)	3	168.0 (283.2)	3	2.3 (2.3)	0.1486

Funding: N/A

Poster #105

COMPARISON OF ROBOTIC ASSISTED RIGHT NEPHRECTOMY TO LAPAROSCOPIC LEFT NEPHRECTOMY IN PATIENTS UNDERGOING LIVING DONOR RENAL TRANSPLANT

Ryan Pickens, MD[1], Kevin Reed, MD[1], Winston Crute, MD[1], Dustin Whitaker, MD[1], Dylan Dangerfield, MD[1], Oscar Grandas, MD[2]

[1]University of Tennessee at Knoxville Department of Urology, Knoxville, TN, [2]University of Tennessee at Knoxville Department of Transplant Surgery, Knoxville, TN

Presented By: Dustin L. Whitaker, MD

Introduction: Laparoscopic left nephrectomy has become the standard approach for living donation. Increased hilar vessel length offers more anatomic flexibility for transplant vascular anastomosis. Occasionally, preoperative renal imaging and functional workup reveals difficult left sided vascular anatomy or differing renal function which may encourage contralateral nephrectomy. This study investigates the outcomes of robotic right nephrectomy versus laparoscopic left nephrectomy in living donor patients.

Methods: This study reviewed data from transplant donor nephrectomy patients who underwent surgery from May 2016 to August 2021. Patient characteristics were recorded and both perioperative and postoperative factors were included in the analysis.
Results: 13 patients (34%) underwent laparoscopic left nephrectomy, and 25 patients (66%) underwent robotic right nephrectomy. Average BMI was 28.2 in left sided patients and 29.4 in right sided patients. Total operative time was similar between right and left nephrectomies (160 vs 170 minutes). Estimated blood loss was 60cc in left sided cases versus 55cc in right sided cases. Mean preoperative creatinine was 0.8 in both groups. On day 1 and 14, post-operative creatinine was 1.1 for right nephrectomies and 1.2 for left nephrectomies. Average hospital length of stay was 1.4 days, although 23 out of 25 right sided patients met criteria for discharge on post-op day 1 versus 6 out of 13 left sided patients. The first 24-hour urine output was 2.2L for right and 2.1L for left nephrectomies. No vascular grafts or special vessel lengthening procedures were required. Transplant allograft surgery times were similar between groups. There were no reports of renal vein thrombosis.
Conclusion: Robotic assisted right donor nephrectomy offers similar outcomes when compared to laparoscopic left donor nephrectomy without the need for vascular grafts or vessel lengthening procedures. The robotic approach provides a technical benefit that allows the surgeon to obtain maximal vessel length which has been a concern with right donor nephrectomies. Furthermore, there were no reports of renal vein thrombosis in our population which has previously been reported in right donor nephrectomies. In conclusion, robotic right donor nephrectomy appears feasible and should be considered in select patients where laparoscopic left nephrectomy is not feasible or ideal.
Funding: N/A

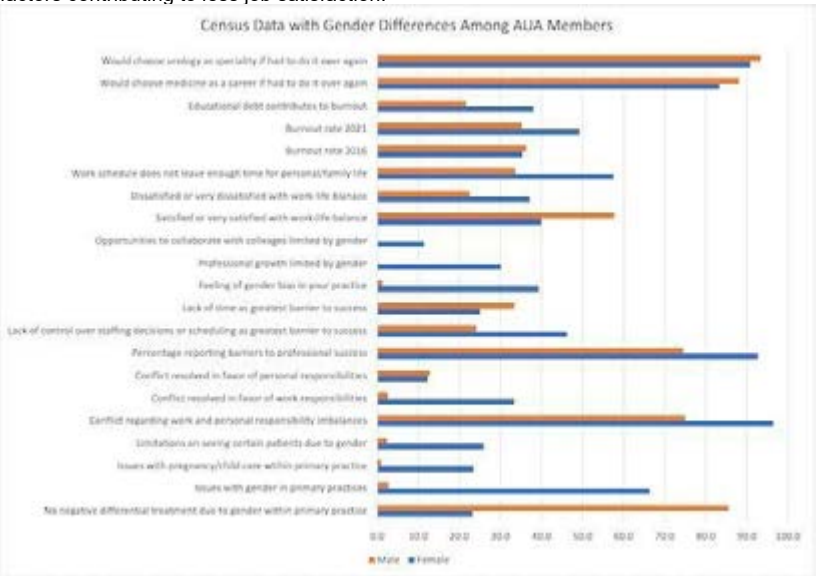
Poster #106

TOWARD GENDER EQUITY: AN EXAMINATION FROM THE AUA WORKFORCE WORKGROUP REGARDING AUA CENSUS DATA TO ESTABLISH KEY DIFFERENCES BETWEEN MALE AND FEMALE UROLOGISTS

Jacqueline Morin, M.D.[1], Andrew Harris, M.D.[2], Kate Kraft, M.D.[3]
[1]University of Kentucky School of Medicine, Lexington, KY, [2]Veterans Affairs Department of Urology, Lexington, KY, [3]University of Michigan School of Medicine, Ann Arbor, MI
Presented By: Jacqueline Morin, MD

Introduction: The American Urologic Association (AUA) Workforce Workgroup routinely submits questions to the AUA to identify factors negatively impacting the urologic community. This study aims to highlight pertinent gender differences potentially impacting career satisfaction and identify areas in which intervention could improve gender discrepancies.
Methods: The 2016-2021 AUA censuses were examined to collate gender-specific data between self-identified male (M) and female (F) urologists. Answers to AUA census questions on topics with potential gender differences were grouped into major categories of workplace treatment and job satisfaction.
Results: In general, percentages were similar throughout the consensuses from 2016-2021, with the most recent reported unless otherwise specified.
F were more likely than M to report negative differential treatment in primary practices (66.3% vs. 2.7%), feel they had limitations of seeing certain patients due to their gender (25.9% vs. 2.4%), experience gender bias at work (39.3% vs. 1.2%), experience issues with childcare (23% vs. 9%), and experience conflict regarding work and personal responsibility (95.4% vs. 75%). F feel more barriers to professional success (93% vs. 75%) and feel lack of control over staffing decisions/scheduling to be the greatest barriers (46.2%), whereas M feel lack of time (33.7%) to be the greatest barrier.
F were less likely than M to report feeling satisfied/very satisfied with their work-life balance (39.9% vs. 57.7%) and more likely to feel they do not have enough time for personal/family life (57.7% vs. 33.6). F were also more likely than M to feel burnout (49.2% vs. 35.3%) which increased notably between 2016 to 2021. F were also more likely to carry substantial education debt (18% vs. 9%) and feel this a contributing factor to burnout (38% vs. 21.6%).

Notably, M and F demonstrated little differences in average worked hours (h) per week (mean 45.7h for M, 43.7h for F) and choosing medicine as a career (88% M, 83.3% F) and urology as a specialty (93.3% M, 90.8% F) if given the opportunity again. Figure 1.
Conclusion: Notable differences in career experience exist based on gender. F are more likely to feel they were treated differently in the workplace due to gender and indicate factors contributing to less job satisfaction.



Funding: N/A

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ANNUAL BUSINESS MEETING AGENDA

Friday, March 18, 2022

I. Call to Order
S. Duke Herrell III, MD, FACS

II. Report from the President
S. Duke Herrell III, MD, FACS

III. Approval of the Minutes of the 2022 Annual Business Meeting
Chad W.M. Ritenour, MD

IV. Secretary Report
Chad W.M. Ritenour, MD

V. Treasurer Report
Lorie G. Fleck, MD, FACS

VI. Historian Report
Paul W.F. Coughlin, MD, FACS

VII. Committee Reports

1. **Nominating Committee Report**
   Glenn M. Preminger, MD
   a. Elections (Vote Required)
2. **Committee on Education and Science**
   David D. Thiel, MD
3. **Bylaws Committee**
   Nicole L. Miller, MD
   a. Proposed bylaws changes (Vote Required)
4. **Finance Committee**
   Stephen B. Riggs, MD, FACS
5. **Membership Committee**
   Rolando Rivera, MD, FACS
6. **Health Policy Committee**
   Terrance C. Regan, MD

VIII. Representative to the Board of Directors of the AUA
Glenn M Preminger, MD

IX. Future Sites Committee
David M. Kraebber, MD

X. Honorary Members
S. Duke Herrell III, MD, FACS

1. **Election of Honorary Members**

XI. New Business

1. **Introduction of Incoming President**
   S. Duke Herrell III, MD, FACS/ Stephen E. Strup, MD, FACS

XII. Adjournment

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MINUTES OF THE 86TH ANNUAL BUSINESS MEETING

Friday, March 18, 2022

UNLESS OTHERWISE NOTED, ACTIONS WERE BY UNANIMOUS VOTE

I. Call to Order – David M. Kraebber, MD

Dr. David Kraebber called the SESAUA 2022 Annual Business Meeting to order on Friday, March 18th at 11:00 a.m.

II. Report from the President – David M. Kraebber, MD

Dr. David Kraebber presented the President's Report to the membership. He summarized his participation in the various state urological society meetings throughout the year. The SESAUA has approved the establishment of a humanitarian endowment fund in partnership with the Puerto Rico Urological Association and the Urology Care Foundation. SESAUA/PRUA/UCF Endowment Fund will be designated to support humanitarian work with in the geographic area of Puerto Rico. Dr. Kraebber also thanked those who donated to the 2021-2022 Presidential Charity, the Section raised over $8,400 for the Island Dog Rescue.

III. Approval of the Minutes of the 2021 Annual Business Meeting – Chad W.M. Ritenour, MD

Dr. Chad Ritenour presented the minutes from the 2021 Annual Business Meeting for the membership's approval.

Action: The minutes from the Annual Business Meeting held on April 24, 2021 were approved as presented.

IV. Secretary Report – Chad W.M. Ritenour, MD

Dr. Ritenour stated that there were over 90 different moderators and speakers on the program in addition to 198 individual abstract presentations. He thanked all those who served as faculty and presenters during the SESAUA Annual Meeting. He reminded the membership of the new abstract awards that were incorporated in the annual meeting. The top podium and poster presentation from each abstract session would receive a monetary prize and be recognized at the podium at the end of the meeting.

V. Treasurer Report – Lorie G. Fleck, MD, FACS

Dr. Lorie Fleck presented highlights to the Section's financials to the membership. She stated that the financial state of the Section remains robust. Despite the cancellation of 2 SESAUA Annual Meetings the Section's fund balance as of December 31, 2021 totaled over $7.7 million. The investment portfolio has performed well in 2021 with a year-end equity balance of $7,706,504.

VI. Historian Report - Paul W.F. Coughlin, MD, FACS

Dr. Paul Coughlin asked for a moment of silence as he read the names of the SESAUA members who recently passed away: Alejandro Aguilar, MD, Joseph Fitzgerald, MD, P. Reddy Kalathoor, MD, Edward Taylor Jr., MD, Ricard Vanderslice Jr., MD, and Richard Vaught, MD.

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VII. Committee Reports

1. Nominating Committee Report – Scott B. Sellinger, MD, FACS

   Dr. Scott Sellinger stated that the Nominating Committee met earlier in the week during the meeting. He presented the nominating slate for the Southeastern Section Board of Directors:

   - President-Elect: Stephen Strup, MD
   - Florida Representatives: Yvonne Koch, MD, Rolando Rivera, MD
   - Florida Alternate Representatives: Arash Rafaei, MD, Jorge Caso, MD
   - Kentucky Representative: Andrew Harris, MD
   - Kentucky Alternate Representative: Mohammed Said, MD
   - Louisiana Representatives: Scott Delacroix Jr., MD, Alexander Gomelsky, MD
   - Louisiana Alternate Representatives: Sean Collins, MD, Nazih Khater, MD
   - North Carolina Representative: Jonathan Hamilton, MD
   - North Carolina Alternate Representatives: Dana Pont, MD, Michael Lipkin, MD
   - Tennessee Representatives: Ryan Pickens, MD, Joe Mobley III, MD
   - Tennessee Alternate Representatives: Kelvin Moses, MD, Jonathan Angelle, MD

   Dr. Sellinger stated that one Kentucky Alternate Representative position remains vacant as the Kentucky State Urological Society would provide the name after their annual meeting in the fall of 2022. The remaining members of the board had current terms and no action was required.

   Action: The SESAUA Board of Directors slate was approved as presented.

   Dr. Scott Sellinger then presented Dr. Glenn Preminger as the SESAUA Representative on the AUA Board of Directors to the membership for approval.

   Action: Dr. Glenn Preminger was appointed as the SESAUA Representative on the AUA Board of Directors.

   Next, Dr. Martha Terris was nominated for the SESAUA Alternate Representative on the AUA Board of Directors.

   Action: Dr. Martha Terris was appointed as the SESAUA Alternate Representative on the AUA Board of Directors.

   Then, Dr. David Kraebber stated that Dr. Rolando Rivera's second term as the Member-at-Large on the SESAUA Nominating Committee is expiring and that he must be replaced. He opened the floor for nominations from the membership and noted that nominees may not reside in North Carolina as there were already 2 members on the Nominating Committee from that state. Drs. Alberto Ramirez-Lopez and Ranjith Ramasamy were nominated from the floor of the position. An electronic vote was conducted.

   Action: Dr. Alberto Ramirez-Lopez was elected as the Member-at-Large on the SESAUA Nominating Committee.

2. Committee on Education and Science – David D. Thiel, MD

   Dr. Thiel thanked the members of the Committee on Education and Science for their participation and contributions to the committee that year. He noted that the committee was working to develop a curriculum for resident training courses in the Section and that additional information would be sent out to the membership once the program was finalized.

3. Bylaws Committee – Nicole Miller, MD

   There were no pending bylaws changes to be presented to the membership.

4. Finance Committee – Stephen B. Riggs, MD, FACS

   Dr. Stephen Riggs summarized the recent activities of the SESAUA Finance Committee. He stated that he had been working with the SESAUA Treasurer, Dr. Lorie Fleck, to divide the SESAUA Investment Portfolio held with Vanguard into two separate accounts. One account would be maintained at $4 million dollars a year in order to support future meetings that may occur without corporate support and the other $3 million dollars would be put into an investment account specifically for the use of future philanthropic projects. The interest earned each year on the philanthropic investment account would be used for a variety of projects throughout the SESAUA.

5. Membership Committee – Rolando Rivera, MD, FACS

   The SESAUA has a total of 2,293 members including 1,198 Active members, 2 Affiliate members, 3 Allied members, 229 Associate members, 94 Honorary members and 767 Senior members.

6. Health Policy Committee – Terrance C. Regan, MD

   The SESAUA Health Policy Committee met during the annual meeting. Dr. Regan provided a summary of the recent activities of the committee along with that of the AUA Public Policy Council.

VIII. Representative to the Board of Directors of the AUA – Martin K. Dineen, MD, FACS

Dr. Martin Dineen provided an update to the membership on the recent activities of the American Urological Association. He encouraged everyone to attend the 2022 AUA Annual Meeting which would take place May 13-16, 2022 in New Orleans, LA. This would be the first in-person annual meeting in three years. He noted that there would be virtual options available for those who were unable to attend the meeting in person.

IX. Future Sites Committee – Jack M. Amie, MD

The SESAUA 2023 Annual Meeting will take place Marcy 15-18, 2023 at the Ritz-Carlton Amelia Island in Amelia Island, Florida.

X. Honorary Members – David M. Kraebber, MD

Dr. David Kraebber presented the following 2022 guest speakers for approval of SESAUA Honorary Membership:

- Bryce Gartland, MD
- John Gore, MD
- James Appel, MD
- Yolanda Wimberly, MD
- Carla Haack, MD
- Brian Chapin, MD
- Kate Kraft, MD
- Alexis Te, MD

Action: The 2022 guest speakers were approved for SESAUA Honorary Membership.

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XI. New Business

Dr. David Kraebber presented Dr. Stanley Duke Herrell III as the SESAUA 2022-2023 President. Dr. Herrell thanked the membership for the opportunity to serve as the SESAUA President.

XII. Adjournment

The SESAUA 2022 Annual Business Meeting adjourned at 11:30 a.m.

Respectfully Submitted,

Samantha Florine
SESAUA Executive Director

PROPOSED BYLAWS CHANGES

ARTICLE V
COMMITTEES

Section B: **Special Committees**

3. Committee on Nominations

a. The Committee on Nominations shall consist of five (5) Members. These are the three (3) most recent living Past Presidents ~~in attendance at the Annual meeting~~ and two (2) at-large Members who are Active Members of the Section and AUA. The At-Large Members are nominated and elected, or appointed by the Board of Directors to fill a vacancy, for a term of two (2) years by the Membership of the Section during the Annual Business Meeting. Those Committee Members elected by the Section Membership shall serve no more than two (2) consecutive terms. No more than two (2) Members of the Committee shall reside in the same state.

b. The Chairperson shall be the Past President with most seniority.

c. If there is a Past-President that needs to recues himself/herself, the fourth most recent Past-President will serve to break a tie if needed.

~~c.~~d. The Committee shall present to the Section Membership at its Annual Business Meeting a slate of nominees of Active Members in good standing in the Section and AUA. There shall be one (1) candidate for each position as follows:

(1) Nominees for positions in AUA~~:~~ shall be in accordance with the Bylaws of the American Urological Association.

(2) Nominees for positions in Section:

(a) President-Elect who automatically shall assume office of President at the end of the term. Any nominee must have had three (3) years of satisfactory experience as a Member of the Board of Directors or have been General Arrangements Chairperson. Each year for one (1) year term.

(b) Historian who shall serve a term of three (3) years and may be re-elected to serve a second three (3) year term.

(c) Members and Alternate Members of the Board of Directors whose immediate predecessors are completing their three (3) year term of service, as prescribed in Article III, after consultation with the State Urological Societies. Term of election is three (3) years.

(d) Secretary of the Section. He/she may not be re-elected. Every three (3) years for three (3) year term:

(e) Treasurer of the Section. He/she may not be re-elected. Every Three (3) years for three (3) year term:

~~(f) No Member of the Nominating Committee shall be eligible for any elective position except that incumbents shall continue for their stated terms of office.~~

~~(g)~~(f) Nominations for all elected positions must be called for from the floor by the President at the Annual Business Meeting before any voting takes place.

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BYLAWS

Amended: April 24, 2021 at the SESAUA Annual Business Meeting

PREAMBLE

***Section A:* Mission**
The Southeastern Section of the American Urological Association, Inc., (Section) is a professional organization devoted to the propagation of the highest standards of medical practice and to the discovery and dissemination of scientific knowledge and information. It is also the function of the Section to promote and advocate for the practice of urology.

***Section B:* Objectives**
The stated objectives of the Section are to perpetuate the finest traditions of the medical arts, to encourage the scientific advances in the field of urology, to promote the improved practice of urology, and to benefit the general welfare. It is the Section's paramount goal to offer increasing responsibilities to those vigorous young colleagues exhibiting enthusiasm and capability.

***Section C:* Code of Ethics**
Members Shall:

1. Conduct professional activities with honesty, integrity, fairness, and good faith.
2. Always treat each other, employees, staff, volunteers, and the public with dignity, respect, and courtesy.
3. With enthusiasm act as a goodwill ambassador for the Section.

ARTICLE I
MEMBERSHIP

***Section A:* Categories**
The Membership of the Southeastern Section of the American Urological Association, Inc., herein afterward known as the Section, shall consist of the following categories:

1. Active Members
2. Senior Members
3. Associate Members
4. Allied Members
5. Honorary Members
6. Corresponding Members
7. Candidate Members

Membership in the Section is afforded solely at the discretion of the Board of Directors and the Section Membership, with the advice of the Membership Committee. Application for membership in the Section must be made on forms approved by the Board of Directors and provided by the Secretary.

***Section B:* Voting Status and Rights**
Only Active and Senior members, and those Active and Senior members who are elected to Honorary Membership, shall be eligible for office or have the right to vote. All members shall be entitled access to the latest available copy of the Articles of Incorporation and Bylaws and the Roster of Membership available on the Section Website.

***Section C:* Mandatory AUA Membership**
Each member of the Section must also join the AUA. Each member of the AUA, except corresponding members, who reside or practice within the Section must also be a member of the Section.

***Section D:* Election/Approval of Membership**
Active and Associate membership applicants shall be approved by the AUA Section Secretaries/ Membership Council periodically throughout the year. Candidate Members shall be approved by the Executive Committee periodically throughout the Association year.

***Section E:* Active Members**
Requirements for membership are as follows:

1. Possession of an unlimited license to practice medicine and surgery in the State, Province or Country of the applicant's practice.
2. Possession of an M.D. or D.O. degree (or United States medical licensure equivalent), and completion of an ACGME accredited urology residency (or

equivalent accreditation organization) or the certifying Board of Urology in the country where practicing.

3. Limitation of practice to the specialty of Urology.
4. Certification by the American Board of Urology(ABU), American Osteophatic Board of Surgery (AOBS), or the certifying Board for Urology in the country where practicing.

Section F: **Senior Members**
Active members are eligible for Senior Membership in the Section if they have been Active Members for 20 years in either the Section or the AUA and are retired, or are permanently disabled.

Section G: **Associate Members**
Requirements for Associate membership are the same as Active membership, except for Board certification. Associate Members shall pay the annual dues, assessments, and initiation fees as determined by the Board of Directors. They shall not be eligible to vote or hold office, nor has right, title or interest in the real or personal property of the Section.

1. Candidate Members Eligible for Fast Track Associate Status. Associate membership in the Section and the AUA will be offered to all Candidate members who have passed the qualifying examination (Part I) of the American Board of Urology or equivalent American Osteopathic Board of Surgery (AOBS) examination.
2. Associate Membership is available to non-member urologists who are practicing within the geographic boundaries of the Section but are not certified by the American Board of Urology or American Osteopathic Board of Surgery (AOBS).

   If an Active Member fails to become recertified as required by the American Board of Urology (or other certifying Board), the AUA and/or Section will transfer the individual to Associate Member Status. If an Active member becomes decertified by the American Board of Urology or other certifying board, the member shall be automatically dropped from membership for non-compliance with AUA and/or Section Bylaws, pursuant to Expulsion and Reinstatement policies.
3. Waiver of First -Year Dues. Associate Members who have passed the ABU certifying examination (Part II) will be transferred to Active membership in both the Section and the AUA and notified that active membership dues are waived for the first year.

Section H: **Allied Members**
Allied membership is available to Non-Physician Scientists and is not usually available for physicians certified by medical boards. However, in exceptional instances, persons in related fields of medicine and science, who do not qualify for other categories of Section Membership, may be considered for Allied Membership provided they have contributed significantly to the specialty of Urology. They shall be nominated by two Active or Senior members who shall furnish the Section Secretary with the curricula vitae and other pertinent information.

Allied Members shall pay the annual dues, assessments and initiation fees as determined by the Board of Directors. They shall not be eligible to vote or hold office.

Section I: **Honorary Members**
Honorary Members shall be scientists who have achieved outstanding prominence in a field of medicine related to Urology, Past Presidents of the Section who have retired from the active practice or Urology, and/or other distinguished urologists. Candidates must be nominated by the President and endorsed by at least two (2) Active or Senior Members. They must be elected by a majority vote by the Board of Directors and will be presented at the Annual Meeting for election. Honorary Members who have been Active or Senior Members shall retain their previous rights in the Section.

Section J: **Corresponding Members**
Corresponding Membership is available to urologists who practice beyond the geographic boundaries of the Section. The applicant shall be a member of the local or national urological organization in his/her country, and a letter of endorsement of that membership shall be submitted to the Section with the application form. If a national organization does not exist within the applicant's country, a waiver of this requirement may be considered by the Board of Directors. The applicant's practice must be limited entirely to the specialty of urology. The applicant must be a graduate of an acceptable medical school who has received a Doctor or Medicine or equivalent degree. The applicant must be in practice for a minimum of two (2) years after completion of residency.

Corresponding Members shall pay the annual dues, assessments and initiation fees as determined by the Board of Directors.

***Section K:* Candidate Members**
Candidate Membership is established to extend Sectional educational and professional advantages to urological residents. The Candidate Member must be practicing and studying within the geographic boundaries of the Section:

1. ACGME. Medical Doctors (MD) or Doctors of Osteopathy (DO) enrolled in a urology residency program approved by the Residency Review Committee and ACGME are eligible for Candidate Membership; and after completing training and passing part 1 of the ABU certifying examination are eligible for Associate Member status (Fast Track), Section G.1. Those who successfully pass all parts of the ABU qualifying examination are eligible for Active Member status, Section E.
2. AOA. Doctors of Osteopathy enrolled in an AOA-approved urology residency training program are eligible for candidate member status. DOs completing their training and passing the American Osteopathic Board of Surgery certifying examination are eligible for Associate Member status, Section G.

***Section L:* Publication of Names**
A report of new members by category admitted during the past twelve months is available on the Section's website.

***Section M:* Transfer of Membership**
An Active, Senior, or Associate member in good standing of the AUA and of another Section of the AUA who moves his or her residence or practice into the territory of this Section, and who meets all membership qualifications, is automatically eligible for membership in the Section upon presentation of credentials to the Board of Directors of the Section. These credentials shall include his or her previous Section records and a letter from that Section's Secretary indicating the applicant's membership status.

***Section N:* Expulsion, Discipline, Resignation and Reinstatement**
All matters of discipline shall be the responsibility of the AUA, in accordance with the Bylaws of the AUA. Members disciplined by the AUA will automatically be disciplined by the Section. Any member expelled by the AUA shall automatically have his or her Section membership terminated. All disciplinary actions taken may be appealed to the AUA in accordance with the Bylaws of the AUA.

Any member who has resigned or whose membership has been deleted for non-payment of dues, or for any other reason, may, after payment of any back dues owed, request reinstatement, subject to the approval of the Section Membership Committee.

ARTICLE II
OFFICERS

***Section A:* Officers of the Section**

1. Officers of the Section shall be the President, the President-Elect, the Immediate Past President, the Secretary, the Treasurer and the Historian.
2. All Officers shall be elected at the Annual Business Meeting from the slate presented by the Committee on Nominations or by nomination from the floor. A majority vote of those present and voting shall be necessary for election.
3. Officers shall serve without financial remuneration and hold office from the conclusion of the Annual Meeting at which they are elected until the completion of their term of office or until their successors are elected in accordance with these Bylaws.
4. Vacancies that occur in any of the Offices may be filled by a majority vote of the Board of Directors.
5. Candidates for office shall be Active or Senior Members in good standing of the Section, or honorary members who previously were Active members in good standing of the Section. In either case, they must be members in good standing of the AUA.

***Section B:* President**

1. The President shall be the Chief Executive Officer of this Section. He/she shall serve as Chairman of the Board of Directors and the Executive Committee. He/she shall

preside at all meetings of these bodies and at the Scientific and Business Meetings of the Section. His/her term of office shall be one (1) year or until his/ her successors are elected and he/she may not be re-elected.

2. He/she shall appoint Special and Ad Hoc Committees and shall make appointments to fill vacancies on committees appointed by the Executive Committee.
3. He/she may call special meetings of the Executive Committee and the Board of Directors.
4. He/she shall direct the attention of the Board of Directors to violations of the Bylaws and to matters of discipline of members.
5. He/she may make nominations for Honorary Membership.
6. He/She shall appoint an individual urologist and spouse to serve as Chair of the Committee on Arrangements.
7. He/She shall be a member of the Committee on Programs.
8. He/She shall be a member ex-officio of all other committees except the Committee on Nominations.

Section C: President-Elect

1. The President-Elect after serving one (1) year term in Office shall be elevated to the Office of President automatically and without standing for election.
2. He/she shall perform any duties which are assigned by the President and shall preside in the absence of the President.
3. He/she shall be a Member of the Executive Committee, Committee on Programs and Board of Directors.

***Section D:* Past President**

- The Immediate Past President shall be a Member of the Board of Directors, the Executive Committee, the Committee on Nominations and the Committee on Programs. His/her term of Office shall expire upon the ascension of the President -Elect to the Office of President.

***Section E:* Secretary**

1. His/her term of Office shall be three (3) years or until his/her successor assumes Office. He/she may not be elected to more than one (1) term.
2. He/she shall keep precise and complete records of all the business activities and correspondence of the Section.
3. He/she shall oversee the application process and membership records, shall receive and maintain the official Section documents, and shall give formal notice of the Annual Meeting and of special meetings. The Secretary shall preserve the Minutes and records of such meetings.
4. He/she shall notify by letter each newly elected Member of his/her election and send him/her a Certificate of Membership with notification to visit the Section website for a copy of the Section Articles of Incorporation and Bylaws. He/she shall notify Members promptly of any change in their membership classifications.
5. He/she shall cause to be supplied at the expense of the Section:
   a. The Membership Directory of the Section shall be made available on the Section's website.
   b. The Program and Abstracts which will be printed, or provided in electronic format or electronically on the Section's website, for distribution for the yearly Meeting only.
6. He/she shall send official notice of the date, time and place of the Annual Meeting to each Member at his/her last known address at least sixty (60) days before the date of the opening session. Notices of Special Meetings giving the purpose, place, date and hour shall be sent at least twenty-one (21) days before the date selected.
7. He/she shall arrange the order of business for meeting of the Executive Committee, Board of Directors and Annual Business Meeting of the Section.
8. He/she shall be a member of the Executive Committee, Board of Directors, the Committee on Programs, the Committee on Bylaws, the Committee on Arrangements and the AUA Membership Committee. The Secretary shall determine the program, including papers and panels, for the Annual Meeting. He/she shall be Chairman of the Committee on Programs.

9. He/she shall report to the Executive Committee at least thirty (30) days prior to the Annual Meeting all existing and expected vacancies on Standing Committees, Special Committees, and Representatives to AUA positions for which the Executive Committee determines appointments according to these Bylaws. The Secretary shall also report to the Committee on Nominations, at least (30) days prior to the Annual Meeting, all existing and expected vacancies for nominees for positions in the AUA and the Section in accordance with these Bylaws.
10. He/she shall notify the AUA of the names of members who have been selected to represent the Section on AUA Committees, and the name of any member who has not maintained Section membership in good standing.
11. He/she shall cause to be published appropriate newsletters during the year. All newsletters must be processed by the Secretary or their designee.
12. He/she shall notify, by letter, each newly elected officers or appointed committee member of his or her election or appointment and of the tenure of that office.
13. The Executive Director shall be the Assistant to the Secretary and shall carry out the routine duties of the Office under the direction of the Secretary.

Section F: **Treasurer**

1. His/her term of Office shall be for three (3) years or until his/her successor assumes Office and may not be elected to more than one (1) term.
2. The Treasurer shall be the custodian of the funds and all the property of the Section. The Treasurer shall work with the Executive Director overseeing all general accounting and financial record keeping functions. He/She shall assure prompt payment of all authorized bills of the Section.
3. He/she shall purchase, sell or transfer securities of the Section only upon recommendation of the Committee on Finance or approval of the Executive Committee.
4. He/she shall, at the expense of the Section, give bond for such sum as may be determined by the Board of Directors, but in no instance less than fifty thousand dollars ($50,000.00).
5. At the discretion of the Executive Committee or the Committee on Finance, he/she shall have an annual compilation made of the finances of the Section by a Certified Public Accountant and shall present a written report at the Annual Meeting of the Section.
6. He/she shall prepare annually a list of Members in arrears and present this list to the Board of Directors.
7. He/she shall be a member of the Board of Directors, the Executive Committee, the Committee on Programs, the Committee on Finance, and the Investment Advisory Committee.
8. The Executive Director shall be the Assistant to the Treasurer and shall carry out the routine duties of the Office under the direction of the Treasurer.

Section G: **Historian**

1. This Section shall have a Historian who is elected by membership. He/she shall serve a term of three years or until their successors assume office, and can be re-elected to serve a second three year term. He/she must be nominated for Office by the Committee on Nominations or from the floor and be elected at the Annual Business Meeting by a majority vote of those present and voting.
2. The Historian is a non-voting member of the Board of Directors and has no functional duties within the Section other than those described below.
3. He/she shall prepare a history of the Section and shall keep records of changes in the Section to its history. He shall present an annual report to the Board of Directors and to the Section at the Annual Business Meeting.
4. He/she shall prepare for publication any historical issues relative to the Section and present them to the Board of Directors.
5. He/she shall be custodian of all records, papers and various paraphernalia which properties are no longer in the custodial care of the Secretary or other Officers of the Section.
6. He/she shall report at the Annual Business Meeting the names of all Members who died in the preceding year.
7. He/she shall be responsible for recording the activities and highlights of each Annual Meeting and shall obtain appropriate documentation of the Meeting.

Section H: **Executive Director**
The Executive Director shall be the chief administrative officer of the Association, and shall report directly to the Board of Directors, of which he/she shall be an ex officio, non-voting member. The Executive Director need not be a physician nor a member of the Section. He/she shall have the authority to carry out all policies and programs of the Section within the framework of the budget and subject to the direction of the elected officers and the Board of Directors.

ARTICLE III
BOARD OF DIRECTORS

Section A: **Board of Directors General Considerations**

1. The Board of Directors, herein afterward known as the Board, shall consist of the Executive Committee, the Chairpersons of the Standing Committees, the Chairperson of the Health Policy Council, the Section Representative to the Board of Directors of the AUA and at least one (1) Director or one (1) Alternate from each state or territory of the Section in which ten (10) or more Active or Senior Members reside. States or territories in which more than one hundred (100) Active or Senior Section Members reside shall have an additional Director and Alternate for each one hundred (100) Active or Senior Members or fraction thereof. Members of the Board must be Active Members of the Section and of the AUA.
2. The Board is responsible for the administration and management of the Section.
3. Directors and one Alternate for each Director shall be elected for a term of three (3) years or until their successors assume office and may not succeed themselves. Serving as an Alternate shall not disqualify a Member from serving as a Director.
4. An unfinished term of a Director shall be served by the Alternate. An alternate serving an unfinished term of less than half of a term shall not be precluded from being elected to an additional term.
5. A majority of the Board of Directors shall constitute a quorum.

Section B: **Meetings**

1. Board shall meet annually in conjunction with the Annual Meeting of the Section.
2. Special Meetings of the Board may be called by the President or by request of a majority of Directors. Notice of special meetings must be sent out by the Secretary to each Board Member and Alternate at least twenty-one (21) days before the date of the Meeting.
3. The matters to be discussed and voted upon at any duly called meeting of the Board of Directors shall not be limited to those set forth in the notice of such meetings.
4. In order to become better acquainted with the activities of the Section, Alternates should attend Meetings of the Board as non-voting members when not substituting for a Director.
5. All meetings of the Board of Directors may be held electronically provided all participants are afforded the ability to participate aurally and communicate verbally.

Section C: **Duties**

1. Order the disbursement of money.
2. Select the time and place of the Annual Meeting of the Section after considering the recommendation of the Committee to select meeting sites. The Annual Meeting may be omitted by a majority vote of the Board.
3. Receive the annual reports of the Secretary, Treasurer, Historian and the Executive, Standing and Special Committees and take any action on the reports it deems appropriate in accordance with these Bylaws.
4. Elect Honorary members from nominations received from the President. Names of elected members shall be read to the Membership at the Annual Business Meeting.
5. Elect every third year by a majority vote one current Member or past Director, other than an Officer, to serve on the Executive Committee of the Section. If the Director is currently serving as a State Director, that State may elect another Director to complete the unfinished term.
6. Elect by majority vote qualified Members to fill Unfinished terms in any elected position of the Section.

7. When the Board of Directors deems it appropriate, it may recommend to the Membership the nomination of any Member considered qualified for service as an officer of the AUA. On approval by the Membership, such nomination shall be forwarded to the AUA Nominating Committee by the Section Member of the Nominating Committee of the AUA.
8. Transact any business not specified or prohibited by these Bylaws.
9. It shall employ the Executive Director whose duties, responsibilities and authority shall be as specified in Article II, Section H of these Bylaws. Report all actions to the Membership at the Annual Business Meeting.

***Section D:* The Executive Committee of the Board of Directors**

1. The Executive Committee shall consist of the President, President- Elect, Immediate Past President, Secretary, Treasurer, Chairperson of the Committee on Education and Science, and one (1) Director elected by the Board for a term of three (3) years or until their successor assumes office. The Director may not succeed himself/herself. The President shall be the Chairperson.
2. Duties.
   a. To conduct the business of the Section between Meetings of the Board of Directors except as otherwise provided in these Bylaws. All action taken by the Committee shall be reviewed by the Board.
   b. Approve Candidate member applications, and Associate and Active candidate members referred by the AUA as stipulated in Article I, Section D.
   c. Appoint all Standing and Special Committees, excluding the Committee on Arrangements and Nominating Committee.
   d. Nominate Section recipients for AUA Awards.
   e. Unfinished terms of Representatives to AUA Committees shall be filled by the Executive Committee.
   f. Constitute the Committee on Programs which is chaired by the Secretary.
   g. At the request of the AUA, nominate three (3) Section Members interested in research to serve on the AUA Research Council. If appointed, the Members will serve as Representatives on the AUA Research Council for a four (4) year term renewable once.
3. The Committee shall meet on call of the President.
4. All meetings of the Executive Committee may be held electronically provided all participants are afforded the ability to aurally communicate simultaneously.

ARTICLE IV
REPRESENTATIVES TO THE AUA

***Section A:* General Considerations**
Representatives to the AUA must be Active Members of the Section and the AUA. They shall reflect the expressed policies of the Section in keeping with the best interest of the AUA.

***Section B:* Representations According to AUA Bylaws**
In accordance with Article V, Section 1 of the Bylaws of the AUA, the Section will have Representatives as follows:

1. Editorial Committee: the number of representatives and terms shall be in accordance with the Bylaws of the American Urological Association. If there is more than one member on the Committee, One Member shall be appointed to serve as Chairperson of the Editorial Committee of the Section.
2. Board of Directors Representative: one (1) Member and one (1) Alternate Member elected in odd years to serve for two (2) years or until his/her successors are elected. The Member shall be limited to two (2) terms of service not counting any term(s) as Alternate.
3. Nominating Committee: one (1) Member and one (1) Alternate to serve for one year or until his/her successors are elected. The terms of service shall be in accordance with the Bylaws of the American Urological Association.
4. Research Committee: the number of representatives and terms shall be in accordance with the Bylaws of the American Urological Association. The Members will serve the first term as Alternates and the latter term as Representatives.

5. Health Policy Council: the number of representatives and terms shall be in accordance with the Bylaws of the American Urological Association. One member will be appointed to Chairperson, another Vice Chairperson, and if more than two members on the Committee, they shall be named members at large.
6. Membership Committee: one (1) Member who is the current Secretary of the Section.
7. Bylaws Committee: the number of representatives and terms shall be in accordance with the Bylaws of the American Urological Association. One member will be appointed to Chairperson, another Vice Chairperson, and if more than two members on the Committee, they shall be named members at large.
8. Audio-Visual Committee: the number of representatives and terms shall be in accordance with the Bylaws of the American Urological Association.
9. Judicial and Ethics Council: the number of representatives and terms shall be in accordance with the Bylaws of the American Urological Association.

***Section C:* Start of Term of Service**
Representatives of the Section to the AUA shall begin their terms of office immediately following the AUA Meeting of the year in which they are elected or appointed.

***Section D:* Responsibilities to Board of Directors**
These Representatives shall report to the Board of Directors annually.

ARTICLE V
COMMITTEES

***Section A:* Standing Committees**

1. Each Standing Committee shall consist of at least six (6) Active Members of the Section. Appointments will be made by the Executive Committee. One of the Committee Members will be named Chairperson and one Vice-Chairperson by the Executive Committee. A Committee Member who is unable to participate actively in the work of the Committee may be replaced by the Executive Committee.

   Two (2) Members of each Committee shall be appointed annually for a term of three (3) years or until their successors are elected and no Member may serve more than two (2) terms on any one Committee. The exception: an individual who rises to the level of Chair of the Committee on Education and Science shall have a three-year term or until their successor is elected as Chair.
2. A Standing Committee Chairperson may appoint sub-committees from the general Membership with a Standing Committee Member as Chairperson.
3. The Chairperson of each Standing Committee shall make a formal report to the Board of Directors annually.
4. There shall be four (4) Standing Committees as follows: (1) Education and Science, (2) Finance, (3) Membership, and (4) Bylaws.

   a. The Committee on Education and Science

   (1) It shall direct the scientific and educational activities of the Section, understanding that promotion of these activities is the primary purpose of the Section. The Committee should recognize that only its strong, dedicated and enlightened leadership can make worthwhile all other Section activities and accomplish the stated objective of the Preamble to these Bylaws. To this end, it should be boldly innovative both in its continuing effort to upgrade the quality of the scientific sessions of the Annual Meeting and in its designs to stimulate the development of strong programs of postgraduate education and research within the Section.

   (2) It shall cooperate with the Committee on Programs in making specific plans for the Scientific Sessions of the Annual Meeting and be responsible for the Visual Education Program, Pyelogram Program and Scientific Exhibits.

   (3) It shall administer the Prizes and Awards Programs of the Section, be responsible for expansion of them and appoint Judging Committees to select the recipients.

   (4) It shall supervise the Postgraduate Education Programs of the Section and cooperate with the AUA Committee on Continuing Education in its activities within the Section.

(5) Its Chairperson shall serve as a Member of the Executive Committee of the Board of Directors, and in so - doing as a Member of the Committee on Programs. Once elected Chair, the term of office shall be three years or until their successor is elected.

b. The Committee on Finance

(1) It shall advise the Board of Directors on the overall fiscal policies of the Section and, with the approval of the Board, formulate fiscal rules and regulations.

(2) The Committee shall examine and verify to the Section the annual compilation of finances of the Section submitted by the Section Treasurer and a compilation of the Arrangements and Seminar Committees. A certified audit of the Section's account shall be requested when deemed appropriate.

(3) The Treasurer shall be a Member ex-officio.

(4) In cooperation with professional investment advisory services employed by the SESAUA shall advise the Treasurer on the sale, purchase, and/or transfer of the investments of the Section.

(5) It shall recommend the Section's investment counselor(s) and/or growth managers; monitor the Section's portfolio at least quarterly for adherence to establish guidelines and performance vs. objectives; and provide formal reports on performance with recommendations for Board of Directors meetings.

c. Committee on Membership

(1) It shall examine applications for Active Membership and Associate Membership that have not been referred by the AUA as stipulated in Article 1, Section D.

(2) It shall solicit new Members from among the qualified Non-member Urologists residing within the geographical boundaries of the Section.

d. Committee on Bylaws

(1) It shall review the Articles of Incorporation and Bylaws annually and make recommendations to the Board of Directors as to any changes that seem desirable.

(2) It shall consider all proposed amendments to the Articles of Incorporation and Bylaws submitted in writing and make recommendations to the Board as to disposition.

(3) It is the responsibility of the Committee to draft proposed changes in the Articles of Incorporation and Bylaws and to furnish them to the Secretary in such a time frame that they may be published and circulated to the Membership at least thirty (30) days in advance of the Annual Meeting.

(4) The Secretary shall be a Member ex-officio.

(5) The Chairperson and the Vice-Chairperson shall serve on the AUA Bylaws Committee.

Section B: **Special Committees**

1. Committee on Programs

a. The Committee on Programs shall consist of the Members of the Executive Committee; the Secretary shall be the Chairperson.

b. Duties.

(1) It shall make long range plans for the content and general format of the Annual Meeting of the Section in close cooperation with the Committee on Education and Science.

(2) It shall arrange the Scientific Program for the Annual Meeting and select from submitted titles of papers those best suited to the contemplated plan of the program.

(3) The Chairperson shall report to the Board of Directors at the Annual Meeting.

2. Committee to Select Meeting Sites

a. The Committee to Select Meeting Sites shall consist of the Secretary, the Treasurer and a Chairperson, who shall be a Past President selected by the Executive Committee. The Chairperson shall serve for no more than five (5) years.

b. It shall select the sites for future Annual Meetings subject to the approval of the Board of Directors.

3. Committee on Nominations

a. The Committee on Nominations shall consist of five (5) Members. These are the three (3) most recent living Past Presidents in attendance at the Annual meeting and two (2) at-large Members who are Active Members of the Section and AUA. The At-Large Members are nominated and elected, or appointed by the Board of Directors to fill a vacancy, for a term of two (2) years by the Membership of the Section during the Annual Business Meeting. Those Committee Members elected by the Section Membership shall serve no more than two (2) consecutive terms. No more than two (2) Members of the Committee shall reside in the same state.

b. The Chairperson shall be the Past President with most seniority.

c. The Committee shall present to the Section Membership at its Annual Business Meeting a slate of nominees of Active Members in good standing in the Section and AUA. There shall be one (1) candidate for each position as follows:

(1) Nominees for positions in AUA: shall be in accordance with the Bylaws of the American Urological Association.

(2) Nominees for positions in Section:

(a) President-Elect who automatically shall assume office of President at the end of the term. Any nominee must have had three (3) years of satisfactory experience as a Member of the Board of Directors or have been General Arrangements Chairperson. Each year for one (1) year term.

(b) Historian who shall serve a term of three (3) years and may be re-elected to serve a second three (3) year term.

(c) Members and Alternate Members of the Board of Directors whose immediate predecessors are completing their three (3) year term of service, as prescribed in Article III, after consultation with the State Urological Societies. Term of election is three (3) years.

(d) Secretary of the Section. He/she may not be re-elected. Every three (3) years for three (3) year term:

(e) Treasurer of the Section. He/she may not be re-elected. Every Three (3) years for three (3) year term:

(f) No Member of the Nominating Committee shall be eligible for any elective position except that incumbents shall continue for their stated terms of office.

(g) Nominations for all elected positions must be called for from the floor by the President at the Annual Business Meeting before any voting takes place.

4. Committee on Arrangements

a. The Committee on Arrangements shall consist of the Executive Committee and one Active of Senior Member in good standing that shall be appointed by the President to serve for one (1) year as Chair. The next meeting year's Arrangements Chair shall serve on the Committee ex-officio. When a meeting does not fall within the Section's boundaries, the Executive committee may elect not to appoint an active or senior member to serve as Chair, and the President shall assume those responsibilities.

b. The Committee on Arrangement shall make all necessary arrangements for the Annual Meeting under the direction of the President. It shall prepare a meeting budget that is financially self-supporting as its objective. The Committee on Arrangements shall keep adequate records of its activities.

c. The Chairperson shall have the power to appoint all local subcommittees and name the Chairperson of each.

d. The Chairperson shall make a final report to the Board of Directors at its next Annual Meeting.

e. With the approval of the President, the Committee shall arrange and supervise the Presidential Dinner to be held during the Annual Meeting. The cost of this dinner shall be borne by the Section. The dinner may be omitted by the majority vote of the Board of Directors.

5. Health Policy Council

a. The Health Policy Council shall advise the Membership on professional relations, socioeconomic, medical, legal and insurance matters as they relate to the teaching and practice of Urology. They shall also advise on National and Local legislative initiatives effecting urology coding and reimbursement issues, and peer review.

b. It shall investigate all questions which concern principles of medical ethics and those involving the rights and standing of Members in relation to other Members to the public under the direction of the Board of Directors.

c. The Committee shall consist of one (1) Member from each state in the Section, Puerto Rico, and Panama plus the Chairperson.

d. The State Representative and his/her alternate shall be elected by the State Society to serve a term of three (3) years.

e. The Chairperson of the Health Policy Council shall be appointed by the Executive Committee for three (3) years and shall serve as one Section Representative to the Health Policy Council of the AUA.

f. The Vice-Chairperson of the Health Policy Council shall be appointed by the Executive Committee for three (3) years and shall serve as the Section's second Representative to the Health Policy Council of the AUA.

g. The Vice-Chairperson of the Health Policy Council may be advanced to be Chairperson of this Council after completion of the three (3) year term.

***Section C:* AD HOC Committees**

1. These Committees are appointed and the Chairperson named by the President annually to perform specific jobs not lying within the purview of any existing Committee. They may be reappointed or reconstituted; however, if the need for the Committee exists beyond three (3) years, it should become a Standing or Special Committee.
2. The Chairperson shall report to the Board of Directors when requested by the President.

ARTICLE VI
MEETINGS

***Section A:* Annual Meetings**

1. The Annual Meeting of the Section shall be held at such time and place as is designated by the Board of Directors. The Annual Scientific Meeting may be omitted by majority vote of the Board.
2. Official notice of the time and place of the Annual Meeting must be sent to each member in the form of a newsletter or otherwise at least ninety (90) days before the meeting.
3. The order of the program of the scientific portion of the Annual Meeting shall be directed by the Secretary in cooperation with the Committee on Programs, the Committee on Education and Science and the Committee on Arrangements.
4. Papers.
   a. Authors who wish to present papers at the Annual Meeting must submit titles and abstracts to the Secretary in accordance with deadlines established by the Committee on Programs.
   b. Time allowed for presenting and discussing papers shall be determined by the Committee on Programs.
5. Officers shall be installed at the end of the Annual Meeting.
6. Business Meeting.
   a. The Annual Business Meeting shall be held during the time of the Annual Meeting.
   b. The order of business at the Annual Business Meeting shall be set by the Secretary.

***Section B:* Special Meetings**

1. Special Meetings of the Section for any purpose other than effecting changes in the Bylaws may be called by a two-thirds (2/3) vote of the Board of Directors and shall be held at such time and place as directed by the Board.

2. Notice of a Special Meeting must be sent to the Members at least twenty-one (21) before such a Meeting. The notice must contain a statement of the business to be conducted, and no other business shall be conducted at the Special Meeting.

***Section C:* Quorum**
The members' registered and eligible to vote who are present at the Annual Business Meeting and at any Special Meetings shall constitute a quorum for such meetings, and, unless otherwise specifically required by these Bylaws or applicable law, the vote of a majority of such members shall be required to approve any action at such meeting.

ARTICLE VII
DUES AND FEES

***Section A:* Dues, Fees and Assessments - Determination**
The annual dues, the initiation fee and special assessments shall be determined by the Board of Directors on advice of the Committee on Finance. The annual dues are payable in advance. Any Member with a past due account over 120 days shall be dropped from the rolls and his/her name presented to the Board of Directors for appropriate action. Members requesting transfer to Senior status may delay payment of dues until the Board of Directors has ruled on their request.

***Section B:* Fiscal Year**
The fiscal year of the Section shall date from January first to December thirty-first.

ARTICLE VIII
TERRITORY

The Section shall comprise the states of Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and the territories of Puerto Rico, Panama and the U.S. Virgin Islands. Individuals who initially join the Section in which they practice, and then at a future date relocate to another Section, may retain Section membership.

ARTICLE IX
SEAL OF CORPORATION

The Corporate seal shall be inscribed thereon the name of the corporation and the word "Seal". Said seal may be altered at the pleasure of the majority of the Membership voting at an Annual Meeting and may be used by causing it or a facsimile thereof to be impressed or otherwise used.

ARTICLE X
AMENDMENTS

***Section A:* Repealing / Amending Bylaws**
A Quorum being present these Bylaws may be repealed or amended by a two-third (2/3) vote of the Members present and voting at any Annual Business Meeting, provided that the proposed revision or amendment is provided to the Membership at least thirty (30) days prior to the Annual Meeting at which such action is to be taken.

ARTICLE XI
RULES OF ORDER

The current edition of Roberts Rules of Order, Newly Revised shall govern the proceedings of the Section unless otherwise provided in these Bylaws.

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NUMERICAL MEMBERSHIP

Active		
Active Member		1,097
Active Member - Transfer into Section		6
	Total Active Count:	*1,103*
Affiliate		
Affiliate Member		2
	Total Affiliate Count:	*2*
Associate		
Associate Member		225
Associate Member - Transfer into Section		1
	Total Associate Count:	*226*
Honorary		
Honorary		101
	Total Honorary Count:	*101*
Senior		
Senior		784
Senior - Transfer into Section		1
	Total Senior Count:	*785*
	Total Membership Count:	*2,217*

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NECROLOGY REPORT

In Loving Memory of Our Members Who Have Passed

These members supported SESAUA during their lifetimes and made contributions to our profession. Although seperated from us by death they are fondly remembers by us all.

David M. Comfort, MD
Springville, AL

Martin K. Dineen, MD, FACS*
Daytona Beach, FL

Harvey W. Johnston, MD
Charlotte, NC

Delutha H. King Jr., MD
Atlanta, GA

David L. McCullough, MD
Winston Salem, NC

Guy A. Montgomery Jr., MD
Opelika, AL

Alan Retik, MD
Boston, MA

James C. Seabury Jr, MD, FACS
Fort Myers Beach, FL

Joseph K. Wheatley, MD
Bodega Bay, CA

**Indicates past president*

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PRELIMINARY TREASURER'S REPORT

The financial state of the SESAUA is stable despite the downward trend of the stock market. Total assets as of December 31, 2022, are $6,845,679, which includes investments of $6,509,176 and other assets totaling $336,502.

In past years, the net profit of our annual meeting was approximately $140,000 to $160,000. Major sources of income include membership dues, corporate support, hotel commissions and meeting registration. Approximately 50% of the revenue is from corporate sponsors, so please continue to support our industry sponsors at this meeting in Amelia Island. Currently we have $594,813 in corporate support for this meeting.

The total operating income as of December 31, 2022, was $975,062. This includes corporate support, meeting registration and membership dues. Total expenses are $896,212, so the net operating income is $78,850. Net income at year end 2022 is a loss due to the stock market.

SESAUA has one active checking account at JP Morgan Chase with a balance of $262,893. There is a savings account at JP Morgan Chase with 94.87% SESAUA investments being held at Vanguard. The investments have decreased as expected due to a dip in the stock market. This has affected our new philanthropy venture, as we had planned on using interest for new projects. I have met with Dr. Steve Riggs, Chair of the Finance Committee, and Vanguard and discussed other options. We would propose that dividends (in place of interest) from our stock portfolio be used for future philanthropy as these numbers will be more consistent despite volatility in the market. This year we have just over $50,000 in dividends to add for new philanthropy projects. Our investment portfolio is similar to the AUA, and we benefit by the AUA investment rate. For the period ending December 31, 2022, the portfolio composition was as follows:

- Fixed income (36%): $1,382,342
- Equities (64%): $2,439,786
- Total investments: (100%). $3,822,128
- Philanthropy: $2,687,949

Current membership status: 1,251 members have paid annual dues; there are 10 unpaid annual dues. We all recognize that our future lies in our younger members, and the SESAUA remains committed to supporting residents. We plan to continue current funding tor residents to attend the annual meeting and also continue other educational opportunities. Funding for volunteerism will also continue in upcoming years.

The Finance committee and Treasurer will continue to work together to look at additional educational and volunteer opportunities for our section members while remaining fiscally responsible to our section.

Thank you for allowing me to serve the last three years as Southeastern Section Treasurer.

I look forward to future service to the SESAUA.

Sincerely,

Lorie G. Fleck, MD, FACS

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ROSTER OF THE STATE SOCIETIES AND OFFICERS

FLORIDA UROLOGICAL SOCIETY
75th Annual Meeting
August 31 - September 3, 2023 | Loews Sapphire Falls Resort | Orlando, FL

President: Adam J. Ball, MD, FACS

Email: info@flaurological.org

GEORGIA UROLOGICAL ASSOCIATION
2023 Annual Fall Meeting
September 7 – 10, 2023 | The Cloister at Sea Island | Sea Island, Georgia

President: Cara B. Cimmino, MD

Email: gua@wjweiser.com

KENTUCKY UROLOGICAL ASSOCIATION
President: Jamie C. Messer, MD

LOUISIANA UROLOGICAL SOCIETY
2023 Annual Meeting
July 14 - 15, 2023

President: Scott E. Delacroix Jr., MD

Email: info@lusweb.org

NC UROLOGICAL ASSOCIATION
7th Annual Meeting
October 7, 2023 | Greensboro Marriott Downtown | Greensboro, NC

President: Michael E. Lipkin, MD, MBA

Email: ncua@wjweiser.com

PUERTO RICO UROLOGICAL ASSOCIATION
73rd Annual Meeting
October 27 - 29, 2023 | Caribe Hilton Hotel | San Juan, PR

President: Marcos Perez-Brayfield, MD

Email: prurological@gmail.com

SC UROLOGICAL ASSOCIATION
President: Thomas Brian Willard, MD

Email: scua@wjweiser.com

SOCIEDAD PANAMEÑA DE UROLOGÍA
President: Ramón Rodríguez Lay, MD

TENNESSEE UROLOGICAL ASSOCIATION
President: S. Duke Herrell III, MD, FACS

Email: tua@wjweiser.com

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PREVIOUS OFFICERS AND ANNUAL MEETING SITES

† Indicates Deceased Member

1932 Birmingham, AL

† Edgar G. Ballenger, MD; Atlanta, GA	Temporary Chair

1933 Richmond, VA

† Montague L. Boyd, MD; Atlanta, GA	Chair
† Edgar G. Ballenger, MD; Atlanta, GA	Vice Chair
† Earl Floyd, MD; Atlanta, GA	Secretary/Treasurer

1934 Atlanta, GA

† Montague L. Boyd, MD; Atlanta, GA	Chair
† Edgar G. Ballenger, MD; Atlanta, GA	Vice Chair
† Earl Floyd, MD; Atlanta, GA	Secretary/Treasurer

1935 Nashville, TN

† Edgar G. Ballenger, MD; Atlanta, GA	President
† H. W.E. Walther, MD; New Orleans, LA	President-Elect
† Earl Floyd, MD; Atlanta, GA	Secretary/Treasurer

1936 Charlotte, NC

† H. W.E. Walther, MD; New Orleans, LA	President
† Hamilton McKay, MD; Charlotte, NC	President-Elect
† Earl Floyd, MD; Atlanta, GA	Secretary/Treasurer

1937 Birmingham, AL

† Hamilton McKay, MD; Charlotte, NC	President
† George Livermore, MD; Memphis, TN	President-Elect
† Earl Floyd, MD; Atlanta, GA	Secretary/Treasurer

1938 Louisville, KY

† George Livermore, MD; Memphis, TN	President
† Earl Floyd, MD; Atlanta, GA	President-Elect
† Raymond Thompson, MD; Charlotte, NC	Secretary/Treasurer

1939 Biloxi, MS

† Earl Floyd, MD; Atlanta, GA	President
† J. Ullman Reaves, MD; Mobile, AL	President-Elect
† Louis M. Orr, MD; Gainesville, FL	Secretary/Treasurer

1941 Jacksonville, FL

† J. Ullman Reaves, MD; Mobile, AL	President
† Jefferson C. Pennington, MD; Nashville, TN	President-Elect
† Louis M. Orr, MD; Gainesville, FL	Secretary/Treasurer

1942 Chattanooga, TN

† Jefferson C. Pennington, MD; Nashville, TN	President
† Louis M. Orr, MD; Gainesville, FL	President-Elect
† Harold P. McDonald, Sr., MD; Atlanta, GA	Secretary/Treasurer

1943 New Orleans, LA

† Louis M. Orr, MD; Gainesville, FL	President
† William E. Coppridge, MD; Durham, NC	President-Elect
† Harold P. McDonald Sr., MD; Atlanta, GA	Secretary/Treasurer

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1946 Augusta, GA

†	William E. Coppridge, MD; Durham, NC	President
†	Hubert K. Turley Sr., MD; Memphis, TN	President-Elect
†	Harold P. McDonald Sr., MD; Atlanta, GA	Secretary/Treasurer

1947 Palm Beach, FL

†	Hubert K. Turley Sr., MD; Memphis, TN	President
†	Robert P. McIver, MD; Jacksonville, FL	President-Elect
†	Harold P. McDonald Sr., MD; Atlanta, GA	Secretary/Treasurer

1948 Hollywood Beach, FL

†	Robert P. McIver, MD; Jacksonville, FL	President
†	Harold P. McDonald Sr., MD; Atlanta, GA	President-Elect
†	Russell B. Carson, MD; Vero Beach, FL	Secretary/Treasurer

1949 Boca Raton, FL

†	Harold P. McDonald Sr., MD; Atlanta, GA	President
†	James J. Ravenel, MD; Charleston, SC	President-Elect
†	Russell B. Carson, MD; Vero Beach, FL	Secretary/Treasurer

1950 Edgewater Park, MS

†	James J. Ravenel, MD; Charleston, SC	President
†	Edgar Burns, MD; New Orleans, LA	President-Elect
†	Russell B. Carson, MD; Vero Beach, FL	Secretary/Treasurer

1951 Memphis, TN

†	Edgar Burns, MD; New Orleans, LA	President
†	Temple Ainsworth, MD; Jackson, MS	President-Elect
†	Russell B. Carson, MD; Vero Beach, FL	Secretary/Treasurer

1952 Boca Raton, FL

†	Temple Ainsworth, MD; Jackson, MS	President
†	W.R. Miner, MD; Covington, KY	President-Elect
†	Russell B. Carson, MD; Vero Beach, FL	Secretary/Treasurer

1953 Havanna, Cuba

†	W.R. Miner, MD; Covington, KY	President
†	Russell B. Carson, MD; Vero Beach, FL	President-Elect
†	Sidney Smith, MD; Raleigh, NC	Secretary/Treasurer

1954 Palm Beach, FL

†	Russell B. Carson, MD; Vero Beach, FL	President
†	Samuel L. Raines, MD; Memphis, TN	President-Elect
†	Sidney Smith, MD; Raleigh; NC	Secretary/Treasurer

1955 New Orleans, LA

†	Samuel L. Raines, MD; Memphis, TN	President
†	Sidney Smith, MD; Raleigh, NC	President-Elect
†	Robet F. Sharp Sr., MD; New Orleans, LA	Secretary
†	Charles Reiser, MD; Atlanta, GA	Treasurer

1956 Hollywood, FL

†	Sidney Smith, MD; Raleigh, NC	President
†	Jarratt P. Robertson, MD; Atlanta, GA	President-Elect
†	Robet F. Sharp Sr., MD; New Orleans, LA	Secretary
†	Charles Reiser, MD; Atlanta, GA	Treasurer

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1957 Atlanta, GA

† Jarratt P. Robertson, MD; Atlanta, GA	President
† Lawrence P. Thackston Sr., MD; Orangeburg, SC	President-Elect
† Robet F. Sharp Sr., MD; New Orleans, LA	Secretary
† Frank M. Woods, MD; LaBelle, FL	Treasurer

1958 Hollywood, FL

† Lawrence P. Thackston Sr., MD; Orangeburg, SC	President
† Robet F. Sharp Sr., MD; New Orleans, LA	President-Elect
† James L. Campbell Jr., MD; Orlando, FL	Secretary
† Frank M. Woods, MD; LaBelle, FL	Treasurer

1959 Louisville, KY

† Robet F. Sharp Sr., MD; New Orleans, LA	President
† Rudolph Bell, MD; Thomasville, GA	President-Elect
† James L. Campbell Jr., MD; Orlando, FL	Secretary
† Hurbert K. Turley, MD; Memphis, TN	Treasurer

1960 Jacksonville, FL

† Rudolph Bell, MD; Thomasville, GA	President
† N. Lewis Bosworth, MD; Lexington, KY	President-Elect
† James L. Campbell Jr., MD; Orlando, FL	Secretary
† Hurbert K. Turley, MD; Memphis, TN	Treasurer

1961 Hollywood-by-the-Sea, FL

† N. Lewis Bosworth, MD; Lexington, KY	President
† Alfred D. Mason Jr., MD; Memphis, TN	President-Elect
† James L. Campbell Jr., MD; Orlando, FL	Secretary
† Henry Comfort Hudson, MD; Birmingham, AL	Treasurer

1962 Belleair, FL

† Alfred D. Mason Jr., MD; Memphis, TN	President
† James L. Campbell Jr., MD; Orlando, FL	President-Elect
† Louis C. Roberts, MD; Greensboro, NC	Secretary
† Henry Comfort Hudson, MD; Birmingham, AL	Treasurer

1963 Nassau, Bahamas

† James L. Campbell Jr., MD; Orlando, FL	President
† Powell G. Fox Sr., MD; Raleigh, NC	President-Elect
† Louis C. Roberts, MD; Greensboro, NC	Secretary
† Douglas E. Scott, MD; Lexington, KY	Treasurer

1964 Belleair, FL

† Powell G. Fox Sr., MD; Raleigh, NC	President
† W. E. Kittredge, MD; New Orleans, LA	President-Elect
† Louis C. Roberts, MD; Greensboro, NC	Secretary
† Douglas E. Scott, MD; Lexington, KY	Treasurer

1965 Miami Beach, FL

† W. E. Kittredge, MD; New Orleans, LA	President
† Douglas E. Scott, MD; Lexington, KY	President-Elect
† David W. Goddard, MD; Daytona Beach, FL	Secretary
† Rafe Banks Jr., MD; Gainesville, GA	Treasurer

1966 Memphis, TN

† Douglas E. Scott, MD; Lexington, KY	President
† Louis C. Roberts, MD; Greensboro, NC	President-Elect
† David W. Goddard, MD; Daytona Beach, FL	Secretary
† Rafe Banks Jr., MD; Gainesville, GA	Treasurer

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1967 Hollywood, FL

†	Louis C. Roberts, MD; Greensboro, NC	President
†	Charles Reiser, MD; Atlanta, GA	President-Elect
†	David W. Goddard, MD; Daytona Beach, FL	Secretary
†	John T. Karaphillis, MD; Belleair, FL	Treasurer

1968 Atlanta, GA

†	Charles Reiser, MD; Atlanta, GA	President
†	David W. Goddard, MD; Daytona Beach, FL	President-Elect
†	R. Prosser Morrow Jr., MD; New Orleans, LA	Secretary
†	John T. Karaphillis, MD; Belleair, FL	Treasurer

1969 Hollywood Beach, FL

†	David W. Goddard, MD; Daytona Beach, FL	President
†	Henry Comfort Hudson, MD; Birmingham, AL	President-Elect
†	R. Prosser Morrow Jr., MD; New Orleans, LA	Secretary
†	Charlton P. Armstrong II, MD; Greenville, SC	Treasurer

1970 TS Hanseatic

†	Henry Comfort Hudson, MD; Birmingham, AL	President
†	Milton M. Coplan, MD; Miami, FL	President-Elect
†	R. Prosser Morrow Jr., MD; New Orleans, LA	Secretary
†	Charlton P. Armstrong II, MD; Greenville, SC	Treasurer

1971 Miami Beach, FL

†	Milton M. Coplan, MD; Miami, FL	President
†	R. Prosser Morrow Jr., MD; New Orleans, LA	President-Elect
†	Samuel S. Ambrose, MD; Atlanta, GA	Secretary
†	George W. Vickery, MD; Gulfport, MS	Treasurer

1972 New Orleans, LA

†	R. Prosser Morrow, Jr., MD; New Orleans, LA	President
†	Charlton P. Armstrong II, MD; Greenville, SC	President-Elect
†	Samuel S. Ambrose, MD; Atlanta, GA	Secretary
†	George W. Vickery, MD; Gulfport, MS	Treasurer

1973 Palm Beach, FL

†	Charlton P. Armstrong II, MD; Greenville, SC	President
†	Hurbert K. Turley, MD; Memphis, TN	President-Elect
†	Samuel S. Ambrose, MD; Atlanta, GA	Secretary
†	Victor A. Politano, MD; N. Miami, FL	Treasurer

1974 Marco Island, FL

†	Hurbert K. Turley, MD; Memphis, TN	President
†	Samuel S. Ambrose, MD; Atlanta, GA	President-Elect
†	William Brannan, MD; The Woodlands, TX	Secretary
†	Victor A. Politano, MD; N. Miami, FL	Treasurer

1975 Atlanta, GA

†	Samuel S. Ambrose, MD; Atlanta, GA	President
†	Rafe Banks Jr., MD; Gainesville, GA	President-Elect
†	William Brannan, MD; The Woodlands, TX	Secretary
†	Victor A. Politano, MD; N. Miami, FL	Treasurer

1976 Hollywood, FL

†	Rafe Banks Jr., MD; Gainesville, GA	President
†	James F. Glenn, MD; Versailles, KY	President-Elect
†	William Brannan, MD; The Woodlands, TX	Secretary
†	John I. Williams, MD; Fort Lauderdale, FL	Treasurer

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1977 New Orleans, LA

†	James F. Glenn, MD; Versailles, KY	President
†	William Brannan, MD; The Woodlands, TX	President-Elect
†	Miles W. Thomley, MD; Winter Park, FL	Secretary
†	John I. Williams, MD; Fort Lauderdale, FL	Treasurer

1978 Louisville, KY

†	William Brannan, MD; The Woodlands, TX	President
†	Victor A. Politano, MD; N. Miami, FL	President-Elect
†	Miles W. Thomley, MD; Winter Park, FL	Secretary
†	John I. Williams, MD; Fort Lauderdale, FL	Treasurer

1979 Memphis, TN

†	Victor A. Politano, MD; N. Miami, FL	President
†	Joseph Ward Hooper Jr., MD; Wilmington, NC	President-Elect
†	Miles W. Thomley, MD; Winter Park, FL	Secretary
†	Fontaine Bruce Moore Jr., MD; Memphis, TN	Treasurer

1980 San Juan, Puerto Rico

†	Joseph Ward Hooper Jr., MD; Wilmington, NC	President
†	Miles W. Thomley, MD; Winter Park, FL	President-Elect
	W. Lamar Weems, MD; Jackson, MS	Secretary
†	Fontaine Bruce Moore Jr., MD; Memphis, TN	Treasurer

1981 Lake Buena Vista, FL

†	Miles W. Thomley, MD; Winter Park, FL	President
†	John I. Williams, MD; Fort Lauderdale, FL	President-Elect
	W. Lamar Weems, MD; Jackson, MS	Secretary
†	Fontaine Bruce Moore Jr., MD; Memphis, TN	Treasurer

1982 New Orleans, LA

†	John I. Williams, MD; Fort Lauderdale, FL	President
	Eugene C. St. Martin, MD; Shreveport, LA	President-Elect
	W. Lamar Weems, MD; Jackson, MS	Secretary
	Edward H. Ray Jr., MD; Lexington, KY	Treasurer

1983 Haines City, FL

	Eugene C. St. Martin, MD; Shreveport, LA	President
	W. Lamar Weems, MD; Jackson, MS	President-Elect
	William Redd Turner Jr., MD; Folly Beach, SC	Secretary
	Edward H. Ray Jr., MD; Lexington, KY	Treasurer

1984 Nashville, TN

	W. Lamar Weems, MD; Jackson, MS	President
†	Fontaine Bruce Moore Jr., MD; Memphis, TN	President-Elect
	William Redd Turner Jr., MD; Folly Beach, SC	Secretary
	Edward H. Ray Jr., MD; Lexington, KY	Treasurer

1985 Marco Island, FL

†	Fontaine Bruce Moore Jr., MD; Memphis, TN	President
	Jack Hughes, MD; Durham, NC	President-Elect
	William Redd Turner Jr., MD; Folly Beach, SC	Secretary
†	Robert N. Webster, MD; Tallahassee, FL	Treasurer

1986 Dorado Beach, Puerto Rico

	Jack Hughes, MD; Durham, NC	President
	William Redd Turner Jr., MD; Folly Beach, SC	President-Elect
†	David M. Drylie, MD; Gainesville, FL	Secretary
†	Robert N. Webster, MD; Tallahassee, FL	Treasurer

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1987 New Orleans, LA

	William Redd Turner Jr., MD; Folly Beach, SC	President
	Roy Witherington, MD; Sarasota, FL	President-Elect
†	David M. Drylie, MD; Gainesville, FL	Secretary
†	Robert N. Webster, MD; Tallahassee, FL	Treasurer

1988 Boca Raton, FL

	Roy Witherington, MD; Sarasota, FL	President
	Edward H. Ray Jr., MD; Lexington, KY	President-Elect
†	David M. Drylie, MD; Gainesville, FL	Secretary
†	Robert B. Quattlebaum Jr., MD; Savannah, GA	Treasurer

1989 Hilton Head, SC

	Edward H. Ray Jr., MD; Lexington, KY	President
†	David M. Drylie, MD; Gainesville, FL	President-Elect
†	Lloyd H. Harrison, MD; Tobaccoville, NC	Secretary
†	Robert B. Quattlebaum Jr., MD; Savannah, GA	Treasurer

1990 Palm Beach, FL

†	David M. Drylie, MD; Gainesville, FL	President
†	Robert N. Webster, MD; Tallahassee, FL	President-Elect
†	Lloyd H. Harrison, MD; Tobaccoville, NC	Secretary
†	Robert B. Quattlebaum Jr., MD; Savannah, GA	Treasurer

1991 Atlanta, GA

†	Robert N. Webster, MD; Tallahassee, FL	President
†	Josiah F. Reed Jr., MD; Montgomery, AL	President-Elect
†	Lloyd H. Harrison, MD; Tobaccoville, NC	Secretary
	James C. Seabury Jr., MD; Fort Myers Beach, FL	Treasurer

1992 Charlotte, NC

†	Josiah F. Reed Jr., MD; Montgomery, AL	President
†	Lloyd H. Harrison, MD; Tobaccoville, NC	President-Elect
	J. William McRoberts, MD; Lexington, KY	Secretary
	James C. Seabury Jr., MD; Fort Myers Beach, FL	Treasurer

1993 Nashville, TN

†	Lloyd H. Harrison, MD; Tobaccoville, NC	President
†	Robert B. Quattlebaum Jr., MD; Savannah, GA	President-Elect
	J. William McRoberts, MD; Lexington, KY	Secretary
	James C. Seabury Jr., MD; Fort Myers Beach, FL	Treasurer

1994 New Orleans, LA

†	Robert B. Quattlebaum Jr., MD; Savannah, GA	President
	Thomas C. McLaughlin, MD; Lakeland, FL	President-Elect
	J. William McRoberts, MD; Lexington, KY	Secretary
†	Hector H. Henry II, MD, MPH, MS; Salisbury, NC	Treasurer

1995 Lake Buena Vista, FL

	Thomas C. McLaughlin, MD; Lakeland, FL	President
	J. William McRoberts, MD; Lexington, KY	President-Elect
	David L. McCullough, MD; Winston-Salem, NC	Secretary
†	Hector H. Henry II, MD, MPH, MS; Salisbury, NC	Treasurer

1996 Las Croabas, Puerto Rico

	J. William McRoberts, MD; Lexington, KY	President
	James C. Seabury Jr., MD; Fort Myers Beach, FL	President-Elect
	David L. McCullough, MD; Winston-Salem, NC	Secretary
†	Hector H. Henry II, MD, MPH, MS; Salisbury, NC	Treasurer

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1997 Naples, FL

James C. Seabury Jr., MD; Fort Myers Beach, FL	President
Cecil Morgan Jr., MD; Birmingham, AL	President-Elect
David L. McCullough, MD; Winston-Salem, NC	Secretary
Valentine A. Earhart, MD; New Orleans, LA	Treasurer

1998 Birmingham, AL

Cecil Morgan Jr., MD; Birmingham, AL	President
David L. McCullough, MD; Winston-Salem, NC	President-Elect
Anton J. Bueschen, MD; Atlanta, GA	Secretary
Valentine A. Earhart, MD; New Orleans, LA	Treasurer

1999 Charleston, SC

David L. McCullough, MD; Winston-Salem, NC	President
William F. Gee, MD; Lexington, KY	President-Elect
Anton J. Bueschen, MD; Atlanta, GA	Secretary
Valentine A. Earhart, MD; New Orleans, LA	Treasurer

2000 Orlando, FL

William F. Gee, MD; Lexington, KY	President
† Hector H. Henry II, MD, MPH, MS; Salisbury, NC	President-Elect
Anton J. Bueschen, MD; Atlanta, GA	Secretary
B. Thomas Brown, MD, MBA; Daytona Beach, FL	Treasurer

2001 New Orleans, LA

† Hector H. Henry II, MD, MPH, MS; Salisbury, NC	President
William F. Gee, MD; Lexington, KY	Past President
Anton J. Bueschen, MD; Atlanta, GA	President-Elect
Joseph A. Smith Jr., MD; Nashville, TN	Secretary
B. Thomas Brown, MD, MBA; Daytona Beach, FL	Treasurer

2002 Naples, FL

Anton J. Bueschen, MD; Atlanta, GA	President
† Hector H. Henry II, MD, MPH, MS; Salisbury, NC	Past President
Valentine A. Earhart, MD; New Orleans, LA	President-Elect
Joseph A. Smith Jr., MD; Nashville, TN	Secretary
B. Thomas Brown, MD, MBA; Daytona Beach, FL	Treasurer

2003 Savannah, GA

Valentine A. Earhart, MD; New Orleans, LA	President
Anton J. Bueschen, MD; Atlanta, GA	Past President
B. Thomas Brown, MD, MBA; Daytona Beach, FL	President-Elect
Joseph A. Smith Jr., MD; Nashville, TN	Secretary
Edward O. Janosko, MD; Wilmington, NC	Treasurer

2004 Oranjestad, Aruba

B. Thomas Brown, MD, MBA; Daytona Beach, FL	President
Valentine A. Earhart, MD; New Orleans, LA	Past President
Joseph A. Smith Jr., MD; Nashville, TN	President-Elect
Dennis D. Venable, MD; Shreveport, LA	Secretary
Edward O. Janosko, MD; Wilmington, NC	Treasurer

2005 Charleston, SC

Joseph A. Smith Jr., MD; Nashville, TN	President
B. Thomas Brown, MD, MBA; Daytona Beach, FL	Past President
Culley C. Carson III, MD; Chapel Hill, NC	President-Elect
Dennis D. Venable, MD; Shreveport, LA	Secretary
Edward O. Janosko, MD; Wilmington, NC	Treasurer

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2006 Rio Grande, Puerto Rico

Culley C. Carson III, MD; Chapel Hill, NC	President
Joseph A. Smith Jr., MD; Nashville, TN	Past President
Edward O. Janosko, MD; Wilmington, NC	President-Elect
Dennis D. Venable, MD; Shreveport, LA	Secretary
Thomas F. Stringer, MD, FACS; Gainesville, FL	Treasurer

2007 Lake Buena Vista, FL

Edward O. Janosko, MD; Wilmington, NC	President
Culley C. Carson III, MD; Chapel Hill, NC	Past President
Dennis D. Venable, MD; Shreveport, LA	President-Elect
Raju Thomas, MD, FACS, MHA; New Orleans, LA	Secretary
Thomas F. Stringer, MD, FACS; Gainesville, FL	Treasurer

2008 San Diego, CA

Dennis D. Venable, MD; Shreveport, LA	President
Edward O. Janosko, MD; Wilmington, NC	Past President
† Martin K. Dineen, MD; Daytona Beach, FL	President-Elect
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FUTURE SESAUA MEETINGS

88th Annual Meeting of the Southeastern Section of the AUA

March 20 - 23, 2024

Marriott Austin Downtown

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