Predicting Treatment Success at Time of Referral for Sacral Neuromodulation for Overactive Bladder (1)

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1. AIMS & OBJECTIVES

Sacral neuromodulation (SNM) is performed for overactive bladder (OAB) symptoms and despite its overall efficacy, identifying reliable predictors of treatment success remains challenging.

This study aims to evaluate clinical predictors of SNM trial and implant success in patients referred to a tertiary UK centre.

2. METHODS

A retrospective audit was conducted of all patients referred for SNM for OAB between 2018 and 2023 at a tertiary UK centre.

Patients who underwent 1-stage percutaneous nerve evaluation (PNE) and/or SNM implantation were included. 156 patients (131 female, 25 male) were included.

Clinical and demographic data were extracted from electronic patient records.

Variables assessed: Age, BMI, neurological history, psychiatric history, cardiac history, smoking history, hypertension, stroke history, migraine, peripheral neuropathy, diabetes, urge incontinence, prior gynaecological surgery, and associated pain.

Trial success was defined as improvement in symptoms leading to listing for SNM implant. Implant success was defined by documented patient and clinician satisfaction in symptoms in clinic correspondence up to 12 months post procedure.

Statistical analysis, including univariate and multivariate logistic regression, was performed using R Studio.

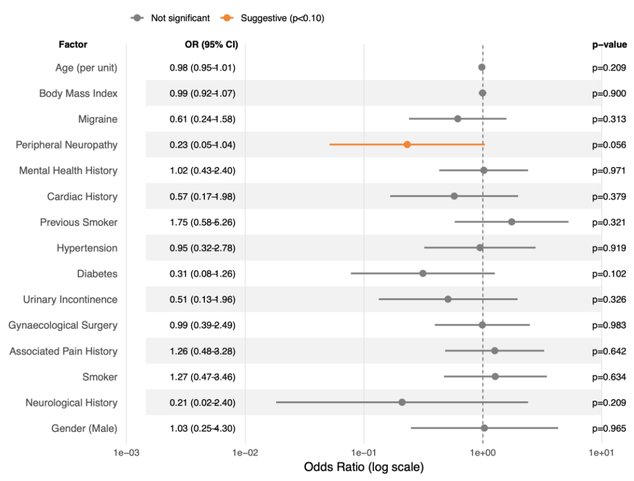
3. RESULTS

Variable	Odds Ratio	95% CI Lower	95% CI Upper	P-value
Age	0.962	0.941	0.984	<0.001
Body Mass Index	1.003	0.951	1.058	0.900
Neurological History	0.350	0.074	1.656	0.185
Migraine	1.859	0.650	5.316	0.247
Peripheral Neuropathy	2.343	0.281	19.508	0.431
Mental Health History	2.226	0.939	5.278	0.069
Cardiac History	0.525	0.180	1.529	0.237
Current Smoker	1.481	0.392	5.596	0.562
Previous Smoker	1.147	0.323	4.080	0.832
Hypertension	0.555	0.236	1.305	0.177
Diabetes Mellitus	0.606	0.171	2.153	0.439
Urinary Incontinence	1.604	0.667	3.856	0.291
Gynaecological Surgery	0.682	0.269	1.733	0.422
Associated Pain History	1.020	0.438	2.371	0.964

Table 1. *Univariate Logistic Regression Analysis of SNM Trial Success*

Table 2. *Univariate Logistic Regression Analysis of SNM Implant Success*

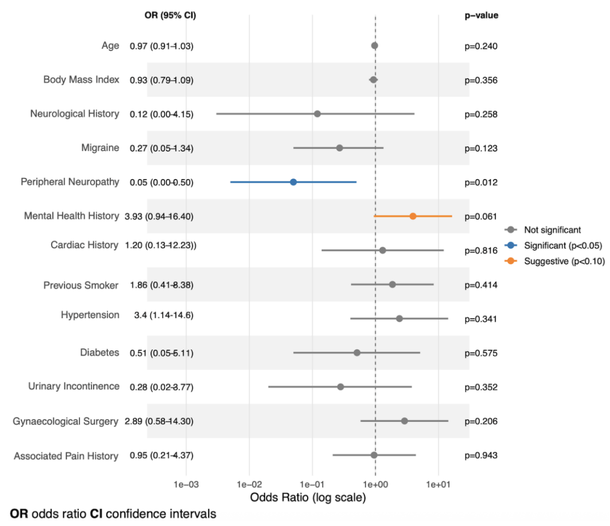
Variable	Odds Ratio	95% CI Lower	95% CI Upper	P-value
Age	0.981	0.951	1.011	0.209
Body Mass Index	0.995	0.923	1.073	0.900
Neurological History	0.209	0.018	2.399	0.209
Migraine	0.615	0.239	1.581	0.313
Peripheral Neuropathy	0.231	0.051	1.038	0.056
Mental Health History	1.016	0.429	2.403	0.971
Cardiac History	0.574	0.166	1.980	0.379
Current Smoker	1.274	0.470	3.457	0.634
Previous Smoker	1.747	0.580	5.261	0.321
Hypertension	0.946	0.321	2.783	0.919
Diabetes Mellitus	0.313	0.078	1.259	0.102
Urinary Incontinence	0.509	0.133	1.957	0.326
Gynaecological Surgery	0.990	0.394	2.489	0.983
Associated Pain History	1.255	0.481	3.278	0.642
Gender (Male)	1.033	0.248	4.300	0.965



OR odds ratio **CI** confidence intervals

Figure 1. *Forest plot showing adjusted multivariate odds ratios for trial success using baseline referral factors*

Figure 2. *Forest plot showing adjusted multivariate odds ratios for implant success using baseline referral factors*



OR odds ratio **CI** confidence intervals

Trial success was achieved in 69.0% (109/158), with 71.1% of these having successful implant

Univariate logistic regression analyses of trial success: increasing age was significantly associated with unsuccessful outcomes (p<0.001). In contrast, mental health history was associated with trial success, showing a trend towards significance (p=0.07).

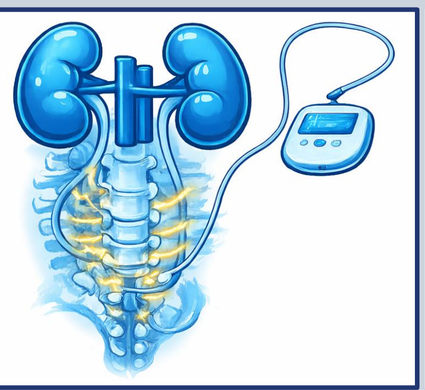
Multivariate logistic regression analyses of trial success: increasing age showed an association with poor outcomes, however, did not reach statistical significance (p=0.07). High BMI showed positive association with trial success, approaching statistical significance (p=0.06).

Univariate logistic regression analyses of implant success: peripheral neuropathy was associated with worse outcomes for SNM and demonstrated a trend toward significance (p=0.06)

Multivariate logistic regression analyses of implant success: peripheral neuropathy was inversely associated with successful implant outcomes (p=0.01). Mental health history showed a positive association with implant success, demonstrating a trend toward significance (p=0.06).

4. CONCLUSIONS

- SNM demonstrates high effectiveness in patients with refractory OAB.
- Increasing age and peripheral neuropathy may negatively influence treatment outcomes, while higher BMI and mental health history may be associated with better response.
- These findings could help refine patient selection for SNM therapy.
- Further prospective studies with larger cohorts are recommended to validate these associations and refine predictive models for SNM outcomes.



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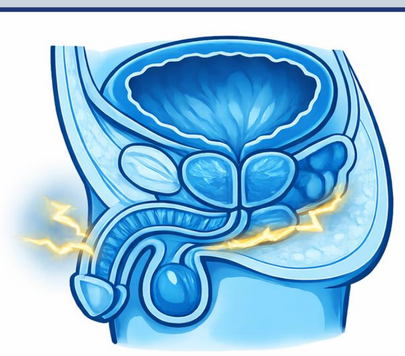

THE ASSOCIATION BETWEEN BLADDER OUTLET OBSTRUCTION, POST-VOID RESIDUAL AND THE INCIDENCE OF BLADDER CANCER: A PROSPECTIVE MULTICENTRE STUDY (2)

Sponsored by Action Bladder Cancer UK | IRAS ID 292684

AUTHORS

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Action Bladder Cancer UK

01. INTRODUCTION

Bladder cancer remains a common malignancy with substantial health and economic burden, largely due to high recurrence rates and the need for prolonged cystoscopic surveillance (1).

Although established risk factors include smoking, occupational carcinogens, chronic bladder irritation, radiotherapy and cyclophosphamide exposure, many older men present without these clear antecedents, suggesting additional contributors to urothelial carcinogenesis (1).

Benign prostatic hyperplasia (BPH) and bladder outlet obstruction (BOO) are highly prevalent with ageing and frequently result in incomplete bladder emptying and elevated post-void residual (PVR) volumes (2). Prolonged urinary stasis may increase urothelial exposure to carcinogens, while obstruction-related inflammation may promote a pro-tumour microenvironment (3).

Observational and genetic studies support an association between BPH and bladder cancer, yet current guidelines do not recognise BOO or PVR as risk factors (1,4,5).

AIMS & OBJECTIVES

Our primary aim was to determine whether incomplete bladder emptying, measured by post-void residual (PVR), is associated with a diagnosis of bladder cancer in patients presenting to haematuria clinics. Secondary aims were to (1) explore whether higher PVR is associated with adverse tumour features including stage, grade and presence of carcinoma in situ, and (2) assess whether objective voiding parameters, particularly maximum flow rate (Qmax), correlate with PVR and bladder cancer risk.

02. METHODOLOGY

We conducted a prospective multicentre observational study across four NHS haematuria clinics (2020–2024), recruiting consecutive referrals aged ≥40 with visible or non-visible haematuria.

- **PVR measurement:** bedside bladder ultrasound; two same-day readings where feasible (mean used)
- **Index assessment:** standard haematuria work-up (imaging + flexible cystoscopy)
- **Outcome:** bladder cancer diagnosis confirmed histologically and tumour characteristics
- **Secondary measure (men):** uroflowmetry (Qmax)
- **Analysis:** PVR as continuous and ≥50 mL threshold; Wilcoxon rank-sum and χ^2 tests; no multivariable regression due to limited cancer events

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03. RESULTS

A total of 239 patients were recruited (mean age 63.7 years, 53.6% male); 19 (8.0%) were diagnosed with bladder cancer.

- PVR was higher in cancer patients than non-cancer patients (16 mL [IQR 1.8–77.8] vs 2 mL [0.0–21.8]; p = 0.002) but not clinically relevant.
- When dichotomised ≥50 mL, elevated PVR was more than twice as common in bladder cancer cases (31.6% vs 13.2%), but this association did not reach statistical significance (p = 0.068).
- No associations were observed between PVR and tumour stage, grade or presence of carcinoma in situ (CIS), nor between PVR and Qmax.

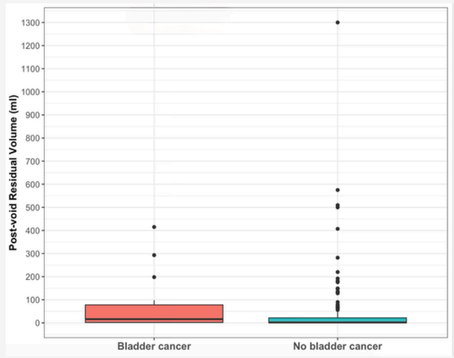

Figure 1. Boxplot of post-void residual (PVR) in patients with and without bladder cancer. Median PVR was higher in bladder cancer patients (16.0 mL [IQR 1.8–77.8]) than in non-cancer patients (2.0 mL [0.0–21.8]; p = 0.002).

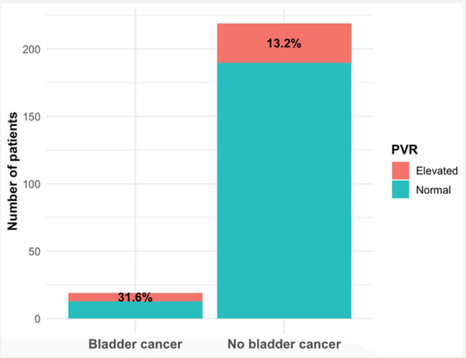

Figure 2. Proportion of patients with elevated (≥50 mL) and normal (<50 mL) post-void residual (PVR) in bladder cancer and non-cancer groups. Elevated PVR was observed in 31.6% of bladder cancer patients versus 13.2% of non-cancer patients (χ^2 test, p = 0.068).

04. DISCUSSION

Prior studies support an association between BPH/BOO and bladder cancer: population cohorts and a meta-analysis suggests a ~1.6–2× higher risk (4). In established non-muscle-invasive bladder cancer, higher PVR has been associated with shorter recurrence-free survival in some studies (3).

To our knowledge, this is the first prospective study to examine PVR and bladder cancer incidence at initial presentation in a haematuria cohort. Bladder cancer patients demonstrated higher PVR than non-cancer patients, with a trend towards increased risk above 50 mL that approached statistical significance.

These preliminary findings support a potential link between incomplete bladder emptying and bladder cancer, but larger, higher-powered studies are required to determine whether PVR represents an independent risk factor.

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3. Fertility Outcomes Following Varicocelectomy in Men with Subclinical Varicocele

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Introduction

Background

- Varicocele is a common finding in infertile men and surgical repair is established for clinical varicocele with abnormal semen parameters (1)
- Subclinical varicocele, defined as a non-palpable lesion detected only on imaging, is frequently identified during infertility work-up (2)
- The fertility benefit of varicocelectomy in subclinical disease remains uncertain and current guidelines advise against routine intervention (3,4)

Aim

- To evaluate reproductive outcomes following varicocelectomy in infertile men with subclinical varicocele, with a focus on:
    - Pregnancy outcomes
    - Post-operative semen parameters

Methods

- Systematic review conducted in accordance with PRISMA 2020
- Inclusion criteria:
    - Infertile men with non-palpable, imaging-diagnosed subclinical varicocele
    - Varicocelectomy of any surgical technique
- Outcomes:
    - Pregnancy rates (where reported)
    - Semen parameters (concentration, motility, morphology, total motile count)
- Risk of bias assessed using RoB 2 and Newcastle–Ottawa Scale
- Narrative synthesis performed due to heterogeneity
- Certainty of evidence assessed using GRADE

Results

Figure 1.
Flow Diagram of Study Selection

- 12 studies included (5-16)
- 477 men underwent varicocelectomy
- Study designs:
    - 3 randomised controlled trials
    - 6 prospective cohort studies
    - 3 retrospective cohort studies

Figure 2.
Pregnancy Outcomes

Figure 3.
Semen Parameter Outcomes

Discussion

- Semen parameter improvements were variable, with sperm concentration showing the most consistent post-operative improvement
- Pregnancy outcomes were reported in only 4 studies and showed wide variation, with no statistically significant differences
- Considerable heterogeneity in study design and outcome reporting limits comparability between studies
- Incomplete reporting of effect estimates and dispersion measures precluded quantitative synthesis and meta-analysis

Conclusion

- Varicocelectomy may be associated with modest improvements in selected semen parameters
- A reliable fertility benefit has not been demonstrated
- The low to very low certainty of evidence supports current guideline recommendations against routine surgical intervention for subclinical varicocele

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Evaluating the Clinical Impact of Ureteral Frozen Section Analysis During Radical Cystectomy: A Single-Center Retrospective Study (6)

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Introduction

Conventionally, urologists are trained to do frozen section analysis (FSA) at the time of radical cystectomy to ensure the ureteric margins are clear of cancer. This is thought to reduce the chances of local recurrence and arguably **upper urinary tract recurrence UUTR**.

The objective of this study is to find out

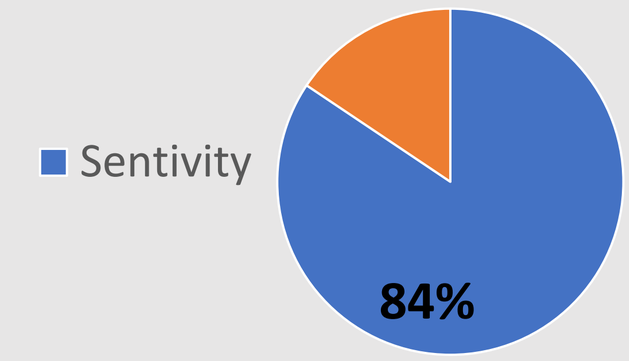
- ❖ If there are any differences in upper urinary tract recurrence and overall mortality between patients who underwent a frozen section analysis during radical cystectomy and those who did not.
- ❖ Assess specify and sensitivity of frozen section analysis.

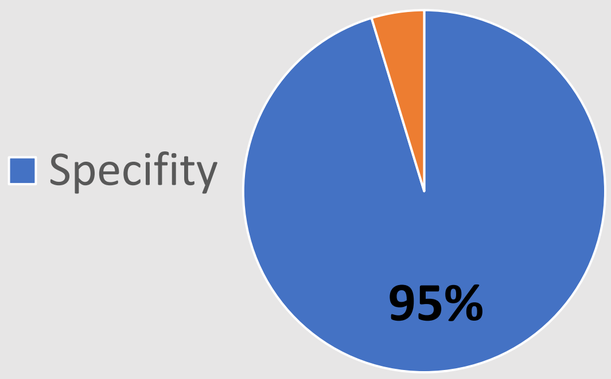
Methods

- Observational retrospective cohort study
- We evaluated data from 164 patients who underwent radical cystectomy in our institution over a five-year period from 2013 to 2018 (The final study cohort comprised 119 patients).
- Basic demographic, clinical, pathological, perioperative, and oncological features were collected retrospectively.
- We compared those who had intra-operative FSA of the ureters and those who did not
- The sensitivity (SN) and specificity (SP) of FSA were calculated.
- We evaluated UUTR in these patients after a median follow-up period of 69 months with a minimum duration of 10 months and a maximum duration of 124 months.

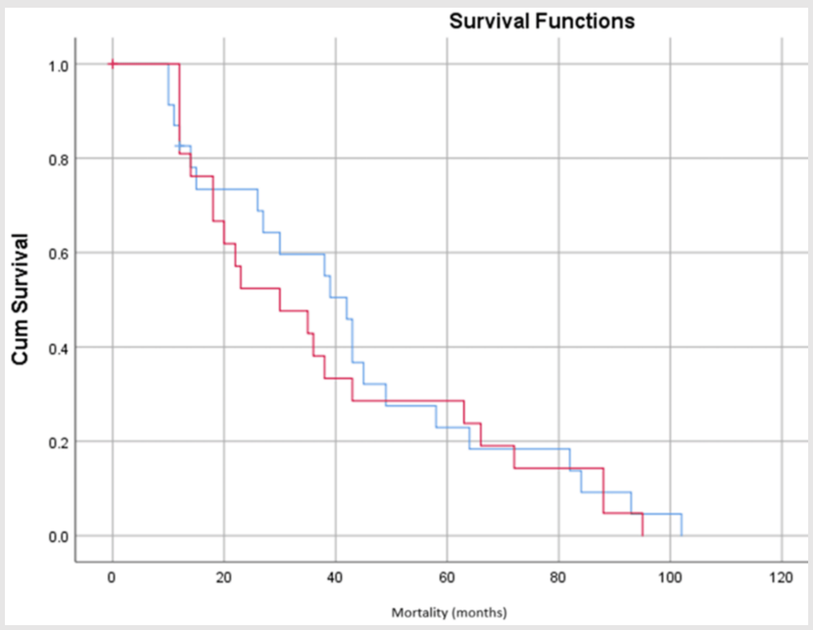
Results

The total number of patients was 164, of which 78 patients had intra-operative FSA of the ureters, while 86 did not.





The Kaplan-Meier test was used to evaluate any differences in survival over time in relation to performing an FSA. The analysis showed no statistically significant relationship between performing an FSA and overall mortality, with a log-rank (Mantel-Cox) value of 0.651



- ❖ The overall mortality rate was 45 patients (37.8%) over a 35-month period.
- ❖ There was no statistically significant relationship between performing an FSA and UUTR, as indicated by Fisher's exact test (p=0.619).

	With Frozen section analysis (61)	Without Frozen section analysis (58)
UUTR	3 (4%)	1 (1.7%)

Discussion

- The overall upper urinary tract recurrence after radical cystectomy is reported to be 2-6%, consistent with the **3.3% observed in our study.**
- Mukha et al. noted that ureteral resection to achieve a negative margin on FSA did not appear to prevent upper tract recurrence and concluded that routine FSA may not be necessary for most patients undergoing RC [1]. Similarly, Schumacher et al. stated that if the ureters were resected at the point where they cross the common iliac vessels, ureteric FSA would be unnecessary [2].
- The current study did not show any differences in the risk of UUTR between the two cohorts. This led to a change in our practice in our institution to omit routine FSA and resect the ureters at the level of the common iliac artery during RC.

Conclusion

Although FSA is sensitive and specific in detecting dysplasia, our data shows that there was **no difference in upper urinary tract recurrences or mortality between the patients who had FSA and those who did not**. Even yet, our study has limitations. Future multicenter studies and systemic reviews will be helpful in providing a more definitive conclusion about this topic.

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The Addition of Naloxegol to ERAS vs. ERAS Alone in Patients Post-Robot-Assisted Radical Cystectomy – A Longitudinal Study (10)

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Introduction

Post-operative ileus (POI) affects up to 24% of patients undergoing cystectomy & ileal conduit diversion (1).

It is a significant cause of morbidity and prolonged hospital stay.

Opioid-based analgesia, as part of enhanced recovery after surgery (ERAS) protocols, contribute significantly to POI (2,3).

μ-opioid receptor antagonists, such as Naloxegol, have been shown to reduce POI in randomised controlled trials, however, its effectiveness in reducing POI following cystectomy and as an addition to ERAS remains unclear (4,5).

We therefore aimed to investigate whether the addition of Naloxegol to ERAS protocols have a beneficial effect on post-operative outcomes compared to ERAS protocols alone.

Methods

- Prospective design
- Patients undergoing robot-assisted radical cystectomy and intracorporeal ileal conduit diversion (RARC), in a large tertiary teaching hospital
- Three operating surgeons
- 130 consecutive cases between 18/10/2021 – 23/06/2025
- Group A received ERAS only and Group B received ERAS and Naloxegol for up to 7 days
- Naloxegol was prescribed as 25mg (12.5mg if GFR <30) by mouth, once daily, to commence on the morning of surgery and to continue until bowels open or up to a maximum of seven days

- Primary outcome was incidence of POI
    - Assessed by time to pass flatus and bowels opening

- Secondary outcomes included:
    - Length of stay (LoS), vomiting, Ryles tube insertion, Clavien-Dindo complications ≥2 and 30-day readmission rates

Results

Table 1. Population Demographics

	ERAS Alone	Naloxegol + ERAS
Total Patients	89 (M72, F17)	41 (M24, F17)
Age (median years)	69 (62,75)	72 (65,74)
ASA (median)	2 (2,3)	2 (2,3)
Charlson Comorbidity Score (Median)	5 (4,6)	6 (5,6)

Table 2. Secondary Outcomes

	ERAS Alone	Naloxegol + ERAS
LoS (median days)	7 (5,10)	8 (7,11)
Vomiting	37 (42%)	16 (39%)
Ryles tube insertions	25 (28%)	9 (22%)
Clavien-Dindo ≥2	3	6
30-day readmissions	15 (n=84)	5 (n=41)

Table 2. LoS: t 0.32, p 0.75; Ryles tube insertions: Incidence rate difference 0.06, 95% Confidence Interval -0.13 to 0.25, p 0.52; Vomiting: Incidence rate difference 0.03, 95% Confidence Interval -0.21 to 0.26, p 0.83

Figure 1. A Box and Whisker Plot Showing Primary Outcomes

Figure 1. Time to pass flatus: t -1.37, p 0.17; Time to open bowels: t -0.28, p 0.78

Discussion

- Whilst we did not demonstrate significant improvements in primary or secondary outcomes, the addition of ERAS to Naloxegol appears safe

- Key limitations of this study include:
    - No randomisation of participants
    - Single patient group (RARC)
    - Single centre
    - Reliance on accuracy of documentation of outcome measures in clinical notes

Conclusion

The addition of Naloxegol to ERAS is safe, but does not appear to improve POI or LoS.
Further research is required to assess if earlier administration of Naloxegol before surgery improves outcomes.

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Post-Discharge Urine Culture Follow-Up in Urology: A Local Audit (12)

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Introduction

Due to high patient turnover, many inpatient urine culture results have not returned prior to discharge. Missed culture review can lead to incorrect antibiotics use, increasing the risk of partially treated infections, urosepsis, increasing rates of readmission and antibiotic resistance.

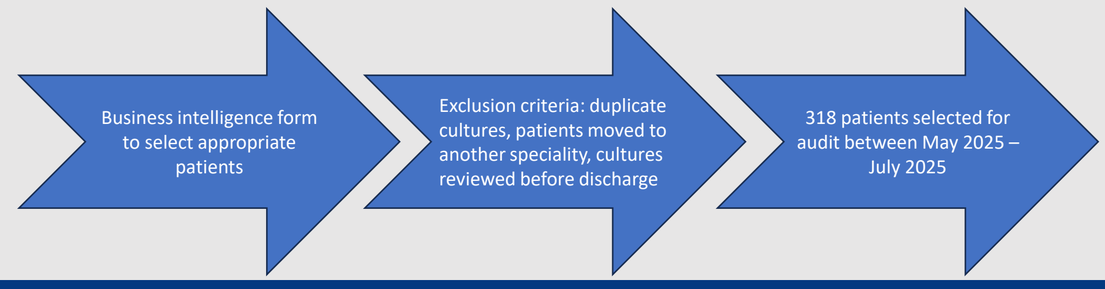
This audit aimed to evaluate whether urine cultures are reviewed post-discharge as per the following guidelines:

- **NICE NG109:** Review the choice of antibiotic and change to a narrow-spectrum one where possible [1]
- **BMA 'Acting upon electronic test results':** There must be clear processes in place so that test results are reviewed and acted on even if the patient is discharged [2]
- **CQC Regulation 12 and 17:** Test results should be communicated effectively; Patients should be contacted if the result needs actioning [3]

Methods

A retrospective audit was conducted on urine culture results from Urology patients discharged within 48h from our Surgical Assessment Unit between May-July 2025. Microbiology results, discharge letters, and electronic prescribing was reviewed.

Patients with admissions longer than 48 hours were excluded. Duplicate urine cultures were excluded. Where there was clear evidence to suggest the urine culture had returned and was reviewed prior to discharge, this was also excluded.



Results and Outcomes

Of the 318 patients included, 68 had positive urine cultures:

- 38 (55.9%) were discharged on the right antibiotics
- 12 (17.6%) were discharged on antibiotics the pathogen was resistant to
- 6 (8.8%) Had no documentation of discharge antibiotics
- 11 (16.2%) Received no antibiotics
- 1 patient self-discharged

None of the cases (0) had documentation to indicate results had been followed up..

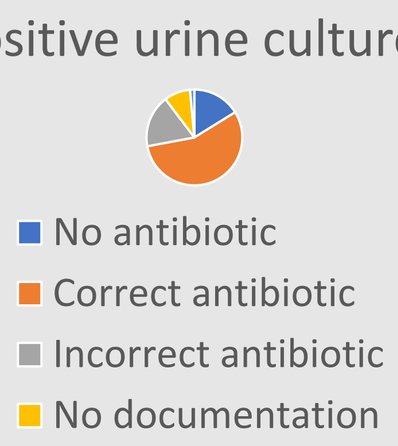


Figure 1: Outcomes of positive urine cultures

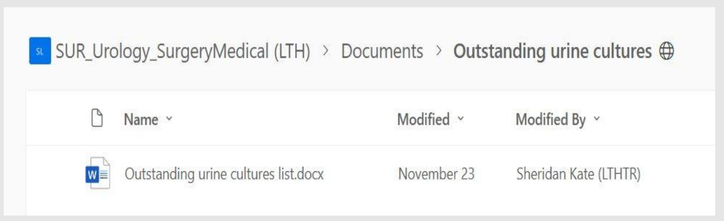


Figure 2: Example document in team's files

To keep track of pending cultures, we created a departmental shared document called 'Outstanding urine cultures'.

Patients discharged with an outstanding culture will be documented in this table, including their name, hospital number and the antibiotic discharged on.

This audit was presented in the departmental meeting to create awareness. A twice weekly review interval was agreed for culture results by resident doctors.

These cultures will be reviewed and patients contacted if further actions are necessary, with a short entry being written on the online system.

The poster below was created and placed in common spaces to remind team members to actively engage with adding patients to the review list and as a reminder for resident doctors to check and review patients on the list to keep it up to date.

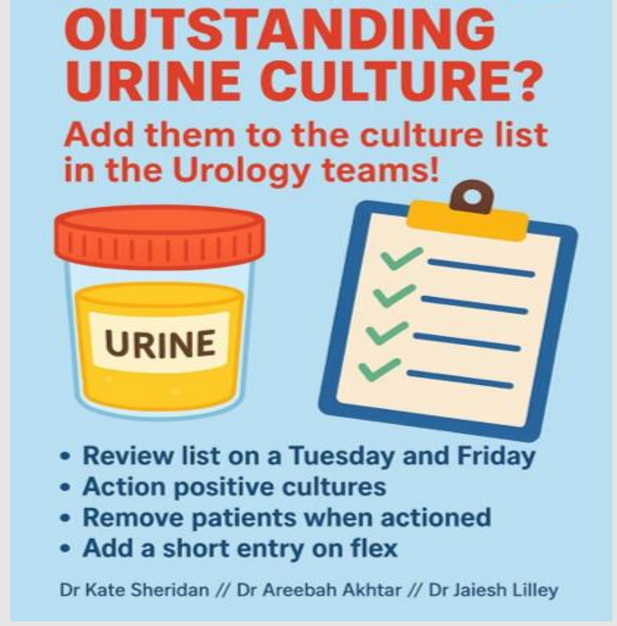


Figure 3: Poster explaining outstanding culture follow up process

Discussion

The North-West has some of the highest rates of antibiotic-resistance in England, highlighting the need for prompt review of urine culture results to ensure patient safety and antimicrobial stewardship. Despite this, follow-up processes vary widely across the region.

Over a 3-month period in Royal Preston Hospital, 12 patients were sent home with incorrect antibiotics, and 11 patients were sent home with no antibiotics.

We aim to tackle ongoing issues with a standardised follow up process for patients with outstanding results, accessible to all urology doctors, with posters to raise awareness.

Conclusion

Follow-up of urine cultures post discharge is below the expected 100% standard, posing risks of missed/undertreated infection and contributing to rising antibiotic resistance. This highlights the need to implement processes to review and action urine cultures after discharge. A re-audit will be carried out in 3-4 months with the above changes in place and aim to see an improvement.

References

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MARK THIS ABSTRACT

Improving Diagnostic Accuracy and Pathway Impact of MRI Bladder for Muscle-Invasive Bladder Cancer: A Three-Cycle Quality Improvement Study (14)

Jehanli L[1], Bhiryani M[1], **Allam M[2]**, Thompson T[2], Starmer B[2], Hanchanale V[2], Keegan S[1]

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Introduction and Aims

Accurate staging of bladder cancer at initial presentation is critical to guide appropriate management. Conventional staging using Transurethral resection of bladder tumour (TURBT) alone can be associated with understaging. Multiparametric MRI bladder has emerged as a useful adjunct for local staging, particularly for muscle-invasive bladder cancer (MIBC).

Our aim was to evaluate the diagnostic accuracy of MRI bladder for detecting MIBC and assess whether iterative changes to MRI protocol and reporting improved staging accuracy and pathway performance over three audit cycles.

Methods

Design: Three cycle quality improvement study

CYCLE 1 (n=27): 2019-2021 → CYCLE 2 (n=24): November 2023-July 2024 → CYCLE 3 (n=24): August 2024-July 2025

Primary outcome: MRI T-stage (Muscle invasion) vs histopathology from TURBT or cystectomy

Secondary outcomes:

- Proportion of MRI performed **pre-TURBT**
- Median time to MRI from request
- Appropriateness of MRI request (local criteria)
- Proportion of CT chest completed prior to MDT

Results

Primary Outcome

- Concordance of muscle invasion between MRI and histology staging increased to 87.5% by cycle 3. (Figure 1)
- Specificity rose to 0.86 (literature 0.88)
- 4/4 cases accurately staged when compared to cystectomy (despite non-concordance with TURBT)

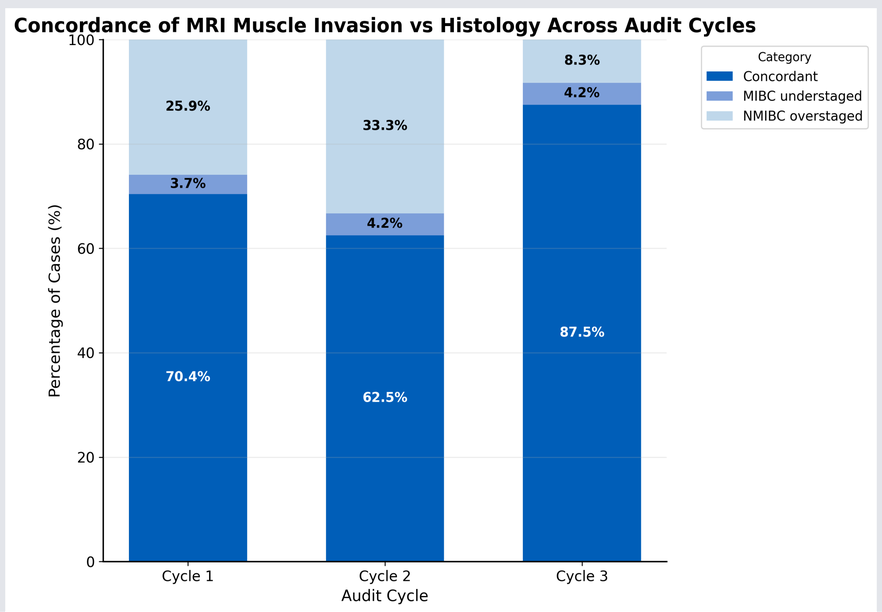

Figure 1. MRI–histology concordance for muscle invasion across audit cycles, demonstrating improved accuracy and reduced overstaging in Cycle 3 following pathway and reporting optimisation.

Changes implemented over 3 cycles

1) Change of MRI protocol to include coronal and axial diffusion weighed imaging (DWI) sequences
2) Reduced slice thickness of dynamic contrast sequence to allow multiplanar reformatting
3) Discussion to include VI-RADS while reporting
4) Increasing awareness of the availability of MRI bladder

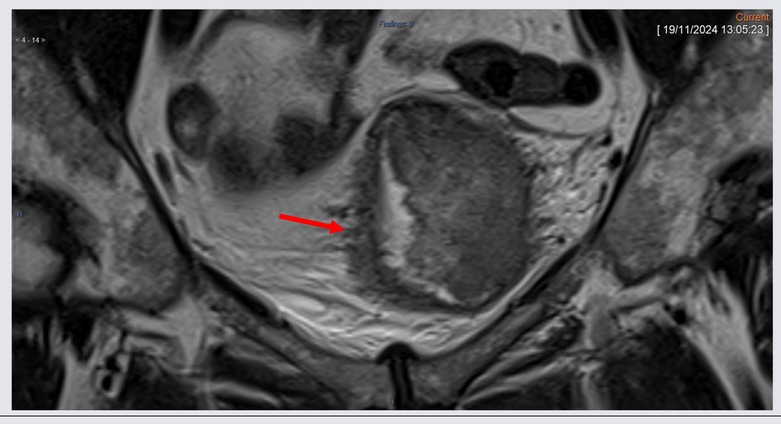

Figure 2: This lesion was staged as T1 on TURBT but there is clear extension of the lesion into the perivesical fat (red arrow). Subsequent cystectomy staged this as T3b.

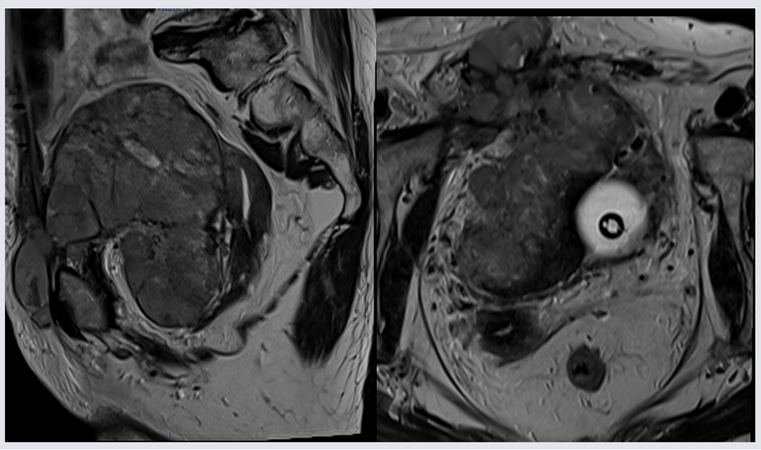

Figure 3: This lesion was staged as pT1 on TURBT but MRI shows extensive T4b disease.

Secondary outcomes (Cycle 3)

- 95.8% of MRI performed pre-TURBT
- 95.8% appropriate MRI requests for suspected MIBC
- Median time to MRI was 7 days
- Number of CT chests completed prior to MDT was 66.6%.

Discussion

Improvements in MRI diagnostic performance were observed following protocol optimisation and structured adoption of VI-RADS. These changes were associated with improved specificity for detecting MIBC.

Study Limitations:

- Small sample sizes
- Limited cases with cystectomy, results compared to TURBT (recognised under-staging)
- Limited MRI T stage and VIRADS documentation

Conclusion

- Diagnostic performance of MRI improves with protocol standardisation and VI-RADS adoption
- MRI can be successfully integrated into a MIBC pathway

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MARK THIS ABSTRACT

ONE-STOP MALE LOWER URINARY TRACT SYMPTOMS CLINIC: TWO-CYCLE AUDIT OF SERVICE QUALITY, EFFICIENCY & PATIENT OUTCOMES

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15

Introduction

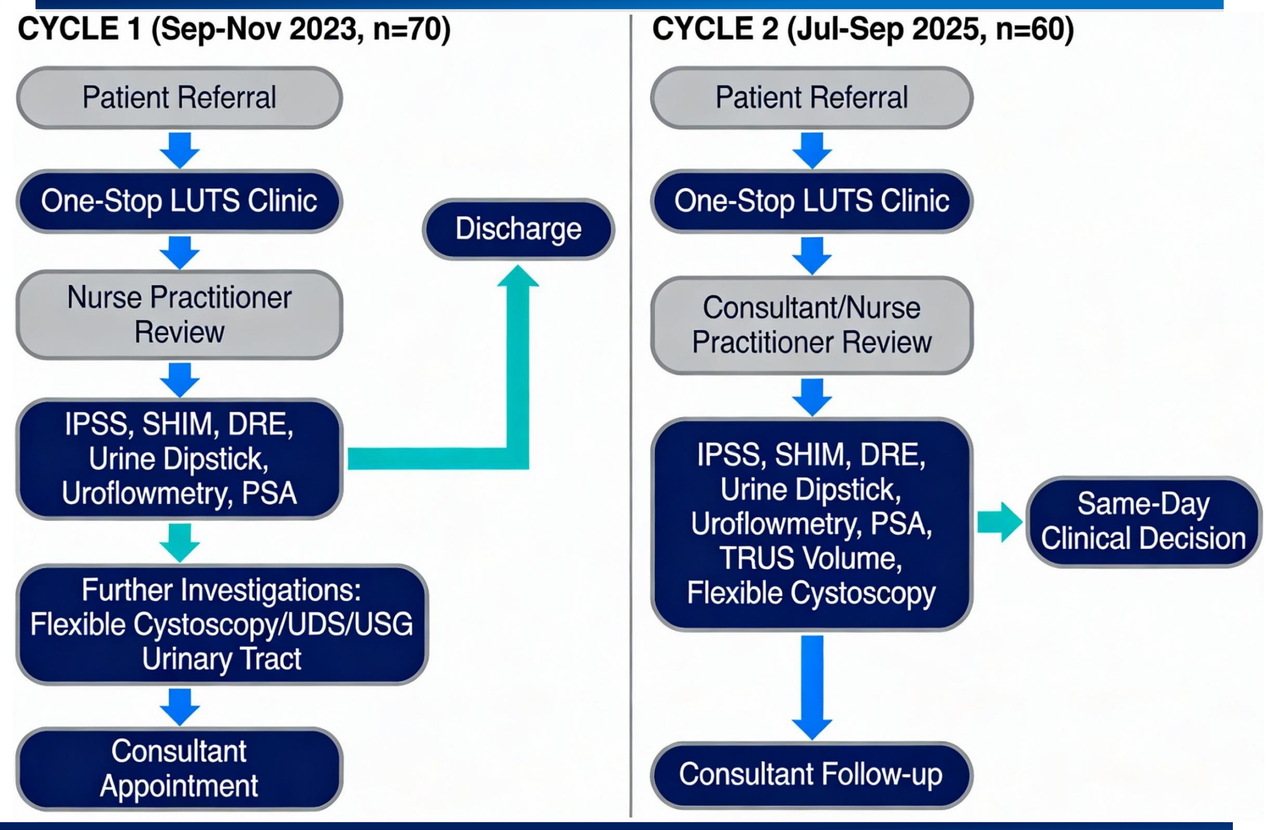
Background & Clinical Significance

- Over one-third of men aged 50+ in the UK experience moderate to severe lower urinary tract symptoms (LUTS), predominantly from bladder outflow obstruction (BOO).

One-Stop Clinic Model:

✓ Single-visit assessment
✓ Streamlined investigations
✓ Same-day treatment planning
✓ Minimized follow-up visits

Methods



Results

Baseline Investigations: 1st Audit vs Re-Audit

Core Assessments (Maintained High Compliance)

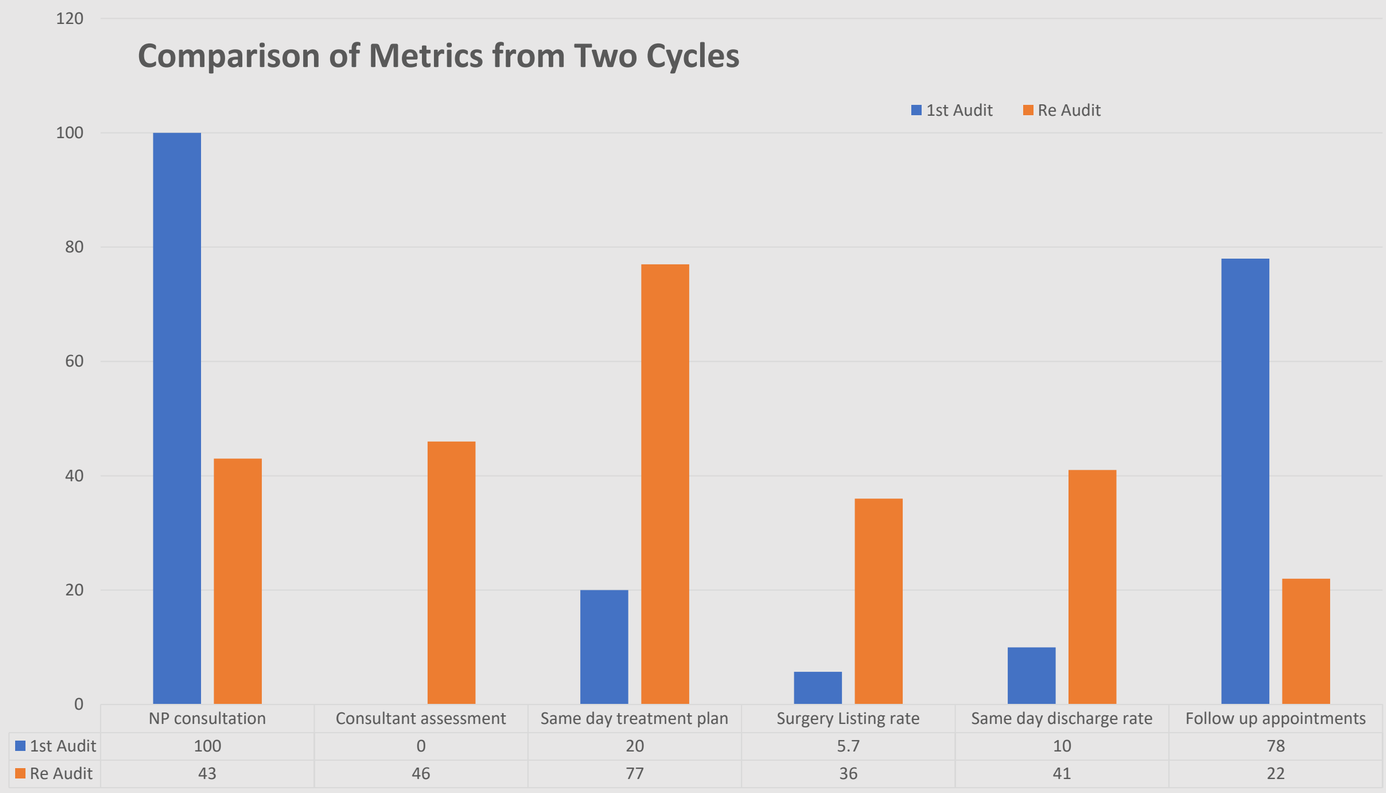
IPSS — 100% both cycles
PSA — 100% vs 90%
Uroflowmetry — 98.3% vs 97%

Enhanced Protocols

SHIM (Sexual Function) — 10% → 100%
Urine Dipstick — 34.3% → 100%
DRE — 78.6% → 93%

Specialist Investigations (Selective Use)

TRUS — 41% → 0% (streamlined)
Flexible Cystoscopy — 57.1% → 27.5% (risk-stratified)
Renal Ultrasound — 10% → 2% (targeted)
UDS — 5.7% → 1% (indicated cases)



KEY HIGHLIGHTS

✓ 6-fold increase in surgical listing rate
✓ 55% reduction in follow-up appointments
✓ 95%+ patient satisfaction maintained

Metric	Result
Quality of care	95%
Treatment decisions	94%
Overall clinic function	96%
Information Prior to Visit	87%

Table 1.
Patient Feedback Results

Discussion

Key Improvements: Cycle 1 → Cycle 2

✓ **Same-Day Consultant Review:** MDT clinic model with 46% same-day consultant assessment
✓ **TRUS Prostate Volumetry:** Staff training improved same-day diagnostic capability (0% → 41%)
✓ **Treatment Decision Rate:** Same-day treatment planning increased from 20% to 77%
✓ **Follow-Up Reduction:** Decreased follow-up appointments from 78% to 22%
✓ **Pre-Clinic Information:** New information packs achieved positive patient feedback (51% rated Excellent)
✓ **Decreased flexible cystoscopy** rate represents appropriate de-escalation of invasive testing through better triage

Conclusion

- The one-stop male LUTS clinic shows sustained quality improvement with enhanced efficiency and reduced follow-up burden.
- The model delivers substantial financial benefits through fewer follow-ups, better theatre utilisation, and optimised resource use.
- Future aims: expand day-case procedures and reduce waiting times further.

References

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MARK THIS ABSTRACT

Introduction of a TULA Service: Initial Experience and Clinical Outcomes (17)

George Sturgess, Peter Smith
Lancashire Teaching Hospitals NHS Foundation Trust

Introduction

Trans-urethral laser ablation (TULA) is a minimally invasive treatment option for patients with non-muscle invasive bladder cancer (NMIBC), typically aimed at individuals with significant co-morbidities, frailty, or older age, where conventional surgical intervention poses higher risks. The uptake of TULA is increasing throughout the UK. GIRFT has recently released guidance for units aiming to introduce a TULA service (1). Here, we present our initial experience after one year of implementing a TULA service.

Methods

This was a retrospective cases series of all patients listed for TULA since introducing the service in August 2024. Patient demographic data, procedural information and clinical outcomes were recorded. Follow-up data included recurrence rate, 30-day re-admission rates and mortality. Recurrence and mortality rates were recorded as a snapshot in October 2025, meaning the entire cohort has not yet had one-year follow-up.

Results

TULA Patient Cohort

There were 51 procedural listings for TULA in 35 different patients. Median age was 88 (IQR 80-89) and 39/51 patients were male. Of patients listed, 44/51 underwent TULA. Three were felt too frail and managed with best supportive care, three had no evidence of tumour and once was listed for TURBT instead due to good overall health. Previous histology was available in 38/51 cases.

Procedural Data

TULA was well tolerated and the procedure was completed in all but two patients (42/44, 95.5%). Time and energy per case are listed in *table 1.* A biopsy was taken in 4/44 cases. Complete resection was achieved in 42/44 cases. One incomplete resection was listed for TURBT and another for best supportive care.

Variable	Value (n = 51)
Gender (male, percentage)	39 (76.5%)
Age (median, IQR)	88 (81-89)
Laser time, seconds (mean, range)	119 (8-827)
Laser energy, joules (mean, range)	550 (33-6186)
Complete resection	42/44 (95.4%)
Recurrence rate	12/19 (63.2%)
30-day re-admission	3 (5.88%), 1 related to TULA (1.96%)
All-cause mortality	8/35 (22.6 %)
Disease-specific mortality	2/35 (5.71%)

Table 1: demographic, procedural and follow-up data for patients undergoing TULA

Follow-up and Outcomes

- Surveillance cystoscopy on a TULA list for 41/48 patients,
- 4/48 were discharged
- 2/48 were listed for TURBT
- 1/48 was referred to oncology

Recurrence was found in 12/19 (62.3%) patients who had interval cystoscopy. The 30-day re-admission rate was 3/44 however only one was related to complications from TULA in a patient with clot retention requiring 3-way catheter and irrigation. Other admissions were generally related to the frailty of the cohort.

All-cause mortality was 8/35 patients however only 2/8 deaths were related to bladder cancer. These two patients were age 88 and 75 and were not fit enough for surgical intervention or systemic therapy.

Discussion

This case series highlights the outcomes of the first year of a TULA service. It confirms that the procedure is well tolerated and safe to perform in the out-patient setting, removing the need for an anaesthetic in higher risk patients. The recurrence rate of 63.2% indicates the need for regular follow-up. Given the high all-cause mortality rate in this elderly patient cohort, some individuals may be better managed with best supportive care.

Conclusion

- TULA is a safe, effective and well tolerated treatment modality for selected patients with NMIBC
- In one year, 43 anaesthetics were avoided, reducing waiting lists
- Patient selection is key in providing an effective TULA service.

References

1. Getting it right first time (GIRFT) (April 2025). GIRFT Urology: Transurethral Laser Ablation for bladder cancer pathway guide. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/04/GIRFT-Urology-guide-to-TULA-for-bladder-cancer-Final-April-2025.pdf

MARK THIS ABSTRACT

Impacts of Surgical approach on postoperative recovery, outcomes and complications following Retroperitoneal versus Transperitoneal robotic assisted partial nephrectomy: A Comparative Audit (18)

Authors: Dr Jaiesh Lilley, Mrs Moon
Affiliations: Lancashire Teaching Hospitals

Introduction

Transperitoneal access (TP) is the most common approach for robotically assisted partial nephrectomy (RAPN) in the UK [1]. Retroperitoneal (RP) may be advantageous for selected cases.
Oncological outcomes, renal function, positive surgical margin rates and major complication rates are similar [2].
Some studies suggest improvements in minor complication, blood loss and operative times [3]. For RP approach, evidence for post operative pain reduction is mixed. Some analyses report reduced length of stay (LOS) [4].

Overall, literature supports oncological equivalence between TP and RP RAPN, with possible recovery advantage for RP including post operative pain and subsequent length of stay.

Methods

We conducted a retrospective review of 78 robotic assisted partial nephrectomy cases from a single centre using the DaVinci Xi, between January 2024 and January 2026. This comprised 39 retroperitoneal and 39 transperitoneal approaches.
We ensured similar tumour size, complexity and demographics such as age and BMI. We compared median post-operative pain scores and length of stay between groups.
Data was collected and descriptive analysis performed for:

- Warm ischaemia time
- Operative time
- Bloods loss
- Complication rates
- Renal function changes
- Histology including positive margins

Results

Demographics & Tumour characteristics

	TP	RP
Average BMI	29	31
Average Age	62	63
Average tumour size	2.99cm	3.19cm
Average Tumour complexity	7	7

Table 1: Patient and tumour characteristics

Table 1 shows the similar demographics between the groups allowing for fair conclusions to be drawn about their subsequent outcomes.

This is also seen within the tumour size and characteristics.

Oncological Outcomes

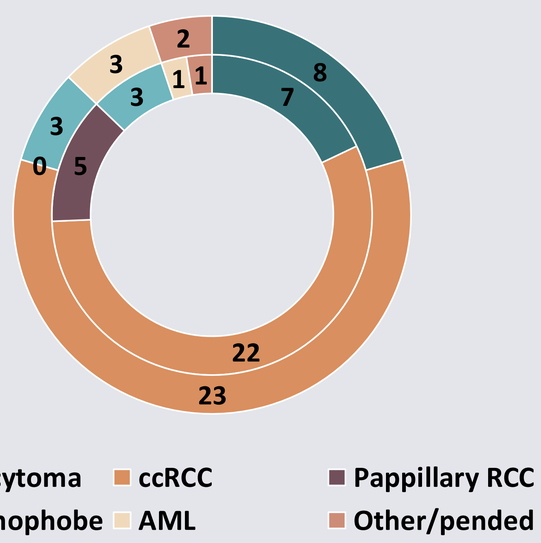

Figure 1: Oncological outcomes RP (Outer ring) v TP (Inner ring)

Intraoperative metrics

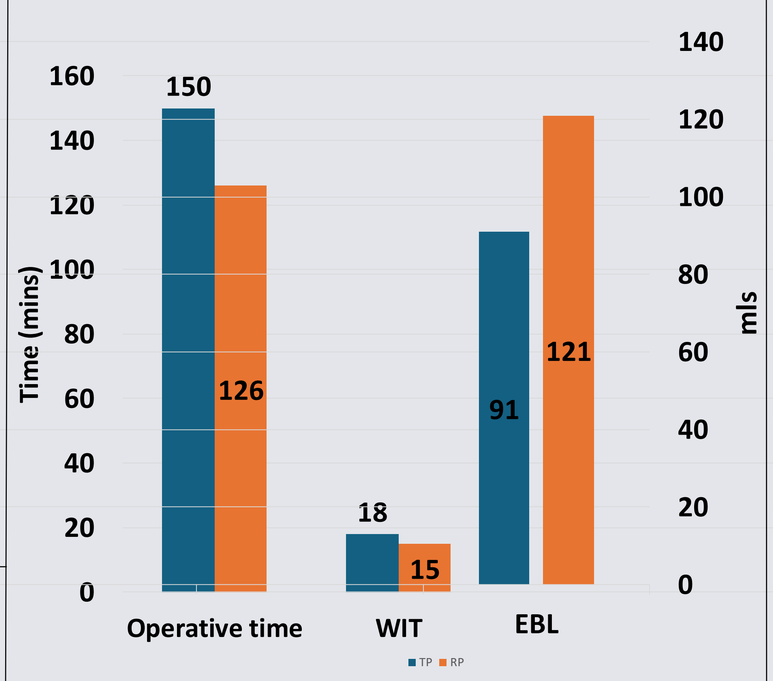

Figure 2: Coupled bar charts displaying Operative time, warm ischaemia time and estimated blood loss in RP versus TP groups

On average RP access led to shorter operative due to earlier access to the renal artery. TP operative times ranged between 110-225 minutes versus RP range of 80-180 minutes. Warm ischaemia times are similar and this is also observed within the ranges for each group.
On average, there was less bleeding with TP approach (121ml vs 91ml), although this difference is not clinically significant.

Post Operative Pain, Length Of Stay and complications

Post operative day 1 pain scores were measured. Patients chose a score of 1-3 for mild, moderate and severe pain. Median pain scores for TP are 2 (n= 39) v RP 1 (n=39).
Median LOS (days) was 2 v 1 for transperitoneal and retroperitoneal groups respectively.

TP reported 15% complication rate versus RP 12.8%. Complications are mostly minor such as hospital acquired pneumonia, wound infection and haematoma. More serious complications, although uncommon included, urine leak and pneumothorax. 1 RP patient required a completion nephrectomy. 1 TP patient died within 30 days.

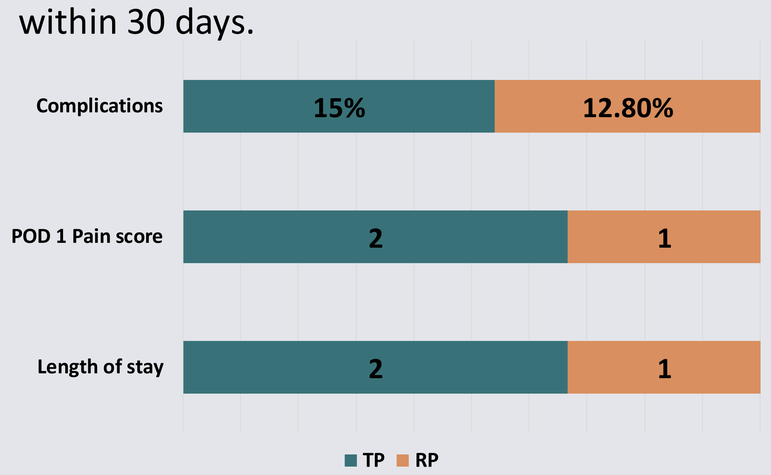

Figure 3: Stacked bar charts displaying post-operative outcomes including complications, pain score and LOS between RP and TP groups

Discussion

This audit reviewed 78 robotic-assisted partial nephrectomies (39 RP and 39 TP) with similar patient demographics and tumour characteristics. RP access had shorter operative duration and comparable WIT. Median post-operative day-1 pain scores were lower and median length of stay was reduced by one day in RP access.

Complication rates were similar and infrequent (TP 15% vs RP 12.8%). Histology outcomes and malignancy incidence were comparable. RP had higher positive margin rate 5% (n=2) versus TP 2.5% (n=1).

Findings may be limited by sample size; selection bias; surgeon preference. Large, randomised, studies with standardised outcome reporting are needed to refine selection criteria.

Conclusion

Where patients are of similar demographic and with similar tumour characteristics, RP provides comparable outcomes with the potential for shorter operative times, reduced pain and reduced LOS. RP should be considered as a oncologically equivalent approach to TP robotically assisted partial nephrectomy.

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MARK THIS ABSTRACT

Abdominal Wall CT Measurements as Predictors of Parastomal Hernia in Patients Undergoing Ileal Conduit Formation: A Retrospective Audit (19)

Authors: Dr Jaiesh Lilley, Dr Areebah Akhtar, Miss Rosie Blades

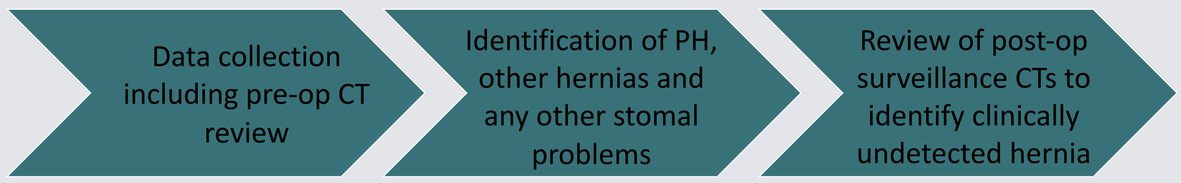
Affiliations: Lancashire Teaching Hospitals

Introduction

Parastomal hernia (PH) is a common complication of procedures involving ileal conduit (IC) formation. Incidence is high and may require further surgical procedures to correct [1]. It is important that we can fully counsel our patients on longer term risks when considering IC surgery. Established risk factors include obesity and previous abdominal surgery. Some studies suggest that abdominal wall parameters can predict parastomal hernia formation in colorectal stomas [2]. There is little data to support the use of CT derived parameters in patients who have undergone IC formation. In patients of similar characteristics, prophylactic use of biological mesh in ileal conduit is safe but does not provide any significantly protective effects within the first two years [3].
Abdominal wall morphology may influence PH formation. We aimed to evaluate the association between CT derived parameters including rectus thickness (RT) and abdominal fat thickness (AFT) in patients undergoing IC formation.

Methods

We performed a retrospective audit of 123 IC formations between 2014–2020 in a single centre. We collected data on patient demographics including Age; BMI; Smoking status; Histology; Complications and mortality data.
Pre-operative CT images were used to calculate CT derived abdominal fat thickness and rectus thickness at the level of the umbilicus. Medical notes and clinic letters were used to identify complications. Due to suspected under-detection of PHs we reviewed all post op surveillance CTs. We compared CT derived rectus thickness and abdominal fat thickness between patients with and without stomal complications.



Results

123 cases were identified in the data search. Records earlier than 2014 were not all digitalised and data sets used past 2020 would not allow a minimum period of 5 year follow up. Average patient age was 68.

IC formation was generally to treat cancer. 6.5% (n= 6) were done for benign pathology.

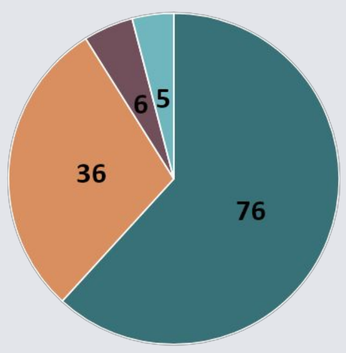


Figure 1: Incidence of Parastomal hernias, other types of hernia and any other stomal complications

34% (n=42) of the cohort experienced a hernia of any type. 86% of these were PH. 5% (n=6) cases experienced other problems related to their hernia including stenosis or retraction.

Interestingly, initial documented reports only revealed 20 PH. CT review of surveillance CTs revealed a further 16 cases.

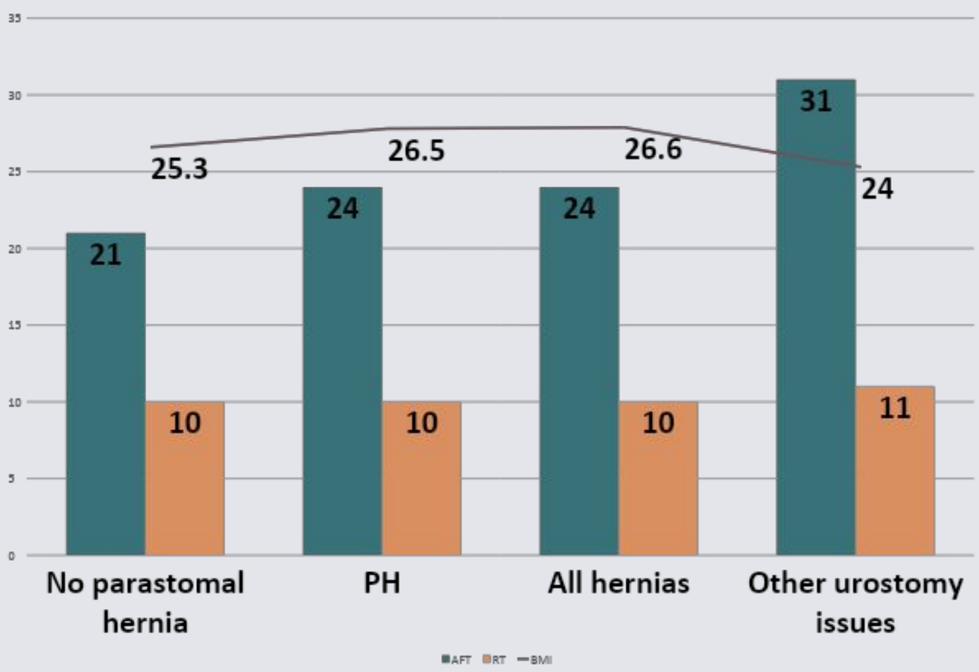


Figure 2: Comparison of pre-op CT derived Rectus thickness, abdominal fat thickness and BMI across groups.

Rectus thickness was comparable between all groups at 10-11mm.

Abdominal fat thickness was overall similar but was subtly higher in PH, all hernias and other stomal pathology.

The AFT findings were mirrored in BMI where higher BMI is associated with increased hernia formation. BMI does not appear to be related with the small group of other urostomy related problems.

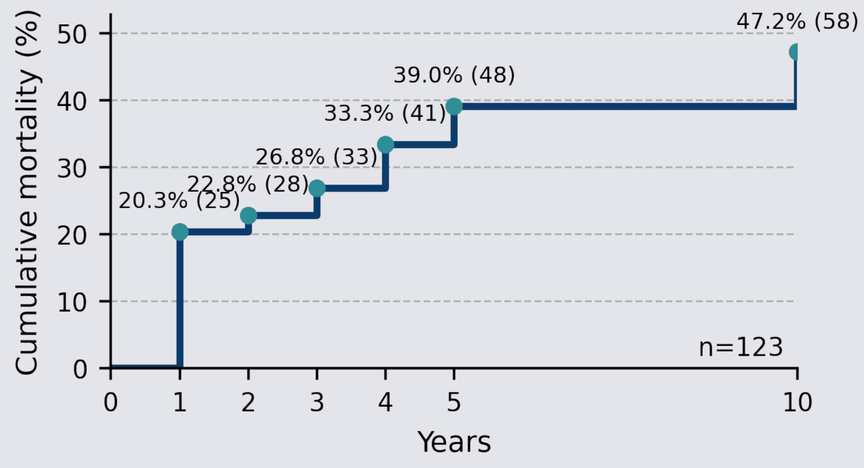


Figure 3: All cause cumulative mortality

All- cause mortality is high in this patient group. Approximately 1/5th of patients had unfortunately died at 1 year.

3-year mortality is 26.8% (n=33)

5-year mortality is 39% (n=48)

10-year mortality is 47.2% (58)

More than 50% of patient's mortality status is unknown as they are now out of area, referred elsewhere or no longer followed up.

Discussion

PH remains a frequent complication following IC formation, and in our cohort one third of patients developed a hernia of any type, with most being parastomal.
Clinical examination may not be adequate to detect parastomal hernias as in this cohort 44% of cases were diagnosed with imaging following focused CT review. However, this does not mean they are symptomatic.
All-cause mortality was high. This has implications for follow-up and for interpreting outcomes

Key limitations include small cohort, retrospective design, basic analysis techniques and potential under-detection.

Conclusion

It is unclear from this small single centre study, if CT derived abdominal wall morphology can predict PH formation in IC cohorts. Larger sample sizes with detailed analysis including survival curves will allow more meaningful interpretations.
High mortality will confound results with many patients dying before complications can occur.

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MARK THIS ABSTRACT

Evaluating the electronic urology referrals : what can be done better ? (20)

Authors: Ahmed Badr, Thomas Thomspon, Suresh Venugopal, Viswanath Hanchanale

Affililations: Liverpool University Hospitals Foundation Trust

Introduction

-Electronic referrals offer streamline communication between clinical teams an on call specialists.

-However the **quality, appropriateness and timeliness** of theses referrals can significantly impact patient safety, resource utilisation and on call team workload.

-Inappropriate or incomplete referrals may lead to **delay in patient care, unnecessary reviews or misallocation of on call team.**

-Therefore evaluating the appropriateness and efficiency of electronic referral made to our team will help identify areas for improvement, optimise resource use and enhance both patient outcomes and on call team workflow.

Methods

-A retrospective audit was conducted of electronic referrals made to the urology on-call registrar over a **4-week period**.

-Referrals from a single day from each week were completely analysed and assessed for clinical appropriateness, availability of a minimum dataset of essential information, urgency and suitability for admin staff or junior level requests.

-Total number of **64 electronic referrals** were analysed

-Data were compared against locally agreed standards and analysed descriptively. .

Results

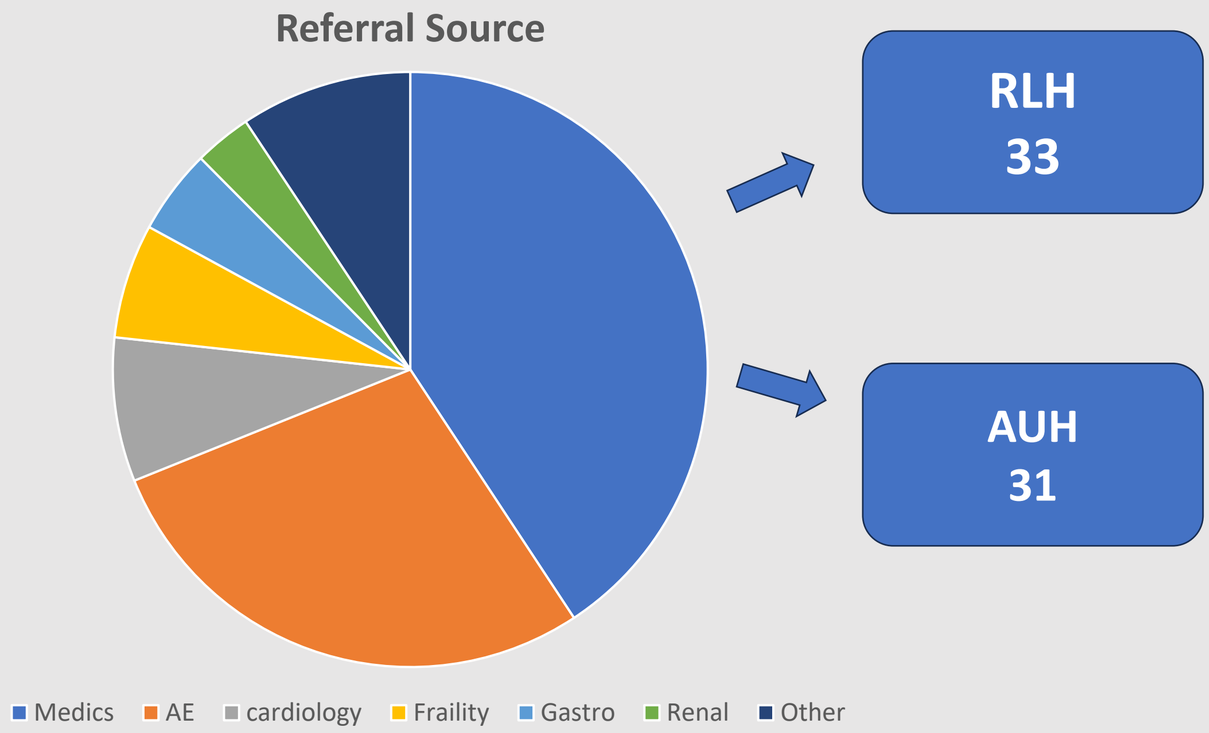
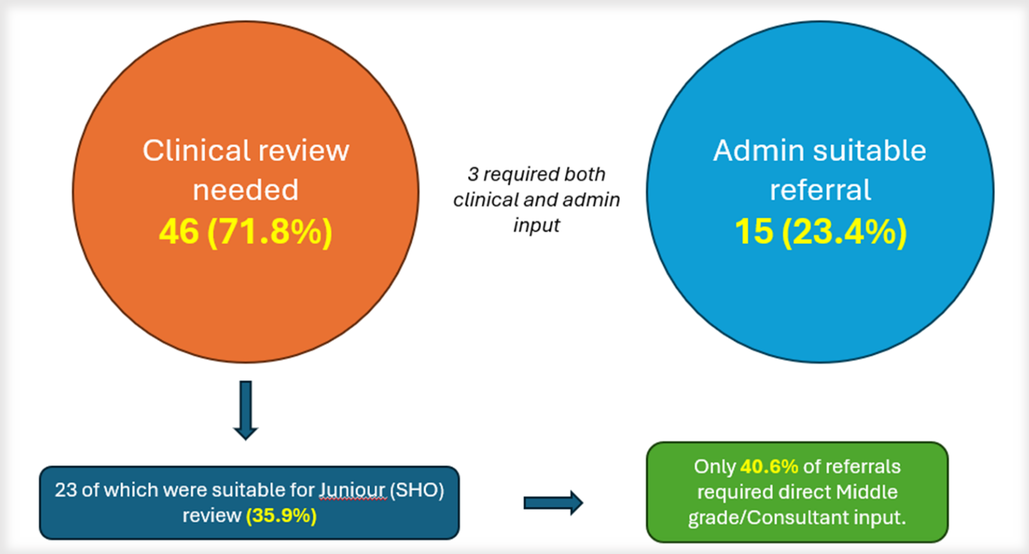


Figure 1 : Sources of referrals by specialty



- **70.3 %** of referrals were responded to within 3 hours (45 of 64)
- **9.3%** of referral were responded to after 24 Hr (6 out of 64), none of which were urgent
- Remaining 20.4% (13 referrals) were processed anywhere between 4-12 hours
- **Urgent referrals** requiring immediate intervention :1 out of 64 responded to within 1 hour.
- 4 out of 64 referrals were sent with incomplete details **(6.25%)**
- 17 of the 64 referrals had been referred once or multiple times in the previous days/weeks **(26.56%)**
- 9 out of 64 referrals were sent after patient already discharged **(14.06 %)**

Discussion

Limitations included :

- Phone calls during the day/night are not accounted for
- Single day from each week in 4 consecutive weeks may not completely represent full picture.

Recommendations to improve service :

- Encouraging direct phone calling to oncall team for urgent referrals rather than sending e-referrals
- In addition , increasing awareness of Junior appropriate referrals via bleep, and providing adequate support for juniors should be supported.
- Increasing awareness of admin suitable pathways with emails of admin teams would also be significantly helpful.

Conclusion

Although electronic referrals enhance accessibility, a substantial proportion remain inappropriate for middle grade review, contributing to overload on the on call team affecting workflow. Refinement of the electronic system, improved referrer awareness, and clearer referral criteria including referrer details may improve the quality and cost-effectiveness of referrals to urology

Notes:

No Conflict of interest , not presented prior to BAUS NW 2026

MARK THIS ABSTRACT

Publication Rates and Predictors of Success Among Abstracts Presented at the 2022 European Association of Urology Congress (22)

Abdul-Hadi Kafagi[1], Nazih Atassi[2], Abdulrahman Al Marzouq[2], Abdul Rhaman Kafagi[2], Hasnain Rashid[3], Amar Sangha[2] , Karyee Chow[1]

[1]Manchester NHS Foundation Trust, Manchester, United Kingdom, [2]University of Manchester, Manchester, United Kingdom, [3]Peninsula Medical School, United Kingdom

Introduction

- Scientific congresses disseminate **new urological research**
- **Publication** determines impact on **guidelines and practice**
- Many **abstracts never reach peer-reviewed publication**
- **EAU 2022** was Europe's largest **post-COVID** urology congress
- Provides a **snapshot of research priorities and influence**

Aim

- This study evaluates **publication outcomes** of EAU 2022 abstracts
- Identifies **predictors of publication success**
- Explores **geographic and sub**specialty trends

Methods

Abstracts Identified: Retrospective observational analysis
All 2022 EAU Annual Meeting abstracts **(n=1,163)**

Data Collected: Authors (#), country & continent of first author, study design, urology subspecialty

Publication Search: PubMed, Scopus, Google Scholar; Careful title/author cross-checking

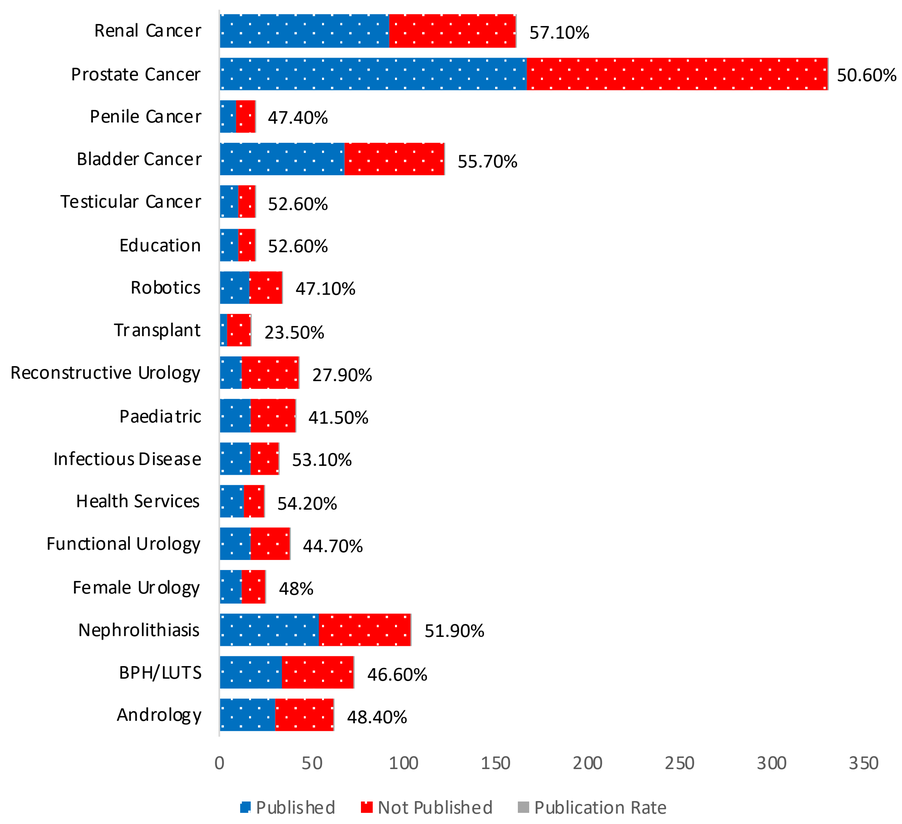
Analysis: Primary outcome: **overall** publication rate
Secondary: time to publication, journal metrics
Factors associated with success: geography, study type, subspecialty, # authors

Overall Publication Rate

Mean Time:
13.7 months

78.7%
within 2 years

By Subspeciality



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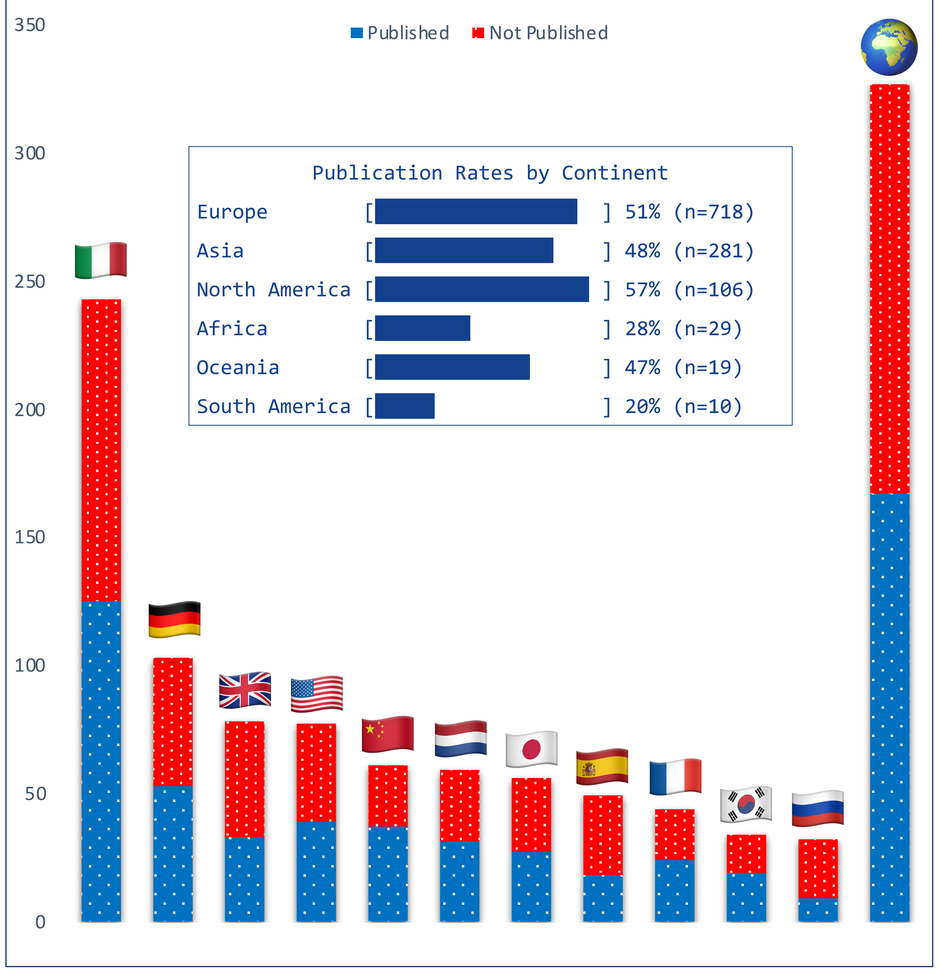
By Geographic Distribution



By Author Count

<5 authors
n=178
OR = 1 (ref)

5–9 authors
n=475
OR = 2.13*

10–20 authors
n=401
OR = 2.19*

>20 authors
n=109
OR = 2.10*

Journal Destination

- **582** papers published across **197 unique journals**
- 60.9% in urology-specific journals
- **Mean Impact Factor (IF):** 5.23 (SD 7.4) | **Median IF:** 3.50
- 50% in IF 3-10, 5% in IF >10 journals

By Study Design

- **Observational studies were most common** (retrospective n=332; prospective n=257) with no association with publication (OR ≈ 1).
- **RCTs** (n=75) had higher but non-significant publication odds (OR ≈ 1.3).
- **Systematic reviews** (n=58) and **basic/translational studies** (n=29) had higher publication odds (OR > 2).
- **Case series/reports** (n=19) had lowest publication odds (OR < 0.2).

Conclusion

Only **1 in 2** EAU 2022 abstracts progressed to publication
- **Study design** and **collaborative authorship** were strong predictors of publication success
- **Oncological subspecialties** dominated research output, while reconstructive and transplant fields were under-represented
- **Geographic disparities** persist in research visibility and dissemination
- Conference presentation is an important first step — but **publication determines academic influence and impact on practice**

Undergraduate Urology Teaching at the UK's Largest Medical School: Findings from a Cross-Sectional Survey (23)

Abdul-Hadi Kafagi[1], Emily Hepburn[1], Nazneen Aslam[1], Ffion Samuel[1], Anjali Mathew[1], Karyee Chow[1]

[1]Wythenshawe Hospital, Manchester NHS Foundation Trust, United Kingdom

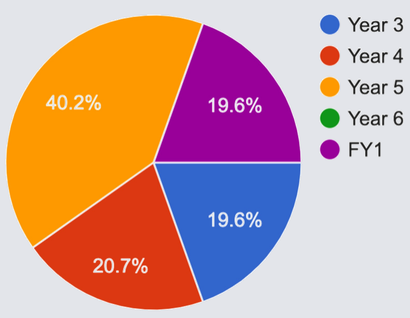
Introduction

- Urological conditions account for **5–10% of GP consultations** and **~20% of acute surgical referrals**
- **Undergraduate urology exposure is variable and often limited** in the UK
- Core urology knowledge and skills are **expected at graduation** and assessed in the **UKMLA**
- Concerns persist regarding **graduate preparedness** for urological practice
- **Aim: To assess medical students' and FY1 doctors' exposure to urology, confidence in core urological knowledge and skills, and preparedness for clinical practice and examinations.**

Methods

- **Study design:** Cross-sectional online survey
- **Participants:** UK medical students (Years 3–5) and FY1 doctors
- **Sample size: n = 92**
- **Outcomes assessed:**
  - Exposure to formal urology placements
  - Confidence in core urological knowledge and emergencies
  - Clinical and procedural experience
  - Perceived preparedness for exams
- **Analysis:** Descriptive statistics

Results

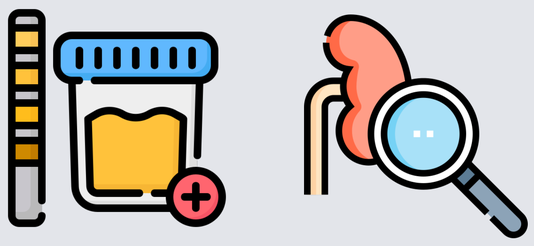


Participants Profile

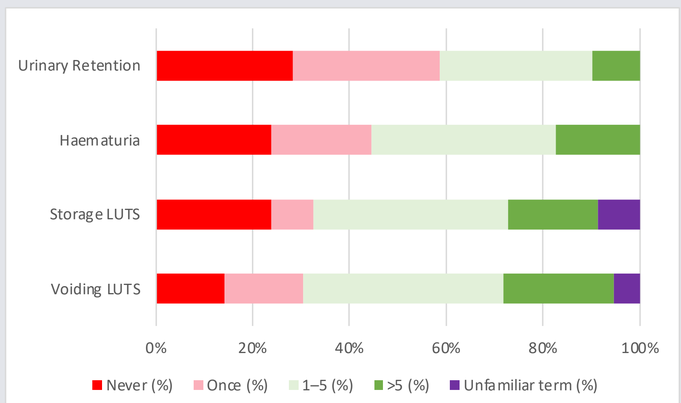
- **92 respondents**
- Year 5 largest group (**40%**)
- **70% female**

Curriculum Exposure & Core Knowledge

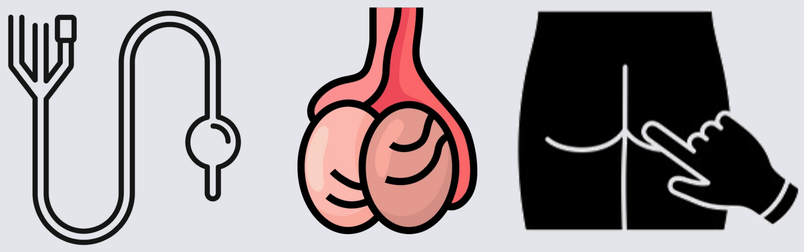
- **60%** have **never completed** a urology placement
- **55%** feel **unprepared for UKMLA examinations**



History Taking

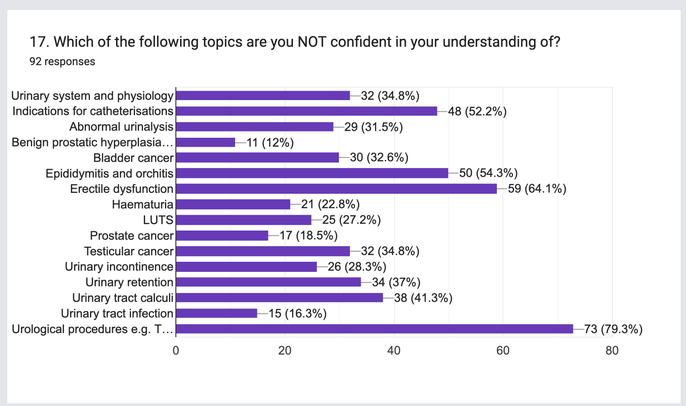


Practical Clinical Skills



- **51%** never inserted a **male catheter**
- **34%** never inserted a **female catheter**
- **71%** never performed a **testicular exam**
- **70%** never performed a **PR exam**

- **48%** not confident interpreting **urine dipstick**
- **84%** not confident requesting **basic urological imaging**
- **84%** unable to differentiate **concentrated urine vs haematuria**
- **70%** do not know difference between **2-way vs 3-way catheter**



Conclusion

- A significant proportion of medical students have **limited urology exposure**.
- Many students **lack confidence in basic urological knowledge and skills** (urine interpretation, imaging, catheter types).
- Knowledge gaps are likely linked to **insufficient clinical placement and practical teaching**.
- Targeted interventions are needed to improve **student preparedness for exams and clinical practice**.

MARK THIS ABSTRACT

Recommendations

- **Increase structured clinical exposure:** Integrate mandatory or elective urology placements into medical school curricula.
- **Hands-on teaching & simulation:** Run workshops for catheterization, urine dipstick interpretation, and basic imaging with direct faculty supervision.
- **Assessment & feedback:** Implement formative assessments to identify gaps and provide targeted feedback on core urology skills.
- **Develop and share practical resources:** Create concise guides and online modules for core knowledge, aligned with UKMLA learning outcomes.

27. Testosterone Replacement After Prostate Cancer Treatment: Is It Safe and Effective?

John Gibson[1,2], Michael George[1,2], Peter Grice[1,2], Amar Mohee[1], Theodora Stasinou[1,2], Ian Pearce[1,2], Vaibhav Modgil[1,2,3]

[1] Department of Urology, Manchester Royal Infirmary, Manchester University NHS Foundation Trust
[2] Manchester Andrology Research Collaborative (MARC), Manchester
[3] University of Manchester, Faculty of Biology, Medicine and Health

Introduction

Background

- Testosterone replacement therapy (TRT) is an effective treatment for symptomatic hypogonadism but remains controversial in men with a history of prostate cancer due to historical concerns regarding oncological safety (1,2).
- As prostate cancer survivorship increases, a growing number of men experience hypogonadism related to ageing or prior androgen deprivation therapy (3,4).

Aim

- To systematically map the existing evidence on the oncological safety and therapeutic efficacy of testosterone replacement therapy in men following definitive treatment for prostate cancer.

Methods

- A scoping review was conducted in accordance with PRISMA-ScR guidelines.
- A systematic search of PubMed, CENTRAL, and Embase was performed in June 2025.
- Eligible studies included peer-reviewed human studies reporting oncological or efficacy outcomes in men receiving TRT following radical prostatectomy or radiotherapy.
- Case series with fewer than 10 participants, conference abstracts, reviews, and studies involving untreated or metastatic disease were excluded.
- Data were synthesised narratively due to clinical and methodological heterogeneity.

Results

- Twelve studies published between 2005 and 2025 were included. Median follow-up ranging from 6 to 189 months (5-16).
- TRT was not associated with an increased risk of biochemical recurrence or cancer progression.
- Reported recurrence rates were low and, in several studies, lower than in non-TRT comparator groups.
- PSA kinetics remained within expected post-treatment parameters, with minor PSA rises not indicative of recurrence.
- All studies reporting hormonal outcomes demonstrated significant increases in total and/or free testosterone, typically restoring eugonadal levels.
- Most studies reported improvements in libido, energy, and sexual function.

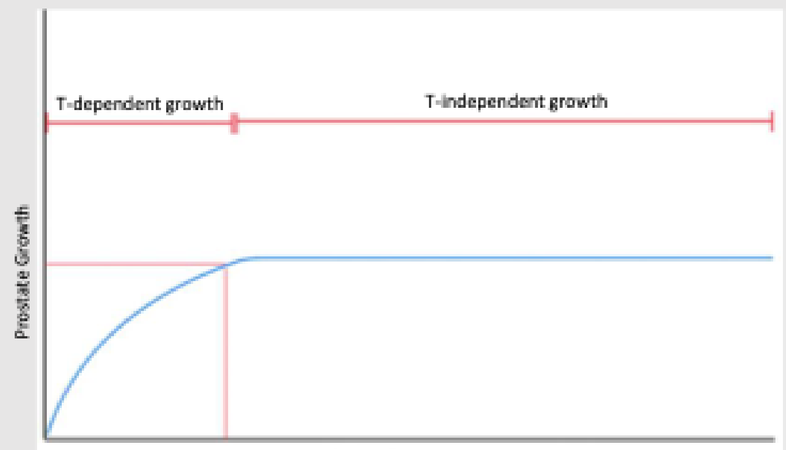


Figure 2.
Schematic illustrating the principles of the testosterone saturation model. Abbreviations: T, testosterone.

Primary treatment	Number of studies	TRT cohort size (min–max)	Key oncological outcome
Radical Prostatectomy	6	10–152	No increased risk of biochemical recurrence. PSA changes remained within non-recurrence thresholds.
Radiotherapy (± ADT)	6	13–98	No confirmed biochemical recurrence attributable to TRT. Minor PSA rises observed without progression.
Overall	**12**	**10–152**	**TRT not associated with increased biochemical recurrence or cancer progression in any study.**

Figure 1.
Oncological outcomes summary

Discussion

- Despite longstanding caution, current evidence suggests TRT may be oncologically safe in carefully selected men following definitive treatment for prostate cancer.
- Findings are consistent with the testosterone saturation model (Figure 2.), which proposes that prostate tissue becomes androgen-saturated at low testosterone levels, beyond which further increases do not stimulate tumour growth.
- Limitations include retrospective study designs, small sample sizes, variable recurrence definitions, and limited representation of high-risk and ethnically diverse populations.

Conclusion

- No study demonstrated increased oncological risk attributable to TRT.
- Biochemical recurrence rates were low and often lower than controls.
- TRT consistently improved testosterone levels and hypogonadal symptoms

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MARK THIS ABSTRACT

Large Scale implementation of a renal cancer patient stratified follow up (PSFU) Pathway (28)

Miss Anna McClune

Salford - Northern Care alliance

Laura Jones, Dr H Price, Dr D Salter-Payne, Dr A Moore, Dr I Antcliffe, Mr S K Tolofari

Background

→ 13,900 new renal cancer cases diagnosis annually, with surveillance for a significant number of years after treatment

→ With rising demand and limited resources, redesigning surveillance pathways is essential to maintain safe and high-quality care

→ Our centre has implemented a digital PSFU pathway in keeping with GM Cancer ratified PSFU Schedule

Methods

→ 900 Patients with renal cancer at our tertiary centre were clinically validated and stratified into risk groups using the Leibovich classification

→ Audit of our current patient groups

→ Multidisciplinary steering group created a follow up schedule

→ Patients classified as low risk were enrolled onto a digital system

→ automatic tracking, timely identification for surveillance, imaging review and highlighting to a clinician for input

How it works

Diagnosed

↓

Treatment

↓

MDT

↓

RISK STRATIFIED

↓

Electronic flag for CT

↓

CT reported

↓

Review / Results

Results over 12 months

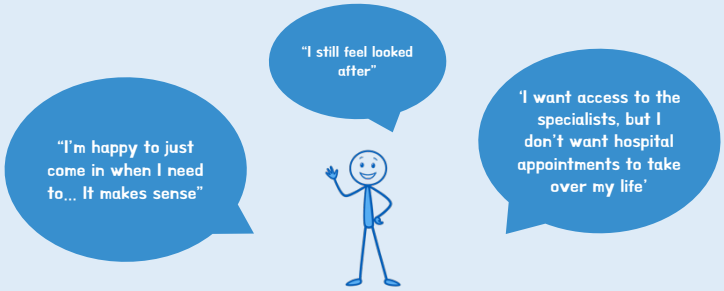
900 patients → 241 Enrolled

450 Consultant appointments

Significant cost saving

192 Hrs CNS activity

Prevent ~9 lost



Conclusion

→ Feasible at a large scale

→ Reducing reliance of human factor processes → enhancing safety

→ Model for wider adoption across trusts

→ Minimising missed follow up

→ Efficient

MARK THIS ABSTRACT

32-The Evolving Role of DRE - A Two-Cycle Comparison

Authors: Waqas Khalil, Mazhar Sheikh, Jawad Islam
Affiliations: Blackpool Teaching Hospitals

Introduction

To assess the consistency and reliability of Digital Rectal Exam (DRE) as a diagnostic tool across two different patient cohorts in the same institution.

Methods

Methodology:

Two retrospective cohort analyses.
Cycle 1: 100 patients (2019-2020).
Cycle 2: 100 patients (2022-2023).
Primary Outcome: Diagnostic performance of DRE (Sensitivity, Specificity, PPV, NPV) for predicting any prostate cancer on biopsy.

Results

A "Normal" DRE Missed Most Cancers:

Cycle 1: A benign DRE missed 56 out of 70 cancers (**80% miss rate**).

Cycle 2: A benign DRE missed 24 out of 79 cancers (**30% miss rate**).

The Bottom Line:

If a patient's DRE felt "benign," they still had a **~65% chance of having cancer** in both time periods.
The DRE's ability to find cancer was inconsistent (20% in Cycle 1 vs. 70% in Cycle 2).

Metric	Cycle 1	Cycle 2
Sensitivity	20.0%	69.6%
Specificity	86.7%	71.4%
PPV	77.8%	87.3%
NPV	31.7%	45.9%

DRE Findings Shifted Dramatically:

- Cycle 1: 18% Abnormal DREs | Cycle 2: 63% Abnormal DREs.
- **The Constant Problem:** A "Benign" DRE was unreliable. It carried a **~65% chance of cancer being present** in both cycles.

Discussion

DRE performance is highly variable and operator-dependent. While an abnormal DRE is meaningful (high PPV), a benign DRE provides **false reassurance** and is unfit for ruling out cancer.

Conclusion

The diagnostic pathway cannot rely on DRE. The combination of **PSA and mpMRI** provides a more objective and reliable foundation for decision-making. DRE should not deter further investigation when clinically indicated.

MARK THIS ABSTRACT

Identifying and reducing cancellations in Urodynamics (34)

A Calmuc, A Atayi, M Abdulmajed, O Ahmad

Mersey West Lancashire Teaching Hospitals NHS Trust

Introduction

Urodynamics (UDS) is an invasive investigation and a key step prior to surgical interventions. However, it is associated with risks and should be reserved as a last-line diagnostic test.

UDS appointment costs **NHS £230**[1]. EAU guidelines recommend UDS for: specific symptoms and/or persistent lower urinary tract symptoms despite medical therapy.

Cancelled NHS appointments contribute to:

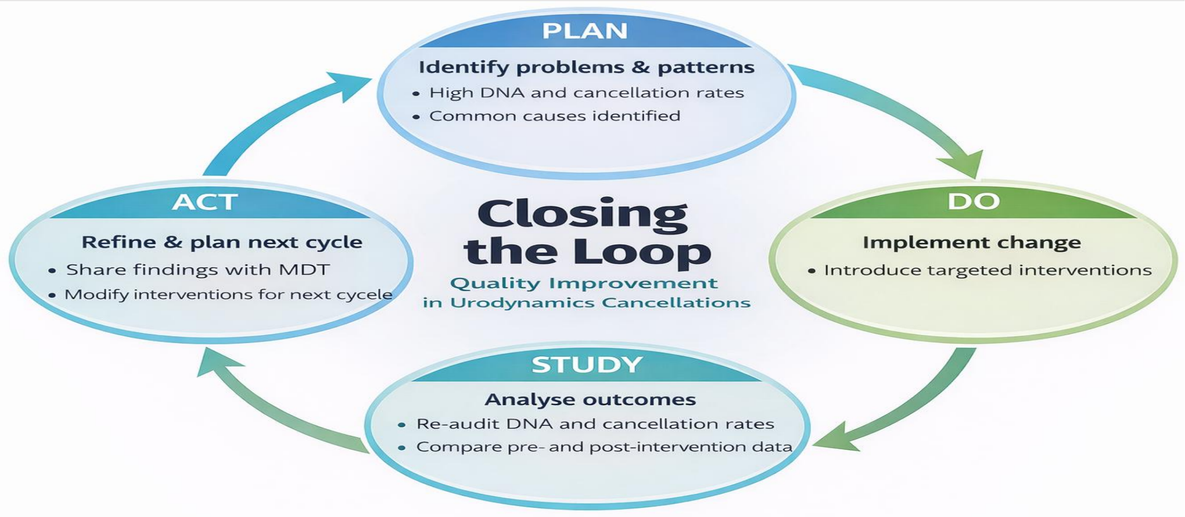
- treatment delays.
- longer waiting lists.

Methods

2 x retrospective audit cycles (May-August 2024/ May-August 2025)

Assessed 100 patients (over 4-month period) in each cycle.

Data (age, sex, reason for UDS, which healthcare booked the test, cancellation reason, was the cancelled intervention changed into a clinic appointment) was retrieved using online clinical case notes.



Results

First cycle

60 patients were male and 40 were female.

A total of 47 patients did not complete their appointment, including:

- **16 did not attend (DNA)** (10 female, 6 male).
- **8 patient cancellations**, due to symptom improvement or lack of understanding of the procedure.
- **6 clinician-initiated cancellations**, due to inappropriate test requests.
- **12 patients** did not stop LUTS medication, as advised.
- **5 patients** unable to proceed due to UTI or other clinical reasons.

High rates of DNA and cancellations in UDS led to wasted clinic capacity, delayed patient care, and **financial loss of £10,810.**

To reduce the cost and cancellation rate, following interventions were implemented:

• Proceeding with UDS where appropriate while patients on LUTS medication(s).
• Remodelling clinician-cancelled UDS appointments into clinic consultations.
• Pre-booking patient counselling, including medication advice and provision of BAUS information leaflets.
• if booked by non-consultant team, UDS requests to be discussed with a consultant.

Second cycle

68 patients were male and 32 were female.

A total of 34 patients did not have their intervention, including:

- **14 DNA** (6 female, 8 male).
- **0 patient cancellations.**
- **13 clinician-initiated cancellations** but the appointment was utilised as a clinic appointment saving the trust **£120** [2] per appointment.
- **0 cancellations** related to failure to stop LUTS medication(s).
- **7 did attend their appointment but cancelled** due to UTI or other reasons (failure for access, not tolerating the procedure).

In this cycle, financial loss is estimated at £6,260.

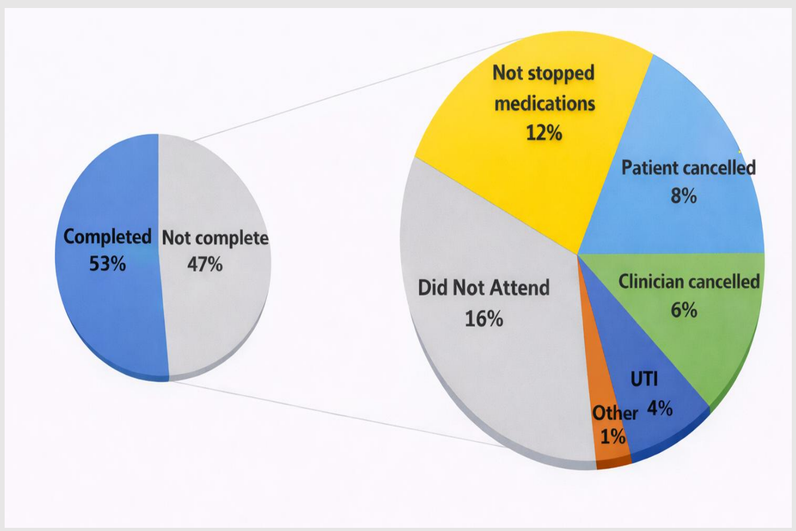


Figure 1. Cancellation rate and reasons.

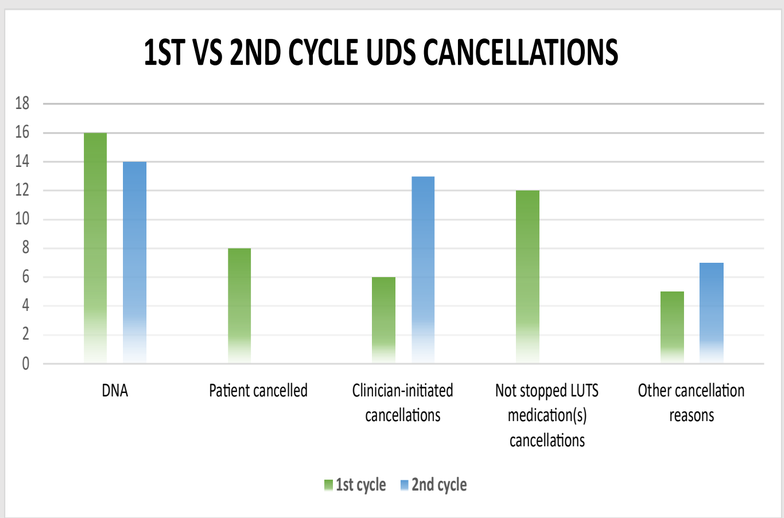


Table 1. 1st vs 2nd cycle cancellations results

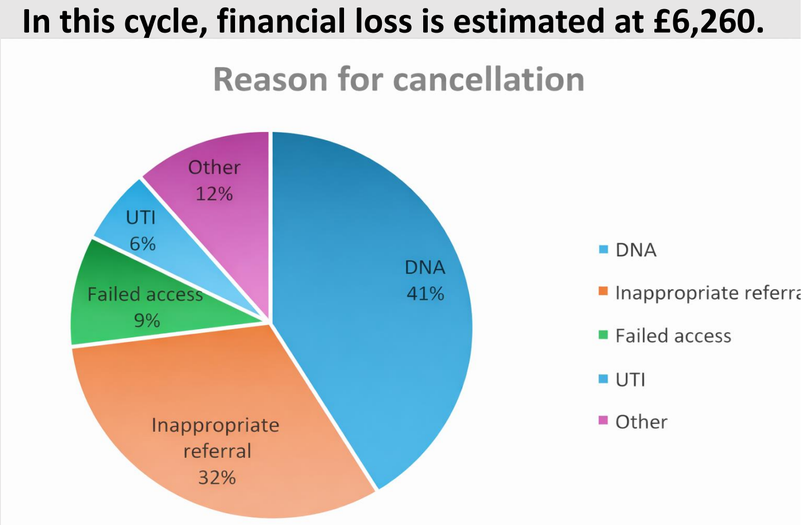


Figure 2. Reason for cancellation (second cycle)

Discussion

This closed loop audit identifies several key contributors to UDS non-attendance, including inadequate patient counselling, inappropriate referrals, failure to discontinue LUTS medication(s), and/or clinician-initiated cancellations.

Following implementation of targeted interventions, the Trust achieved a **cost saving of £4,550**, with **no patient cancellations** and **no cancellations related to failure to stop LUTS medication**.

However, **further improvements** are required to reduce the inappropriate referrals and DNA. Planned next steps include:

- Implementing a vetting system for UDS.
- Educate the medical staff on when to request UDS to avoid unnecessary interventions and delay in treatment.
- Call the DNAs to assess if this intervention is still required to avoid future DNAs.

Conclusion

Despite initial financial benefit to trust, further improvements are required to bring the number close to none. Therefore, UDS requests should be streamlined to help:

- reduce the cancelation rates.
- reduce the number of patients on the waiting list.
- reduce the delay in treatment, particularly in men with non-neurogenic LUTS.

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MARK THIS ABSTRACT

Delayed Escalation in Anterior Urethral Stricture Disease
A visual audit of referral pathways leading to definitive treatment
(36)

L Mehyar, A Chuang, L Clarke, L Olson
Department of Urology, Northern Care Alliance NHS Foundation Trust, UK

Northern Care Alliance
NHS Foundation Trust

Background and Aims

Background:

- Direct vision internal urethrotomy (DVIU) and urethral dilatation are common first-line treatments for anterior urethral stricture disease.
- Repeated endoscopic intervention may delay access to definitive management.

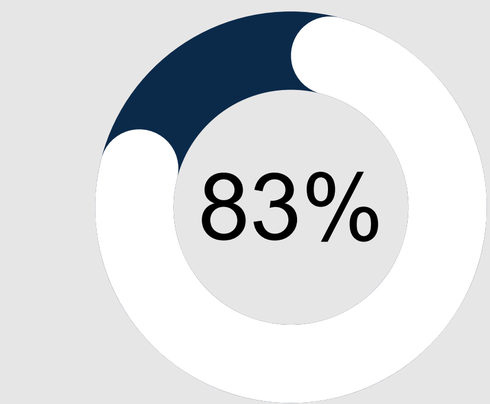
Objectives:

- To evaluate pre-referral assessment and escalation patterns in men with anterior urethral stricture disease.

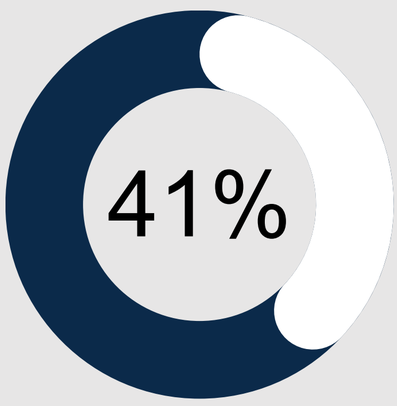
Methods

- Retrospective quality improvement audit of 29 men treated with Optilume for anterior urethral stricture disease between 2020–2025.
- Data collected: referral source, pre-referral investigations (urethrogram and uroflowmetry), patient reported outcome measure (PROMs) documentation, prior endoscopic management, and escalation patterns.

Key Results



Patient reported outcomes measures (PROMs) missing



≥2 prior DVIU/dilatations

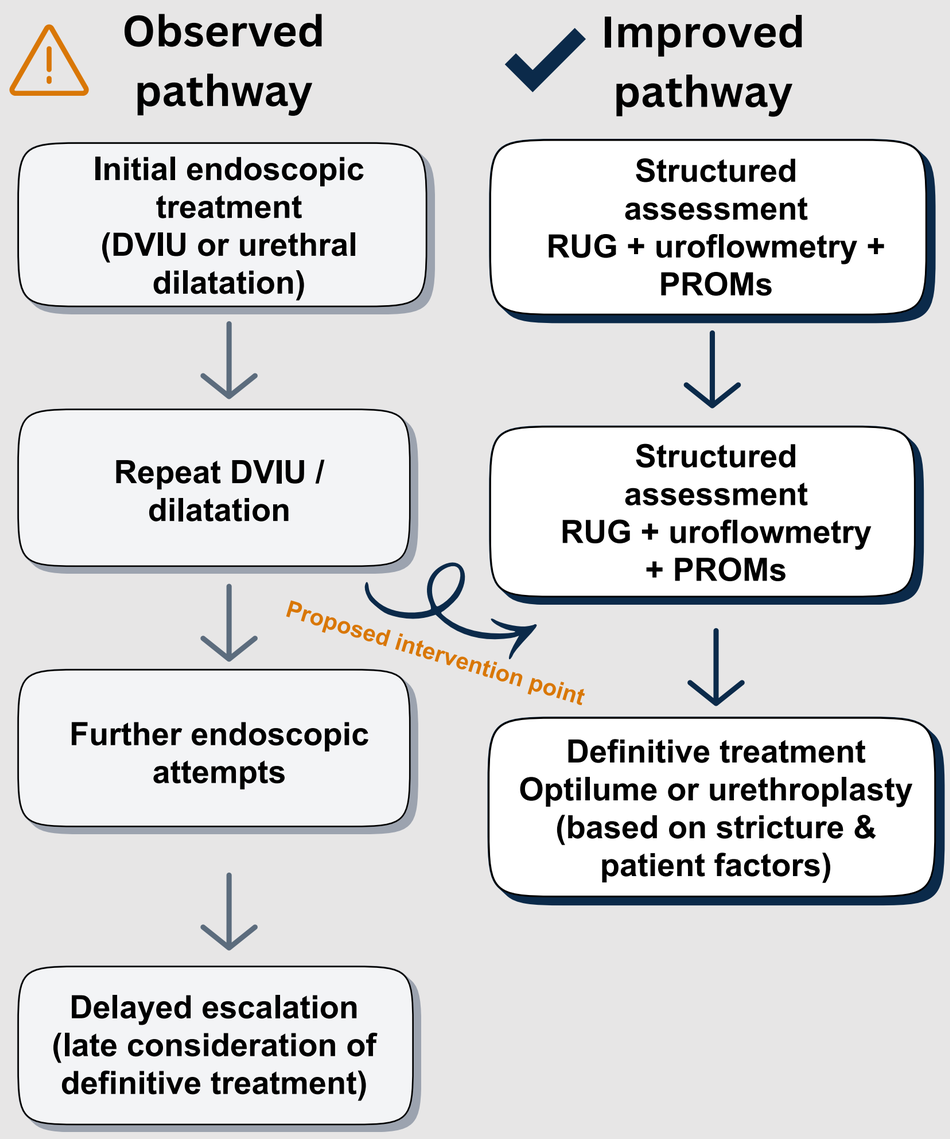


Figure 1. Observed pathway demonstrating delayed escalation following repeated endoscopic treatment and a proposed improved pathway incorporating structured assessment and earlier access to definitive management.

Key findings:

- Median age 56 years (mean 54); all patients male
- 14 internal and 15 external referrals
- Urethrogram and uroflowmetry completed in 23/29
- PROMs undocumented in 24/29 (83%)
- ≥2 prior DVIU/dilatations in 12/29 (41%)
- Definitive treatment was frequently preceded by delayed escalation.
- Detailed stricture characteristics (including length) were inconsistently documented in patients with multiple prior endoscopic treatments, limiting subgroup analysis.

Proposed referral checklist

For men with anterior urethral stricture disease:

- ☑ Retrograde urethrogram available
- ☑ Uroflowmetry ± post-void residual documented
- ☑ PROMs completed
- ☑ Number of prior endoscopic treatments recorded
- ☑ Early reconstructive review considered (Optilume or urethroplasty)

Conclusion

Incomplete assessment and delayed escalation are common prior to definitive treatment. Standardised referral pathways may improve timing and appropriateness of care.

Guideline context

Interpretation informed by EAU Guidelines on Urethral Strictures (2023–2024), including strong recommendations for structured assessment prior to reconstructive decision-making and avoidance of repetitive endoscopic treatment when definitive options are viable.

MARK THIS ABSTRACT

Genetic Testing Referrals for Inherited Renal Cancers (38)

Alexander Hampson, Joshua Blewitt, Rahul Mistry
Mersey West Lancs NHS Trust

Introduction

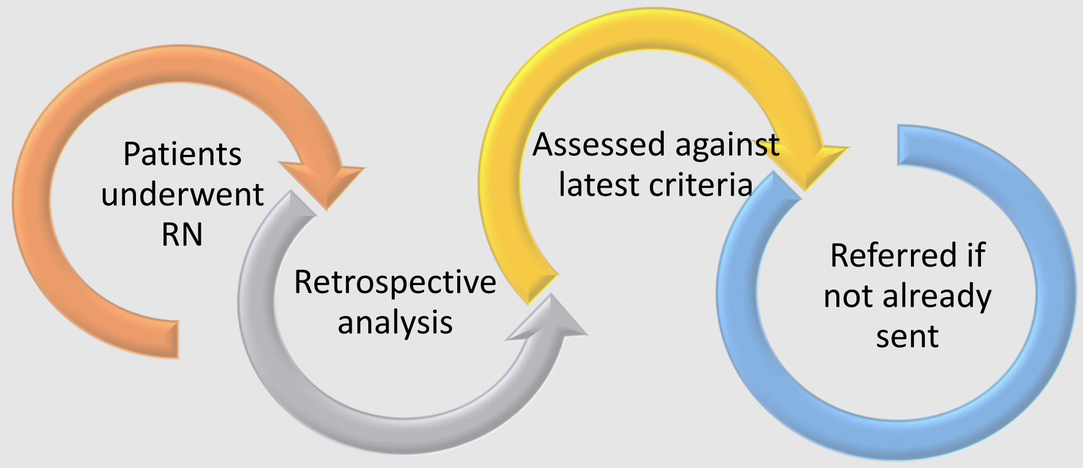
With between 5-8% of renal malignancies being genetically inherited, genetic testing is vital to risk stratifying recurrence and dictating follow up pathways for both patients and their families.

The National Genomic Test Directory (NGTD) publishes testing criteria for inherited malignancies and routinely revises these criteria based on risk factors and available funding for testing.[1]

The criteria for inherited renal cancer were revised 3 times in 2025 (January [2], May and July[1]), with key changes being an increase in the age from 40 to 46 and a differentiation between first degree and second-degree relatives age when diagnosed.[2]

Methods

A retrospective data analysis was conducted of all patients who underwent a radical nephrectomy (RN) since the criteria changes in January 2025 to September 2025. 33 patients were identified and were assessed against the latest criteria to check eligibility for genetic testing.



Results

Eligibility

33 patients were identified as undergoing radical nephrectomy between Jan and Sep 2025.

7 patients were under the age of 46 and therefore met Criteria 1.
4 of these patients met no other criteria for referral
1 of these 7 met Criteria 2: Type 2 papillary HLRCC associated RCC.
1 of these 7 met Criteria 3: Bilateral/multifocal renal cancer.
1 of these 7 met Criteria 4: first degree relative with renal cancer.

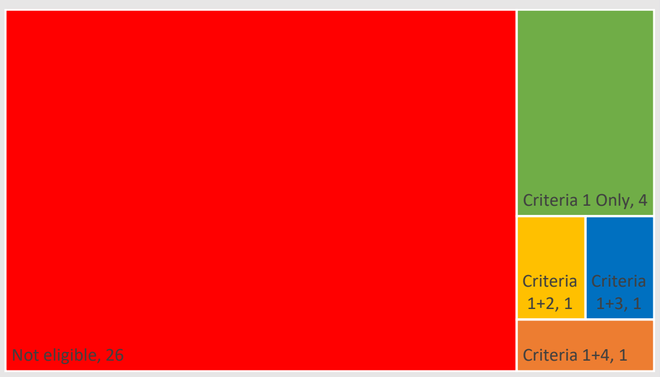


Figure 1.
Overall Eligibility for Genetic referral

R224 Inherited renal cancer[1]

Testing Criteria

1. Renal cancer (≤ 46 years), OR
2. Type 2 papillary HLRCC associated RCC (WHO pathology definition) OR tubulo-papillary renal tumour at any age , OR
3. Bilateral/multifocal renal cancer (any age), OR
4. A renal cancer AND first degree relative with renal cancer, both cases diagnosed under 60 years of age
5. A renal cancer AND second degree relative with renal cancer, both cases diagnosed under 50 years of age
6. Renal cancer and features of inherited cancer syndrome such as:
   - o Cerebellar/spinal haemangioblastoma
   - o Retinal angioma
   - o Phaeochromocytoma/paraganglioma
   - o Spontaneous pneumothorax
   - o Fibrofolliculomas
   - o Trichodiscomas
   - o Cutaneous Leiomyomata
   - o Uterine leiomyomas (under 40 years of age with pathology suggesting FH variant)
   - o Mesothelioma
   - o Uveal melanoma

Adherence

Only 3 of whom would have been eligible using the criteria prior to January.

3 out of 7 patients (43%) who were eligible for testing were actually sent for testing, though subsequent referrals have now been sent.

4 patients were aged between 40 and 46 making them ineligible in the old guidance but now eligible in the updated guidance.

Genetic Findings

So far, One Patient was found to have Fumarate Hydratase (FH) mutation and Hereditary leiomyomatosis and renal cell cancer syndrome (HLRCC).

They are on annual surveillance imaging, and their immediate family has been tested.

Discussion

Referrals for Genetic testing are not frequently discussed within the wider cancer MDT. They are Consultant to Consultant referrals and do not have the same failsafe systems that other aspects of cancer care often have.

Any changes of guidance, such as this, may not be distributed widely through the urological community and therefore could take time to permeate clinical practice.

We have now implemented this as an aspect of our MDT discussions of renal cancer cases and are investigating other urological genetic referral criteria.

Conclusion

Updates to national guidance can have significant implications to patients care. The distribution and dissemination of these changes and auditing them to ensure compliance is vital to ensuring the best possible care is provided.

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MARK THIS ABSTRACT

High Risk Prostate Cancer Variation Audit: A One-Year Analysis in a Tertiary Teaching Hospital (44)

Fatima Kayali MBBS(Hons), MRCS[1], Shannon Jordan MBChB, MRCS[1], Benjamin Starmer MBChB, FRCS[1]

Affiliations

1. Department of Urology, Liverpool University Hospitals NHS Foundation Trust, Liverpool, UK

Introduction

•The NICE guidance suggests high-risk localised prostate cancer patients should be offered radical prostatectomy or alternatively radical radiotherapy in combination with ADT . Gleason 8, 9 or 10, PSA>20 or staged at T3 and above.

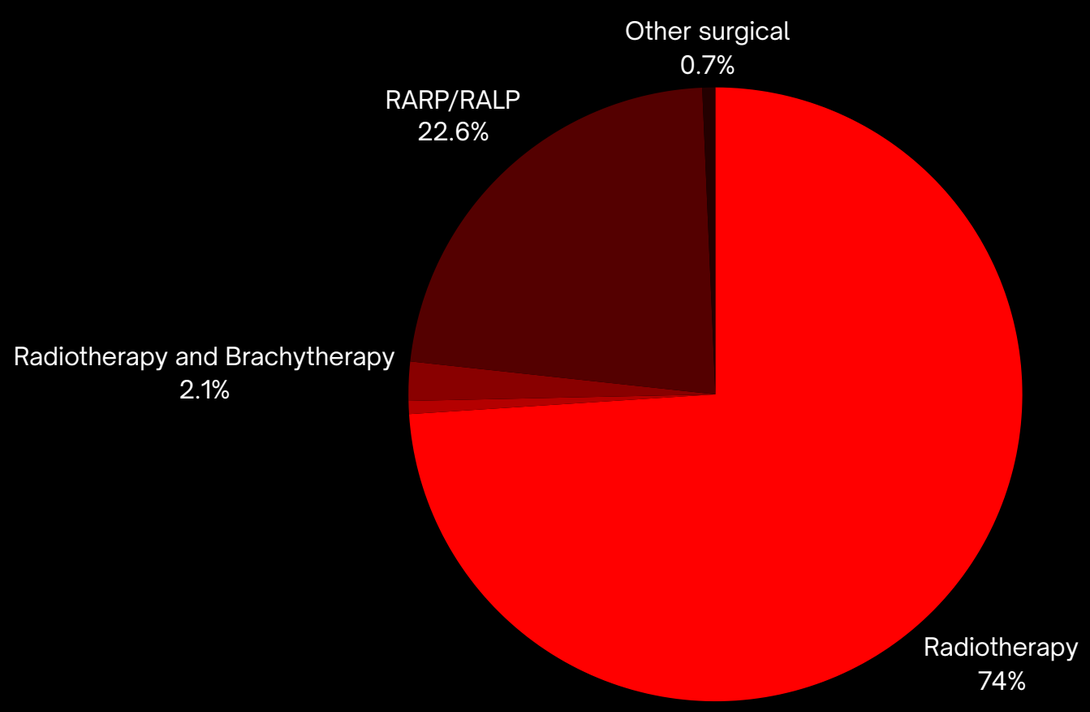
•The 2025 National Prostate Cancer Audit State of the Nation Report highlighted that the proportion of men with high risk, or locally advanced prostate malignancy who were offered radical treatment within 12 months was 69% (range 46-87%) in England.

Methodology

All high-risk patients referred to a tertiary specialist MDT between 06/02/2023-12/01/2024 were included. Data including their PS, CCI, PSA on presentation, ISUP GG and 30-day, 1-year and 2-year outcomes was collated.

Findings

Out of the 170 patients included, 146 patients (86%) received radical treatment within twelve months of the MDT, whilst 24 patients (14%) didn't. Those excluded were deemed for watchful waiting (n=14), active surveillance (n=5), due to patient choice (n=3), or other (n=2). On presentation, the mean age was 66.95 years with a median CCI of 4 and an average PSA of 27.34. At 2-year follow-up, 11%(n=18) showed evidence of disease recurrence, with an overall mortality rate of 2.4% (n=4) secondary to infection/sepsis (n=3) and metastatic disease (n=1).



Treatment	Number of Patients
Radiotherapy	108
Brachytherapy	1
Radiotherapy and Brachytherapy	3
RARP/RALP	33
Other surgical	1

Conclusion

With rising numbers of prostate malignancy, it is paramount that MDTs nationally are suitably identifying high-risk patients and offering them radical treatment as deemed appropriate. Further analysis into the long-term oncological outcomes may help identify subgroups that may benefit or could be spared from radical treatment accordingly.

45. IMPACT OF DIRECT SURGEON FEEDBACK USING A REAL-TIME 'TURBT DASHBOARD' ON DETRUSOR MUSCLE SAMPLING AT FIRST TURBT

Stockport NHS Foundation Trust

Authors: B Stimler, M Gray, J Dyer

Affiliations: Stepping Hill Hospital

MARK THIS ABSTRACT

INTRODUCTION

Detrusor muscle sampling at first TURBT is a marker of TURBT quality and essential for tumour staging and planning timely definitive management as well as corelating with improved oncological prognosis in high grade bladder cancer[1]

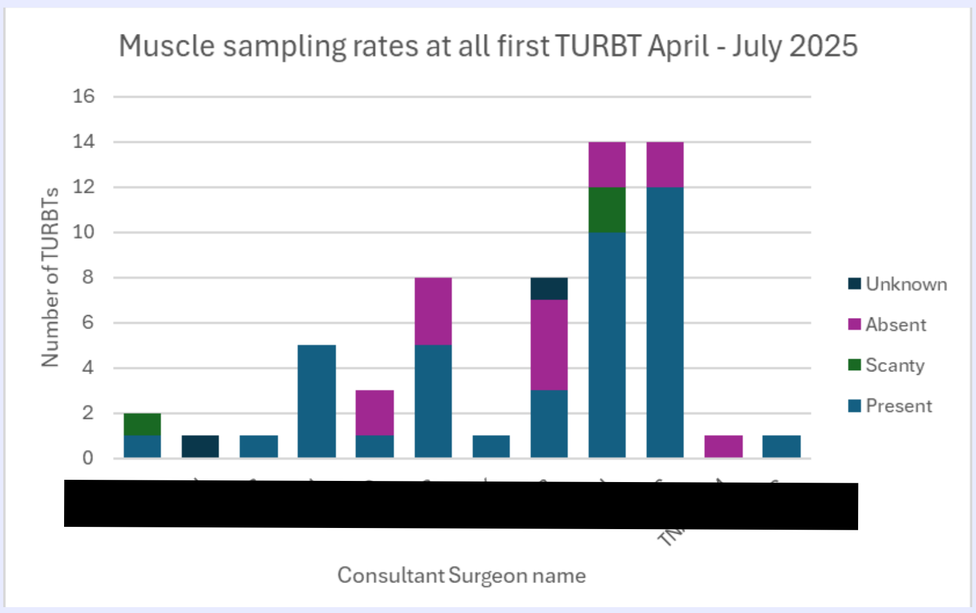


Figure 2: Graph presented at July 2025 audit meeting showing muscle rates at first TURBT per surgeon (anonymised)

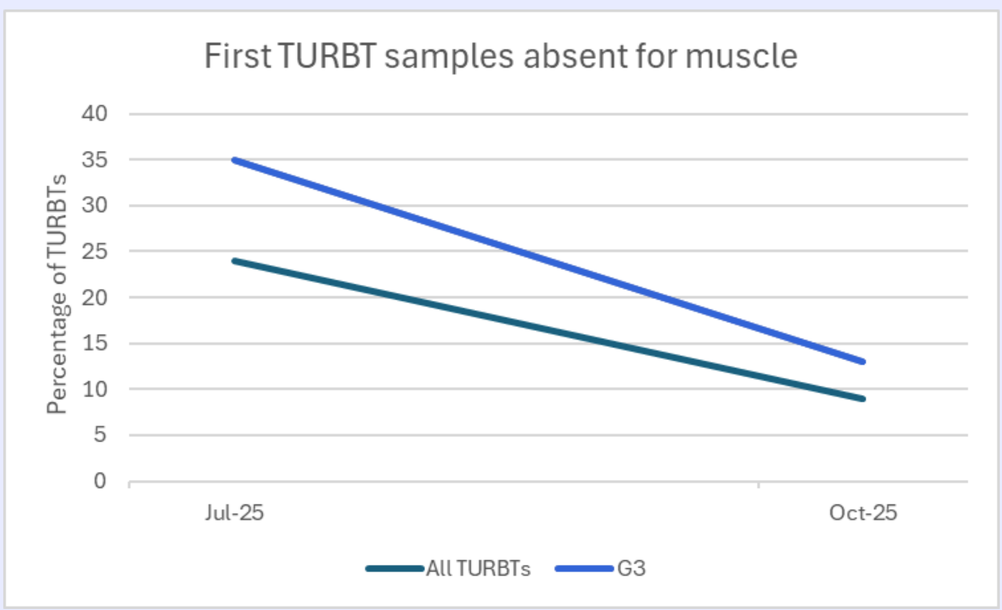


Figure 3: Percentage of first TURBT samples with absent muscle in a pre and post dashboard period

CONCLUSION

Based on our single centre data, feedback to surgeons on muscle rates, as a surrogate measure of TURBT quality, resulted in a reduction in samples negative for muscle. The 'TURBT dashboard' continues to auto-populate in real time with surgeon specific muscle rates, negating the need for continuous manual data collection. This will be regularly presented at quarterly departmental audit meetings, aiming to maintain high rates of muscle sampling in first TURBT through continuous surgeon feedback.

METHODOLOGY

We designed a real-time 'TURBT dashboard' (Fig. 1), in collaboration with the Business Intelligence Team, which documents surgeon specific muscle rates, auto-populated from histology reports. Prior to introduction of the 'dashboard', we performed a single centre retrospective analysis over a 3-month period assessing muscle presence in TURBT specimens. We presented this at our quarterly audit meeting along with introduction of the dashboard. Second cycle data from the 'dashboard' was then presented at the following audit meeting.

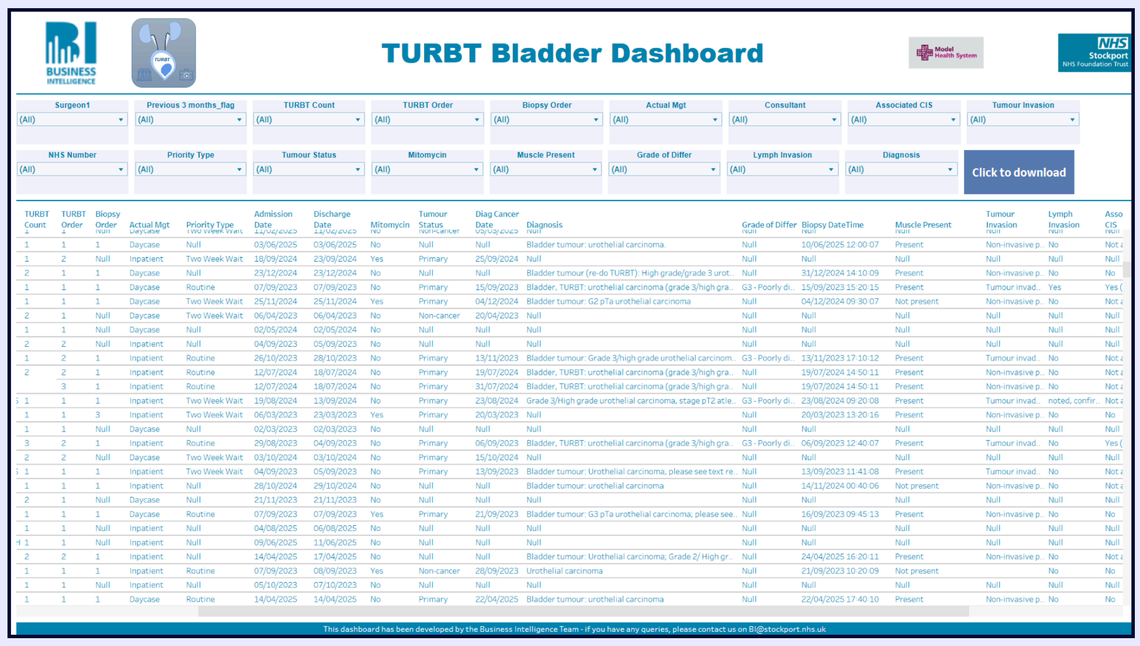


Figure 1: Example of the 'TURBT dashboard'

RESULTS

In a 'pre-dashboard' period, between April – July 2025, 59 TURBTs were performed. Muscle was absent in 24% (14) of all TURBTs and 11% (3) of 28 TURBTs for G3 disease. Data was then analysed from the 'TURBT dashboard' for the second cycle. Between August – October 2025, 45 TURBTs were performed, muscle was absent in 9% (4) of all TURBTs and 4% (1) of 25 TURBTs for G3 disease. Total decrease in muscle absence was statistically significant using chi-square test (p=0.048).

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Follow up of patients on a suspected prostate cancer pathway with a positive MRI scan, but biopsy negative for prostate cancer: results from a single UK centre (47)

Sophie Rivett, Sohail Nakhuda, Craig Jones

Stockport NHS Trust, Manchester

Introduction

- **1 in 6 UK males** will get a **prostate cancer** diagnosis in their lifetime[1].
- The 2018 **Getting It Right First Time (GIRFT)** report highlighted **substantial national variation** in management of suspected prostate cancer.
- Updated **recommendations** published in 2024 define **biopsy thresholds** based on **MRI** findings and **PSA density**.
- There remains **limited guidance** for men who have a **positive MRI** (PIRADS 4/5) but **negative biopsy**.
- We evaluated subsequent clinical decisions for this group within a single diagnostic and treatment centre.

Methods

- We conducted a **retrospective review** of patients referred on a suspected prostate cancer pathway between **26/10/2021-24/11/2023**.
- Inclusion criteria: Men with a **PIRADS 4/5 MRI** and **no evidence of prostate cancer on initial biopsy**.
- Data collected: PSA at referral, prostate volume, MRI date, highest PIRADS score, biopsy date, MDT date, MDT outcome, recommended next steps, and current patient status
- Management plans were categorized as: PSA follow-up only; PSA follow-up with planned repeat MRI; repeat biopsy; discharge to primary care.

Results

- **101 patients** met inclusion criteria
  - Only 19% were discharged back to their GP
  - 82% remained under secondary care follow up
  - 6% with an initially negative biopsy were found to have prostate cancer

PIRADS	n	PSA + MRI + Biopsy follow up (n)	PSA only follow up (n)	PSA + MRI follow up (n)	MRI only follow up (n)	Discharge to GP (n)
4	78	3	32	23	3	17
5	23	2	11	8	0	2
Total	101	5	43	31	3	19

Table 1. Initial management of patients with a positive MRI (PIRADS 4/5) but negative prostate biopsy stratified by PIRADS score.

Of those that had a repeat biopsy (n=5) 80% were found to have prostate cancer.
Of those that had prostate cancer (n=6) 1 had private biopsy following MRI and 1 had iliac bone biopsy following lesion on MRI.

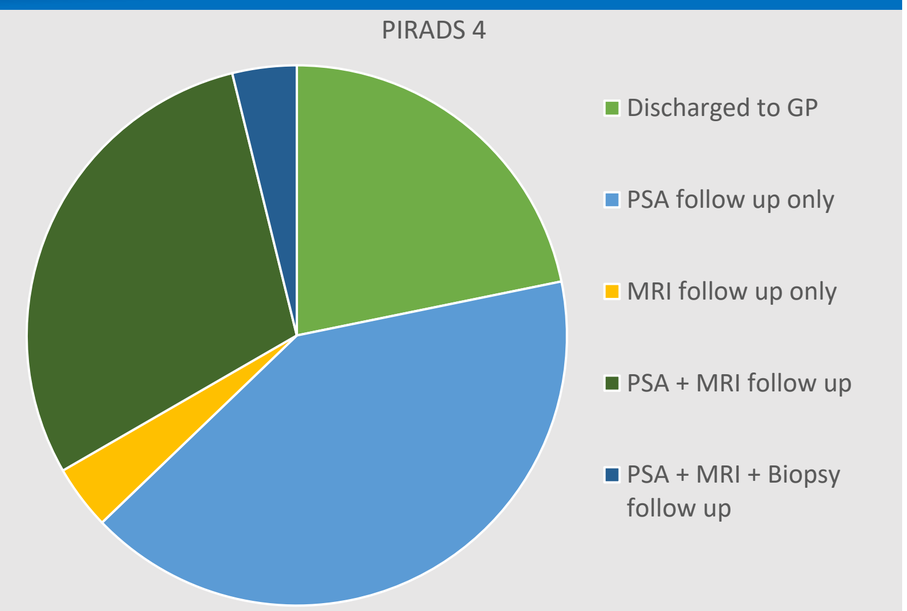

Figure 1. Management of patients with PIRADS 4

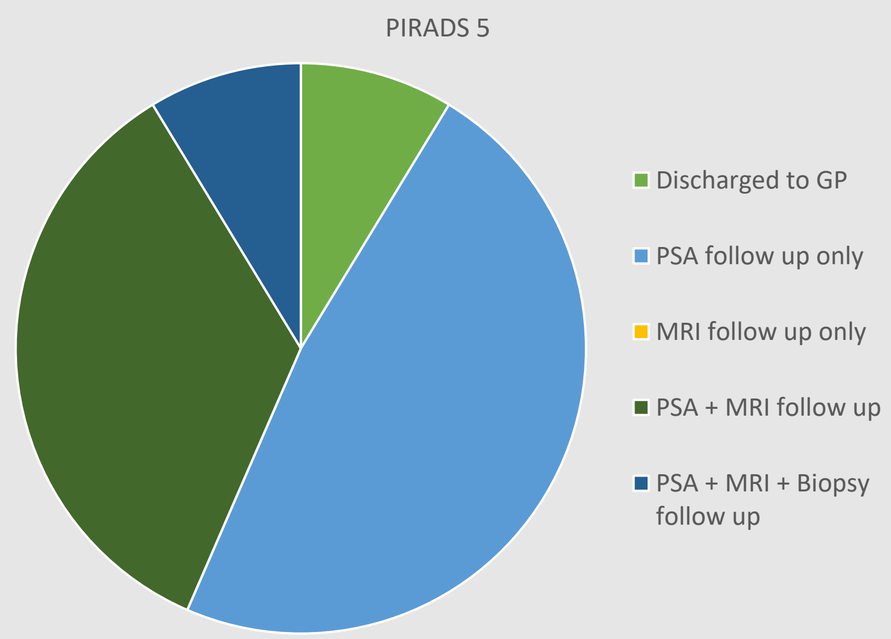

Figure 2. Management of patients with PIRADS 5

Discussion

GIRFT recommend MDT involvement for those with PIRADS 4/5 and discharge only for those with equivocal MRI and negative biopsy[2].
Is prostate density a useful tool in helping stratify patient's risk[3]?
Can patients be managed based on which area of the prostate was biopsied[4]?
Is there a role for further non-invasive tests like PMSA PET/CT[5]?

Conclusion

- **No standardised approach** for managing patients with positive MRI but negative biopsy on a suspected prostate cancer pathway.
- There is need for clearer **evidence-based guidance**.

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MARK THIS ABSTRACT

18 Months Evaluation of Aquablation service provision (48)

Alexander Hampson, Nick Harrison, Richard Jones, John McCabe
Mersey West Lancs NHS Trust

Introduction

Aquablation is at the forefront of novel surgical BPH treatment but is only available within the NHS in a limited number of trusts.[1,2]

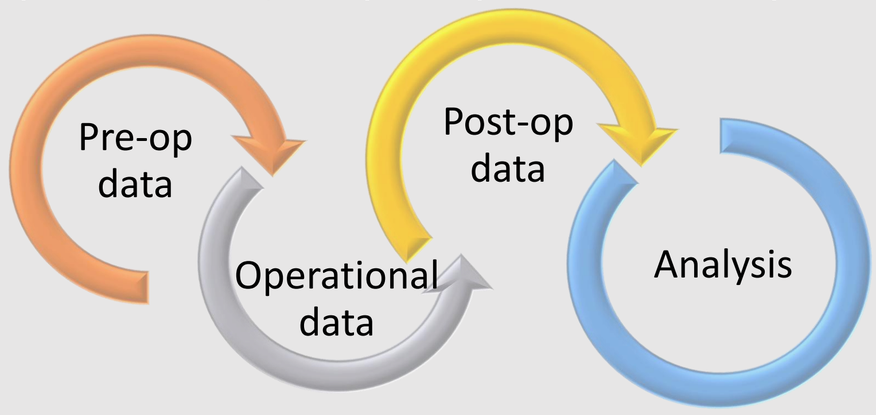
This is the 18 month evaluation for our aquablation service, assessing its feasibility based on patient and hospital factors.

We have also evaluated the evolution of this service, displaying the timeline of implementation and improvement.

Methods

A prospective data analysis was performed of patients undergoing aquablation since its implementation in April 2024.

Data collected included patient demographics, PSA and prostate volume, pre-operative assessment of LUTS including IPSS and Qmax, intra-operative data including operative time and complication rates, and post-operative follow up information.



Results

Demographics

129 patients underwent aquablation surgical treatment between April 2024 and November 2025.

Average Age	68.2
Average PSA	4.68
NHS Patient	81
Private Patient	30
Out of Area Patient	18
Average Prostate Size	78.1
Largest	222
Smallest	24

Table 1. Patient Demographics

Intra-operative Data

Average Operative Time (Mins)	48.8
Number who required a third pass	5
Average Total Pass Time (Seconds)	447
Number of Day Cases	24
Number of Non-day cases (Not PP or OOA)	58
	29.27%
Average Length of Stay (Hrs)	31.0

Table 4.
Intra-operative Data

Post-operative

Cases of malignancy	2
Average Qmax (ml/s)	19.2
Qmax Improvement	10.1
Average IPSS	8.2
IPSS Improvement	14.4
Average QoL	1.2
QoL Improvement	3.5

ED	4	3.1%
Incontinence	2	1.6%
Retreatment Rate	3	2.33%

Table 5. Post-operative data

Imaging

TA USS	38
TR USS	15
MRI	31
CT	7
DRE	11

Table 2.
Imaging Modality

Pre-operative Data

Average Qmax	9.0
Average IPSS	22.7
Average QoL	4.7

Table 3.
Pre-operative data

Evolution of Service Provision

	First 6 months	Middle 6 Months	Last 6 months
Theatre productivity (Mins)	57.42	47.11	42.04
Day cases	4	10	9
	11.1%	47.6%	36.0%

Table 7.
Evolution of Service Provision

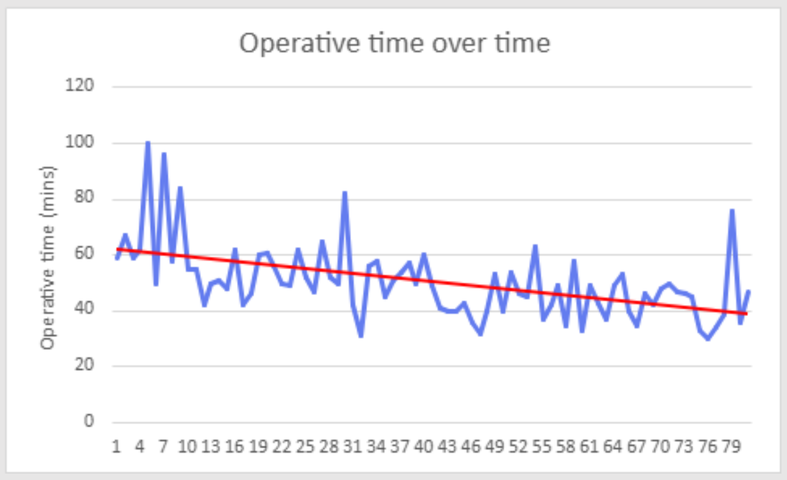


Figure 1.
Operative time over time

Discussion

We demonstrate a considerable improvement in IPSS of 14.4 points, in QoL of 3.5, and Qmax improvement of 10.1ml/s.

We have also assessed theatre efficiency during this period, demonstrating consistent and continued improvements in operative time, with an overall downtrend, pearson coefficient of -0.533.

We present overall day case rates of 29.3% but demonstrate that this was slow to implement in the first 6 months (11%) but improve drastically over the next two 6 month periods (47.6% and 36%).

Conclusion

Aquablation offers a safe, efficacious alternative to TURP and HOLEP, with equivalent functional side effect profiles to widely adopted MISTs such as Rezum and Urolift. Favourable day case rates and procedure times offer the potential to improve productivity in line with the benchmarks set through the GIRFT improvement programme.

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MARK THIS ABSTRACT

One-year audit of suspected prostate cancer referrals: correlation between mpMRI findings, PSA d and biopsy histology in a single UK diagnostic and treatment centre (52)

Authors: Omar Desouky, Helen Stephens, Craig Jones
Affililations: Stockport NHS Foundation Trust

INTRODUCTION

- Suspected prostate cancer referrals place a significant burden on diagnostic pathways, and efficient triage is essential.
- mpMRI is central to risk stratification, PSA density (PSAd) is increasingly used alongside MRI to refine risk and support biopsy decision-making.
- Aim: To evaluate the relationship between mpMRI findings (PI-RADS), PSAd, and biopsy outcomes in men referred via a suspected prostate cancer pathway at Stockport NHS Foundation Trust.

METHODS

- Retrospective review of referrals on the suspected prostate cancer pathway who underwent mpMRI in 2024.
- Data collected: age, PSA, prostate volume, PSAd, PI-RADS score, biopsy status, and biopsy histology.
- Outcomes:
  - csPCa on biopsy, biopsy rates by PI-RADS, PSAd.
- Analysis: Descriptive statistics; PSAd as median (IQR); cancer/csPCa detection across PI-RADS categories

RESULTS

MRI Results

- 647 men underwent mpMRI during the Audit period.

Median PSAd by MRI category:

- **P≤2**: **0.09** (IQR 0.06–0.12)
- **P3**: **0.13** (IQR 0.085–0.18)
- **P4**: **0.13** (IQR 0.09–0.19)
- **P5**: **0.28** (IQR 0.17–0.47)

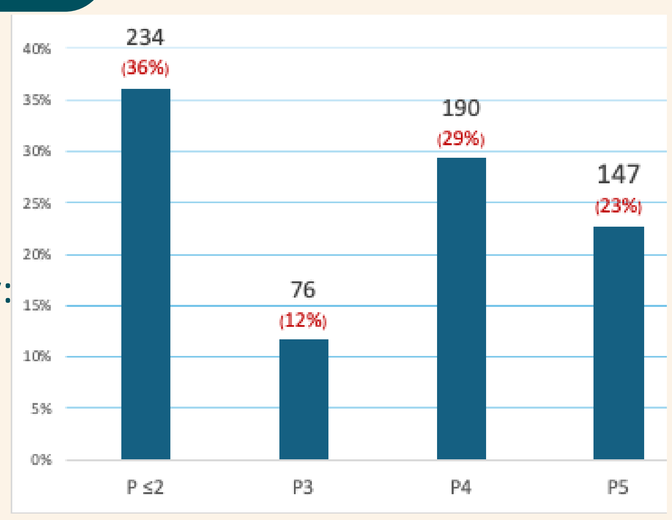


Figure 1: MRI PIRADS distribution

Biopsy and histology

- 356 (55%) proceeded to biopsy.

Median PSAd by histology group:

- **csPCa**: **0.21** (IQR 0.13-0.35)
- **Benign**: **0.12** (IQR 0.08-0.16)
- **Non significant cancer**: **0.14** (IQR 0.1-0.21)

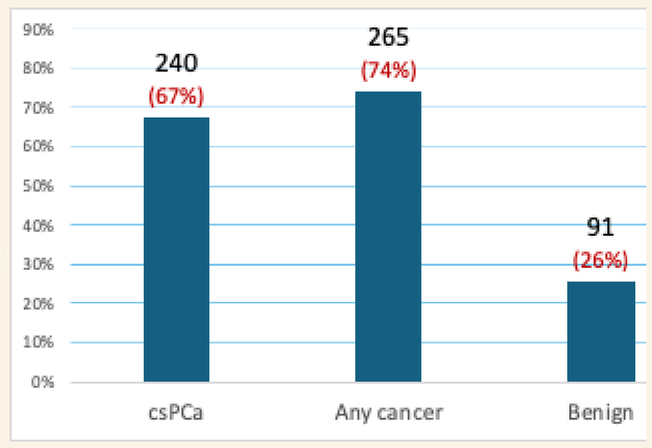


Figure 2: Histology among biopsied men

Biopsy rates and PI-RADS

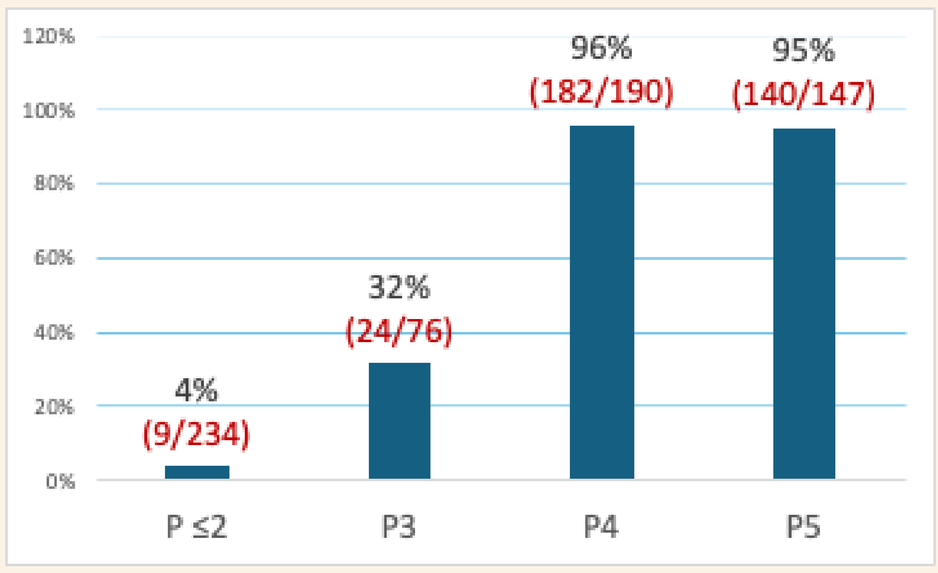


Figure 3: Biopsy rates and PIRADS category

Table 1: Comparison of csPCa and benign rates by PI-RADS score and corresponding Median PSAd.
n (%). PSAd (IQR) *Interquartile Range

	PI-RADS ≤2	PI-RADS 3	PI-RADS 4	PI-RADS 5
All	**n= 234** **PSAd= 0.09** (0.06-0.12)	**n= 76** **PSAd = 0.13** (0.09-0.18)	**n= 190** **PSAd= 0.13** (0.09-0.19)	**n=147** **PSAd= 0.28** (0.17-0.47)
csPCa	**n= 4** (44%) **PSAd= 0.26** (0.17-0.35)	**n= 9** (38%) **PSAd= 0.19** (0.15-0.39)	**n= 100** (55%) **PSAd= 0.15** (0.1-0.22)	**n=126** (90%) **PSAd= 0.3** (0.18-0.48)
Benign	**n= 4** (44%) **PSAd= 0.29** (0.20-0.39)	**n= 12** (50%) **PSAd= 0.19** (0.15-0.24)	**n= 66** (36%) **PSAd= 0.11** (0.08-0.16)	**n=9** (6%) **PSAd=0.12** (0.09-0.17)

Table 2: Grade group distribution among biopsied men with csPCa

PI-RADS category	GG2 n (%)	GG3 n (%)	GG4–5 n (%)
PI-RADS 4 (n=182 biopsied)	**63 (35%), PSAd 0.15** (0.09-0.22)	**29 (16%), PSAd 0.14** (0.1-0.235)	**8 (4%), PSAd 0.19** (0.17-0.27)
PI-RADS 5 (n=140 biopsied)	**45 (32%), PSAd 0.21** (0.15-0.33)	**48 (34%), PSAd 0.34** (0.33-0.57)	**33 (23%), PSAd 0.39** (0.2-0.76)

DISCUSSION

- Biopsy yield for csPCa was high, particularly in P4–5.
- PSAd increased with MRI suspicion and with csPCa, supporting PSAd as an adjunct to MRI when counselling and planning biopsy.
- Very low biopsy rates after benign MRI but 44% csPCa rates, consider more biospies especially in raised PSAd
- Rates of high grade cancer (GG4 and 5) were singificantly higher in the PI-RADS 5 group

CONCLUSION

- mpMRI-based triage yields high csPCa detection, especially in P4–5.
- PSA density adds value alongside MRI particularly in equivocal scans.
- P5 had 90% csPCa rates, and 23% of G4 or G5 cancer

MARK THIS ABSTRACT

53 Enhancing Radiation-Safety Practices and Reducing Occupational Radiation Exposure in Endourology: A Closed-Loop Audit of Thyroid-Shield Compliance

Ms Lydia Chang, Mr Peter Smith

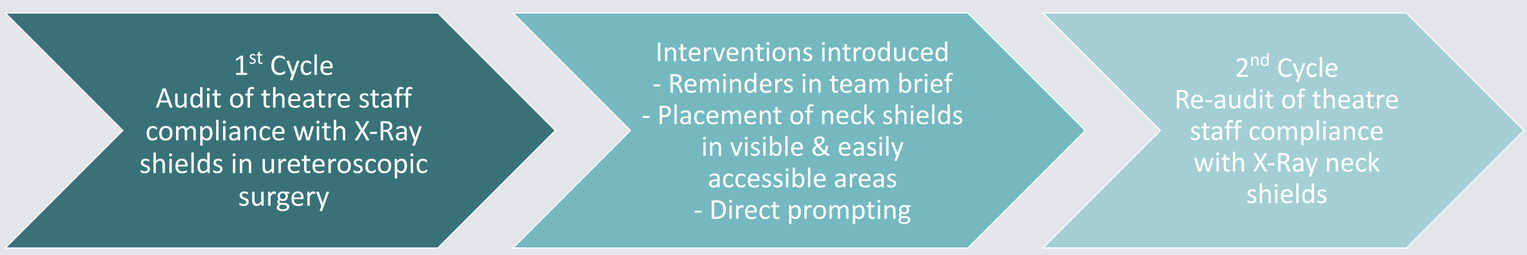
Lancashire Teaching Hospitals NHS Trust

Introduction

Endourological procedures such as ureteroscopy expose theatre staff to ionising radiation, and consistent use of thyroid (neck) shields is essential to minimise occupational exposure. UK Health and Safety Executive (HSE) regulations emphasise adherence to the As Low As Reasonably Achievable (ALARA) principle. A baseline audit in our department demonstrated suboptimal thyroid-shield use among theatre staff during ureteroscopic procedures. This closed-loop audit evaluated whether simple, targeted interventions could improve compliance.

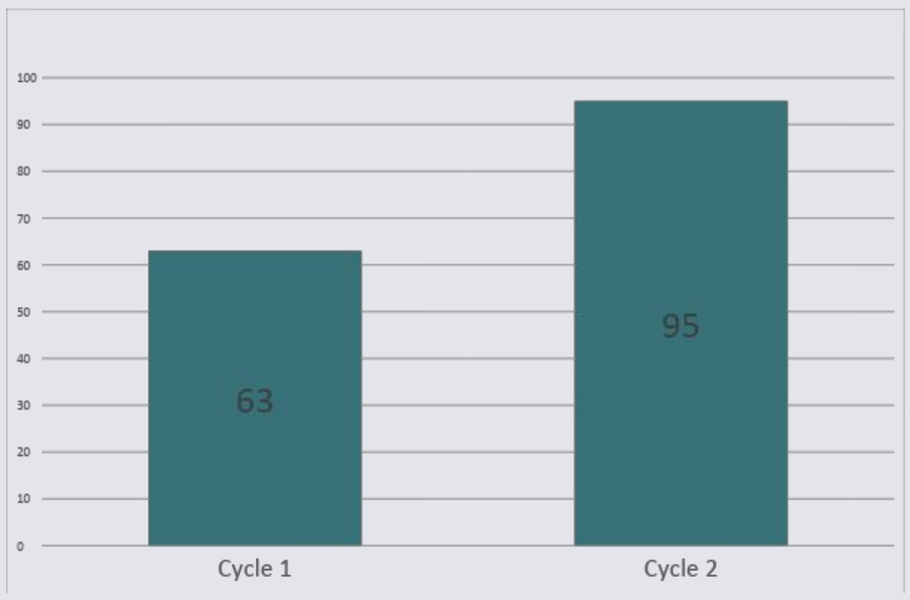
Methods

The audit was conducted in a UK hospital over two cycles. During each cycle, theatre staff present during ureteroscopic surgery were observed for compliance with wearing x-ray neck shields. Nine procedures were reviewed in the pre-intervention cycle and nine in the post-intervention cycle. Following baseline data collection, interventions included reminders during the theatre team brief, placing neck shields in visible and easily accessible locations, and directly prompting non-compliant staff. The same observational method was used in the second cycle, and reasons for non-compliance were recorded.



Results

Average compliance with thyroid-shield use improved from 63% at baseline to 95% following intervention. Common reasons for non-compliance included lack of awareness regarding the need for neck shields and difficulty locating equipment. After the interventions were introduced, both awareness and accessibility improved, contributing to the substantial increase in compliance.



Discussion

This closed-loop audit demonstrates that simple, targeted interventions significantly improved theatre staff compliance with thyroid-shield use during ureteroscopy. Non-compliance was mainly due to lack of awareness and difficulty accessing equipment. Addressing these barriers aligned practice with ALARA principles and UK radiation-safety guidance. Despite small numbers, improvements were substantial, supporting ongoing reinforcement and re-audit.

Conclusion

Low-cost, targeted interventions significantly improved thyroid-shield compliance during ureteroscopy. Continued education and re-audit are essential to maintain radiation-safety standards.

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5. Sulieman A et al. *Radiation exposure to medical staff during fluoroscopic urological procedures.* **European Urology**.

MARK THIS ABSTRACT

Preoperative urine testing before elective urological surgery: are we adhering to the GIRFT guidelines? (54)

Teejaswinee Puddo, Kirolos Michael, Sohaib Ibn-Iftikhar Uddin, Adam Bromby
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, Greater Manchester, United Kingdom

INTRODUCTION

Preoperative urinary tract infections and asymptomatic bacteriuria can increase the risk of postoperative infections and potentially lead to procedure cancellations in patients undergoing elective urological surgery. GIRFT guidelines in April 2025[1] recommended that, for asymptomatic patients, a urine MC&S be performed two weeks prior to the procedure date for elective, mucosal-breaching endourological operations. Treatment for positive urine cultures is to be commenced 48 hours prior to surgery.

Aim: To assess adherence to these recommendations by our unit.

METHODOLOGY

- Retrospective review over 2 months of patients who underwent elective **TURBT**, **TURP**, **URS**, **FURS** and **PCNL** (identified through coding).
- Analysed whether the patients had urine testing performed, the timing of this in relation to surgery and how results were actioned.
- Data was collected from patients' electronic case notes and was input into and analysed using Microsoft Excel.

RESULTS

80 Patients: 9 TURP 32 URS/FURS 2 PCNL 2 TURBT+URS 35 TURBT

Figure 1: Number of patients who had Urine MC&S performed per procedure

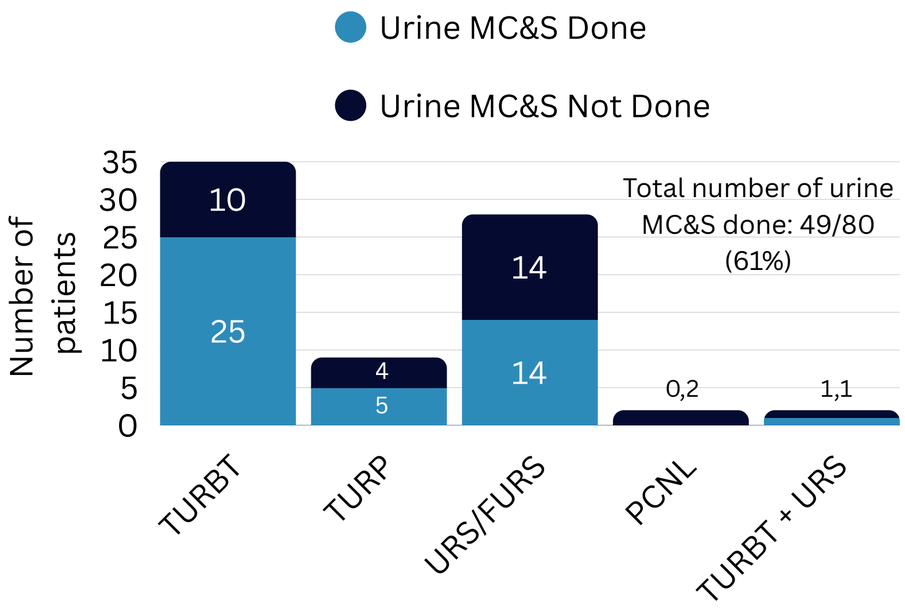


Figure 2: Duration (days) between latest Urine MC&S and Operation

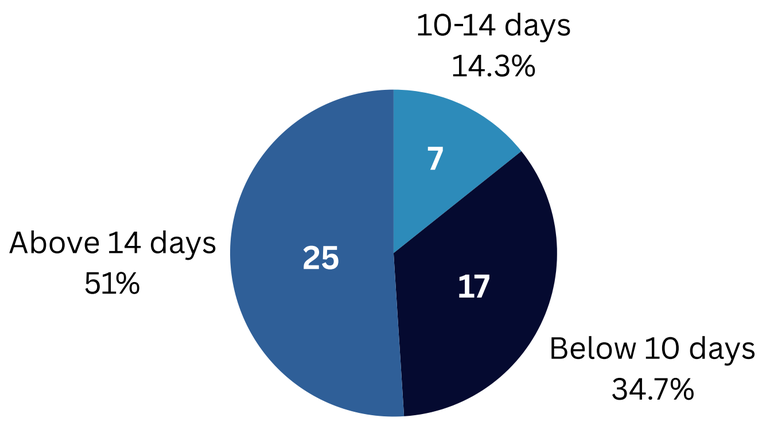
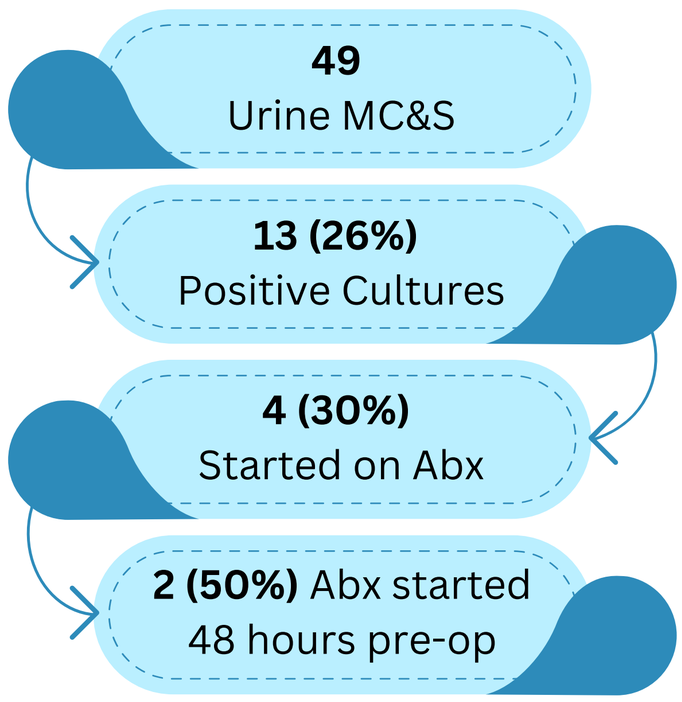


Figure 3: Proportion of positive cultures and initiation and timing of antibiotics



54/80 (68%) had a urine dipstick performed: 34 positive and 20 negative results:

- Of 34 positive dipsticks: 29 (85%) patients had subsequent urine MC&S
- Of 20 negative dipsticks: 2 (10%) had subsequent urine MC&S

100% of patients had prophylactic antibiotics at the time of procedure

1 cancellation identified due to untreated pre-op urine MC&S positive for *Klebsiella pneumoniae*

NO documentation of symptamology for UTI at time of preoperative assessment for any patient!

NOTE: 83 patients were initially identified with 3 patients excluded as they were already on antibiotics for a UTI at time of preoperative assessment, leaving 80 patients included in the final analysis.

CONCLUSIONS & DISCUSSION

- Adherence to guidelines remains suboptimal
- Only 61% of the patients had a urine MC&S performed. A significant proportion of patients had a urine dipstick performed and urine MC&S sent off only if the dipstick was positive - GIRFT guidelines do not recommend urine dipsticks due to their poor accuracy and unreliability
- Majority of urine MC&S which were obtained were done so over 10-14 days prior to the to-come-in date
- Only a minority of patients with asymptomatic bacteriuria were appropriately treated with antibiotics 48 hours prior to their procedure. However, all patients received targeted antibiotic prophylaxis at the time of the operation
- Paucity of documentation on symptomatology of UTI at time of preoperative assessment

Discussion: The conclusions reflect process-related factors such as the absence of checklist prompts and variable awareness of the GIRFT guidance, highlighting the need for targeted interventions.

INTERVENTIONS

1) Presentation at local governance meeting to raise awareness on issue and guidance
2) Checklist at preoperative assessment to ensure urine MC&S sent, reviewed, and appropriately treated

LIMITATIONS

Difficult to identify all cancelled procedures as a result of untreated preoperative UTI or asymptomatic bacteriuria as data collected on patients who had their procedures only.

MARK THIS ABSTRACT

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55. Real-World Effectiveness of Optilume: A Multicentre Greater Manchester Cohort Study

A Chuang[1], S Awida[2], O Desouky[3], A Gutierrez[1], J Suppree[2], A Fatuga[3], A Sharqawi[2], A Sinclair[3], L Olson[1]

[1]Salford Royal Hospital, [2] Royal Bolton Hospital, [3]Stepping Hill Hospital

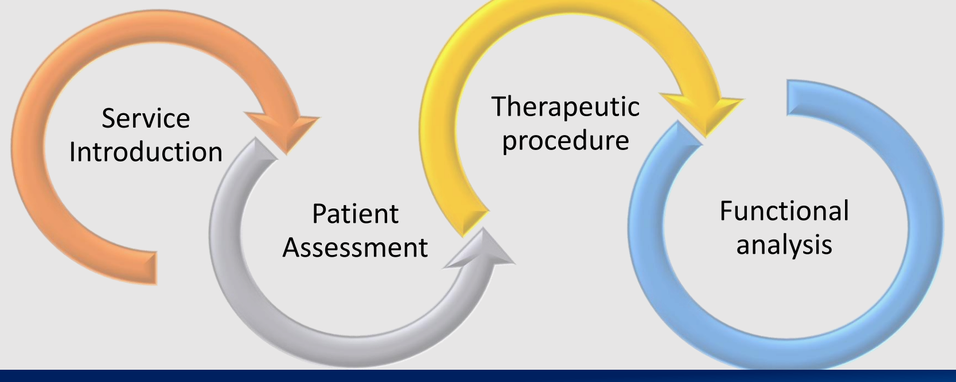
Introduction

Drug-coated balloon dilatation (Optilume) is a novel, minimally invasive option for urethral stricture disease which combines mechanical dilatation with paclitaxel delivery to inhibit scar formation. Clinical trials (ROBUST) have demonstrated encouraging medium-term outcomes, with reduced need for reintervention and sustained symptom relief. UK real-world outcome data remain limited. This study presents early multicentre experience from three high-volume NHS centres across Greater Manchester.

EAU recommendation	Level of evidence
Drug (paclitaxel) coated balloon dilatation is associated with higher anatomic patency rates (at six months) and lower risk of retreatment (at one year) as compared to standard dilatation/ DVIU in patients with short (<3 cm), bulbar strictures that underwent at least two prior failed endoscopic treatments	1b

Methods

A retrospective review was performed of all patients undergoing Optilume across Salford Royal Hospital, Royal Bolton Hospital and Stepping Hill Hospital since service introduction in 2024. Data collected included demographics, previous urethral interventions, stricture characteristics, operative details, postoperative complications and functional outcomes. Follow-up included symptom assessment, uroflowmetry, and post-void residual (PVR) where available.



Results

Demographics/ Patient cohort

- Multicentre data from high volume centres within Greater Manchester - Salford Royal, Stepping Hill and Royal Bolton
- 91 patients had Optilume to date
- 29 patients from Salford Royal, 34 patients from Stepping Hill, 28 patients from Royal Bolton
- Started in June 2024 at Royal Bolton, October 2024 at Stepping Hill and Salford Royal
- All males
- Average age 57; median age 56

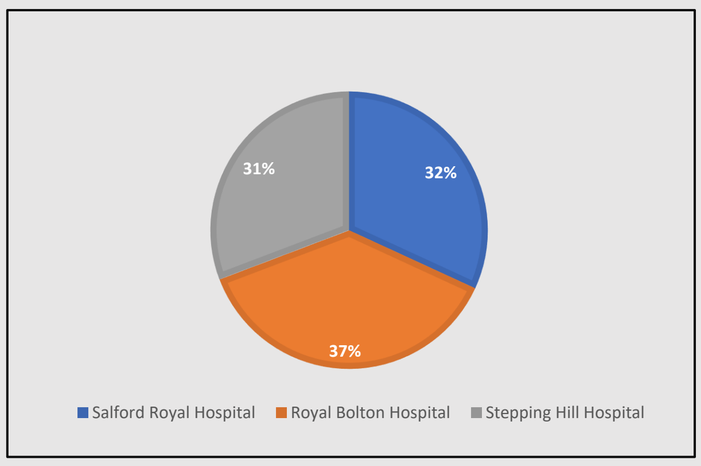


Figure 1.
Distribution of Patients by Participating Centre

Pre-procedure

- First presentation: 17/91
- Previous intervention: 74/91 (previous DVIU, urethral dilatation, hypospadias repair, urethroplasty)
- >2 DVIU or/and urethral dilatation: 26/74
- Previous urethroplasty: 17/74 (consistent across hospitals - 5 Salford patients, 6 Stepping Hill patients, 6 Bolton patients)
- 48/91 had ≥2 cm urethral stricture
- 90/91 had Optilume for anterior stricture; 1/91 had Optilume for posterior urethral stricture

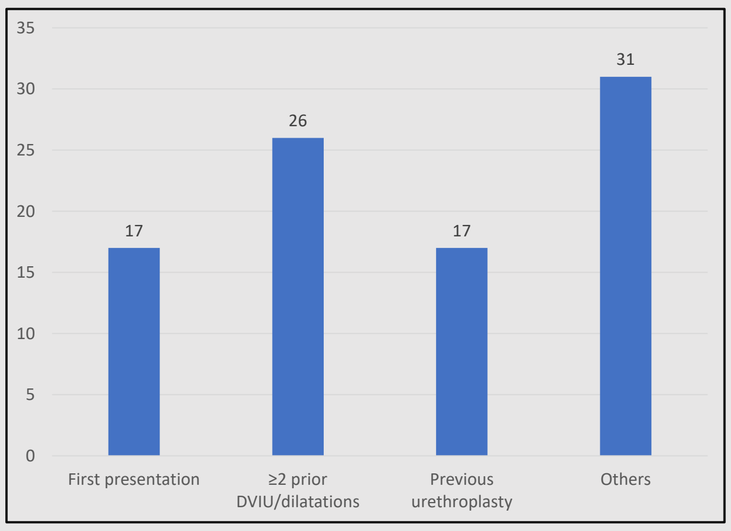


Figure 2.
Prior Treatment Burden Before Optilume

Post procedure/ functional outcome

- Median and mean follow up time at 4 months
- Only 1 post operative complication with post operative urosepsis/ UTI
- 46/61 satisfied at first initial follow up
- 15/61 unsatisfied at first follow up; of which 13/15 from Royal Bolton Hospital – high prevalence for obliterated and ≥2cm stricture
- Mean reduction in IPSS by 5.32
- Mean increase in Qmax by 5.29mL/s
- Mean reduction in post void residual (PVR) bladder volume by 54.4 mL. Upper limit 342 reduction & lower limit + 142mL.
- Interestingly, only 3 was not satisfied post Optilume treatment with an 'increase/ no change' in post void residual volume.

Key results

Patient satisfaction: 75% (46/61)
IPSS: −5.32 points
Qmax: +5.29 mL/s
PVR: −54.4 mL
Safety profile: 99%

Discussion

This real-world multicentre cohort demonstrates that Optilume is a safe minimally invasive option for urethral stricture disease, even in a heavily pre-treated population. Early functional and symptomatic improvements were observed with minimal complications. Early dissatisfaction was concentrated in patients with long or obliterated strictures, highlighting the importance of careful patient selection and expectation management. Short follow-up and incomplete data are acknowledged limitations, with ongoing follow-up required to assess durability.

Conclusion

Optilume delivers meaningful early functional improvement in urethral stricture disease. Outcomes are less predictable in long or complex strictures, highlighting the need for careful patient selection. Longer-term follow-up is ongoing.

References

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MARK THIS ABSTRACT

57-The Critical Role of Systematic Biopsy in the MRI Era: A Two-Cycle Audit of 200 Patients Validating Guideline Recommendations

Authors: Mr Bilal Quddus, Mr Waqas Khalil, Mr Mazhar Sheikh, Mr Jawad Islam

Affililations: Blackpool Teaching Hospitals

Introduction

The diagnostic pathway for prostate cancer has been revolutionized by multiparametric MRI (mpMRI) and targeted biopsy (TBx), a change supported by level 1 evidence from the **PRECISION trial (2018)**. Reflecting this, the **European Association of Urology (EAU) 2023 guidelines** recommend mpMRI prior to initial biopsy. However, a crucial debate centers on whether to omit systematic biopsy (SBx) when a target is identified. Contrary to this trend, the **MRI-FIRST trial (2019)** demonstrated that 21% of clinically significant prostate cancers (csPCa) would be missed without SBx, leading the **EAU to strongly recommend a combined approach** to avoid under-detection.

Methods

Methodology: A retrospective analysis of 200 patients undergoing combined MRI-TBx and template SBx was conducted over two cycles: Cycle 1 (2019-2020, n=100) and Cycle 2 (2022-2023, n=100). The primary outcome was the incidence of csPCa detected exclusively in SBx cores.

Aim: To quantify the incremental value of SBx in detecting csPCa (Gleason Grade Group ≥ 2) missed by TBx alone across two sequential cohorts and to benchmark our local performance against international guideline standards.

Standards: The **EAU (2023) guidelines** state: "In biopsy-naïve men with a positive MRI, a combined approach (targeted + systematic) is strongly recommended." This is due to a consistent SBx-only csPCa rate of **5-15%** in contemporary literature **(Drost et al., Cochrane Review, 2020)**.

Results

Cycle 1: Of 61 patients with cancer, **18 (29.5%)** had csPCa diagnosed exclusively by SBx.

Cycle 2: Of 55 patients with cancer, **11 (20.0%)** had csPCa diagnosed exclusively by SBx.

Pooled Analysis: Across 200 patients, **29 of 116 cancer patients (25.0%)** had their csPCa detected solely by SBx.

Comparison with International Standards: Our pooled SBx-only csPCa rate of **25.0% substantially exceeds the 5-15% range** cited by the EAU and the **5-10%** rate reported in large meta-analyses. This confirms that in our clinical setting, SBx is not merely additive but fundamental to accurate diagnosis.

Conclusion

Our audit provides powerful local validation for the EAU's strong recommendation. The high and persistent rate of SBx-only csPCa unequivocally demonstrates that systematic biopsies are indispensable in our practice. Omitting SBx would have led to one in four men with csPCa being misdiagnosed or under-graded, representing a significant patient safety issue.

Recommendations

1. **Sustain Standard Practice:** The combined TBx+SBx approach must be maintained as the mandatory institutional standard.
2. **Root Cause Analysis:** A multidisciplinary review is needed to investigate the factors behind our higher-than-expected SBx-only csPCa rate.
3. **Enhanced Informed Consent:** Patient discussions must include our local data on the ~25% risk of missing csPCa without systematic biopsies.

MARK THIS ABSTRACT

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Rezum treatment following failure of medical therapy provides durable outcomes in the treatment of men who are voiding with ongoing LUTs (58)

Andrew Atayi[1], Alexis Helsel[2], Richard Glendinning[1], Nigel Parr[1]

1. Arrowe Park Hospital 2. Department of Statistics AUA Linthicum Maryland USA

Introduction

- North American pivotal Rezum studies demonstrated a mean IPSS Reduction of 51% at 24 months post treatment[1].
- Participants in that study:
    1. Were treated without prior medical therapy (MT)
    2. Had prostate volume (PV) restrictions of 30-80cc
    3. Did not have routine median lobe injection
- These conditions on Rezum treatment are uncommon in the European setting
- We evaluated whether similar outcomes occur when these limitations are removed and assessed for pre-treatment prognostic factors and treatment variables.

Methods

- From 2019 to 2024, 2 surgeons treated 146 patients with Rezum
- Patients unable to void were excluded
- Planned assessment were scheduled at baseline, 6 weeks, 3 months, 6 months, 12 months, and 24 months.
- Linear regression analysis was used to model the change in International Prostate Symptom Score (IPSS), Q-max, ratio of voiding to storage symptoms and post void residual (PVR) from baseline through 12-months controlling for age, surgeon, injection sites & density, and baseline scores.

Results

Table 1. Patient Baseline Demographics and Characteristics

Characteristic	Mean (SD, range)	N
Age (years)	67.79 (7.37, 45-86)	136
Year enrolled, n (%)		136
2019	20/136 (14.7)	
2020	34/136 (25.0)	
2021	27/136 (19.9)	
2022	29/136 (21.3)	
2023	20/136 (14.7)	
2024	6/136 (4.4)	
Treating Provider, n (%)		136
Provider 1	73/136 (53.7)	
Provider 2	63/136 (46.3)	
IPSS	24.54 (5.15, 10-35)	135
Obstructive	14.22 (3.67, 3-20)	134
Irritative	10.3 (2.75, 3-15)	134
Obstructive/IPSS	0.58 (0.09, 0.25-0.8)	134
IPSS QOL	4.67 (1.02, 3-6)	131
Qmax	9.74 (3.49, 1-22)	133
PVR	154.98 (129.44, 0-521)	130
PSA	3 (2.36, 0.23-14)	136
Prostate Volume (PV)	58.56 (20.97, 28-126)	132
Catheter Days	10.58 (11.17, 1-90)	130
Total Injections	5.67 (2.05, 2-12)	136
Any Median Lobe Injections (Y), n (%)	89/136 (65.4)	136
Injection Density (Injections/Prostate vol)	0.10 (0.03, 0.02-0.20)	132
Voiding (Y), n (%)	136/136 (100)	136
Medical Management (Y), n (%)	131/136 (96.3)	136
Alpha Blockers (Y), n (%)	130/136 (95.6)	136
5ARis (Y), n (%)	90/136 (66.2)	136
Anticholinergics (Y), n (%)	14/136 (10.3)	136
RUTIs (>=1) / Prostatitis, n (%)	3/133 (2.3)	133
Re-Catheterization (Y), n (%)	25/136 (18.3)	136
Imaging, n (%)		131
Ultrasound	82/136 (62.6)	
MRI	45/136 (34.4)	
TRUS	1/136 (0.8)	
No imaging	3/136 (2.3)	
Post-Operation Antibiotics (Y), n (%)	136/136 (100)	136
Any Complications, n (%)	15/136 (11)	136

Table 1. Patient Baseline Demographics and Characteristics

- 136 patients were included in final analysis
- 76 (56%) had an assessment at 6 weeks, 68 (50%) at 3 months, 85 (63%) at 6 months, 81 (60%) at 1 year, and 64 (47%) at 2 years.
- 96% of patients had a trial of medical management as demonstrated in Table 1
- Mean IPSS at baseline was 24.5 with a 13-point reduction seen at 24 months ($p<0.001$)
- Statistically significant improvement in IPSS, Q-Max, Obstructive symptoms, QOL and PVR are demonstrated in Figures 1-4.

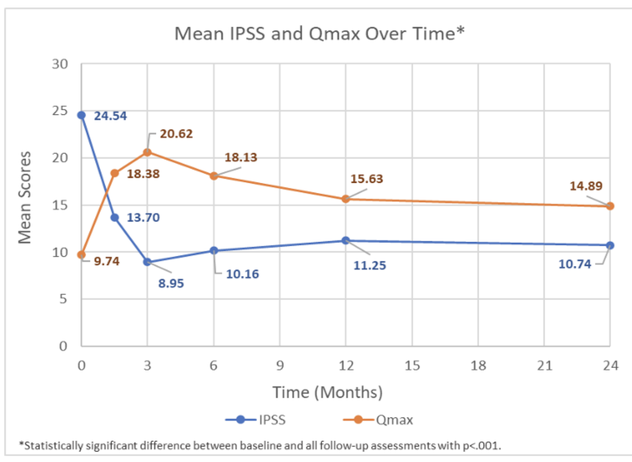

Figure 1: Linear Regression Models demonstrating changes in IPSS and Qmax over 24 months

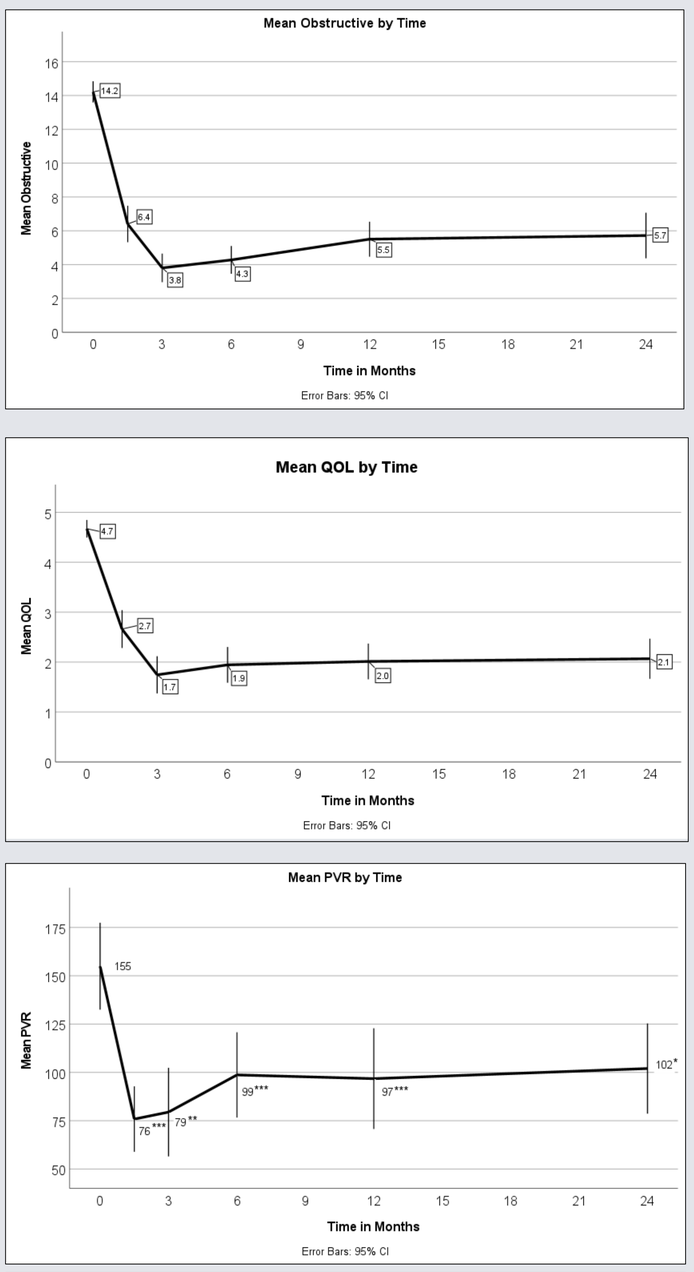

Figure 2-4: Linear Regression Models demonstrating changes Obstructive symptoms, QOL and PVR over 24 months

Discussion

- Rezum is a novel BPH therapy that can be used to successfully treat prostates with prominent median lobe.
- We perform under GA as we believe precise injections is more reliable with total lack of patient movement but this needs further study in a randomized setting.
- Post-op catheterisation was initially 1 day per 10cc of prostate volume (I.e 60cc = 6 days) but we found this impractical, soon adopting routine TWOC at 7 days
- All complications were grade 1-2 including temporary relapse of LUTs over several weeks secondary to prostatic cavity drainage, haematuria, UTI and retention
- One limitation of our study was incomplete follow up data across scheduled timepoints, which was aggravated by the Covid pandemic.

Conclusion

1. Outcomes mirror pivotal North American studies, suggesting MT failure does not impair outcomes of Rezum.
2. Lack of correlation between PV and outcomes suggests initial volume restrictions are unnecessary.
3. Rezum is a reliable and simple minimally invasive technique with *rapid post-operative recovery.*

References

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MARK THIS ABSTRACT

Accuracy of mpMRI Staging in Prostate Cancer: Correlation with Final Histopathology and Implications for Positive Surgical Margin Rates (59)

Authors: J Tooke, R. Brough, A. Jaffar, C. Jones, N. Oakley, V. Tang, P Cleaveland

Affiliations: Stockport NHS Foundation Trust

Introduction

Multiparametric MRI (mpMRI) is widely used for local staging of prostate cancer (1). However, discrepancies between pre-operative mpMRI-based clinical staging and postoperative histopathology after robotic assisted laparoscopic prostatectomy (RALP) remain common (2).

Understanding patterns of upstaging and downstaging and associated oncologic risks such as positive surgical margins (PSMs) is useful for optimising preoperative decision-making (3).

This first cycle investigated the prevalence of T stage change between mpMRI and histopathology at Stepping Hill Hospital (SHH) and the impact of upstaged tumours on positive margins following RALP.

Methods

Population: Patients who underwent RALP at SHH between January 1st 2021 and August 27th 2025. Data was collected retrospectively from perioperative recordings and histopathology reports.

Demographic Data: Age, BMI, ASA grade and Gleason score.

Outcomes: mpMRI staging, histopathological staging and positive margins. Clinically significant PSMs were defined as positive surgical margins greater than 3mm.

Analysis: mpMRI T stage was compared with final histopathological stage. PSMs were evaluated relative to upstaging, downstaging, or no change between MRI and pathological staging – chi squared test was used for significance.

Results

Population

- 770 patients found over the 56-month period.
- 10 were removed due to missing data, usually due to abandoned operation.
- The remaining 760 were eligible for analysis.

Demographics	N=760
	N (95% CI)
Age	66 (51-81)
BMI	N (percentage of total)
<18.5	3 (0.4%)
18.5-25	142 (18.7%)
25-30	429 (56.4%)
30-35	163 (21.4%)
35-40	21 (2.8%)
40+	2 (0.3%)
ASA	N (percentage of total)
I	26 (3.4%)
II	670 (88.2%)
III	64 (8.4%)
Gleason Score	N (percentage of total)
6	3 (0.4%)
7	723 (95.1%)
8	15 (2.0%)
9	19 (2.5%)

Table 1. Demographic data of cohort

Staging

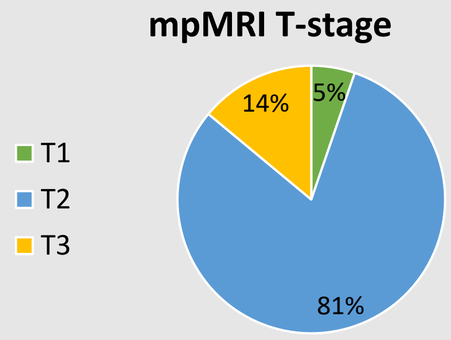

Figure 1. Distribution of mpMRI T-stages

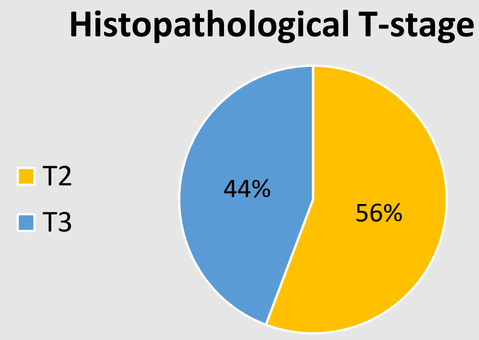

Figure 2. Distribution of histopathological T-stages

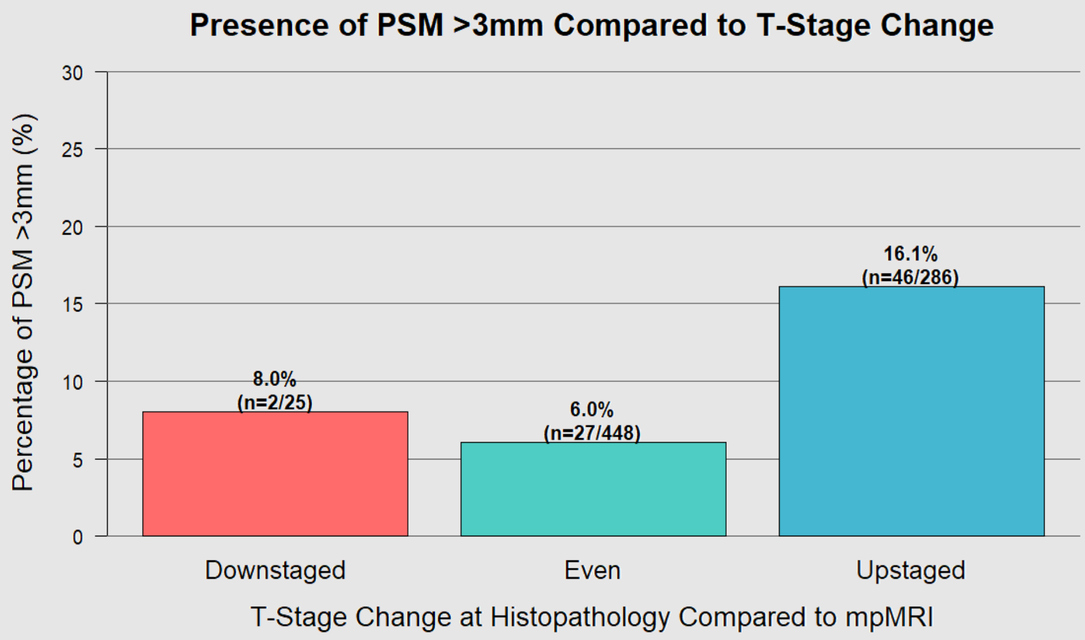

Figure 3. Presence of clinically significant PSMs stratified by change in T-Stage between pre-operative mpMRI and post-operative histopathology. P <0.001 *Created in R Studio (4)*

Discussion

- 14% of patients were staged T3 pre-RALP. This increased to 44% of patients at post-RALP histopathology.
- Upstaged prostates were twice as likely to have PSM >3mm than those unchanged or downstaged (p<0.001).
- mpMRI staging limitations are inherent but may vary with stage, patient and prostate size and shape, and centre (2,3).
- Impact on prognosis would benefit from additional analysis of prostate-specific antigen (PSA) at six-week and one-year follow-up and is planned for future audit.

Conclusion

Understaging is associated with higher rates of PSMs, highlighting the importance of recognising mpMRI's limitations. Thorough pre-operative mpMRI planning may help reduce PSM rates and is now being discussed for implementation at SHH.

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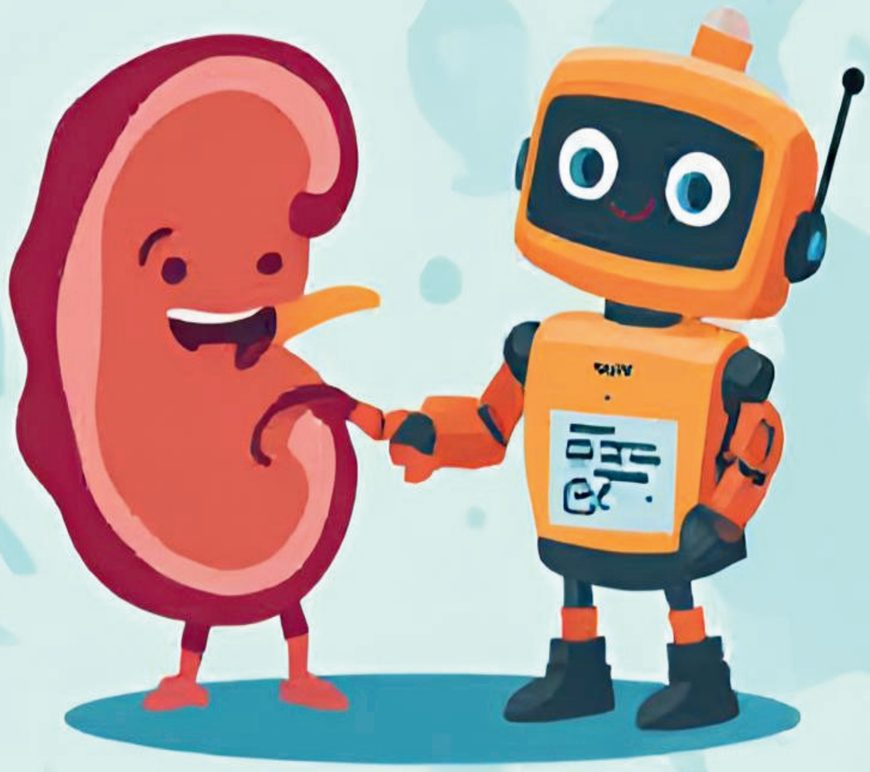
MARK THIS ABSTRACT

Can AI Hold It's Water?

Agreement Between Consultants and an AI Triage Tool - a Pilot Diagnostic Concordance Study (61)

Dr Azeem Kapasi - Urology JCF

Mr Laurence Clarke - Consultant Urologist



95%

Consultant Acceptance rate

85%

Agreement in clinic allocation

ZERO RED-FLAGS MISSED

95%

Agreement between AI and Consultant Triage

ONLY 2/40

Discrepancy in acceptance

WHATS NEXT?

Larger Studies

Real-time workflow

Automated replies

BLIND STUDY

Immediate safety essential

Salford Royal Foundation Trust

BAUS NWU26

MARK THIS ABSTRACT

Capturing job-plan data: A pilot study of a simple online method for granular capture of information about direct clinical care (67)

Helen Stephens[1], Theodora Stasinou[1,2], Stephen R Payne[1,2]

1. Department of Urology, Manchester University NHS Foundation Trust
2. Workforce, British Association of Urological Surgeons (BAUS)

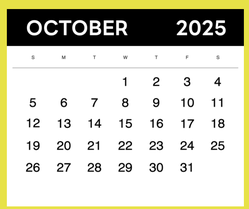
Introduction

BAUS has collected workforce data from its membership since 2009 but information about clinical activity and sub-specialist work has been elusive. Acquiring job plan information would fill this knowledge gap, guiding strategic planning of core and sub-specialist services across the UK to meet demands.

Methods

Anonymised online questionnaire

Urologists in the North-West



3 week period

Information collected

- Demographic and institutional data
- Total Programmed Activities (PA's)
  - DCC- direct clinical care
  - SPA- supporting professional activities
  - EPA- extra programmed activities
- Core vs sub-specialist work
- Time for questionnaire completion

Results

50
Responses

Demographically representative sample of UK urologists

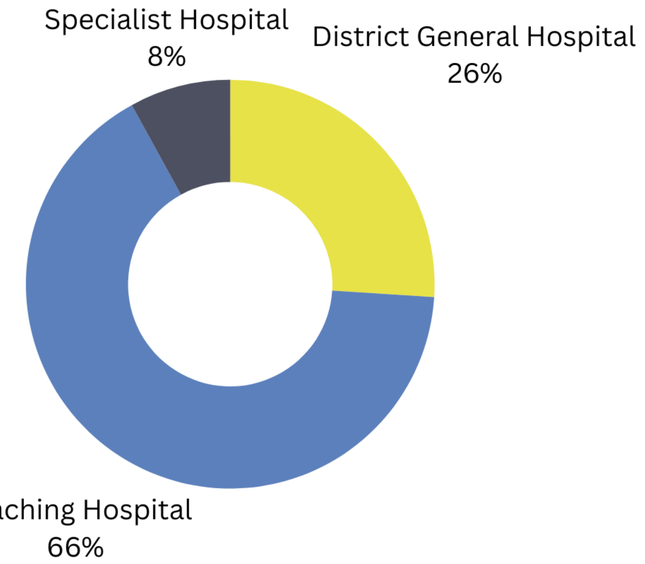


Figure 1: Hospital type

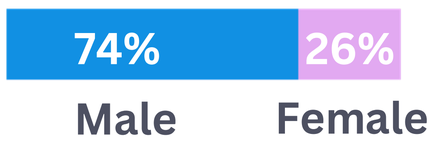


Figure 2: Gender Split

Feasibility

2.34 minutes

Average time to complete the questionnaire

Contracted activity

	Mean	Median	Range
PAs	11.24	12.00	7-13
SPAs	1.65	1.90	0.5-2.65
DCC as % of total PAs	68%	72%	46-91%

Table 1: Contracted activity, and the proportion of total PAs constituting DCC

46% of consultants undertook EPAs

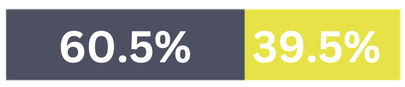


Figure 3: Percentage of total contracted work (core vs sub-specialist)

The majority of Urologist's (>50%), spend <10% of their PA's doing sub-specialist work

Sub-specialist work	% contribution to total sub-specialist work
Academic work	11.81
Andrology	13.89
Endourology	20.83
Female and Functional	11.11
Oncology	20.14
Paediatric	11.11
Reconstructive	11.11

Table 2: Split of sub-specialist activity

Conclusions

This study has demonstrated that an online repository of job planning data is easy to use. An annual return can give detailed information about core and sub-specialist clinical activity that is superior to historic data accrued via the BAUS database. If applied longitudinally, online job plan data could provide valuable information for service planning at local, regional and national levels.

Mark this abstract!

Enhancing Trainee Proficiency in Robotic Surgery: A Quality improvement project and a closed loop audit in a North-West Urology Centre, UK (69)

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Stockport NHS Trust, Greater Manchester, UK

Introduction

Robot-assisted surgery (RAS) is integral to contemporary urological practice, yet structured robotic training remains limited and is not formally embedded within the UK urology curriculum.

This project aimed to evaluate the impact of a multidisciplinary robotic urology simulation workshop on trainee confidence in key robotic competencies.

Methods

A focused robotic simulation workshop was delivered with industry support to five trainees (CT1, ST3 ×2, ST4 ×2). Teaching was provided by a consultant urologist, robotic fellow, senior trainees, a clinical fellow, an advanced nurse practitioner, and an industry instructor. The programme covered equipment familiarisation, docking/undocking, troubleshooting, bedside assisting, emergency undocking, and simulation on the da Vinci X system.

Fourteen key intraoperative competencies relevant to common robotic procedures were assessed in the study, checking the experience with RAS (console & bedside) and Confidence (1–5 scale) across 14 competencies as outlined at baseline, immediate post course and 1month post course.
Competencies assessed include the following: Port Insertion; Haem-lock application; Suction to clear field; Docking(+Instruments); Metal clip; Suction for Traction; Removing & Replacing Instruments; Endoscopic stapler use; Application of Haemostatic adjuncts (flow-seal); Routine Undocking; Emergency Undocking; Targeting; Camera Cleaning; and Insertion and removal of sutures

Results

Course feedback was highly positive: 80% of attendees rated all four simulations as excellent, with the remainder rated good. Emergency undocking received excellent ratings overall. Baseline confidence across all competencies assessed was low (1–3/5), reflecting limited and opportunistic exposure. Across nearly all competencies there was marked improvement in confidence immediately following training demonstrating the immediate impact of structured hands-on training.
Specifically, post-training assessment demonstrated a 1–2-point increase in confidence across most domains, with the greatest improvements in port insertion, docking, suction use, targeting, suture insertion/removal, and camera cleaning.
Delayed post training assessment showed that confidence in most competencies remained significantly higher than baseline suggesting meaningful retention, although some competencies showed slight regression indicating skill decay with limited practice opportunities.

Discussion

This QIP and closed-loop audit demonstrates that a focused, consultant-led hands-on training session:

- Significantly increases trainee confidence in core RAS bedside skills
- Improves readiness for supervised independence
- Provides sustained confidence retention despite limited further exposure

The findings support national concerns regarding inconsistent RAS access for trainees and reinforce the value of protected, structured robotic training programmes.
These findings justify the establishment of regular simulation and bedside-skills training sessions in alignment with the JRCPTB and BAUS training strategies.

Conclusion

A structured, multidisciplinary workshop markedly improved trainee confidence in essential robotic skills, underscoring the growing desire among trainees for greater exposure and more effective use of available training opportunities in robotic surgery.

Recommendations

1. Incorporate annual robotic bedside skills workshops with dedicated faculty.
2. Ensure protected simulator access (minimum 1–2 hours weekly).
3. Introduce a regional modular competency checklist aligned with the 14 assessed skills for trainee logbooks.
4. Develop a rotational robotic training pathway involving all three subspecialty teams.
5. Repeat this audit annually to track long-term effectiveness

MARK THIS ABSTRACT

Are We Over-Stenting? A Single-Centre Audit of Ureteric Stent Use After Uncomplicated Ureteroscopy (73)

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Manchester Royal Infirmary

BAUS NWU26

Introduction

- Ureteric stents are commonly placed following ureteroscopy (URS) for stone disease
- Stents are associated with pain, LUTS, infection, and unplanned re-presentations
- National guidelines advise against routine stenting after uncomplicated URS[1]
- Despite this, real-world practice varies considerably[2]

Aims:

- To evaluate ureteric stent use and short-term outcomes following uncomplicated URS at a single centre
- To assess compliance with national guideline recommendations

Methods

Retrospective single-centre audit (January-December 2024)

Included:

- Uncomplicated rigid or flexible URS (RURS/FURS)
- Presumed complete stone clearance

Excluded:

- Planned second-stage URS or stented and re-listed
- PCNL/ECIRS
- Concomitant procedures
- Non-stone indications

Outcomes assessed:

- Stent insertion rate
- Day-case vs inpatient admission
- 30-day emergency re-presentation
- Post-operative complications (Clavien-Dindo ≧ 2)

Results

Case Overview

143 URS procedures met inclusion criteria

- 91 stented (63.6%)
- 52 non-stented (36.4%)

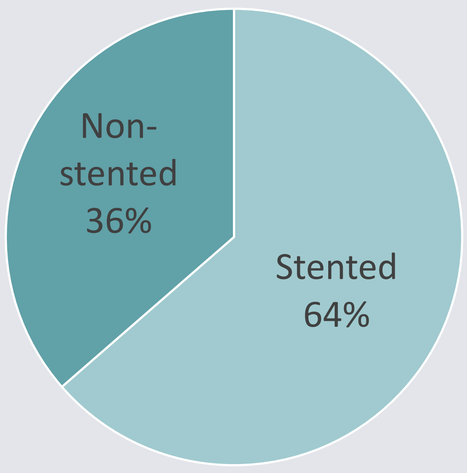

Figure 1: Routine ureteric stenting remains common following uncomplicated URS

Day Case vs. Overnight Stay

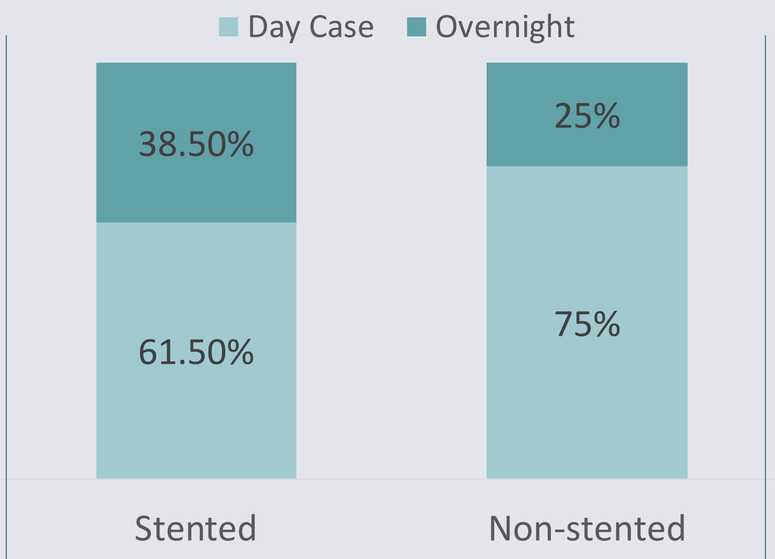

Figure 2: Non-stented patients were more likely to undergo day-case procedures

Length of Stay

Stented group

- Day-case: 56 (61.5%)
- Overnight admission: 35 (38.5%)
- Mean inpatient stay: 1.2 (range 1-5)

Non-stented group

- Day-case: 39 (75%)
- Overnight admission: 13 (25%)
- Mean inpatient stay: 1.2 days (range 1-3)

Re-presentations & Complications

Stented group

- A&E re-presentations: 7 (7.7%)
  - Pain: 2
  - UTI: 5
- Complications:
  - 1 ureteric stricture

Non-stented group

- A&E re-presentations: 2 (3.8%)
  - Pain: 1
  - UTI: 1
- Complications:
  - 1 calyceal perforation requiring nephrostomy.

Figure 3: Stent insertion did not reduce 30-day emergency re-presentations

Discussion

- Routine stenting occurred in nearly two-thirds of uncomplicated URS cases
- No demonstrable reduction in:
  - Emergency re-presentation
  - Length of stay
  - Complication rates
- Overall complication rates were low with no clinically meaningful difference between groups
- Stent-related symptoms likely contribute to avoidable patient burden
- Findings highlight an opportunity to standardise practice and improve guideline adherence

Conclusion

- Routine ureteric stenting after uncomplicated URS does not reduce complications or re-presentations
- Reducing unnecessary stenting may:
  - Improve patient experience
  - Reduce emergency attendances
  - Lower healthcare costs

References

1. National Institute for Health and Care Excellence (NICE). *Renal and ureteric stones: assessment and management (NG118)*. London: NICE; 2019 Jan 08.
2. National Institute for Health and Care Excellence (NICE). *Renal stones: quality standard briefing paper*. London: NICE; 2019 Sep.

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