

PROCEEDINGS OF THE



WELSH UROLOGICAL SOCIETY
SOCIETY CYMDEITHAS WROLEG
CYMRAEG

25TH AND 26TH JANUARY 2018

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Metropole Hotel, Temple Street, Llandrindod
Wells. LD1 5DY

Welsh Urological Society

Annual Meeting

Sponsored by the pharmaceutical companies

25th & 26th January 2018

Venue: Metropole Hotel, Temple Street, Llandrindod

Chairman:	Mr Neil Fenn
Secretary:	Miss Jane French
Treasurer:	Mr Owen Hughes
Event Organiser:	Mr Neil Fenn
Event Co-ordinator:	Mrs Janine Hillier

Pharmaceutical companies will be present on the day with exhibition stands

Welsh Urological Society Annual Meeting 25th & 26th January 2018

Academic Programme Thursday 25th January 2018

11:00 WUS Business meeting

12:30 Buffet lunch

13:50 Welcome and Housekeeping

14:00 Training afternoon with presentation and debates

Should all patients with a raised PSA have a mpMRI ahead of a prostate biopsy?

Matthew Jeffries (against) v Nicholas William Gill (for)

15:00 Tom Crosby, Consultant Oncologist, Velindre Hospital, Cardiff

17:30 – 20:00 Curry / Rice with trade exhibition

Academic Programme Friday 26th January 2018

09:00 Guest speakers

Functional and reconstructive urology at University Hospital of Wales

Oleg Tatarov, Consultant Urological Surgeon, University Hospital of Wales

10:00 – 11:00 Coffee and Trade exhibition

11:00 Huw Williams Prize presentation

13:30 Close of meeting

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A Ahmad, S. Roushias, C. Sullivan
Department of Urology and Radiology, Morriston Hospital, Swansea

Title: Review of the outcomes of percutaneous nephrostomy (with or without ureteral stent) insertion for benign and malignant ureteral obstruction in north Wales: A 5-year retrospective multi-centric analysis.

Authors: M Abdulmajed 1, Kim Da Costa 2, J Ma2, S Agarwal 3, C Seipp 4

1 Urology Specialist Registrar, Health Education North West, **2** Core Surgical Trainee, Wrexham Maelor Hospital, Wales, **3** Consultant Radiologist, Wrexham Maelor Hospital, Wales, **4** Consultant Urologist, Wrexham Maelor Hospital, Wales.

Introduction: Renal decompression following ureteral obstruction is a common urological emergency. Malignant obstruction patients often have poor life-expectancy and the impact of decompression on survival is questionable [1]. We herein review outcomes of ureteral obstruction management in north Wales.

Materials and methods: Records of nephrostomy requests from 3 hospitals between January 2012 and February 2016 were retrospectively reviewed. Information on patient demographics, primary pathology, performance status (PS), change in renal function and outcomes were recorded.

Results: Over 62 months, 584 nephrostomy requests were received. Demographic and request details are shown in figure 1. Benign obstructions constituted 29.5% (n=172) of total requests (figure 2). In malignant obstruction, nephrostomy failure after a median of 14 days and stent insertion failure or obstruction after a median of 40 days were recorded in 15 (8.4%) and 38 (17.7%) patients, respectively. Malignant obstruction group was associated with higher mortality at an early stage (53.2% in 3 months) with no noticeable impact of age, PS or change in renal function variables on survival (figure 4).

Conclusion: Decompression of malignant obstruction may not improve survival and can involve multiple interventions. Hence, the decision to decompress should be individualised and involve a multi-disciplinary discussion.

References:

[1] Allen DJ, Longhorn SE, Philp T et al. Percutaneous urinary drainage and ureteric stenting in malignant disease. Clin Oncol 2010; 22(9): 733-9.

HOSPITAL ADMISSION FOLLOWING TRANSRECTAL ULTRASOUND SCAN AND PROSTATE BIOPSY

Introduction: Transrectal Ultrasound Guided Biopsy (TRUS) and prostate biopsy are used for histological diagnosis of prostate cancer. We studied the complications following this common procedure which required hospitalization.

Methods: We conducted a retrospective cohort study of patients attending our unit for biopsy by TRUS between November 2003 and March 2016. Patients were administered different prophylactic antibiotics before the procedure (following local protocol) : Ciprofloxacin 500mg, Gentamycin 160mg and Metronidazole 1g suppository (Nov 2003 – Dec 2004) n=215; Ofloxacin 400mg (Jan 2005 – Dec 2012) n=1911; Ciprofloxacin 750mg (Jan 2013 – Mar 2016) n=1064. Patients who were admitted with complications within four weeks post procedure were included in the study.

Results: We analyzed n=3237 patients who underwent biopsy. Mean age of our study sample was 73 (44-80) years. PSA ranged between 0.3 to 498.2ng/ml.

Out of 3237, 75 (2.3%) patients were admitted with complications within four weeks post TRUS prostate biopsy. Acute Urinary retention (AUR) was seen in 11 (0.3%), Hematuria 18 (0.6%), Per Rectum (PR) bleed 4 (0.1%), Urosepsis 5 (0.2%), Urinary Tract Infection (UTI) 34 (1%). There was no statistically significant difference between the standard/extended core biopsies and hospital admission (p=0.33).

We further analysed our data based on the prophylactic antibiotic used. A chi-square analysis was done to determine any difference in the incidence of post biopsy infections among the three groups, which was not statistically significant (p=0.47).

Conclusion: There was no statistically significant difference in complication rate between the three groups receiving different prophylactic antibiotics

	Ciprofloxacin 500mg + Gentamycin 160mg stat+ Metronidazole 1g (n=215) (Nov 2003 – Dec 2004)	Ofloxacin 400mg (n=1911) (Jan 2005 – Dec 2012)	Ciprofloxacin 750mg (n=1064) (Jan 2013 – Mar 2016)
AUR	0 (0%)	6 (0.3%)	5 (0.5%)
Hematuria	0 (0%)	11 (0.6%)	7 (0.7%)
PR bleed	0 (0%)	2 (0.1%)	2 (0.2%)
Urosepsis	1 (0.5%)	3 (0.2%)	1 (0.1%)
UTI	2 (0.9%)	18 (0.9%)	13 (1.2%)
No complications	211 (98.1%)	1870 (97.9%)	1036 (97.4%)

**Patient Reported Outcome Measures (PROM) post
Robotic Assisted Laparoscopic Radical Prostatectomy (RALP)**

Haitham Abdelmoteleb, Elizabeth Bois, Novelita Alzate,
Jon Featherstone, Howard Kynaston, Krishna Narahari
University Hospital of Wales, Cardiff

Introduction

Patient Reported Outcome Measures (PROMs) are regarded as the gold standard to assess functional outcomes post radical prostatectomy for localized prostate cancer. PROMs measure a patient's health status and health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes as perceived by patients

IIEF5¹ and Urinary function domain of EPIC 26 questionnaires² are independently validated and internationally recognized PROMs for patients undergoing radical prostatectomy (RP).

Patients and Methods

A comprehensive analysis of a prospectively maintained PROM database was carried out for patients who underwent surgery at UHW during the period Sept 2015 – Sept 2016. This allowed for a minimum 12 months follow up period. The questionnaires used were IIEF-5 for sexual function and the urinary incontinence domain of the EPIC-26 for urinary function. This was measured pre-operatively (baseline), at 3, 6 and 12 months after surgery.

UHW PROM database is maintained by an independent non-clinical member of the Urology research team (Elizabeth Bois). The questionnaires are posted out to the patient's home address along with a pre-paid return envelope enclosed. Questionnaires are returned directly to the research team. All questionnaires are completed outside of the hospital setting, in patients' own home, to remove clinician bias.

Results

116 men with a mean age of 55 years \pm 8.6 years underwent RALP between September 2015 and September 2016. The overall completion rate of the questionnaires was 82%. Functional outcome results are shown in table 1.

Conclusion

Our results compare favourably to those published in Protect data and represent the first independent PROM based functional outcome publication for the South Wales Robotic Prostatectomy service.

BCG treatment for 'highest risk' non muscle-invasive bladder cancer in a tertiary centre; should these patients be treated differently?

Ellul T, James B, Bose P, Kandaswamy G

Morrison Hospital, Swansea

Introduction

The 2017 EAU guidelines for the management of non muscle-invasive bladder cancer have included a 'highest risk' group. This differs from current NICE guidelines and therefore we aimed to assess outcomes of 'highest risk' patients receiving intravesical BCG.

Methods

A database of patients undergoing BCG treatment was compiled prospectively for demographics, treatments and outcomes over the past 8 years. This database was interrogated to assess outcomes.

Results

134 patients with at least 2-year follow-up were included. Of these, 48 (36%) would be classified as 'highest risk'. Bladder cancer-specific mortality at 2 years was 9.6% with a median survival of 30 months post BCG (range 7-83). 38% of patients' disease progressed on BCG, of these 50% underwent cystectomy and 11% had radiotherapy. In a subgroup analysis of 'highest risk' patients, 19 patients had passed away (40%) with a median survival post BCG of 31 months (range 10-80). A high incidence of secondary cancers was noted throughout the database, primarily lung cancer.

Conclusion

This cohort exhibits very aggressive disease pattern, but there does not appear to be a significant difference in outcomes for 'highest risk' patients. Further analysis of disease-specific variables is required to understand its nature in this population.

Dynamic Sentinel Lymph Node Biopsy (DSNB) as an alternative to modified radical inguinal lymphadenectomy: South Wales Series 2017.

Ameen T⁺. Slee J⁺. Brown G^{*}. Bose P⁺. Younis, A⁺.

⁺Morriston Hospital, Swansea.

^{*}Royal Glamorgan Hospital, Llantrisant

Introduction

Staging of Penile cancer using lymph nodes has significant prognostic insinuation. Traditional radical and modified inguinal lymph node dissections (LND) have a considerable associated morbidity. EAU guidelines have recommended the use of Dynamic Sentinel Lymph Node Biopsies (DSNB) as an alternative to LND to assess the nodal status of patients with intermediate and high risk and clinically-negative nodal status in penile malignancies.

Primary management of Penile Cancer in South Wales is centralised in Morrision and Royal Glamorgan Hospitals. Lymphadenectomy and DSNB procedures are undertaken in Morrision Hospital.

We have evaluated the use of DSNB in this patient cohort.

Methods

To date 10 patients have undergone technetium radio-guided inguinal DSNB since March 2017 following primary surgery to remove penile malignancies (>/G2pT1). Intra-operatively patients are given patent blue; subcutaneous and circumferentially around the penile base. Nodes are sampled using a gamma probe and sent for histo-chemical analysis. Data was collected prospectively and updated concomitantly.

Results

Of the 10 patients whom underwent DSNB, none was found to have metastatic squamous cell carcinoma however; one was incidentally diagnosed with lymphoma. Single patient re-presented with an inguinal haematoma that was managed conservatively and one had urinary retention that was felt unrelated to the procedure.

Discussion

We report our experience with the first 10 patients who had DSNB procedure. There is a significantly reduced morbidity in all patients who have undergone DSNB compared to the previously performed LND. The series continues to expand and demonstrates that as the sole centre in Wales to be performing DSNB, we are confirming the positive outcomes suggested by EAU guidance. Further studies

needed in the long term to compare DSNB vs LND in terms of survival and prognosis.

A Success story: a South Wales experience of pre-cystectomy neoadjuvant chemotherapy (NAC) in muscle invasive bladder cancer treatment

Jenny Hayes, Adnan Ahmed, Matthew Jefferies, Stella Roushias, Gokul KandaSwamy, Pradeep Bose, Jim Wilson, Adam Carter

Introduction

NAC is the standard of care for patients with muscle invasive bladder cancer (MIBC) offering a 5% 5-year survival benefit. Furthermore patients found to have a pathological complete response (pT0) following NAC exhibited favorable survival.

We conducted an outcome review of NAC use across 2 sites in South Wales: Royal Gwent (RGH) and Morriston Hospitals (MH).

Methods

A retrospective data analysis was conducted.

Results

88 radical cystectomies were performed in RGH between 2012-2017 for transitional cell carcinoma (TCC), 60 having MIBC. 93 radical cystectomies were performed in MH between 2014-2017 for TCC, 53 having MIBC. The Male:Female ratio was 3:1. 62/113 (54.9%) received NAC. The majority received 3 cycles of gemcitabine and cisplatin, with a low drop out rate. There was no significant additional morbidity in those receiving NAC.

On final histology 50% of all patients receiving NAC were downgraded from muscle invasive to pT0 (29%) or pT<2 (21%) disease, compared to 16% who did not.

Conclusion

We report a high rate of NAC use, with all eligible patients being offered NAC. We show that NAC is safe with a low drop out rate and comparable morbidity. NAC offers significant tumour regression with high pathological responses rates.

Rejecting USC asymptomatic non-visible haematuria patient referrals is safe and effective: results of a prospective audit.

Maike Eylert, Danielle Comley, Adam Carter

Royal Gwent Hospital, Newport

Introduction: NICE USC referral guidance in 2015 prompted a new local pathway with a standard letter used for rejecting referrals with asymptomatic non-visible haematuria.

Patients and methods: From our prospective database of rejected patients, we selected the first 12 months of patients and individually reviewed any scans, referrals to Urology and outcomes over the 12 months following rejection.

Results: 147 referrals were rejected (15% of haematuria referrals). 29 patients had further relevant imaging following rejection. 45 patients were re-referred up to 12 months later, of which 40 were accepted and seen. One patient was re-referred with frank haematuria 12 months later and diagnosed with ureteric TCC G3pT1+CIS, completely excised, and has remained clear at 8 months post-surgery. One patient had a tiny papillary area, ?atypia/tiny G1pTa on histology. Counting both cases, our missed cancer rate is 1.3%. Our haematuria clinic wait reduced from 40 days to <10 days.

Conclusion: The new pathway has allowed rapid assessment of patients with more worrying symptoms. The missed cancer rate fits well within the <3% expected, as per NICE definition. We have introduced a patient letter as a safety net, stating to see their GP again if ever visible haematuria develops.

Intravesicle Injection of Botulinum A Toxin for the Treatment of Overactive Bladder in Anticoagulated Patients – Is it Safe?

Luton O, Smith H, Lindley A, Kneen A, Lewis-Russell J, Younis A.
Department of Urology. Morriston Hospital, Swansea, Wales.

Introduction

Botulinum Toxin A (BoNT-A) proved effective minimally invasive treatment of overactive bladder (OAB) refractory to medical therapies.

Since its licensing by the Medicines and Healthcare Products Regulatory Agency (MHRA) in Sept 2012 there has not been a formal guideline produced to aid surgeons in the management of patients receiving concomitant antiplatelet or anticoagulant therapy.

Although Intravesical BoNT-A injections are carried out in clinics and regularly performed under local anaesthetic there still exists reports of treatment-related significant adverse events (SAE) (20%–43%). Acute urinary retention (AUR), large post-void residual (PVR) requiring clean intermittent self-catheterisation (CISC) and urinary tract infection (UTI) are common SAEs.

Haematuria is a well-documented and common risk with urinary tract procedures however; there is a lack of evidence quantifying type, duration and severity. In studies claim rates of 3.6-5.2% of total patients experience haematuria however up to 21% in another– this may be concerning in patients who are anticoagulated.

Currently there are no studies or guidelines published regarding the concomitant use of both anticoagulant therapies and intravesical use of BoNT-A. Due to the theoretical risk of bleeding patients taking anticoagulants were either excluded from trials or had their anticoagulants ceased one week prior to procedure.

Aim

The aim of this single centre retrospective study is to explore potential significant adverse effects (SAE) of intravesical BoNT-A with concomitant anti-platelet and/or anticoagulation therapy.

Method

Patients were identified from Morriston Hospital Urology Department intravesical BoNT-A procedural lists using name and hospital identification number between January 2013 to December 2016 (4 years).

A standard proforma was used and applied to all procedural encounters. Data was obtained from electronic medical records (operation notes, discharge summaries, clinic letters and medication records).

Data was analysed by the Morriston clinical audit department. Significant Adverse Effects were classified as follows: Gross haematuria (lasting more than 72 hours/ requiring medical attention), AUR/ PVR >150ml requiring CISC, UTI, Failure of treatment, Weakness, Allergic reaction

Can multiparametric MRI prostate signal the end of the nuclear medicine bone scan in prostate cancer staging?

W Coomer, N Gill, Z Yang , B Huey, M Robinson, A Carter

Royal Gwent Hospital, Newport

Introduction

With the increased use of multiparametric MRI (mpMRI) for detection and staging of prostate cancer nuclear medicine bone scan may not be necessary. The main aim of the study was to assess whether patients with prostate cancer would be accurately screened for metastatic disease by mpMRI prostate alone.

Methods

A retrospective cohort study between October 2013 and January 2016 of patients with imaging of both a nuclear medicine bone scan and a prostate mpMRI within 100 days of each other. The results of both scans were analysed to assess the results.

Results

228 patients were identified for study. 206 of patients had an mpMRI scan with no evidence of bony metastases with only 2 cases of bony metastases detected by bone scan, however both patients had high volume pathological lymphadenopathy on mpMRI. 16 patients had positive mpMRI scans for bone metastases and their bone scans subsequently agreed with these findings. The remaining 6 patients had mpMRI scans reported as equivocal but were subsequently found to have no bony metastases.

Conclusions

No case of clinically significant bone metastases was missed on mpMRI prostate and subsequently detected on bone scan. Bone scan is not required for staging prostate cancer

An audit of non-contrast CT KUB scan length in the detection of ureteric stones: are we over radiating our patients?

A. Ahmad, S. Roushias, C. Sullivan

Department of Urology and Radiology

Morrison Hospital, Swansea

Abstract

Introduction:

Non-contrast CT KUB is the gold standard investigation for ureteric colic ¹. As clinicians, we have a responsibility to minimise patient exposure to ionising radiation. ²

The Royal College of Radiologists (RCR) recommend the scan should not exceed more than 10% of scan length above the upper pole of the kidneys, ³ which is documented anatomically as the superior endplate of T12 vertebra

Our audit aims to evaluate current practice against these guidelines.

Methods:

Retrospective analysis of 100 non-contrast CT KUB between July and August 2017 for patients with ureteric colic.

Results:

- 24% of CT KUBs were compliant with RCR guidelines = 76% over-scan rate.
- Median vertebral level of scan commencement was upper border of T10 (Range: T5 lower–L1).
- Median level of the upper pole of the highest kidney was the mid-pole of T12 (Range: T10 lower–L2 upper).
- 57.9% (n=44) preventable over-scan and 42% (n=32) potentially preventable over-scan.

Conclusion:

Potentially, 76% of all CT KUB patients are over-scanned, with no significant diagnostic benefit. As such, we have altered practice so that CTKUB scans commence between T10-T12 and scans to the level of the pubic symphysis. We will re-audit in 6 months.

