Learning from History Convened by Ballarat Urology #USANZVSM22

Final Program



2022 USANZ VICTORIAN SECTION MEETING

Friday 21 October 2022

The Events Centre, Collins Square Melbourne, Victoria

Urological Society of Australia and New Zealand (USANZ) Victorian Section Meeting (VSM) 2022















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The Events Centre, Collins Square Melbourne, Victoria #USANZVSM22 Learning from History

Conveners' Welcome

Dear colleagues,

We are excited to welcome you to the 2022 scientific meeting of the Victorian Section of the Urological Society of Australia and New Zealand. This meeting has been a part of the urology professional development calendar for many decades and is an essential component of urology advanced trainee education in Victoria.

After more than 2 years of COVID restrictions, this will be the first face-to-face Victorian Section Meeting since 2019 and we are looking forward to seeing a healthy turnout of urologists, urology nurses, trainees and junior doctors.

This year it is Ballarat's turn to host the meeting and we have chosen the theme "Learning from History" to reflect the rich past and vibrance of our historic city.

The meeting itself will be held in Melbourne on Friday 21 October 2022 at The Events Centre, Collins Square in Melbourne's Docklands. The format reflects past programs and starts with a trainee education session in the morning followed by presentation of submitted research papers. Concurrent to this will be a nurses' program covering the topics of Prostate Cancer, Bladder Cancer, Overactive Bladder and Catheter Management. In the afternoon, there will be sessions on Urinary Tract Infection, Challenges in Modern Cancer Care and Non-Clinical Skills for the Urologist. We believe we have compiled a varied and thoughtprovoking program that will have appeal across a wide spectrum. The USANZ Victorian Section AGM and dinner will follow.

We are fortunate to have as keynote speaker, Dr Samantha Pillay; a well-known Adelaide urologist with expertise in female and functional urology. She was nominated for South Australian of the Year for 2022 and is also an author of children's books and a cookbook.

We would like to thank our sponsors and exhibitors for their support of the meeting. In particular we would like to thank our major sponsors AstraZeneca and Ipsen.



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Lydia Johns Putra FRACS Urology Program Convener



Kim Kennedy

Nurses' Program Convener



The Events Centre, Collins Square Melbourne, Victoria

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MEETING

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2022 USANZ /ICTORIAN SECTION MEETI

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Keynote Speaker



Samantha Pillay

Samantha is no stranger to overcoming adversity, having experienced a late diagnosis of congenital hip dysplasia led to multiple corrective surgeries as a child. After starting school in a wheelchair, she finished school at age 16, completed medical and surgical training, and became the first female urological surgeon in South Australia.

With a vision to deliver specialised incontinence treatments to the women of South Australia, she became the first urologist in Australia to exclusively specialise in female and functional urology, establishing Continence Matters in 2002, subsequently building her single surgeon practice into a Centre of Excellence. She is a passionate businesswoman and entrepreneur.

Dr Pillay has served on numerous National and State boards and committees, including as Chair of the Female Urology Special Advisory Group for the Urological Society of Australia and New Zealand from 2007 to 2013. She was the first female to represent South Australia on the Board of Urology from 2003 to 2006, the first female scientific convenor for their Annual Scientific Meeting in 2007, and the first female chair of the South Australian Urology section in 2017.

Samantha, a single mother, has devoted her career as a surgeon to treating incontinence, reducing the stigma, and educating doctors, health professionals and the community. She has developed an online Continence Course to educate health professionals in an often-neglected area in medical education.

Samantha challenges career gender stereotypes and breaks the glass ceiling for women. She advocates for healthy living to reduce preventable chronic disease and resilience to overcome whatever life throws you. As a woman of colour born to migrant parents of a mixed marriage, she advocates for diversity, inclusion, and anti-discrimination.

She is a two-time Amazon Nol Best Selling author of:

The No Recipe Cookbook – a cookbook for people who don't cook, and When I'm a Surgeon – The first in the Inspirational Careers for Kids picture book and activity book series.

Book Three; When I'm an Astronaut, due for release in 2022, follows the recent release of Book Two; When I'm an Entrepreneur.

Samantha was one of four finalist nominees for SA Australian of the Year 2022.



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Invited Speakers





Paul Anderson

Paul Anderson is a Consultant Urologist at the Royal Melbourne and Epworth Hospitals. He is the Associate Director of Medical Education at the Royal Melbourne Hospital Clinical School

at the University of Melbourne. He has an active research portfolio involving surgical, medial and biomarker trials particularly in the fields of bladder cancer and benign prostatic hyperplasia. He is an Associate Editor for BJUI Compass and is an examiner for the Urology Fellowship Examinations.



Patrick Charles

Associate Professor Patrick Charles is a physician in Infectious Diseases and General Medicine at both Austin Health and Warringal Private Hospital, in Heidelberg. He has research interests

in managing recurrent UTIs and community-acquired pneumonia.



Richard Grills

Associate Professor Richard Grills is the Director of Robotic Surgery and Director of Urological Surgery at Barwon Health and the Chair of the Medical Advisory Committee at St

John of God Hospital, Geelong. He is a previous Chair of the Board of Urology, and is involved in surgical training and designing education courses for RACS.



Jeremy Grummet

Jeremy Grummet is Clinical Associate Professor at Monash University, supervising PhD and Master of Surgery students, and a Consultant Urologist at Alfred Health. Jeremy is

a member of the EAU Guidelines Prostate Cancer Panel, co-founder of MRI PRO, the global online trainer for reading prostate MRI, and is Co-Principal Investigator of the LIBERATE registry for Focal Brachytherapy.



Dennis Gyomber

After 10 years of solo private practice, Dennis has transitioned to fulltime public work at Northern Health, where he has been appointed Divisional Director of Surgery. His focus over

the coming years will be to improve the efficiency, quality and safety of surgical services.



Alex Meakin

Alex is a general radiologist, practising in Ballarat for 20 years. Alex shares his home with his wife, four teenage children and two French bulldogs. He enjoys cycling, back country skiing and

water polo. He dislikes heights.

Briony Norris



Dr Briony Norris is a urological surgeon at The Royal Melbourne Hospital, Eastern Health, Ballarat Health Services, The Australian Prostate Center and Epworth. After completing

her medical training through the University of Melbourne in 2006, she attained her FRACS Urology through the Royal Australasian College of Surgeons in 2016. Briony developed a keen interest in minimally invasive surgery and furthered her training with an international clinical fellowship in robotic surgery and endourology at the New York University Langone Medical Centre (New York). She has presented at local and international conferences and has been published in many peerreviewed journals. Briony has a keen interest in the education of medical students and trainees and is a Clinical Lecturer at the University of Melbourne, Department of Surgery.



Weranja Ranasinghe

Dr Weranja Ranasinghe is a Consultant Urologist and Urologic Oncology surgeon at Monash Health and Austin Health and has joint academic

appointments at Monash and La Trobe Universities. His research interests are in prostate and bladder cancers.



2022 USANZ VICTORIAN SECTION MEETING

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Invited Speakers

Nurses' Program



Kristy Andrew

Kristy is a Women and Mens' Pelvis Health Physiotherapist completed undergraduate study at LaTrobe University 1995, and Post-grad Certificate in Pelvic Floor

Rehabilitation in 2001. She has worked in the public and private sector and is currently employed at Ballarat Allied Health Private Practice and also teach Gender Health Module to third year physiotherapy students at ACU. Kristy has been involved with pelvic floor training pre and post prostatectomy since 2001 but has significantly increased this aspect of her business in the past 10 years. There is clear evidence that pelvic floor muscle training plays an important role in the restoration of continence for men post prostatectomy, and she feels she is in a very fortunate position to be able to assist this patient group maximise their recovery.



Helen Crowe AM

Helen has been working in urology for over 30 years, and was instrumental in establishing urology nursing professional organisations in Australia. She was the first urology nurse

practitioner appointed in Australia, working in a private practice. She is now working at Australian Prostate Centre providing nursing and survivorship support for men with prostate cancer at all stages of their disease. Helen has extensive urological clinical and research experience and has over 20 publications in peer-reviewed journals, primarily related to prostate cancer. She has also received numerous awards for her research presentations and publications, and has received research grants funding her projects.



Lachlan Dodds

Lachlan Dodds has been practising urology in Ballarat for over 20 years. He has a broad experience in treating urological cancers with particular reference to prostate, kidney and

bladder cancer and has skills in laparoscopy. He has a sub-specialty interest in paediatric urology. Lachlan is Head of the Urology Unit at Ballarat Health Services. He is a Director of a Ballarat Community organisation focusing on men's mental health and suicide prevention in the region.

David Gray



Dave is a Urology Nurse Practitioner, currently working with Urology Consultants Victoria at Epworth Freemasons, East Melbourne. Special urological interests include men's

health and urological malignancies, particularly prostate cancer. Dave is passionate about education and professional development within the urological nursing field. Dave has a Masters of Nursing (Urology and Continence) and completed his Masters of Nursing (Nurse Practitioner) in 2016. Dave was previously an addicted golf tragic, but now enjoys spending his free time with his family and also slow grilling on his Weber.



Andrea Green

Andrea originally completed her General Nurse Training at the Hamilton Base Hospital in the mid 1980's before moving to NSW where she gained a year's experience in a general

surgical ward. Andrea then completed her midwifery training in Toowoomba, Queensland and practiced as a midwife in a busy birthing suite in NSW. Her move back to Victoria led to Andrea specialising in Maternal & Child Health Nursing, Midwifery and Sexual & Reproductive Health Nursing. It was during a ten-year stint as a Pap tester that Andrea developed a passion for continence. Since then Andrea has enjoyed a 22-year career in continence, working for Ballarat Health Services, now Grampians Health. Andrea enjoys working with children and tackling the tricky bowel issues. When not at work, Andrea can be seen touring the countryside in her Volkswagen Kombi.



Jana Middlemis

Jana is a Functional Urology Nurse Practitioner working at Bendigo Health and Goldfields Urology. She specialises in functional urological disorders, urodynamics and is a qualified nurse

endoscopist.



MEETING SE

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Scientific Program Program correct at time of print.

Friday 21 October 2022

7:00am - 8:30am	Registration and Arrival Breakfast	11:10am	Medical student perceptions: Who wants to be a urologist?	
8:00am - 10:00am	Education		Jessica Wynn	
	Chair: Richard McMullin	11:17am	Role of urology nurse practitioners in reducing inter-hospital transfers in regional centres Ellen O'Connor	
	Urodynamics Workshop Johan Gani, Modher Al-Shawi, Rob Forsyth, Lachlan Dodds, Lydia Johns Putra			
		11:24am	RPN – A robot-specific surgical difficulty	
8:30am - 10:00am	Concurrent Session 1 (Nurses'): Bladder Cancer/ Prostate Cancer		anticipate difficulty of robotic partial nephrectomy based on pre-operative imaging	
	Chairs: Kay Talbot & Moira Czurlowski			
8:30am	Hormone therapy for prostate cancer Helen Crowe	Clancy Mulholland 11:31am Outcomes of active surveillance for low- vs		
9:00am	Pelvic floor muscle training for men post		intermediate-risk prostate cancer Arveen Kalapara	
	Kristy Andrew	11:38am	Financial toxicity in prostate cancer: When cost affects treatment	
9:30am	Erectile Dysfunction following radical		Paolo Masangcay	
	David Gray	11:45am	Organ transplant and active surveillance; Coexistence or contraindication? A systematic review. Sachin Perera	
10:00am - 10:30am	Morning tea with the industry			
10:30am - 12:30pm	Concurrent Session 2 (Urology): Research Presentations	11:52am	Same day discharge for robot-assisted radical prostatectomy: A prospective cohort study documenting an Australian approach	
	Chair: Homi Zargar			
	Panel: Joseph Ischia & Kathryn McLeod			
10:35am	Sepsis after elective renal stone surgery:		Clancy Mulholland	
	A to year study comparing extracorporear shockwave lithotripsy and ureterorenoscopic laser lithotripsy in an Australian population Matthew Farag	11:59am	Redefining 18F DCFPyl PSMA-PET detected local recurrence from radical prostatectomy histopathology Sophie Tissot	
10:42am	Redside methylene blue penbrostogram	12:06pm	The impact of lymphovascular invasion on long-term cancer outcomes following radical prostatectomy Niranjan Sathianathen Low toxicity of focal low-dose-rate (LDR) brachytherapy for low-intermediate risk prostate cancer Timothy Harkin	
	Simeon Ngweso			
10:49am	lodinated hydrogel as a tissue fiducial marker for image-guided radiation therapy in bladder cancer Alice Thomson			
		12:13pm		
10:56am	Development and validation of a method for			
	detection of circulating tumour DNA in non- muscle-invasive bladder cancer Ruchira Nandurkar	12:20pm	Robotic surgeons need more than just technical skills. Sophia Tissot	
11:03am	Bladder neck onabotulinumtoxin a injection for primary bladder neck obstruction Andrew Silagy		oopine 115500	



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Scientific Program (cont'd)

Program correct at time of print.

10:30am - 12:30pm	Concurrent Session 2 (Nurses'): Overactive Bladder/ Catheter Care/ Cystitis
10:30am	<i>Chairs: David Gray & Mitch Stevenson</i> Radiation cystitis and recalcitrant haematuria Lachlan Dodds
11:00am	Percutaneous tibial nerve stimulation (PTNS): What you need to know Jana Middlemis
11:30am	Catheter care & funding options from a community perspective Andrea Green
12:00pm	OAB pathway/ management Samantha Pillay
12:30pm - 1:30pm	Lunch with the industry
1:30pm - 3:30pm	Session 3: Urinary tract infection: New paradigms & Challenges in cancer care
	Chairs: Rob Forsyth & Lachlan Dodds
1:30pm	UTIs – The Role of the Microbiome. An ID Physician's Perspective Patrick Charles
1:45pm	Non antibiotic treatment for UTI Samantha Pillay
2:00pm	Antibiotic guidelines Paul Anderson
2:15pm	Overcoming BCG shortages: 2022 and beyond Weranja Ranasinghe
2:35pm	Impact of new technology on training Richard Grills
2:55pm	Bosniak classification debate Alex Meakin & Briony Norris
3:15pm	Discussion

5:50pm - 4:00pm	Alternoon tea with the industry
4:00pm - 5:30pm	Session 4: The value of non-clinical skills for the urologist
	Chair: Lydia Johns Putra
4:00pm	Transferrable skills in surgery - Keynote Address Samantha Pillay
4:30pm	Diversifying your career: Hard lessons learnt Jeremy Grummet
4:50pm	The next peak Dennis Gyomber
5:10pm	Panel Discussion
5:30pm - 6:30pm	USANZ Annual General Meeting
7:00pm - 10:30pm	Meeting Dinner



2022 USANZ VICTORIAN SECTION MEE

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General Information

Venue

The 2022 USANZ Victorian Scientific Meeting is being held at The Events Centre, Collins Square, Tower 2, Level 5, 727 Collins Street, Melbourne, Victoria.

For more information about the venue please visit: www.collinssquare.com.au/events-meetings/ venues/conferences-events/

Registration Desk

The registration desk will be located on Level 5, The Events Centre, Collins Square, Melbourne, Victoria.

Opening hours: Friday 21 October 2022: 7:30am - 5:00pm

Industry Exhibition

Morning tea, lunch and afternoon tea will be served in the industry exhibition in the Anteroom.

Meeting Dinner

Friday 21 October 2022 | 7:00pm - 10:30pm *Pre-dinner drinks start at 6:15pm in the foyer.* Venue: Anteroom, The Events Centre, Collins Square Dress Code: Business attire/smart casual

All registrations are inclusive of one (1) ticket to the Meeting Dinner unless otherwise stated in the registration brochure.

Additional tickets can be purchased at the registration desk for \$110.00 (inc GST).

Continuing Professional Development (CPD) Program

This educational activity has been approved in the RACS CPD Program. RACS Fellows, Specialist International Medical Graduates (SIMGs) and surgeons participating in the RACS CPD Program can claim one point per hour in Educational Activities (maximum 8 points).

Participation in this activity will be entered into your RACS CPD which can be accessed through ehub.

Parents' Room and Childminding Services

A parents' room will be available at the venue, please visit the registration desk if required.

Below is a list of childcare agencies that offer inhome childcare in Melbourne.

RACS/USANZ accepts no liability for any of the below-listed childcare companies and it is up to the individual to choose and be responsible for their bookings.

Asharon Agency www.asharonagency.com.au/home

Rockmybaby Australia www.rockmybaby.com.au/pages/home

Abracadabra Childcare Services www.abrachild.com.au/

Special Dietary Requirements

Please note that the venue is responsible for all catering at the meeting and RACS Conferences and Events Management and USANZ does not inspect or control food preparation areas or attempt to monitor ingredients used. You should contact the venue directly for all special dietary requirements during the meeting, irrespective of whether details have been provided to RACS. If RACS requests information about your dietary requirements for a specific event RACS will endeavour to forward the information provided to the venue (time permitting). RACS will not retain information provided for future events, so you must verify your requirements for each event. Even if information is requested or provided, RACS takes no responsibility for ensuring that the venue acknowledges your dietary requirements or that these requirements can be met. In all cases you must verify for yourself that your dietary requirements have been met and RACS refutes any and all liability for any failure to adequately provide your special dietary requirements or any consequential damage resulting from such failure.



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General Information (cont'd)

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Intention to Photograph

Please be advised that photographs may be taken during the meeting and reproduced by the meeting organiser/USANZ.

These photographs may be used for the following purposes:

- Projection onsite
- Reporting on the meeting in online and hard copy publications
- Marketing a future meeting, including online and hard copy publications
- Publishing in RACS/USANZ publications

If you do not wish to be included in a photograph, please advise the photographer.

Car Parking

There are several public car parks within walking distance of Collins Square.

- Marvel Stadium (700m away)
- Wilson Parking
 - Southern Cross Station Car Park
 - South Wharf Retail Car Park (850m)
- Secure Parking
 - 700 Collins Street (0.16km away)
 - 737 Bourke Street Car Park (0.17km away)

Public Transport

The Events Centre, Collins Square is positioned within the CBD and within close proximity to public transport.

If catching the train, the venue is 200m from Southern Cross Station.

Alternatively, tram stop D15-Batmans Hill/Collins St (Tram 48 and 11) is located just outside the venue.





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References: 1. Diphereline Approved Product Information. 2. Shore ND et al. Urologic Nursing 2013; 33:236-44

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Abstracts

Sepsis After Elective Renal Stone Surgery: A 10 year study comparing Extracorporeal Shockwave Lithotripsy and Ureterorenoscopic Laser Lithotripsy in an Australian Population

<u>Dr Matthew Farag</u>¹, Dr Clancy Mulholland, Dr Deanne Soares, Mr Daniel Lenaghan

MEETING

¹Monash Health, Melbourne, Australia, ²St Vincent's Hospital, Melbourne, Australia

Aims: To compare the rate and predictors of septic complications after shock wave lithotripsy (SWL) and flexible ureteroscopy (FURS) in an Australian population.

Methods: Hospital admission data were extracted from the Victorian Admitted Episodes Dataset (VAED) regarding all elective admissions for SWL and FURS for treatment of intrarenal stones from 2009 to 2018. Sepsis was defined by the ICD-10 diagnostic code, A41.

Results: There were 13,154 inpatient episodes analysed, comprising SWL (6033) and Ureterorenoscopic Laser Lithotripsy (7121). Males made up 67.43% of SWL patients and 63.34% of FURS patients. Median age was 57 years in both groups. Median American Society of Anaesthesiologists physical status classification grade (ASA) was 2 for both groups, but proportionally more FURS patients were ASA 3-4 (p<0.001). Post-operative sepsis was more common in the FURS group (1.43% versus 0.03%), as was Intensive Care Unit (ICU) admissions (1.00% versus 0.10%). Average length of stay (LOS) was longer for FURS (1.43 days vs 1.06 days). There were 4 inpatient deaths, all from the FURS group. FURS procedure, female gender and a higher ASA were each independent predictors of sepsis.

Conclusions: FURS has a significantly higher relative risk of post-operative sepsis than SWL. While overall risk is low, higher comorbidity (ASA grade 3 or 4) and female gender are independent predictors of sepsis. For these patients in particular, SWL should be considered as a potentially safer alternative to FURS.

Low toxicity of focal low-dose-rate (LDR) brachytherapy for low-intermediate risk prostate cancer

<u>Dr Timothy Harkin^{1,2}</u>, Dr Lloyd M. L. Smyth¹, Dr Elliot Anderson², A/Professor Richard O'Sullivan^{3,4}, Dr Andrew Ryan⁵, A/Professor Jeremy Grummet^{2,6}, Dr Andrew W. See¹

¹Icon Cancer Centre, Richmond, Australia, ²Department of Surgery, Central Clinical School, Monash University, Melbourne, Australia, ³Lumus Imaging, Richmond, Australia, ⁴Department of Medicine, Monash University, Melbourne, Australia, ⁵TissuPath Specialist Pathology Services, Mount Waverley, Australia, ⁶Epworth Healthcare, Richmond, Australia

Aims: While whole-gland LDR brachytherapy is a standard treatment option for localised prostate cancer, the burden of genitourinary and rectal side effects remains considerable. Focal therapy in highly selected patients aims to minimise adverse events without compromising oncological outcomes. This study describes the acute genitourinary and rectal toxicity following focal LDR brachytherapy for low-intermediate risk prostate cancer.

Methodology: An ongoing, prospective, multi-centre clinical registry of patients who underwent focal LDR brachytherapy for low-intermediate risk prostate cancer from September 2019 (LIBERATE Clinical Registry, Icon Cancer Centre) was utilised to evaluate toxicities up to at least 12 months following implant. Patients with fewer than 12 months of follow-up were excluded. Clinician assessments for genitourinary or rectal toxicity were conducted at six weeks following implant, and three-monthly thereafter. Adverse events were graded as per CTCAE v5 guidelines.

Results: Thirty-four patients were included for analysis, with a median follow-up duration of 17 months. Twenty patients (58.8%) experienced Grade 1 urinary toxicities; of these, 17 (85.0%) resolved within a median of three months. No Grade 2 or greater urinary toxicities occurred. New or worsened erectile dysfunction (ED) occurred in 20 patients (58.8%), with 9 (26.5%), 6 (17.6%), and 5 (14.7%) experiencing Grade 1, 2, and 3 ED respectively. Eight cases





Abstracts (cont'd)

of new ED (40.0%) resolved to baseline within three months. Anorectal toxicity was recorded in four patients (11.8%), with three (8.8%) and one (2.9%) Grade 1 and 2 events respectively. Anorectal toxicity resolved in three of these patients (75.0%) within three months.

Conclusion: These early results of the LIBERATE Clinical Registry suggest that focal LDR brachytherapy for the treatment of low-intermediate risk prostate cancer has a highly favourable side effect profile, supporting the rationale for focal therapy to maximise quality of life in selected patients undergoing treatment with curative intent.

Outcomes of active surveillance for low- vs intermediate-risk prostate cancer

Dr Arveen Kalapara¹, Jeremy Grummet^{1,2}, Mark Frydenberg^{1,2,3}

N MFETING

¹Department of Surgery, Monash University, Melbourne, Australia, ² Australian Urology Associates, Malvern, Australia, ³ Cabrini Institute, Cabrini Health, Malvern, Australia

Aims: To compare surgical outcomes and biochemical recurrence (BCR) in men with GS 6 and GS 3+4 prostate cancer on active surveillance (AS) who progress to treatment.

Methodology: We analysed the records of men undergoing AS at a single institution between 2001-2022. Inclusion criteria were: GS 6 or GS 3+4(\leq 10%), stage \leq cT2, PSA <20 ng/mL and <50% positive cores. Triggers for treatment included pathological, clinical progression, or patient choice. Primary outcome was rate of BCR (PSA >0.2ng/mL). Secondary outcomes were rates of AS cessation, and adverse pathology (AP, GS \geq 4+3 and/or pT3b) on subsequent radical prostatectomy (RP). Categorical variables were compared using Fisher's exact test, and Kaplan-Meier analysis and log rank test were used to compare BCR-free survival.

Results: 381 men underwent AS, with median follow up of 7.1 years (IQR, 4.5-10). 305 commenced with GS 6 and 76 (20%) with GS 3+4. 161 (42%) progressed to treatment, and 24 (6%) to watchful waiting. 47 men (62%) with GS 3+4 ceased AS, greater than 138 (45%) with GS 6 (p=0.014). 120 men (31%) underwent RP, including 29 (24%) with GS 3+4 at inclusion. 23 of 91 (25%) with GS 6 had AP, similar to 4 of 29 (14%) GS 3+4 (p=0.30). 19 (21%) with GS 6, similar to 5 (17%) with GS 3+4 experienced BCR (p=0.87). Median time to BCR was similar between GS 6 (66 months, 42-93) and GS 3+4 (55 months, 42-69) (p=0.47). 4 men (1%) developed metastatic disease, all of whom had GS 6 at inclusion.

Conclusion: Patients with GS 3+4 prostate cancer at inclusion are more likely to progress to treatment on AS than those diagnosed with GS 6 disease. However, rates of adverse pathology and BCR are similar between these groups. As such, selected men with GS 3+4 prostate cancer may be safely managed with AS.

Financial Toxicity in Prostate Cancer: When Cost Affects Treatment

Dr Paolo Masangcay¹, Dr Lydia Johns Putra², Associate Professor David Pierce³

¹Ballarat Health Services, Ballarat, Australia, ²Ballarat Health Services, Ballarat, Australia, ³The University of Melbourne, Parkville, Australia

Aims: Men with prostate cancer can experience substantial financial costs from tests, treatment and recovery time away from work. Australian men in rural and regional areas have worse prostate cancer outcomes than those in metropolitan areas. Financial toxicity refers to the burden of financial cost on the well-being of patients and their caregivers. The COmprehensive score for Financial Toxicity (COST-FACIT) questionnaire is a validated tool to measure financial toxicity but its use in the Australian context has been limited. The COST-FACIT questionnaire gives a maximum score of 44 with a higher score indicating less financial toxicity.

The aim of this pilot study is to explore financial toxicity in men with prostate cancer in a regional population.





Abstracts (cont'd)

Methodology: An electronic questionnaire was sent to 519 patients with prostate cancer between 2017 and 2020 in the Grampians region of Victoria. The questionnaire included the COST-FACIT tool and a separate question on whether cost affected treatment decisions. Statistical analysis was done with SPSS.

Results: 65 men returned a completed questionnaire. Their average age was 69 years (range 54-84). The mean COST-FACIT score was 33.5 (SD 7.5) indicating limited overall financial toxicity. Ten respondents reported that financial cost influenced their treatment decision. Those in this subgroup were more likely to have private health insurance and be self-employed and less likely to be retired.

Conclusion: We found limited financial toxicity from prostate cancer patients in the Grampians Region as determined by the COST-FACIT tool. Despite this, a subgroup of 10 men reported their financial situation influenced their treatment decision. Increased awareness in the community of the cost of prostate cancer may enable better financial planning in this group. In addition, recognition among clinicians that a patient's financial situation may influence their treatment decisions may allow early referral for financial assistance and involvement of social supports.

Same Day Discharge for Robot-Assisted Radical Prostatectomy: A Prospective Cohort Study Documenting an Australian Approach

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Aim: To document an Australian experience of facilitating same-day discharge after Robot-Assisted Radical Prostatectomy (RARP) and review the associated patient and complication-outcomes. The introduction of robotic surgical systems has significantly impacted urological surgery, arguably more so than other surgical disciplines. The focus of our study was length of hospital stay - patients have traditionally been discharged day 1 post-robotassisted radical prostatectomy (RARP), however, during the ongoing COVID-19 pandemic and consequential resource limitations, our centre has facilitated a cohort of same day discharges with initial overwhelming success.

Methodology: We conducted a prospective tertiary single-centre cohort study of a series of all patients (n=28) -undergoing RARP between January and April 2021. All patients were considered for a day-zero discharge pathway which consisted of strict inclusion criteria. At follow up, each patient's perspective on their experience was assessed using a validated post-operative satisfaction questionnaire. Data was reviewed retrospectively for all those undergoing RARP over the study period, with day-zero patients compared to overnight patients.

Results: Overall, 28 patients 20 (71%) fulfilled the objective criteria for day-zero discharge. Eleven patients (55%) agreed pre-operatively to day-zero discharge and all were successfully discharged on the same day as their procedure. There was no statistically significant difference in age, BMI, ASA, Charlson score or disease volume. All patients indicated a high level of satisfaction with their procedure. Median time from completion of surgery to discharge was 426mins (7.1h) in the day-zero discharge cohort.

Conclusion: Day-zero discharge for RARP appears to deliver high satisfaction, oncological and safety outcomes. Therefore, our study demonstrates early success with unsupported same day discharge in carefully selected and precounselled patients.





Abstracts (cont'd)

MEETING

RPN – A Robot-specific surgical difficulty score developed to more accurately anticipate difficulty of Robotic Partial Nephrectomy based on pre-operative imaging

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Aim: Surgical difficulty of partial nephrectomy (PN) varies depending on the operative approach. Current nephrometry scoring systems for assessing surgical difficulty have not been specifically produced to evaluate difficulty in cases being considered for robotic PN. We aimed to develop and validate an easy to use, robotic-specific classification of renal masses for preoperatively assessing surgical difficulty of robotic partial nephrectomy to facilitate safer robotic partial nephrectomy.

Methodology: Unlike other nephrometry scores, RPN has a foundation of survey data of a large number of high-volume expert robotic surgeons. Forty-five experienced robotic surgeons from around the world independently reviewed de-identified CT images of 144 patients with renal tumours to access surgical difficulty using a 1-10 Likert scale. Multiple linear regression was conducted, and a risk score was developed by rounding the regression coefficients. The RPN classification was compared with existing RENAL, PADUA, and SPARE scoring systems. External validation was performed using prospective surgical data from 248 patients who underwent robotic partial nephrectomy.

Results: The mean (SD) score for surgical difficulty was 5.2 (1.9). Linear regression analysis indicated that RPN classification correlated strongly with surgical difficulty score (R2 = 0.802). Comparatively, the R2 values for the other scoring systems were: RENAL (0.659), PADUA (0.749), and SPARE (0.701), indicating that the RPN classification system outperformed the other three scoring systems. In prospective validation using objective surgical parameters, all classification models performed equally and did not show significant correlation.

Conclusions: The proposed RPN classification is the first validated renal classification system of surgical difficulty specific to robotic PN. This study suggests that this system outperforms the RENAL, PADUA, and SPARE scoring systems in predicting preoperative surgical difficulty of robotic PN. This classification, relying on less variables than these currently existing systems, is easy to use in clinical practice.



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Abstracts (cont'd)

Development and Validation of a Method for Detection of Circulating Tumour DNA in Non-Muscle-Invasive Bladder Cancer

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Aims: Non-muscle-invasive bladder cancer (NMIBC) poses a burden on healthcare due to its high recurrence rate (40-80%), necessitating long-term surveillance. Cystoscopies are employed annually to monitor for recurrences or progression. Assessment of circulating tumour DNA (ctDNA) in the bloodstream/urine is of interest, as it may introduce a simpler, non-invasive means of surveillance between cystoscopies. It can also correlate tumour mutations with aggressive disease, facilitating patient risk stratification and earlier intervention with intensive therapy. Currently, ctDNA assessment mainly relies on next generation sequencing (NGS), which is expensive and time-consuming. This study aimed to assess whether droplet digital PCR (ddPCR), which is comparatively quick and inexpensive, could reliably detect NMIBC in archived tumour samples.

Methods: We selected 10 common mutations found in NMIBC, based on data from the Memorial Sloan Kettering Cancer Centre (MSKCC), that when cumulatively added to a gene panel, each would increase the panel's capacity to detect cancer in a large proportion of NMIBC patients. DNA extracted from archival paraffin-embedded tissue blocks of NMIBC specimens was run against the panel of 10 gene mutations using ddPCR to assess for their presence.

Results: Altogether, 70 NMIBC samples were processed, of which 69 possessed at least one of the mutations within our gene panel, conferring a 98.6% detection rate, with a median of 4 (range 0-8) mutations detected per sample. This compares to the predicted 68% detection rate observed in the MSKCC cohort, which used NGS technology.

Conclusion: Our ddPCR technique utilising a 10-gene-panel appears to be highly sensitive, enabling detection of mutations in the majority of patients with NMIBC. Additionally, specific mutations in the panel may provide complementary prognostic information to aid in patient disease management. Prospective assessment of blood and urine samples is underway to determine the potential clinical utility of this technique.

Bedside Methylene Blue Nephrostogram

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Aims: Percutaneous renal stone surgery often requires nephrostomy tube insertion. Timing of nephrostomy tube removal is based on clinical assessment, CTKUB or antegrade nephrostogram. The primary purpose of the study was to review the utility of performing a bedside methylene blue nephrostogram to confirm ureteral patency prior to nephrostomy removal.

Methodology: Two patients were selected for the initial proof-of-concept study. One patient underwent a prone-PCNL for a left partial-staghorn stone. One patient had a supine mini-PCNL for a left 8mm proximal ureteric stone in a left-to-right transureteroureterostomy. Both patients had a 10Fr Cook Cope Loop nephrostomy tube inserted postoperatively.

Both patients had 2-5ml methlyene blue instilled via the nephrostomy tube on day-1 with the tube then clamped. A formal antegrade nephrostogram was performed on day-2. Costs between antegrade nephrostogram and bedside methylene blue nephrostogram were compared.



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Abstracts (cont'd)

Results: Both patients tolerated the bedside methylene blue nephrostogram and ureteral patency was indicated by the presence of blue urine. Definitive confirmation of ureteral patency was obtained by a subsequent antegrade nephrostogram.

A bedside methylene blue nephrostogram takes approximately 2 minutes to perform, costs \$26 for a 5ml vial of methylene blue, requires no extra staff or equipment and exposes the patient to no radiation.

A formal antegrade nephrostogram takes at least 90 minutes including patient transport time, costs \$160 excluding staff and equipment costs, exposes the patient to radiation and requires availability of interventional radiology. A CTKUB cost \$400 and also exposes the patient to radiation.

Conclusion: Bedside methlyene blue nephrostogram is a tolerable, easy, quick, cheap, safe and accurate way to confirm ureteral patency following percutaneous renal surgery in patients with a nephrostomy tube. With current limited staffing, scrutinised resource allocation and potential contrast shortages, bedside methylene blue nephrostogram can be adopted as a standard approach to care.

Role of Urology Nurse Practitioners in reducing inter-hospital transfers in regional centres

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Background: A visiting urology services has been established at Hamilton Base Hospital, Western Victoria over the past 20 years to meet a clinical area of need. During this period a urology Nurse Practitioner (uNP) role has been developed, which involves the care and management of urology patients locally, working in close association with the visiting urologist. This research aims to assess the impact of the uNP role in the provision of regional urological care with a focus on prevention of inter-hospital transfer.

Methods: A retrospective analysis of medical records was performed identifying clinical entries, notes and correspondence performed by the uNP between January 2016 and December 2019. Each clinical encounter was scaled according to a clinical severity model and assessed for uNP care resulting in potential prevention of inter-hospital transfer.

Results: A total of 184 patients with 654 individual patient assessment encounters were identified for inclusion over the 36-month period and classified according to the adapted clinical severity scale. Mean age of patients was 72 years (range 19 – 94 years). The majority of uNP consultations (77%) included category 1 normal post-operative clinical review, 18% category 2, 4% category 3 and 0.05% category 4. Most interventions for category 3 and 4 patients related to major bleeding issues, suprapubic catheter troubleshooting, difficult catheter insertion and haemodynamic instability. A total of 19 patients whose urology issues would typical require inter-hospital transfer were able to be managed locally.

Conclusions: Transferring an acute patient from a regional to a tertiary hospital for specialist care is often necessary but costly for the health service, patient and their family. The presence of a dedicated uNP for initial management and interventions of urology patients in regional centres often assists in determining the acuity, need and urgency for patient transfer, as well as preventing unnecessary transfers.





Abstracts (cont'd)

MFETING

Organ Transplant and Active Surveillance; Coexistence or Contraindication? A Systematic Review.

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Introduction: Prostate cancer (PCa) has generally been accepted as a contraindication to solid organ transplant to prevent cancer progression or acceleration in an immunocompromised host. Candidates for organ transplant with low risk PCa are channelled into radical treatments to become eligible recipients. These men would otherwise be suitable for active surveillance (AS) and avoid potential treatment harms. In the setting of end stage disease, withholding organ transplant presents a greater mortality risk to the patient than low risk malignancy. We aim to provide a review of oncological outcomes for men on AS who undergo solid organ transplant.

Methodology: We perform a systematic review of the current literature for solid organ transplant patients with low risk PCa and highlight the oncological outcomes. Exclusion criteria was applied.

Results: 2 articles were included after applying criteria with N=753 transplanted patients(1, 2). N=476 were diagnosed with ISUPI PCa. Overall mortality (OM) was 3-4 years shorter for transplant recipients compared to a matched cohort of men without transplant (8.5 vs 12.5 years, P=0.003). Prostate Cancer Specific mortality (PCSM) demonstrated no difference in both studies between transplanted men and a matched cohort of non-transplanted men with PCa (HR= 0.88, 95% CI = 0.54 – 1.45, P=0.70).

Conclusion: We present a systematic review of cancer outcomes in men with low risk PCa who undergo solid organ transplant. There is no difference in PCSM for transplanted versus non transplanted men with PCa. A blanket rule on treatment of low risk PCa prior to transplantation may not be warranted.

References:

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The impact of lymphovascular invasion on long-term cancer outcomes following radical prostatectomy

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Aims: To evaluate the impact of lymphovascular invasion on long-term prostate cancer outcomes following radical prostatectomy.

Methodology: A consecutive sample of patients with localised prostate cancer undergoing radical prostatectomy in a multicentre database was included in the analysis. Postoperative PSA measurements and clinical examinations were taken at 3, 6 and 12 months and afterwards yearly. Further diagnostic imaging was obtained with a rising PSA or clinical suspicion. Recurrence-free survival (RFS) and metastases-free survival (MFS) were analysed as a time-toevent outcome using Kaplan-Meier analyses with log-rank tests. To assess the effect of LVI, we created multivariable Cox proportional hazards models adjusting for relevant clinical and demographic characteristics.





Abstracts (cont'd)

Results: A total of 3,732 men were included for analysis with a median follow-up of 44 months. LVI was detected in 18% (n=682). LVI was associated with an increased risk of metastasis [HR 2.2, 95%CI 1.7-3.0] and recurrence [HR 2.1, 95%CI 1.8-2.5]. This finding was consistently noted on subgroup analysis of men with both intermediate- and high-risk prostate cancer.

Conclusion: Lymphovascular invasion is a prognostic indicator of adverse recurrence- and metastasis-free survival following surgery for prostate cancer. This can assist with risk-stratification following radical treatment and possibly aid decision-making regarding adjuvant treatment.

Bladder Neck Onabotulinumtoxin A Injection For Primary Bladder Neck Obstruction

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Aim: To evaluate clinical outcomes following bladder neck injection of Onabotulinumtoxin A for primary bladder neck obstruction.

Methodology: A multi-institutional retrospective analysis was undertaken of men and women treated with at least one instillation of Onabotulinumtoxin A between May 2011 and May 2018. All patients included in the study underwent video urodynamics to diagnose primary bladder neck obstruction and had a cystoscopy to exclude anatomical causes of obstruction. The primary outcome was patient-reported symptom improvement on first clinical follow-up. Secondary outcomes were 30-day Clavien-Dindo complications and continuation of Onabotulinumtoxin A therapy.

Results: This study comprised 5 men and 8 women with a median age of 40. Nine patients failed alpha-blocker therapy previously and none had undergone surgery for primary bladder neck obstruction. Twelve patients attended at least one follow-up appointment, with 75% reporting improvement in symptoms. The favourable response rate was higher in men compared with women (100% vs 57.1%, p=0.034).

Postoperative complications were transient retrograde ejaculation (n=1) and a lower urinary tract infection (n=1). Six of the 9 patients who reported symptom improvement received additional injections, 2 were lost to follow up and 1 had a bladder neck incision.

Conclusion: In select patients, bladder neck injection of Onabotulinumtoxin A appears to be a safe and efficacious therapy for primary bladder neck obstruction with reasonable adherence.





Abstracts (cont'd)

Iodinated Hydrogel as a Tissue Fiducial Marker for Image-Guided Radiation Therapy in Bladder Cancer

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Aim: This is a retrospective study reporting on the safety and feasibility of an iodinated hydrogel tissue fiducial marker (IH TFM) for image guided radiation therapy in the treatment of muscle invasive bladder cancer.

Materials and Methods: From September 2015 to July 2017, four patients diagnosed with muscle invasive unifocal transitional cell carcinoma (TCC) bladder cancer were included in the study. Under general anaesthetic, patients underwent cystoscopic injection of IH into their tumour base. Patients subsequently underwent image guided RT. The total prescription was 64.0-66.0Gy in 2.0Gy per fraction. Daily online cone-beam CT (CBCT) matching to IH TFM were performed throughout the course of radiation therapy (RT) to verify the extent of daily treatment shifts. IH volume, its stability and visibility were also evaluated.

Results: The volume of IH TFM remained consistent over the course of bladder radiotherapy. IH TFM match recorded the largest variations in the supero-inferior (SI) and antero-posterior (AP) directions with the largest geometrical shift of 5mm recorded. If bony landmark was used, a margin of up to 17.4mm in the AP direction would be required to ensure adequate clinical target volume (CTV) coverage. In this study, we found IH TFM to be well tolerated and feasible, with no major adverse events noted as a result of injection.

Conclusion: This study demonstrates that IH TFM can be safely injected into the bladder mucosa and can be considered as a fiducial marker for bladder cancer.

Robotic Surgeons Need More Than Just Technical Skills.

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Introduction: In the robotic surgery era, unique challenges in communication within the operating theatre have arisen. The surgeon is situated away from the patient bedside in an immersive console, relying solely on verbal communication. Educators have a responsibility to train robotic non-technical skills (NOTS) in parallel to the technical skills. Simulation based training, in a fully immersive environment is the most effective way of teaching NOTS.¹

Methods: Surgical and NOTS experts developed a NOTS robotic surgery guideline inclusive of information on situational awareness, decision making, communication, teamwork, leadership and workload management. Robotic surgical experts provided NOTS scenarios based on real life experiences, unique to robotic surgery, themes of which formed the foundation of the scenarios. The fully immersive operating room environment, equipment, sounds, and characters in the scenarios were developed. Scenarios were critiqued by surgeons, education and simulation experts and a professional actor. Guidelines on hosting the debrief using the Pendletons method of feedback were created. Student summative and formative assessment parameters were developed in line with the RACS assessment criteria.

Results: Multiple twenty-minute scenarios were developed. 11 participants over two separate programs have undertaken the NOTS training. Of the participants, 82% were very satisfied with their experience of the NOTS scenarios, and 90% strongly agreed that it was relevant and transferable to their clinical practice. Supervising surgeons and NOTS experts noted common areas for participants to develop were in their communication, situational awareness, and workload management.



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Abstracts (cont'd)

Conclusion: Teaching robotic NOTS in a fully immersive simulation environment provides students with an opportunity to challenge and develop their skills without placing a patient at risk. It allows operating team members to practice challenging scenarios unique to robotic surgery.

1. Griffin et al. Non-technical skills: a review of training and evaluation in urology. World Journal of Urology. 38;1653-1661. (2020)

Redefining 18F DCFPyl PSMA-PET Detected Local Recurrence from Radical Prostatectomy Histopathology

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Introduction: Prostate-specific membrane antigen (PSMA) positron emission tomography (PET) improves accurate localisation of tumour recurrence in patients with biochemical recurrence post-radical prostatectomy. Correlations exist between disease recurrence and poor histopathological parameters such extra prostatic extension (EPE) and positive surgical margins. We aim to assess topographic concordance between these histopathological features and the location of the PSMA PET local recurrences, qualitatively and quantitatively.

Methods: Our cohort was selected from the 100 men who received a 18F-DCFPyL PET scan through IMPPORT trial, a prospective non-randomised study completed by GenesisCare Victoria. Eligibility included patients with a rising PSA (>0.2 ng/mL) post radical prostatectomy and PSMA PET detected local recurrence. Histopathological parameters collated included the location of tumour, EPE and positive margins. Criteria for the location and 'concordance' between histopathological features and local recurrences were predefined.

Results: 24 patients were eligible, median age was 71 years old, PSA 0.37ng/ml and time between prostatectomy and PSMA PET was 2.6 years. 15 patients had recurrences within the vesicourethral anastomotic region and 9 within the lateral surgical margins. 100% concordance in the left to right plane between tumour location and local recurrence was found, with 79% of these lesions concordant three-dimensionally, hence across cranio-caudal, left-right and anterior-posterior planes. 10/16 (63%) patients' with EPE had three-dimensional concordance between the location of their EPE and their local recurrence. 5/9 (55.5%) of patients' with positive margins had three-dimensional concordance between the position of their positive surgical margin and their local recurrence. In quantitative assessment, 17 of the 24 patients, had local recurrences that correlated with the location of their original tumour in the cranio-caudal plane.

Conclusion: Local recurrence is highly concordant with the position of the tumour within the prostate. Predicting the location of local recurrence using the location of the EPE and positive margins is less helpful.



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Abstracts (cont'd)

Medical Student Perceptions: Who Wants to be a Urologist?

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Aims: As selection for urology training is highly competitive, it is important that the most suitable and appropriate doctors apply. Perceptions about urology training and practice influence the decision to apply to urology training. This study looks at the perceptions of Australian medical students towards urology and what influences them to pursue a career in urology.

Methodology: An online questionnaire was sent to 111 medical students and included generic statements about urology, presence of a mentor and likelihood of pursuing urology as a specialty in the future. Data analysis was conducted on SPSS.

Results: Seventy-nine responses were received, of which 68 were complete and included in the analysis. Gender distribution was Male:Female 29:39. Twenty-one students (30.9%) considered urology a likely, possible or neutral choice. Younger age was a predictor of students who might consider urology. Other predictors were perceptions that urology training is flexible and that urology practice has a wide range and diverse patient interactions. Perceptions that urologists have flexible careers, are approachable, have high career satisfaction and good work-life balance were also predictors. Gender, stage of clinical training, time spent on urology placement and presence of a mentor were not predictive of students choosing urology as a specialty.

Conclusion: More needs to be done to inform medical students that flexible training is possible in urology and that urology practice is diverse in order to make urology a more attractive choice of specialty.



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