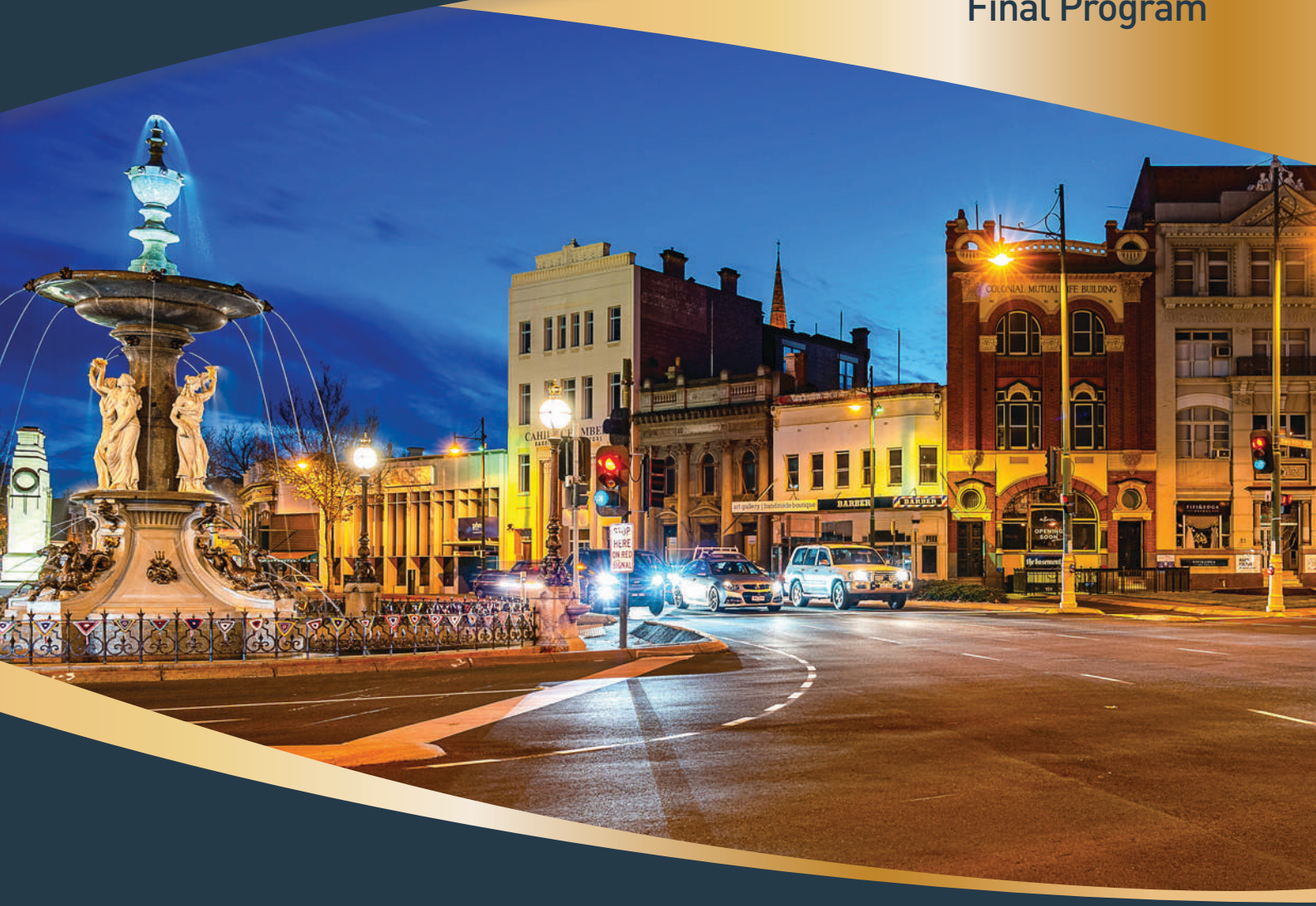
Setting the Gold Standard

Final Program



2025 USANZ VICTORIAN SECTION MEETING

Saturday 11 October 2025

All Seasons Bendigo, Victoria

UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

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Conveners' Welcome

Dear Colleagues,

We are both excited to welcome you to the 2025 Victorian Section Meeting of the Urological Society of Australia and New Zealand (USANZ). After several state meetings in Melbourne, we have decided to take the 'show on the road' and invite you (and your family) to join us in Bendigo (Victoria's Top Tourism Town 2024) for either a day or the weekend.

Bendigo is a city with a golden history with gold found in the mid 1800s which led to one of the first mass migrations to Australia. That is why Bendigo boasts some of the country's most impressive architecture, gardens, art and cultural experiences. The meeting program aims to build on this history with the theme – *"Setting the Gold Standard"*. This will include a half day trainee education workshop at the Central Deborah Gold Mine on Friday afternoon, followed by the main nursing and medical program on Saturday at the All Seasons Bendigo with a focus on practising urology to the gold standard, including speakers from various disciplines to keep us up to date across all fields of medicine. We are excited to have Prof Henry Woo from NSW join us to keep us up to date in all things prostate! We hope to provide this learning under the umbrella of 'edutainment'!

As well as the education program, we will be hosting a special 'gold-themed' dinner on Friday night at Harvest for both delegates and their partners. This venue embodies the fact that Bendigo is Australia's first UNESCO City of Gastronomy. Our chef for the evening is Marsha Busse, a pastry specialist, who has worked around the world (including Restaurant Gordon Ramsay, London, and Heston Blumenthal's The Fat Duck), and has come back home to Bendigo. Seats will be limited due to the venue size, so we encourage early registration if you are planning to attend. *Please note that the dinner is not sponsored or funded by industry.*

Even if you miss out on dinner, we are starting the main program at 10:00am on Saturday so there is plenty of time to grab a Harvest almond croissant before you join us at the meeting venue. There are also many family-friendly eating options and activities to partake in, and our organising team will be happy to provide recommendations.

We would like to thank our sponsors and the RACS organising team for their support of this event as without them it wouldn't be possible for you to have the opportunity to enjoy our great city.

A/Prof Janelle Brennan
Urology Program Convener

Ms Jana Middlemis
Nurses' Program Convener

Sponsors & Exhibitors

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Keynote Speaker

Professor Henry Woo
New South Wales

Professor Henry Woo is the Head of the Department of Urology at Blacktown Hospital in Sydney. He is also the Director of Uro-Oncology and Head of Robotics at the Chris O'Brien Lifehouse Comprehensive Cancer Centre. He is an Honorary Professor at the Australian National University and a Conjoint Professor at Western Sydney University.

Invited Speakers – Urology Program

Dr Kirsty Belfrage
Bendigo, Victoria

Dr Kirsty Belfrage is a Consultant Anaesthetist who works in Bendigo and the surrounding region. Dr Belfrage completed her medical degree at Monash University and obtained Fellowship with ANZCA in 2018. She has completed additional postgraduate qualifications with Master of Medicine (Pain Management) through University of Sydney and Master of Health Professions Education through Monash University. Dr Belfrage has a mixed clinical practice covering a broad range of surgical sub-specialities across both private and public hospitals.

Dr Thomas Carins
Bendigo, Victoria

Dr Thomas Carins is an O&G that has completed a fellowship in Female Pelvic Reconstructive surgery. He specialises in pelvic floor reconstruction, urinary incontinence, and minimally invasive surgery. Thomas has attended multiple aid trips in South Sudan to help with surgical repair of prolapse, as well as rectovaginal, urethrovaginal and vesicovaginal fistulas.

Associate Professor Niall Corcoran
Melbourne, Victoria

A/Prof Niall Corcoran is head of urology at Western Health and a VMO at RMH/Frankston. His main interests are prostate and bladder care, as well as improvements in surgical quality.

Dr Rohan Hall
Bendigo, Victoria

Dr Rohan Hall is a busy regional urological surgeon based in Bendigo with an interest in uro-oncology and reconstructive urology. He is Deputy chair of the Victorian Section of urological training. Rohan has been a member of the Urological SET selection committee for 4 years. He is a senior instructor on the CCrISP course for RACS.

Dr Lydia Johns-Putra
Ballarat, Victoria

Dr Lydia Johns-Putra is a urologist who has lived and worked in Ballarat since 2009. Lydia chairs of the Board of Urology of the Royal Australasian College of Surgeons (RACS). In addition, she participates in outreach work in Madagascar with the humanitarian not-for-profit organisation Australian Doctors for Africa.

Dr Daniel Lenaghan
Melbourne, Victoria

Dr Daniel Lenaghan is a urologist at St Vincent's Public and Werribee Mercy Hospitals. He has research interests in stone disease (epidemiology, ESWL and supine mini-PCNL) and urethral stricture disease.

Dr Chau Wang Ng
Bendigo, Victoria

Dr Chau Wang Ng is a nephrologist, general and obstetric medicine physician at Bendigo Health and St John of God Bendigo Hospital. He has completed post-fellowship training with Clinical Diploma in Palliative Medicine (RACP) and Obstetric Medicine Certificate (SOMANZ). He is a Graduate of the Chapter of Perioperative Medicine (ANZCA). He is the Final Year Academic Lead at Monash Rural Health Bendigo.

Dr Anthony Ta
Melbourne, Victoria

Dr Anthony Ta is a urologist who trained in Melbourne before completing a robotic uro-oncology fellowship in London. He worked as a robotic pelvic oncology surgeon at University College Hospital in London for three years before returning to Melbourne in 2023. He currently performs robotic cystectomies at St Vincent's Health.

Invited Speakers – Urology Program (cont'd)

Associate Professor Lih-Ming Wong
Melbourne, Victoria

A/Prof Lih-Ming Wong is an academic uro-oncologist in Melbourne Australia. Through involvement in research, teaching and quality improvement, Ming has received over 1 million dollars in funding and has 70+ peer reviewed publications including leading a phase 3 trial comparing diagnostic accuracy between mpMRI and PSMA-PET/CT. At St Vincent's he implemented the robotic program, obtained funding for robotic fellow and prostate cancer nurses, and is a board member of the Aitkenhead Centre for Medical Discovery.

Associate Professor Dixon Woon
Melbourne, Victoria

A/Prof Dixon Woon is a consultant urologist at Eastern Health, Austin Health, and Epworth Health, Victoria, Australia. Dixon is the Deputy Leader of the USANZ Genitourinary Oncology Special Advisory Group. Dixon's clinical and academic interests include robotic surgery, complex uro-oncology, prostate cancer biomarkers, and surgical equity.

Invited Speakers – Nurses' Program

David Heath
Bendigo, Victoria

David Heath from Bendigo is a Urology Nurse Practitioner (NP) that works in both the public and private sectors. Dave was one of the original positions for specialist Prostate cancer nurses in 2012. Over the years, his role has grown to include bladder and renal cell cancer as well as prostate. This expansion of his role resulted in further studies in the form of a Masters in Nursing (Nurse Practitioner) course which he completed in 2016.

Dave's current role involves the long term follow up of patients with urological cancers and side effect management. Dave undertakes cystoscopy surveillance for urothelial cancers and investigation of hematuria and also performing Prostate biopsies and placement of fiducial seeds prior to radiotherapy. Dave is a member of ACNP, USANZ, ANZUP, VUNS, CNSA and also remains affiliated with the PCFA.

Dr Ellen Kelsey
Bendigo, Victoria

Dr Ellen Kelsey is an unaccredited urology registrar at Bendigo Health with an interest in regional and rural healthcare.

Cheryl Ludwik
Bendigo, Victoria

Cheryl Ludwik is a Bendigo based pelvic health physiotherapist who has completed relevant post graduate studies at Melbourne University and University of South Australia. Cheryl is a senior clinician at both Bendigo Health Continence and Pelvic Floor Clinic and Physiotherapy Centre Bendigo. Her interests include men's health, prolapse management and pelvic pain.

Dr Jess Wynn
Bendigo, Victoria

Dr Jess Wynn is an unaccredited urology registrar based in Bendigo. She is passionate about delivering a high standard of healthcare to patients from regional Victoria. Her research interests include medical education and diversity and representation in surgery.

Invited Speaker – Trainee Education Workshop

Lisa Hall
Bendigo, Victoria

Lisa trained as a teacher. She taught in Aboriginal communities and Universities in central Australia for 20 years. Lisa commenced with Monash Rural Health Bendigo and the NW Victoria Regional Training Hub in 2020 and now teaches doctors how to teach. She lives on a property in Maldon with two kelpies.

Program at a Glance

Program correct at the time of distribution (September 2025). Please refer to the next page for the full program.

For details of the Trainee Education Workshop and Welcome Dinner on Friday 10 October 2025, please visit the Meeting Website.
https://surgeons.eventsair.com/usanz25/

Saturday 11 October 2025

9:30am – 10:00am	Welcome coffee/Morning tea with Industry	
10:00am – 11:30am	Session 1: The Gold Standard in Urology	
11:30am – 12:00pm	Session 2: Paying it Forward - Re-interpreting the Gold Standard in the 3rd World	
12:00pm – 1:15pm	Lunch with Industry	
12:45pm – 1:15pm	USANZ Annual General Meeting	
1:15pm – 3:10pm	Concurrent Session 3A: Research Presentations *Including presentation topics on:* Real World Audits - Are we doing as well as we think? The Cutting Edge: Novel Research Quick Fire: Insights from the Literature Inflammatory Conditions in Urology	Concurrent Session 3B: Nursing: The Pelvic Floor and Beyond, Sitting in the Hot Seat – Case Studies in Urology Nursing Practice
3:10pm – 3:40pm	Afternoon tea with Industry	
3:40pm – 4:15pm	Session 4: The Profession at Large	
4:15pm – 5:00pm	Session 5: The Gold Standard in Medicine	

Final Program

The organising committee reserves the right to change the program and timings. Please refer to the final program closer to the meeting for program details.

SATURDAY 11 OCTOBER

9:30am – 10:00am Welcome coffee/Morning tea with Industry
Fernery Room

10:00am – 11:30am Session 1: The Gold Standard in Urology
Chairs: A/Prof Janelle Brennan and Ms Jana Middlemis
Lansell 1 & Bassford 1

10:00am Acknowledgement of Country
Introduction to the meeting
A/Prof Janelle Brennan

10:05am PI in the Sky? A Critical Appraisal of Artificial Intelligence Redefining Prostate MRI Accuracy
Dr Jonathan O'Brien

10:10am Long-term Outcomes of Men on Active Surveillance for Prostate Cancer Without Early Progression: Implications for Deintensifying or Stopping Surveillance - A Critical Appraisal
Dr Christopher Soliman

10:15am Prostate cancer update
A/Prof Niall Corcoran

10:25am Critical appraisal: ROBUST III Randomized Controlled Trial Evaluating the Optilume Drug-Coated Balloon for Anterior Urethral Strictures
Dr Samantha Koschel

10:30am BPH/Male LUTS update
Prof Henry Woo

10:45am En Bloc Versus Standard (Piecemeal) Resection of Bladder Tumour: A Critical Appraisal of the EBSTAR Randomised Trial
Dr Kirby Qin

10:50am Critical appraisal: Standard or Extended Lymphadenectomy for Muscle-Invasive Bladder Cancer
Dr Liang Qu

10:55am Bladder cancer update
Dr Anthony Ta

11:05am Complication rates and outcomes of suction devices in ureteroscopy and retrograde intrarenal surgery: A systematic review
Dr Daniel Crisafi

11:10am Kidney stone update
Dr Daniel Lenaghan

11:20am Kidney cancer update
Dr Dixon Woon

11:30am – 12:00pm Session 2: Paying It Forward – Re-interpreting the Gold Standard in the 3rd World
Chairs: A/Prof Janelle Brennan and Ms Jana Middlemis
Lansell 1 & Bassford 1

11:30am Madagascar
Dr Lydia Johns-Putra

11:40am South Sudan
Dr Thomas Carins

11:50am Sri Lanka
Dr Rohan Hall

11:55am Q&A

12:00pm – 1:15pm Lunch with Industry
Fernery Room

12:45pm – 1:15pm USANZ Annual General Meeting
Lansell 2

1:15pm – 3:10pm Concurrent Session 3A: Research Presentations
Chairs: Dr Rohan Hall and Dr Ania Sliwinski
Lansell 1 & Bassford 1

Real World Audits – Are we doing as well as we think?

1:15pm Real World Experience with Optilume
Dr Brendan Dittmer

1:21pm Clinical audit: comparison of nurse practitioner and doctor performed transperineal prostate biopsy in a regional public hospital
Dr Samantha Koschel

1:27pm Predictors of Pathological Upstaging from TURBT at Radical Cystectomy: A single-centre retrospective analysis
Miss Xinyi Wei

1:33pm Bladder Cancer Variant Histology: A Five-Year Retrospective Cohort Study
Dr Thomas McMaster

1:39pm Retrospective audit of minor and major complication rates after open radical cystectomy – a single centre study.
Dr Christopher Soliman

1:45pm There and Back Again: A 10 year Audit into Penile Cancer in Victoria
Dr Jonathan O'Brien

The Cutting Edge: Novel Research

1:54pm Efficacy and safety outcomes of Bulkamid urethral bulking in men with post-prostatectomy stress urinary incontinence
Dr Jeremy Cheng

2:01pm PSMA PET for Active Suveillance: An update from the CONFIRM Trial
Dr Jonathan Carll

2:08pm Safe pressures for ureteroscopic suction access sheaths: converting ureteroscopic pressures to flow
Dr Jordan Santucci

2:15pm Insights from PSMA PET/CT into recurrence patterns and therapeutic implications in patients with biochemical recurrence after radical prostatectomy and salvage radiotherapy
Dr Yajat Dua

Quick fire: Insights from the Literature

2:24pm Grading the Risk – Comparing existing nomograms in predicting outcomes post Radical Nephroureterectomy for upper tract urothelial carcinoma
Miss Xinyi Wei

2:30pm Cutting to the point: a guideline of guidelines review on kidney-sparing versus radical surgery in UTUC
Dr Abdullah Al-Khanaty

2:36pm Chasing the Nadir: PSMA-PET Changes Following ADT in Prostate Cancer
Dr Cynthia Wells

2:42pm Comparative Accuracy of Ultrasound Modalities in Differentiating Benign and Malignant Small Testicular Masses: A Systematic Review
Dr Yajat Dua

Inflammatory conditions in urology

2:50pm Advancing Women in Surgical Leadership: A Narrative Review of Key Barriers and Drivers
Dr Jessica Wynn

2:55pm Selecting Urology Trainees; are we moving in the right direction? Perspective from Australian surgical trainees with an elite sport background
Ms Hedda Cooper

3:00pm Scribe Smarter, Not Harder: How AI Scribes Stack Up Against Human Clinicians
Dr Alice Thomson

3:05pm Battle of the Botox – Differences in injection number and site for iOAB between Urologists and Gynaecologists
Dr Ellen Kelsey

1:15pm – 3:10pm Concurrent Session 3B: Nursing Session: The pelvic floor and beyond, Sitting in the hot seat - Case Studies in Urology Nursing Practice
Chairs: Ms Jana Middlemis and Mr David Heath
Lansell 2

1:15pm Reflections of a registrar working with nurse practitioners
Dr Jess Wynn

1:25pm How the nurse practitioner can support the rural and regional sub-specialty junior doctor
Dr Ellen Kelsey

1:35pm How to assess pelvic organ prolapse
Dr Thomas Carins

1:45pm High tone pelvic floor dysfunction
Mrs Cheryl Ludwik

2:15pm Australian nurse practitioner prostate biopsy service
Mr David Heath

2:45pm Patient Experience: High grade bladder cancer - diagnosis and treatment
Ms Jana Middlemis

3:10pm – 3:40pm Afternoon tea with Industry
Fernery Room

Final Program (cont'd)

3:40pm – 4:15pm **Session 4: The Profession at Large**
Chairs: Dr Lydia Johns-Putra and Mr David Heath
Lansell 1 & Bassford 1

3:40pm Robotic funding and the public system
A/Prof Lih-Ming Wong

3:55pm A urologist's perspective of the patience experience
Prof Henry Woo

4:05pm The psychology of female urology
A/Prof Janelle Brennan

4:15pm – 5:00pm **Session 5: The Gold Standard in Medicine**
Chairs: Dr Ania Sliwinski and Mr David Heath
Lansell 1 & Bassford 1

4:15pm Update in gynaecology
Dr Thomas Carins

4:25pm Update in anaesthesia
Dr Kirsty Belfrage

4:35pm Update in nephrology
Dr Chau Ng

4:45pm Q&A

4:55pm Presentation of prizes and meeting close

General Information

Venue

The 2025 USANZ Victorian Section Meeting is being held at the All Seasons Bendigo, 171-183 McIvor Hwy, Bendigo, Victoria 3550. For more information about the venue, please visit: www.allseasonsbendigo.com.au.

Registration Desk

The registration desk will be located at the Fernery Room, All Season Bendigo, Victoria.

Opening hours: 9:00am to 5:00pm, Saturday 11 October 2025

Industry Exhibition

The industry exhibition will be held in the Fernery Room of the All Seasons Bendigo. Morning tea, lunch, and afternoon tea will be served in the industry exhibition room.

Internet Facilities

Wireless internet will be available throughout the meeting. Details will be made available onsite.

Certificate of Attendance

A certificate of attendance will be circulated electronically at the conclusion of the meeting.

Continuing Professional Development (CPD)

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. RACS Fellows who have provided their RACS ID at the time of registration will have their RACS CPD automatically updated in their ehub.

Special Dietary Requirements

Please note that the venue is responsible for all catering at the meeting. RACS Conferences and Events Management and USANZ do 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.

Parents' Room and Childminding Services

A parents' room will be available at the venue. Please visit the registration desk if required. For childcare services in Bendigo, please visit: www.connectgreaterbendigo.com.au > Groups > Education and Learning > Childcare and Early Years Centres.

RACS/USANZ accepts no liability for any of the listed childcare companies on the website provided. It is up to the individual to select a suitable carer and be responsible for their bookings.

Intention to Photograph

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

These photos may be used for the following purposes:

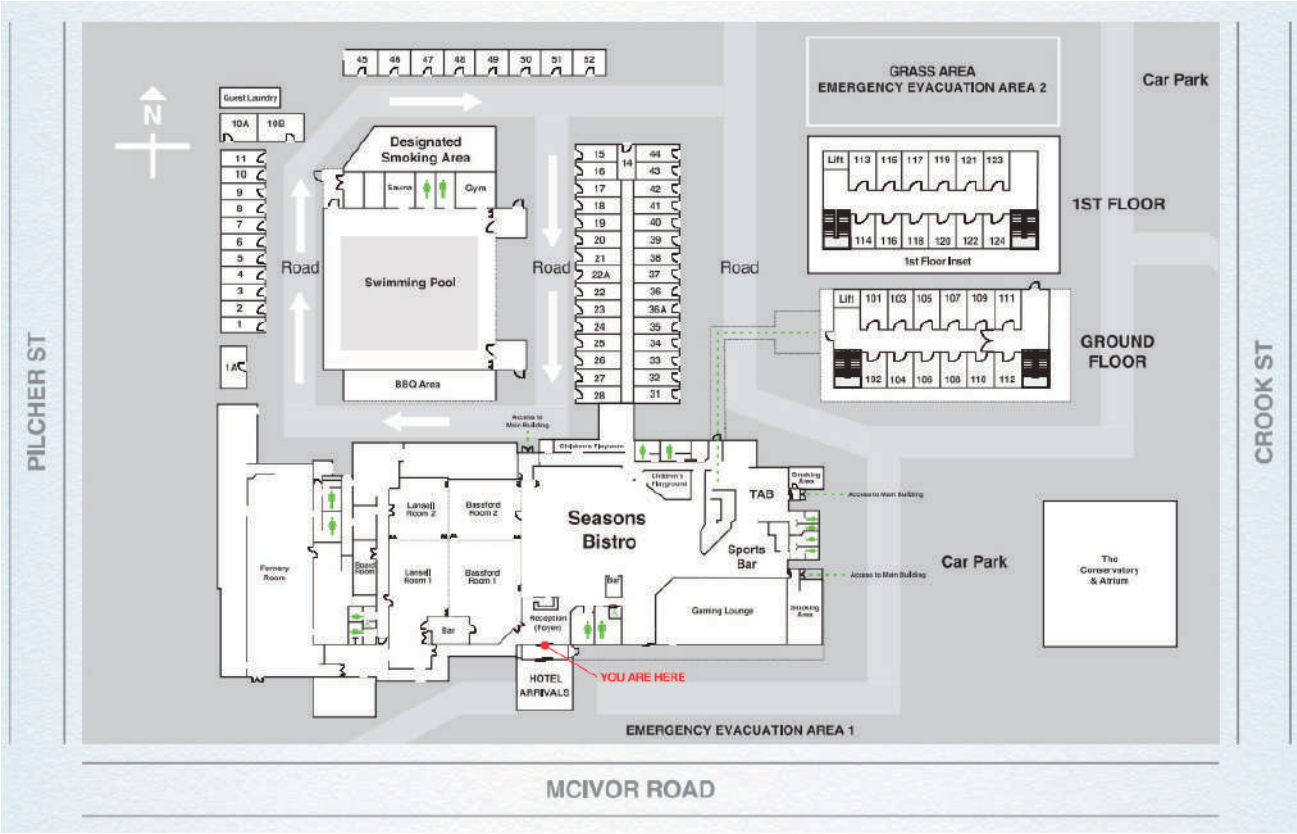
- Projection onsite
- Reporting on the meeting online
- Marketing a future meeting, including online and hard copy publications
- Publishing in RACS and USANZ publications

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

Car Parking

The All Seasons Bendigo has dedicated and signed conference car parking, please **do not** park in the general hotel car parking. All parking is free of charge.

Venue Map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Car Park
1ST FLOOR
1st Floor Inset
GROUND FLOOR
Seasons Bistro
TAB
Sports Bar
Gaming Lounge
Car Park
The Conservatory & Atrium
HOTEL ARRIVALS
YOU ARE HERE
EMERGENCY EVACUATION AREA 1

Verbal Abstracts

Note: Abstracts are listed in alphabetical order of the presenter's surname.

CUTTING TO THE POINT: A GUIDELINE OF GUIDELINES REVIEW ON KIDNEY-SPARING VERSUS RADICAL SURGERY IN UTUC

Al-Khanaty A, Hennes D, Delgado C, Dinneen E, Perera M, Bolton D, Murphy D, Eapen R, Lawrentschuk N

Peter MacCallum Cancer Centre

Introduction & Objectives:
Upper tract urothelial carcinoma (UTUC) is uncommon but poses difficult trade-offs between oncological control and renal preservation. International guidelines diverge on when to recommend kidney-sparing surgery (KSS) versus radical nephroureterectomy (RNU). We reviewed major society guidance to map consensus and highlight controversies.

Methods:
We examined recommendations from the EAU, AUA, NCCN, NICE, and Canadian Urological Association. Emphasis was placed on risk stratification, indications for KSS, and the role of adjunctive measures such as intravesical chemotherapy.

Results:
The EAU strongly endorses risk stratification, recommending KSS—including ureteroscopic or percutaneous ablation and segmental ureterectomy—for carefully selected low-risk disease, with mandatory second-look ureteroscopy. Post-RNU, it advises single-dose intravesical chemotherapy to reduce bladder recurrence. In contrast, the AUA and NCCN remain more conservative, favouring RNU as the default and reserving KSS for imperative indications such as solitary kidney or renal insufficiency. NICE is less prescriptive, supporting nephron-sparing approaches in selected patients where renal preservation is crucial. Outcome data reflect this equipoise: large registry analyses demonstrate no detriment in cancer-specific mortality for small (<2 cm), low-grade tumours treated endoscopically, while emerging modalities such as endoscopic cryoablation suggest further potential. Despite this, practice remains heterogeneous, reflecting both evidence gaps and differing tolerance for oncological risk.

Conclusions:
Guidelines vary substantially in their enthusiasm for kidney-sparing management of UTUC. While the EAU explicitly promotes conservative surgery in low-risk disease, the AUA and NCCN continue to default to radical surgery. This discord highlights uncertainty regarding long-term oncological equivalence and underscores the need for stronger prospective data to guide safe, risk-adapted renal preservation strategies.

PSMA PET FOR ACTIVE SUVEILLANCE: AN UPDATE FROM THE CONFIRM TRIAL

Dr Jonathon Carll, Prof Nathan Lawrentschuk, Dr Laurence Liu, the CONFIRM Team

EJ Whitten Centre for Prostate Cancer Research

Materials and Methods:
CONFRIM is a prospective multi-centre trial which is enrolling men on active surveillance with high-risk features. Participants receive a PSMA-PET scan and repeat MRI 3-6 months after initial diagnosis, prior to a confirmatory biopsy. Any additional PSMA- avid lesions which were not present on initial MRI are targeted at the time of biopsy. The patient's case is then presented to a MDM, where recommendations regarding continuing active surveillance, or proceeding to definitive treatment are made based upon the results of both the MRI-Guided biopsy, and the PSMA-PET guided biopsy.

Inclusion criteria for patients with high-risk features

- Men with ISUP Grade Group 2 disease deemed suitable for active surveillance (Low volume, small percentage of pattern 4)
- Men with ISUP Grade Group 1 disease with a PIRADS 4/5 lesion on initial MRI
- Men with ISUP Grade Group 1 disease with a PSA >10 ng/ml or PSA Density > 0.15ng/ml/ml
- Men with ISUP Grade Group 1 disease that is high volume-

Verbal Abstracts (Cont'd)

Results:
So far 178/223 men have been recruited and enrolled on the trial. Of the first 60 patients enrolled in the trial, PSMA PET guided confirmatory biopsy changed patient management in 20% of cases. The MDM subjectively felt that PSMA PET was useful in decision making in a further 33% of cases, where it provided reassurance that the patient was suitable to continue active surveillance due to nil PSMA avid lesion (n=14), presence of unifocal disease (n=4), and resolution of discordance between original and repeat MRI (n=2).

Conclusion:
CONFIRM is a world-leading trial which examines if PSMA-PET can be a useful tool in men undergoing active surveillance. Early results are promising, with final results expected in the next 12 months. It is nearing the end of recruitment, so any new referrals would be much appreciated.

EFFICACY AND SAFETY OUTCOMES OF BULKAMID URETHRAL BULKING IN MEN WITH POST-PROSTATECTOMY STRESS URINARY INCONTINENCE

Jeremy Cheng, Olivia Darby, Charles Han

Ramsay Health Care

Aims:
To determine the safety and efficacy of polyacrylamide hydrogel (PAHG, Bulkamid®) for post-prostatectomy incontinence (PPI), as measured by the post-operative complication rate, change in number of urinary incontinence pads used per 24 hours, and rate of treatment failure (requiring further invasive surgery excluding repeat PAHG injection).

Methodology:
This was a single-operator retrospective cohort study of men undergoing intra-urethral injection of PAHG (Bulkamid®) for PPI. Bulkamid® was injected transurethrally at multiple sites around the membranous urethra until mucosal coaptation was achieved. Patients were assessed for any post-procedural complications. At each pre-procedural and post-procedural assessment, the average number of urinary continence pads per 24 hours was recorded. If patients were still experiencing significant bothersome symptoms, they were offered additional continence surgery in the form of either repeat PAHG, insertion of Adjustable Transobturator Male Sling (ATOMS) device, or insertion of artificial urinary sphincter.

Results:
16 men were included, with a total of 24 individual procedures. Median follow up was 10 (3-37) months. Two men developed urinary retention, with successful trial of voids. There were no other complications. Overall, average pad use decreased by a median of 1 (-1-1.25). The highest number of decreased pads was 9. Overall, 13 (81%) patients were either completely pad free or had decreased pad numbers compared to baseline. Four patients (25%) required further continence surgery at a median of 13 (6-24) months. There were no statistically significant differences in baseline patient characteristics or treatment technicalities between the success and failure groups.

Conclusion:
This is the first study exploring PAHG (Bulkamid®) in men with PPI. It is safe, quick and minimally-invasive. Overall efficacy and success rates are promising, with an encouraging number of men completely pad-free or requiring fewer pads, and not requiring further surgery. It may also have a role in delaying more invasive surgery.

SELECTING UROLOGY TRAINEES; ARE WE MOVING IN THE RIGHT DIRECTION? PERSPECTIVE FROM AUSTRALIAN SURGICAL TRAINEES WITH AN ELITE SPORT BACKGROUND

Hedda Cooper, BSc, MD; Olivia Sibillin, BSc, MD; Alice McNamara MBBS, FACSEP

MP Sport Physicians

In 2025 in Australia, to become a Urology trainee, the current selection guidelines heavily focus on conference attendance and research, along with having extra tertiary qualifications and time spent in rural areas. However, prior to 2024 the selection criteria included room for excellence in other fields including recognition of sporting achievements. Similarly, many other surgical programs around Australia have moved away from recognising prior life achievements in recent years. In this survey we asked fifteen open ended questions to elite athletes who are now surgeons or aspiring surgeons. Our aim was to form an idea of what skills their sporting background may have developed which helps them be excellent surgeons/surgical trainees. 75% of participating individuals had represented their country

Verbal Abstracts (Cont'd)

in various sports over years to decades at World Championship and Olympic levels. 75% of participants were surgeons or surgical trainees, with 25% being surgical residents. When asked about the top 3 skills they believed they had developed, 80% stated discipline or determination. When asked about the parallels between elite sport and surgery, 90% stated that both involved high pressure situations with high stakes. Similarly, when participants were asked if they believed former athletes are well suited to surgical careers, 100% of participants stated yes for reasons including the ability to work well in teams with desire to work towards a shared goal and perfectionism with great attention to detail. Others stated ability to deal with challenges in a greater capacity. This limited data gives us a narrow insight into the minds of elite athletes now pursuing surgical careers and what skills they have developed over years of pursing excellence in another field. Should it be considered by USANZ or other surgical training programs when selecting future candidates?

COMPLICATION RATES AND OUTCOMES OF SUCTION DEVICES IN URETEROSCOPY AND RETROGRADE INTRARENAL SURGERY: A SYSTEMATIC REVIEW

Dr Daniel Crisafi, Dr Sam Sii, Dr Anne Hong, Prof Damien Bolton, Mr Greg Jack

Austin Health

Introduction:
Negative pressure suction devices during retrograde intrarenal surgery (RIRS) are designed to overcome commonly encountered issues including poor visibility, residual fragments and elevated intra-renal pressures (IRP).

This systematic review evaluates the safety profile and efficacy of novel suction devices compared to current practices in the management of renal and upper ureteral stones.

Methods:
A systematic search of the literature was conducted on 21th December 2024 using Embase, Medline and Scopus. Only English papers involving adult populations with typical anatomy were accepted.

Results:
Thirty-five articles were deemed suitable for the purposes of this review. Various methods of suction-assisted RIRS have been described, including suction ureteral access sheaths (S-UAS), tip-flexible suction ureteral access sheaths (TFS-UAS) and in-scope suction devices, as a means to improve the safety and efficacy of RIRS.

Suction devices have shown significant advantages by vacuuming debris to improve visibility and maximise stone clearance, even for larger stones typically managed by percutaneous nephrolithotomy. Particularly impressive results have been noted using TFS-UAS given its capability to perform targeted stone fragmentation and simultaneous suctioning. Improved stone-free rates, shorter operating times, and fewer auxiliary surgeries have subsequently been observed compared to traditional access sheaths.

The use of intelligent pressure monitoring has the added benefit of maintaining low IRP intra-operatively, which reduces infectious complications like fever and sepsis. Therefore, these techniques may offer substantial health economic benefits by reducing operating time, intra-operative costs and hospital stays.

Conclusion:
Suction technology in RIRS optimises stone clearance and reduces complication rates by improving visibility, evacuating debris and also maintaining low IRP. With further research, it promises to be a useful adjunct to current practices.

REAL WORLD EXPERIENCE WITH OPTILUME

Brendan Dittmer, David Homewood, Justin Chee

Western Health, Footscray Hospital

Aim:
Male urethral stricture disease is common. The Optilume® drug-coated balloon (Optilume), in industry sponsored studies (ROBUST III)[1], demonstrated significant improvement over traditional endoscopic treatments. We aim to determine how the results of ROBUST III compares against a cohort of real world patients with urethral strictures treated during our initial experience of Optilume, and to a similar cohort of patients that underwent gold standard urethroplasty.

Verbal Abstracts (Cont'd)

Methodology:
We assessed freedom from intervention (FFI), IPSS, QoL, Qmax and PVR. 18 of 21 patients fitting the inclusion criteria were treated with Optilume in real world (ORW) setting between April 2020 and May 2021 had complete data (2 year follow up). We retrospectively looked at 49 patients who had urethroplasty (UP) between Jan 2019 and Mar 2020, 21 of these patients fit the inclusion criteria for Optilume, 17 have complete data (5 year follow up). We compared these 2 groups to 3 year outcomes of Optilume RCT ROBUST III (ORCT).

Results:
FFI for UP, ORW and ORCT were 94.1% Vs 57.1% Vs 71.9% respectively (see table 1). UP performed better in all areas including IPSS, QoL, Qmax and PVR. Real world outcomes for Optilume appear to less impressive than ORCT but still better than repeated traditional endoscopic therapies.

Conclusion:
Our real world data confirms that urethroplasty remains the gold standard in the treatment of male bulbar urethral strictures. Optilume in the real world does not live up to current data. Optilume shows promise above traditional endoscopic therapies but its exact role is yet to be determined.

Reference:
1. Srikanth, P., DeLong, J., Virasoro, R., & Elliott, S. P. (2025). A Drug-Coated Balloon Treatment for Urethral Stricture Disease: Three-Year Results from the ROBUST III Study. *Journal of Endourology*. https://doi.org/10.1089/END.2024.0718/ASSET/IMAGES/END.2024.0718_FIGURE3.JPG

COMPARATIVE ACCURACY OF ULTRASOUND MODALITIES IN DIFFERENTIATING BENIGN AND MALIGNANT SMALL TESTICULAR MASSES: A SYSTEMATIC REVIEW

Yajat Dua, Niranjan Sathianethan

Royal Melbourne Hospital

Background:
The increasing detection of incidental small testicular masses (STMs) through scrotal ultrasound has created a clinical dilemma, as most are benign but often undergo surgical excision. Conventional ultrasound (US) has limited specificity, leading to unnecessary orchiectomies. Advanced imaging modalities including contrast-enhanced ultrasound (CEUS) and elastography have emerged as potential tools to improve diagnostic accuracy.

Methods:
A systematic review of eight studies (2013–2022) evaluating CEUS, elastography, and conventional US in differentiating benign versus malignant STMs was conducted. Data on study design, patient cohorts, lesion characteristics, ultrasound modalities, histopathology correlation, and diagnostic accuracy (sensitivity, specificity, PPV, NPV, AUROC) were extracted.

Results:
Across studies (n≈454 patients; n≈459 lesions), CEUS consistently improved specificity (up to 95–100%) compared with conventional B-mode US (specificity often <70%). Elastography (strain and shear-wave) demonstrated high diagnostic accuracy with AUROCs >0.85, particularly when combined with conventional US or CEUS. Multiparametric approaches (combining CEUS, elastography, and grayscale US) achieved the best discrimination, with reported AUROCs up to 0.96. Malignant lesions typically showed heterogeneous or rapid enhancement on CEUS, while benign lesions demonstrated homogeneous slow enhancement or higher elasticity. Limitations included small sample sizes, heterogeneous methodologies, and limited prospective validation.

Conclusions:
CEUS and elastography outperform conventional US in differentiating benign from malignant STMs, reducing unnecessary surgical excision. Multiparametric ultrasound approaches appear most promising, with excellent diagnostic accuracy. Larger prospective multicentre studies are warranted to validate these modalities and guide investigative pathways for small testicular mass evaluation.

Verbal Abstracts (Cont'd)

INSIGHTS FROM PSMA PET/CT INTO RECURRENCE PATTERNS AND THERAPEUTIC IMPLICATIONS IN PATIENTS WITH BIOCHEMICAL RECURRENCE AFTER RADICAL PROSTATECTOMY AND SALVAGE RADIOTHERAPY

Dr Yajat Dua, Dr Haidar Alsaffar, Dr Shen Oon, Dr Umar Khan, Associate Professor Marlon Perera, Associate Professor Daniel Moon

Peter MacCallum Cancer Center, Victoria, Australia

Introduction:

Prostate cancer patients experiencing double biochemical recurrence (dBCR) after radical prostatectomy (RP) and salvage radiotherapy (sRTx) face clinical challenges. Advanced imaging, particularly PSMA PET/CT, provides insights into recurrence patterns, aiding therapeutic decisions.

Methods:

This retrospective cohort study included 48 patients with dBCR. Preliminary analysis of 18 patients who underwent restaging PSMA PET/CT assessed baseline characteristics, recurrence patterns, and outcomes, stratified by PSA levels.

Results:

The average age at RP was 69 years. European Association of Urology (EAU) risk categories included favourable-intermediate (22%), unfavourable-intermediate (39%), and high-risk (39%). All 18 patients received sRTx, with 4 receiving extended EBRT to lymph nodes and prostate, 4 EBRT to the prostate, and 16 receiving intermittent androgen deprivation therapy (ADT). Median PSA at PSMA PET/CT for dBCR was 1.43ng/mL. Recurrence patterns included prostate bed (17%), nodal (17%), and distant metastases (44%); 2 patients showed no radiological recurrence. PSMA PET/CT demonstrated an 89% detection rate, with 70% showing radiological progression at a median of 65 months post-sRTx.

Therapeutically, 10 patients started ADT, 9 started androgen receptor pathway inhibitors, and 9 underwent metastasis-directed therapies using stereotactic ablative body radiotherapy or external beam radiotherapy targeting nodal or bone recurrences. Median PSA level at last follow-up was 1.2ng/mL, with 77.5 months mean follow-up post sRTx.

Conclusion:

PSMA PET/CT reliably detects dBCR, aiding tailored strategies like MDT and systemic therapy. Future research should optimize PSMA-guided treatment pathways to improve outcomes in this population.

BATTLE OF THE BOTOX – DIFFERENCES IN INJECTION NUMBER AND SITE FOR IOAB BETWEEN UROLOGISTS AND GYNAECOLOGISTS

Ellen Kelsey, Kathryn McLeod

Barwon Health University Hospital Geelong

Background:

Idiopathic overactive bladder (iOAB) can impact patients' quality of life. IntradetrusorOnabotulinumtoxinA (BTN/A) is an efficacious treatment option for iOAB refractory to lifestyle and medical interventions, although the most effective procedural techniques have yet to be determined. In Australia and New Zealand BTN/A for iOAB is performed by urologists, urogynaecologists and gynaecologists. Given no best practice data on procedural techniques is available a survey was conducted among specialists, urologist's gynaecologists and urogynaecologists, performing BTN/A for iOAB to assess the number of and sites of injection for female BNT/A naïve patients, of particular interest was trigone injection.

The trigone has traditionally been avoided for injections due to a theoretical risk of vesicoureteral reflux, though supporting evidence is weak and cases are rare. Recent studies suggest that BTN/A injection into the trigone is safe and may improve intradetrusor BTN/A efficacy. Similarly, reducing the number of injection sites may also enhance procedure outcomes.

Methods:

A survey was conducted to gather a broad spectrum of experiences while ensuring participant confidentiality. Survey questions were created by the lead investigator (EK) and supervising urologist (KM). Only practising urologists and gynaecologists in Australia or New Zealand were eligible; others were excluded. Recruitment was done via USANZ and RANZCOG, providing participants with a REDCap survey link or QR code.

Verbal Abstracts (Cont'd)

Results:
There was a total of 76 respondents. For number of injection sites urologists concentrate in 10–19 sites, while Gynaecologists and Urogynaecologists more often extended into 20–29 sites

For inclusion of trigone injection into standard injection paradigms Gynaecologists and Urogynaecologists use it significantly more (21%) compared with Urologists (4%) but numbers were still low.

Conclusion:
Optimisation of procedural techniques could improve outcomes and tolerability for BTN/A injection for iOAB patients and inform further research and guidelines

CLINICAL AUDIT: COMPARISON OF NURSE PRACTITIONER AND DOCTOR PERFORMED TRANSPERINEAL PROSTATE BIOPSY IN A REGIONAL PUBLIC HOSPITAL

Dr Samantha Koschel, Dr Kristy Wu, Mr Dave Heath, A/Prof Janelle Brennan

Bendigo Health

Background:
With more PSA screening being performed, pressure is placed on our health system to facilitate urgent prostate biopsies particularly in regional centres where access to a urologist may be limited. Training nurse practitioners to perform transperineal prostate biopsies is an avenue to improving timely diagnosis.

Aims:
The aim of this clinical audit is to compare the accuracy of nurse practitioner (NP) performed MRI-targeted transperineal prostate biopsy with those performed by consultant urologists or urology registrars.

Methods:
A retrospective audit was undertaken of transperineal prostate biopsies at Bendigo Health from 2024 to 2025, with 50 cases performed by a single NP and 50 cases by urology registrars or consultants reviewed. All biopsies were undertaken using cognitive MRI targeting and modified Barzell template.

Results:
Demographics were similar, with the NP group having a median PSA of 7.5, PSA density of 0.13, and 81% having a targetable PIRADS 3-5 lesion on MRI. The urologist group had a median PSA of 6.1, PSA density of 0.11 and 70% had a PIRADS 3-5 lesion.

NP performed biopsies detected CaP in 80%, compared to 83% of the doctor performed biopsies. MRI target concordance was better in the urologist group at 94% compared to 78% in the NP group, though this is likely confounded by small numbers. The doctor group had a higher number of cores without prostate tissue, with an average of 0.4 cores per biopsy compared to 0.12 in the NP group.

Conclusions:
Nurse practitioner performed transperineal prostate biopsies are comparable to those performed by urology registrars and consultants in this single centre audit.

CRITICAL APPRAISAL: ROBUST III RANDOMIZED CONTROLLED TRIAL EVALUATING THE OPTILUME DRUG-COATED BALLOON FOR ANTERIOR URETHRAL STRICTURES (ELLIOTT ET AL., J UROL 2022)

Dr Samantha Koschel

Bendigo Health

Study design:
The ROBUST III study evaluated the safety and efficacy of the Optilume drug-coated balloon (DCB) compared to standard endoscopic management with DVIU, uncoated balloon dilatation or urethral dilatation with sounds.

The study adhered to strict eligibility criteria - adult males with anterior strictures ≤12Fr and ≤3cm, ≥2 prior endoscopic treatments, IPSS ≥11 and Qmax <15ml/s. Participants were randomised 2:1 treatment vs control, which was stratified by prior pelvic RT and number of prior endoscopic treatments.

A total of 127 participants were randomised and accounted for, with 79 in the DCB arm and 48 in the control arm.

Verbal Abstracts (Cont'd)

Methodology:
Participants were blinded through 6 months when the primary efficacy endpoint was assessed but could be unblinded if they experienced recurrent stricture requiring intervention. Twelve control arm participants were unblinded prior to the six month mark and crossed over to the DCB arm.

Surgeons were not blinded to the intervention which may have biased their interpretation of anatomical success or stricture recurrence at cystoscopy.

Patient and stricture characteristics were similar between groups, including location, length and diameter of stricture, prior pelvic RT, and number of previous dilations.

Results:
At 6 months, anatomical success was 74% in the DCB group and 26.8% in the control group, with a difference of 44.4% (95% CI 27.6-61.1) which was statistically significant ($p<0.0001$). Anatomical success was defined by atraumatic passage of a 16F flexible cystoscope or 14F catheter through the treated area. Model based estimates were used to account for missing data as urethral lumen assessment was only performed in 108/127 participants.

Freedom from repeat intervention at 1 year was significantly higher in the DCB group at 83.2% compared to the control arm at 21.7% using Kaplan-Meier estimates.

Adverse events were matched between groups, though the DCB group had higher rates of post procedure haematuria and dysuria.

No cost analysis was performed.

BLADDER CANCER VARIANT HISTOLOGY: A FIVE-YEAR RETROSPECTIVE COHORT STUDY

Thomas McMaster, Gabrielle Hoskin, David Homewood, Abigail Attwell-Heap, Joanne Perry-Keane, Chandrasekhar Perumalla, Samarth Chopra

Sunshine Coast University Hospital

Aims:
We aim to compare the prevalence of variant histology to the current literature, as well as examine overall survival of VH compared to pure urothelial.

Methods:
A five-year retrospective cohort study, including 80 consecutive patients at a tertiary centre in Queensland, Australia. Inclusion criteria: patients >18 years old with localised bladder cancer and underwent open cystectomy between January 2019 to December 2024, with curative intent. Exclusion criteria included metastatic disease or palliative treatment. Statistical analysis was performed using R version 4.4.1, with statistical significance reported at $p < 0.05$.

Results:
Variant histology was observed in twenty-one cases (26% vs 14.6-25%1-3). Aggressive VH subtypes included: micropapillary (6.3% vs 0.6-5%1-3), sarcomatoid (5% vs 0.3-1%1-3) and plasmacytoid (3.8% vs 0.17-3%1-3). Four cases of VH received neoadjuvant chemotherapy. Kaplan-Meier analysis showed no statistical difference in overall survival (OS) between urothelial and variant histology ($p = 0.53$).

Conclusion:
In our data, we observed a higher prevalence of aggressive bladder subtypes of VH compared to current literature. However, there was no difference in overall survival between urothelial and non-urothelial cases, largely due to timely decision for upfront radical cystectomy.

References:
1. Shah RBMD, Montgomery JSMDMHSA, Montie JEMD, Kunju LPMD. Variant (divergent) histologic differentiation in urothelial carcinoma is under-recognized in community practice: Impact of mandatory central pathology review at a large referral hospital. *Urologic Oncology: Seminars and Original Investigations*. 2013;31(8):1650-5.
2. Moschini M, D'Andrea D, Korn S, Irmak Y, Soria F, Compérat E, Shariat SF. Characteristics and clinical significance of histological variants of bladder cancer. *Nature Reviews Urology*. 2017;14(11):651-68.
3. Lobo N, Shariat SF, Guo CC, Fernandez MI, Kassouf W, Choudhury A, et al. What Is the Significance of Variant Histology in Urothelial Carcinoma? *European Urology Focus*. 2020;6(4):653-63.

Verbal Abstracts (Cont'd)

PI IN THE SKY? A CRITICAL APPRAISAL OF ARTIFICIAL INTELLIGENCE REDEFINING PROSTATE MRI ACCURACY

Jonathan O'Brien

Peninsula University Hospital

Background:
The Prostate Imaging—Cancer Artificial Intelligence (PI-CAI) study (Saha et al., Lancet Oncology, July 2024) evaluates whether an AI system can match or outperform radiologists in detecting clinically significant prostate cancer (csPCa) on MRI, addressing challenges like diagnostic workload and interobserver variability.

Methods:
This international, paired, non-inferiority, confirmatory study retrospectively analysed 10,207 MRI scans (2012–2021), including 2,440 cases with biopsy-confirmed Gleason grade group ≥ 2 cancer. The AI model was trained and tuned on 9,207 scans from 11 Dutch centres and tested on 1,000 scans across centres in the Netherlands and Norway. A multi–reader, multi–case study involved 62 radiologists from 45 centres in 20 countries, using PI-RADS 2.1 on 400 paired cases. The primary outcomes were sensitivity, specificity, and area under the ROC curve (AUROC), benchmarked against both radiologist performance and multidisciplinary standard-of-care readings, with histopathology and at least three years' follow-up as reference standards.

Results:
In the 400-case reader comparison, the AI system achieved superior and non-inferior performance: AUROC 0.91 (95% CI 0.87–0.94) vs radiologists' AUROC 0.86 (95% CI 0.83–0.89; $p < 0.0001$). At a comparable PI-RADS ≥3 threshold, the AI detected 6.8% more csPCa at equal specificity or reduced false positives by 50.4% while maintaining sensitivity of ~89.4%. However, when compared with standard multidisciplinary readings over 1,000 cases, non-inferiority was not confirmed: AI specificity was marginally lower (68.9% vs 69.0%) at equal high sensitivity (~96.1%).

Conclusion:
The PI-CAI system demonstrates promise, outperforming radiologist readers under PI-RADS 2.1 and nearing standard-of-care performance in detecting csPCa. These findings highlight its potential as a decision-support tool in diagnostic workflows—though prospective validation is needed before clinical implementation.

THERE AND BACK AGAIN: A 10 YEAR AUDIT INTO PENILE CANCER IN VICTORIA

Jonathan S. O'Brien, David Homewood, Henry Pan, Jiasian Teh, Liang G. Qu, James Churchill, Brian D. Kelly, Todd G. Manning, Declan G. Murphy, Damien Bolton, Jeremy Goad, Dixon Woon, Niall Corcoran, Justin Chee, Nathan Lawrentschuk

Peninsula University Hospital

Background:
Penile cancer is a rare malignancy, with an incidence of ~1 in 100,000 men in Western countries. Outcomes range from curable localised tumours to aggressive disease with high morbidity and mortality. In Australia, comprehensive epidemiological data and national guidelines remain limited. To address this, we conducted a multi-institutional retrospective audit as a foundation for the proposed Australian Penile Cancer Registry, aiming to characterise local disease burden, treatment patterns, and outcomes.

Methods:
We audited patients with invasive penile squamous cell carcinoma (PSCC) treated between January 2016 and March 2025 by sub-specialist uro-oncologists across metropolitan and regional Victorian hospitals. Demographic, clinical, pathological, and treatment data were collected using standardised REDCap protocols. Treatment was guided by multidisciplinary team (MDT) discussions, with complex cases undergoing centralised uro-oncology MDT review. Outcomes included overall survival (OS), recurrence-free survival (RFS), and lymph node staging accuracy. More recently, data collection transitioned from retrospective to prospective entry supported by BioGrid.

Results:
A total of 112 patients were identified, median age 67 years. HPV positivity was present in 28%, without significant OS impact. Partial penectomy was the primary intervention in 82% of cases. Dynamic sentinel node biopsy (DSNB) showed high diagnostic performance, with 95% sensitivity and 99% negative predictive value. Five-year OS and RFS were 82% and 76%, respectively. Larger tumour size correlated independently with reduced OS, while age, HPV status, circumcision history, tumour differentiation, and surgery type were not predictive.

Verbal Abstracts (Cont'd)

Conclusion:
Oncological outcomes for PSCC in this Victorian cohort align with those reported from centralised penile cancer services internationally. This study shows that high-volume sub-specialists can deliver effective care within a decentralised system, supporting a national penile cancer registry.

EN BLOC VERSUS STANDARD (PIECEMEAL) RESECTION OF BLADDER TUMOUR: A CRITICAL APPRAISAL OF THE EBSTAR RANDOMISED TRIAL

Kirby Qin, Paul Manohar, Nieroshan Rajarubendra

Monash Health

Aims:
This critical appraisal evaluates the EBSTAR trial (European Urology, 2024), a multicentre randomised controlled study comparing transurethral en bloc resection of bladder tumour (ERBT [sic]) with standard (piecemeal) resection (SR [sic]) in patients with non–muscle-invasive bladder cancer (NMIBC). The study aimed to assess whether ERBT improves the 1-year recurrence rate without compromising safety.

Methodology:
The trial enrolled 350 patients with bladder tumours ≤3cm from 13 centres in Hong Kong between 2017 and 2020. Patients were randomised 1:1 to receive ERBT or SR. The primary endpoint was 1-year recurrence rate, analysed using a modified intention-to-treat approach in patients with histologically confirmed NMIBC. Secondary outcomes included detrusor muscle sampling, progression rate, operative time, complications, and need for second-look resection.

Results:
A total of 276 patients were included in the final analysis (143 ERBT, 133 SR). At one year, the recurrence rate was significantly lower in the ERBT group (29%) compared to SR (38%) ($p = 0.007$; HR 0.57, 95% CI 0.36–0.91). Subgroup benefit was observed in patients with single tumours, Ta stage, or EAU intermediate-risk disease. Progression to muscle-invasive disease occurred in three SR patients (2.6%) and none in the ERBT group ($p = 0.065$). ERBT had a longer operative time but comparable rates of complications and detrusor muscle sampling. Second-look resection revealed residual disease in 26% (ERBT) and 22% (SR), with no upstaging in either arm.

Conclusion:
The EBSTAR trial provides Level 1 evidence that ERBT reduces recurrence in appropriately selected NMIBC patients without increased morbidity. These findings support ERBT as a potential first-line endoscopic technique for bladder tumours up to 3cm.

CRITICAL APPRAISAL: STANDARD OR EXTENDED LYMPHADENECTOMY FOR MUSCLE-INVASIVE BLADDER CANCER

Liang Qu

Department of Urology, Peninsula Health

Aim:
To critically appraise the randomized controlled trial by Lerner et al 2024 regarding the role of standard versus extended lymphadenectomy during radical cystectomy for muscle-invasive bladder cancer.

Methodology:
A review was performed of the manuscript, regarding the survival outcomes of patients with muscle-invasive bladder cancer who underwent standard vs extended lymphadenectomy. The Critical Appraisal Skills Programme checklist was used to evaluate the quality of the study. The results were summarised, and the study's internal and external validity were assessed and reported.

Results:
In this multicentre trial from US and Canada, 592 patients were included and randomized between extended or standard lymphadenectomy. No difference was observed in disease-free survival (hazard ratio 1.10, 95% CI: 0.86 to 1.40; $p = 0.45$). The percentage of patients with an adverse event of grade 3 to 5, or death within 90 days after surgery, was 44% in the standard group and 55% in the extended group ($p = 0.01$). Overall, this study was a well-designed trial, with clear inclusion criteria, appropriate sample size, balanced randomisation, and adequate follow-up of median 6.1 years. The statistical analysis was sound, with a reported intention-to-treat analysis and minimal loss-to-follow-up. The study's generalisability to the Australian setting may be limited however, due to the focus on high-volume centres in this study and the patient population studied.

Verbal Abstracts (Cont'd)

Conclusion:
Lerner et al conducted a high quality study that demonstrated no benefit in disease-free survival for extended compared to standard lymphadenectomy, and instead, a higher proportion of adverse events. This study was well designed with high compliance and follow up.

Reference:
Lerner SP, Tangen C, et al, SWOG S1011 Trial Investigators. Standard or Extended Lymphadenectomy for Muscle-Invasive Bladder Cancer. N Engl J Med. 2024 Oct 3;391(13):1206-1216.

SAFE PRESSURES FOR URETEROSCOPIC SUCTION ACCESS SHEATHS: CONVERTING URETEROSCOPIC PRESSURES TO FLOW

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Aim:
To establish practical, size-specific negative pressure operating limits for suction ureteral access sheaths (sUAS).

Methods:
Irrigation inflow was measured using an 8.7 Fr flexible ureteroscope with a 3.9 Fr working channel at varying pressures, tested under three conditions: no instrument, 270 µm laser fibre, and 1.9 Fr basket. Outflow was measured through 10/12, 11/13, and 12/14 Fr sUAS (40 and 50 cm) with negative pressure suction (Neptune 3™ system) applied at 30-second intervals across 50–300 mmHg. Inflow and outflow were interpolated to derive conservative suction pressure limits for each sheath configuration.

Results:
Irrigation inflow ranged 30–130 mL/min across pressures (50 cmH_2O–300 mmHg). Working channel instruments reduced inflow (mean ±2SD change: basket –57.1% ±1.6%; laser fibre –42.1% ±2.1%). Outflow varied from 5 mL/min (10/12 Fr, 50 mmHg) to 700 mL/min (12/14 Fr, 300 mmHg), with strong linearity between suction pressure and outflow (R^2: 10/12 Fr 0.99; 11/13 Fr 0.99; 12/14 Fr 0.94). Higher scope-to-sheath ratios (SSR) reduced outflow, while valve opening decreased it by 70.8% on average. Shorter 40 cm sheaths increased outflow modestly (+13.3%) compared to 50 cm sheaths of the same diameter. Flow equilibrium was achieved with 50–80 mmHg suction for 11/13 and 12/14 Fr sUAS. The narrower 10/12 Fr sheath (SSR 0.87) required 150–300 mmHg to maintain equilibrium of outflow with inflow.

Conclusions:
Operating room suction systems can generate extreme negative pressures (>500 mmHg) that risk excessive outflow when using sUAS. Conservative application of sUAS negative pressure is essential. Our data suggest that 50–80 mmHg suction suffices for most 11/13 and 12/14 Fr sUAS cases, while smaller sheaths may require higher suction. Increasing irrigation pressure can counterbalance high outflow; however, the introduction of instruments through the working channel significantly diminishes inflow and may negate this effect.

RETROSPECTIVE AUDIT OF MINOR AND MAJOR COMPLICATION RATES AFTER OPEN RADICAL CYSTECTOMY – A SINGLE CENTRE STUDY.

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Department of Urology, Western Health, Victoria, Australia

Objective:
Radical cystectomy is associated with one of the highest complication burdens in urological oncology. This audit aimed to quantify both minor (Clavien–Dindo [CD] I–II) and major (CD ≥ IIIa) complications within 90 days of open radical cystectomy at a single tertiary centre, benchmarked against published standards.

Methods:
We conducted a retrospective review of consecutive adult patients undergoing open radical cystectomy between 2019 and 2024 at Western Health. Complications were identified from hospital records, coded using a structured complication dictionary, and mapped to the Clavien–Dindo classification. The primary outcome was the proportion of patients experiencing at least one major complication (CD ≥ IIIa). Secondary outcomes included the distribution of complication grades, event-level rates, length of stay (LOS), readmission, and transfusion rates.

Verbal Abstracts (Cont'd)

Results:
113 patients (median age 70 years, IQR 65–77; 81.4% male) were included. All underwent ileal conduit diversion. Any complication: 87.6%; ≥2 complications: 85.8%; major complications: 31.0%. Across 423 recorded events: CD I 20.8%, CD II 63.4%, CD IIIa 5.0%, CD IIIb 6.1%, CD IV 4.3%, CD V 0.5%. Event-level major rate was 15.8%. LOS median 8 days (IQR 7–14); 90-day readmission 35.4%; peri-operative transfusion 37.2%.

Conclusions:
Event-level major complications were within the ~≤20% benchmark reported in large series, but patient-level major morbidity remained above target. Quality improvement initiatives should focus on prevention and early management of minor events and targeted pathways for high-impact complications.

LONG-TERM OUTCOMES OF MEN ON ACTIVE SURVEILLANCE FOR PROSTATE CANCER WITHOUT EARLY PROGRESSION: IMPLICATIONS FOR DEINTENSIFYING OR STOPPING SURVEILLANCE - A CRITICAL APPRAISAL.

Christopher Soliman

Department of Urology, Barwon Health

Background:
Active surveillance (AS) is the preferred management strategy for men with low-risk prostate cancer, balancing avoidance of overtreatment with the need for oncological safety. However, there is limited evidence on whether men who remain stable for many years can transition to less intensive monitoring or even stop surveillance altogether.

Objective:
To critically appraise recent evidence on long-term oncological outcomes among men progression-free for ≥5 years on AS and to evaluate whether deintensification strategies may be appropriate.

Methods:
A large, single-centre retrospective analysis from a prospectively maintained AS cohort (UCSF) was reviewed. Eligible patients had Grade Group 1 disease, ≥3 biopsies, no upgrading for the first 5 years, and at least 10 years of follow-up. Key outcomes were grade upgrade, major upgrade (≥Grade Group 3), treatment, metastasis, prostate cancer–specific survival, and overall survival. Cox regression identified predictors of upgrading.

Results:
Among 1668 men, 774 (46%) were progression-free at 5 years. Median follow-up was 10.5 years. Upgrade-free survival at 10, 12, and 15 years was 56%, 45%, and 21%, while major upgrade–free survival was 88%, 83%, and 61%. Treatment-free survival remained high (86%, 83%, 73%), and metastasis-free and cancer-specific survival exceeded 98%. Predictors of upgrade included older age, higher BMI, greater biopsy core positivity, and PSA density.

Conclusions:
Men stable on AS for ≥5 years demonstrate excellent long-term survival with very low risks of metastasis or prostate cancer death. These findings support consideration of reduced-intensity surveillance in carefully selected patients. Incorporating age, BMI, tumour volume, and PSA density into decision-making could individualise care and improve quality of life. Prospective research is required to validate deintensification pathways and establish standardised protocols

SCRIBE SMARTER, NOT HARDER: HOW AI SCRIBES STACK UP AGAINST HUMAN CLINICIANS

Alice Thomson, Marlon Perera, Nathan Lawrentschuk

Peter MacCallum Cancer Centre

Aim:
To evaluate the accuracy and efficiency of clinicians compared to AI medical scribes when documenting urology patient encounters.

Methodology:
This was a prospective, non-randomised observational studies. Urology clinicians and AI medical scribes freely available in Australia were used to analyse three recorded, fictitious urology clinical encounters. Participants and the AI scribe were then asked to generate a consultation note and a letter to the referring doctor. The time taken to complete the documentation, accuracy, error rate and quality of documentation was assessed.

Verbal Abstracts (Cont'd)

Results:
Five AI scribes and eight doctors were used in this analysis, each completing the task for three clinical scenarios. AI scribes completed the task in an average time of 5.16 minutes (SD +/- 0.31 seconds), compared to doctors who completed the task in 10.58 minutes (SD +/- 4.87 seconds), a significantly faster amount of time (P = 0.0001). AI notes were slightly more accurate (AI scribes 93.39% +/- 5.08%; doctors 85.64% +/- 12.14%; p<0.05). AI scribes made fewer errors (AI scribes 0.40 +/- 0.91; doctors 1.48 +/- 2.2; p>0.05). Finally, blinded assessment of the letters using a Likert scale rated AI scribes more favourably (4.33 +/- 0.82 vs 3.10 +/- 2.28, p < 0.05).

Conclusion:
AI scribes completed the task significantly faster than doctors, with greater accuracy, fewer errors and higher rated letters. Doctors face increasingly more complex patient care, greater demand for service and an ever-growing burden of administrative tasks. By working with AI scribes, doctors may be able to reduce the amount of time dedicated to documentation whilst maintaining or even improving accuracy. More time may then be dedicated to clinical care for patients, improving doctor-patient relationships and clinician job-satisfaction.

GRADING THE RISK – COMPARING EXISTING NOMOGRAMS IN PREDICTING OUTCOMES POST RADICAL NEPHROURETERECTOMY FOR UPPER TRACT UROTHELIAL

Xinyi Wei[1,2], Tran Ngoc An Huynh[1], Samiha Arulshankar[1,2], James Huang[1], Nieroshan Rajarubendra[1], Kevin Chu[1], Matthew Harper[1], Scott Donnellan[1], Weranja Ranasinghe[1,2]

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Aims:
Upper tract urothelial carcinoma (UTUC) is an uncommon yet aggressive disease that is often understaged on imaging and initial pathology. We aim to validate published prognostic nomograms using our cohort to determine the most optimal model for risk stratification following radical nephroureterectomy (RNU).

Methodology:
We retrospectively analysed 103 UTUC patients treated with RNU.Overall (OS), cancer-specific (CSS), progression-free (PFS) and recurrence-free survival (RFS) were compared by tumour grade. Uni- and multi-variable Cox regression identified grade-specific predictors of OS. External validation of three nomograms: Seisen [1], Abdul-Muhsin [2], and Cha [3] was performed using Harrell's C-index and bootstrap-corrected calibration.

Results:
High-grade tumours had worse 5-year OS (53.1% vs 85.8%, p<0.01), CSS (71.4% vs 93.3%, p=0.052), and PFS (52.2% vs 85.8%, p=0.002), with similar RFS (40.55% vs 44.04% p=0.56). In high-grade cases, lymphovascular invasion (LVI) remained independently associated with poor OS; no significant predictors were identified in the low-grade cohort. The Seisen nomogram showed the highest discrimination for 5-year CSS (C-index 0.814), with strong calibration. Abdul-Muhsin showed good discrimination for OS (C-index 0.708), but poorer performance and miscalibration for CSS (C-index 0.651). Cha's model showed moderate-to-good discrimination (CSS C-index 0.770; RFS C-index 0.605), with poor RFS calibration.

Conclusions:
The Seisen nomogram demonstrated superior predictive accuracy for CSS, likely due to its inclusion of key clinical and pathological factors. Abdul-Muhsin and Cha models showed moderate discrimination but inconsistent calibration. Tumour grade, stage, and LVI remain key prognostic factors. Incorporating nomograms alongside grade specific variables can refine postoperative risk stratification, guide adjuvant therapy and surveillance planning in UTUC.

References:
[1] Seisen T et al. BJU Int. 2014;114(5):733-40.
[2] Abdul-Muhsin H et al. Urol Oncol. 2021;39(2):133.e9–e16.
[3] Cha EK et al. Eur Urol. 2012;61(4):818–25.

Verbal Abstracts (Cont'd)

PREDICTORS OF PATHOLOGICAL UPSTAGING FROM TURBT AT RADICAL CYSTECTOMY: A SINGLE-CENTRE RETROSPECTIVE ANALYSIS

Xinyi Wei, Yashvrdhan Khanna, Tran Ngoc An Huynh, Samiha Arulshankar, James Huang, Nieroshan Rajarubendra, Kevin Chu, Scott Donnellan, Weranja Ranasinghe

Monash Health

Aims:
Pathological upstaging between transurethral resection of bladder tumour (TURBT) at radical cystectomy (RC) worsens outcomes in urothelial carcinoma. Therefore, identifying predictors is essential to guide neoadjuvant therapy (NAC).

Methodology:
We retrospectively analysed 198 patients who underwent RC from February 2008 to February 2025 at a tertiary centre. Upstaging is defined as an increase in pathological stage between the last TURBT and RC. Demographic, peri-operative and pathological variables were assessed with uni- and multivariable logistic regression.

Results:
Of the 191 patients reviewed, 21 cases were excluded as the TURBT specimen lacked muscularis propria and 7 for incomplete records, leaving 170 evaluable patients. Upstaging was observed in 87 patients (51.2%), including 81 (45%) from organ-confined (OC) to non-organ confined (nOC) disease. At TURBT, 6 (3.5%) were Ta, 5 (2.9%) were Tis, 23 (13.5%) were T1, 131 (77.1%) were T2, 5 (2.9%) were T4. All T4 cases were due to prostatic invasion.

Univariable analysis showed lower odds of upstaging with NAC (OR 0.29, p=0.01), overweight BMI (OR 0.39, p=0.03) while lymphovascular invasion (LVI) greatly increased risk (OR 10.02, p<0.001). Multivariable modelling confirmed NAC as independently protective (OR 0.084, p =0.04) and LVI as the dominant predictor of up-staging (OR 13, p < 0.001).

Conclusion:
Our study confirms that pathological upstaging between TURBT and RC remains frequent, occurring in nearly half of patients. LVI is the strongest independent risk factor for upstaging, consistent with the findings of a large retrospective study by Turker et al.[1] Conversely, NAC markedly reduced upstaging. Further prospective multicentre studies are needed to validate these findings and refine risk-stratification tools.

Reference:
1. Turker, Polat et al. "Upstaging of urothelial cancer at the time of radical cystectomy: factors associated with upstaging and its effect on outcome." BJU international vol.110,6 (2012): 804-11. doi:10.1111/j.1464-410X.2012.10939.x

CHASING THE NADIR: PSMA-PET CHANGES FOLLOWING ADT IN PROSTATE CANCER

Cynthia Wells, Bodie Chislett, Nathan Lawrentschuk

Royal Melbourne Hospital

Introduction:
Androgen deprivation therapy (ADT) is a cornerstone of prostate cancer (PCa) treatment. While prostate-specific antigen (PSA) levels are the traditional marker for treatment response, the role of prostate-specific membrane antigen (PSMA) positron emission tomography (PET) scans in monitoring ADT effectiveness is not yet established. This review aims to evaluate the available literature to determine the timeline of PSMA avidity changes following ADT and assess its utility in monitoring treatment response.

Methods:
A comprehensive literature search was conducted on PubMed, Embase, and Cochrane databases for studies that included PCa patients receiving ADT as a single therapy. Included studies required a baseline PSMA-PET scan and a repeat scan at least four weeks after ADT commencement to exclude the transient PSMA flare.

Results:
Five studies (n=178) were included, with median time to repeat PSMA-PET ranging from 43 to 230 days. Most studies reported a statistically significant decrease in SUVmax and tumour volume. Longer follow-up studies (155 and 230 days) showed a halving of the total number of lesions, while a shorter 6-week study found no complete lesion disappearance and detected new metastases. Subgroup analyses consistently showed reduced PSMA avidity across primary, nodal, and bone lesions.

Verbal Abstracts (Cont'd)

Conclusion:
This literature review demonstrates a consistent and statistically significant decrease in PSMA uptake in prostate cancer lesions following ADT. The duration of ADT appears to be a critical factor, with longer treatment periods (approximately 5-7.5 months) providing clearer evidence of PSMA suppression and lesion resolution. While PSMA-PET shows promise for assessing ADT response, future research with standardised reporting of metrics like SUVmax and lesion burden, along with extended follow-up periods, is necessary to precisely define its role and clinical utility.

ADVANCING WOMEN IN SURGICAL LEADERSHIP: A NARRATIVE REVIEW OF KEY BARRIERS AND DRIVERS

Jessica Wynn, Janelle Brennan

Bendigo Health, Bendigo

Background:
Diversity in surgical teams is essential to the delivery of inclusive patient-centred care. Female leadership remains underrepresented in surgery despite increasing numbers of women selected for surgical training. This narrative review aims to highlight persistent gender disparities and the distinct barriers faced by women seeking leadership roles within surgical specialties.

Methology:
A narrative review was conducted using keywords relating to gender disparities, gender bias and gender barriers in surgical leadership. Articles focusing on current patterns in female leadership in surgery and associated barriers, drivers to female ascent in leadership were included. Articles were reviewed and thematically analysed to summarise factors influencing women's advancement into leadership roles in surgery.

Results:
The literature shows gender disparities in surgical leadership, with women underrepresented in local senior roles such as department chairs and in professional societies. Challenges faced by females in surgical leadership are multifactorial. Barriers identified include gender bias, a perceived male-dominated culture, limited mentorship, work-life balance challenges, which may be compounded by family or childbearing responsibilities. Key drivers encouraging female pursuit of surgical leadership roles include inherent strong leadership personality traits which are fostered, strong mentorship, positive cultural shifts, supportive institutions and exposure to opportunities.

Conclusion:
Despite growing female representation in surgical training, substantial gender disparities persist in leadership. Ensuring factors that act as drivers to female ascent in surgical leadership are nurtured and barriers are targeted and mitigated are essential to encouraging female leaders in surgical leadership. Ultimately promoting diversity and inclusion within surgical leadership has far-reaching implications including cultural shifts within the specialty, workforce planning, and most importantly can improve the quality of surgical care delivered to patients.

Poster Abstracts

Note: Abstracts are listed in alphabetical order of the presenter's surname.

FIRST DOCUMENTED CASE WORLDWIDE OF SYNCHRONOUS ROBOTIC RIGHT HEMICOLECTOMY AND PARTIAL NEPHRECTOMY USING A SINGLE DOCK WITHOUT REPOSITIONING

Abdullah Al-Khanaty, David Hennes, Eoin Dinneen, Carlos Delgado, Satish Warrier, Alexander Heriot, Declan Murphy, Renu Eapen, Rebecca Shine, Daniel Moon

Peter MacCallum Cancer Centre

Introduction & Objectives:

Synchronous colorectal and renal tumours are rare, with incidence 0.03–4.85%. Minimally invasive synchronous resections are technically challenging as they often require repositioning, redocking, or additional ports, prolonging operative time and increasing complexity. We present the first documented case worldwide of synchronous robotic right hemicolectomy and right partial nephrectomy performed in a single dock, without repositioning, using the same ports.

Methods:

A 66-year-old female with regrowth of a caecal lesion previously resected endoscopically (tubulovillous adenoma with low- and high-grade dysplasia with intramucosal carcinoma) was found on staging imaging to have a synchronous 29 mm right mid-pole anterior clear-cell renal cell carcinoma. Following multidisciplinary review, she underwent synchronous robotic resection. A right lateral tilt position was used, with ports placed to optimise access to both surgical fields. Partial nephrectomy was performed first, with warm ischaemia time of 14 minutes and 3 seconds, followed immediately by hemicolectomy using the same ports without undocking.

Results:

Total operative time was 210 minutes with blood loss of 300 mL and no transfusion. Recovery was uneventful with discharge on day 6 and no complications within 30 days. Final pathology confirmed a 27 mm clear-cell renal cell carcinoma, ISUP grade 2, confined to the parenchyma with negative margins, and a 35 mm tubulovillous adenoma with low-grade dysplasia at the ileocaecal valve, clear of margins, with 0/7 nodes involved. Compared with published synchronous robotic resections requiring repositioning or redocking, this operative time was more than 100 minutes shorter. Additional advantages included fewer incisions, improved cosmesis, reduced contamination risk, and streamlined workflow.

Conclusions:

Single-dock, no-reposition synchronous robotic right hemicolectomy and partial nephrectomy is feasible, safe, and efficient. This first-in-world case highlights the evolving role of robotics in complex multivisceral resections.

FROM SHOCKWAVES TO SCOPES: TWO DECADES OF CHANGING PRACTICE IN AUSTRALIA

Abdullah Al-Khanaty, David Hennes, Eoin Dinneen, Carlos Delgado, Gregory Jack, Nathan Lawrentschuk, Damien Bolton, Marlon Perera

Peter MacCallum Cancer Centre

Background:

Management of upper tract stone disease has shifted markedly over the past two decades. Extracorporeal shock wave lithotripsy (ESWL) was once the mainstay, but advances in endoscopic technology and flexible ureteroscopes have driven rapid growth in pyeloscopy. Percutaneous nephrolithotomy (PCNL) remains reserved for complex stone burdens. Despite these changes, national data on temporal and geographical trends in Australia are limited.

Methods:

Medicare Benefits Schedule (MBS) item numbers for ESWL (36546), pyeloscopy (36654, 36656), and PCNL (36627, 36639, 36645) were extracted for all Australian states between 2000–2024. Rates were standardised per 100,000 population using publicly available data. Trends were analysed over time and compared across jurisdictions.

Results:

ESWL declined substantially, from >15 per 100,000 in 2000 to <7 per 100,000 in 2024, with near-abandonment in South Australia and Western Australia. Victoria maintained the highest relative use, reaching 19 per 100,000 in 2024. PCNL remained consistently low volume (<2 per 100,000) across all jurisdictions, reflecting its role for complex burdens only. Pyeloscopy showed exponential growth, rising from <1 per 100,000 in 2001 to >40 per 100,000 nationally in 2024. Growth was most pronounced in New South Wales (58 per 100,000) and Victoria (39 per 100,000), with smaller states mirroring this trajectory. By 2015, pyeloscopy had overtaken ESWL in every state.

Poster Abstracts (Cont'd)

Conclusion:
Over 25 years, the surgical management of urolithiasis in Australia has transformed. ESWL, once dominant, has been supplanted by pyeloscopy, while PCNL has remained stable but limited. These findings highlight the rapid uptake of endoscopic technology and provide key insights for workforce training, infrastructure, and resource allocation as stone surgery continues to evolve.

AN AUDIT OF PSMA IMMUNOHISTOCHEMISTRY STAINING ON TRANSPERINEAL PROSTATE BIOPSIES: A SINGLE SURGEON EXPERIENCE

Dr Jonathon Carll, Prof Nathan Lawrentschuk, A/Prof Andrew Ryan

EJ Whitten Centre for Prostate Cancer Research

Materials and Methods:
A retrospective audit of of 223 men who underwent transperineal prostate biopsy by a single surgeon over 42 months was performed. 74 men who had undergone biopsies that found a new diagnosis of prostate cancer had PSMA Immunohistochemistry staining performed at request of the surgeon. The intensity of staining for PSMA IHC was reported as a visual score and graded from 0-3+.

Results.
Of 74 men who had PSMA IHC staining done on their samples, 47 men had concordant lesions on PSMA PET scan. Patients with with concordant lesions on PSMA PET expressed a higher average amount of PSMA on IHC staining, as well as higher pre-biopsy PSA's and median grade group than those that did not have concordant PSMA-avid lesions.

Conclusions:
PSMA IHC done on biopsy specimens can be predictive of finding concordant lesions on PSMA PET scans and is associated with higher grade and worse disease. It shows potential as a pathological marker, and may be useful in detecting men which will have avid disease on their PSMA PET Scan.

FOCAL IRREVERSIBLE ELECTROPORATION FOR THE TREATMENT OF LOCALISED PROSTATE CANCER: A SYSTEMATIC REVIEW

Jeremy Cheng, Mohammadmehdi Adhami, Helen Kavnoudias, Jeremy Grummet

Monash University

Aims:
To summarise the oncological outcomes, functional outcomes, and safety profile of focal irreversible electroporation (IRE) for the treatment of localised prostate cancer (PCa).

Methodology:
A search was performed across four electronic databases: MEDLINE, Embase, Web of Science, and Cochrane Database of Systematic Reviews. 620 articles were screened after removal of duplicates. 73 full-texts were reviewed.

Results:
31 articles representing 29 studies were included. Focal IRE patients ranged from 10-411 patients. Median follow-up ranged from six to 60 months. Three studies reported exclusively on salvage-IRE, and three reported on both primary- and salvage-IRE. A combination of all risk-groups was included. Margins ranged from not present to 10mm. Early post-IRE imaging within one month of treatment was performed in 14 studies. Post-treatment biopsy was performed in 23 studies, ranging from six to 18 months after IRE. In-field recurrence rates ranged from 0-33% and 0-10% in the primary and salvage settings respectively. Out-of-field recurrence rates ranged from 0-33% and 0-14% respectively. Retreatment rates ranged from 0-37% in the primary setting and 0-24% in the salvage setting. There was an overall decrease in pad-free patients in seven out of 17 studies and a deterioration in urinary patient-reported outcome measures (PROMs) in three studies, all of which included salvage IRE. Baseline erections sufficient for intercourse decreased in 12 studies and deterioration in sexual function PROMs occurred in 11 out of 16 studies. Clavien-Dindo III events occurred in six studies. One death occurred but deemed unrelated to IRE. Rectourethral fistula was reported in two studies.

Conclusions:
Oncological outcomes, although still maturing, appear promising. Functional outcomes compare favourably against whole-gland treatment and other focal modalities. Focal IRE also appears to have a role in salvage treatment. Comparative studies are needed to evaluate its role amongst the growing array of treatment options for localised PCa.

Poster Abstracts (Cont'd)

UROLOGIST UNDERUTILISATION OF ANDROGEN RECEPTOR PATHWAY INHIBITORS FOR METASTATIC HORMONE SENSITIVE PROSTATE CANCER: A NARRATIVE REVIEW

Dr Daniel Crisafi, Mr Dixon Woon, A/Prof Joseph Ischia, Prof Damien Bolton

Austin Health

Background:
The management of metastatic hormone-sensitive prostate cancer (mHSPC) has evolved dramatically over the last decade. There has been a shift toward earlier treatment intensification, including the use of androgen receptor pathway inhibitors (ARPIs)—apalutamide, enzalutamide, and darolutamide—alongside standard androgen deprivation therapy (ADT). Despite this, ARPI uptake among urologists remains poor and largely confined to medical oncology. This narrative review summarises real-world utilisation and limitations to ARPI prescription among urologists and highlights the importance of overcoming these barriers.

Methods:
A systematic search of Embase, Medline, and PubMed was conducted by two independent reviewers, with a third resolving conflicts. Only original articles addressing real-world ARPI utilisation and barriers to uptake among urologists were included, resulting in a review of 35 articles.

Results:
In the United States, ARPIs are increasingly used by oncologists for mHSPC, yet urologists' patients often do not receive this standard of care. International consensus supports treatment intensification regardless of disease volume. Reassuringly, data from five European countries and the US show a trend toward earlier ARPI use and reduced time to treatment intensification between 2016–2018 and 2019–2020. Barriers to ARPI uptake among urologists include low prescriber confidence, concerns about tolerability, uncertainty around treatment intensification timing, limited survival benefit data, and financial constraints. Educational initiatives and influence from opinion leaders have been shown to help overcome these barriers.

Conclusion:
Internationally, ARPI uptake for mHSPC remains low among urologists due to a complex interplay of physician, patient, and systemic factors. Targeted research and education are needed to address these barriers and support appropriate ARPI initiation in urological practice.

PATIENTS WITH HIGH-RISK FEATURES ON ACTIVE SURVEILLANCE FOR PROSTATE CANCER

Yajat Dua, Sophie Goodman, Henry Pan, Sachin Perera, Niranjan Sathianathen, Marlon Perera, Declan Murphy, Nathan Lawrentschuk

Royal Melbourne Hospital

Aims:
Active surveillance (AS) is a crucial management option for men with low-risk prostate cancer. This review evaluates AS in men with higher-risk features including family history, PI-RADS 4-5 lesions, and favorable ISUP Grade Group 2 disease.

Methods:
A comprehensive literature review was performed using PubMed, Embase, and The Cochrane Library. Studies included men with family history of prostate cancer or associated cancers, PI-RADS 4-5 lesions on MRI, and intermediate-risk GG2 disease managed with AS. Men with life expectancy under 10 years or prior active treatment were excluded.

Results:
Recent evidence suggests family history is associated with increased progression risk on AS, but literature does not support excluding men based on family history alone. Two single-center studies found PI-RADS 5 lesions had increased disease progression, with 70% progressing to ISUP GG2 and 25-33% progressing to ISUP GG3 or higher at confirmatory biopsy. Growing evidence supports AS for intermediate-risk ISUP GG2 patients with favorable risk features. Although GG2 disease increases progression risk and may necessitate active management in up to 50% within five years, AS can be considered for men with favorable intermediate-risk disease without high-risk pathological, biochemical, radiological, and clinical features.

Poster Abstracts (Cont'd)

Conclusions:
Active surveillance remains important for low-intermediate risk prostate cancer, preventing overtreatment of clinically insignificant disease and reducing treatment-related risks. For men with higher-risk features, AS should still be offered as an option for carefully selected patients following informed discussion and close surveillance. Novel imaging such as PSMA PET as a screening and risk stratification tool is being investigated. AS in higher-risk patients remains controversial, requiring further studies to determine long-term outcomes and refined inclusion criteria.

CASE FROM BALLARAT BASE HOSPITAL, VICTORIA - EPIDIDYMAL CAVERNOUS HAEMANGIOMA MIMICKING TESTICULAR TORSION

Siyu Huang, Thomas McLean, Annjaleen Hansa, Jordan Santucci, Andrew Silagy, Lydia Johns-Putra

Grampians Health Ballarat

Aims:
Epididymal haemangioma represents a rare aetiology of paratesticular masses. Cavernous haemangiomas are vascular malformations formed by clusters of dilated blood vessels prone to leakage. To date, only five cases of epididymal cavernous haemangioma have been reported in the literature. Here, we describe a paediatric case of epididymal cavernous haemangioma and detail our management strategy and clinical decision-making process.

Methodology:
We report a case of a 15-year-old adolescent who presented with acute onset left testicular pain and swelling. The patient underwent urgent scrotal exploration due to concern for testicular torsion. Intraoperatively, the left testis was found to be necrotic and a decision to perform an orchiectomy was made. Dissection of the orchidectomy specimen revealed a diffusely haemorrhagic testis. Histological examination demonstrated an irregular collection of dilated vessels throughout the epididymis, in keeping with a cavernous haemangioma.

Results:
We report a case of epididymal cavernous haemangioma in an adolescent presenting with acute testicular pain and swelling. Urgent scrotal exploration was performed for suspected torsion, but extensive intratesticular haemorrhage led to loss of testicular viability and necessitated orchiectomy. While some reported cases had a more gradual onset, epididymectomy was only rarely possible. Cavernous haemangiomas are congenital vascular malformations that typically grow in line with the host, most commonly occurring in the brain; genital involvement remains rare. Review of the literature reveals just 55 documented cases of testicular haemangiomas.

Conclusion:
This case highlights epididymal cavernous haemangioma as a rare cause of acute scrotal symptoms mimicking torsion. Despite prompt surgical intervention, testicular viability was lost due to haemorrhage. Symptom onset can be acute or subtle and may resemble various testicular conditions. As a rare condition, our case serves an educational purpose for clinicians encountering similar presentations.

METHOD OF RETROGRADE BLADDER PREFILL PRIOR TO TRIAL OF VOID: PATIENT AND CLINICIANS EXPERIENCES A SCOPING REVIEW

E Kelsey, Y He, J Brennan, R Hall

Bendigo Health

Objectives:
Retrograde pre-fill of the bladder post procedurally prior to trial of void has been investigated and found to have faster time to first void and decrease to discharge time without any associated adverse effects. The objective of this study is to identify if there is any research available on the best method of filling and patient and staff experiences with filling methodology.

Methods:
A systematic scoping review was conducted utilising Preferred Systematic Reviews and Meta Analyses (PRISMA) extension for Scoping Review checklist guidelines. The search strategy intended to assess methods of retrograde pre-fill and data on patient or clinician's experiences or perspectives with post procedural pre-fill. The search strategy was overseen by two specialist urologist and any study relating to these concepts was included. Two investigators independently reviewed the titles and abstracts.

Poster Abstracts (Cont'd)

Results:
118 articles were screened for title and abstract by two reviewers. 24 full text articles were reviewed, and 8 articles underwent in depth analysis, this process. There was no data available concerning or comparing the method or volume of prefill. Articles were included if they disclosed if they filled the bladder and the method and volume of filling, articles were also included for analysis if they examined patient or clinicians' perspectives on filling. The analysis of the included articles found that. There were three main methods of prefilling prior to TOV including syringe fill, gravity drip fill. The volume of fills ranged between 150-500ml. Several studies stopped the fill when there was patient discomfort, or the patient felt urge, but this was not routinely done. Of all but one of the articles prefill found similar of not improved time to first void, decreased time to discharge (even if not statistically significantly) and maintained the efficacy and safety regarding rates of TOV success and infection

Conclusion:
Further high-quality randomised control trials are needed to develop a best practice protocol method of bladder prefilling prior to TOV.

WHOLE PROSTATE GLAND /FOSSA, PHOTODYNAMICALLY DIRECTED THERAPY, FOR PROSTATE CANCER

Donald Murphy, Avni Sali, Karin Reid, Daniel Garama

National Institute of Integrative Medicine (NIIM)

Aim:
Presentation to the Urology Society members, the evolving role of Phototherapy(PDT) for prostate cancer(PCa): Orphan no more.

Method:
The clinical summation of Phase 1 and 2 trials and ten year audit of the Phase1 trial results, have been collated. Patients remain under watchful care.

Trial entry, PSA elevation, positive PCa biopsy and negative staging tests, (CT scan and Bone Scan) Phase1 trial. Refined to PSMA Pet scan and mpMRI, microscopic staging studies -Phase 2 trial.

Primary PCa and BCR patients, after failed curative treatments included.

Prostate cancer profile results collated, together with innovative scientific, Urinary Proteomic studies, real time fluorescent prostate cancer imaging and Circulating Cancer Cells (CTC) will all be described.

Over 1000 fractionated PDT sessions and over 500 Photosensitiser(PS) doses, were delivered on an Outpatient/clinic basis, assisted by experienced nursing staff, with laser safety accreditation.

Results:
All safety criteria were met, with no significant treatment side effects or skin, sunlight photosensitivity.

1. The primary treatment group with 79% PCa specific survival, continue with No Harm: in respect to urinary, bowel and sexual function, median of 15 years post PCa diagnosis.
2. The BCR group had a comparative 84% survival, median of 16 years post diagnosis and carry the known S/E.
3. The comparative pre and post treatment, Urinary Proteomic studies described PCa cell death, inflammatory, vascular and statistically significant, host immune responses to their cancer.
4. Described Photo-diagnostic(PDD) intra-treatment fluorescent imaging of the cancer cells.
5. Reported Reversion of pre-treatment positive PSMA studies, to normal post PDT.
6. Reported alteration of prior mpMRI images, post PDT.

Conclusions:
A whole prostate gland or residual fossa BCR treatment, with a Patented PS, specifically targeting only cancer cells. Contrasting the Index lesion of known focal treatments. Potentially to become available to all Urologists and 3rdWorld countries. PDT, orphan no more!

Poster Abstracts (Cont'd)

ASSESSING THE FEASIBILITY AND VALIDITY OF A CROSS-SPECIALTY BLEEDING SIMULATION MODEL IN ROBOTIC SURGERY – A PILOT STUDY

Henry Yen-Cheng Pan, Miriam Randles, Courtney Evans, Sheri Newman, Grace Burke, Matthew Gray, Nyasha Sibanda, Tayla Fay, Kirsten Larkins, Anthony J Costello, Alexander Heriot, Briony Norris, Dean Driscoll, Helen M Mohan, Satish K Warrier

International Medical Robotics Academy, North Melbourne, Victoria, Australia

Background:
The growth of robotic surgery necessitates the development of optimised training curriculums to ensure surgical standards and patient safety. There is a paucity in intra-operative complication simulation training to assess technical and non-technical skills in the current landscape. This study aims to assess the feasibility and validity of a novel standalone hydrogel model to simulate intra-operative bleeding and measure the responses of participants to bleeding in robotic surgery, by comparing trainees and expert level skills.

Methods:
A prospective mixed-methods design study was designed with institutional ethics approval. 15 registered medical practitioners completed simulations at The International Medical Robotics Academy. The simulations were performed on the da Vinci™ Xi robotic system, using a two vessel hydrogel model connected to low and high flow simulated blood. Participants dissected and skeletonised the vessels, then managed unannounced bleeding. Non-technical skills were assessed with the Surgery Task Load Index (SURG-TLX) and Interpersonal and Cognitive Assessment for Robotic Surgery (ICARS) scores. Technical skills were assessed with the Global Evaculative Assessment of Robotic Skills (GEARS) score.

Results:
There were 5 robotic experts, 4 intermediate learners and 6 novice learners. The non-technical skills scores of experts were superior to the learners (p=0.003) in both SURG-TLX (p=0.004) and ICARS (p=0.004) domains. GEARS scores were improved with increasing experience (p=0.007). Feedback obtained from participants established the face validity of the model. Overall, experts made few errors and used constant verbalisation, intermediate learners used force and pressure inappropriately, and novices ineffectively used instruments and had limited communication.

Conclusion:
This pilot study successfully demonstrates the feasibility and validity of a model to assess surgical trainees' skills in managing intra-operative bleeding. This is an important step towards improving robotic training curriculums.

PERCUTANEOUS NEPHROSTOMY INSERTION IN THE SETTING OF ANTICOAGULATION: TO TUBE OR NOT TO TUBE?

Sachin Perera, Snigdha Gurrala, Nisal Ekanayake, Anne Hong, John El Khoury, Tatenda Nzenza, Associate Professor Dixon Woon, Heath Liddell

Eastern Health

Aims:
To systematically review recent literature (2020–2025) on percutaneous nephrostomy (PCN) insertion in patients on anticoagulation. Primary outcomes were angioembolisation or additional procedures. Secondary outcomes were transfusion requirement or haemoglobin (Hb) drop >20 g/L.

Methodology:
Databases and guideline repositories were searched for studies assessing PCN in anticoagulated or antithrombotic patients. Observational series and interventional radiology (IR) guidelines were synthesised.

Results:
Evidence remains limited. A 2025 case–control study of 34 anticoagulated patients undergoing emergency PCN found no major complications, similar transfusion rates (4 vs 3 patients), and no significant Hb difference compared with controls[1]. A prospective audit of 368 ultrasound-guided PCNs reported transfusion in 1.9% of cases, though not stratified by anticoagulation[2]. Contemporary IR guidance classifies PCN as a high-bleeding-risk procedure and recommends careful peri-procedural antithrombotic management (3). No recent series reported increased rates of angioembolisation in anticoagulated cohorts.

Poster Abstracts (Cont'd)

Conclusion:
Current evidence suggests PCN can be performed safely in selected anticoagulated patients, with low transfusion rates and no increase in major haemorrhagic complications. However, data is sparse and underpowered for rare outcomes such as angioembolisation. Prospective multicentre studies are needed to define safety thresholds and standardise anticoagulation management.

References:
1. Kılıç Ş, Aydın C, Doğan H, Şimşir A, Kılınç MT, Ateş F, et al. Antithrombotic therapy does not jeopardize emergency percutaneous nephrostomy. Bağcılar Med Bull. 2025;10(1):11–7.

ASSESSING THE EDUCATIONAL QUALITY OF ROBOTIC-ASSISTED PARTIAL NEPHRECTOMY VIDEOS: A SYSTEMATIC REVIEW

Akarsh Singh, Tayla Fay, Ting Zhang, Kristy Mansour, David Wetherel, Owen Niall

International Medical Robotics Academy, Melbourne, Australia Department of Urology

Introduction:
Partial nephrectomy is the gold standard of treatment for patients with pT1 or multifocal renal cell carcinoma. Robotic-assisted partial nephrectomy (RAPN) offers a minimally invasive approach and improved patient outcomes when compared to open and laparoscopic techniques. This systematic review aimed to assess the quality of available videographic resources for robotic-assisted partial nephrectomy.

Methods:
A systematic review was conducted to evaluate the quality of publicly accessible, peer-reviewed videographic robotic partial nephrectomy content. A comprehensive predefined search strategy was conducted using the PubMed, Ovid, and Web of Science databases. Video quality was assessed using the Ro-VEGaS score—a modified Lap-VEGaS metric, and anatomical structures were assessed with regard to labelling and verbalisation. Four independent reviewers assessed the technical steps and identified key learning points with reference to the Ro-VEGAS framework.

Results:
Analysis revealed variable adherence to the Ro-VEGaS framework with a mean score of 14/20 (ranging from 8 to 18). Anatomic labelling also had great variability but was suboptimal in most videos. The most commonly labelled structures were the kidney, renal artery and renal vein. Notably, no video provided viewer orientation cues, and none labelled the renal mass.

Conclusion:
Videos accompanying publications serve as valuable tools for disseminating surgical techniques. However, their educational impact could be substantially improved by adhering to standardised guidelines. Currently, no universally accepted gold standard exists for surgical video education. This review proposes simple measures to produce high quality robotic-assisted partial nephrectomy videos, including systematic structure and anatomic labelling.

MANAGEMENT OF BCG-INDUCED LOWER URINARY TRACT SYMPTOMS: CURRENT EVIDENCE AND FUTURE DIRECTIONS

Monica Thet (HMO, Royal Melbourne Hospital), Nathan Lawrentschuk (Head of Urology, Royal Melbourne Hospital)

Royal Melbourne Hospital

Background:
Intravesical Bacillus Calmette–Guérin (BCG) remains the gold standard adjuvant therapy for intermediate- and high-risk non-muscle invasive bladder cancer (NMIBC). Despite its proven efficacy in reducing recurrence and progression, BCG treatment is frequently limited by bothersome lower urinary tract symptoms (LUTS). These adverse effects lead to treatment discontinuation in up to 20% of patients. Effective strategies to prevent or mitigate BCG-induced LUTS are therefore essential.

Aims:
This review summarises current evidence on the management of BCG-induced LUTS, evaluating available therapeutic interventions and their limitations.

Poster Abstracts (Cont'd)

Methodology:
A systematic search of PubMed and EMBASE was conducted in July 2025 using MeSH and free-text terms related to "BCG vaccine," "lower urinary tract symptoms," and "therapeutics." Eligible studies included randomised trials and prospective studies assessing interventions for LUTS in patients receiving BCG.

Results:
From 199 identified records, 20 articles were reviewed in full and 5 met inclusion criteria. Interventions evaluated included ofloxacin, celecoxib, phenazopyridine, oxybutynin, mirabegron, hyaluronic acid and chondroitin sulfate. While some agents showed consistent benefit in reducing BCG-related LUTS, evidence for anticholinergics was conflicting, with reports of both symptom improvement and worsening. Phenazopyridine demonstrated efficacy in relieving pelvic pain, and celecoxib and mirabegron showed symptomatic benefit, though data were limited by small sample sizes and heterogeneous outcome measures. Emerging interest in atropine offers a novel avenue for reducing detrusor overactivity, but clinical evidence remains preliminary.

Conclusion:
BCG-induced LUTS represents a barrier to treatment adherence and patient quality of life. Current therapeutic options are limited and inconsistently effective. Future research should focus on larger, well-designed randomised trials, standardised symptom assessment tools, and exploration of novel agents to optimise management.

UNDERSTANDING URETERIC STENTS IN PRIMARY HEALTH CARE: A SCOPING REVIEW OF CLINICIAN KNOWLEDGE AND MANAGEMENT

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Background/ Aims:
Ureteric stents are commonly used in practice to relieve ureteric obstruction. Ureteric stents carry expected side effects but also carry risk of complications which can be more serious such as infection, blockage or migration. Side effects from a stent in situ include dysuria, urinary frequency, urgency and urinary tract discomfort. Up to 80% of patients are affected and these patients make up a large portion of urological presentations in the primary care setting. Despite their frequency of use, there is variability in understanding and management of ureteric stents outside of urology. This scoping review aims to map the current knowledge, perceptions and clinical practices regarding ureteric stents amongst primary care physicians.

Methods:
This scoping review was undertaken according to PRISMA guidelines. An online literature search was undertaken on both medical databases and the grey literature. Search terms related to ureteric stent side effects and ureteric stent complications and the diagnosis and management of these conditions in the primary care setting. Articles were identified, screened and relevant data was extracted.

Results:
This scoping review did not return any studies related directly to primary care physician understanding of ureteric stent pain. This scoping review has uncovered a need for targeted education for primary care physicians in the recognition and management of stent side effects and the workup for more serious complications such as infection, blockage and stent migration.

Conclusion:
There are currently no studies which explore primary care provider confidence in management of ureteric stents. Given the prevalence of the condition, there is a need for enhanced primary care physician understanding of ureteric stents through education and standardised guidelines. This will allow community management of expected stent side effects and empower prompt escalation if there are concerns regarding stent complications

Notes

2025 USANZ VICTORIAN SECTION MEETING

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