ANNUAL MEETING OF THE IRISH SOCIETY OF UROLOGY (ISU)

Friday 15th – Saturday 16th September 2017
Kingsley Hotel, Cork

CPD Accreditation
Friday 15th September 2017: 7 CPD Credits
Saturday 16th September 2017: 6 CPD Credits
It is my great pleasure to welcome you all to the 2017 Irish Society of Urology Annual Conference, which is being held in Cork city, the self-proclaimed “real capital” of Ireland. In keeping with Cork’s favourite anthem, the conference is taking place on the banks of the River Lee, at the Kingsley Hotel, which is beautifully situated beside the river.

Despite the intercollegiate move away from mandatory research, we have had a very healthy 94 abstracts submitted. Many thanks to all who submitted their research and my congratulations to the authors of the 78 abstracts which were accepted for presentation. I would encourage those who were not successful on this occasion to continue to develop their projects with a view to successful application next year.

We are both delighted and honoured to welcome our distinguished international and national guest speakers to the 2017 ISU Annual Conference. Paul Russo and Karim Touijer from the world-renowned Memorial Sloan Kettering Cancer Center are internationally respected experts in the fields of renal cancer and prostate cancer, and I am eagerly awaiting their respective guest lectures, which I know will be of great interest and benefit to all in attendance. John Lavelle, who is a graduate of RCSI, will provide a welcome non-oncological balance with his contributions on functional urology, a field in which John also has a well-established international reputation. I also await, with great anticipation, the session involving our national guest speaker, Colm Henry, National Clinical Advisor to the HSE, who will address the recently developed HSE healthcare plan. This session will be in conjunction with our own Vice-President, Eamonn Rogers, who is also the current urology clinical advisor to the HSE. I look forward to vibrant open discussion and debate following these two presentations at the session.

An innovation at this year’s conference is the introduction of parallel sessions, which are designed to give our trainees direct access to the international guest lecturers, in the format of case presentations. I do hope that our trainees will participate energetically in these sessions, which will allow for more open and less formal discussion, and will be of real educational benefit from the clinical perspective.

Our Annual Conference dinner will be held at a venue steeped in history and tradition, and we are grateful to University College Cork for giving the ISU access to the famous Aula Maxima. Weather permitting, the drinks reception will be held in the Quad, which is truly one of the most beautiful and inspiring university settings I have seen. I hope that you will all have a wonderful evening there, at the end of what I trust will be an academically and socially enlightening experience at the 2017 ISU Annual Conference.

I would like to offer sincere thanks to all of the sponsors who have given generous financial support to the conference. I would ask you to please do spend time at the trade exhibition during the coffee and lunch breaks at the meeting. I am very grateful to Paul and Roisin at the Kingsley Hotel for their patience, organisation and hospitality. A personal thank you to Claire Phelan, who has been a rock throughout all of the planning and arrangements and without whom the conference would not have been possible. Thanks also to the Programme Committee, including Barry, Frank and Eamonn, for their constant input and support.

Finally, thanks most of all to my wife and soulmate, Siobhan, and to my family, who have been so supportive in every way possible during what has been a busy time as Vice-President and subsequently President of the Irish Society of Urology.

It has been a great honour to serve the ISU as your President.

Peter C. Ryan MCh FRCSI
President, Irish Society of Urology
## SCIENTIFIC Programme

### FRIDAY 15TH SEPTEMBER 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30 – 09.00</td>
<td>Registration</td>
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<tr>
<td>09.00 – 10.30</td>
<td>Podium Session 1: General Urology</td>
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<td>10.30 – 11.00</td>
<td>Refreshments and Exhibition</td>
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<tr>
<td>11.00 – 13.00</td>
<td>Poster Session 1: General Urology</td>
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<tr>
<td>13.00 – 14.00</td>
<td>Lunch and Exhibition</td>
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<tr>
<td>14.00 – 15.00</td>
<td>Podium Session 2: Prostate Cancer: Diagnosis</td>
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<tr>
<td>15.00 – 15.30</td>
<td>Guest Lecture: Dr Karim A. Touijer, MD, MPH  MD, FACS</td>
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<td>Memorial Sloan Kettering Cancer Center, New York</td>
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<tr>
<td>15.30 – 15.50</td>
<td>Refreshments and Exhibition</td>
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<tr>
<td>15.50 – 16.50</td>
<td>Podium Session 3: Urological Oncology</td>
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<tr>
<td>16.50 – 17.20</td>
<td>Guest Lecture: Dr Paul Russo, MD, FACS</td>
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<td>17.20 – 17.50</td>
<td>Guest Lecture: Dr John P Lavelle, MB, FRCSI</td>
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<td>Clinical Associate Professor Urology, Stanford University</td>
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<tr>
<td>18.00 – 18.30</td>
<td>ISU Annual General Meeting</td>
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### SATURDAY 16TH SEPTEMBER 2017

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<tr>
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<td>Poster Session 2: General Urology</td>
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<td>11.10 – 11.30</td>
<td>Refreshments and Exhibition</td>
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<td>11.30 – 13.00</td>
<td>Parallel Sessions:</td>
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<td>(A) Urological Trainees’ Corner</td>
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<td>• Functional Urology</td>
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<td>• Renal Cancer</td>
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<td>• Prostate Cancer</td>
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<td>(B) New Healthcare and Cancer Strategies: What are the Challenges for Urology? (Consultants session)</td>
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<tr>
<td></td>
<td>• Mr Eamonn Rogers, MCh, FRCSI, Consultant Urologist, GUH</td>
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<td>• Dr Colm Henry, MD, FRCPI, National Clinical Advisor to HSE</td>
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<td>13.00 – 14.00</td>
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<td>Podium Session 4: General Urology</td>
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<td>15.30 – 16.30</td>
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<td>17.30 – 17.45</td>
<td>Awards presentation:</td>
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<td>• Oral and Poster presentation prizes</td>
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<td>• RCSI - Anthony Walsh / Ipsen Travelling Fellowship</td>
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<td>17.45</td>
<td>Conclusion</td>
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## SOCIAL Programme

### FRIDAY 15TH SEPTEMBER 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
<th>Details</th>
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<tbody>
<tr>
<td>19.30</td>
<td>Buffet Supper</td>
<td>Fairbanks Restaurant, Kingsley Hotel, Cork</td>
<td>Dress code: Informal</td>
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<tr>
<td>19.15</td>
<td>Coach departs the Kingsley Hotel for UCC</td>
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<td>19.30</td>
<td>Drinks Reception</td>
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<tr>
<td>20.00</td>
<td>Irish Society of Urology Annual Dinner</td>
<td>Aula Maxima, UCC</td>
<td>Dress code: Jacket and tie</td>
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<td>Presentation of the Irish Society of Urology Medal</td>
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### PLEASE NOTE:
You must sign in at the registration desk on both days of the meeting in order to receive the full amount of CPD credits for the meeting. CPD credits cannot be awarded without a signature.

Follow on Twitter: @ISU_Urology
Use the meeting hashtag: #ISU17
irishsocietyofurology.ie
Friday 15th September 2017

08.30 – 09.00  Registration

09.00  Introduction: Mr Peter Ryan, President ISU

PODIUM SESSION 1: GENERAL UROLOGY

09.00 – 10.30  Co-Chair: Mr John Thornhill, Tallaght Hospital, Dublin
                  Co-Chair: Mr Eamonn Kiely, Cork University Hospital, Cork
                  Venue: Deane Woodward Suite

09.00 – 09.10  Profiling of radioresistant prostate cancer cells identifies deregulation of key protein
  S Inder, M Bates, N McDermott, J Domad J, J Schneider, G Erdmann, S Finn,
  P Manecksha, T H Lynch, L Marignol

1 Radiobiology and Molecular oncology, Applied Radiation Therapy Trinity, Discipline of Radiation Therapy,
   Institute of Molecular Medicine, Trinity College Dublin, Ireland, 2 Department of Urology, St James’s Hospital,
   Dublin, Ireland, 3NMI TT Pharmaservices, Berlin, Germany, 4 Department of International Health, Mount Sinai
   School of Medicine, New York, USA, 5 Department of Histopathology, St James’s Hospital, Dublin, Ireland.
   6 Department of Surgery, Trinity College, Dublin

09.10 – 09.20  What breaks flexible ureteroscopes?
  RM Evans, O Abusanade, K Randhawa, S Woolsey, A Pahuja, T Thompson, D Connolly

1 Belfast City Hospital, Belfast, Northern Ireland

09.20 – 09.30  Does bariatric surgery replace Incontinence surgery for morbidly obese women with urinary incontinence?

Surgical Department, Bon Secours Hospital - Cork (Ireland), Urogynaecology Department, Cork University Hospital - Cork (Ireland)

09.30 – 09.40  Life expectancy calculation in urology: Are we equitably treating older patients?
  Nikita R. Bhatt, Niall F. Davis, Kieran Breen, Hugh Flood, Subhasis Giri

Department of Urology, University hospital Limerick, Limerick, Ireland

09.40 – 09.50  Remembering the forgotten stent – Evidence from an automated electronic ureteric stent register

1 Cork University Hospital, Wilton, Cork, Ireland. 2 University of Nottingham, UK. 3 SVUH, Dublin, Ireland

09.50 – 10.00  Outcomes of living donor kidney transplantation in Ireland
  LC McLoughlin, SW Considine, NF Davis, Y Williams, G Smyth, R Power, P Mohan, DM Little

Department of Urology and Transplantation, Beaumont Hospital, Dublin 9

10.00 – 10.10  Surgical outcomes after donor nephrectomy for living-donor kidney transplantation in Ireland
  LC McLoughlin, SW Considine, NF Davis, Y Williams, G Smyth, R Power, DM Little

Department of Urology and Transplantation, Beaumont Hospital, Dublin 9
**10.10 – 10.20**  Urological admissions due to complications of radiotherapy: more than a trivial matter  
DB Hennessey\(^1\), JL Ma\(^1\), BP Newell\(^1\), DM Bolton\(^1,2\), N Lawrentschuk\(^1,2\)  
\(^1\)Department of Urology, Austin Health, Heidelberg, Victoria, Australia, \(^2\)Department of Surgery, University of Melbourne, Heidelberg, Victoria, Australia

**10.20 – 10.30**  Altmetric score versus traditional citation metrics: are the most highly cited urology papers the most widely disseminated in the media?  
O’Connor EM\(^1\), Nason GJ\(^2\), O’Kelly F\(^3\), Manecksha RP\(^4\), Loeb S\(^5\)  
\(^1\)Department of Urology, St. Vincent’s University Hospital, Elm Park, Merrion Road, Dublin 4, \(^2\)Department of Urology, Mater Misericordiae University Hospital, Dublin 7, \(^3\)Department of Urology, Our Lady’s Children’s Hospital, Crumlin, Dublin 8, \(^4\)Department of Urology, Tallaght Hospital, Tallaght, Dublin 24, \(^5\)Department of Urology, James’s Hospital, James’s Street, Dublin 8, \(^6\)Department of Urology and Public Health, Laura & Isaac Perimutter Cancer Centre, New York University, NY, USA

**10.30 – 11.00**  Refreshments and Exhibition

**POSTER SESSION 1: GENERAL UROLOGY**

**11.00 – 13.00**  
Co-Chair: Mr Barry McGuire, St. Vincent’s University Hospital, Dublin  
Co-Chair: Mr Stephen Connolly, Mater Misericordiae University Hospital, Dublin  
Venue: Deane Woodward Suite

**Poster 1**  
The diagnostic role of ultrasound in assessment of the acute scrotum, a pictorial and pathological review  
M Brassil\(^1\), C O’Brien\(^1\), M B Cotter\(^2\), P Govender\(^1\), W Torreggiani\(^3\)  
\(^1\)Radiology department, Tallaght Hospital, Dublin, Ireland, \(^2\)Pathology department, Tallaght Hospital, Dublin, Ireland.

**Poster 2**  
Urology on the inside: managing the needs of the incarcerated  
MS Floyd Jr, R Mistry, EPM Williamson, DG Machin, AD Baird  
Department of Urology, University Hospital Aintree, Lower Lane, Liverpool, L9 7AL, UK

**Poster 3**  
The virtual outpatient clinic – a modern method of managing urology patients?  
S. H. Weller\(^1\), H. Mahdi\(^1\), D. Connolly\(^1\), W. Elbaroni\(^1\)  
Belfast City Hospital, Belfast, Northern Ireland

**Poster 4**  
Outcomes from the introduction of a combined urology outpatient clinic  
Browne C\(^1\), Dowling C.M.\(^1\), O’Malley P.\(^1\), Nusrat N.\(^1\), Walsh K.\(^1\), Jaffry S.\(^1\), Rogers E.\(^1\), Durkan G.C.\(^1\), D’Arcy F.T\(^1\)  
\(^1\)University College Hospital Galway, Ireland

**Poster 5**  
Increased mid-abdominal circumference is a predictor for surgical wound complications in kidney transplant recipients: A prospective cohort study  
M Taha, NF Davis, R Power, P Mohan, J Forde, G Smyth, DM Little  
Department of Transplant Surgery and Urology, Beaumont hospital, Dublin, Ireland
| Poster 6 | A prospective observational study of the prevalence of incidental findings on multi-detector computed tomography angiography and urography (MDCT) in donor nephrectomy patients  
Beaumont Hospital, Dublin, Ireland |
| --- | --- |
| Poster 7 | Incidence of amputation after simultaneous pancreas and kidney transplantation versus kidney transplantation alone  
MacCraith E¹, Davis NF, Browne C, Mohan P, Hickey D  
¹Department of Urology and Transplant Surgery, Beaumont Hospital, Dublin, Ireland |
| Poster 8 | Long-term outcomes of renal transplantation in patients with Systemic Lupus Erythematosus (SLE) and Wegener’s Granulomatosis  
¹Department of Renal Transplantation and Urology, Beaumont Hospital, Dublin, Ireland |
| Poster 9 | Management and outcomes of prostate cancer in kidney transplant recipients  
UM Haroon¹, NF Davis¹, JC Forde¹, IA Cheema¹, DM Little¹, P Mohan¹, GP Smyth¹, RE Power¹  
¹Department of Transplant, Urology and Nephrology, Beaumont Hospital, Dublin, Ireland |
| Poster 10 | The Flutter Valve sign: Does the degree of intravesical prostatic protrusion at flexible cystoscopy predict urinary retention?  
Ogbodo E, Ryan PC  
Dept. of Urology, Bon Secours Hospital, Cork |
| Poster 11 | Awareness of testicular torsion amongst Irish parents  
Yap, Lee Chien¹, Cozman, Claudiu¹, Patterson, Ken¹, Cullen, Ivor M¹, Dowling, Catherine², Darcy, Frank²  
¹University Hospital Waterford, Waterford, Ireland, ²Galway University Hospital, Galway, Ireland |
| Poster 12 | Clinical significance of haematuria in the anticoagulated patient  
Eoin MacCraith¹, Ciodhna Browne¹, Garrett Durkan¹, Kilian Walsh¹, Catherine Dowling¹, Frank D’Arcy¹  
¹Department of Urology, University Hospital Galway, Galway, Ireland. |
| Poster 13 | Urinary catheterisation – Are we doing enough to prepare our future junior doctors?  
Clare O’Connell¹, Nikita R. Bhatt¹, TED McDermott¹, Robert J. Flynn¹, Rustom P. Manecksha¹,², Arun Z. Thomas¹,²  
¹Department of Urology, Tallaght Hospital, Dublin, Ireland, ²Department of Surgery, Trinity College Dublin, Ireland |
| Poster 14 | A prospective audit on the effect of training and educational workshops on the incidence of urethral catheterisation injuries  
Nikita R. Bhatt¹, Niall F. Davis¹, Mark R. Quinlan¹, Robert J. Flynn¹, TED McDermott¹, Arun Z. Thomas¹,², John A. Thornhill¹, Rustom P. Manecksha¹,²  
¹Department of Urology, Tallaght Hospital, Dublin, Ireland, ²Department of Surgery, Trinity College Dublin, Ireland |
| Poster 15 | **Antithrombotic agents and haematuria: A systematic review**  
Nikita R. Bhatt¹, Niall F. Davis¹, Robert J. Flynn³, TED McDermott¹, Rustom P. Manecksha²,³, Arun Z. Thomas⁴,²  
¹Department of Urology, Tallaght Hospital, Dublin, Ireland, ²Department of Surgery, Trinity College Dublin, Ireland |
| --- | --- |
| Poster 16 | **Quantitative Analysis of Innovation in Urology**  
Nikita R. Bhatt¹, David M. Dalton⁴, Niall F. Davis¹, TED McDermott¹, Robert J. Flynn¹, Arun Z. Thomas¹,³, Rustom P. Manecksha¹,³  
¹Department of Urology, Tallaght Hospital, Dublin, Ireland, ²Royal College of Surgeons in Ireland, Dublin, ³Department of Surgery, Trinity College Dublin, Ireland |
| Poster 17 | **A prospective audit of various components of operating room utilisation times during initial phase of a cross specialty dual console Xi robotic surgery program**  
Broe MP¹,², Looney AT¹,², David S¹,², Nabi N¹,², Norton S¹,², Elhag S¹,², Giri SK¹,²  
¹Department of Urology, University Hospital Limerick, Limerick, Ireland, ²Department of Robotic Surgery, University Hospital Limerick, Limerick, Ireland |
| Poster 18 | **Finding the balance: Continence versus retention in patients treated with intradetrusor injection of Onabotulinumtoxin A (Botox)**  
O’Connor EM, Hegazy M, Walsh AL, Lennon GM  
St. Vincent’s University Hospital, Elm Park, Merrion Road, Dublin 4 |
| Poster 19 | **Investigation of recurrent urinary tract infections in premenopausal women: is it a wasteful use of resources?**  
Broe MP¹,², Norton S¹,², Looney AT¹,², David S¹,², Nabi N¹,², Elhag S¹,², Giri SK¹,², Nama G, Akram M, Giri SK¹,²  
¹Department of Urology, University Hospital Limerick, Limerick, Ireland |
| Poster 20 | **Red patches biopsy and urine cytology during cystoscopy: is it worth the trouble?**  
Nabi Nauman, David Silviu, Tansey Paul, Akram Muhamad, Nama Girish, Giri Subhasis  
University Hospital Limerick, Limerick, Ireland |
| Poster 21 | **A single center experience of active surveillance for low risk prostate cancer**  
O’Connor EM, Nason GJ, Considine SW, O’Brien MF  
Department of Urology, Cork University Hospital, Wilton, Cork |
| 13.00 – 13.50 | Lunch and Exhibition |
## PODIUM SESSION 2: PROSTATE CANCER: DIAGNOSIS

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Authors</th>
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<tbody>
<tr>
<td>13.50 – 14.00</td>
<td>Changing practices regarding the detection of ASAP and HGPIN at trans-rectal ultrasound guided biopsy of the prostate</td>
<td>A.L. Walsh, G. O’Flanagan, D. Moran, E.M. O’Connor, M Matenhalia, M Hegazy, B McGuire, G Lennon, D Quinlan, D Galvin</td>
<td>Department of Urology, St. Vincent’s University Hospital</td>
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<tr>
<td>14.00 – 14.10</td>
<td>The current role of transperineal template prostate biopsies in Ireland</td>
<td>A.L. Walsh, D Moran, EM O’Connor, G O’Boyle, D Galvin, D Bouchier-Hayes, G Durkan, C Small, F O’Brien, P Kelly, N Hegarty, K O’Malley, TH Lynch</td>
<td>1. Department of Urology, St. Vincents University Hospital, Dublin, Ireland, 2. Department of Urology, University Hospital Galway, Co. Galway, Ireland, 3. Department of Urology, Galway Clinic, Co. Galway, Ireland, 4. Department of Radiation Oncology, University Hospital Galway, Co. Galway, Ireland, 5. Department of Urology, Cork University Hospital, Cork, Ireland, 6. Department of Radiation Oncology, Cork University Hospital, Cork, Ireland, 7. Department of Urology, Mater Private Hospital, Dublin, Ireland</td>
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<tr>
<td>14.10 – 14.20</td>
<td>The predictive ability of pre-operative magnetic resonance imaging to detect pathological outcomes in prostate cancer</td>
<td>Nason GJ, O’Connor EM, Considine SW, Moss B, MacMahon D, Buckley J, O’Regan K, O’Brien MF</td>
<td>1. Department of Urology, Cork University Hospital, Wilton, Cork, Ireland, 2. Department of Urology, University Hospital Waterford, Waterford, Ireland, 3. Department of Radiology, Cork University Hospital, Wilton, Cork, Ireland</td>
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<tr>
<td>14.20 – 14.30</td>
<td>MRI-TRUS fusion-guided prostate biopsy - correlation of MRI findings with biopsy histology</td>
<td>M O’Sullivan, ML Gargan, E McEvoy, R Flynn, TED McDermott, R Manecksha, W Torreggiani, R Browne, E Ward</td>
<td>1. Department of Radiology, Tallaght Hospital, Dublin 24, Ireland, 2. Department of Urology, Tallaght Hospital, Dublin 24, Ireland</td>
</tr>
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GUEST LECTURE
15.00 – 15.30  
The Role of Molecular Imaging in the Diagnosis and Staging of Prostate Cancer  
Dr Karim A. Touijer, MD, MPH, MD, FACS  
Memorial Sloan Kettering Cancer Center, New York  
Chair: Mr Peter Ryan, President, Irish Society of Urology

15.30 – 15.50  
Refreshments and Exhibition

PODIUM SESSION 3: UROLOGICAL ONCOLOGY
15.50 – 16.50  
Co-Chair: Mr Ivor Cullen, University Hospital Waterford  
Co-Chair: Mr Frank O’Brien, Cork University Hospital, Cork  
Venue: Deane Woodward Suite

15.50 – 16.00  
Outcomes Post Radical Orchidectomy in Ireland 1994-2013  
HA Ferris¹, D Murray², P Walsh³, E Nolan², P Sweeney², D Galvin⁵

¹Health Service Executive, Ireland, ²National Cancer Control Program, Ireland, ³National Cancer Registry, Ireland, ⁴Mercy University Hospital, Cork, Ireland, ⁵St Vincent’s & Mater Hospitals, Dublin, Ireland

16.00 – 16.10  
Lymph node management in patients with low and intermediate risk penis cancer  
Cozman, Claudiu¹; Yap, Lee Chien¹; Patterson, Ken¹; Daly, Padraig J¹; Cullen, Ivor M¹

¹University Hospital Waterford, Waterford, Ireland

16.10 – 16.20  
15 years of penile cancer – an Irish perspective  
Anderson S¹, Breen KP², Sweeney P²

¹Department of Urology, Cork University Hospital, Cork, Ireland, ²Department of Urology, Mercy University Hospital, Cork, Ireland

16.20 – 16.30  
Surgical management of upper tract urothelial carcinoma: outcomes from a single institution over 10 years  
M Matanhelia, D Moran, DW Mulvin, GM Lennon, DJ Galvin, DM Quinlan  
St Vincent’s University Hospital, Dublin, Ireland

16.30 – 16.40  
The role of percutaneous biopsy in the evaluation of indeterminate small renal masses  
JB Lenihan¹, EJ Redmond¹, EM Bolton¹, MS Inder¹, S Moreau¹, RP Manecksha¹,², TH Lynch¹,²

¹Department of Urology, St. James’ Hospital, Dublin, Ireland, ²Department of Surgery, Trinity College, Dublin, Ireland

16.40 – 16.50  
DB Hennessey¹,³, N Kinnie², DM Bolton¹,³, D Moon²,³, N Lawrentschuk¹ ¹,³, YK Chan¹,³,⁴

¹Department of Surgery, Austin Health, The University of Melbourne, Victoria, Australia, ²Division of Cancer Surgery, Peter MacCallum Cancer Centre, The University of Melbourne, Victoria, Australia, ³Olivia Newton-John Cancer and Wellness Centre, Austin Health, Heidelberg, Victoria, Australia, ⁴Epworth Freemasons Hospital, East Melbourne, Victoria, Australia, ⁵Epworth Richmond Hospital, Richmond, Victoria, Australia
Friday 15th September 2017 (contd.)
Afternoon / Evening

GUEST LECTURE
16.50 – 17.20  The Rationale for Partial Nephrectomy: “Counter Intuitive”
Dr Paul Russo, MD, FACS
Memorial Sloan Kettering Cancer Center, New York
Venue:  Deane Woodward Suite

GUEST LECTURE
17.20 – 17.50  Urinary Tract Infections in Patients with Neurogenic Bladder
Dr John P Lavelle, MD, FRCSI
Clinical Associate Professor Urology, Stanford University
Venue:  Deane Woodward Suite
Chair:  Mr Peter Ryan, President, Irish Society of Urology

18.00 – 18.30  ANNUAL GENERAL MEETING OF THE IRISH SOCIETY OF UROLOGY

SOCIAL PROGRAMME
19.30  Buffet Supper
Kingsley Hotel, Cork
Dress code: Informal
### POSTER SESSION 2: GENERAL UROLOGY

**09.00 – 11.10**  
**Co-Chair:** Mr David Quinlan, St. Vincent’s University Hospital, Dublin  
**Co-Chair:** Mr James Forde, Beaumont Hospital, Dublin  
**Venue:** Deane Woodward Suite

| Poster 22 | Audit of time of referral to flexible cystoscopy in a high volume referral centre  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| Patterson K., Yap L. C., Cozman C., Cullen I., Daly P.  
| Department of Urology, University Hospital Waterford, Waterford, Ireland. |

| Poster 23 | Tailored approaches in the management of Peyronie’s disease  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| Yap, Lee Chien¹, Cozman, Claudiu¹, Patterson, Ken¹, Daly, Padraig J¹, Cullen, Ivor M¹  
| ¹ University Hospital Waterford, Waterford, Ireland |

| Poster 25 | Surgical outcomes from a rapid access prostate assessment clinic  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| Kelly Niall¹, Durkan Garrett¹  
| ¹ University Hospital Galway, Galway, Ireland |

| Poster 26 | Impact of Rapid access Prostate cancer clinics in the diagnosis and treatment of prostate cancer  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| S M Inder¹, ² M Broe, ³ M Burke, ⁴ J Forde, ⁴ D Mulvin, ⁴ D Galvin, ⁴ R Conroy, ⁶ G Lennon  
| ¹ Radiobiology and Molecular oncology, Applied Radiation Therapy Trinity, Discipline of Radiation Therapy, Institute of Molecular Medicine, Trinity College Dublin, Ireland, ² Department of Urology, St James’s Hospital, Dublin, Ireland, ³ Department of Urology, Beaumont Hospital, Dublin, Ireland, ⁴ Department of Urology, St Vincent’s University Hospital, Dublin, ⁵ Department of Urology, University Hospital Limerick, Ireland, ⁶ Department of Epidemiology and Public Health Medicine, Royal college of Surgeons in Ireland |

| Poster 27 | Assessment of patient satisfaction score- Comparison between Rapid access prostate cancer clinics (RAPCs) and general urology outpatients clinics  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| S M Inder¹, ² M Broe, ³ M Burke, ³ J Forde, ³ D Mulvin, ³ D Galvin, ⁴ R Conroy, ⁶ G Lennon  
| ¹ Radiobiology and Molecular oncology, Applied Radiation Therapy Trinity, Discipline of Radiation Therapy, Institute of Molecular Medicine, Trinity College Dublin, Ireland, ² Department of Urology, St James’s Hospital, Dublin, Ireland, ³ Department of Urology, Beaumont Hospital, Dublin, Ireland, ⁴ Department of Urology, St Vincent’s University Hospital, Dublin, ⁵ Department of Urology, University Hospital Limerick, Ireland, ⁶ Department of Epidemiology and Public Health Medicine, Royal college of Surgeons in Ireland |

| Poster 28 | Do awareness campaigns impact referrals to rapid access prostate clinic?  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| JSA Khan¹, P O’Malley¹, G Durkan¹, FT D’Arcy¹, C Dowling¹  
| ¹ Galway University Hospital, Galway, Ireland |

| Poster 29 | Establishment of a National Prostate Cancer Registry including both clinical data and patient reported outcomes; Initial Data from IPCOR Project  
|-----------|------------------------------------------------------------------------------------------------------------------|  
| S Bracken¹, A Murphy¹, F Sullivan², R McDermott³, L Sharp³, D Galvin³  
| ¹ Molecular Medicine Ireland, Dublin, Ireland, ² University Hospital Galway, Galway, Ireland, ³ Meath and Adelaide Hospital, Dublin, Ireland, ⁴ National Cancer Registry, Cork, Ireland, ⁵ St Vincent’s and Mater Hospitals, Dublin, Ireland |
### Saturday 16th September 2017 (contd.)

#### Morning

<table>
<thead>
<tr>
<th>Poster 30</th>
<th>Long-term outcomes of en-bloc renal transplantation from paediatric donors into adult recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Considine SW(^1), Davis NF(^1), McLoughlin L(^1), Mohan P(^1), Forde JC(^1), Power R(^1), Smyth G(^1), Little DM(^1)</td>
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<td>(^1). Department of Transplant Surgery and Urology, Beaumont hospital, Dublin, Ireland</td>
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<thead>
<tr>
<th>Poster 31</th>
<th>Incidence and outcome for micropapillary variant of transitional cell carcinoma of the bladder in transplant patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Catalin Constandache(^1), Gordon P. Smyth(^1), Richard E. Power(^1), Ponnusamy Mohan(^1), James Forde(^1), Christian Gulmann(^2), Niall F. Davis(^1), Dilly Little(^1)</td>
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<td>(^1). Department of Urology and Transplant Surgery, Beaumont Hospital, Dublin, Ireland, (^2). Department of Histopathology, Beaumont Hospital, Dublin, Ireland</td>
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</tbody>
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<thead>
<tr>
<th>Poster 32</th>
<th>Comparing methods of ureteric stenting, a retrospective analysis of differing practices</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>JA O’Kelly(^1), UM Haroon(^1), NA Abdullah(^2), MA O’Neill(^1), A Rauf(^2), SW Considine(^1), L McLornan(^1), BB Maguire(^1), IA Cheema(^1), JC Forde(^1)</td>
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<tr>
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<td>(^1). Department of Urology, Connolly Hospital, Dublin, Ireland, (^2). Department of Urology, Beaumont Hospital, Dublin, Ireland</td>
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<thead>
<tr>
<th>Poster 33</th>
<th>Between a rock and a hard place: failing at initial investigation of renal stone disease</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Eva Browne(^1), Vijay Narayanan(^1), Niall F Davis(^1), Liza McLornan(^1)</td>
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<td></td>
<td>(^1). Department of Urology and Transplantation, Beaumont Hospital, Dublin 9, Ireland, (^2). Department of Emergency Medicine, Beaumont Hospital, Dublin 9, Ireland</td>
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<tr>
<th>Poster 34</th>
<th>The new disposable digital flexible ureteroscope; In-vivo and in-vitro assessment and cost effective analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hennessey DB(^*), Fojecki G, Papa N, Lawrentschuk N, Bolton D</td>
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<td>Department of Urology, Austin Health, Heidelberg, Victoria, Australia</td>
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<th>Poster 35</th>
<th>Mini-PCNL: More than tract size</th>
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<tbody>
<tr>
<td></td>
<td>DB Hennessey, NK Kinnear, A Troy, D Angus, DM Bolton, DR Webb</td>
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<tr>
<th>Poster 36</th>
<th>Changing trends in Percutaneous Nephrolithotomy (PCNL) patients</th>
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<tbody>
<tr>
<td></td>
<td>Clements, J.M.1, Johnston, D1, Duggan, B1</td>
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<td>(^1). Department of Urology, Ulster Hospital, Upper Newtownards Rd, Dundonald Belfast, Northern Ireland, BT16 1RH</td>
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<th>Poster 37</th>
<th>A snapshot review of Urology training – a single center 12 month study</th>
</tr>
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<tr>
<td></td>
<td>AU Nic an Riogh, D Good, KJ Breen, M Alzubbi, M Abdelrahman, S Omer, EA Kiely, KM O’Connor, MF O’Brien, CM Brady</td>
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<td>Department of Urology, Cork University Hospital, Cork</td>
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<th>Poster 38</th>
<th>Career intentions of trainee Urologists in Ireland</th>
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<tr>
<td></td>
<td>AU Nic an Riogh(^1), KJ Breen(^1), P Stassen(^1), S Omer(^1), M Abdelrahman(^1), P Sweeney(^2), EA Kiely(^1), K O’Connor(^1), MF O’Brien(^1), CM Brady(^1)</td>
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<td>(^1). Department of Urology, Cork University Hospital, Wilton, Cork, (^2). Department of Urology, Mercy University Hospital, Cork</td>
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<th>Poster 39</th>
<th>The application of the RENAL nephrometry score to an Irish population</th>
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<td></td>
<td>AU Nic an Riogh, G Nason, E O’Connor, KJ Breen, S Omer, MF O’Brien</td>
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<td>Department of Urology, Cork University Hospital, Cork</td>
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</table>
Expanding the indications of robotic urological surgeries beyond the prostate - An initial Irish experience with the dual-console Da Vinci Xi* surgical system
Looney AT1, Browne C2, Broe MP3, David S1, Nabi N1, Akram M1, Nama G1, Giri SK1

Incidence of renal cell carcinoma in Ireland: a 10 year review
Yap, Lee Chien1, Cozman, Claudiu1, Patterson, Ken1, Cullien, Ivor1, Daly, Padraic1
1. University Hospital Waterford, Waterford, Ireland

Outcome of laparoscopic nephrectomy in lateral decubitus position without table flexion using 5mm telescope via a 5mm port
Samah Elhag, Silvu David, Subhasis K Giri
University Hospital Limerick, Ireland

An assessment of outcomes of the artificial urinary sphincter for male urinary incontinence
Gregory Nason1, Patrick Rohan1, Kevin Keane1, Mohammed Aboelmaagd1, Nabeel Kuwajia1, Ann Foran1, Kiaran O’Malley1,2
1. Department of Urology, Mater Misericordiae University Hospital, Dublin 7, Ireland, 2. Department of Urology, Mater Private Hospital, Dublin 7, Ireland

11.10 – 11.30 Refreshments and Exhibition

PARALLEL SESSIONS
11.30 – 13.00
(A) TRAINES’ CORNER
(Case presentations for discussion with urology trainees. 30 min sessions repeated x3)
(1) Functional Urology
Dr John P Lavelle, MB, FRCSI
Clinical Associate Professor Urology, Stanford University
Venue: Kingdon Ward 2
(2) Renal Cancer
Dr Paul Russo, MD, FACS
Memorial Sloan Kettering Cancer Center, New York
Venue: Wright Suite
(3) Prostate Cancer
Dr Karim A. Touijer, MD, MPH, MD, FACS
Memorial Sloan Kettering Cancer Center, New York
Venue: Kingdon Ward 1

(B) NEW HEALTHCARE AND CANCER STRATEGIES: WHAT ARE THE CHALLENGES FOR UROLOGY?
(Consultants session)
Mr Eamonn Rogers MCh FRCSI
Consultant Urologist, Bon Secours Hospital – Galway, Urology Advisor to HSE, Vice- President, ISU
Dr Colm Henry MD FRCSI
National Clinical Advisor and Group Lead Acute Hospitals Division, HSE

Debate and Discussion: Conclusions
Venue: Deane Woodward Suite
Co - Chair: Mr Richard Power, Beaumont Hospital, Dublin
Co - Chair: Mr Paddy O’Malley, University Hospital Galway
Saturday 16th September 2017 (contd.)
Afternoon

13.00 – 14.00  Lunch and Exhibition

PODIUM SESSION 4: GENERAL UROLOGY
14.00 – 15.10  Co-Chair: Mr Ciaran Brady, Cork University Hospital, Cork
Co-Chair: Mr Kiaran O’Malley, Mater Misericordiae University Hospital, Dublin
Venue: Deane Woodward Suite

14.00 – 14.10  Ventral approach Urethroplasty: 7 year outcomes from a tertiary referral centre
MS Floyd Jr, PCB Anderson
Department of Urology, Russels Hall NHS Foundation Trust, Pensett Road, Dudley, West Midlands, DY1 2HQ, UK

14.10 – 14.20  Sacral Neuromodulation for detrusor hyperactivity with impaired contractility
DB Hennessey¹, N Hoag², J Gani³
¹Department of Urology, Austin Hospital, Heidelberg, Victoria, Australia, ²Department of Urology, Victoria General Hospital, Victoria, British Columbia, Canada

DB Hennessey DB ³, L MacLellan ¹, JL Alexander ¹, Ms Millard ¹, CE Byrne ¹, J Gani ³, A Nunn ¹.
¹Victorian Spinal Cord Service, Austin Health, Heidelberg, Victoria, Australia, ²Department of Urology, Austin Health, Heidelberg, Victoria, Australia

14.30 – 14.40  Blunt Renal Trauma: Validation of a conservative follow-up imaging strategy
Department of Urology, Cork University Hospital, Cork, Ireland

14.40 – 14.50  Urotrauma in pelvic and acetabular fractures: ten-year audit of a national referral center
Nikita R. Bhatt⁴, Niall F. Davis⁴, Rajiv Merchant⁴, Michael Leonard⁴, Brendan J O’Daly⁴, John F. Quinlan⁴, Rustom Manecksha⁴, Affiliations
⁴Department of Urology, Tallaght hospital, Dublin, Ireland, ³Department of Trauma and Orthopaedics, Tallaght hospital, Dublin, Ireland, ²Department of Surgery, Trinity College Dublin, Ireland

14.50 – 15.00  A multi-centre cohort study evaluating the role of inflammatory markers in patients presenting with acute ureteric colic (MIMIC)
M Matanhelia¹, T Shah2, C Gao³, S Cashman³, A Nambiar³, B Lamb², M Cumberbatch², V Kasivisvanathan², D Smith⁴, BURST Collaborative MIMIC Study Group
¹St Vincent’s University Hospital, Dublin, Ireland, ²British Urology Researchers in Surgical Training, London, United Kingdom, ³University College London Hospital, London, United Kingdom

15.00 – 15.30  Refreshments and Exhibition
<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation</th>
<th>Authors</th>
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<tbody>
<tr>
<td>15.30 – 15.40</td>
<td>Positive Surgical Margins Post Radical Prostatectomy: Influences and Implications</td>
<td>Croghan, SM.1, Galvin, DJ.1 [1] Mater Misericordiae University Hospital, Dublin, Ireland</td>
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<tr>
<td>15.40 – 15.50</td>
<td>Clinicopathological features of prostate cancer diagnosed in Irish men aged less than 50 years between 2006-2016 in a single institution</td>
<td>Lynch OE[1], Lonergan PE[1], O’Connell C[1], McEvoy E[1], Fitzmaurice K[1], Loftus B[1], Thomas AZ[1], Manecksha RP[1]</td>
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<td>15.50 – 16.00</td>
<td>Active Surveillance for low risk prostate cancer in the Mater Misericordiae University Hospital: a 5 year experience</td>
<td>A. Foran[1], S. Croghan[1], P. Rohan[1], A. Nic an Rioghair[1], PE Lonergan[1], C. McGarvey[1], S. Connolly[1], N. Hegarty[1], KJ. O’Malley[1], D. Galvin[1]</td>
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<td>16.00 – 16.10</td>
<td>Adjuvant versus Salvage Radiotherapy Post Radical Prostatectomy: A Single Centre 5-Year Review</td>
<td>Croghan, SM.1, Foran, AT.1, Galvin, DJ.1 [1] Mater Misericordiae University Hospital, Dublin, Ireland</td>
</tr>
<tr>
<td>16.10 – 16.20</td>
<td>Complications of Robot Assisted Laparoscopic Prostatectomy</td>
<td>AU Nic an Rioghair[1], S O’Meara[1], DJ Lundon[1], KJ O’Malley[1],2</td>
</tr>
<tr>
<td>16.20 – 16.30</td>
<td>Robotic-assisted Laparoscopic Radical Prostatectomy in men with a pathological prostate weight greater than 100 grams</td>
<td>O’Meara S[1], Nic an Riogh AU[1], Lundon D1, O’Malley KJ1&amp;2.</td>
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\[1\] Department of Urology, Mater Misericordiae University Hospital, Eccles Street, Dublin 7
\[2\] Department of Urology, Mater Private Hospital, Dublin 7
Saturday 16th September 2017 (contd.)
Afternoon / Evening

GUEST LECTURE
16.30 – 17.00  The Role of Surgery in Locally Advanced and Oligometastatic Prostate Cancer
Dr Karim A. Touijer, MD, MPH  MD, FACS
Memorial Sloan Kettering Cancer Center, New York
Venue:  Deane Woodward Suite

GUEST LECTURE
17.00 – 17.30  The Role of Surgery for Locally Advanced, Locally Recurrent and Metastatic Renal Cancer
Dr Paul Russo, MD, FACS
Memorial Sloan Kettering Cancer Center, New York
Venue:  Deane Woodward Suite
Co-Chair:  Ms Catherine Dowling, University Hospital Galway
Co-Chair:  Mr Frank O’Brien, Cork University Hospital, Cork

17.30 – 17.45  AWARDS
Oral and Poster presentation prizes
RCSI - Anthony Walsh / Ipsen Travelling Fellowship

17.45  CONCLUSION OF MEETING

SOCIAL PROGRAMME
19.15  Coach departs the Kingsley Hotel for UCC

20.00  Irish Society of Urology Annual Dinner
Aula Maxima, UCC
Dress code: Jacket and tie
Presentation of the Irish Society of Urology Medal
DR JOHN P. LAVELLE

is an associate professor of urology at the Stanford Department of Urology. He works primarily at the Veterans Administration Palo Alto Health Care System. His clinical practice specializes in neurourology at the SCI and Polytrauma units of the VAPAHCs. Dr. Lavelle research interests include patient outcomes, neurogenic bladder, overactive bladder, incontinence and benign prostatic hyperplasia. Originally from Ireland, Dr. Lavelle studied Medicine at the Royal College of Surgeons in Ireland graduating in 1984. He earned a postgraduate degree in Medical Science from the National University of Ireland in 1986, in Anatomy. He completed his Fellowship in General Surgery at the Royal College of Surgeons in Ireland in 1989. In 1990, Dr. Lavelle moved to the United States. He was a Research Fellow at the University of Iowa from 1990-1993. He completed his Urology residency at the University of Pittsburgh in 1998 followed by an AFUD fellowship and NIH Training fellowship with Dr. Michael Chancellor in Neurourology and Urodynamics.

DR PAUL RUSSO

is Attending Surgeon and Professor of Urology at Memorial Sloan Kettering Cancer Center and Weill Cornell College of Medicine in his 33rd year of service. Dr. Russo is trained as a urological oncologist and for 20 years has had a focused interest in kidney cancer- both clinically localized and advanced. Surgical interests include kidney sparing strategies for localized disease and complex surgical approaches to locally advanced, recurrent, and metastatic renal cancer. He has lead best practice guideline committees and participated extensively in clinical trials in both localized and advanced kidney cancer. Dr. Russo also leads a multidisciplinary kidney cancer research team consisting of clinicians, basic scientists, epidemiologists, and pathologists and has published extensively in this disease.

DR KARIM TOUIJER

is an Attending Surgeon at Memorial Sloan Kettering Cancer and Professor of Urology at The Weill Medical College of Cornell University in New York. Dr Touijer received a Master’s in Public Health from Harvard University focusing on comparative effectiveness research and is an expert in the use of advanced laparoscopic /robotic surgical techniques to treat patients with genito-urinary cancers.

Dr Touijer’s research focuses on the development of innovative minimally invasive techniques such as laparoscopy, robotic assisted surgery, and image guided interventions, the comparison of minimally invasive surgery to conventional open surgery with regards to cancer control and impact on the quality of life, and the implementation of quality outcome metrics to objectively measure and assess surgical performance. His laboratory research collaboration focuses on studying lymph node metastases for genitourinary malignancies using cancer targeted nanotechnology probes and molecular imaging.
Profiling of radioresistant prostate cancer cells identifies deregulation of key protein

S Inder, 1, 2 M Bates, 1 N McDermott, 1 J Domad J, 1 J Schneider, 3 G Erdmann, 3 S Finn, 5, R P Manecksha, 2, 6 T H Lynch, 2, 6 L Marignol 1

1Radiobiology and Molecular oncology, Applied Radiation Therapy Trinity, Discipline of Radiation Therapy, Institute of Molecular Medicine, Trinity College Dublin, Ireland
2Department of Urology, St James’s Hospital, Dublin, Ireland
3NMI TT Pharmaservices, Berlin, Germany
4Department of International Health, Mount Sinai School of Medicine, New York, USA
5Department of Histopathology, St James’s Hospital, Dublin, Ireland
6Department of Surgery, Trinity College, Dublin

Introduction
Radiotherapy (RT) has a prominent role in the management of prostate cancer patients. Novel molecular radiobiology is required to enhance the decision-making process for radiotherapy. This study aimed to identify the impact of fractionated radiation exposure on the protein profile of prostate cancer cells.

Methods
The protein profiles of a previously generated isogenic model of radioresistant 22Rv1 prostate cancer cells through exposure to 30 x 2-Gy dose fractions was performed using the Digiwest High Content Protein Profiling technology. Differentially expressed proteins between the radioresistant (RR-22Rv1) and wild type (WT-22Rv1) cells were independently validated using Western Blots. Relationship with radioresistance was examined using clonogenic assays.

Results
The expression levels of 64 proteins were significantly different in RR22Rv1, when compared to WT-22RV1 cells, including the androgen receptor, p53, YB-1, members of the Notch (Notch-1, Notch-3), apoptosis (bcl-xL) and DNA repair (PARP, ATR) signalling pathways. Treatment with Notch, YB-1 and PARP inhibitor modified the clonogenic survival capacity of these cells following radiation exposure.

Conclusion
This study identifies candidate proteins with potential for the development of a protein-based prognostic assay for radiotherapy prostate cancer patients.

What breaks flexible ureteroscopes?
RM Evans1, O Abusanade1, K Randhawa1, S Woolsey2, A Pahuja1, T Thompson1, D Connolly1
1 Belfast City Hospital, Belfast, Northern Ireland

Introduction
Flexible ureteroscopy is a valuable tool in the urologist’s armamentarium, providing visualisation and access to the renal pelvis for diagnostic and therapeutic purposes. In order to achieve this utility they possess attributes that make them inherently fragile and expensive to replace or repair. Re-useable scopes have a classically quoted lifespan of between six to fifteen uses but new auxiliary equipment can extend this. The advent of digital technology has led to the development of single use ureteroscopes. This presents an opportunity to achieve cost savings by identifying procedures where the risk of damage is high and substituting out re-usable scopes. We aimed to identify patient and operative characteristics that may predict flexible ureteroscope damage.

Methods
A panel of endourologists designed a proforma to capture a wide range of patient and operative characteristics during flexible ureteroscopy procedures. Using data from the surgical equipment department all cases of damaged flexible ureteroscopes were identified between 2013 and 2016. The individual theatre event after which the scope was reported broken was then scrutinised using patient notes, radiological systems and electronic records to establish trends.

Results
Thirty-eight flexible ureteroscopes were damaged during thirty-seven elective procedures. Median operative time was seventy-five minutes. Thirteen took place in a day procedure unit and twenty-four in main theatres. Thirty procedures were performed for stone clearance including three percutaneous nephrolithotomies, twenty-three of which were recurrent stone formers. Six procedures were performed for diagnostic reasons and one for management of a ureteric stricture with a memokath stent.

Two patients had urinary diversions and three ureteroscopies were performed in an antegrade fashion. Sixteen patients already had a double J stent in situ. Nineteen patients had stone baskets passed through the working channel and twenty-two, a LASER fibre. Ureteral access sheaths could not be advanced in eleven cases including the procedure damaging two scopes, which required a super stiff wire to access the renal pelvis. Twenty-three of the stone clearance surgeries where performed on multiple stone burdens. Stone burden existed in five upper poles, seven mid poles, seventeen lower poles, five renal pelvi and three ureters. Only two cases were not supervised by a consultant endourologist.

Conclusion
Our data would suggest that common factors leading to flexible ureteroscope damage are inability to pass an access sheath, high stone burden and location...
within the lower pole of the kidney. Single use flexible ureteroscopes may be considered when these features combine.

References

Does bariatric surgery replacing Incontinence surgery for morbidly obese women with urinary incontinence?


1Surgical Department, Bon Secours Hospital - Cork (Ireland), 2Urogynaecology Department, Cork University Hospital - Cork (Ireland).

Introduction
Obesity impact negatively on pelvic floor support and is strongly associated with urinary incontinence in women. Aim of the study is to evaluate the effect of bariatric surgery and subsequent weight loss on a consecutive series of morbidly obese women with urinary incontinence at 1 year postoperative.

Methods

Results
41% of our female patients (151/366) reported urinary incontinence. 40% (61/151) completed a questionnaire at one year post-operative. The mean age (SD) was 50(8.39) yrs. The mean (SD) post-operative weight drop was 49(21) kg and % excess weight loss was 74(22)%. 66%(44) underwent laparoscopic gastric bypass and the reminder underwent laparoscopic sleeve gastroectomy. 34% reported symptoms of stress incontinence (SUI), 21% reported symptoms of overactive bladder (OAB), and 44% reported symptoms of mixed incontinence. Post-operatively the mean ICIQ-UI SF score reduced from 9.3(4.4) to 4.5 (5) (< 0.01, paired t-test). The improvement in severity score did not correlate with improvement in BMI (Pearson, r = -0.11). The cure rate for SUI, OAB and mixed incontinence, was 41%, 38% and 48% respectively. However, this did not reach statistical significance. Forty-four percent of women reported complete resolution of their symptoms.

Conclusion
Bariatric surgery results in long-term cure or improvement in female urinary incontinence in the majority of patients. These results suggest that bariatric surgery should be the primary consideration in morbidly obese women with urinary incontinence.

References

Life expectancy calculation in urology: Are we equitably treating older patients?

Nikita R. Bhatt, Niall F. Davis, Kieran Breen, Hugh Flood, Subhasis Giri
Department of Urology, University hospital Limerick, Limerick, Ireland

Introduction
The incidence of cancer increases with age over a third of cancers diagnosed in people over the age of 75 years. Cancer mortality also increases with age being highest in >85 years of age. With an ageing population and increasing life expectancy, chronological age ideally should not be a determinant in clinical decision making. The aim of this study was to determine the utilisation of life expectancy calculation in urology by clinicians in the United Kingdom and Ireland.

Methods
A 5-question survey determining life expectancy utilization in urology was sent out to the members of the Irish Society of Urology (ISU) and the British Association of Urological Surgeons (BAUS). The responses were compared between the two countries to determine any difference in practice.

Results
A total of 208 (Ireland 29, UK 179) urologists including consultants and trainees responded to the survey giving a response rate of 17%. The majority of urologists in both countries were aware of methods available for life expectancy calculation (61%), but a majority had never utilised life expectancy analysis in practice (71%) and continued to use ‘eye balling’ as a technique to estimate life expectancy (81%). Though life expectancy tables were not utilised frequently in clinical decision-making or in MDT setting in both countries, the rates in UK (11% clinic, 10% MDT) were significantly lower than Ireland (31% clinical, 24% MDT) (p=0.002, chi-square).

Conclusion
This survey reveals clinical decision-making in urology in the UK and Ireland is not based on objective, accurate measures such as life expectancy analyses. Relying on chronological age or eyeballing to form decisions can lead to lower treatment standards in older patients.

Remembering the forgotten stent – Evidence from an automated electronic ureteric stent register

Stassen PN1, Considine S1,2, Omer S1, O’Kelly J3, Nic An Riogh, A1, Anderson, S1, Moss B1,2, Brady C3, Kiely E3, O’Brien MF1
1 CORK UNIVERSITY HOSPITAL, WILTON, CORK, IRELAND 2 UNIVERSITY OF NOTTINGHAM, UK 3 SVUH, DUBLIN, IRELAND

Introduction
Delayed removal of Ureteric Stents has long been associated with increased morbidity (1). Various types of stent registry have been trialled to minimise forgotten stents, including logbooks and card indexes, but their usefulness has been questioned (2,3). An electronic
Outcomes of living donor kidney transplantation in Ireland

LC McLoughlin, SW Considine, NF Davis, Y Williams, G Smyth, R Power, P Mohan, DM Little
Department of Urology and Transplantation, Beaumont Hospital, Dublin 9

Introduction
Living donor kidney transplantation has been performed in Ireland since 1972. Herein, we report on recipient surgical outcomes after living donor kidney transplant.

Methods
226 patients underwent a living donor kidney transplant in Ireland from January 2007 to December 2015. Data were retrospectively collected on patient demographics, graft and surgical outcomes.

Results
The median recipient age was 38.5 years (IQR 3-77 years). 155 (69%) were male while 71 (31%) were female. The mean BMI was 25.2 (SD4.1).

The median wait time before living donor transplant was 1 year (IQR 0-11yrs), the median duration of renal replacement therapy prior to transplant was 2 years (IQR 0-13yrs).

170 (75%) recipients did not have a previous transplant. 41 (18%) had one previous, 12 (5.5%) had 2 previous, 1 (0.5%) had 3 previous; transplant history was unrecorded in 2 (1%) patients. The median peak panel reactive antibody was 42% (IQR 0-100%). 58 (26%) recipients had a “full house” (0.0.0.) HLA mismatch

The left kidney was transplanted in 203 (90%) patients; the right in 23 (10%).

Delayed graft function occurred for a mean of 5 days (IQR 1-22 days) in 11 (5%) recipients.

Graft failure due to rejection (1%), graft nephrectomy for haemorrhage control (0.5%) and thrombosis (6%); occurred in 17 (7.5%) with a graft survival rate of 92.5%.

Surgical complications included renal artery stenosis (1%), renal vein/artery thrombosis (6%), urine leak (2%), lower limb ischaemia (1%), lymphocele (1%), wound complications (4%), and ureteric stricture (0.5%).

Conclusion
Living-donor kidney transplant is a safe, well tolerated and effective procure to treat end stage kidney failure. The living-donor program is necessary to increase the organ pool available for transplant.

Surgical outcomes after donor nephrectomy for living-donor kidney transplantation in Ireland

LC McLoughlin, SW Considine, NF Davis, Y Williams, G Smyth, R Power, DM Little
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Introduction
Donor nephrectomy for living donor kidney transplantation has been performed in Ireland since 1972. Herein, we report on donor surgical outcomes after nephrectomy for living donor transplant.

Methods
226 patients underwent a living donor nephrectomy in Ireland from January 2007 to December 2015. Data were retrospectively collected on patient demographics, renal vasculature anatomy, and surgical outcomes.

Results
The median donor age was 43 (IQR 22-67), 50% were female and 50% male. 187(83%) patients were living-related donors (LRDs), while 39 (17%) were living-unrelated donors (LURDs).

127 (56%) underwent a hand-assisted laparoscopic nephrectomy, 2 of these were converted to open, with a 1.6% conversion rate. 33 (15%) underwent a laparoscopic nephrectomy, 2 were converted to open with a 6% conversion rate. 57 (25%) underwent an open nephrectomy. Surgical approach was unrecorded in 9 (4%) cases. Minimally invasive techniques were offered to all donors after 2010.

The left kidney was donated in 203 (90%)
cases, the right in 23 (10%).

143 (63%) donor kidneys had a single renal artery and vein. 18 (8%) had single vessels with early bifurcation. Multiple vessels (>1 renal artery and vein) were present in 51 (23%) donors, vascular anatomy was unrecorded in 14 (6%) cases.

An intra-operative vascular injury occurred in 5 (2%) cases; to a small polar vessel in 3, and a major vessel in 2 cases.

5 (2.2%) sustained Clavien-Dindo type 1 complications; 3 (1%) sustained type 2 complications; 3 (1%) had type 3b complications, and 1 (0.4%) type 4 complication occurred. We report no mortality in this series.

Conclusion
Donor nephrectomy is a safe procedure, well tolerated and necessary to increase the organ pool available for transplantation.

Urological admissions due to complications of radiotherapy: more than a trivial matter

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Introduction
Complications are an undesired side effect of any treatment and radiotherapy is no different. The aim of this study was to quantify the burden of these side effects on a tertiary referral Urology department.

Methods
A prospective study of all urology admissions in a six-month period to a tertiary referral urology centre was performed. Patients admitted with complications due to radiotherapy were included in the study. Data obtained included patient demographics, radiotherapy details, complication type and management required.

Results
A total of 1198 patients were admitted; 921 (77%) were elective and 277 (23%) were emergency admissions. 13/921 (1.4%) of elective admissions and 20/277 (7.2%) of emergency admissions were due to radiotherapy complications. Radiotherapy complications were the fourth most common reasons for emergency admission, ahead of acute urinary retention. 21 patients accounted for these 33 admissions. 39 separate complications due to radiotherapy were diagnosed, with some patients having multiple complications. The median time to onset of complication was four years, IQR (1-9). The surgical intervention rate was 66.6%. The commonest procedures were washout with/without clot evacuation or diathermy in theatre (15.8%) and urethral dilatation/bladder neck incision (15.8%). Two urinary diversions and one cystoprostatectomy & urinary diversion was performed.

Conclusion
Radiotherapy complications are not inconsequential and account for a significant proportion of a tertiary urology department’s emergency workload. These complications generally occur years after radiotherapy and frequently require surgical intervention.

Altmetric score versus traditional citation metrics: are the most highly cited urology papers the most widely disseminated in the media?
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Introduction
Discordance exists between scientific impact and media attention. Altmetrics are non-traditional measures of impact which are composite scores that include social media and traditional media sharing of an article. The aim of this study was to assess whether a correlation exists between newsworthiness (Altmetric score) and the scientific impact markers such as citation analysis, impact factors and levels of evidence.

Methods
The top 5 most cited articles for the year 2014 and 2015 from the top 10 ranking urology journals (scientific impact group) were identified. The top 50 articles each in 2014 and 2015 were identified from Altmetric support based on media activity (media impact group). We determined the number of citations that these articles received in the scientific literature, and calculated correlations between citations with Altmetric scores.

Results
In the scientific impact group, the mean number of citations per article was 37.6, and the most highly cited articles were oncology guidelines. The mean Altmetric score in these articles was 14.8, There was a weak positive correlation between citations and Altmetric score (rs = 0.35, 95% CI 0.16-0.52, p<0.001). In the media impact group, the mean Altmetric score was 121.1 and most widely shared articles all related to sexual medicine. In this group, the mean number of citations was 9.7 and there was a weak negative correlation between Altmetric score and citations (rs = -0.20, p = 0.046).

Conclusion
The top articles based on Altmetric scores were not highly cited, suggesting that publications receiving the most media attention may not be the most scientifically rigorous, or that this audience places greater value on different subjects than the scientific community.
In some instances, subsequent examinations were performed. A wide range of pathologies were identified using radiological image examples and pathology correlates.

**Introduction**

In this educational exhibit we aim to discuss the imaging correlates. Using image examples and pathological review, we will outline in this exhibit we will discuss the imaging correlates. Using radiological image examples and pathology correlates.

**Methods**

We carried out a retrospective study of all emergency referrals for testicular ultrasound over a 4 year period to the paediatric and adult ultrasound service in our centre. We examined the initial referrals and clinical details and the ultrasound images were read by two senior radiology specialist registrars under the supervision of a specialist uroradiologist. A wide and varied number of pathologies were identified which we will outline in this exhibit using image examples and pathological correlates.

**Results**

378 emergency adult and 94 emergency paediatric ultrasound examinations were performed. A wide range of pathologies were identified with specific imaging features and in some instances, subsequent histological and gross pathological correlates are demonstrated.

**Conclusion**

The role of ultrasound in the acute scrotum is to narrow the differential diagnosis, to allow conservative management or to expedite surgery. In this exhibit we aim to give a detailed evaluation of the varied pathology that is identified on these examinations using radiological image examples and pathology correlates.

**Poster 2**

Urology on the inside: managing the needs of the incarcerated

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**Introduction**

Despite a substantial body of literature on the physical and mental health of the prison population there remains a paucity of data pertaining to the specific urological requirements of prisoners.

**Methods**

A 12 month prospective study was performed recording all clinical episodes made by persons detained by Home Office Licence presenting to a University Hospital. A proforma recorded detainee demographics, nature of complaint, admission details, outpatient attendances plus surgical and endoscopic interventions. New cancer diagnoses were also recorded.

**Results**

A total of 77 clinical episodes were made by 47 patients. All patients were male. One special high security psychiatric hospital and 7 prisons accounted for the referral base. A total of 18 separate presenting complaints were noted including acute trauma. Outpatient attendances accounted for 38 episodes and emergency admissions accounted for 9. The commonest reason for outpatient attendance was investigation of lower urinary tract symptoms followed by testicular mass evaluation. A total of 12 patients required elective theatre and 9 required emergency theatre. Eleven patients required endoscopic procedures. The commonest reason for emergency theatre was removal of a foreign body, followed by scrotal exploration and emergency shunting for priapism. Rigid cystoscopy was the commonest elective procedure performed. Two urothelial cancers were diagnosed. Seven patients failed to attend appointments.

**Conclusion**

Referrals from the prison service impact significantly on a urology unit’s workload. Difficulties arise with access to emergency theatre and repeat presentations. Additionally, the transient nature of the prisoner population makes follow up and investigation difficult.

**Poster 3**

The virtual outpatient clinic – a modern method of managing urology patients?

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**Introduction**

Virtual outpatient clinics (VOC) have being introduced as an alternative to a face to face outpatient review. We report the results of a virtual telephone clinic of new and review urology outpatients.

**Methods**

All patients contacted as part of a virtual outpatient clinic between November 2015 to November 2016 were identified. Patients were contacted by a single urology consultant on an ad hoc basis based on their GP referral or a previously organised investigation. The reason for referral, outcome following the consultation and possible time and cost savings were assessed.

**Results**

A total of 139 patients were included with 97 patients being new referrals. The majority of new referrals were requests for vasectomy (44.6%) and...
imaging confirmed stone disease (17%), whilst review patients were to discuss abnormal imaging results (63%).

67.7% of new patients were booked directly for treatment, 12.3% had further investigations arranged and 12.3% were discharged. Only 0.3% needed further outpatient review.

Median time from GP referral to virtual clinic review was 4 weeks. Cost savings of a virtual clinic compared to a standard outpatient review were £18,348.

Conclusion
The virtual telephone clinic is a safe and efficient alternative to the outpatient department in appropriately selected patients with significant hospital cost and time-saving benefits.

Poster 4
Outcomes from the introduction of a combined urology outpatient clinic
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Introduction
The British Association of Urological Surgeons suggest review of eleven new patients and fifteen return patients per consultant per clinic[1]. A combined “one stop” clinic review facilitates discharge of 42% of patients[2]. 25% of Irish urologists are compliant with ideal clinic numbers[3]. A combined urology clinic staffed by four consultants and four non-consultant hospital doctors (NCHDs) was trialled in our institution alongside the existing standard urology clinic. This clinic is supported by a pre-clinic radiology meeting and a synchronous urology clinical nurse specialist (CNS) clinic. This clinic aims to provide greater discharge rates, a higher likelihood of patients seeing a consultant and the ability to cross-refer between subspecialties.

Methods
We carried out a retrospective review of clinic attendances from May to July 2016. Patient outcomes were recorded for both the combined clinic and the standard clinic.

Results
54% of patients were seen by a consultant in the combined clinic compared to 20% in the standard clinic. The waiting time for new patients in the combined clinic was reduced by 39% over one year. The rate of discharge for new patients was 14.8% in the combined clinic compared to 5.9% in the standard clinic. Overall patient outcomes are outlined in Table 1.

<table>
<thead>
<tr>
<th>Patient outcome</th>
<th>Combined clinic</th>
<th>Standard clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged (overall)</td>
<td>21.1%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Procedure booked</td>
<td>26.8%</td>
<td>34.1%</td>
</tr>
<tr>
<td>Admitted</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Further clinic review</td>
<td>51.8%</td>
<td>55.4%</td>
</tr>
</tbody>
</table>

Table 1 Overall patient outcomes

Conclusion
The introduction of a combined urology outpatient clinic with the support of pre-clinic radiology meeting and synchronous urology CNS clinic facilitates patient discharge.

References

Poster 5
Increased mid-abdominal circumference is a predictor for surgical wound complications in kidney transplant recipients: A prospective cohort study
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Introduction
Kidney transplant recipients (KTR) are at a risk of developing surgical site wound (SSW) complications due to their immunosuppression. We aimed to determine if increased mid-abdominal circumference (MAC) is predictive for wound complications.

Methods
A prospective study was performed on the recipients from October 2014 to October 2015. A wound complication was defined as post-operative SSW requiring unanticipated intervention in the first month. ‘Controls’ consisted of the recipients without SSW complication and ‘cases’ consisted of the recipients with SSW.

Results
146 patients underwent kidney transplantation and 107 met the criteria. SSW complications were documented in 28 (26%) patients. Patients that developed a complication had a significantly greater MAC and body mass index (BMI) (p=0.001 and p=0.011 respectively). On single and multiple logistic regression analyses, MAC was a significant predictor for developing a surgical wound complication (p=0.02).

Conclusion
Increased MAC is a significant predictor for SSW complications in KTR. Methods for measuring visceral adiposity may be useful for stratifying KTR with an increased risk of SSW complication.

References
A prospective observational study of the prevalence of incidental findings on multi-detector computed tomography angiography and urography (MDCT) in donor nephrectomy patients

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Introduction
Prospective renal donors are a select population of healthy individuals that have been thoroughly screened for significant comorbidities prior to undergoing multi-detector computed tomography angiography and urography (MDCT). Our aim was to determine the prevalence of incidental findings on preoperative MDCT in a healthy cohort of potential living donors for kidney transplant.

Methods
A prospective study was performed on prospective living kidney transplant donors in a National Kidney Transplant Centre. Study inclusion criteria were all potential kidney donors that underwent MDCT during the living donor assessment process over a 5-year period (January 2012-2017).

Results
Overall 375 potential living donors proceeded to MDCT, the mean age was 44.33 years (range: 21–71.5). In total, there were 228 incidental findings in 158 patients. Of the 375 potential donors undergoing CT, 193 (51%) proceeded to living donor nephrectomy. Ninety-seven (44.33 years (range: 21–71.5). In total, there were 228 incidental findings in 158 patients. Of the 375 potential donors undergoing CT, 193 (51%) proceeded to living donor nephrectomy. Ninety-seven (50%) patients in the donor cohort had an incidental finding on MDCT compared to 131 (72%) in the non-donor cohort. Bosniak 1 renal cysts were the most common incidental finding (n=46) followed by liver cysts <1cm and urinary tract calculi (n= 42 and 21 respectively). There was one incidentally detected pathologically proven malignancy.

Conclusion
A variety of incidentally detected lesions of moderate to high importance were detected in this healthy patient cohort. Patients undergoing assessment with MDCT for living donor nephrectomy should be counselled on the medical, financial and psychological implications of incidentally detected lesions during the kidney transplant evaluation process.

Incidence of amputation after simultaneous pancreas and kidney transplantation versus kidney transplantation alone
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Introduction
Simultaneous pancreas and kidney (SPK) transplantation remains the gold standard treatment for patients with diabetes and end-stage renal disease. Studies comparing peripheral arterial disease complications after SPK transplant versus kidney transplantation alone (KTA) have yielded conflicting results. The objective of this study was to investigate the incidence and risk factors for amputation after SPK transplant compared to KTA after a minimum follow-up of 10 years.

Methods
An analysis was performed on a prospectively maintained database of 81 SPK transplants and 43 kidney transplantation alone (KTA) consecutively performed in one centre between December 1992 and January 2006. Primary outcome variables were incidence of amputation per patient, total number of amputations and type of amputation performed. Data are presented as a mean ± standard deviation.

Results
Seven patients (9%) in the SPK cohort and one patient (2%) in the KTA cohort underwent amputation (p=0.001). Fifteen amputations were performed in total and 4 patients required ≥2 amputations. The latency period between transplantation and amputation was 133.57 ± 49.43 months in the SPK cohort and 168 months in the KTA group.

Conclusion
Patients are at a significantly greater risk of amputation after SPK transplantation compared to KTA for type 1 diabetes despite insulin independence.

Long-term outcomes of renal transplantation in patients with Systemic Lupus Erythematosus (SLE) and Wegener’s Granulomatosis
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Introduction
SLE and Wegener’s Granulomatosis (WG) are systemic inflammatory conditions associated with renal failure, with potential for recurrence following transplantation. These patients are regularly treated with immunosuppression regimes or cyclophosphamide which are risk factors for secondary malignancies such as bladder cancer.

Methods
Data from transplant recipients with ESKD due to SLE and WG in a National Kidney Transplant Centre between 1982 and 2016 was examined. The primary outcome variable was long-term allograft survival. Secondary outcome measures were incidence of delayed graft function, primary disease recurrence and serum creatinine at follow-up.

Results
Ninety-eight patients (59 female, 39 male) were included of which 60 had SLE and 38 had WG. Mean recipient age was 42.3 ± 14.4 years and median follow-up was 108 (1-313) months. Renal allograft survival was 94.7% at 1 year, 83.5% at 5 years and 70.5% at 10 years. There were 17 instances of graft failure, 1 due to recurrence of primary disease (SLE). Median time-to-graft failure was 112 (1 - 393) months.

Mean creatinine at most recent follow-up was 144.5 ± 67.8 µmol/ L Delayed graft function occurred in 8 patients for median 6 (2-27) days and 3 patients were lost to
follow-up. There were 21 mortalities of which 5 (24%) were due to a secondary malignancy. Median time-to-death was 115 months (4 - 225).

Conclusion
Patients with SLE andWG undergoing renal transplantation have a longstanding history of immunosuppression and should be counselled on their increased risk of mortality from secondary malignancies during their follow-up.

References
3 Besarani D et al. BJU Int. 2007 Sep;100(3):502-5.

Poster 9
Management and outcomes of prostate cancer in kidney transplant recipients
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Introduction
Risk factors for prostate cancer (PCa) such as age, gender and race are often found in kidney transplant recipients (KTR). We evaluated the natural history and management of PCa in KTR.

Methods
A retrospective analysis of KTR with a concomitant diagnosis of PCa in the Irish National Kidney Transplant Centre between 1964 and 2015 was performed. Primary outcome variables were incidence, management and clinical outcomes after PCA diagnosis. Secondary outcomes were morbidity and allograft function from treatment.

Results
Of the 4,048 KTR, 3020(63.9%) were male with a median age 52(range 23-70). Overall, 43(1.7%) KTR were diagnosed with PCA. Thirty-four(79%) patients were diagnosed with PCA after their kidney transplant at a median interval of 113(range 7–372) months. Overall incidence of PCa in male KTR >20 years was 174/100,000 patient-years compared to 160/100,000 patient-years in Irish males. Mean KTR age at PCa diagnosis was 65(range 53-78) years. Median PSA at diagnosis was 10.3(range 3.9-59)ng/mL. In total, 20(59%) patients had curative treatment(1 open radical-retropubic prostatectomy, 1 perineal prostatectomy and 18(90%) radical radiotherapy). A further 1 patient is on active surveillance, 4(12%) patients are on watchful waiting and 9(26%) patients have been treated with androgen deprivation therapy.

There were 14(41%) deaths, with an estimated patient-survival at 10 years post PCa diagnosis of 56% (95% CI. 35.5-72.5). 5(36%) were PCa associated mortalities and there was no PCa mortalities in curative group.

There were 3(9%) allograft failures after the diagnosis of PCa, one in the curative group.

Conclusion
PCa incidence is increasing in the KTR cohort. Radical surgery and radiotherapy can be safely used as curative treatment options. Management guidelines need be developed to optimise treatment options in this unique patient cohort.

Poster 10
The Flutter Valve sign: Does the degree of intravesical prostatic protrusion at flexible cystoscopy predict urinary retention?
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Introduction
Enlargement of the prostate gland due to BPH can cause in some cases significant intravesical protrusion (IVPP), potentially causing a “flutter valve” resistance to bladder emptying (similar to ileocecal valve), which can be demonstrated by MRI scans. The role of this valve in the pathogenesis of urinary retention has not been established. Flexible cystoscopy has long been used in the investigation of men with lower urinary tract symptoms (LUTS) and the retrograde view on flexible cystoscopy allows for assessment and grading of IVPP. This pilot study assessed the role of the flutter valve sign (FVS) as a predictor of obstruction-related urinary retention, with a potential role for optimising choice of treatment.

Methods
In this prospective study, we measured the FVS in 122 males who underwent flexible cystoscopy as part of LUTS assessment. Intravesical prostate protrusion was graded from 0 to 4, (0= no protrusion, 1= mild, 2= moderate, 3= severe, and 4= very severe protrusion). We further grouped FVS scores into two: 0-2 (negative FVS) and 3-4 (positive FVS). These patients were also assessed for urinary retention using uroflowmetry and ultrasonic post-void residual scans (average of 3 studies) and the results compared to the FVS data. We evaluated the sensitivity, specificity and predictive values of the flutter valve sign seen on flexible cystoscopy for prediction of significant urinary retention.

Results
Of the 24 patients who had a positive FVS, 20 were true positives and 4 were false positives. The remaining 98 patients had a negative FVS. Out of 67 patients who had significant post void residual scans, 20 were truly positive while 47 were falsely negative, when correlated with the flutter valve sign. Our results showed a specificity of 92%, a positive predictive value (PPV) of 83% and a negative predictive value (NPV) of 50%. While the average residual urine in patients with a positive FVS was 145mls, the average residual in those with a negative FVS was 50mls.

Conclusion
A positive flutter valve sign accurately predicts urinary retention post voiding. In this respect, it may be a useful aid for treatment selection in patients with BPH and LUTS. Further studies are indicated to assess the FVS as a predictor of risk of development chronic urinary retention.
Poster 11
Awareness of testicular torsion amongst Irish parents

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Introduction
Testicular torsion is the most concerning underlying cause of acute scrotal pain that can lead to loss of the affected testicle(1). Whether a torted testicle can be salvaged surgically is directly affected by prompt presentation and diagnosis(2). This raises the question of public knowledge of testicular torsion and the implications of delayed presentation. This study aims to assess the level of awareness as well as knowledge of testicular torsion amongst an Irish population.

Methods
An anonymous questionnaire was distributed to parents attending general paediatric clinics and an acute paediatric unit. Questions were designed to assess the awareness of testicular torsion, understanding of the critical timeframe to presentation, and urgency of response.

Results
Forty eight percent of respondents had not heard of testicular torsion. 50% of parents reported they would seek help immediately if their child had mild testicular pain and 82% if their child had severe testicular pain. 22% were aware of the higher risk age bracket of 12-18yrs and 30% were aware of the critical window of 6hrs for scrotal exploration. Of those parents with boys only 18% had discussed the issue of acute scrotal pain with their child.

Conclusion
This study highlights the lack of awareness of testicular torsion amongst parents as well as the lack of knowledge of the critical time frame to scrotal exploration. Ultimately this may contribute to delays in presentation and subsequent testicular salvage.

References

Poster 12
Clinical significance of haematuria in the anticoagulated patient

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Introduction
Haematuria can be a sign of significant pathology of the urinary tract, although no cause is found in up to 61% of patients. Urologists frequently encounter patients with haematuria who are taking oral anticoagulation. These patients require full diagnostic evaluation. However, these are limited data on the diagnostic yield in this patient group. The objective of this study was to evaluate the prevalence of oral anticoagulant use among patients with haematuria and the incidence of pathology found.

Methods
Three hundred and sixty-six patients with a diagnosis of haematuria were evaluated at a tertiary-care hospital. All patients had a diagnostic evaluation comprising of cystoscopy and upper tract radiological evaluation (ultrasoundography or CT urography). Data are presented as a mean ± standard deviation.

Results
The mean age was 58±14 years. The prevalence of oral anticoagulant use was 21%. Ischaemic heart disease was the most common indication for anticoagulation and aspirin was the most frequently prescribed anticoagulant. The incidence of pathology was 28% in the anticoagulated group versus 20% in the control group. Benign prostatic hyperplasia, urolithiasis and bladder cancer were the most commonly diagnosed conditions.

Conclusion
Haematuria cannot be attributed to oral anticoagulant use and requires prompt diagnostic evaluation. Oral anticoagulant use may potentiate haematuria and lead to a more rapid diagnosis of certain significant urological conditions.

Poster 13
Urinary catheterisation – Are we doing enough to prepare our future junior doctors?

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Introduction
Urinary catheterisation (UC) is a common bedside procedure, and forms part of the core clinical skills training in undergraduate medical schools.

Objective
We set out to survey final year medical students about their skills training and clinical experience of urinary catheter insertion.

Methods
An online anonymous questionnaire was administered to Final Year medical students approaching the end of their clinical attachments in hospital.

Results
A total of 55 medical students responded to the survey. All students had attended 2 weeks of clinical skills
training during their final medical year, with simulation based training in UC, 14 students (25%) felt their clinical skills training as undergraduates had adequately prepared them to perform UC, while a further 29 (53%) felt they were somewhat prepared, and 12 students (22%) felt they were not adequately prepared. Only 11 students (20%) had performed UC during their hospital attachments. 21 students (38%) had witnessed UC by a member of a medical team without performing it themselves. 23 students (42%) had neither performed nor witnessed UC during their clinical attachments.

Conclusion
A significant proportion of final year medical students feel under-prepared to perform UC at the end of medical school. A large number had no clinical experience of this procedure. While most students are satisfied with the standard of clinic skills teaching gained as undergraduates, more needs to be done to involve medical students in UC during hospital attachments.

Poster 14
A prospective audit on the effect of training and educational workshops on the incidence of urethral catheterisation injuries
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Introduction
The incidence of iatrogenic urethral catheterization (UC) injuries is approximately 0.3%. Resultant complications are associated with patient morbidity and unnecessary healthcare costs. Our aim was to investigate whether educational training workshops decreased the incidence of UC related injuries.

Methods
A prospective audit was performed to calculate incidence, morbidity and costs associated with iatrogenic UC injury from January to July 2015. Educational workshops were then conducted with healthcare staff and training modules for junior doctors. UC related incidence, morbidity and costs in the subsequent 6-month period were recorded prospectively and compared with the previous data.

Results
The incidence of iatrogenic UC injuries reduced from 4.3/1000 catheters inserted to 3.8/1000 catheters after the intervention (p=0.59). Morbidity from UC increased in the second half in the form of increase in cumulative additional inpatient hospital stay (22 to 79 days, p=0.25), incidence of urosepsis (n=2 to n=4) and need for operative intervention (n=1 to n=2). The cost of managing UC injuries almost doubled in the period after the training intervention (£50,449 to £90,100)

Conclusion
Current forms of educational and training interventions for UC did not significantly change morbidity or cost of iatrogenic UC injuries despite a decrease in incidence. Improved and intensive training protocols are necessary for UC to prevent avoidable iatrogenic complications as well as a safer urethral catheter design.

Poster 15
Antithrombotic agents and haematuria: A systematic review
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Introduction
The incidence of antithrombotic-related haematuria. Risk of haematuria with individual agents is not known.

Aim: To determine the risk of haematuria with antithrombotic agents used in practice and to evaluate incidence of urological etiology in antithrombotic-related haematuria

Methods
PRISMA guidelines were followed to conduct a systematic review using search engines PUBMED and SCOPUS with the terms “(haematuria) OR (hematuria) OR urinary bleeding) AND ((anticoagulants) OR anticoagulation) OR noac) OR novel anticoagulants) OR antiplatelet) OR dabigatran) OR rivaroxaban) OR apixaban) OR warfarin) OR aspirin) OR heparin) OR dipyridamole)”, only including articles in English language. Raw data was used to perform a pooled analysis.

Results
The initial search revealed 381 articles, 60 articles were included after abstract review, 22 studies were included after full text analysis containing 175,114 patients. Risk of haematuria was highest with warfarin (27%) followed by dabagatrin (2.2%) and rivaroxaban (1%). Unfractionated heparin (3.7%) had a higher tendency to cause haematuria than low molecular weight heparin (1.2%). Haematuria with antiplatelets was relatively lower (0.3%); aspirin had the highest risk (0.9%) while clopidogrel (0.1%) and ticagrelor (0.2%) were less likely to cause haematuria. Risk of major haematuria was highest in dabagatrin (37%) amongst anticoagulants and clopidogrel among antiplatelets (33.3%). Aspirin (37%) and warfarin (36%) were most common agents involved in haematuria related to anticoagulant/antiplatelets. Urological pathology was identified in 44% (234/532) of cases, malignancy in 24%.

Conclusion
This systematic review provides a comprehensive update on anticoagulant/antiplatelet related haematuria for the urologist.
Poster 16
Quantitative Analysis of Innovation in Urology
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Introduction
Patent metrics allow identification of emergent technological innovations and such trends are valuable to understand progress in the field of urology. Patents and publications have been validated to measure innovation diffusion in healthcare technology.

Aim: To use patent and publication data to assess major areas of technological innovation in urology in the last 20 years.

Methods
Patent and MEDLINE databases were searched between 1980 and 2012 electronically using the terms urology OR urological OR urologist AND “surgeon” OR “surgical” OR “surgery”. Patent codes obtained were grouped in technology clusters, then further analysed with individual searches, and growth curves were plotted. Compound Annual Growth Rates (CAGR) were obtained over the last 5 and 10 years. Patents were correlated with publications as a measure of scientific support.

Results
The initial search revealed 417 patents and 20,314 publications. The top 5 technology clusters in descending order were Surgical instruments including Catheters, Minimally Invasive Surgery (MIS), Lasers, Robotic surgery and Image guidance; MIS was the most dominant cluster in the last 10-years comprising 30% granted patents while Robotic surgery showed the highest patent (22%) and publication (37%) CAGR over the last decade. Publication and patent growth rates were closely correlated (Pearson coefficient 0.78, p<0.01), but publication growth rate remained consistently higher suggesting good scientific backing behind urological innovation.

Conclusion
MIS was the highest performing technology cluster in the last decade with Robotic surgery emerging as a top performer with high patent growth rate and good publication support. Scientific vigilance behind innovation in urology is reassuring.

Poster 17
A prospective audit of various components of operating room utilisation times during initial phase of a cross specialty dual console Xi robotic surgery program
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2 Department of Robotic Surgery, University Hospital Limerick, Limerick, Ireland

Introduction
The setup and docking of the da Vinci surgical system are assumed to extend overall operating times and were offered as an early criticism of the technology(1). Improving these times has a benefit for the whole robotic surgical team(2). We aimed to study prospectively the individual component times of robotic procedures performed at our institution.

Methods
A cross specialty robotic surgery programme was introduced at our institution in 2016 using dual-console Da Vinci Xi robot. A prospective study was conducted to assess the times taken for each element of the preparation and completion of a robotic procedure. An independent nurse was responsible for data collection. The outcomes included port placement time, robot docking time, console time as well as total procedure time and total operating room(OR) time.

Results
So far 37 urological caseshav been performed. The results are presented below (table 1). After initial learning curve, setup was consistently maintained for robotic partial nephrectomy and radical nephrectomy. Longer setup times were associated with retroperitoneal approach and patients with previous intra-abdominal operation. Anaesthetic time made up 36% of the total theatre time. Console time accounted for less than half of total OR time.

Table 1. Procedure component times for robotic urological procedures

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port placement time</td>
<td>14.6</td>
<td>3-35</td>
</tr>
<tr>
<td>Robot docking time</td>
<td>17.6</td>
<td>7-45</td>
</tr>
<tr>
<td>Console time</td>
<td>152.1</td>
<td>6-219</td>
</tr>
<tr>
<td>Total procedure time</td>
<td>240.4</td>
<td>124-295</td>
</tr>
<tr>
<td>Total operating room</td>
<td>327.4</td>
<td>172-485</td>
</tr>
</tbody>
</table>

Conclusion
It is beneficial to record and review individual temporal elements of robotic procedures. Procedure setup time in particular can be optimised in this way. Non-surgical aspects of total OR utilisation time remain a challenge.
References

Poster 18
Finding the balance: Continence versus retention in patients treated with intradetrusor injection of Onabotulinumtoxin Toxin A (Botox)
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Introduction
The aim of our study was to assess and compare the efficacy of onabotulinum-A toxin [Botox (Allergan; 100U/vial)] intradetrusor injections in idiopathic and neurogenic detrusor overactivity (IDO and NDO) resistant to anticholinergic treatment with respect to patient satisfaction and rates of urinary retention.

Methods
We prospectively obtained data on all patients who underwent Botox injections in our institution over an eighteen month period from September 2015 to March 2017. Demographic information, number of injections, and dose delivered were captured. Patients were assessed with baseline urodynamics and monitored post-injection for side effects, satisfaction, and symptom improvement.

Results
Overall, 41 patients (median age 55 years, range 19-80) were included in our study. The female-to-male ratio was 5.8:1. A total of 33 patients had idiopathic detrusor overactivity (IDO), whereas the aetiology was neurogenic in 8. Over the 18 month study period, 11 patients received Botox for the first time, with 12 patients having previously received one injection, 12 patients two injections and 6 patients three or more injections. Of the IDO group, 44.4% (n=8) of patients who received 100U Botox needed to self-catheterise for >14 days, whereas 46.7% (n=7) of those who received 200U or greater had to self-catheterise for >14 days. However, this was not statistically significant (p=0.9023).

Conclusion
Intradetrusor onabotulinum-A toxin remains an effective treatment for patients with both idiopathic and neurogenic detrusor overactivity.

Poster 19
Investigation of recurrent urinary tract infections in premenopausal women: is it a wasteful use of resources?
Broe MP, Norton S, Looney AT, David S, Nabi N, Elhag S, Nama G, Akram M, Giri SK
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Introduction
Urinary tract infections (UTIs) are the most common clinical bacterial infections in women, accounting for nearly 25% of all infections(1). Extensive diagnostic work up of patients with recurrent lower UTIs is not supported in the guidelines(2). Despite this, in practice many patients are referred to urology service from their family physician for investigation of recurrent UTIs. We aimed to assess the workload and diagnostic yield associated with such investigations.

Methods
A retrospective analysis was performed of all renal ultrasounds carried out under the urology service at our institution from January 2013 to December 2016. Those included were female patients of all ages with the indication of recurrent UTIs. Any previous imaging of kidneys in the previous 6 years was also assessed. A review of patients who underwent cystoscopy was also carried out.

Results
There were 1182 renal ultrasounds ordered over a four-year period, 416 of which had recurrent UTIs as the primary indication. Mean age was 56.4 years (range 14-90). 16% had non-visible and 4% visible haematuria. In total 85% of ultrasounds for recurrent UTIs were normal, which increased to 94% for those aged under 45 years. 6.3% reported mild scarring, 2.7% new stones, 1.5% minor dilatation of collecting system, 1.5% Bosniak IIF cysts. There were no clinically significant findings for the women under 45 years who underwent cystoscopy.

Conclusion
The diagnostic yield of renal ultrasound and flexible cystoscopy to investigate recurrent UTIs in women under 45 years is extremely low. These valuable resources are better reserved for the investigation of visible haematuria.

References
**Poster 20**

**Red patches biopsy and urine cytology during cystoscopy: is it worth the trouble?**

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*University Hospital Limerick, Limerick, Ireland*

**Introduction and objectives**

One of the most common indications for cystourethroscopy is the evaluation of visible and microscopic hematuria. Other indications include LUTS and recurrent UTIs. Biopsy of the red patches found during flexible cystoscopy is routinely performed to establish diagnosis of bladder malignancies. The aim of this study was to analyse the histology of the biopsy specimens.

**Material and Methods**

This was a retrospective study performed during January 2012 and January 2017 and included a total of 5842 patients who underwent flexible cystoscopies. 2680 were investigated for hematuria, LUTS and UTIs. The rest as follow up for bladder carcinoma. A total of 102 patients of 2680 had red patches without any obvious tumors.

**Results**

Of all, 40 had visible hematuria, 27 male and 13 female. 38 patients had microscopic hematuria, of them 24 male and 14 female. 15 male patients with LUTS and 9 patients with UTIs, with 2 male and 7 female. Urine cytology was performed in all patients with hematuria. 40 males and 16 females were smokers. Mean age of biopsy was 60.8 years (range 24-80 years).

In all, 19 (27.9%) male patients had chronic inflammatory changes, 12 (17.6%) acute inflammatory changes, 13 (19.1%) vascular ectasia, cystitis cystica in 8 (11.7%). Only 2 patients with visible hematuria and history of smoking were found with CIS.14 (20.5%) reported as normal. In the female group, 9 (26.4%) had chronic inflammatory changes, 5 (14.7%) acute changes, 5 (14.7%) vascular ectasia, cystitis cystica in 13 (38.2%) and 2 (5.8%) reported as normal. Urine cytology was positive for malignant cells in only 2 of the patients with visible hematuria.

**Conclusion**

Red patches biopsy and urine cytology can be a useful diagnostic tool only in high risk patients with visible hematuria and chronic history of smoking.

**Poster 21**

**A single center experience of active surveillance for low risk prostate cancer**

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**Introduction**

Active surveillance (AS) continues to emerge as a valid management strategy for patients with low-risk prostate cancer. We present a single center AS patient cohort.

**Methods**

A total of 99 patients were enrolled on the AS program in our institution between November 2012 and March 2016. This was a retrospective cohort study from a prospectively maintained database.

**Results**

The mean patient age was 61.9 (median = 63, range 46-78) at enrolment. The median PSA of patients enrolled was 6.45 ng/mL (range 2.0-15.8). In total, 81.8% (n=81) of patients had a repeat confirmatory biopsy within 1 year with 38 patients having a further TRUS biopsy and 6 going on to have a transperineal biopsy. 71.7% of patients underwent MRI imaging. Overall, 75.8% (n=75) of patients remain on AS. In the remainder; 21 patients have undergone definitive treatment, while 1 patient died of other causes. 2 patients were lost to follow up. The majority of patients (n=20) who underwent definitive treatment of their prostate cancer did so because of disease upgrade on repeat biopsy, with one patient electing to undergo radiotherapy due to a rising PSA. Of the 21.2% referred for definitive treatment, 7 patients underwent radical prostatectomy, 9 external beam radiotherapy, and 5 brachytherapy.

**Conclusion**

Our data support AS as a management strategy for patients with low-risk prostate cancer.
PODIUM SESSION 2: PROSTATE CANCER: DIAGNOSIS

PODIUM SESSION 2: PROSTATE CANCER: DIAGNOSIS

Changing practices regarding the detection of ASAP and HGPIN at trans-rectal ultrasonaged guided biopsy of the prostate

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Department of Urology, St. Vincent’s University Hospital

Introduction

We assessed Irish practice with regards to high-grade prostatic intraepithelial neoplasia (HGPIN) and atypical small acinar proliferation (ASAP) on trans-rectal ultrasound guided biopsy (TRUS) of the prostate and correlate this to international guidelines. We examined the rate of re-biopsy in our institution and rate of progression to invasive prostate carcinoma (PCa).

Methods

A survey regarding HGPIN/ASAP on TRUS biopsy was distributed to Irish consultant urologists. Data was analysed on the survey monkey platform and anonymised. We performed a retrospective review of all TRUS biopsies performed in our institution over a five year period. All benign cases were reviewed for HGPIN/ASAP, re-biopsy rate and PCa progression.

Results

The response rate was 51%. 100% of institutions reported HGPIN and ASAP on biopsy. 60% of consultants rebiopsied if HGPIN/ASAP found with 17%, 33% and 12.5% biopsying at 3, 6 and 12 months respectively. 95% of patients underwent PSA follow-up. 40% reported a change in practice with HGPIN re-biopsied less frequently than ASAP and MRI commonly performed.

4075 biopsies from 3424 patients were performed over 5 years. 2004 (49%) biopsies were reported benign. The rate of detection of ASAP/HGPIN was 5% with a 57% re-biopsy rate, highest in the ASAP group. 50% of re-biopsies detected PCa.

Conclusion

Guidelines recommend rebiopsy of multifocal HGPIN and ASAP. ASAP has a higher rate of progression to PCa and higher need for re-biopsy. Our data would indicate that repeat biopsy is infrequently performed in these men. The use of MRI in the detection of PCa is an emerging tool affecting re-biopsy rate.

The current role of transperineal template prostate biopsies in Ireland

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² Department of Urology, University Hospital Galway, Co. Galway, Ireland
³ Department of Urology, Galway Clinic, Co. Galway, Ireland
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⁶ Department of Radiation Oncology, Cork University Hospital, Cork, Ireland
⁷ Department of Urology, Mater Private Hospital, Dublin, Ireland

Introduction

Template transperineal (TP) biopsy is performed more frequently in patients with suspected prostate cancer (PCa). It has superior sensitivity and specificity to trans-rectal ultrasound guided (TRUS) biopsy with lower complication and sepsis rates. This is at the cost of a general anaesthetic, operating room time and increased expense.

We analysed the results of all TP biopsies performed across Ireland over a three year period to assess its role in the diagnosis and active surveillance (AS) of PCa.

Methods

Demographic, histopathologic and radiologic data was collected retrospectively across four centres performing TP biopsies.

Results

434 TP biopsies were performed. 95% of men had at least one prior TRUS biopsy. MRI data was available on 309 patients, 256 of these had a pre-biopsy MRI. 160 (63%) MRI’s detected a lesion suspicious for PCa. 257 (59%) biopsies were positive for PCa. 161 (63%) had significant disease requiring radical treatment. Tumour location data was available on 222 patients, of these 129 had an anteriorly located tumour. 154 patients underwent TP biopsy as part of an AS programme, 154 (53%) of these were upgraded on biopsy.

Conclusion

TP biopsy is superior to TRUS biopsy in the detection of PCa, especially in anterior tumours. It should be considered for men prior to inclusion in an AS programme as 53% of our series were significantly upgraded. There is a role for the use of MRI prior to biopsy in men with a rising PSA to aid in targeted biopsy of lesions.

The predictive ability of pre-operative magnetic resonance imaging to detect pathological outcomes in prostate cancer

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² Department of Urology, University Hospital Waterford, Waterford, Ireland
³ Department of Radiology, Cork University Hospital, Wilton, Cork, Ireland

Introduction

Accurate preoperative knowledge of tumour stage and extracapsular extension (ECE) are important in preoperative planning to achieve the best oncological and functional results at radical prostatectomy (RP). The aim of this study was to assess the predictive ability of multiparametric MRI for detecting pathological outcomes at RP.

Methods

A retrospective review was performed of all patients who underwent RP by a single surgeon over a 4 year period. Histopathological characteristics from
the RP specimen were compared to pre-operative MRI staging. All cases were discussed preoperatively at the departmental multidisciplinary meeting.

**Results**

MRI signal abnormalities were detected in 26 (17.9%) out of 145 patients undergoing RP, 22 suggesting or consistent with ECE and 4 with seminal vesicle invasion (SVI). Of these, 10 had ECE and 1 had SVI on final histology. The sensitivity and specificity of MRI for detecting ECE were 27.3% and 87.6%, respectively. The sensitivity and specificity of MRI for detecting SVI were 11.1 and 97.8%, respectively. The positive predictive values for determining ECE and SVI were 75.9% and 94.4%. For low risk disease, the NPV for ECE and SVI was 80 and 56.3%, respectively. For intermediate or high risk disease, the NPV for ECE and SVI was 77.6% and 94.6%, respectively.

**Conclusion**

MRI has good specificity but poor and heterogeneous sensitivity for local prostate cancer staging. Further modification of technique and sequencing as well as standardised reporting (PIRADS) is required to improve the accuracy of MRI.

**MRI-TRUS fusion-guided prostate biopsy - correlation of MRI findings with biopsy histology**

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2 Department of Urology, Tallaght Hospital, Dublin 24, Ireland

**Introduction**

Magnetic resonance imaging (MRI) has evolved to become an integral component in the diagnosis of prostate cancer. The PIRADSv2 MRI scoring system is in widespread clinical use, however few studies have validated it’s accuracy in detecting clinically significant cancers. Targeted biopsy of the prostate using MRI data has also been shown to improve detection of significant cancer [1, 2]. We correlate the histology from our MRI-US fusion guided prostate biopsies with PIRADS-v2 scores.

**Methods**

We reviewed patients who underwent fusion biopsy between August 2015 and March 2017. We collated data on age, prior TRUS biopsy results, lesion location on MRI and subsequent fusion biopsy histology. Each MRI had a PIRADSv2 score prospectively assigned by two consultant radiologists in consensus. Histological results were reviewed and correlated with PIRADSv2 score.

**Results**

67 biopsies performed, average age 66.7 years.

39/67 had positive histology (58%).

28/67 had negative histology (42%).

<table>
<thead>
<tr>
<th>PIRADS v2 Score</th>
<th>No. of patients</th>
<th>% with positive histology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>75</td>
</tr>
<tr>
<td>5</td>
<td>28</td>
<td>92.8</td>
</tr>
</tbody>
</table>

Lowest grade of disease detected G 3+4

**Conclusion**

Our results to date add to the burden of proof that MRI-TRUS fusion biopsy can be a very useful tool in the diagnosis and management of prostate cancer, with significant potential to change management. We have also demonstrated excellent correlation between high PIRADSv2 scores and positive histology.

**References**


**Our Centre Experience: MP-MRI-US fusion targeted biopsy value and efficacy**

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**Introduction**

Most prostate cancers can be diagnosed using Transrectal Ultrasound Guided Prostatic Biopsy (TRUS biopsy). However, combination of imaging and sampling can sometimes give inaccurate information. Microfocal ‘cancers’ of little clinical significance are frequently detected, whereas the incidence of false negative biopsies (serious tumours not detected) may be as high as 35% in first-time biopsies (1). Early detection of clinically significant Prostate Cancer would likely save many lives. A combined approach of prior imaging using MRI and then Targeted TRUS Biopsy could be used to improve prostate biopsy efficiency.

**Methods**

A retrospective review was performed for 122 patients who underwent Targeted Prostatic Biopsies which were performed by MRI–ultrasound fusion technique in 119 patients with elevated or raising PSA. A total of 39 patients did not have standard biopsy prior to Targeted Biopsy. All patients underwent multi parametric magnetic resonance imaging prior to targeted biopsy.

**Results**

Median age of patients was 63.5, median PSA was 7.5ng/ml, and median prostatic volume was 49. 52 patients had negative standard prostatic biopsy, 11 of them had two previous biopsies, and 7 had three or more
biopsies. 21 patients was low grade and low volume disease

MRI-US fusion targeted prostate biopsy was positive for prostate cancer in 76 out of 122 (62%). Of these 76, 53 (69.7%) patients had high grade disease (Gleason 7 or more). There were 23 cases of positive Target Biopsy from 52 patients with previous benign TRUS biopsy (44.2%). Of those without a previous biopsy, 21 of 39 cases were positive for prostate cancer on Target Biopsy (53.8%). 9 from 21 (42.8%) patients become higher grade disease from those low grades by standard biopsy. Average number of cores is 9 cores. The area of high suspicious in MP-MRI has high percentage of positivity to prostate cancer and mostly high grade disease.

Conclusion

Multi parametric MRI is an excellent method by which to diagnose prostate cancer, particularly in the case of clinically important disease. Patients with negative standard TRUS guided prostatic biopsy and persistently elevated PSA, and also those on active surveillance, may be the best candidates for targeted biopsy. Targeted biopsy less complication rates, less number of cores. We suggest targeted (MP-MRI –US fusion) to all high risk patients instead of starting by standard TRUS biopsy.

References


Clinically Significant prostate cancer detection with MRI- US Fusion biopsy

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Introduction

The current standard for diagnosing prostate cancer (PCa) relies on a systematic trans-rectal ultrasound-guided (TRUS) biopsy which has low accuracy and is associated with complications. A software-based magnetic resonance imaging-ultrasound fusion targeted biopsy (MRI-US FB) approach has been proposed to overcome these issues.

Aim: To determine accuracy of this MRI-US FB approach in two Irish centers.

Methods

A multi-centric prospective study was conducted on patients undergoing MRI-US FB approach between August 2015 and March 2017. All patients had undergone multipara-metric MRI with MR-US fusion amenable lesions which were scored according to the PI-RADS classification from the European Society of Urogenital Radiology’s MR prostate guidelines. The Artemis biopsy tracking system was used to fuse the stored MRI with real-time US.

Results

A total of 120 patients (median age 66) underwent MRI-US FB. Median PSA = 10.9 ng/ml and prostate volume = 55 cc. Pca was found in 68% (n=74) of patients, 54% (n=40) had previous negative TRUS biopsies. Gleason ≥7 cancers were found in total of 85% (n=69/120) patients out of which 39% were found in PI-RADS 3 lesions (n=9/23), 62% of PI-RADS 4 lesions (n=23/37) and 75% of PI-RADS 5 lesions (n=44/60). PI-RADS score significantly correlated with Gleason score ≥7 on biopsy (p=0.01, chi-square). The Positive Predictive Value (PPV) of MRI based on MR-US fusion biopsy was 58%.

Conclusion

Prostate lesions identified on MRI can be accurately targeted using MR-US fusion biopsy and findings of biopsy correlate well with level of suspicion on MRI.

Pre-prostate biopsy MRI: Do we still need systematic biopsies in the era of fusion biopsies?

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2Department of Surgery, Trinity College Dublin, Ireland

Introduction

Complications associated with prostate biopsies have led to the advent of techniques to try and omit biopsies or repeat procedures. Magnetic Resonance Imaging (MRI) can help target lesions but the need for biopsies in patients with negative MRIs and the role of systematic biopsies in patients undergoing targeted biopsies is unknown.

Aim: To investigate MRI accuracy in identifying clinically significant lesions and the correlation between MRI and Transrectal Ultrasound (TRUS)-guided prostate biopsy results.

Methods

A prospective study was performed in a single center on patients undergoing MRI prior to systematic TRUS biopsies. Significant prostate cancer was defined as Gleason score ≥3+3. MRI and TRUS biopsy results were analysed to identify correlation between PI-RADS score and histology and the sensitivity, specificity, positive and negative predictive value (PPV, NPV) of MRI.

Results

There was no correlation between PI-RADS score and TRUS histology (p=0.40, chi-square): 40% of PI-RADS 5 lesions were histologically negative or insignificant and 40% PI-RADS 3 lesions were significant histologically. The sensitivity, specificity, PPV and NPV of target lesions on MRI based on TRUS results was 100%, 23%, 62%, and 100% respectively. Significant cancer was sampled in 24% cases in the contralateral lobe to the index lesion on MRI.

Conclusion

MRI picked up all significant cancers but a quarter of the cases showed additional significant disease outside the abnormal area. MRI is a helpful adjunct in investigating prostate cancer but cautious clinical application is necessary and omitting systematic or random biopsies based on MRI results is not advisable.
PODIUM SESSION 3: UROLOGICAL ONCOLOGY

PODIUM SESSION 3: UROLOGICAL ONCOLOGY
Outcomes Post Radical Orchidectomy in Ireland 1994-2013

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Health Service Executive, Ireland 1, National Cancer Control Program, Ireland 3, National Cancer Registry, Ireland 3, Mercy University Hospital, Cork, Ireland 4, St Vincent’s & Mater Hospitals, Dublin, Ireland 5

Introduction
Testicular cancer is relatively rare but is the most common cancer in men under 40 years of age. Patients generally have an excellent prognosis due to its early presentation, radio/chemo sensitivity and the production of tumour markers allowing for early detection and treatment. Although the majority of cases are curable, testicular cancer still poses a significant burden due to the toxicity of treatment, effects on employment and potential impact on fertility.

Methods
This audit evaluated outcomes post Radical Orchidectomy in Ireland 1994-2013 using the National Cancer Registry of Ireland (NCRI) database of 2763 patients. Five year net survival was calculated using the Pohar-Perme method for hospital type, surgical consultant speciality and surgical caseload. The statistical models were adjusted for confounding variables such as age and stage at diagnosis.

Results
There is a strongly statistically significant association between higher Consultant Surgeon caseload and improved survival outcomes. The survival benefit was strongest for surgeons who performed > 5.2 cases per year (p=0.001).

Radical Orchidectomy performed by specialist surgeons had better survival outcomes than those performed by non-specialist surgeons. This finding was just statistically significant for the ten-year period 1994-2003 (p=0.049). Overall significance for 1994-2013 was p=0.71.

Conclusion
Ireland is not adhering to the European Association of Urology guidelines as Radical Orchidectomy surgeries are not all performed in high volume centres with specialist surgeons. This report supports the centralisation of testicular cancer services as initially recommended in the 2007 National Cancer Control Strategy.

References

Lymph node management in patients with low and intermediate risk penis cancer
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Introduction
The management of regional lymph nodes is decisive for long-term patient survival in penis cancer. Cure can be achieved in metastatic disease confined to the regional lymph nodes. Management of regional lymph nodes in penis cancer is stage-dependent. In clinically node-negative patients (cN0), micrometastatic disease occurs in about 25% of cases and is related to the local tumour stage and grade.

Methods
A retrospective study was performed of all men with penis cancer and clinically node-negative patients (N=18) managed in our unit over a 24 month time period. Their final stage and grade, imaging and survival were collated and a database established.

Results
4 patients were commenced on a groin surveillance regimen.
12 patients with impalpable inguinal adenopathy underwent bilateral dynamic sentinel lymph node biopsy (BDSLNB). An average of 3.2 nodes was retrieved per groin. 2 patients underwent radical inguinal lymphadenectomy. 5 patients experienced wound complication post BDSLNB (seroma). Progression and recurrence free survival at this early time point is 100%.

Conclusion
Risk stratifying clinically node negative penis cancer patients maximises the opportunity for cure while minimising the potential for morbidity associated with radical inguinal lymphadenectomy.

15 years of penile cancer – an Irish perspective
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2 Department of Urology, Mercy University Hospital, Cork, Ireland

Introduction
The aim of this study was to perform the first national review and to evaluate clinicopathological factors affecting survival.

Methods
All cases of penile cancer in Ireland between 1995 and 2010 were identified through the National Cancer Registry of Ireland (NCRI) and analysed to identify factors affecting survival.

Results
Three hundred and sixty cases of penile cancer were identified. The mean age at diagnosis was 65.5 years. The majority of cases (88%, n=315) occurred in those over 50, with only
3% (n=11) occurring in those under 40. Squamous cell carcinoma (SCC) accounted for 91% (n=328) of cases.

Of those patients with stage recorded, the majority were Stage \(\leq 2\) (Stage 0 = 1% (n=3), Stage 1 =25% (n=90), Stage 2 =21% (n=74), Stage 3=14% (n=51), Stage 4=6% (n=23), Stage unspecified 33% (n=119). Eighty percent (n=289) of patients underwent surgery, with 57% (n=206) and 24% (n=87) undergoing partial penectomy and total penectomy respectively.

Mean overall survival (OS) was 77 months, and 5 year relative survival was 69.7% (95%CI: 59.1 – 77.8%). OS decreased as stage of disease and age increased; stages 0-2 OS 83 months, stages 3-4 OS 51 months, and in patients <60 versus ≥60 years, OS 104 versus 63 months respectively.

Conclusion
Penile cancer is a rare condition, with an average of 24 new cases per year. It predominantly affects men over the age of 50 with the majority proceeding to surgical intervention. Decreases in OS are seen with increasing age and stage of disease. Greater awareness of the disease and earlier patient presentation are key to optimising treatment outcomes.

Surgical management of upper tract urothelial carcinoma: outcomes from a single institution over 10 years
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St Vincent’s University Hospital, Dublin, Ireland

Introduction
Nephroureterectomy remains the standard treatment for localised upper tract urothelial carcinoma (UTUC), with other surgical options available for small low-grade tumours. There is a paucity of data specific to Irish patients undergoing surgical management of UTUC. We present a review of surgical management of UTUC from a single institution over 10 years.

<table>
<thead>
<tr>
<th>TABLE 1</th>
</tr>
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<tbody>
<tr>
<td>PARAMETER</td>
</tr>
<tr>
<td>Tumour location</td>
</tr>
<tr>
<td>Ureter</td>
</tr>
<tr>
<td>Renal Pelvis</td>
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<tr>
<td>Multifocal</td>
</tr>
<tr>
<td>Final T-stage</td>
</tr>
<tr>
<td>(\leq pT1)</td>
</tr>
<tr>
<td>(pT2)</td>
</tr>
<tr>
<td>Final grade</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>CIS present</td>
</tr>
<tr>
<td>Positive margin</td>
</tr>
</tbody>
</table>

Recurrence of disease occurred in 27 (46.6%) patients, of which 22 (81.5%) had high grade and 5 (18.5%) had low grade disease. Average time to recurrence was 12 months and 28.4 months for those with high grade and low grade disease respectively. Overall 5 year survival was 50%. Of those who did not survive 5 years, 93% had high grade disease. Disease free survival at 5 years was 34.5%.

Conclusion
This select Irish cohort suggests that UTUC is a rare but aggressive condition with a significant mortality rate for patients, even in those deemed fit for operative management.

The role of percutaneous biopsy in the evaluation of indeterminate small renal masses
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Introduction
Most incidentally diagnosed small renal masses (SRMs) are found to be malignant on surgical resection. However, percutaneous biopsy of indeterminate SRMs can further characterise lesions beyond radiological features, allowing risk stratification of low grade and benign masses.

Aim
The aim of this study was to investigate the pathology, accuracy and clinical outcomes of percutaneous biopsy for SRMs in our institution.

Methods
All percutaneous renal biopsies carried out between March 2014 and March 2017 were identified from a prospectively collected database. The indication for biopsy was to further evaluate indeterminate SRMs.

Results
Forty-nine biopsies were performed within the study period. Malignant lesions were confirmed in 37 biopsies (75.5%), with 35 renal carcinomas [clear cell (28), papillary (5), chromophobe (2)], 1 transitional cell carcinoma and 1 liposarcoma. Seven lesions were diagnosed as benign (14.2%) [oncocytoma (5), angiomyolipoma (2)].
Twenty-five patients were planned for surgical resection (radical nephrectomy (12), partial nephrectomy (13). The histopathological concordance between biopsy and surgical excision was 77.7%. Five biopsies were non-diagnostic [insufficient sample (2), normal parenchyma (1), inflammatory tissue (2)]. Two patients had repeat biopsies confirming renal carcinoma. One patient proceeded directly to partial nephrectomy. One patient had mass ablation without histological confirmation of malignancy. The final patient continues on active surveillance.

**Conclusion**

Percutaneous renal biopsy is not necessary where a diagnosis of renal carcinoma is conclusive radiologically. However, it is useful in characterising indeterminate lesions, where the confirmation of benign pathology may avoid the need for surgical intervention.


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**Introduction**

Some complex renal tumours due to their size, location and proximity to the hilum may preclude a minimally invasive approach to nephron sparing surgery. We describe our technique, illustrated with images and videos, of robotic partial nephrectomy for challenging renal tumours.

**Methods**

A study of 249 patients who underwent robotic partial nephrectomy (RPN) in multiple institutions was performed. Patients were identified using a prospective RPN database. A complex renal lesion was defined as a RENAL nephrometry score ≥10. Data was presented as median (interquartile range) and difference between groups was examined.

**Results**

31 (12.4%) of RPN were for complex renal. Median age was 57 (50.5 – 70.5) years. 21 (67.7%) were male, 10 (32.3%) were female. American Society of Anesthesiologists score was 2 (2 - 3). Median operative time was 200 (50 – 265) min, median warm ischaemia time was 23 (18.5 – 29) min, and median blood loss was 200 (50 – 265) ml. There were no intraoperative complications, 2 (6.4%) of patients had a post-operative complications. 1 (3.2%) patient had a positive margin. Length of stay was 3.5 (3 – 5) days. Median follow up was 12.5 (7 – 24) months, there were no recurrences. RPN did result in statistical significant changes in renal function 3 months post RPN compared to preoperative renal function, p=0.0001.

**Conclusion**

RPN is a safe approach for select patients with complex renal tumours and may facilitate tumour resection and renorrhaphy for challenging cases, offering a minimally invasive surgical option for patients who may otherwise require open surgery.
Audit of time of referral to flexible cystoscopy in a high volume referral centre

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Introduction
Although haematuria can be associated with benign conditions, 20-25% of people presenting with visible haematuria, and 5-10% of people presenting with non-visible haematuria will have an underlying urological malignancy. [1] According to NICE guidelines, patients with visible haematuria with suspected urological malignancy should be seen by a specialist within 2 weeks of referral.

Methods
A retrospective analysis was performed of bladder tumour resections of 116 patients between April 2015 and January 2016. Using the IPMS system the date of each patient’s original referral was recorded. An analysis of reason for referral and date of diagnosis by flexible cystoscopy was performed using EndoRaad system.

Results
Of the 116 patients who underwent TURBT in that timeframe, only 14 patients (12%) were seen for flexible cystoscopy within 2 weeks of referral as suggested by NICE guidelines. The average time to flexible cystoscopy for patients referred with visible haematuria who were found to have subsequent bladder cancer was 18 weeks.

Conclusion
It has been shown that a delay in diagnosis of bladder cancer can lead to increased risk of death from disease, independent of tumour stage or grade. [2]

The main contributing factors to delay in diagnosis is the high volume of referrals and lack of access to a dedicated endoscopy unit.

Poster 23
Tailored approaches in the management of Peyronie’s disease

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Introduction
Peyronie’s disease (PD) is a benign fibrotic disorder of the tunica albuginea of the penis, which can cause penile pain, curvature, shortening, erectile dysfunction, and psychological distress. Various medical and surgical therapies have been used to treat this condition (1). Progressive angulation can compromise intromission. Surgery is indicated when penile curvature prevents satisfactory sexual function.

Methods
A retrospective study was performed of all men referred to the outpatients department over an 18 month period with peyronie’s disease and whom met criteria for surgical intervention (N=15). All had stable peyronie’s disease (> 6 months) causing significant sexual dysfunction and requesting intervention.

Patients were evaluated pre and post operatively by way of an International Index of Erectile Function (IIEF) and Peyronie’s Disease Questionnaire. Degree of angulation and penile length were assessed pre and post operatively. A variety of diagnostic modalities including MRI (N=4), patient photos (N=10), and intracavernosal alprostadil injections (N=12) were used in determining optimum surgical approach. A variety of surgical techniques were used depending on the clinical picture including plaque incision and grafting (Lue’s procedure) (N=2), tunica albuginea plication (Nesbit procedure) (N=12), and insertion of a penile implant (N=1).

Results
Significant improvements in both sexual function and degree of penile curvature were observed in all patients post operatively. Penile length loss averaged 1.2cm in plication procedures. 4/15 patients experienced minor complications (haematoma, penile pain).

Conclusion
Surgery remains an effective and safe method for the treatment of PD with high rates of curvature correction, restoration of sexual function, and patient satisfaction. Careful patient selection with detailed consultation, as well as choice of surgical technique is a key step in ensuring good outcomes and patient satisfaction.

References
Poster 25
Surgical outcomes from a rapid access prostate assessment clinic
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Introduction
Rapid Access Prostate Assessment Clinics (RAPAC) were established to provide early assessment and treatment of prostate cancer in 2009. We aim to present the surgical outcomes of men referred from these clinics for radical surgical treatment of their prostate cancers.

Methods
A prospectively-maintained database of all radical prostatectomy (RP) patients referred from RAPAC at Galway University Hospital and University Hospital Limerick was compiled, detailing demographic, surgical, pathological and functional outcomes data.

Results
508 men underwent RP between August 2010 and December 2016, comprising 208 open prostatectomies (ORP), 167 laparoscopic prostatectomies (LARP) and 133 robotic prostatectomies (RARP). Mean patient age was 59 years and mean presenting PSA was 8.4 ng/ml. Data is displayed in table below.

<table>
<thead>
<tr>
<th>Group</th>
<th>ORP</th>
<th>LARP</th>
<th>RARP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>62</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>PSA</td>
<td>8.2</td>
<td>8.4</td>
<td>8.1</td>
</tr>
</tbody>
</table>

ORP had shortest mean operating time (p<0.001), though mean blood loss (p<0.001) and mean length of stay was longer (p<0.001).

62% of patients had T2 tumours in their final histology specimens with 38% being T3. 46% were ISUP Grade Group 2, 20% ISUP Grade Group 3 and 19% ISUP Grade Group 1. Patients with T3 tumours were more likely to have positive surgical margins (34%), positive lymph nodes (17%) and detectable PSA (17%) at follow-up (all p<0.01), as compared to T2 tumours.

Functional outcome data is available for most patients with 70% of patients reporting continence and 13% reporting potency at 6 month follow-up, with rates significantly higher for those undergoing RARP as compared ORP and LARP.

Conclusion
Patients referred from the RAPAC receive excellent surgical outcomes, matching those of similar cohorts previously reported in the literature.

References

Poster 26
Impact of Rapid access Prostate cancer clinics in the diagnosis and treatment of prostate cancer
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3 Department of Urology, Beaumont Hospital, Dublin, Ireland
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5 Department of Urology, University Hospital Limerick, Ireland
6 Department of Epidemiology and Public Health Medicine, Royal college of Surgeons in Ireland

Introduction
Rapid Access Prostate Cancer Clinics were introduced to allow early detection of prostate cancer 1. Comparative data is required to assess if RAPCs led to changes in diagnosis and treatment of Prostate cancer.

Methods
A retrospective study was carried out, analysing data of patients referred to SVUH with suspected prostate cancer between January 2008 and December 2014. The RAPC was considered as the intervention between group 1 (before RAPCs) and group 2 (post RAPCs introduction).

Results
Results were categorised as group 1, group 2. 1670 patients were included (367, 1303: group 1, group 2). The median referral P.S.A was 8.14, 6.6. Abnormal DRE was found in 31.3%, 28.8% with a PPV of 58.4%. Average waiting time was 34.7, 17.9 days. Positive TRUS biopsies were seen in 61.1%, 56.25% patients. Low grade disease was found in 31.5%, 32.6%. Intermediate grade prostate cancer was found in 39.5%, 41%. High grade prostate cancer was found in 28.5%, 26.3%. Patients were staged T1 (12%, 12.4%), T2 (53.2% 60%), T3 (24.7%, 24.4%) and T4 (10.1%, 3%). Metastatic disease was found in 14.6%, 4.7% of patients (P<0.001). Patients underwent prostatectomy (39%, 23.1%), Radiotherapy (31.5%, 45.5%) and Active surveillance (13.5%, 18.3%).

Conclusion
RAPCs led to a decrease in waiting time to review and diagnosis, a decrease in PSA level at referral and an increase in number of patients suitable for radical treatment. Furthermore, a decrease in patients diagnosed with metastatic prostate cancer was seen after the introduction of RAPCs.

References
Poster 27
Assessment of patient satisfaction score—Comparison between Rapid access prostate cancer clinics (RAPCs) and general urology outpatient clinics

S M Inder, M Broe, M Burke, J Forde, D Mulvin, D Galvin, R Conroy, G Lennon

Introduction
Prostate cancer is the second most common cause of death in Irish males and considered as the most prevalent cancer in men in Ireland 1. RAPC was introduced in St Vincent’s University Hospital in December 2010. Currently no data has been published about Irish patient experience and satisfaction score pre and post the introduction of the RAPCs.

Methods
Data was retrospectively collected between January 2008 and December 2014. Patients were grouped according to the clinics they attended; before (Group 1) and after (Group 2) the RAPCs introduction. The short version of Prostate Cancer Questionnaire for patients (PCQ-P) was used to assess patient experience and satisfaction scores.

Results
1670 patients were included and the average age of patients was 62.1 years (group 1) and 61.6 years (group 2). The median referral PSA was 8.14 and 6.6 from group 1 and group 2 respectively. 170 (group 1) and 182 (group 2) questionnaires were sent and 135 (38.4%) responses were received; 74 (43.5%) from group 1 and 61 (33.5%) from group 2.

Responses were categorised and tested separately. Mann-Whitney U test showed significant difference for categories 1 (GP visit and referral) and 3 (Diagnosis and treatment) with a p value < 0.05. Patients from group 2 had a better satisfaction score, mainly for data regarding “GP visits and referral” (P=0.0329) and “Diagnosis and Treatment decision” (P=0.0114).

Conclusion
RAPCs has led to an improved care experience with higher patient satisfaction scores.

References

Poster 28
Do awareness campaigns impact referrals to rapid access prostate clinic?

JSA Khan, P O’Malley, G Durkan, FT D’Arcy, C Dowling

Introduction
Assessment for clinical suspicion of prostate cancer is performed at rapid access prostate clinics (RAPC). Referrals to RAPC are made by General Practitioners (GPs) commonly after men either seek out a PSA test or further information on prostate cancer. Criteria for referral to a RAPC include an abnormal digital rectal examination and/or 2 consecutively elevated PSA readings at least 6 weeks apart. We examined referral patterns to determine whether awareness campaigns such as Movember impacted the numbers of referrals to RAPC.

Methods
A retrospective review of all new referrals to the Galway RAPC was performed for the years 2014 – 2016. The date of referral by the general practitioner was noted and the total number of referrals per month was recorded.

Results
A total of 1,998 new referrals were received between January 2014 and December 2016. Monthly presentations are represented in Figure 1. The mean number of referrals each month was 55.5. The busiest month for referrals was May 2014 with 88 referrals. January cumulated most referrals across the 3 years with a total of 202 averaging 66.33 referrals a year. The majority of all referrals were received in the first 3 months of the year.

Conclusion
Given that RAPC protocol asks for 2 raised PSAs at least 6 weeks apart, the increased numbers of referrals in January may be attributed to higher numbers of initial GP attendances for PSA tests in November, prostate cancer awareness month, the month the international Movember campaign takes place.

Figure 1.
Number of referrals received each month

Monthly Referrals for each year

41
Poster 29
Establishment of a National Prostate Cancer Registry including both clinical data and patient reported outcomes; Initial Data from IPCOR Project
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² University Hospital Galway, Galway, Ireland
³ Meath and Adelaide Hospital, Dublin, Ireland
⁴ National Cancer Registry, Cork, Ireland
⁵ St Vincent’s and Mater Hospitals, Dublin, Ireland

Introduction
Little national data exists on the clinical details, treatment options, patient reported outcomes and results of prostate cancer treatment in Ireland. Through a global effort supported by Movember and the Irish Cancer Society, a detailed clinical dataset is being collected on all men newly diagnosed with prostate cancer.

Methods
Across 15 prostate cancer hospitals in Ireland, all men newly diagnosed with prostate cancer are registered in the IPCOR database. All are invited to complete baseline (pre-treatment) patient reported outcome measurement (PROM) using the EPIC 26 questionnaire, and repeated annually thereafter. Annual clinical, hospital specific and physician specific reports are then generated.

Results
Over 2500 men diagnosed with prostate cancer have now been registered in the IPCOR database. A retrospective study was performed on all men who completed questionnaires. A IPCOR research fellow is now in place, and a detailed analysis of this data will be presented.

Conclusion
The collection of a detailed clinical dataset linked with PROM data will empower healthcare decision makers, providing them with the data required to improve patient access and support the treatment options with the best outcomes for patients. Detailed clinical reports, hospital reports and physician reports will be provided to drive change and improvements in patient care.

References

Poster 30
Long-term outcomes of en-bloc renal transplantation from paediatric donors into adult recipients
Considine SW¹, Davis NF², McLoughlin L², Mohan P³, Forde JC², Power R², Smyth G², Little DM³
¹ Department of Transplant Surgery and Urology, Beaumont hospital, Dublin, Ireland

Introduction
Transplant units are exploring strategies to increase the availability of donor kidneys. The use of en-bloc kidney transplantation (EBKT) from very young paediatric donors represents one potential solution (Figure 1). We present our long-term experience with paediatric EBKT among adult recipients.

Methods
Data from all EBKT recipients in the National Kidney Transplant Centre between 1994 and 2016 was examined. The primary outcome variable was long-term en-bloc allograft survival rate. Secondary outcome variables were incidence of allograft thrombosis, incidence of delayed graft function, overall patient survival and serum creatinine at most recent follow-up.

Results
Twenty paediatric to adult EBKTs were performed between 1994 and 2016. Mean donor age was 1.56 ± 0.79 years (Range: 7 months to 3 years) and mean recipient age was 46.4 ± 12.6 years. Mean recipient weight was 56.7 ± 11.8kg.

Mean follow-up was 119.9 ± 55.36 months (36 - 264). One patient was lost to follow-up after 120 months. There were no cases of graft thrombosis or delayed graft function. Overall graft survival was 100% at one year, 89.9% at 5 years and 70.3% at 10 years. Mean serum creatinine after the follow-up period was 71 ± 20.9 µmol/L.

Two patients developed graft failure 53 and 108 months after transplantation respectively, the first of whom died 53 months later. Three other patients died during the follow up period with functioning grafts.

Conclusion
En-bloc paediatric kidney transplantation is associated with excellent long-term allograft and patient survival and is a feasible strategy for increasing the transplant donor pool for carefully selected recipients.

Poster 31
Incidence and outcome for micropapillary variant of transitional cell carcinoma of the bladder in transplant patients
Catalin Constandache¹, Gordon P. Smyth¹, Richard E. Power¹, Ponnusamy Mohan¹, James Forde¹, Christian Gulmann², Niall F. Davis¹, Dilly Little¹
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² Department of Histopathology, Beaumont Hospital, Dublin, Ireland

Introduction
Micropapillary variant of transitional cell carcinoma of the bladder is associated with advanced stage at presentation and a poorer prognosis. Herein, we review the incidence of micropapillary variant of bladder transitional cell carcinoma in patients after renal transplantation.

Methods
A retrospective study was performed on all patients that received a renal transplant between January 1976 and March 2017 (n=4447).

Primary variables were incidence, management, overall survival and latency period between transplantation and the diagnosis of bladder tumour.
**Results**

In the study period, 19 patients were diagnosed with bladder tumours in transplant recipients, of which 4 had micropapillary variant of TCC as the histological subtype, representing 21%. 3 out of 4 (75%) presented with locally advanced disease, and all of them received radical cystectomy as treatment; 2 cases received adjuvant chemotherapy due to metastatic disease. The latency time between transplantation and diagnosis is 100 months, range between 40 and 193 months. Despite the radical treatment followed by adjuvant therapy, one patient died because of metastatic disease 8 months after her initial diagnosis.

Interestingly, patients with micropapillary variant of TCC were transplanted only after year 2000, and received suppression protocol with Tacrolimus, MMF and Prednisone.

**Conclusion**

Micropapillary variant of TCC in bladder tumours is more prevalent in transplantation patients compared to general population, and is associated with poor prognosis due to its aggressive histological form and the advanced stage at diagnosis. Close observation of patients with organ transplantation and risk factors with regular urinalysis, urinary tract imaging and urethro-cystoscopy may improve the outcome of these patients.

**References**

European Association of Urology Guidelines

Campbell&Walsh Urology, 10th Edition

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**Introduction**

Stent symptoms and removal cause significant morbidity for patients. (1) Stents with magnetic retrieval are a minimally invasive alternative to traditional stents which are removed cystoscopically. (2) We compare our patients experience with regard stent symptoms and stent removal.

**Methods**

Using our prospective stent registry in two hospitals, we identified 60 patients having undergone stenting post ureteroscopy. In site A, aliphatic polyurethane urotech BlackStar stents with magnetic retrieval are used, and in site B, Cook soft polyurethane and boston-scientific perculflex stents are used with cystoscopic retrieval. Theatre logbooks were reviewed to determine stenting indication. A validated Ureteral Stent Symptoms Questionnaire (USSQ) and procedural numeric pain scale were used to assess patient symptoms. Cost-analysis was performed for each technique.

**Results**

Thirty patients underwent magnetic stent extraction and thirty patients underwent flexible cystoscopy. There were 19 men and 11 women with a mean age of 46.5years (range 29-73) in site A and 22 men and 8 women in site B with mean age 53.3years (range 25-85). Results of the USSQ and procedural pain scores are demonstrated in table 1. Work performance was effected for a longer period in the flexible cystoscopy group (mean 4.9 vs 1.10, p-value = 0.028). The magnetic stent group had a lower median duration of stenting (6.5 vs 21 days, p-value <0.001). There were no documented complications related to stent removal in either group. Mean cost saving per patient was €290.50 using magnet retrieval.

**Conclusion**

Magnetic stents offer an alternative method of internalised stenting while obviating the need for a subsequent endoscopic procedure. Early results show magnetic stents are a cost effective option with comparable symptom and procedural pain scores to other stents.

**References**


**Table 1.** USSQ scores, procedural pain score, duration of stenting

<table>
<thead>
<tr>
<th></th>
<th>Urotech black-star US</th>
<th>Cook soft polyurethane US, bostonscientific perculflex US</th>
<th>Confidence Interval</th>
<th>p value</th>
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<tr>
<td>Urinary Symptoms</td>
<td>27</td>
<td>28</td>
<td>(-5.16, 2.56)</td>
<td>0.501</td>
</tr>
<tr>
<td>Pain Symptoms</td>
<td>13.6</td>
<td>15.1</td>
<td>(-4.03, 1.12)</td>
<td>0.261</td>
</tr>
<tr>
<td>General Symptoms</td>
<td>12.1</td>
<td>13.6</td>
<td>(-3.83, 0.83)</td>
<td>0.202</td>
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<tr>
<td>Work Performance</td>
<td>8.9</td>
<td>8</td>
<td>(-0.828, 2.717)</td>
<td>0.286</td>
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<tr>
<td>Additional Problems</td>
<td>8.6</td>
<td>9.8</td>
<td>(-2.897, 0.430)</td>
<td>0.143</td>
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<tr>
<td>Procedural Pain Score</td>
<td>2.4</td>
<td>3.5</td>
<td>(-2.310, 0.110)</td>
<td>0.074</td>
</tr>
<tr>
<td>Median Duration of Stenting</td>
<td>6.5</td>
<td>21</td>
<td>(-18.00, -10.00)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**Poster 32**

**Comparing methods of ureteric stenting, a retrospective analysis of differing practices**

JA O’Kelly1, UM Haroon1, NA Abdullah2, MA O’Neill1, A Rauf1,2, SW Considine1, L McLornan1, BB Maguire1, IA Cheema1,2, JC Forde1,2

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**Poster 33**
Between a rock and a hard place: failing at initial investigation of renal stone disease

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² Department of Emergency Medicine, Beaumont Hospital, Dublin 9, Ireland

**Introduction**
Urolithiasis is a very common presenting complaint in the emergency department and the diagnosis is usually made by CT scanning. Serum and urine tests constitute a necessary adjunct to the management of urolithiasis. EAU guidelines recommend that all patients with a first presentation of a renal or ureteric calculus should undergo a "succinct biochemical workup" which includes a serum urate and calcium.

**Methods**
Between October 2016 and March 2017 those patients who had undergone CT scanning for diagnosis renal or ureteric calculus were identified. Inclusion criteria were confirmation of renal stone disease and first presentation with this. Exclusion criteria were existing diagnosis of urolithiasis and no evidence of calculus found on CT. Further analysis was then carried out to determine if these patients had undergone the recommended biochemical workup.

**Results**
158 patients were identified using these criteria, of which 106 were eligible according to the set criteria. Of these, only 24.5% had a serum calcium tested and only 3.8% had a uric acid tested. The patient cohort comprised 45% female and 55% male patients. The age ranged from 17 to 79 years with a median age of 48 years.

**Conclusion**
These results show a serious deviation from current guidelines. Approximately 86% percent of patients did not undergo the appropriate biochemical testing. Highly recurrent disease is seen in just over 10% of patients and identifying these patients is imperative to guide future treatment. This audit highlights the need for standardized renal colic pathways in our emergency departments.

**References**

**Poster 34**
The new disposable digital flexible ureteroscope; In-vivo and in-vitro assessment and cost effective analysis

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**Introduction**
The single use digital flexible ureteroscope (fURS), the LithoVue is an evolution in fURS design. We aim to measure the capability of this instrument in-vivo, in-vitro, and to compare it to standard FURS scopes in regard to manoeuvrability and cost effectiveness.

**Methods**
The LithoVue was examined and compared to Olympus URF-V and Storz Flex Xc instruments. LithoVue scopes was used in 3 patients for the treatment of renal calculi. Finally, a study of standard FURS usage at our institution was performed for to assess the cost effectiveness of reusable instruments.

**Results**
Flexion of the LithoVue is 285°, the URF-V is 180° and the Flex Xc is 283°. Deflection for the LithoVue is 286°, the URF-V is 270° and the Flex Xc 219°. Superior range of movement of the LithoVue was maintained in both directions with an assortment of instruments in the working channel. The LithoVue then demonstrated acceptable ergonomics, manoeuvrability and image quality in-vivo treatment of renal stones in 3 patients. Cost analysis of 265 consecutive fURS procedures, revealed 15 occasion’s major damage, costing $162,628 AUD. Meaning the median cost per case is $695 AUD. The cumulative cost of 28 cases with reusable FURS is approximately $50,000 AUD.

**Conclusion**
The LithoVue single use flexible ureteroscope that is analogous to reusable fURS scopes in regard to standard technical metrics. In 3 patients it performed commendably. Depending on its initial purchase cost it may also represent a cost saving for hospitals when compared to cumulative costs of maintaining reusable FURS.

**Poster 35**
Mini-PCNL: More than tract size

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**Introduction**
Mini percutaneous nephrolithotomy (mPCNL) has been a treatment option for decades. Despite advantages, uptake has been slow. This may be due to the fact that no mPCNL sets existed. This has changed with the new MIP system. The aim of this study is to evaluate MIP system in the Australian environment.

**Methods**
Consecutive patients undergoing mPCNL procedures with the MIP system were enrolled. Patient position, ASA classification, puncture location, stone clearance, post-operative drainage and complications were recorded, and features unique to MIP were noted.

**Results**
30 patients underwent 32 mPCNL procedures. Mean stone size was 17mm IQR (10.75 - 21.25) and the mean number of stones was 1 IQR (1-2). Stone clearance rate was 96.5%, IQR (95 – 100). Complication rate was 9.3%. No patient required a transfusion. In addition to these outcomes, we noted that that MIP system has many advantages over cPCNL. It is easy to learn, can be performed in both supine
and prone positions. It is safe for supra-
costal puncture, provides excellent
access to nearly all calyces and upper
ureter, has multiple stone treatment
options, can be used as an adjunct
to conventional PCNL and can be
performed as a tubeless procedure.

Conclusion
Our experience with the MIP system
has demonstrated several advantages
over conventional PCNL. mPCNL with
MIP system has several features that
suggest it should be considered as an
alternative or adjunct to conventional
PCNL, ureteroscopy and ESWL.

Poster 36
Changing trends
in Percutaneous
Nephrolithotomy (PCNL)
patients
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Introduction
Percutaneous Nephrolithotomy
(PCNL) is the preferred method for
management of large (>2cm) renal and
upper ureteral stones. Evolution of this
surgical technique has led to a minimally
invasive alternative, the mini-PCNL.

Methods
We compared our experience of both
techniques from January 2014 - present
with the introduction of a mini-PCNL
technique from May 2015 onwards. The
primary outcome was rate of successful
stone clearance. Secondary outcomes
were post-operative length of stay and
postoperative morbidity. We employed
a paired student t-test with a P value
<0.05 considered statistically significant.

Results
29 patients were identified (M20:F9),
16 mini-PCNL and 13 conventional
PCNL. The mean age in the mini-PCNL
group was 58.2 (range 17-76) versus
52.1 (range 33-73). Mean stone size in
mini-PCNL group was 27.1mm (median
= 25mm) versus 26.4mm (median =
23mm). Stone clearance was achieved
in all cases in the mini-PCNL group
compared to 92% in the conventional
group. The average post-operative
length of stay in the mini-PCNL group
was 3 days (median = 3, range 1-6 days)
versus 4.8 days (median = 5, range 3-7
days). (t = 3.74, df = 12, p = 0.003). This
result was statistically significant. 30-day
readmission rates were 6% (mini-PCNL)
and 8% (conventional) respectively.
2 wound infections were observed in
the conventional group. No bleeding
complications necessitating blood
transfusion or mortality were observed
in either group.

Conclusion
We observed a higher rate of successful
stone clearance through mini-PCNL with
a statistically significant shorter post-
operative length of stay.

Poster 37
A snapshot review of Urology
training – a single center 12
month study
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Brady
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Introduction
The introduction of the European
Working Time Directive, as well as
increasing numbers of mandatory
training days and theatre closures
(introduced in 2011) has raised concerns
as to how trainees will achieve surgical
competency. The aim of this study
was to identify changes in numbers
of procedures being performed over
a seven year period, in particular
with relation to core urology training
procedures.

Methods
A retrospective review was performed
using theatre logbooks to determine the
number and type of procedures
performed during 2009, 2011 and 2016
(555) and 2011 (443). This number
however increased by 41% when we
compared 2011 to 2016 (628). This
increasing number is likely due to the
appointment of a new Consultant
Urologist and an associated increase in
theatre sessions from 2.5 per week to
four per week. There is similar increase
in 'core urology training procedures'.
This number appears to be largely due
to an increased number of paediatric
cases such as circumcisions and
orchidopexies (see table 1). The number
of certain procedures such as TURPs and
orchidectomies have declined during
this time – with 56% less TURPs being
performed in 2016 as there was in 2009
(14, 32), and 66% less orchidectomies
(6, 18).

Conclusions
There is a concerning decrease in the
exposure of trainees to certain core
procedures. Care should be taken to
help trainees achieve competence
in these areas. Options to improve
exposure in these areas should be
investigated.

Table 1. Numbers of core urology
training procedures.

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<tr>
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<td>TURP</td>
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<td>23</td>
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<td>Ureteroscopy</td>
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<td>34</td>
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<tr>
<td>Epididymal cyst excision</td>
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<td>1</td>
</tr>
<tr>
<td>Orchidectomy</td>
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<td><strong>Total:</strong></td>
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</table>
Poster 38
Career intentions of trainee Urologists in Ireland
AU Nic an Righ1,2, KJ Breen1, 2, P Stassen1, S Omer1, 2, MA Abdelrahman1, 2, P Sweeney1, EA Kiely1, K O’Connor1, MF O’Brien1, CM Brady1, 2
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Introduction
Workforce planning is essential in all surgical specialties. In Ireland, most trainees pursue a fellowship at the end of their surgical training in order to increase knowledge and to improve competency with surgical techniques.

The aim of this study was to assess Urology trainees’ career intentions and to determine the factors that influence trainees in this regard.

Methods
A 10-item, self-administered questionnaire survey was distributed to all specialist registrars in Urology in Ireland.

Results
16 completed responses were received (84.2% response rate).

81% (n=13) of those surveyed had already chosen a subspecialty area(s) of interest. Uro-Oncology was the most popular, with 69.2% (n=13) of trainees interested in pursuing a career in this area. This was followed by endourology and reconstruction with 18.75% (n=3) interested in a career in each of these specialties.

When surveyed on reasons for choosing a particular subspecialty 62.5% (n=10) reported that exposure to the specialty was a major influencing factor, followed by variety of operations (n=6), enthusiastic trainers (n=5) and personal interest (n=5).

All respondents wanted to complete a fellowship and Canada and Australia were the most commonly chosen areas.

Conclusions
An understanding of trainees’ career intentions is useful for both career decision making and workforce planning. This study highlights the importance of exposure and enthusiastic trainers in subspecialty selection. It raises the point that trainees should get adequate exposure to all subspecialties during training – this may help to increase the number of trainees pursuing careers in less popular areas such as paediatric urology, female urology and andrology.

Poster 39
The application of the RENAL nephrometry score to an Irish population
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Introduction
The Renal Nephrometry Score is an anatomical classification system for renal masses. The RENAL score has been shown to predict the incidence of post-operative complications a partial nephrectomy. The aim of our study was to assess the predictive ability of the RENAL score in an Irish population.

Methods
A retrospective analysis was carried out of 52 patients who underwent an open partial nephrectomy from 2011 to 2016. Theatre logbooks and the HIPE database were used to identify all patients who underwent an open partial nephrectomy at our institution under a single surgeon. A RENAL score was calculated for patients using their available imaging. Patient records were analyzed for information regarding complications.

Results
All 52 patients had a RENAL score calculated. Of these patients, there were 36.5% low (n=19), 55.7% (n=29) intermediate and 7.6% (n=4) high score lesions. There was no significant difference in operative parameters such as cold ischemic time and estimated blood loss across the three groups. Morbidity in our cohort was low and included bleeding warranting further procedures (n=1), perinephric collection (n=4), wound infection/dehiscence (n=2). There was no significant difference in complication rates across all 3 groups.

Conclusions
The RENAL score is a valuable tool for delineating renal tumour anatomy and this can aid surgical decision making. It can also help us counsel patients better with regards to expected post-operative complications.

Poster 40
Expanding the indications of robotic urological surgeries beyond the prostate - An initial Irish experience with the dual-console Da Vinci Xi* surgical system
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2University of Limerick, Ireland

Introduction
The landscape of the surgical management of urologic conditions has dramatically changed in recent times, both for benign and malignant pathologies. The benefits of Robotically-Assisted Radical Prostatectomy have been well documented1, 2, but little has been published nationally regarding the benefits of robotically-assisted urologic procedures beyond the radical prostatectomy. We report our initial experience with a variety of non-prostatic urological procedures utilizing a dual-console Da Vinci Xi* surgical system.

Methods
Analysis of our robotically-assisted urology cases was performed from a prospectively maintained database. Data were collected by independent third party. The dual-console Da Vinci Xi © Surgical Robot* was utilised for all cases. The type and number of procedures were recorded, along with patient demographics, length of stay, and morbidity and mortalities as per the Clavien-Dindo classification.

Results
A total of 37 procedures were performed within the initial 9 months. The median patient age was 64. The median ASA score was 2 and median length of stay was 4 days. There were 20 partial nephrectomies, 11 radical nephrectomies, 2 Anderson-Hynes pyeloplasties, 2 adrenalectomies...
(1 transperitoneal and 1 retroperitoneal), 1 radical nephro-ureterectomy with bladder cuff excision and 1 ureterectomy with bladder cuff excision. The median estimated blood loss was 75ml. One procedure was converted to open. Two procedures were performed utilising the dual console platform. 3 patients experienced Clavien-Dindo Grade 2 Complications. There were no Grade 3 or above complications.

Conclusion
Our study shows that robotic-assisted surgery can be safely implemented beyond radical prostatectomy and the indication and scope of robotic urological surgery is likely to expand further.

References
* (Intuitive Surgical Ltd, CA, USA)

Poster 41
Incidence of renal cell carcinoma in Ireland: a 10 year review
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1 University Hospital Waterford, Waterford, Ireland

Introduction
Kidney cancer is the 16th most common cause of cancer-specific death worldwide. Renal cell carcinoma (RCC) incidence rates are higher in developed countries, where up to half of the cases are discovered incidentally. More recent studies have shown that incidence levels are on the incline globally with a decline in mortality in only a few developed countries but Ireland has shown an increase in both incidence and mortality (1).

Methods
Data on all histologically confirmed primary adenocarcinomas of the kidney according to the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) were collected from the database of the National Cancer Registry of Ireland (NCRI) from 2003 to 2013. Age adjusted rates for the general population were conducted using age specific population data.

Results
There were 3,801 renal adenocarcinomas diagnosed over the 10 year period. Almost a third of tumours were found incidentally (1103/3801). Age adjusted incidence rates for both male and females increased from 6.64 to 9.38 per 100,000 over 10 years with an APC (annual percentage change) of +3.5%. The number of pT1 tumours has risen from 39.7% to 48.6%. Age-standardised mortality rate increased from 1.07 per 100,000 in 2003 to 4.32 per 100,000 in 2013, an annual percentage change of +15%.

Conclusion
Our findings have shown over the past 10 years in Ireland the continuous increase in the incidence of renal cell carcinomas as well as the rising levels of incidental tumours. While the increased incidence of RCC in Ireland can be attributed somewhat to the increased use of imaging the rise may also be influenced by the significant rise in modifiable risk factors as seen in other developed countries.

References

Poster 42
Outcome of laparoscopic nephrectomy in lateral decubitus position without table flexion using 5mm telescope via a 5mm port
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Objective
Laparoscopic nephrectomy (LN) in lateral decubitus position without flexion (LDPWF) can potentially minimize risk of patient position related complication during operation. Furthermore use of 10 mm port for telescope increases operation time and potentially increases risk of incisional hernia. Thus aim of our study is to investigate feasibility and safety of LN in LDPWF using 5mm telescope.

Methods
We retrospectively reviewed peri-operative outcome of patients who underwent LN in LDPWF using 5mm telescope it our institution between April 2013 - March 2016. Data collected from histopathology database, HiPE (hospital in-patient entry) database, chart review and theatre log book review. Our outcome measures are incidence of position related complications, duration of operation, visibility, blood transfusion, open conversion, intra-operative and post-operative complications and incisional hernia.

Results
Total of 128 patients who underwent LN using 5mm telescopes. Median operation time was 3 hours. One converted to open. In 90% cases histology was renal cell carcinoma (pT1 – pT3) with no positive margin. Remaining 10% were benign. Lesion size varied from 20-115mm. Median length of stay was 5 days. 8% received blood transfusion. There were no Clavian 3 or more complications or position related complication. No incisional hernia were noted during follow-up.

Conclusion
LN in LDPWF using 5mm telescope via 5mm port is an effective and safe approach. It has the potential to reduce patient positioning time, port closure time and can potentially avoid complication associated with table flexion and port-site hernia.

References
1 Glassman DT, Merriam WG, Trabulsi EJ, Byrne D, Gomella L. Rhabdomyolysis after laparoscopic nephrectomy. JSLS
Follow up, 14 (23%) require 1 pad, 4 (6.6%) require 2 or more pads. One (1.6%) has had it deactivated and uses a condom catheter and 4 (6.6%) have had subsequent urinary diversions. 16 (26.2%) patients required a revision or replacement procedure.

Conclusion
The artificial urinary sphincter provides a durable and predictable solution to the very disabling problem that is moderately-severe, stress urinary incontinence.

PODIUM SESSION 4: GENERAL UROLOGY
Ventral approach Urethroplasty: 7 year outcomes from a tertiary referral centre

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Introduction
Urethral stricture disease is an uncommon pathology with an incidence of 0.9%. Reconstruction remains a specialised field, and is typically concentrated in high volume centres. Specific to our centre the ventral onlay technique is used when using buccal mucosal or prepuceal grafts for both bulbar and penobulbar strictures.

Methods
All patients who underwent ventral urethroplasty over a 7 year period were studied. We examined type of graft used, complications, compliance with endoscopic follow up at 2 years and failure rate: defined as the need for urethrotomy, dilatation or formal redo urethroplasty within 2 years following initial procedure.

Results
A total of 191 cases were performed. The majority underwent buccal mucosal graft placement (187, 97.9%). Two year endoscopic follow up was available for 141 cases (73.8%) with 33 patients (17.2%) having < 2 year follow up. The cumulative failure rate was 3.6%. 7 required intervention; 2 urethrotomies, 3 redo urethroplasties, 1 dilatation and 1 was managed conservatively. 12 patients (6.2%) were lost to follow up. Complications were noted in 24 patients (12.5%): 6 patients with ejaculatory difficulties, 4 with UTI's, 2 bladder stones, 2 scrotal dysaesthesias and 2 with oral numbness > 6 months. Voiding dysfunction was present in 2 patients, 1 patient developed unlar nerve palsy and 1 developed perineal pain. 4 developed urethral benign pathologies. One patient had an incidental detection of a urethral neoplasm.

Conclusion
Ventral approach urethroplasty is a successful method with a cumulative failure rate of 3.6% and represents another method of graft placement with results comparable to larger series.

Sacral Neuromodulation for detrusor hyperactivity with impaired contractility

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Introduction
Detrusor hyperactivity with impaired contractility (DHIC) is a challenging condition to manage. Sacral neuromodulation (SNM) is a proven treatment modality for both the individual aspects of DHIC. To date, data reporting the outcome of SNM for DHIC is lacking.

Methods
Consecutive patients undergoing SNM for DHIC were followed prospectively, from April 2013 to October 2016. Patient demographics, bladder diaries, subjective response rates, ICIQ-OAB and PGI-I scores were recorded. Success was defined as greater than 50% improvement in storage symptoms and a 50% improvement in voided volume or reduction of post-void residual volumes.

Results
20 patients underwent stage 1 trial of SNM for DHIC. Median age was 68.5, IQR (54.25 -76.25). 13 (65%) patients were female.
14/20 (70%) of patients had a significant treatment response, 9/20 had a response to both elements of DHIC, 4/20 patients had a response to the detrusor overactivity (DO) alone and 1/20 had a response to the voiding component alone. 12/20 (60%) patients proceeded to insertion of an IPG. At mean follow-up of 17 months, IQR (1.5 – 35), 11/12 (91.7%) of patients are still using the SNM for DHIC. Median PGI score is 2, IQR (2 – 4). SNM for DHIC resulted in statistically significant improvements in voided volume (p=0.016), PVR (p=0.0296), ICIQ-OAB score (p<0.0001) and ICIQ-OAB bother score (p=0.016) 

Conclusion
This is the first study we know of to report the results of SNM for DHIC. SNM is associated with satisfactory success rates, treating both the detrusor hyperactivity, and impaired contractility components of this condition.

The effect of optimum bladder management on the prevalence of urinary tract infections in spinal cord injury patients

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2 Department of Urology, Austin Health, Heidelberg, Victoria, Australia

Introduction
Correct long term bladder management is key in reducing the rate of urinary tract infection (UTI) in spinal cord injuries (SCI) patients. The aim of this study was to determine which method of bladder drainage was associated with the lowest incidence of UTI.

Methods
Data was collected on new 143 SCI patients admitted to the Victorian Spinal Cord Service. Data included, patient characteristics, injury data, bladder management and diagnosis of UTI. IDC were the initial bladder management, when possible patients were converted to intermittent catheterisation (IC) or suprapubic catheter (SPC).

Results
58 (40%) of patients developed 1 or more UTI. 51 (49%) of male patients developed a UTI, whereas 7 (18%) of female patients developed a UTI. The change in incidence rate of UTI for IDC vs. long-term bladder management (IC and SPC) was 1.61 to 0.76 per 100 person-days. Removing the IDC resulted in a significant reduction in symptomatic UTIs when compared with all other bladder management. (p=0.001). The change in incidence rate of UTIs for IDC vs. IC was 1.65 to 0.83 per 100 person-days. IC resulted in a significant drop in symptomatic UTIs diagnosed. (p=0.018). The change in incidence rate of UTIs for IDC vs. SPC was 1.42 to 0.52 per 100 person-days. Changing from an IDC to an SPC also resulted in a significant reduction in symptomatic UTIs. (p=0.004).

Conclusion
This study highlights the importance of removing IDC and switching alternative long-term bladder management in SCI patients. Both IC and SPC significantly reduced the number of symptomatic urinary tract infections diagnosed.

Blunt Renal Trauma: Validation of a conservative follow-up imaging strategy

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Introduction
AUA guidelines suggest that follow-up imaging post-renal trauma is not routinely required for American Association for the Surgery of Trauma (AAST) grade I-III renal injuries but early CT imaging is prudent for grade IV-V renal injuries. Our aim was to determine the yield of follow-up imaging in patients sustaining renal trauma at our major trauma unit and prospectively validate a new conservative follow-up imaging strategy.

Methods
All patients who attended Cork University Hospital with a diagnosis of blunt renal injury from 1999-2016 were included. Relevant patient demographics, operative records, complications, date and results of all imaging were reviewed. Injuries were graded by a radiologist using the AAST Organ Injury Scale and were grouped as low-grade (I, II, III) or high-grade injuries (IV, V). We correlated clinical outcomes with repeat imaging results. A new conservative follow-up imaging strategy was introduced in 2012.

Results
One hundred and fifty patients (155 renal units) were identified, 86% were male. Low-grade injuries accounted for 69% of cases, all were managed conservatively with a complication rate of 3%. Forty-four patients (31%) had high-grade injuries; 3 cases required nephrectomy and 1 case required angio-embolisation, 91% were managed conservatively with a complication rate of 17%. All patients with complications were symptomatic, prompting repeat imaging. Results of routine repeat imaging did not independently predict any complication or prompt urologic intervention. Following the introduction of a conservative follow-up imaging strategy in 2012, we have safely reduced CT reimaging in high grade injuries by 41% (p=0.018).

Conclusion
Routine follow-up imaging for renal injuries grades I-III is unnecessary in the absence of clinical deterioration. Follow-up imaging of high grade renal injuries (IV, V) should be guided by the presence of urine extravasation in addition to clinical and laboratory criteria. AUA guidelines are clinically appropriate in a major tertiary trauma unit in Ireland but can be tailored further to reduce repeat CT imaging of Grade IV renal injuries.

Urotrauma in pelvic and acetabular fractures: ten-year audit of a national referral center

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2Department of Trauma and Orthopaedics, Tallaght hospital, Dublin, Ireland
3Department of Surgery, Trinity College Dublin, Ireland
Introduction
Urotrauma can be fatal and lead to long term disability, 80% is associated with pelvic fractures.

Methods
A retrospective review of urotrauma in pelvic fractures was performed from January 2006 to December 2016 in a national pelvic trauma center in Ireland. Pelvic fracture referrals over the year 2016 were reviewed for adherence to guidelines.

Results
Incidence of urotrauma was 2.7% (n=31/1141). Commonest injury was urethral (55%), followed by bladder (29%) and renal (16%). Median patient age was 45 years (19-85 years) and the male:female ratio was 2.5:1. Mechanism of injuries included road traffic accidents (n=14, 44%), fall from a height (n=8, 25%), agricultural/industrial accidents (n=5, 16%) and self-harm (n=3, 9.3%). Urethral injuries were commonly associated with Anterior Posteriror Compression and Lateral Compression (LC) pelvic fractures, bladder injuries were more likely associated with LC injuries (67%), renal injuries occurred LC and associated acetabular fractures. Out of 175 pelvic fracture referrals in 2016, in 9/19 (n=5 frank haematuria, n=4 microscopic haematuria, n=1 trauma imaging) patients with suspected urotrauma further urological imaging was not performed.

Conclusion
Urotrauma is rare in pelvic fractures and is associated most commonly with lateral compression injuries. There was poor adherence to guidelines in pelvic referrals with regards to identification/documentation of clinical signs and specific urological imaging. This could lead to missed injuries and potential long-term morbidity.

A multi-centre cohort study evaluating the role of inflammatory markers in patients presenting with acute ureteric colic (MIMIC)

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2 British Urology Researchers in Surgical Training, London, United Kingdom
3 University College London Hospital, London, United Kingdom

Introduction
There is conflicting evidence on the role of raised inflammatory markers in acute ureteric colic and spontaneous stone passage. MIMIC aimed to assess whether white blood cell (WBC) count at presentation is associated with likelihood of spontaneous stone passage.

Methods
Design: Multi-centre cohort study in 71 centres
Primary Outcome: Spontaneous stone passage (SSP)
Inclusion criteria: Acute renal colic with CT-KUB confirmed ureteric stone.

Follow up: 6 months

Results
Of 4181 patients, 75% (n=3127) were discharged with conservative management. 80% (n=2516) had a confirmed outcome. Overall SSP rate for this cohort was 74% (n=1863).

WBC was not significantly associated with SSP on either univariate or multivariate analysis (adjusted OR 0.99 [95% CI 0.99-1.00], p = 0.527).

The strongest predictors of SSP were stone size (OR 0.57 [95% CI 0.53-0.61], p=0.00001) and position (OR 3.31 [95% CI 2.60-4.22], p=0.00001). Stone clearance rate was 84% and 42% for stones measuring 0-5mm and ≥6mm respectively. Stone clearance rate was 51%, 69% and 83% for proximal, mid and distal ureteric stones respectively.

Conclusion
MIMIC is the largest contemporary cohort assessing outcomes from acute ureteric colic. Our data shows that WBC should not be used to influence decisions on whether to discharge or perform intervention. However, stone size and position should inform clinical decisions. This data will be used to develop a risk calculator predicting spontaneous stone passage.

PODIUM SESSION 5:
PROSTATE CANCER:
TREATMENT

Positive Surgical Margins
Post Radical Prostatectomy:
Influences and Implications
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Introduction
Presence of positive surgical margins (PSMs) in prostatectomy specimens is associated with increased biochemical recurrence. We aimed to assess local rates of PSMs and evaluate implications on outcome.

Methods
A 5-year retrospective review of radical prostatectomies performed by a single surgeon was performed. Pathology reports were reviewed, determining margin status, pTN stage and Gleason score. Positive surgical margins were classified as focal (<3mm margin involvement;≤2 locations) or extensive (≥3mm/multifocal).

Results
A total of 144 radical prostatectomies were performed 2011-2016 (143 open, 1 laparoscopic). Mean follow up was 22.8 (3-61) months. The overall rate of margin positivity was 29.86% (43/144). Of the PSM group, mean preoperative PSA was 12.28 (4.1-76.7); 30.23% (13/43) had pT2 and 69.77% had pT3 tumours. Surgical Gleason 7 was recorded in 67.44% (29/43), and 69.77% had pT3 tumours. Surgical Gleason 7 was recorded in 67.44% (29/43), Gleason 8 in 11.63% (5/43) and Gleason 9 in 18.6% (8/43) of the PSM group. Of 39 patients with positive margins and available follow up data, 20.5% (8/39) experienced biochemical recurrence and 79.5% (31/39) are disease free, of whom 32.26% (10/31) received adjuvant therapy.
radiotherapy. Of patients with negative margins, mean pre-operative PSA was 8.72 (3-24.8). Gleason score was 7 in 72.28% (73/101), Gleason 8 in 6.93% (7/101) and Gleason 9 in 9.9% (10/101) of this R0 resection group.

Conclusion
Higher rates of PSMs are seen in patients with other predictors of aggressive disease. Despite this, overall rates of biochemical recurrence appear relatively low, even in the absence of adjuvant therapy. No clear difference was demonstrated in outcomes based on extensive versus focal margin involvement.

References

Clinicopathological features of prostate cancer diagnosed in Irish men aged less than 50 years between 2006-2016

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Introduction
While prostate cancer is primarily a disease of older men, prostate cancer in younger men represents an important clinical subgroup which has not been adequately studied in an Irish cohort. We evaluated the clinicopathological features of prostate cancer diagnosed in men aged less than 50 years in a single institution over a 10 year period.

Methods
We retrospectively reviewed all men aged less than 50 years diagnosed with prostate cancer in our institution between 2006-2016.

Results
117 men in total were identified with a mean age of 47.9 (+/- 2.6) years at diagnosis. The mean PSA was 7.6 (+/- 8.8) ng/ml. One man was diagnosed following TURP and the rest following TRUS biopsy. The majority of tumours were Gleason Score (GS) 3+3 (37.6%) or GS3+4 (43.6%) while GS4+3, GS 4+4, GS4+5 and GS5+4 comprised 10.3%, 5.1%, 2.6% and 0.9% of cases respectively. The pathology was adenocarcinoma in all cases. 17.1% of men had clinically palpable disease (T2) at diagnosis. 8.5% of men had a family history of prostate cancer. Perineural invasion was present in 35% of cases whereas, lymphovascular invasion was present in 0.9% of cases. There was evidence of extraprostatic extension in 1.7% of biopsies. Overall, 53% and 10.3% of men in the cohort were classified as D’Amico intermediate or high risk disease respectively.

Conclusion
While prostate cancer is unusual in men aged less than 50 years of age, when diagnosed in our cohort, the majority were found to be D’Amico intermediate or high risk disease.

Active Surveillance for low risk prostate cancer in the Mater Misericordiae University Hospital: a 5 year experience

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Introduction
Active surveillance is an effective management option for men with low risk prostate cancer, which entails initial expectant management rather than immediate treatment. Our aim was to describe utilisation of active surveillance (AS) in men diagnosed with low risk prostate cancer at our institution.

Method
A prospective database was maintained of all men seen in the Rapid Access Prostate Clinic since January 2010. Data collected included demographics, PSA levels, biopsy results, and treatment plans.

Results
The database included 204 patients. Ages ranged from 42 to 77 (mean of 63). The mean period of follow up was 34.2 (5-64 months). Cancer specific and metastases free survival was 100%. 136 (67%) are still undergoing AS.

Initial PSA ranged from 0.7ug/L to 25ug/L (mean: 7.3ug/L). 23 patients had initial PSA readings of over 10ug/L of these 14 (60.8%) are still undergoing AS. 32 patients (16%) had Gleason 3+4 disease on their initial biopsies, 17 of which are still undergoing AS.

33 patients underwent Radiotherapy. 24 underwent radical prostatectomy; (14 pt2, 4 pt3). Final grading on surgical specimen: 4 grade (3+3), 12 grade 7(3+4) and 2 grade 8 (4+4). One procedure was abandoned, 5 went for surgery elsewhere.

Of the 14 who underwent prostatectomy in our institution, 2 patients had biochemical recurrence, 1 of whom required salvage radiotherapy.

Conclusions
Active surveillance is a safe treatment option for patients with low to intermediate prostate cancer, and can be used in carefully assessed patients with low volume Gleason 3+4 prostate cancer.
Adjuvant versus Salvage Radiotherapy Post Radical Prostatectomy: A Single Centre 5-Year Review

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Introduction
Much debate exists regarding optimal timing of radiotherapy post surgical management of prostate cancer. We aimed to review institutional trends and outcomes relating to radiotherapy in adjuvant versus salvage settings post radical prostatectomy.

Methods
A five-year retrospective review of radical prostatectomies was conducted (2011 – 2016). All patients referred for radiotherapy following prostatectomy were identified. Timing of radiotherapy, indications for administration, and outcomes were recorded.

Results
144 radical retropubic prostatectomies were performed. Twenty-nine surgical patients (20.14%) were referred for radiotherapy 20.14% (29/144). Of this group, 58.62% (17/29) were referred for adjuvant, and 41.38% (12/29) for salvage radiotherapy. Mean follow up from time of radiotherapy was 27.94 months. Indications for adjuvant radiotherapy following MDT discussion were multifactorial. They included N1 status (23.52% (4/17)) and positive surgical margins (76.47% (13/17)), alongside Gleason score ≥8 (47% (8/17)) and pT3 tumour stage (76.47% (13/17)). Of the adjuvant group followed up (n=15), 73.33% (11/15) are disease-free and 26.67% (4/15) experienced subsequent recurrence and alive with disease. Salvage radiotherapy was indicated due biochemical recurrence in 12 patients. Salvage group variables were R1 resections (41.67%, 5/12), surgical Gleason ≥8 (58.34% (7/12)) and pT3 tumour stage (66.67% (8/12)). Of patients post salvage therapy, 77.78% (7/9) are disease free and 2/9 (22.23%) lost to follow up.

Conclusion
Preliminary results suggest good outcomes with use of radiotherapy in the salvage setting. Salvage group patients had less adverse prognostic factors than those given adjuvant therapy, however. Further research is required to guide formation of clear patient selection criteria for each approach.

References

Complications of Robot Assisted Laparoscopic Prostatectomy

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Introduction
Robot assisted laparoscopic prostatectomy (RALP) is becoming the leading surgical treatment for prostate cancer. Oncologic and functional outcomes are frequently reported however, our interest was to assess the safety of RALP. The specific aim of this study was to audit the complications in men undergoing RALP at our institution.

Methods
A prospective database was kept of all patients undergoing RALP. Information recorded included clinico-pathologic features, functional outcomes and complications.

Results
Between 2010 - 2016 we performed 900 RALP. This included patients with high risk disease, elevated BMI and previous pelvic/prostatic surgery. 90 patients (10%) suffered some form of complication. There were no mortalities in the first 90 days post-operatively.

There were four rectal injuries identified and repaired intra-operatively. Two cases early in the series (9, 25) were converted to open.

26 patients (2.8%) had Clavien-Dindo I complications. 23 patients (2.5%) had Clavien-Dindo II complications including two pulmonary emboli and five wound infections. Five patients required blood transfusion (last being case 588).

Six patients returned to theatre for emergency intervention including an obturator vein injury, a rectal injury and anastomosis re-do. One patient presented with a vesico-rectal fistula two weeks post-operatively and underwent fistula repair, re-do anastomosis and colostomy formation.

Late complications included port-site hernia (n=10), bladder-neck contractures (n=3), and urethral stricture (n=15). Sling...
procedures were performed in 16 patients, and six required artificial urinary sphincter insertion.

**Conclusion**
Although minimally invasive, RALP is a major procedure, associated with potentially major morbidity. Complications occur even in experienced hands but appear to be higher in the first 500 cases. Caution is urged as the clamour to establish robotic programs and to ascend the learning curve grows.

**Robotic-assisted Laparoscopic Radical Prostatectomy in men with a pathological prostate weight greater than 100 grams**
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**Introduction**
Robotic-assisted laparoscopic prostatectomy (RALP) is rapidly becoming the treatment modality of choice for localised prostate cancer. Greater prostate size is often associated with a technically more difficult procedure, peri-operative complications and poorer functional outcomes. Thus alternate therapies are frequently chosen as a first line approach. However these are not without their own complications, both functional and oncological. We aim to show that the use of RALP as primary treatment of choice is a safe and effective treatment for cancer in very large glands.

**Method**
A single surgeon series of prospectively collected data on 635 men who had RALP was reviewed. From this cohort, clinico-pathological data was collated from men with a pathological prostate weight ≥100g. Pre-operative staging was negative for metastatic disease.

**Results**
18 (2.9%) men in total had a pathological prostate weight ≥100g. Pre-operative PSA levels ranged from 3.8 to 16ng/ml. Mean patient body mass index was 28.8 kg/m2. 3 (16.7%) had a Gleason grade of 8-10 on pre-operative biopsy. A median lobe was identified in 5 cases (27.7%). Average prostate weight was 124g (range 102-212g).

Mean intra-operative blood loss was 286mls (range 50-700mls). One post-operative complication was recorded (Clavien Dindo Grade 3b).

The mean Gleason grade of 7 (range 6-10) was the same on pre and post-operative pathology. 14 (78%) were T2 and 4 (22%) were T3 on final pathology. Four patients (22%) had positive margins, all were focal (<3mm) and all involved the apex. Mean pathological tumour involvement was 15% of the gland (range 5-60%). All patients were N0 and M0 on post-operative staging.

Mean follow-up was 22.9 months (range 2-60 months). At most recent follow-up the PSA was detectable in 4 (22%) men. Of these, three have received adjuvant treatment; 1 received only chemotherapy, 1 radiotherapy and hormones, and 1 radiotherapy and chemotherapy. Fifteen patients are completely dry, with 3 (16.7%) still relying on pads. Erectile function had returned spontaneously in 1 patient, and was satisfactory in 4 with adjuncts.

**Conclusion**
Large Prostate Size is not synonymous with high-risk disease, and thus RALP is a suitable primary treatment option in men with large prostates. This avoids the side effects associated with other treatments as well as providing satisfactory peri-operative and long term functional and oncological outcomes.
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