

Yorkshire
Urology
Audit
Group
2023
Abstracts Booklet



Analgesia Use in Ureteric Colic

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Introduction:

Urinary tract stones accounted for 25% of emergency admission to urology department with severe abdominal and loin pain. NICE and BAUS recommended NSAIDs as first line analgesia as study had shown it is more effective than morphine with lesser side effect profile. Aim: This retrospective audit aimed to review the percentage of patients who have NSAID prescribed as first line analgesia in the absence of contraindications.

Method:

Patients presented acutely with CT proven urinary tract stones to the emergency department between February to June 2023 were included in this audit by screening through PACS. Data collected included, age, stone location, analgesia use.

Results:

In total 53 patients presented acutely with renal colic over 4 months. 72% are male patients, average age of 54 years old. 75.5% (n=40) has NSAID prescribed as first line analgesia. Within this cohort of patients 19 has NSAIDs only, 9 has NSAIDs + paracetamol combination, 12 has NSAIDs + paracetamol + opioids combination. Of the 24.5% (n=13) that does not have NSAID as first line analgesia, 5 has paracetamol only, 7 has opioids only and 1 has paracetamol and opioids combination.

Conclusions:

While majority of patients had been given NSAID as first line analgesia, further room for improvement should be identified to improve analgesia use in patients presented with renal colic. Recommendations suggested included creating a renal colic analgesia tab on the electronic Prescribing and Medicine Administration. Further re-audit can be done to investigate the relationship between analgesia use and admission rate.

Minimizing Radiation dose in non-Contrast CT KUB for Ureteric Colic Audit

Authors: Dr Farhan Jarra Dr Abdelrahma Hamdy

Institution: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Background:

Renal/ureteric colic is a common condition with an annual incidence of 1–2 cases per 1000 people and a high recurrence rate. CT KUB is a commonly performed procedure in emergency departments as it is first-line test in suspected renal colic. However, with the increased use of ionizing radiation in medical practice it is important to assess if these modalities are used appropriately.

Our Aim:

To assess current local practice in CT KUB imaging alongside national data aimed at minimizing the radiation doses & adherence to accepted practice.

Method:

We underwent a retrospective analysis of 104 non-contrast CT KUB in July 2022 for patients with suspected renal/ureteric colic. PACS images were individually reviewed to assess the cranial level at which scan commences & level at which kidneys start. Data was collected and radiation Doses monitored in milliGrey (mGy) (standardized measure of radiation dose output of a CT scanner)

Results:

A total of 104 non-contrast CT KUB was included where 50 (49%) scans commenced from superior border of T10- T12 Level & 52 (51%) of scans commenced above T10- T12 Level. A further 1% started below T12 level. Only 1% (1) of scans showed upper poles of left kidney above T10. Individuals scanned at T10 or below (50/104) received on average 6.9mGy of radiation while individuals scanned at levels above T10 (52/104) received on average 9.82mGy of radiation.

Conclusion:

Our results show 51% of scans have commenced above the recommended level (T10) in CT KUB imaging exposing individuals to higher amounts of radiation on average than individuals who were scanned at the accepted level of T10.

Subsequently our data has shown that individuals scanned at T10 or below were closer to the national recommended dose of radiation published by NDRL (National Diagnostic reference levels)

Suggested change:

1. Liaise with Radiology department and present our audit to CT radiographers to assess DNR level for CT KUB.
2. To improve compliance of CT KUB to the guidelines
3. Complete audit loop in a few months

References:

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Collaborative audit to evaluate the regional prevalence, diagnosis and management of patients with cystinuria

Authors: Mr Sabir Mohammad (1), George Sturgess (2), Dr John Stoves (1), Mr Matthew Young (2), Mr James Forster (1)

Institution: Bradford Teaching Hospitals NHS Foundation Trust (1), Mid Yorkshire Teaching Hospitals NHS Trust (2)

Introduction:

Cystinuria is a rare autosomal recessive abnormality of transmembrane cystine transport/absorption, causing 1-2% of renal stones. The EAU recommends urine dilution and alkalinisation, and tiopronin in selected patients. A collaborative audit was suggested by the Yorkshire Urolithiasis Group to investigate regional prevalence and consistency/variance of clinical management.

Patients and methods:

A retrospective review was undertaken of all cystinuria patients seen in two centres since 2013. Patients' medical records and imaging were accessed to gain information regarding investigations, admissions, interventions and medical treatment.

Results:

Fifty one patients were identified, 48 had analysis of complete datasets. Twenty one were females, 27 males. One quarter had a 1st degree relative affected. Median age at diagnosis was 25.5 years [1.6 – 54]. Seventeen patients (35%) had a creatinine level at diagnosis of >90umol/L. One patient required dialysis.

Thirty one patients had hospital admissions, with admission rates per year of <0.5 in 64.6%, 0.5-1 in 23%, 1-3 in 8% and >3 in 4%. Eight patients required an emergency nephrostomy, 12 had acute temporising stent and 18 had acute URS/laser. Elective stone treatment was with ESWL in 15, URS in 33 and PCNL in 14 patients.

All patients were offered potassium citrate. Poor compliance was observed, with 11 patients currently receiving potassium citrate monotherapy and a further 16 also receiving captopril, tiopronin or penicillamine.

Conclusion:

Cystinuria is a rare but important cause of urolithiasis, causing multiple admissions/interventions in many patients. This project is being extended with additional centres in West and South Yorkshire contributing data.

Ureteric stents: congested waiting lists, longer dwell times and the impact on patient and trust.

Authors: Miss Naomi Drye, Mr Ash Kumar

Institution: York NHS foundation Trust

Introduction

Timely management of ureteral stents is essential as prolonged dwell times leads to multiple complications. We assessed a single trusts waitlist in relation to stents, use of stent registry, dwell times and associated outcomes.

Methods

A 12-month retrospective review of procedures with a pre-op stent was performed. Data was collected on dwell times, procedure length, length of stay, plus stent related admissions and infections. Duration on the waitlist and stent dwell times was also reviewed.

Results

149 of 242 patients on the waitlist had a stent in situ, 44% had been on the waitlist >6 months. 48% had had the stent for >6 months. From the retrospective review 29 procedures had a pre-op stent. 73% had a dwell time >6 months, these on average had longer procedures (57mins vs 40 min), stays in hospital (4.8 vs 1.1 days) and more admissions (60% vs 44%) and infections (45% vs 22%) whilst a stent is in situ. 42% of stents were not added to stent registry. 45% of stents were inserted prior to waitlist entry, with no indication of stent duration.

Conclusion

There is poor compliance with recommended stent management with many dwell times >6 months. Despite a small sample size we demonstrate an impact of long dwell times on admission and procedures. As well as the impact on patients this highlights a potential financial impact on trusts from delayed management of ureteric stents. The current stent registry is poorly used and adds little value in prioritising, triage or managing stents.

A novel approach to the BAUS information leaflets for bladder outlet obstruction Surgery: An Addition to GIRFT

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Institution: Castle Hill Hospital, Hull Teaching Hospital NHS Trust

Introduction:

A myriad of minimally invasive procedures is available for management of bladder outlet obstruction (BOO) and GIRFT (Get It Right the First Time) recommends use of accurate, understandable, and accessible patient information leaflets with support of patient decision aids (PDAs). This volume of literature which patients must go through can be overwhelming. To avoid this, a summarized leaflet was developed to help patients understand treatment options and make informed decisions.

Materials and methods:

Patients from the one-stop lower urinary tract symptom clinic were enrolled in the study and provided with a summarised leaflet (Pack-1) and BAUS leaflets (Pack-2). Patients completed an anonymous feedback questionnaire at the end of the clinic.

Results:

A total of 50 patients (n=50) were included in the study. 43 patients (86%) preferred Pack-1 over Pack-2 and a similar number of patients agreed that all the necessary information was provided. 45 patients (90%) found Pack-1 easy to read and understand. All patients agreed that Pack 1 was about the right length and helpful overall. Majority of patients said that it 'read well', 'concise', 'clear' and 'saved time'.

Conclusion:

Treatment choices for patients with BOO are complex and each procedure will produce different outcomes and side-effects, and failure to address them can have devastating consequences. Communicating these issues and being confident that patients have understood is a challenge but is also central to the process of informed consent. Hence an accurate, understandable, and accessible information leaflet is vital to improvement of service, reducing variation in practice, improving experience and save resources.



PDF Document: <https://rb.gy/0rwjb>

Is it acceptable to communicate with patients using SMS test message?

(In certain contexts)

Authors: Mark Johnson, Karen Griffiths, Helen Akthar, Helen Baker, Beth Farrer, Sarah Haston & Hassan Khan

Institution: Airedale General Hospital

Introduction:

SMS text messaging is routinely used to remind patients of OPA and have been successfully used to promote health intervention. To the authors knowledge, there is no previous urological literature regarding its use to convey negative test results or provide patient information. There is evidence that timely results reduce patient anxiety

Method:

Patients were communicated with via SMS text message in the following contexts: (1) To convey negative/normal biochemical, radiological or histological test results; (2) Sending patient information (e.g. BAUS leaflets). Text messaging was not used for abnormal results. A detailed letter was also sent to the patient and the GP. All patients were asked to complete an online questionnaire to assess their acceptability of SMS use. All patients were consented to receive text messages.

Results:

In total 25 patients completed the questionnaire. Twenty four of the 25 found receipt of their text message convenient; 25/25 patients found this form of communication acceptable; 23/25 respondents would be happy to receive a text message again and 13/25 felt that their anxiety was reduced by receiving the message.

Conclusion:

SMS test messages appear to be an acceptable form of communication for normal/negative results and for providing patient information.

Prostate artery embolization – a successful single-centre experience

Authors: Taha Shiwani, Costa Tingerides, James Lenton, Chandra Biyani

Institution: Leeds Teaching Hospitals NHS Trust

Background

Prostate artery embolization (PAE) is a novel, minimally invasive treatment option for patients with lower urinary tract symptoms (LUTS) or urinary retention from benign prostatic hyperplasia (BPH), or for patients with refractory prostatic haemorrhage (1). Unlike traditional surgical options, PAE does not require general anaesthetic, and may be more likely to preserve sexual function (1).

Standards

The Cardiovascular and Interventional Radiological Society of Europe (CIRSE) defines technical success in PAE as embolization of at least one hemi-prostate (2). For the treatment of LUTS, clinical success requires a post-operative International Prostate Symptom Score (IPSS) <18 (or >25% decrease) and an IPSS-Quality of Life (IPSS-QoL) score <4 (or ≥ 1 point decrease), with an expected success rate of 75% (2). Monitoring of International Index of Erectile Function (IIEF) scores is also recommended.

Indicators & Targets

1. 100% of procedures achieve at least hemi-embolization.
2. 75% have clinically significant reductions in IPSS and IPSS-QoL scores.
3. 100% of patients have an IIEF score recorded pre- and post-operatively.

Methodology

All PAE procedures performed in Leeds Teaching Hospitals NHS Trust from 2019 to 2022 were reviewed.

Results

19 procedures were performed. 12 were performed for LUTS in patients with BPH.

1. 100% achieved at least hemi-embolization.
2. 83% of those treated for LUTS had clinically significant reductions in IPSS and IPSS-QoL scores.
3. 0% of patients had an IIEF score recorded.

Action plan

IIEF scores will be incorporated into a symptom booklet that will be provided to patients pre- and post-operatively.

References

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Greenlight Laser Prostatectomy: Day Case Surgery in Elderly Patients with Voiding Difficulties

Authors: Miss. H. Tsoi, Mr. G. Weight, Mr. P. Cutinha, Mr. S. Rajpal

Institution: Royal Hallamshire Hospital, Sheffield Teaching Hospitals NHS Foundation Trust

Aim

Greenlight-laser prostatectomy (GLLP) is a popular treatment option for bladder outlet obstruction and lower urinary tract symptoms. In this retrospective study, we aim to explore the patient and perioperative factors associated with successful day-case outcome following GLLP and suggest means to enhance day-case rate.

Methods

Patients who underwent GLLP at a UK tertiary centre between June 2018 and November 2021 were included in this study. Retrospective data covering patient demographics, perioperative parameters and postoperative outcomes were collected using the electronic records systems.

Results

305 patients were included in this study with a median age of 74. The most common indication (62.6%) for the procedure was patient's wish to be free from long-term or intermittent catheters, followed by failed medical therapy (36.4%). 84.6% of patients had an ASA ≥ 2 , and 32.1% took anticoagulant or antiplatelet therapy.

64.2% of patients were performed as day case, and only 10.5% of patients required more than a single night admission. Day case surgery was feasible in all patient groups, but patient comorbidity had a significant impact on day-case rate (ASA 1 = 83.3%, ASA 2 = 67.7%, ASA 3 = 43.6%, $p=0.0003$).

The 3-month readmission rate was 10.8%. 91.2% of patients were catheter-free post-op.

Conclusion

Our study shows that GLLP should be performed as a day-case procedure for all patients unless specific patient factors mandate otherwise. Patient comorbidity has a significant impact on day-case success for GLLP.

It is suitable for elderly and comorbid patients with appropriate patient optimisation and robust peri-operative pathways.

Network Variation in Testicular Cancer Management: A Two Cycle Audit

Authors: George Sturgess, Subramanian Sundaram

Institution: Mid-Yorkshire Teaching NHS Trust

Introduction

Mid-Yorkshire Hospitals (MYH) manage new testicular tumours from both our own catchment area and Barnsley. To facilitate prompt orchidectomy and onward referral to oncology a streamlined pathway is in use at MYH, however, there were delays noted to diagnosis and treatment in Barnsley. Each refers to a different oncology centre across the network.

Methods

The first cycle compared 11 consecutive orchidectomies from both sites processed through MDT, recording time from a positive ultrasound to first clinical contact, orchidectomy and time to onward oncology referral. Efficiency was compared between MYH and Barnsley and areas for improvement identified.

Results

Average time from an US suggesting tumour to first clinical contact was one (0-5) day in MYH and nine (0-16) days in Barnsley while average time to surgery was 11 days (3-23) and 18 days (6-45), respectively. Average time to oncology referral from first clinical contact was 11 days in MYH and 37 days in Barnsley. Patients requiring chemotherapy were treated more quickly from MYH (n=4). A new pathway was created in Barnsley in conjunction with radiology with all new tumours referred from ultrasound to urology for same-day assessment, and same-day ultrasound was available from clinic. A second cycle of audit of eight patients showed reduced time to diagnosis to four days but an increase in time to orchidectomy which was due to staffing issues locally.

Conclusion

A joint pathway reduces the time taken for patients with radiologically confirmed testicular tumours to be assessed by urology. There is variation in the patient pathway for onward referral to oncology.

Radical Prostatectomy: An Open or Shut Case?

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Institution: Sheffield Teaching Hospitals NHS FT

Introduction

Open Radical Prostatectomy (ORP) was followed by laparoscopic (LRP), then Robotic Assisted Radical Prostatectomy (RARP), this growing to 92% of cases by 2019. This retrospective study analysed patterns of practice at a single centralised unit to evaluate trends and reasons for choice of approach.

Patients and methods

Between 2012 – 2022 inclusive, 2161 men with prostate cancer underwent attempted prostatectomy with 2153 completed. Electronic medical records were reviewed to determine which procedures were undertaken by year. For the 282 ORPs, data were collected on reasons for undergoing open surgery, length of stay and complications.

Results

See Table 1. Reasons for ORP included previous surgery in 50 (31.6%), patient preference in 28 (17.7%), comorbidities precluding laparoscopy in 21 (13.3%), obesity in 19 (12.0%), previous radiotherapy in 16 (10.1%), failed RARP in 8 (2.8%) and massive prostate in 5 (3.1%). Median stay 3.0 nights (SD=2.1). Clavien Dindo 3+ complications reported in 16 (5.7%). All conversions related to technical issues.

Conclusion

Although RARP has become the dominant, there remain a proportion for whom it is impossible. Maintaining an alternative and ensuring training is a challenge.

Year	ORP	LRP	RARP	Conversions	Abandoned (%)	Totals
2012/2013	98	169	27	1	0 (0)	295
2014/2015	67	0	320	2	3 (0.8)	392
2016/2017	34	0	431	2	6 (1.3)	473
2018/2019	28	0	471	1	4 (0.8)	504
2020/2021	33	0	288	0	1 (0.3)	322
2022	22	0	165	0	8 (4)	195
TOTAL	282	169	1702	6	22 (1)	2181

Real world high-risk non-muscle invasive bladder cancer: Long-term outcomes from a consecutive cohort screened for the BRAVO randomised feasibility trial of radical cystectomy versus intravesical BCG immunotherapy

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Introduction: Patients with high-risk non-muscle-invasive bladder cancer(HRNMIBC) represent a comorbid group with heterogenous clinicopathological behaviour. Here we describe long-term outcomes for screened BRAVO trial patients within South Yorkshire. This multi-centre, randomised feasibility trial(ISRCTN12509361) compared radical cystectomy(RC) to intravesical BCG in HRNMIBC patients(ethical approval:16/YH/0268).

Patients and Methods: Consecutive participants were identified prospectively in BRAVO screening logs. Demographics and randomisation status were retrieved. Retrospective case review established clinical outcomes. The primary outcome was to evaluate overall survival(OS) in this prospectively screened cohort. Secondary outcomes included progression-free survival(PFS), metastasis-free survival(MFS), and cancer-specific survival(CSS). Kaplan-Meier and multiple logistic regression(MLR) analysis were performed to explore the impact of patient, tumour, and treatment factors on PFS, MFS, CSS, and OS. Significance was defined as $p < 0.05$.

Results: In total, 193 consecutively screened patients were included. Median(IQR) age was 72(67-79)years, 154(79.8%) were male, and 46(23.8%) were randomised. Median(IQR) follow-up was 55(46-61)months. Primary treatment received was BCG in 106(54.9%), RC in 43(22.3%), hyperthermic intravesical mitomycin-C in 6(3.1%), and other treatment in 37(19.2%). RC for primary treatment failure was required in

15(7.8%) additional patients. There were 29(15.0%) progression events, 19(9.8%) metastasis events, and 55(28.5%) deaths during follow-up; only 17(8.8%) were cancer-specific deaths. Table 1 describes patient, tumour, and treatment factors associated with PFS, MFS, CSS, and OS. Significant association included: older age(≥ 70 years) with poorer PFS, MFS, CSS, and OS; randomisation and diagnosis outside a uro-oncology centre with improved OS; presence of carcinoma-in-situ(CIS) with reduced MFS. Survival outcomes significantly differed by first treatment. Limitations include retrospective case review, lack of comorbidity and instillation data, mixed treatment allocation, and low metastatic/cancer-specific events.

Conclusions: At almost 5 years, data from this prospectively screened HRNMIBC cohort highlight that cancer-specific death are low. Older age impacts outcomes, but confounding comorbidity data is lacking. Presence of CIS reduces MFS, hence, early RC should be considered.

Table 1: Evaluation of patient, tumour, and treatment factors associated with PFS, MFS, CSS, and OS			
Factor	Kaplan-Meier analysis Hazard ratio [95% CI] p value		MLR p value
Progression-free survival			
Age (≥70 versus < 70)	0.26 [0.13 to 0.55]	0.0036	0.012
Sex (male versus female)	1.25 [0.51 to 3.08]	0.63	-
BRAVO (randomised versus non-randomised)	0.37 [0.21 to 0.64]	0.0057	0.59
Tumour stage (≥T1 versus Ta)	1.33 [0.64 to 2.77]	0.44	-
CIS (yes versus no)	1.74 [0.82 to 3.69]	0.13	-
Variant pathology (yes versus no)	0.72 [0.21 to 2.51]	0.21	-
Detrusor in TURBT (yes versus no)	0.57 [0.24 to 1.36]	0.15	-
Re-TURBT performed (yes versus no)	1.11 [0.50 to 2.46]	0.80	-
First treatment received	-	0.045	
Diagnosed at UOC (yes versus no)	0.61 [0.28 to 1.32]	0.18	-
Metastasis-free survival			

Age (≥ 70 versus < 70)	0.23 [0.094 to 0.58]	0.011	0.036
Sex (male versus female)	0.69 [0.22 to 2.13]	0.47	-
BRAVO (randomised versus non-randomised)	0.37 [0.21 to 0.67]	0.011	0.47
Tumour stage ($\geq T1$ versus Ta)	2.75 [1.11 to 6.81]	0.032	0.051
CIS (yes versus no)	3.40 [1.35 to 8.56]	0.0081	0.0089
Variant pathology (yes versus no)	1.13 [0.24 to 5.27]	0.87	-
Detrusor in TURBT (yes versus no)	0.68 [0.24 to 1.96]	0.44	-
Re-TURBT performed (yes versus no)	0.92 [0.34 to 2.45]	0.86	-
First treatment received	-	0.34	-
Diagnosed at UOC (yes versus no)	0.68 [0.26 to 1.77]	0.70	-
Cancer-specific survival			
Age (≥ 70 versus < 70)	0.17 [0.066 to 0.45]	0.0077	-
Sex (male versus female)	0.45 [0.14 to 1.49]	0.11	-
BRAVO (randomised versus non-randomised)	0.35 [0.12 to 1.03]	0.15	-
Tumour stage ($\geq T1$ versus Ta)	2.56 [1.01 to 6.48]	0.051	-
CIS (yes versus no)	2.31 [0.87 to 6.13]	0.081	-
Variant pathology (yes versus no)	1.35 [0.26 to 7.08]	0.69	-
Detrusor in TURBT (yes versus no)	0.57 [0.19 to 1.74]	0.26	-
Re-TURBT performed (yes versus no)	1.01 [0.36 to 2.87]	0.98	-
First treatment received	-	0.24	-
Diagnosed at UOC (yes versus no)	0.92 [0.34 to 2.52]	0.87	-
Overall Survival			
Age (≥ 70 versus < 70)	0.33 [0.19 to 0.56]	0.0004	0.0034
Sex (male versus female)	0.88 [0.45 to 1.71]	0.70	-
BRAVO (randomised versus non-randomised)	0.27 [0.15 to 0.49]	0.0025	0.012

Tumour stage ($\geq$ T1 versus Ta)	0.86 [0.50 to 1.47]	0.58	-
CIS (yes versus no)	0.85 [0.49 to 1.46]	0.56	-
Variant pathology (yes versus no)	0.80 [0.32 to 2.00]	0.66	-
Detrusor in TURBT (yes versus no)	0.71 [0.38 to 1.32]	0.23	-
Re-TURBT performed (yes versus no)	0.64 [0.36 to 1.14]	0.098	-
First treatment received	-	<0.0001	-
Diagnosed at UOC (yes versus no)	0.55 [0.32 to 0.97]	0.026	0.012

PSA Surveillance post mpMRI

Authors: Mr Adam Gerrish – ST4 Registrar, Mr Yasir Hassanein – Urology Consultant

Institution: Huddersfield Royal Infirmary

Introduction:

2ww PSA referrals are becoming increasingly common, creating a significant workload for Urologists. As we move towards PSA screening, patients with normal investigations (MRIs and biopsies) need to be safely discharged to facilitate adequate clinic space for patients with positive histology.

Methods:

MRI Prostates outcomes from January 2023 at our unit were retrospectively audited. These patients' subsequent follow up over the following 9 months was then analysed.

Results:

39 MRI Prostates were undertaken in January 2023. 16 were reported as PIRADS 2, 10 were PIRADS 3, 10 were PIRADS 4, and 3 were PIRADS 5.

Of patients with PIRADS 2 on their MRI, only 1 was discharged back to GP with a target PSA, and 15 were committed to follow up by Urology. 7 patients had subsequent lower PSA and were discharged. 1 PSA rose (on-going follow up). 8 patients didn't have their PSA re-checked.

11 patients had negative biopsies. Only 1 of these patients was discharged initially. 2 patients repeat PSA fell (discharged). 4 patient repeat PSA rose (under surveillance). 4 patient had no repeat PSA.

Discussion:

PSA below normal age range	Refer back once above normal age range values
PSAD <0.15	Refer back once PSAD >0.15 (target PSA calculated by prostate volume)
PSAD >0.15 and biopsies -ve	PSAv and PSAdt PSA surveillance

The above proposed changes would only commit 4 patients to urology follow up. 21 patients could be discharged back to their GP for an annual PSA.

Complete audit cycle of Day-Case Transurethral Resection of Bladder Tumours (TURBT) and the impact of implementing the “Rule of 3s”

Authors: Ms. S. Gosein, Mr. C. Molokwu, Mr. R. Bowie, Mr. S. Basu

Institution: Bradford Teaching Hospital NHS Foundation Trust (BTHFT)

INTRODUCTION

Getting It Right First Time (GIRFT) identified TURBT as one of the index day-case procedures for Urology. The GIRFT report showed BTHFT day-case TURBT rate was 23.3%, compared to a 43% national average, with some centres achieving up to 71%. Low day-case TURBT rates exposes patients to hospital acquired infections and contributes to the bed burden. We conducted an audit on TURBT cases to determine factors contributing to overnight stays, and to identify selection criteria for a day-case TURBT service.

METHOD

A retrospective study was done analysing six months (January – June 2022) of TURBTs at BTHFT. We identified the factors contributing to inpatient admissions post-TURBT. Those factors that could be identified pre-operatively were used to develop criteria for day-case selection. We then implemented changes based on our findings and a re-audit was conducted analysing three months (June – August 2023) of TURBTs.

RESULTS

In 2022, 9 out of 63 TURBTs done in 6 months (14%) were day-cases. The “Rule of 3s” day-case pathway was developed and implemented. Parameters selected were tumour size ≤ 3 cm, number of tumours ≤ 3 , American Society of Anaesthesiologist (ASA) grade ≤ 3 , Clinical Frailty Score (CFS) ≤ 3 and presence of responsible adult overnight. After implementation of the “Rule of 3s”, 10 out of 32 TURBTs in the re-audit (31%) were day-cases.

CONCLUSION

An increase of 17% in day-case TURBTs was achieved in 2023 after implementation of the “Rule of 3s”. It can therefore serve as a guide for safely achieving higher day-case TURBT rates.

Postoperative outcome of patients underwent robotic-assisted radical cystectomy on 90 days follow-up

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Institution: Bradford Teaching Hospitals NHS Foundation Trust (1)

Introduction

Robotic-assisted radical cystectomy (RARC) is superseding open cystectomy due to multiple benefits noted in the iROC study which evaluated the effects of open vs robotic assisted cystectomy. We report our 90 days complication and readmission rates over a 5 year period.

Patients and Methods

Retrospective review of all patients undergoing RARC at our centre over 60 months was carried out via review of electronic patient records for readmission and complication. Complications are classified per Clavien-Dindo system.

Results

In 174 RARC over 52 months, 58 readmissions or complications occurred within 90 days of surgery (33%). 34 readmissions occurred within 30 days. 27 admissions occurred within 61-90. 7 patients needed multiple readmissions (4.02%).

46 (26.4%) patient experienced complication of Clavien-Dindo 2 or greater within 90 days. The 90-day mortality was 2.9% (n=5) while it was 1.1% (n=2) for the first 30 days.

Complications requiring operative or radiological intervention are as below. 4 patients (2.3%) developed urinary leak that required drainage. 2 patients developed urinary obstruction requiring drainage (1.1%)

12 patients developed prolonged ileus or SBO with 1 requiring operative intervention. 1 intra-operative rectal injury necessitating colostomy (0.6%). 3 patients developed ileo-anastamotic leak necessitating laparotomy (1.74%)

13 (7%) patients developed intra-abdominal collections of whom 9 (5%) required percutaneous drainage. 1 patient experienced post operative bleeding requiring embolization.

Conclusion

Readmission and 90 days post RARC complications appear to be in line with established data for open cystectomy although ileus rates appear to be lower. Mortality at 90 days appears to be lower (2.9 vs 5%).

Bone Scans in Prostate Cancer: Audit and Pilot Service Evaluation

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Background:

Radioisotope bone scans are performed in prostate cancer to detect early metastatic bone lesions. Worldwide shortages of radioisotopes mean challenging guidelines and looking for a reduction in unnecessary bone scans.

Standard:

NICE guidelines recommend: Do not routinely offer isotope bone scans to people with Cambridge Prognostic Group 1 or 2 prostate cancer.

Aims:

To detect what proportion of bone scans are in patients with PSA >10, or Gleason 3+4 = 7 or higher, or stage T3a or higher

To evaluate if it is safe to increase the standard threshold to PSA >20, Gleason 3+4 = 7 or higher or stage T3a or higher

Method:

Data was provided for all bone scans performed 01/01/22 to 31/12/22 at RHH

ICE software was used to review scan reports, biochemistry results and histopathology results

Data was analysed in Microsoft Excel

Results:

1031 bone scans were reviewed. 224 suitable cases were identified as first presentation biopsy-confirmed prostate cancer.

26 (11.6%) of bone scans were positive for bone metastasis

1 (0.4%) bone scan was performed in a patient with PSA <10 and Gleason 3+3 = 6

1 (0.4%) bone scan in a patient with PSA <20 was positive for metastatic disease

Conclusion:

Compliance with audit standards were excellent.

Within the limitations of this service evaluation, it is reasonable to consider increasing the PSA threshold to >20 for bone scans in the first presentation of prostate cancer.

Action Plan:

Change criteria for bone scanning prostate cancer patients to PSA >20.

Re-audit after 1 year.