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ANNUAL MEETING OF THE
IRISH SOCIETY OF UROLOGY (ISU)

Friday 18th and Saturday 19th September 2015

Limerick Strand Hotel
Dear members, guests and exhibitors, welcome to our 2015 Irish Society of Urology Annual Meeting.

Following our membership survey on choice of venue, we have located to the Strand Hotel in Limerick combining your requests for accessibility, functionality, and price sensitivity. By request we have reverted to a Friday/Saturday format to suit your busy work schedules.

Our scientific programme is again impressive and I thank our Academic Selection Committee who have endeavoured to include as many high quality abstracts as possible into the sessions.

A major programme change this year is the inclusion of a management session devoted to a comprehensive review of our Irish Society of Urology, its constitution and its roles. To make space in the schedule without reducing our poster and podium sessions there are no invited lectures or council meeting.

Urology remains grossly undeveloped in Ireland compared to the other surgical disciplines. There are acute crises in training, manpower and urology health care delivery, and the future of research. Also important, we must optimise international relationships, develop public relations, and foster our North/South constituency.

Our ISU must become influential within the ‘Centres of Power’ such as RCSI, HSE and Medical Council that make crucial decisions concerning governance, training and health care delivery in Irish Urology. Medical underwriting and Health Insurance companies are likewise relevant. Our society must be proactive but we require an updated constitution and a mandate from members to move forward with the four year strategy as envisaged by myself and our Vice President Peter Ryan.

I am indebted to the many members who volunteered at council to take on various roles. They and our trainee rep will update us on developments during the last year at our management session. I encourage all to take part in the lively debate they will provoke.

Our gala dinner (not black tie) has reverted to Saturday night enabling us to socialise without the pressure of work the following day. A first prize and medal for best scientific presentation and a second prize will be awarded at the dinner. At members request our social programme has been priced to encourage as many consultants, trainees and guests as possible to attend.

I look forward to meeting you all in Limerick.

Yours sincerely,

John Thornhill, M.Ch. F.R.C.S.I
President, Irish Society of Urology
PROGRAMME AT A GLANCE

SCIENTIFIC PROGRAMME

Friday 18th September 2015
13.00–14.00 Lunch, Exhibition & Poster Viewing
14.00–15.30 Poster Session 1: Prostate Cancer
15.30–16.00 Refreshments, Exhibition & Poster Viewing
16.00–17.30 Poster Session 2: General Urology

Saturday 19th September 2015
08.30–10.30 Session 1: Prostate Cancer
10.30–11.00 Refreshments & Exhibition
11.00–13.00 Session 2: General Urology
13.00–14.10 Lunch & Exhibition
14.10–16.00 Management Session 1: Crises or Challenges Facing Irish Urology?
16.00–16.15 Refreshments & Exhibition
16.15–17.05 Management Session

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 awarded to the programme

Follow on Twitter: @ISU_Urology
Use the meeting hashtag: #ISU15
SOCIAL PROGRAMME

Friday 18th September 2015

19.30 CONFERECE BUFFET SUPPER
Limerick Strand Hotel
(Dress code: Informal)

Saturday 19th September 2015

19.30 ISU GALA DINNER, INCLUDING PRESENTATION OF PRIZES AND LIVE MUSIC
Limerick Strand Hotel
(Dress code: Smart)
IRISH SOCIETY OF UROLOGY (ISU) SCIENTIFIC MEETING

Kindly sponsored by:

PLEASE NOTE:
Sponsorship assists towards the scientific meeting only.
No funding received for exhibition space at this meeting is used towards the social aspects of the programme.
Friday 18th September 2015

13.00–14.00  Lunch and Meet Our Exhibitors

Poster Session 1: PROSTATE CANCER
Chairman Mr Kilian Walsh, Bon Secours, Galway
Chairman Mr Frank O’Brien, Cork University Hospital, Cork

14.00–15.30

POSTER 1  AN IRISH PROSTATE CANCER RISK CALCULATOR
R. Foley\textsuperscript{1,2}, K. Murphy\textsuperscript{3,4}, D. Lundon\textsuperscript{1,2,5}, A. Perry\textsuperscript{6}, R. Power\textsuperscript{7},
G. Durkan\textsuperscript{8,9}, F.O’ Brien\textsuperscript{10,11}, K. O’Malley\textsuperscript{5}, D. Galvin\textsuperscript{2,5},
T.B. Murphy\textsuperscript{3,4}, R.W. Watson\textsuperscript{1,2}

Conway Institute of Biomolecular a Biomedical Research, University
College Dublin\textsuperscript{1}
School of Medicine and Medical Science, University College Dublin\textsuperscript{2}
School of Mathematical Sciences, University College Dublin\textsuperscript{3}
Insight Centre for Data Analytics, University College Dublin\textsuperscript{4}
Department of Urology, Mater Misericordiae University Hospital,
Dublin\textsuperscript{5}
Institute of Molecular Medicine, Trinity College Dublin\textsuperscript{6}
Department of Urology, Beaumont Hospital, Dublin\textsuperscript{6}
Department of Urology, University Hospital Galway\textsuperscript{8}
Department of Urology, University Hospital Limerick\textsuperscript{9}
Department of Urology, University Hospital Waterford\textsuperscript{10}
Department of Urology, Cork University Hospital\textsuperscript{11}

POSTER 2  MULTI-PARAMETRIC MAGNETIC RESONANCE IMAGING-
TRANSRECTAL ULTRASOUND FUSION TARGET
TRANSPERINEAL PROSTATE BIOPSY: INITIAL IRISH
EXPERIENCE
A. Aslam, J. Drumm, M. Akram, H.D. Flood, S.K. Giri
University Hospital Limerick, Limerick

POSTER 3  ACCURACY OF MULTIPARAMETRIC MAGNETIC
RESONANCE IMAGING IN THE DIAGNOSIS OF PROSTATE
CANCER: A COMPARISON OF PROSTATIC ZONAL
ANATOMY BETWEEN MPMRI SCANS AND RADICAL
PROSTATECTOMY SPECIMENS
E. Ogbodo\textsuperscript{1}, P. Ryan\textsuperscript{2}, V. McDermott\textsuperscript{3}, T. Cooney\textsuperscript{4}, P.C. Ryan\textsuperscript{1,4}
POSTER 4 TRANSPERINEAL BIOPSY– INITIAL EXPERIENCE AT A SINGLE IRISH CENTRE
M. Samuji¹, K. O’Regan¹, J. Buckley¹, P. Sweeney², M.F. O’Brien¹,³, C. Heffron¹, N. Mayer¹, P. Kelly¹
Cork University Hospital, Cork¹
Mercy University Hospital, Cork²
University Hospital Waterford, Waterford³

POSTER 5 PROSTATE VOLUME ESTIMATION CAN SIGNIFICANTLY IMPROVE PROSTATE CANCER DIAGNOSIS
R. Foley¹,², K. Murphy³,⁴, D. Lundon¹,²,⁵, G. Durkan⁶, R. Power⁷, D. Galvin²,⁵, T.B. Murphy³,⁴, R.W. Watson¹,²
Conway Institute of Biomolecular & Biomedical Research, University College Dublin¹
School of Medicine and Medical Science, University College Dublin²
School of Mathematical Sciences, University College Dublin³
Insight Centre for Data Analytics, University College Dublin⁴
Department of Urology, Mater Misericordiae University Hospital, Dublin⁵
Department of Urology, University Hospital Galway⁶
Department of Urology, Beaumont Hospital, Dublin⁷

POSTER 6 REDUCTION OF POST TRUS BIOPSY SEPSIS
A. Downey, G. Hann, A. Thwaini
Belfast City Hospital, Belfast, Northern Ireland

POSTER 7 THE HIDDEN BURDEN OF OUTPATIENT REPEAT PSA TESTING IN A PROSPECTIVE COHORT
E. Browne¹, F. O’Kelly¹, D. Lundon¹, P. Daly¹, D. Galvin¹, N. Hegarty¹, J. Thornhill², K. O’Malley¹
Mater Misericordiae University Hospital, Dublin¹
Tallaght Hospital, Dublin²

POSTER 8 TRANSITIONING FROM OPEN TO ROBOT ASSISTED RADICAL PROSTATECTOMY: A SINGLE SURGEON EXPERIENCE OF THE FIRST 50 CASES
S. Considine¹, E. Bolton¹, D. Moran¹, K. Canavan², P. O’Malley², D. Bouchier-Hayes¹, G. Durkan¹,²
Galway University Hospital³
Galway Clinic, Galway⁴

POSTER 9 PRIOR BLADDER OUTFLOW SURGERY (PBOS) OR LARGE PROSTATE VOLUME DOES NOT ADVERSELY AFFECT BIOCHEMICAL RECURRENCE-FREE SURVIVAL IN LOW DOSE RATE PROSTATE BRACHYTHERAPY: AN INTERMEDIATE TERM ANALYSIS
A. Goggins¹,², H. Yamamoto¹,⁶, H. Moller³, J. Withington¹, R. Beaney¹, S. Morris³, P. Acher³, B. Challacombe¹, P. Dasgupta¹,², R. Popert¹
POSTER 10  THE LONG AND THE SHORT OF IT: IRELAND’S FIRST DEDICATED PENILE REHABILITATION CLINIC
D. Lundon, F. O’Kelly, C. McGarvey, P. Hegarty, N. Hegarty, D. Galvin, K. O’Malley, P. Daly
Mater Misericordiae University Hospital, Dublin

POSTER 11  ADJUSTABLE SUBURETHRAL SLING (MALE REMEEX SYSTEM) IN THE TREATMENT OF MALE SUI
S. Considine¹, D. Moran¹, E. Bolton¹, U. Haroon¹, G. Nama¹, H. Ghous¹, A. Cham¹, R. Siddiqui¹, S. Jaffry¹,²
Galway University Hospital, Galway
Galway Clinic, Galway

POSTER 12  TRANS-OBTURATOR URETHRAL SLING PLACEMENT FOR TREATMENT OF POST PROSTATECTOMY URINARY INCONTINENCE: A SAFE AND EFFECTIVE PROCEDURE
Department of Urology, St James’s Hospital, Dublin

POSTER 13  IMPACT OF URETHRAL SPHINCTION LENGTH ON URINARY CONTINENCE AFTER RADICAL TREATMENT OF PROSTATE CANCER: A MAGNETIC RESONANCE IMAGING BASED STUDY
E.J. Redmond¹, H.D. Flood¹, O. Fagan², O. Ohio², M. El Bassiouni¹, G. Durkan¹, S. Giri¹
University Hospital Limerick, Limerick
Graduate Entry Medical School, University of Limerick

POSTER 14  THE EFFICACY OF VACUUM ERECTILE DEVICES (VED) POST RADICAL PROSTATECTOMY- THE INITIAL EXPERIENCE OF THE FIRST DEDICATED VED CLINIC IN IRELAND
Department of Urology, Beaumont Hospital, Dublin

15.30–16.00  Refreshments and Exhibition
TIPS, TECHNIQUES AND STRATEGIES TO OPTIMIZE CLEARANCE OF LARGE INTRARENAL CALCULI IN MORBIDLY OBESE PATIENTS
F.T. D’Arcy¹,², D. O’Kane¹, P. Liodakis¹, N. Lawrentchuk¹,³,⁴, D. Webb¹, D. Bolton¹,⁴, R.P. Manecksha¹,⁵
Urology Unit, Department of Surgery, Austin Health, University of Melbourne, Melbourne, Victoria, Australia¹
Department of Urology, University Hospital, Galway²
The Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia³
Ludwig Institute for Cancer Research, Austin Hospital, Melbourne, Victoria, Australia⁴
Department of Urology, St James and Tallaght Hospitals, Dublin⁵

A REVIEW OF THE ANATOMICAL VARIATIONS OF THE URETER AND THEIR IMPLICATIONS FOR SURGICAL INTERVENTION
J. Costelloe, N. Mahony, P. Tierney, W. Ryan, D. Barry
Department of Anatomy, Trinity College Dublin, Dublin

TAILORED LENGTH PERMANENT STENTS FOR THE TREATMENT OF URETERIC OBSTRUCTION
E.M. Bolton¹, S. Considine¹, D. Moran¹, R. Siddiqui¹, A. Cham¹, N. Nusrat¹, G. Durkan¹, E. Rogers¹, K. Walsh¹, S. Jaffry¹
Galway University Hospital, Galway¹

DO CLOSED END DOUBLE-PIGTAIL URETERIC STENTS IMPROVE PATIENT QUALITY OF LIFE WHEN COMPARED TO OPEN ENDED STENTS: A PROSPECTIVE STUDY
E.M. Bolton¹, S. Considine¹, D. Moran¹, U. Haroon¹, H. Ghous¹, N. Nusrat¹, G. Durkan¹, E. Rogers¹, K. Walsh¹, S. Jaffry¹
Galway University Hospital, Galway¹

NEWBORN UNDESCENDED TESTES: DO MOST REALLY DESCEND?
C.E. Houstoun¹, P.M. Filan², E.A. Kiely³
4th Year Medicine, University College Cork¹
Department of Neonatology, Cork University Maternity Hospital²
Department of Urology, Cork University Hospital³

TESTICULAR TUMOUR REFERRAL PATTERNS: THE EMERGENCY DEPARTMENT HAS BECOME A COMMON PATHWAY
Department of Urology, St. Vincent’s University Hospital, Dublin
POSTER 21  BLUNT SCROTAL TRAUMA - IS SURGICAL EXPLORATION ALWAYS NECESSARY?
E.J. Redmond, F.T. MacNamara, S.K. Giri, H.D. Flood
University Hospital Limerick, Limerick

POSTER 22  A COMPARATIVE ANALYSIS OF THE HIDDEN WORKLOAD OF GERIATRIC CONSULTS WITHIN UROLOGICAL SURGERY – IS IT TIME FOR THE APPOINTMENT OF A UROGERIATRICIAN?
C. Kelly, F. O'Kelly, D. Lundon, N. Hegarty, K. O'Malley, D. Galvin, P. Daly
Mater Misericordiae University Hospital, Dublin

POSTER 23  THE IMPACT OF A STRUCTURED CLINICAL TRAINING COURSE ON INTERNS’ SELF-REPORTED CONFIDENCE WITH CORE CLINICAL UROLOGY SKILLS
C. Browne¹, S. Norton¹, J.M. Nolan², J.F. Sullivan¹, M. Quinlan¹, M. Sheikh¹, T.E.D. McDermott¹, T.H. Lynch¹, R.P. Manecksha¹
Department of Urology, St James’ Hospital, Dublin¹
School of Medicine, Trinity College Dublin²

POSTER 24  IMPACT OF 2004 ISUP/WHO CLASSIFICATION ON BLADDER TRANSITIONAL CELL CARCINOMA GRADING – A FIFTEEN YEAR REVIEW FROM AN IRISH TEACHING HOSPITAL
L.C. Yap, A. Aslam, S.K. Giri
University Hospital Limerick, Limerick

POSTER 25  THE SUBURETHRAL TENSION ADJUSTABLE SLING (REMEEX SYSTEM) IN THE TREATMENT OF RECURRENT FEMALE URINARY INCONTINENCE
S. Considine¹, D. Moran¹, E. Bolton¹, U. Haroon¹, G. Nama¹, H. Ghous¹, A. Cham¹, R. Siddiqui¹, S. Jaffry¹,²
Galway University Hospital, Galway¹
Galway Clinic, Galway²

POSTER 26  LAPAROSCOPIC ADRENALECTOMY FOR PHAEOCHROMOCYTOMA: IS IT CONTRAINDICATED?
S.K. Giri, L. McLoughlin, E.J. Redmond, A. Aslam, H.D. Flood
University Hospital Limerick, Limerick

POSTER 27  EFFICACY AND SAFETY OF 120-W GREENLIGHT HIGH-PERFORMANCE SYSTEM LASER PHOTO VAPORIZATION OF THE PROSTATE IN THE SURGICAL DAY WARD
S. Considine¹, J. Forde¹, E. Bolton¹, D. Moran¹, S. Jaffry¹,²
Galway University Hospital, Galway¹
Galway Clinic, Galway²

POSTER 28  CAN RADIOFREQUENCY ABLATION OF RENAL TUMOURS BE PERFORMED AS A DAY CASE PROCEDURE?
A. McCloskey¹, D.B. Hennessey¹, A. Thwaini¹, W. Lone²
Department of Urology, Belfast City Hospital¹
Department of Interventional Radiology, Belfast City Hospital²
POSTER 29  A PROSPECTIVE STUDY EVALUATING THE COST OF IATROGENIC URETHRAL CATHETERISATION INJURIES
Department of Urology, Tallaght Hospital, Dublin

SOCIAL PROGRAMME

19.30  Conference Buffet Supper, Limerick Strand Hotel
Dress Code: Informal
Session 1: PROSTATE CANCER

Chairman Mr Kiaran O’Malley, Mater Misericordiae University Hospital & Mater Private Hospital, Dublin
Chairman Mr Garrett Durkan, University Hospital Galway

08.30–10.30

08.30–08.40 THE PREDICTIVE ABILITY OF PRE-OPERATIVE CONVENTIONAL MAGNETIC RESONANCE IMAGING FOR DETECTING EXTRA-PROSTATIC EXTENSION AT RADICAL PROSTATECTOMY
A. Aslam\(^1\), G. Nason\(^2\), S. Kiely\(^1\), F. Wallis\(^3\), G.C. Durkan\(^4\), S.K. Giri\(^1\)
Department of Urology, University Hospital Limerick\(^1\)
Department of Urology, Beaumont Hospital, Dublin\(^2\)
Department of Radiology, University Hospital Limerick\(^3\)
Department of Urology, University College Hospital Galway\(^4\)

08.40–08.50 DETECTION OF LOCALIZED PROSTATE CANCER USING MULTIPARAMETRIC MAGNETIC RESONANCE IMAGING GUIDED TRANSRECTAL ULTRASOUND PROSTATE BIOPSIES: IMPROVED DETECTION OF HIGHER GRADE CANCERS
E. Ogbodo\(^1\), P. Ryan\(^2\), V. McDermott\(^3\), T. Cooney\(^4\), P.C. Ryan\(^1,4\)
Department of Urology, Bon Secours Hospital, Cork\(^1\)
Department of Pathology, Bon Secours Hospital, Cork\(^2\)
Department of Radiology, Bon Secours Hospital, Cork\(^3\)
Department of Surgery, University College Cork, Cork\(^4\)

08.50–09.00 EARLY EXPERIENCE WITH TRANS-PERINEAL TEMPLATE BIOPSY FOR THE DIAGNOSIS OF PROSTATE CANCER IN THE WEST OF IRELAND
S. Considine\(^1\), G. O’Boyle\(^2\), F. Jamaludin\(^2\), J. Khalid\(^2\), F. O’Sullivan\(^2\), E. Rogers\(^1\), K. Walsh\(^1\), S. Jaffry\(^1\), N. Nusrat\(^1\), G. Durkan\(^1\)
Department of Urology, Galway University Hospital, Galway\(^1\)
Department of Radiation Oncology, Galway University Hospital, Galway\(^2\)

09.00–09.10 IMPROVING MULTIVARIABLE PROSTATE CANCER RISK ASSESSMENT USING THE PROSTATE HEALTH INDEX
R.W. Foley\(^1,2\), L. Gorman\(^1\), N. Sharifi\(^3\), K. Murphy\(^4\), H. Moore\(^3\), A.V. Tuzova\(^5\), A.S. Perry\(^5\), T.B. Murphy\(^8,6\), D.J. Lundon\(^1,2,7\), R.W.G. Watson\(^1,2\)
A COMPARISON OF FUNCTIONAL OUTCOMES FOLLOWING ROBOTIC ASSISTED, LAPAROSCOPIC AND OPEN RADICAL PROSTATECTOMIES IN A RAPID ACCESS COHORT
G.J. Nason, S. White, G.P. Smyth, R.E. Power
Department of Urology, Beaumont Hospital, Dublin

THE ROBOTIC 500 SERIES: DRIVING THE CHANGE IN RADICAL PROSTATE SURGERY
F. O’Kelly¹, D. Lundon¹, R. Keenan¹, A. Rauf¹, P. Daly¹, K. O’Malley¹²
Mater Misericordiae University Hospital, Dublin
Mater Private Hospital, Dublin

RADICAL PROSTATECTOMY FOR LOCALLY ADVANCED PROSTATE CANCER: FUNCTIONAL AND ONCOLOGICAL OUTCOMES
A. Aslam¹, S. Kiely¹, F. Wallis², G.C. Durkan³
Department of Urology, University Hospital Limerick, Limerick
Department of Radiology, University Hospital Limerick, Limerick
Department of Urology, University College Hospital Galway, Galway

PEYRONIE’S DISEASE FOLLOWING RADICAL PROSTATECTOMY: INCIDENCE IN A POPULATION WITH FORMAL PRE OPERATIVE ASSESSMENT
J.F. Sullivan¹, R. Tal¹, M. Heck¹, M. Bernstein¹, C.J. Nelson², J.P. Mulhall¹
Male Sexual & Reproductive Medicine Program, Urology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, NY, USA
Department of Psychiatry and Behavioural Sciences, Memorial Sloan-Kettering Cancer Center, New York, NY, USA

GLEASON 7 PROSTATE CANCER IN THE ERA OF RAFC: DOES PRIMARY GRADE 4 DISEASE STILL HAVE A WORSE OUTCOME?
Department of Urology, St. Vincent’s University Hospital, Dublin

SURGERY FOR POST-PROSTATECTOMY INCONTINENCE: A 10-YEAR, TWO CENTER REVIEW
S. Considine¹, E. Bolton¹, D. Moran¹, U. Haroon¹, K. Walsh¹²
10.10–10.20 HOSPITAL BURDEN OF LONG-TERM GENITOURINARY AND GASTROINTESTINAL TOXICITY AFTER RADICAL RADIOTHERAPY FOR PROSTATE CANCER
E.J. Redmond¹, K.S. Dolbec², A.S. Fawaz², H.D. Flood¹, S.K. Giri¹
Department of Urology, University Hospital of Limerick, Limerick¹
Graduate Entry Medical School, University of Limerick²

10.20–10.30 HEALTH PROFESSIONAL’S VIEWS ABOUT THE ACCEPTABILITY AND IMPLEMENTATION OF ALTERNATIVE MODELS OF PROSTATE CANCER FOLLOW-UP
A. Timmons¹*, R. Gooberman-Hill², P. Gallagher³, M. Molcho⁴, A.A. Thomas⁴, A. Pearce¹, L. Sharp⁵
National Cancer Registry Ireland, Cork¹
Musculoskeletal Research Unit, University of Bristol, Bristol, UK²
School of Nursing and Human Sciences, DCU, Dublin³
Department of Health Promotion, NUIG, Galway⁴
Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK⁵

10.30–11.00 Refreshments and Exhibition

**Session 2: GENERAL UROLOGY**

**Chairman**
Mr John McKnight, Ulster Hospital

**Chairman**
Mr Eamonn Rogers, Bon Secours Hospital, Galway

11.00–13.00

11.00–11.10 LONG TERM OUTCOMES OF BLADDER NECK PLACEMENT OF THE SPARCrTM SLING FOR STRESS URINARY INCONTINENCE- A SINGLE SURGEON EXPERIENCES
Francis S., L.C. McLoughlin, M. Gleeson, H.D. Flood
Department of Urology, University Hospital Limerick, Limerick

11.10–11.20 EROSION OF MID-URETHRAL POLYPROPYLENE MESH SLINGS FOR FEMALE STRESS URINARY INCONTINENCE: SURGICAL MANAGEMENT AND OUTCOMES
K.J. Breen, C.E. Nolan, B. Barea, G.J. Nason, T. Creagh
Department of Urology and Renal Transplantation, Beaumont Hospital, Dublin

11.20–11.30 THE EVOLVING MANAGEMENT OF RENAL ONCOCYTOMAS: 15-YEAR EXPERIENCE FROM A TERTIARY REFERRAL CENTRE
Department of Urology, Tallaght Hospital, Dublin
11.30–11.40  A SINGLE CENTRE EXPERIENCE OF ZERO-ISCHAEMIA LAPAROSCOPIC PARTIAL NEPHRECTOMY
Department of Urology, St James’ Hospital, Dublin

11.40–11.50  PATIENT OUTCOMES FOLLOWING OPEN PARTIAL NEPHRECTOMY FOR RENAL TUMOURS
B.W. Cham, G. Nama, H. Ghouses, S. Jaffrey, K. Walsh, E. Rogers, G.C. Durkan, N.B. Nusrat
Department of Urology, University College Hospital Galway

11.50–12.00  TOTAL PENILE GLANS RESURFACING TO MAXIMIZE PENILE FORM AND FUNCTION IN PENILE CANCER: MI-PECANS
F. O’Kelly¹, D. Lundon¹, I. Cullen², P. Sweeney³, P. Hegarty¹,⁴
Mater Misericordiae University Hospital, Dublin¹
University Hospital Waterford²
Mercy University Hospital, Cork³
Mater Private Hospital, Dublin⁴

12.00–12.10  PREVENTING URETHRAL TRAUMA BY INADVERTENT INFLATION OF CATHETER BALLOON WITHIN THE URETHRA DURING CATHETERISATION: EVALUATION OF A NOVEL SAFETY SYRINGE AFTER CORRELATING TRAUMA WITH URETHRAL DISTENSION AND CATHETER BALLOON PRESSURE
N.F. Davis¹,², R.O.’C. Mooney², C.V. Cunnane², E.M. Cunnane², J.A. Thornhill¹, M.T. Walsh²
Department of Urology, Tallaght Hospital, Dublin¹
Centre for Applied Biomedical Engineering Research, Materials and Surface Science Institute, University of Limerick, Limerick²

12.10–12.20  ADMISSION OF PATIENTS WITH ACUTE URINARY RETENTION LEADS TO A DEFINITIVE MANAGEMENT DECISION
Department of Urology, St. Vincent’s University Hospital, Dublin

12.20–12.30  SELF-REPORTED AETIOLOGY AND RATES OF SELF-REPORTED SURGICAL BURNOUT AMONGST U.K. AND IRISH UROLOGISTS
F. O’Kelly¹, R. Manecksha¹, D. Quinlan², A. Reid³, A. Joyce³, K. O’Flynn³, M. Speakman³, J. Thornhill¹
Tallaght Hospital, Dublin¹
St. Vincent’s University Hospital, Dublin²
British Association of Urological Surgeons³

12.30–12.40  GERIATRIC UROLOGY: AN EVOLVING SUBSPECIALTY WITH INCREASING WORKLOAD
A. Aslam, S. Francis, L.C. Yap, H.D. Flood, S.K. Giri
Department of Urology, University Hospital Limerick, Limerick
12.40–12.50 IS TESTICULAR PAIN AND VOMITING PATHOGNOMONIC FOR TESTICULAR TORSION IN PUBERTAL BOYS? IMPLICATIONS FOR LAY AND MEDICAL EDUCATION
A. Aslam¹, L.C. Yap¹, G.J. Nason², N. Kelly¹, K. Domanska³, S.K. Giri¹, H.D. Flood¹
University Hospital Limerick, Limerick¹
Beaumont Hospital, Dublin²
University of Limerick, Limerick³

12.50–13.00 SELECTION OF PATIENTS FOR ESWL IN THE ERA OF FLEXIBLE URETEROSCOPY (FURS). CAN HOUNSFIELD UNITS PREDICT SUCCESSFUL OUTCOME?
Galway University Hospital, Galway

13.00–14.10 Lunch and Exhibition

Session 3: MANAGEMENT SESSION: CRISES OR CHALLENGES FACING IRISH UROLOGY
Chairman Mr John Thornhill, President, Irish Society of Urology
Chairman Mr Peter Ryan, Vice-President, Irish Society of Urology

14.10–16.00

14.10–14.15 MANAGEMENT SESSION INTRODUCTION
Mr John Thornhill

14.15–14.55 TRAINING (REALITY OF DIRECT ACCESS FOR TRAINING)
Mr Ciaran Brady

14.55–15.15 CRISIS IN MANPOWER
Mr David Mulvin
Mr Eamonn Kiely

15.15–15.35 ISU CONSTITUTION
Mr Gordon Smyth

15.35–15.50 ISU FINANCIAL REVIEW
Mr Hugh Flood

15.50–16.00 NORTH/SOUTH RELATIONS
Mr Peter Ryan
Mr Brian Duggan

16.00–16.15 Refreshments and Exhibition

16.15–16.25 INTERNATIONAL RELATIONS
Professor Thomas Lynch

16.25–16.35 PUBLIC RELATIONS (A NEW WORLD)
Mr Rustom Manecksha
Mr Richard Power

16.35–16.45 THE FUTURE OF RESEARCH
Mr David Galvin

16.45–16.55 TRAINEES NEEDS
Ms Lisa Smyth

16.55–17.05 PRESIDENTS SUMMARY
Mr John Thornhill

SOCIAL PROGRAMME

19.30 Gala Dinner, Limerick Strand Hotel
Including the Presentation of Prizes and Live Music
(Dress Code: Smart)
Session 1: Prostate Cancer

Poster 1
An Irish prostate cancer risk calculator
R FOLEY1,2, K MURPHY3,4, D LUNDON1,2,5, A PERRY5, R POWER5, G DURKAN5,6, F O’BRIEN7,8, K O’MALLEY9, D GALVIN2,6, TB MURPHY3,4 and RW WATSON1,2
1Conway Institute of Biomolecular and Biomedical Research, University College Dublin; 2School of Medicine and Medical Science, University College Dublin; 3School of Mathematical Sciences, University College Dublin; 4Insight Centre for Data Analytics, University College Dublin; 5Department of Urology, Mater Misericordiae University Hospital, Dublin; 6Institute of Molecular Medicine, Trinity College Dublin; 7Department of Urology, Beaumont Hospital, Dublin; 8Department of Urology, University Hospital Galway; 9Department of Urology, University Hospital Limerick; 10Department of Urology, University Hospital Waterford; 11Department of Urology, Cork University Hospital

Introduction: Accurate risk stratification of patients pre-biopsy is essential for the diagnosis of prostate cancer (PCa). The objective of this study is to build an Irish PCa risk calculator to facilitate the decision for prostate biopsy within the Irish population.

Methods: The clinical information of 2899 patients from 6 Irish rapid access prostate centres was analysed. A risk calculator for the diagnosis of PCa and another for the diagnosis of high grade (Gleason ≥7) PCa were created via logistic regression. The models underwent 10 fold cross validation and were internally validated in each cohort. The components of the risk calculators are age, digital rectal examination, family history of PCa, prior negative biopsy and PSA level.

Results: The Irish Prostate Cancer Risk Calculator (IPRC) demonstrated a significantly improved predictive ability over PSA alone, in terms of both PCa and high grade PCa (P < 0.001). The AUC values of the IPRC in each cohort are shown in Table 1. The novel model also demonstrated a net benefit on decision curve analysis and a suitable calibration in each cohort.

Conclusion: An Irish prostate cancer risk calculator created from a national collection of patients can allow for individualised risk stratification and can be used to improve clinical decision making in Irish men under investigation for PCa.

Table 1 AUC Values Of The Irish Prostate Cancer Risk Calculator (IPRC) and Prostate Specific Antigen (PSA) in 6 Irish Cohorts

<table>
<thead>
<tr>
<th>Cohorts</th>
<th>Patients (n)</th>
<th>Prostate Cancer</th>
<th>High Grade (Gleason ≥7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IPRC</td>
<td>PSA</td>
</tr>
<tr>
<td>Cohort 1</td>
<td>982</td>
<td>0.70</td>
<td>0.67</td>
</tr>
<tr>
<td>Cohort 2</td>
<td>679</td>
<td>0.65</td>
<td>0.54</td>
</tr>
<tr>
<td>Cohort 3</td>
<td>399</td>
<td>0.72</td>
<td>0.58</td>
</tr>
<tr>
<td>Cohort 4</td>
<td>318</td>
<td>0.69</td>
<td>0.61</td>
</tr>
<tr>
<td>Cohort 5</td>
<td>307</td>
<td>0.63</td>
<td>0.55</td>
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<tr>
<td>Cohort 6</td>
<td>214</td>
<td>0.69</td>
<td>0.56</td>
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</table>

Poster 2
Multi-parametric magnetic resonance imaging-transrectal ultrasound fusion target transperineal prostate biopsy: Initial Irish experience
A ASLAM, J DRUMM, M AKRAM, HD FLOOD and SK GIRI
University Hospital Limerick

Introduction: Multi-parametric magnetic resonance imaging (mpMRI) appears to be an excellent method to identify clinically important prostate cancer (PCa). The use of mpMRI-transrectal ultrasound (TRUS) fusion target transperineal prostate (FTTP) biopsy is rapidly evolving and does require development and can be used to improve clinical decision making in Irish men under investigation for PCa.

Table 1 AUC Values Of The Irish Prostate Cancer Risk Calculator (IPRC) and Prostate Specific Antigen (PSA) in 6 Irish Cohorts

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</tr>
</tbody>
</table>

Results: Median age, PSA and number of previous biopsy episodes were 65 year, 10 and 2 respectively. Median number of cores per target lesion was 3. Median number of cores outside target was 12. Overall CDR was 64% (8/14). CDR for target lesion was

yield, and Gleason score (GS) were prospectively collected. Participants underwent a 3T mpMRI with diffusion weighted dynamic contrast enhancement, perfusion scan and preoperative mapping. One experienced uroradiologist graded all suspicious lesions on a 5-point Likert scale. MRI-TRUS-FTTP biopsies were performed in 14 patients with advanced image registration software. Minimum of 2 cores were taken from target area and 12 cores form outside target area. Overall and target area cancer detection rate (CDR) were calculated.

Results: Median age, PSA and number of previous biopsy episodes were 65 year, 10 and 2 respectively. Median number of cores per target lesion was 3. Median number of cores outside target was 12. Overall CDR was 64% (8/14). CDR for target lesion was
Diagnosis of localised prostate cancer (PCa) is currently dependent on sampling the prostate gland by needle biopsy. Improved preoperative identification and staging of PCa using multiparametric MR (mpMRI) scans is currently under assessment. The accuracy of MR scans in this regard and the value of MR-targeted needle biopsy remain controversial.

We prospectively assessed the accuracy of mpMRI (1.5 Tesla) in detecting PCa lesions in a series of 57 patients who underwent pre-biopsy mpMRI, followed by TRUS biopsies and subsequently radical prostatectomy for clinically significant localised PCa. The MR scans were reported on an individual zone basis (apex/middle/base, right/left, anterior/posterior). The RRP specimens were similarly reported pathologically for the presence of PCa using the same zonal anatomy. The results of mpMRI and RRP specimens were correlated and sensitivity and specificity of mpMRI were calculated.

mpMRI showed positivity for PCa in 58 out of 636 prostatic zones in this series. MR detectable PCa was identified in 140 out of 636 prostatic zones. The results on mpMRI compared to histology were as follows: true positive—38, false positive—20, true negative—422, false negative—156, giving a positive predictive value of 66% and a negative predictive value of 73%.

This study shows that mpMRI scanning contributes to the accuracy of preoperative diagnosis and staging of localised PCa. The data support the use of mpMRI in the pre-biopsy assessment of patients who are scheduled for prostate biopsy.

Poster 4
Transperineal biopsy – Initial experience at a single Irish centre
M SAMUJI1, K O’REGAN1, J BUCKLEY1, P SWEENEY2, MF O’BRIEN1,2, C HEFFRON1, N MAYER1 and P KELLY1
1Cork University Hospital; 2Mercy University Hospital, Cork; 3University Hospital Waterford

Introduction: There is increasing use of transperineal biopsy (TP biopsy) in both the diagnosis and active surveillance of prostate cancers. TP biopsy offers the potential to reduce sampling error, an inherent risk with standard transrectal (TRUS) biopsy. Here we report the initial experience of TP biopsy at Cork University Hospital (CUH).

Methods: This is a retrospective review of the initial TP biopsies undertaken at CUH between December 2012 and April 2015. The indications for TP biopsy at CUH include: (see figure 1).

1. The presence on MRI of an imaging target suspicious for prostate carcinoma unlikely to be sampled by repeat standard TRUS biopsy. Cognitive fusion biopsies are performed in addition to standard template.

2. Persistent clinical suspicion of prostate cancer despite prior negative TRUS biopsy.

TP biopsy was not used as part of an active surveillance protocol.

TP biopsy was undertaken as a day case procedure in brachytherapy theatre in the lithotomy position under GA using an aseptic technique and utilizing a standard brachytherapy template. The Guy’s Hospital transperineal sector biopsy technique was adopted. Antibiotic prophylaxis consisted of co-amoxiclav only.

Results: Forty-five patients underwent TP biopsy. 24 (53%) were diagnostic of prostate cancer, including 18 (40%) with clinically significant disease (defined as Gleason ≥3 + 4 = 7). Four patients developed acute urinary retention. One patient...
Experience haematuria No patient to date has experienced a UTI/episode of sepsis.

**Conclusions**: Initial experience suggests a high yield of clinically-significant prostate cancers. Procedure-related toxicities appear reassuring to date.

**Poster 5**

**Prostate volume estimation can significantly improve prostate cancer diagnosis**

R FOLEY1,2, R MURPHY1,2, D LUNDON1,3,5, G DURKAN5, R POWER2, D GALVIN2,3, TB MURPHY1,2 and RW WATSON1,2

1Conway Institute of Biomolecular and Biomedical Research, University College Dublin; 2School of Medicine and Medical Science, University College Dublin; 3School of Mathematical Sciences, University College Dublin; 5Insight Centre for Data Analytics, University College Dublin; 6Department of Urology, Mater Misericordiae University Hospital, Dublin; 7Department of Urology, University Hospital Galway; 8Department of Urology, Beaumont Hospital, Dublin.

**Introduction**: The decision for prostate biopsy is a difficult one. In order to diagnose prostate cancer (PCa) most effectively, we must use the best possible risk factors. The objective of this study is to examine whether an estimation of prostate volume could improve patient risk stratification in line with the ERSPC risk calculator.

**Methods**: The risk of PCa in 2001 patients from 4 Irish hospitals was calculated according to two leading PCa risk calculators, the PCPT-RC and ERSPC-RC. The ERSPC-RC includes a prostate volume estimate based on transrectal ultrasound, classified as small, medium or large (<30, 30-50 or >50 cm³). The use of these categories potentially allow for prostate volume to be estimated on digital rectal examination (DRE).

**Results**: The ERSPC-RC significantly (P < 0.001) outperformed the PCPT-RC in the prediction of PCa, with an AUC of 0.71 compared to 0.64. The ERSPC-RC also demonstrated a superior net benefit on decision curve analysis and an improved calibration in this Irish cohort.

**Conclusion**: The performance of the ERSPC-RC demonstrates that the inclusion of prostate volume in risk stratification prior to prostate biopsy will improve PCa diagnosis in Ireland. However prostate volume from transrectal ultrasound is currently not clinically applicable in the decision making timeline. Volume estimation by DRE could represent a reliable surrogate and more appropriate method to make use of this important risk factor. If the prostate volume can be estimated accurately on DRE, this risk factor will become a powerful tool for the diagnosis of PCa in Irish men.

**Poster 6**

**Reduction of post TRUS biopsy sepsis**

A DOWNEY, G HANN and A THWAINI

Belfast City Hospital, Belfast, Northern Ireland

**Introduction**: TRUS biopsy of prostate is the mainstay of diagnosis of prostate cancer however carries a 10% risk of UTI and 2% septicaemia. Antibiotic prophylaxis is given pre-biopsy – in our unit 120 mg Gentamicin IV pre-procedure, 500 mg PR Metronidazole post-procedure and 3 days 500 mg BD PO Ciprofloxacin. A perception of rising incidence of post-biopsy sepsis in our unit led to a closed loop audit.

**Methods**: Data was collected retrospectively over 3 months from 98 patients. Following a literature review and discussion with local microbiology department the dose of IV gentamicin pre-procedure was increased to 240 mg. Data was then collected prospectively for 65 patients over 3 months. 24/98 (24%) of patients in the initial loop had undergone previous biopsy and 10/65 (15%) in the second loop.

**Results**: 14/98 (14%) of patients in the initial loop had post TRUS-BP sepsis – 3 admitted; one patient required transfer to ICU. 6/14 (42%) had undergone previous biopsy. Following the introduction of increased gentamicin dosage the incidence of infection decreased to 3/65 (6%) – all admitted but none requiring ICU admission. 2/3 (66%) had undergone previous biopsy.

**Conclusion**: Introduction of higher dose IV Gentamicin pre-biopsy reduced the incidence of post biopsy sepsis from 14% to 6%. Patients who have had a previous biopsy appear to be at higher risk – there is rising evidence that increased quinolone resistance is associated with increasing post-biopsy sepsis. Our unit is currently investigating use of rectal swabs to identify at risk patients to further decrease the incidence of post-biopsy infection.

**References**

1. Lorb G1, Benenson S, Rosenberg S, Gofrit ON, Pode D. “A single dose of 240 mg gentamicin during transrectal prostate biopsy significantly reduces septic complications” Urology. 2013 Nov;82:998–1002

**Poster 7**

**The hidden burden of outpatient repeat PSA testing in a prospective cohort**

E BROWNE1, F O’KELLY1, D LUNDON1, P DALY1, D GALVIN1, N HEGARTY1, J THORNHILL2 and K O’MALLEY1

1Mater Misericordiae University Hospital, Dublin; 2Tallaght Hospital, Dublin.

**Introduction**: Failure to follow up non-PSA test results poses a challenge in an outpatient setting. Although an increasing number of primary care practices have implemented electronic ordering with direct links to hospital laboratories for results, increased volumes of tests and the time consuming nature of follow-up places further pressures with failure to appropriately follow-up on abnormal results, increased costs, and medico-legal implications. What is also currently unknown is on whom the onus of responsibility lays.

Table 1 Complications

<table>
<thead>
<tr>
<th>N = 46</th>
<th>Complication</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 3</td>
<td>Urinary Retention</td>
<td>78cc gland, successful TWOC</td>
</tr>
<tr>
<td>Case 20</td>
<td>Urinary Retention</td>
<td>96cc gland, successful TWOC</td>
</tr>
<tr>
<td>Case 27</td>
<td>Urinary Retention</td>
<td>120cc gland, TURP</td>
</tr>
<tr>
<td>Case 42</td>
<td>Urinary Retention</td>
<td>80cc gland, successful TWOC</td>
</tr>
<tr>
<td>Case 37</td>
<td>Haematuria</td>
<td>Admitted overnight for observation, resolved</td>
</tr>
</tbody>
</table>
Methods: We carried out a prospective outpatient cohort study of 250 consecutive men (2013–2015) over two hospital sites. Inclusion criteria were those men who were being followed up by urology with PSA blood testing. Exclusion criteria included first appointments and those men in whom tests other than PSA were ordered by urology. Univariate and multivariate analyses were performed using SPSS v20© (IBM corporation).

Results: The median pt age wa 67.2 years (46–88) with 78% cases were initially seen at consultant/registrar level. 64% tests were for follow-up, 81.2% samples had a combination of 21 different serology tests at an added cost of >£18,000. Abnormal serology resulted in 53 referrals. 26% letters made reference to abnormal serology other than PSA.

Conclusion: Failure to follow-up test results in an outpatient setting is a combination of systems and physician interaction. There is currently no Irish legislature in place to safeguard hospital physicians from malpractice complaints, with precedence evident in the UK. This study demonstrates an under-appreciation of the levels of expenditure, resources and risk when addressing ambulant PSA testing.

References

Poster 8
Transferring from open to robot assisted radical prostatectomy: A single surgeon experience of the first 50 cases
S CONSIDINE1,2, E BOLTON1, D MORAN1, K CANAVAN2, P O’MALLEY3, D BOUCHIER-HAYES2 and G DURKAN1,2
1Galway University Hospital; 2Galway Clinic

Introduction: Robot-assisted radical prostatectomy (RARP) has emerged as a popular alternative to Open Radical Prostatectomy, allowing shorter length of hospital stay and lower rates of transfusion, while retaining oncologic equivalence. However, RARP remains a technically demanding procedure with a significant learning curve, even for surgeons experienced with the open operation.

Methods: We present results of the first 50 cases of RARP performed by an experienced prostate cancer surgeon.

Results: Cases were performed between January 2014 and January 2015, equating to a mean of 0.96 operations per week. Mean patient age was 58.4 ± 6 years with mean PSA 7.01 ± 3.6 at time of surgery. Distribution of TRUS biopsy histology was Gleason 3+3 (19), 3+4 (25), 4+3(4), and higher (2). Mean operative time was 190 ± 34.5 min and median blood loss 400 mL (75–1000). Median length of stay was 2.5 days (2–7). Two cases were converted to open (bleeding, abnormal anatomy) and 1 case abandoned due to unresectable disease. Perioperative complications occurred in four patients (ileus (2), bladder injury (1), PE (1)). Histology showed T2 disease in 84.8% and T3 in 15.2%. Positive margins were seen in 7 patients, 4 of whom had T3 disease. PSA was undetectable in 95% (n = 37) at 6 weeks, 93.1% (n = 27) at 3 months and 80% (n = 4) at 1 year. Return to continence was achieved in 65% at 6 weeks, 88% at 6 months and 100% at 6 months.

Conclusion: Despite representing the first cases performed, our series demonstrates peri-operative, oncological and functional outcomes in keeping with those from major international series.

Poster 9
Prior bladder outlet surgery (PBOS) or large prostate volume does not adversely affect biochemical recurrence-free survival in low dose rate prostate brachytherapy: An intermediate term analysis
A GOGGIN1,2, H YAMAMOTO1,2, H MOLLER1,4, J WITHERINGTON3, R BEANEY3, S MORRIS1, P ACHER2, B CHALLACOMBE1, P DASGUPTA1,2 and R POPERT3
1Department of Urology, Guy’s & St. Thomas’ NHS Foundation Trust, London, UK; 2Queen’s University Belfast, UK; 3Division of Transplantation Immunology & Mucosal Biology, NIHR Biomedical Research Centre, King’s College London, UK; 4Division of Cancer Studies, Guy’s & St. Thomas’ NHS Foundation Trust, London, UK

Introduction: PBOS and large prostates have been considered contraindications to permanent prostate brachytherapy implant (PPB) due to unacceptable toxicity and technical difficulties leading to poor oncological control [1]. This study aims to determine the outcomes of patients with PBOS and the influence of prostate size on oncological control.

Methods: Patients undergoing monotherapy PPB for low to intermediate prostate cancer between 2003–2013 were assessed. Primary outcome was biochemical recurrence free survival (BRFS) defined by PSA rise >2 ng/mL above nadir. Secondary outcomes were the incidence of toxicity according to the Radiation Therapy Oncology Group toxicity grading, salvage therapy and PSA nadir. Univariate Kaplan-Meier, multivariate cox proportional hazards and logistic regression analyses were conducted.

Results: A total of 411 patients were identified including 76 (19%) with PBOS. Median follow up was 43 months and mean D90 was 171 (±13) Gy. Grade 3 toxicity was experienced in 12 patients, 9/333 of non PBOS and 5/78 of PBOS patients (P = 0.15). There was no significant difference in actuarial BRFS between those with and without PBOS (P = 0.66). Favourable BRFS was observed in larger prostate volumes when analysed by size quartiles (P = 0.02). Multivariate analysis (Fig. 1) showed large prostate volume as the only independent pre- treatment predictor of BRFS (P = 0.023). Post-treatment variables found prostate volume (HR = 0.931, P = 0.019), PSA nadir (P = 0.002) and time to nadir (P < 0.001) to be independent predictors of BRFS.

Conclusion: Larger prostate glands experience better BRFS after PPB than smaller glands. History of PBOS did not affect BRFS nor increase the incidence of grade III toxicities. Therefore PBOS and large prostate size are not a reason to deny patients PPB.

References
Fig. 1 Multivariate analysis of pre and post-treatment variables for biochemical recurrence free survival (BRFS) after PPB.

Introduction and Aims: Radical surgery and radiotherapy are highly effective in improving prostate cancer survival, but both have significant side effects: Erectile dysfunction is the most frequent side effect and also the primary impact on quality of life after radical prostatectomy. Erectile Dysfunction post radical therapy is due to any combination of neuropraxia, arterial insufficiency, veno-occlusive disease, hormonal changes and psychological factors.

The purpose of this study was to characterise the demographics, characteristics...
and initial outcomes of men attending Ireland’s first dedicated penile rehabilitation clinic in the Mater Misericordiae University Hospital.

**Methods:** Prospective collection of relevant data was performed on all men referred to this service between September 2014 and March 2015. Data was collated and analysed in Minitab v16.

**Results:** The median age of attendees was 60 years, all attendees underwent treatment for malignancy, 96% of whom underwent radical retropubic prostatectomy. Self-reported compliance with vacuum erectile device therapy 1 month post commencement was 100%. At a median follow up of 3 months there was a significant improvement in quality of life ($P < 0.05$) and sexual health indices ($P < 0.05$).

**Conclusion:** Although prostate surgery has been pioneered by Irish surgeons more than a century ago, the first dedicated rehabilitation clinic for the most significant side effect of the treatment of prostate cancer was recently opened. Demand, patient satisfaction and early outcomes from this service suggest that expansion of its offerings can further improve health related quality of life outcomes for men undergoing radical pelvic surgery.

**Poster 11**

**Adjustable suburethral sling (male remex system) in the treatment of male SUI**

*S CONSIDINE1, D MORAN1, E BOLTON1, U HAROON1, G NAMA2, H GHOUS2, A CHAM2, R SIDDIQUI2 and S JAFFRY1,2

1Galway University Hospital, Galway; 2Galway Clinic, Galway

**Introduction:** Stress urinary incontinence is a known complication of surgical intervention to the prostate, which has significant effects on patient’s quality of life. We performed a retrospective review to evaluate the effectiveness of a readjustable sling for the treatment of male stress urinary incontinence (SUI).

**Methods:** Between 2007 and 2015, 21 male patients with moderate to severe SUI were operated on with the use of a readjustable sling (MRS) at two hospital sites. The cause of incontinence was radical prostatectomy in 19 patients (2 post adjuvant EBRT) and TURP in 2. Duration of incontinence ranged from 1 year to 3 years.

**Results:** All patients required a second adjustment under GA in the surgical day ward between 1 and 36 months after surgery. After that, 20 patients (95.2%) were considered cured (17 of them wore no pads at all, and 3 used small pads or sanitary napkins for security but normally remained dry); the remaining 1 case showed significant symptomatic improvement. Mean follow-up time was 36 months (range: 16–50). Complications included 1 (4.2%) intraoperative bladder perforation and 3 mild perineal haematoma (14.2%). Most patients experienced minor perineal discomfort or pain in the peri-operative period, which was easily treated with oral medications.

**Conclusions:** The MRS allowed readjustment of the suburethral sling pressure at the immediate or midterm postoperative period, which a resultant achievement of excellent midterm results in 95.2% of patients without significant postoperative complications.

**Poster 12**

**Trans-obturato r urethral sling placement for treatment of post prostatectomy urinary incontinence: A safe and effective procedure**

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Department of Urology, St James’s Hospital, Dublin

**Introduction:** Male stress urinary incontinence after radical prostatectomy (RP) is a distressing symptom and surgical options include the artificial urinary sphincter or peri-urethral sling. We report long term results from our series of advance peri-urethral sling insertions.

**Methods:** Study population consisted of a consecutive cohort of men undergoing sling insertion following RP. Parameters assessed included pre and post-operative urinary function, 24 h pad use, complications rates and further treatments. Degree of incontinence was categorised as mild (1–2), moderate (3–5) or severe (>5). The ICIQ-SF was used to assess symptom severity and quality of life outcomes.

**Results:** Sixty patients were included in the study with 18.3% having had adjuvant radiation (RT) post RP. Mean age 67 years with average time to sling post RP 34 months. Mean follow up 32 months. Pre-operative degree of incontinence: mild 23%, moderate 54%, severe 23%. Seventy-two percent experienced complete resolution of symptoms post sling, 10% significant improvement, with 18% having no reduction in pad use. Eight of 14 patients with severe incontinence were classified as cured. 64% with an unsatisfactory outcome had adjuvant RT. The ICIQ-SF score decreased from a baseline 18.3 (9–21.0) to 8.0 (0–20) ($P < 0.001$), CI 95% (7.9–12.7), 80% of survey respondents stated they would recommend this operation to a friend.

**Conclusion:** Peri-urethral slings are effective and safe for all degrees of post RP urinary incontinence and are associated with improved quality of life parameters. We would suggest its use in selected patients in preference to an artificial urinary sphincter.

**Poster 13**

**Impact of urethral sphincter length on urinary continence after radical treatment of prostate cancer: A magnetic resonance imaging based study**

*EJ REDMOND1, HD FLOOD1, O FAGAN2, D OHIO3, M EL BASSIOUNI1, G DURKAN1 and S GIRI4

1University Hospital Limerick, Limerick; 2Graduate Entry Medical School, University of Limerick

**Introduction:** The urethral sphincter complex is a fundamental component of the male continence mechanism. We hypothesise that pretreatment urethral sphincter length (USL) visualised on Magnetic Resonance Imaging (MRI) is crucial for recovery of urinary function following radical treatment. The aim of this study was to investigate the influence of USL on urinary continence following radical treatment of prostate cancer (PCa).

**Methods:** All PCa patients who underwent pretreatment MRI in our institution between January 2012 and December 2012 were identified from the radiology database. Only patients aged between 50 and 70 were included in analysis. Disease specific quality of life was assessed using the EPIC questionnaire. The USL of each patient was measured by two independent reviewers and correlated with urinary continence. Each patient was at least two years post radical treatment.
Results: Forty-three patients met the inclusion criteria for this study. Eight patients who underwent radical prostatectomy and two patients who underwent radical radiotherapy had continued urinary incontinence. The median age of both wet and dry groups were comparable (63 years vs 66.2 years). The median USL was significantly shorter in the wet group than the dry group (5 mm vs 10.5 mm).

Conclusion: We observed wide variation in the USL in this study. A shorter USL as measured on preoperative MRI is likely to influence urinary continence following radical treatment for PCa.

Poster 14
The efficacy of vacuum erectile devices (VED) post radical prostatectomy - the initial experience of the first dedicated VED clinic in Ireland
GJ NASON, M TWFORD, S WHITE, E DUNNE, GP SMYTH and RE POWER
Department of Urology, Beaumont Hospital, Dublin

Introduction: The use of vacuum erectile devices (VED) have been shown to be aid return of erections as part of penile rehabilitation programs post prostatectomy. The aim of this study is to assess patients’ experience of the first VED clinic in Ireland.

Methods: A retrospective chart review was performed of all patients who have attended the clinic. Each patient underwent a one-to-one educational session with a manufacturer representative using the VED (SOMAerect Response II). A voluntary telephone questionnaire was conducted regarding their use of the VED and their experience of the clinic.

Results: Forty-eight patients have attended the clinic to date. The mean age of patient was 63.2 years. The mean initial PSA was 4.8. 20 had Gleason 3+3, 23 Gleason 3+4, 3 had Gleason 4+3 and 2 had Gleason 4+4 disease. The mean pre-operative and 3-month postoperative IIEF scores were 22 and 11 respectively, (P = 0.0001).

Thirty-eight patients responded. Twenty-five are currently sexually active. Of these, 21 achieve erections sufficient for intercourse. The mean erection hardness grading scale score is 3. All found the VED clinic useful regarding the technical aspects of using the pump and would recommend the pump to other men with ED.

Of those who are not sexually active, only one reported issues with the pump.

Conclusion: The introduction of a dedicated VED clinic is a useful adjunct for the treatment of ED post RP. Patients were satisfied with the clinic and most found the VED effective.

Session 2: General Urology
Poster 15
Tips, techniques and strategies to optimize clearance of large intrarenal calculi in morbidly obese patients
FT D’ARCY1,2, D O’KANE1, P LIOODAKIS1, N LAWRENTCHUK3,4, RP MANECKSHA1,5, D WEBB1 and D BOLTON1,4
1Urology Unit, Department of Surgery, Austin Health, University of Melbourne, Melbourne, Vic., Australia; 2Department of Urology, University Hospital, Galway; 3The Peter MacCallum Cancer Centre, Melbourne, Vic., Australia; 4Ludwig Institute for Cancer Research, Austin Hospital, Melbourne, Vic., Australia; 5Department of Urology, St James and Tallaght Hospitals, Dublin

Introduction & Objectives: The increasing incidence of obesity in developed countries has been associated with multiple comorbidities including urolithiasis. Body habitus and anaesthetic considerations may limit the operative options available to morbidly obese patients who need to have their complex stone disease treated. Staggered sessions of flexible ureterorenoscopy (FURS) and laser lithotripsy are sometimes the only feasible option open to these patients. We outline techniques the operating urologist can use to maximize stone clearance in these complicated patients.

Methods: This presentation outlines how PICC line insertion significantly speeds up induction of anesthesia and allows prompt administration of IV antibiotics in a postoperative urosepsis scenario.

Results: Fig. 1 (A) Bifid right ureter (B) Gonadal vein (C) Inferior vena cava (D) Abdominal aorta (E) Right common iliac artery

Poster 16
A review of the anatomical variations of the ureter and their implications for surgical intervention
J COSTELLOE, N MAHONY, P TIERNEY, W RYAN and D BARRY
Department of Anatomy, Trinity College Dublin, Dublin

Introduction: This aim of this study was to describe the variations present in the anatomy of the ureter in a series of cadaveric donors. An improved knowledge of these variations could reduce the risk of ureteric injury during surgical procedures. The advent of endourology has led to urological cases accounting for most cases of ureteric injury [1]. In up to 25.8% of cases of ureteric injury, the surgeon reported difficulties due to distorted anatomy [2].

Methods: Twelve cadavers (5 male, 7 female) were selected. The ureter was accessed via a transperitoneal approach and dissected from the level of the renal hilum to the vesicoureteric junction. A series of measurements (Table 1) and the presence of variations were recorded. The results were photographed throughout (Figs 1, 2).

Results: Fig. 1 (A) Bifid right ureter (B) Gonadal vein (C) Inferior vena cava (D) Abdominal aorta (E) Right common iliac artery

Fig. 2 (A) Left extra renal pelvis (B) Ureter (C) Distended left renal vein (D) Gonadal Vein

Conclusion: This study allowed the quantification of ureteric parameters and anatomical relations via donor dissection. The advantage of this method over surgical studies is that it permits an unlimited field of dissection, while also avoiding some of the errors in measurement inherent in imaging studies.
Table 1 Measurements in cm

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean total length of the ureter</td>
<td>24.16 ± 2.17</td>
</tr>
<tr>
<td>Mean total length of the right ureter</td>
<td>24.02 ± 2.87</td>
</tr>
<tr>
<td>Mean total length of the left ureter</td>
<td>24.29 ± 1.32</td>
</tr>
<tr>
<td>Mean distance (from the PUJ) crossed by gonadal vessels</td>
<td>6.49 ± 1.89</td>
</tr>
<tr>
<td>Mean distance (from the PUJ) crossed by uterine artery</td>
<td>20.59 ± 1.43</td>
</tr>
<tr>
<td>Mean distance (from PUJ) crossed by vas deferens</td>
<td>14.83 ± 7.9</td>
</tr>
<tr>
<td>Mean distance from the point crossed by the uterine artery to the margin of the cervix</td>
<td>3.11 ± 0.82</td>
</tr>
<tr>
<td>Mean distance from lateral border of abdominal aorta to midpoint of abdominal ureter</td>
<td>4.52 ± 1.51</td>
</tr>
</tbody>
</table>

Variations identified
- Duplication of ureter (1)
- Extra renal pelvis (1)

References

Poster 17
Tailored length permanent stents for the treatment of ureteric obstruction
EM BOLTON, S CONSIDINE, D MORAN, R SIDDQUI, A CHAM, N NUSRAT, G DURKAN, E ROGERS, K WALSH and S JAFFRY
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Introduction: Minimally invasive management of patients with ureteric obstruction continues to pose challenges. Conventional polymeric ureteric stents have bothersome side effects.

We present our single institution experience with tailored long-term ureteric stent placement using Allium and Memokath 051 stents. Both stents are composed of a nickel-titanium alloy and the Allium lined with a non-permeable co-polymer.

Methods: Data collected on 30 patients is included. The ureteral stent symptom questionnaire (USSQ) was administered to all patients. CT IVU with sagittal views were performed 3 months post-insertion.

Results: Twenty-four patients had benign ureteric strictures and 6 malignant obstructions. All patients had pain and/or hydronephrosis before treatment. The short segment self-expanding Allium stent was inserted in 9 patients, and a Memokath 051 thermo-expandable stent in remaining patients. Balloon dilatation was necessary in 18 cases prior to stent placement. Insertion was complicated by ureteric perforation in 1 patient and conservative management applied. An 87% (26/30 patients) primary patency rate was observed in total, 100% (9/9) with the Allium stent.

Stent migration was observed in 4 patients with Memokath 051 stents and 0 patients with Allium stents. Noted complications were mild flank pain lasting a few days post-implantation, and self-limiting hematuria. We found that the newer metal stent, particularly the Allium stent scored significantly better than the conventional polymeric stent on most components of the USSQ.

Conclusions: The self-expanding Allium ureteric stent represents an effective minimally invasive treatment of ureteric stenosis in both malignant and benign cases due to its inherent tensile strength.

Poster 18
Do closed end double-pigtail ureteric stents improve patient quality of life when compared to open ended stents: A prospective study
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Galway University Hospital, Galway

Introduction: Vesicoureteral reflux (VUR) leading to flank pain has been demonstrated with ureteric JJ stents in animal models; observed in 63% of renal units during filling and 80% during voiding. Ureteric stenting also leads to reduced peristalsis due to smooth muscle spasm, resulting in lower urine flow, increased VUR and stent related symptoms.

Conventional ureteric stents have a central lumen and multiple side holes.

We hypothesise that less morbidity is encountered in patients receiving stents with a closed proximal end within the renal pelvis.

Methods: Prospective data collection. Patients were blindly randomised into 2 stent groups; open/open JJ stents (Group 1) and open/closed JJ stents (Group 2).

The ureteral stent symptom questionnaire (USSQ) was administered to all patients at baseline and every 7 days post-placement; Visual Analogue Scale graded from 1 to 5 (mild to severe symptoms). Parameters evaluated: flank pain during micturition, macroscopic haematuria and suprapubic pain caused by bladder spasm, analgesic requirement.
Results: Twenty patients have been enrolled to date in each group. Eight patients in Group 2 did not tolerate open/open stents previously. Data collection is ongoing as study end point is stent removal. Preliminary data shows that 17/20 (85%) patients in Group 2 are consistently scoring 1 on USSQ, compared to 15/20 (75%) patients in Group 1 scoring 3. Final study outcomes will be presented at the meeting.

Conclusions: Patients with closed proximal end stent appear to have lower USSQ pain scores and analgesic requirement on days 7, 14, 21 and 28, resulting in greater ureteric stent tolerability.

Poster 19
Newborn undescended testes: Do most really descend?
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14th Year Medicine, University College Cork; 2Department of Neonatology, Cork University Maternity Hospital; 3Department of Urology, Cork University Hospital

Introduction: Spontaneous descent of the cryptorchid testis is rare after 6 months of age, and clinical practice is based on the standard teaching of a 70% spontaneous testicular descent rate in full-term infants.1 However, a recent report of a spontaneous descent rate of 8.9% of 429 cryptorchid testes, with a mean age of presentation of 2.7 months casts doubt on this teaching.2

All infants born at Cork University Maternity Hospital (CUMH) have a newborn examination performed by a neonatologist predischARGE. Our current protocol advises that any boy with cryptorchidism is reviewed in outpatients at 6–12 months. If cryptorchidism persists a referral is made to Urology.

This study investigates the spontaneous testicular descent rate in cryptorchid boys born in (CUMH) and identified at their predischarge newborn examination (before the onset of the cremasteric reflex).

Methods: All boys diagnosed with cryptorchidism at the newborn examination between January 2009 and December 2012 were included. The hospital records of these boys were reviewed and the outcome regarding testicular descent is reported.

Results: Sixty seven boys (84 undescended testes) were included. Thirty one testes (37%) spontaneously descended and 53 (63%) did not and proceeded to surgery. When 7 boys with syndromes associated with cryptorchidism were excluded, leaving 60 boys (74 testes), a spontaneous descent rate of 41% (30) testes was found.

Nine of these 60 boys were premature and 8 of the 16 cryptorchid testes in this group descended. Only one of the 10 undescended testes in the 7 boys with associated syndromes (Trisomy 21, Pradar Willi, Spina Bifida) spontaneously descended.

Conclusions: Contrary to standard teaching, our study agrees with a recent report that the newborn undescended testis is likely to remain so. Earlier surgical referral is therefore appropriate to facilitate surgery within 12 months as recommended.3 Spontaneous descent is marginally more likely in premature boys and very unlikely in those with associated syndromes.

References

Poster 20
Testicular tumour referral patterns: The emergency department has become a common pathway
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Introduction: An average of 132 cases of testicular cancer per year have been diagnosed in Ireland over the last 20 years, with incidence has increasing over that time (1). Prompt diagnosis and treatment remain a priority but access to outpatient investigation is an issue for GPs. A rapid access testicular cancer clinic in Cork has published positive early results with ongoing as study end point is stent removal. Preliminary data shows that 17/20 (85%) patients in Group 2 did not tolerate open/open stents previously.

Methods: A retrospective analysis was performed of patients who underwent radical orchidectomy for testicular cancer in our institution from 2012 to 2014. The referral pathway of these patients was compared to patients undergoing the same procedure from 2002 to 2004. Further data was analysed such as indication for referral, duration of symptoms, tumour type and stage.

Results: Over the last 3 years a total of 47 patients underwent radical orchidectomy for malignancy. In total, 32% were admitted through the emergency department (ED), versus 5.8% of patients 10 years ago. Of those admitted through ED 13 were referred by GP, with 2 self referrals. In 66% of cases patients presented with an abnormal feeling testicular mass, 20% were query epididymo-orchitis. The median length of symptoms was 4 weeks. These patients had no difference in tumour stage or nodal disease compared to those referred through outpatients.

Conclusion: There has been a significant increase in testicular tumours referred directly to ED compared to a decade ago. A rapid access testicular cancer clinic could provide a better referral pathway.

References
who underwent ultrasonography for blunt scrotal trauma between 1998 and 2014. Each patient was contacted by telephone to assess for testicular atrophy.

**Results:** Thirty-eight consecutive patients were identified for inclusion in the study. Sixty-three percent (24/38) were diagnosed with significant testicular injury. One patient with testicular rupture underwent immediate exploration with partial orchidectomy and repair of the tunica. In this single case, the decision to operate was based on the individual preference of the surgeon on call. When contacted as part of the study, this patient reported testicular atrophy. The remaining 37 patients were managed conservatively regardless of ultrasound findings. Of these, 3 patients reported testicular atrophy. None reported chronic pain or required delayed orchidectomy. Four patients underwent repair of an asymptomatic post-traumatic hydrocele.

**Conclusions:** Our experience shows that the outcome from conservatively managed blunt scrotal trauma is superior to case series where the testis was surgically explored.

**Poster 22**

A **comparative analysis of the hidden workload of geriatric consults within urological surgery – Is it time for the appointment of a urogeriatrician?**

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**Introduction:** Few studies exist investigating the aetiology and outcomes of urology inpatient referrals, with most focusing on aspects of urethral catheter care and education. This is relevant in an era of increasing patient expectations and dwindling physician numbers.

**Methods:** All consultations to the urology service were identified from the Electronic Patient Record (EPR) inpatient consultation system from January 2010 to June 2014. Consults were categorized according to patient/referral team demographics as well as follow-up data on investigations, interventions and subsequent outpatient appointments.

**Results:** Three thousand and four-hundred and fifty-six inpatient consults were recorded during this 52-month review. 1989 (57.5%) patients were >65 years old. There was a male preponderance of 77.5% with 10.4% >90 years old (65–100 year). The transfer rate of geriatric patients to the urology service was 6%, half of the overall transfer rate, and there were significantly greater levels of consults in this age group nearly all measured criteria. Time implications for this cohort stood at 1000 h (5 h/week). Estimated non-procedural costs amounted to €220,000 (€110 per consult).

**Conclusion:** Geriatric inpatient consultations constitute a significant workload for urology. The majority of these do not result in definitive management leaving significant cost/time implications. Providing structured referral guidelines, risk stratification improving communication with referring teams, may help optimize and streamline services. This cohort of patients represents a significant hidden burden of service commitment, not typically captured in key performance indices.

**References**

**Poster 23**

The **impact of a structured clinical training course on interns’ self-reported confidence with core clinical urology skills**

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**Introduction:** Undergraduate training in core urology skills is lacking in many Irish training programmes (1–2). Our aim was to assess interns’ clinical experience and confidence with core urological competencies in a university teaching hospital.

**Methods:** A questionnaire survey covering exposure to urology and confidence with core clinical skills was circulated to all interns. The group then attended a skills course covering male/female catheterization, insertion of 3-way catheters, bladder irrigation and management of long term suprapubic catheters. The group were surveyed following the course.

**Results:** Thirty-two interns completed the pre-course survey (group 1) and 26 interns completed the post-course survey (group 2). 24/45 (53%) had no experience of catheter insertion on a patient during their undergraduate training. 26/45 (58%) were unsupervised during their first catheter insertion. 12/45 (27%) had inserted a female catheter. 18/45 (40%) had inserted a 3-way catheter. 12/45 (27%) had changed a suprapubic catheter.

40/45 (89%) in group 1 reported ‘good’ or ‘excellent’ confidence with male urinary catheterization, compared to 25/27 (92.5%) in group 2. 18/45 (40%) in group 1 reported ‘none’ or ‘poor’ confidence with female catheterisation, compared to 7/27 (26%) in group 2. 22/45 (49%) in group 1 reported ‘none’ or ‘poor’ confidence with insertion of 3-way catheters, compared to 2/27 (7%) in group 2. 32/45 (71%) in group 1 reported ‘none’ or ‘poor’ confidence in changing long term suprapubic catheters, falling to 3/27 (11%) in group 2.

**Conclusion:** This study raises concerns about interns’ practical experience in urology. We suggest that this course improves knowledge and confidence with practical urology skills, and should be incorporated into intern induction.

**References**
Poster 24

Impact of 2004 ISUP/WHO classification on bladder transitional cell carcinoma GRADING – A fifteen year review from an Irish teaching hospital

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Introduction: Tumour grade and stage of transitional cell carcinoma (TCC) not only influence treatment but also are strong prognostic indicators for recurrence, progression, and survival rates. The 1973 World Health Organisation (WHO) grading system allows Grade 1 to 3 while 2004 WHO/ISUP system classify as low grade (LG) or high grade (HG). Aims of our study were to explore the period of implementation of 2004 WHO/ISUP grading system and to determine whether this has caused significant grade migration to HG or LG.

Methods: Histopathology reports (n = 600) with confirmed TCC from January 2000 to March 2015 were included for this study. Reports were examined in detail for 1973 WHO TCC grading (G1 = well differentiated low grade tumours, G2 = moderately differentiated, intermediate grade, G3 = poorly differentiated high grade tumours) and 2004 WHO/ISUP grading (LG = Low grade and HG = high grade) system. Year of change in reporting and any overlapping period were noted. Year of diagnosis and pathological parameters were compared.

Results: There has been a shift towards using the WHO/ISUP classification since 2013 at our institution. From 2000 to 2012 an average of 48.5% were reported G1; 36.5% G2, and 15% G3. This compares to 65% as LG and 30% as HG with a small proportion (5%) reported as G2 during the period between 2013 and March 2015.

Conclusions: There has been slow implementation of the 2004 ISUP/WHO grading system at our institution with a diminishing number of Grade 2 being reported. This has resulted in comparable increase in high and low grade categories.

Poster 25

The suburethral tension adjustable sling (remeex system) in the treatment of recurrent female urinary incontinence

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Introduction: Sub-urethral slings are an effective treatment strategy in the management of stress urinary incontinence. We report the objective and subjective outcomes of suburethral tension adjustable sling (Remeex system) implantation for recurrent stress urinary incontinence (SUI) following failed surgical intervention.

Methods: Twenty-four female patients with severe recurrent SUI, underwent Remeex system positioning between April 2007 and February 2015. Pre-operatively, patients were evaluated by physical examination, flexible cystoscopy and urodynamics. All patients were referred after either 1 or 2 failed surgeries for incontinence. Outcomes at follow up were recorded based on physical examination and pad tests.

Results: At the follow-up visit, 23 (95.8%) patients were cured and 1 (4.1%) reported symptomatic improvement. In particular, the total mean pad weight decreased and the total mean questionnaire score increased. Sling tension readjustment was needed during follow-up in all patients 4 weeks after the surgery and then a year later in 8 patients (33.3%). Complications included persistent urinary retention (7.6%) and seroma formation (15.3%) of which one was infected, but were easily treated.

Conclusion: The Remeex sub-urethral sling system produced excellent results in recurrent stress incontinence with a low complication rate. The main character of this system is flexibility and reliability due to the ability to continuously adjust tension based on symptoms.

Poster 26

Laparoscopic adrenalectomy for phaeochromocytoma: Is it contraindicated?

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University Hospital Limerick

Introduction and Aim: Laparoscopic adrenalectomy (LA) is becoming standard for most surgical diseases of the adrenal gland. However it has been suggested that catecholamine effects associated with phaeochromocytoma render the laparoscopic approach a more challenging and a more morbid procedure. The purpose of this study was to compare the outcomes of LA for phaeochromocytoma and non-phaeochromocytoma.

Methods: The hospital records of all patients who underwent LA Between 2012 to March 2015 were reviewed. The preoperative diagnosis was documented, as well as the pathologic diagnosis, operative details, complications, and length of hospital stay.

Result: Total of 15 patients underwent LA. Three had phaeochromocytoma, four aldosteronoma, one hamartoma, one adrenal carcinoma, one angiomyolipoma and 5 had non-functioning adenoma. Mean operative blood loss between phaeochromocytoma group and non-phaeochromocytoma group were 120 and 100 mL respectively. The mean operative time was 140 minutes for phaeochromocytoma group and 120 min for non-phaeochromocytoma group. Mean length of hospital stay was 3.4 versus 2.5 day. The differences were not statistically significant. One patient in the non-phaeochromocytoma group was converted to open. There was no Clavien grade 2 or more complications.

Conclusion: Laparoscopic adrenalectomy is a safe technique with excellent peri-operative outcome for most adrenal lesions, including phaeochromocytomas.

Poster 27

Efficacy and safety of 120-W greenlight high-performance system laser photo vaporization of the prostate in the surgical day ward

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Introduction: High-Performance System (HPS) laser photo vaporization of the prostate (PVP) is a widely used procedure nowadays. The safety and efficacy of the procedure has been affirmed in patients with benign prostatic hyperplasia (BPH). We investigated the safety and efficacy of HPS laser PVP in the surgical day ward
setting at a busy tertiary referral hospital in Ireland.

**Methods:** All the patients who underwent the procedure as a day-case procedure are included. They were assessed pre-operatively using detailed history, physical examination including digital rectal examination (DRE). Their symptoms were assessed using IPSS, flow rates, pvr and in some cases CMG. The quantity of irrigant used, energy used and size of catheter inserted were recorded post operatively. Patients were discharged with an indwelling catheter for 24 hours. They were evaluated for symptomatic and flow rate improvements after 6 weeks. Morbidity, length of stay, the duration of catheterization and readmission rates were evaluated and recorded.

**Results:** The objective symptom score and flow-rate improvements were equivalent to those previously published for transurethral resection of the prostate (TURP). The patients’ mean preoperative prostate size was 51.0 ± 32.7 ml and their mean prostate-specific antigen was 4.5 ± 27.9 ng/ml. The average operating time was 24.5 ± 12.2 minutes and the average applied energy during surgery was 152.18 ± 89.495 J. Postoperative objective and subjective parameters in all groups were significantly improved compared with preoperative values.

**Conclusions:** Based on our results, we suggest day-case Laser PVP as a safe, effective and cost-effective treatment for symptomatic benign prostatic hyperplasia in selected patients.

This is associated with significantly increased costs compared to a day-case procedure. The aim of this study is to assess the feasibility of day case RFA.

**Methods:** An analysis of consecutive patients who underwent RFA of renal masses was performed. Data were recorded prospectively on each patient using the electronic patient records (EPR). Data collected included RENAL Nephrometry score, complications, post procedure systemic inflammatory response syndrome (SIRS), need for analgesia, need for anti-emic drugs and use of antibiotics.

**Results:** Data was collected on 36 consecutive patients and was included in the study. The mean age was 69.6 years. The median American Society of Anesthesiologists (ASA) score was 3. The median RENAL Nephrometry score was 6.1 (27%) patients received injectable analgesia. 7 (19.4%) patients received injectable anti-emetic medication. 12 (33%) patient’s required injectable medication of any kind. No patients required antibiotics. No patients required surgical, endoscopic or radiological intervention.

**Conclusion:** Based on post procedure data, the majority of patients could take oral medication to relieve their symptoms and therefore may not need to stay in hospital. However other factors such as social circumstances and medical co-morbidities need to be taken into account when selecting patients for day case RFA.

**POSTER 29**

**A prospective study evaluating the cost of iatrogenic urethral catheterisation injuries**

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**Introduction:** Insertion technique is vital to prevent urethral trauma during urethral catheterisation (UC). At present, education programmes are helpful for inexperienced healthcare professionals but are not compulsory and successful UC remains operator dependent. Traumatic UC is associated with increased length of stay, resource utilisation and surgical intervention.1,2

**Aim:** To determine the cost of iatrogenic urethral injuries managed in a tertiary referral centre over a 12-week period.

**Methods:** A prospective study was performed to monitor iatrogenic urethral injuries secondary to traumatic UC over a 12-week period from January 12, 2015 to April 12, 2015. Inclusion criteria were all referrals from district hospitals and inpatient consultations for iatrogenic urethral injuries caused by UC. The cost of managing catheter related injuries was estimated by adding costs of resources utilised. Patient demographics were prospectively maintained in a database by the department of urology.

**Results:** Eight iatrogenic urethral injuries were recorded in the 12-week period. Four patients were referred from district hospitals and four were inpatient consultations. Management included open surgery for a ruptured bladder (n = 1), flexible cystoscopy (n = 5), suprapubic catheterization (n = 1), three-way catheter (n = 1) and catheter re-insertion (n = 6). The cost of acutely managing these injuries was approximately € 20,000 including theatre costs, ambulance transfer, hospital stay, procedural and equipment costs and follow-up care.

**Conclusion:** Iatrogenic injuries during UC represent a major cost burden to the healthcare system. Training programmes should be compulsory for all healthcare professionals routinely involved in catheterisation procedures.
The aim of this study was to assess the predictive ability magnetic resonance imaging for detecting extra-prostatic invasion (EPE) at radical prostatectomy (RP).

Methods: A retrospective review was performed of all patients who underwent a radical prostatectomy and who had a pre-operative MRI. Radiology reports were compared to final histopathological reports by an independent blinded reviewer. MRI was defined by microscopic extension outside capsule and/or invasion of seminal vesicle. Sensitivity, specificity, positive and negative predictive values were calculated from radiological reports.

Results: 88 patients underwent pre-operative MRI prior to radical prostatectomy. The mean age was 59.5 years. The mean PSA was 9.49. 35 (39.8%) patients had Gleason 3 + 3 disease, 39 (44.3%) had Gleason 3 + 4, 8 (9%) had Gleason 4 + 3, 6 (6.8%) had Gleason >8 disease. MRI showed organ confined disease in 58 (65.9%), 32 (36.4%) had a positive margin while 43 (48.9%) had EPE. MRI had a sensitivity of 31.8%, specificity of 80.5%, PPV 63.6%, NPV 52.4% and overall accuracy of 55.3%.

Conclusion: Conventional MRI has low sensitivity but high specificity for determining EPE. Pre-operative findings need to be considered with caution until the quality of MRI improves. Factors influencing MRI quality include multi-parametric imaging sequences and standardised reporting.

Detection of localized prostate cancer using multiparametric magnetic resonance imaging guided transrectal ultrasound prostate biopsies: improved detection of higher grade cancers

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Patients who have raised PSA are currently tested for prostate cancer (PCa) by structured transrectal ultrasound biopsy sampling of the gland using 12 standardized biopsy sites. Multiparametric MRI scanning (mpMRI) is currently under assessment internationally as a means of improving the targeting of TRUS biopsies, using either cognitive or computed fusion techniques. This ongoing study assesses the accuracy of mpMRI guided TRUS prostate biopsies.

All patients with raised PSA undergoing TRUS guided prostate biopsies at our institution have a pre-biopsy mpMRI performed. A total of 76 patients underwent mpMRI guided biopsies of the prostate gland. Cognitive fusion techniques were applied in all cases. All biopsies were assessed for PCa using standard histological technique.

Fifty of the 76 patients who underwent MR targeted biopsies were positive for PCa. A significant learning curve showed improved results comparing the early and later periods of the study. Of the histologically positive mpMRI targeted biopsies, the majority (68%) were Gleason score 7 or higher.

Conclusion: Conventional MRI has low sensitivity but high specificity for determining EPE. Pre-operative findings need to be considered with caution until the quality of MRI improves. Factors influencing MRI quality include multi-parametric imaging sequences and standardised reporting.

Detection of localized prostate cancer using multiparametric magnetic resonance imaging guided transrectal ultrasound prostate biopsies: improved detection of higher grade cancers

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Patients who have raised PSA are currently tested for prostate cancer (PCa) by structured transrectal ultrasound biopsy sampling of the gland using 12 standardized biopsy sites. Multiparametric MRI scanning (mpMRI) is currently under assessment internationally as a means of improving the targeting of TRUS biopsies, using either cognitive or computed fusion techniques. This ongoing study assesses the accuracy of mpMRI guided TRUS prostate biopsies.

Multiparametric MRI fusion-guided biopsies improve the diagnosis of PCa using the TRUS biopsy technique. Biopsy samples using mpMRI/TRUS fusion appear to detect higher grade and potentially more clinically significant prostate biopsies.

Early experience with trans-perineal template biopsy for the diagnosis of prostate cancer in the west of Ireland

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Introduction: Trans-Perineal (TP) Template Biopsy a valuable tool in the diagnosis and staging of prostate cancer. In 2014, the Departments of Radiation Oncology and Urology in Galway University Hospital established a TP biopsy service for the population of the west of Ireland.

Methods: We performed a retrospective review of patients undergoing TP Biopsy in GUH between January 2014 and April 2015.

Results: Forty-nine patients underwent TP biopsy with mean age 62.9 ± 7.2 years. Indication for biopsy was rising PSA with multiple negative TRUS biopsies (30), restaging of patients on Active Surveillance (7), Biochemical Recurrence following radiotherapy or brachytherapy (6) and others (6). Median PSA at time of biopsy was 11.5 (1.8–157). Patients had undergone a median of 2 (0–6) TRUS biopsies prior to TP biopsy. Histology demonstrated prostate cancer in 36 patients, with one patient being diagnosed with ‘atypical cells’ and 12 benign tissue. Distribution of Gleason Grades was 3 + 3 (12), 3 + 4 (9), 4 + 3 (6), 4 + 4 (6), 4 + 5 (3), 5 + 5 (0). Mean number of cores taken was 26.4 ± 7.8 and mean positive cores was 5.79 ± 3.97 with median maxi-
Improving multivariable prostate cancer risk assessment using the prostate health index

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1Conway Institute of Biomolecular Research, University College Dublin, Dublin; 2UCD School of Medicine and Medical Science, University College Dublin, Dublin; 3Department of Biochemistry, Beaumont Hospital, Dublin; 4UCD School of Mathematical Sciences, University College Dublin; 5Institute of Molecular Medicine, Trinity College Dublin, Dublin; 6Insight Centre for Data Analytics, University College Dublin, Dublin; 7Department of Urology, Mater Misericordiae University Hospital, Dublin

Introduction: The decision to proceed prostate biopsy is informed by Prostate Specific Antigen (PSA) level, digital rectal examination (DRE), and clinical information. The objective of this study was to analyse the clinical utility of a risk calculator incorporating a novel biomarker along with these risk factors.

Methods: Serum isolated from 250 men with pre-biopsy blood draws was analysed for total PSA, free PSA and p2PSA. From this, the phi score was calculated \( \phi = (p2PSA/\text{fPSA})/\text{PSA} \). Two clinical prediction models were created consisting of age, family history, abnormality on digital rectal exam, prior negative biopsy and either PSA or phi score respectively. Calibration plots, receiver-operating characteristic (ROC) curves as well as decision curves were generated to assess the performance of the three models.

Results: The PSA model and phi model were both highly calibrated in this cohort. The AUC value for the phi model and PSA model and PCPT were 0.77 and 0.71 respectively for the prediction of PCa and 0.79 and 0.72 for the prediction of high grade PCa. Decision curve analysis demonstrated a superior net benefit of the phi model in the diagnosis of both PCa and high grade PCa.

Conclusion: A logical and standardised approach to the use of clinical risk factors can allow for more accurate risk stratification of men under investigation for PCa. The measurement of p2PSA and the integration of this biomarker into a clinical prediction model can increase the accuracy of risk stratification, helping to better inform the decision for prostate biopsy.

A comparison of functional outcomes following robotic assisted, laparoscopic and open radical prostatectomies in a rapid access cohort

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Introduction: Minimally invasive techniques have been proposed to improve functional outcomes post radical prostatectomy. The aim of this study was to assess the trifecta outcomes (cancer control, continence and potency) post radical prostatectomy (RP).

Methods: A retrospective review of all patients who underwent radical prostatectomy from a rapid access cohort was performed. Clinico-pathological data and functional outcomes were recorded. Urinary continence (ISIQ-SF) and potency (IIEF-SF) were assessed pre- and post-operatively.

Results: Between 2011 and 2014, 292 patients underwent radical prostatectomy (85 robotic assisted, 100 laparoscopic, 107 open). The mean age was 61.3 (range 48–73) with a mean initial PSA was 6.2 ng/ml (range 1.9–21.1). There were no differences between Gleason grade and pathological stage. There was no difference in positive surgical margin rate. There was earlier return of continence (0–1 pads) at 3 months with minimally invasive techniques compared to open (96% vs 85% – \( P = 0.001 \)) however no significant difference from 6 months onwards. There were improved potency rates favouring the robotic approach at 3, 6 and 9 months (\( P = 0.0001, P = 0.01 \) and \( P = 0.04 \) respectively). Potency rates were comparable at 12 months between the minimally invasive approaches.

Conclusion: Compared to robotic-assisted RP and laparoscopic RP, open RP was associated with poorer functional outcomes however oncological outcomes were equivalent.

The robotic 500 series: Driving the change in radical prostate surgery

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Introduction: Robot assisted laparoscopic prostatectomy has become widely used in the management of prostate cancer worldwide; however, its availability in Ireland remains low since first used in 2007. From a health economic perspective, this procedure is still under evaluation with challenges including accreditation, training, efficacy, and cost. The only published series from Ireland examined the experience with the first 125 robotic procedures, with favourable outcomes. This larger series illustrates highly deliverable outcomes across NCCP-directed performance indices.

Methods: Retrospective analyses of a prospectively collected database by a single surgeon over a 5-year period from (2010–2014) was performed. Focus was given to the postoperative trifecta of oncological control, continence and erectile function. However data also included clinico-pathological demographics, operative time, and complications. Univariate and multivariate analyses were performed using SPSS v20© (IBM corporation).

Results: Mean PSA levels were 7.6 ng/ml, with a mean age of 62 years. 31% of patients were high-risk preoperatively (≥pT3; ≥Gleason 8). Over the study time period, mean operative times reduced from 336 min to 115 min (\( P < 0.05 \)), length of stay from 5 to 2 days, and estimated blood loss of 340–50 ml (\( P < 0.01 \)). 47% patients were pad-free at 3/12 post-op, followed by 95% at 9/12 (\( P < 0.05 \)). 34% underwent a bilateral nerve sparing procedure.

Conclusion: This is the largest robotic series to originate from Ireland. Despite debate regarding learning curves, access and cost, it continues to demonstrate the ability to deliver equivalent/superior outcomes to national benchmarks, whilst
allowing the patient the established advantages of minimally invasive surgery.

References

**Radical prostatectomy for locally advanced prostate cancer: Functional and oncological outcomes**

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**Introduction:** Different options are available for the treatment of locally advanced prostate cancer (LACaP). We assessed the functional and oncological outcomes of men undergoing radical prostatectomy (RP) by a single surgeon.

**Methods:** From 2010 to 2014, 88 men attending the Rapid Access Prostate Clinic (RAPC) at University Hospital Limerick (UHL) underwent RP for LACaP. Continence was defined as using 0–1 pads in 24 hours. Potency was defined as an erection sufficient for penetration with/out the use of PDE5 inhibitor. Biochemical recurrence was defined as a PSA ≥ 0.2.

**Results:** Mean patient age was 60 (range 40–69) years. Median PSA was 11 (range 2.7–40) ng/mL. Of 88 patients with clinically LACaP on pre-operative staging, 39 were downstaged, leaving 49 (56%) patients with pathologically proven LACaP. Median follow-up was 2 (range 1–5) years. 30 (34%) patients had positive surgical margins. Thirty nine (80%) patients had extraprostatic extension (pT3a disease) and 10 (20%) had seminal vesicle invasion (pT3b). Three patients (6%) had Gleason 4 + 5 disease, 5 (10%) had Gleason 4 + 4 disease, 16 (33%) had Gleason 4 + 3 disease, 20 (41%) had Gleason 3 + 4 disease and 5 (10%) had Gleason 3 + 3 disease. All patients had an extended pelvic lymph node dissection (EPLND), and of these 2 (2.8%) had lymph node metastases. With a minimum of one year follow-up 37 patients (76%) were continent and 12 men (24%) were using 2 or more pads. Eighteen (20%) men had pre-existing erectile dysfunction and were excluded. In the remaining 70 (79.5%), 28 men (40%) were potent, but 42 (60%) men had no erections even with PDE5 inhibitors. Fourteen (20%) men were using a vacuum pump device. Biochemical recurrence was recorded in 5 (10%) patients, 2 with Gleason 4 + 5 disease, 2 with Gleason 4 + 4 and 1 with Gleason 4 + 3.

**Conclusion:** RP should be offered to suitable men with LACaP and can be performed with acceptable functional outcomes. Surgery should not be withheld in men with LACaP as clinical overstaging is common with significant rates of pathological downstaging after RP. Higher grades of LACaP predispose to biochemical recurrence.

**Peyronie’s disease following radical prostatectomy: Incidence in a population with formal pre operative assessment**

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**Introduction:** A single previous study has reported a link between radical prostatectomy (RP) and Peyronie’s disease (PD). Absent was evidence of expert preoperative assessment to rule out pre-existing PD. Our aim was to define the incidence of PD in men who attended a single sexual medicine expert pre and post RP and to determine predictors of same.

**Methods:** Study population: (i) had RP as monotherapy for localized prostate cancer (ii) post-RP erectile dysfunction (ED) (iii) pre and post op evaluation for PD and (iv) developed PD within 3 years after RP. This cohort was compared to individuals post RP who did not develop PD. Univariate analysis included: age, race, co-morbidities, RP approach, pathological staging, nerve sparing status, self-reported erectile function (EF) pre and post RP and use of ICI therapy. Point-biserial correlations and logistic regression were performed.

**Results:** 276 men comprised study cohort. Mean patient age 56 ± 8 years. Race: 77% White, 16% African–American, 7% other. Co-morbidities: 46% hypercholesterolemia, 42% smokers, 38% hypertension, 11% diabetes, 4% CAD and 1% PVD. 17.4% developed PD post-RP. Mean time to develop PD following RP was 12 ± 8 months (m), with 77% of PD sufferers developing within 18 m. 77% had dorsal curvature with 69% reporting instability. Mean curvature 27 ± 13 (range 5–50) degrees. Univariate and multivariable models revealed no significant predictors of PD post-RP.

**Conclusion:** In this population who received preoperative assessment by a PD expert, one in six men with ED after RP developed PD, the majority within first 18 m. No predictors have yet been identified.

Table 1 Comparison between Gleason 3 + 4 and Gleason 4 + 3 patients

<table>
<thead>
<tr>
<th></th>
<th>Gleason 3+4</th>
<th>G4+3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age at diagnosis</td>
<td>60.39</td>
<td>59.94</td>
</tr>
<tr>
<td>Mean pre-operative PSA</td>
<td>6.9</td>
<td>9.4</td>
</tr>
<tr>
<td>Seminal vesicle involvement (T3b)</td>
<td>0/97 (0%)</td>
<td>9/70 (12.9%)</td>
</tr>
<tr>
<td>Extra prostatic extension (T3a)</td>
<td>9/97 (9.3%)</td>
<td>28/70 (40%)</td>
</tr>
<tr>
<td>Positive margins</td>
<td>13/97 (13.4%)</td>
<td>33/70 (47.1%)</td>
</tr>
<tr>
<td>Biochemical Recurrence</td>
<td>2/97 (2.1%)</td>
<td>16/70 (22.9%)</td>
</tr>
<tr>
<td>Post operative radiotherapy</td>
<td>12/97 (12.4%)</td>
<td>36/70 (52.2%)</td>
</tr>
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</table>
Gleason 7 prostate cancer in the era of RAPC: Does primary grade 4 disease still have a worse outcome?
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Introduction: The differences between primary Gleason 4 and primary Gleason 3 patterns in terms of biochemical recurrence and cancer specific mortality are well described (1). Rapid Access Prostate Clinics (RAPC) were introduced as part of the National Cancer Control Programme. They have led to a large increase in the detection of prostate cancer along with lower grade, lower PSA at diagnosis and expedited treatment pathways (2). We analysed all Gleason 7 radical retropubic prostatectomies (RRP) performed at our institution since the introduction of a RAPC.

Methods: A retrospective analysis was carried out of all Gleason 7 RRP s performed over a 7 year period, 2008–2014. Specimens with a primary Gleason 3 were compared to primary Gleason 4 in terms of extra prostatic extension, positive margins, tumour stage and seminal vesicle involvement. Other outcomes assessed were the need for post-operative radiotherapy and biochemical recurrence.

Results: In total, 240 RRP s were performed in our institution since the introduction of the RAPC. Of these 97 were Gleason 3 + 4 and 70 were Gleason 4 + 3. The comparative results can be seen in Table 1.

Conclusion: Despite the introduction of the RAPC and earlier detection of prostate cancer, primary Gleason 4 on histology is still a worse prognostic indicator. It needs to be treated as a more aggressive form of disease (3).

References

Surgery for post-prostatectomy incontinence: A 10-year, two center review
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Introduction: The incidence of postoperative urinary incontinence following radical prostatectomy is reported as between 13% and 17% (1), depending on the operative approach utilised. Management options include physiotherapy, pad use, medical management, urethral sling procedures and artificial urethral sphincter (AUS) insertion. We present our experience with surgical management of post prostatectomy incontinence over a 10-year period.

Patients and Methods: We performed a retrospective audit of all treated referrals for post-prostatectomy incontinence over a 10-year period from 2 academic centres.

Results: 41 patients were identified for inclusion. All patients had undergone Open, Laparoscopic or Robotic Prostatectomy. Cystoscopy and urodynamic assessment were performed prior to surgical intervention in all cases. 36 patients underwent AUS insertion, with Advance slings placed in the remaining 5. Outcome was measured by pad usage at 3 months post incontinence surgery. AUS insertion resulted in a reduction of pad usage by a mean of 80% with a 50% reduction in pad usage seen with Advance slings. Three patients required removal of sphincter for infection, all of whom had received prior radiotherapy.

Conclusions: This retrospective study confirms the significant symptomatic benefit of AUS insertion in patients with post prostatectomy incontinence. Radiotherapy would appear to confer a higher risk of post-operative infection. Our Advance sling cohort was small, but achieved a modest benefit from the procedure.

References

Hospital burden of long-term genitourinary and gastrointestinal toxicity after radical radiotherapy for prostate cancer
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Introduction: Radical treatment options for prostate cancer (PCa) include radical radiotherapy (RT) and radical prostatectomy, both of which appear to have comparable oncological outcomes. Patient choice of treatment is often influenced by local availability of the treatment modality. The aim of this study was to investigate the hospital burden of long-term genitourinary and gastrointestinal toxicity among patients with PCs who were treated with radiotherapy at our institution.

Methods: The radiotherapy department database was used to identify all patients who underwent radiotherapy for PCs from January 2006 to January 2008. The patient administration system from each public hospital in the region was interrogated and all patient points of contact were recorded. All patients had at least five years of follow up. Individual patient charts were reviewed and factors which might influence outcomes documented.

Results: A total of 112 patients were identified. The mean age at diagnosis was 66 (44–76) and the median PSA was 12.1 (3.2–38). Thirty-five patients (31%) required acute hospital admission. Fifteen patients had more than 2 A+E attendances. Fifteen patients (13%) were investigated for genitourinary toxicity. Forty-seven patients (42%) underwent investigation of gastrointestinal side-effects and 44% of these required argon therapy (21/47).

Conclusion: This study found that a significant hospital burden related to. With the introduction of activity based funding in the hospital setting, the morbidity and additional cost of managing such complications should be taken into consideration. It is also important that patients are counselled carefully in relation to these potential long-term side-effects.
Health professional’s views about the acceptability and implementation of alternative models of prostate cancer follow-up

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Introduction: Growing numbers of cancer survivors, the resultant burden on hospital resources, and concerns about the ability of post-treatment prostate cancer follow-up by clinicians in specialist centres to meet survivors’ supportive care needs has led to interest in developing alternative models of cancer follow-up such as hospital-based nurse-led, GP-led, and patient-initiated follow-up, and shared care.

Methods: We carried out in-depth, semi-structured, interviews with 23 multi-disciplinary health professionals involved in prostate cancer follow-up in Ireland. Participants were asked for their views about different types of follow-up, any barriers or anything that would need to be in place to facilitate implementation of alternative models. Analysis drew on the extended Normalisation Process Theory (eNPT) framework (May, 2013) to investigate the likelihood of successful implementation.

Results: Most participants reported a need for new models of follow-up. All of the models of follow-up discussed were acceptable to some extent. However, the participant’s perception of the ability of the health setting and health professionals involved to implement and sustain alternative models influenced preferences. Things that would need to be in place to facilitate implementation of alternative models were identified. Fewer perceived barriers to implementation of nurse-led follow-up and many potential benefits were highlighted compared to community-based models. It was suggested that elements of shared care could improve the community based follow-up.

Conclusions: Although all alternative models of follow-up are acceptable, our findings suggest there are fewer barriers to implementation of hospital-based nurse-led follow-up compared to other alternative models of follow-up in our setting. May C (2013). Towards a general theory of implementation. Implementation Science 8:18.

Session 2: General Urology

Long term outcomes of bladder neck placement of the sparcTM sling for stress urinary incontinence – A single surgeon experience

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Introduction: The SPARC™ sling system is widely used for the treatment of stress urinary incontinence. Variations exist in the urethral region into which the sling is placed; traditionally polypropylene slings are placed at the mid-urethra. We report the long-term outcomes of bladder neck placement of the SPARC™ sling by a single surgeon.

Methods: A longitudinal retrospective analysis of all 332 patients who underwent primary SPARC™ sling surgery at our institution between 2006 and 2014 was conducted. Relevant patient demographics and pre-operative urodynamic findings including abdominal leak point pressure (ALLP) and maximum flow rate (Qmax) were collected. Post-operative Urinary Distress Inventory (UDI-6) and Incontinence Impact Questionnaires (IIQ-7) were completed by patients to evaluate outcomes.

Results: Preoperative urodynamics demonstrated a mean ALLP of 56.6 cmsH2O (range 50–70 cmsH2O) and a mean Qmax of 30.2 ml/sec (range 9.8–66 ml/sec). After a mean follow up of 4 years (range 1–8) 67.7% of patients reported a subjective cure in their SUI after primary SPARC™ sling insertion. 12% developed de novo detrusor overactivity confirmed by post operative urodynamics. 4% failed to void post operatively and temporarily performed self-intermittent catheterization. 10% underwent further incontinence procedures including injection of intra-urethral bulking agents and repeat sling procedures. With additional incontinence procedures the subjective cure rate was 90%. Mean UDI-6 scores post operatively were 8 (range 2–14) while the mean IIQ-7 scores were 5 (2–8).

Conclusion: Bladder neck placement of the SPARC™ sling is an effective treatment for stress urinary incontinence and results in excellent post operative symptomatic improvement evidenced by the UDI-6 and IIQ-7 scores.

Erosion of mid-urethral polypropylene mesh slings for female stress urinary incontinence: Surgical management and outcomes

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Introduction: We present our management of vaginal and lower urinary tract mesh erosion after mid-urethral polypropylene mesh sling using a combination of surgical techniques including partial wide mesh excision, urinary tract reconstruction ± re-do polypropylene sling versus autologous rectus fascia pubo-vaginal sling (RFS).

Methods: All patients who underwent placement and revision of mid-urethral polypropylene mesh slings from 2009–2014 were identified. A retrospective chart review was undertaken.

Results: Of 411 sling procedures, 21 patients (5%) required revision for erosion, 18/21(86%) were managed using a transvaginal approach. The median age was 48 years (IQR 42–49), the majority were overweight or obese (59%) and median time from sling placement to symptoms was 40 months (range 1–120 months). The location of erosion was the urethra (n = 12), bladder (n = 3), vagina (n = 6). All patients had complete resolution of the mesh complication and 20/21 (95%) of their primary symptom. There were no major intraoperative complications. Of the patients with urethral erosion 8/12 (66%) underwent re-do polypropylene sling (n = 5) or RFS (n = 3), resolution of stress urinary incontinence (SUI) was achieved in 78%. Of the patients with bladder erosion, 1/3 underwent RFS with resolution of SUI in all three patients. Of the patients with vaginal erosion, 3/6 (50%) underwent re-do polypropylene sling (n = 1) or RFS (n = 2), resolution of SUI was achieved in 4/6 (66%).

Conclusions: Mesh erosion after mid-urethral polypropylene mesh sling is not
uncommon but can be successfully managed using a transvaginal approach and wide excision of mesh. A concomitant or delayed re-do polypropylene sling or autologous RFS can be offered and safely performed to treat existing SUI or if SUI recurs.

The evolving management of renal oncocytomas: 15-year experience from a tertiary referral centre

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Introduction: Oncocytes represent 3–7% of all solid renal tumours (1). Imaging techniques are less useful for preoperative diagnosis and renal biopsy is the only reliable diagnostic modality (2). Traditionally, the treatment of oncocytomas has been surgical excision; however their excellent long-term prognosis has popularised conservative and minimally invasive ablative techniques for the management of these benign tumours (3).

Aim: To review the evolving management and follow-up of renal oncocytomas in a tertiary institution over a fifteen-year period and to investigate the relationship between radiological and histopathological diagnosis of renal oncocytomas.

Methods: A 15-year retrospective cohort study was performed from 1st January 2000 to 31st December 2014. All patients with a confirmed pathological diagnosis of renal oncocytoma after surgical excision or on renal biopsy were included. Exclusion criterion was absence of confirmed pathological diagnosis.

Results: A total of 37 oncocytomas were reported in 36 patients. The median age was 57 years and the male:female ratio was 1.25. Median tumour size was 4.8 cm. Bilateral oncocytomas (n = 2), multifocal oncocytomas (n = 1) and oncocytomas with vascular invasion (n = 3) were reported. Pre-operative imaging was negative for oncocytoma in all patients. Twenty-four patients underwent radical nephrectomy, 8 underwent partial nephrectomy and five underwent conservative/ minimally invasive management.

Conclusion: Pre-operative imaging does not accurately diagnose renal oncocytoma. The management of oncocytomas has evolved from radical surgery to nephron sparing and minimally invasive management techniques.

References

A single centre experience of zero-ischaemia laparoscopic partial nephrectomy

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Introduction: Nephron-sparing surgery in the form of partial nephrectomy is increasingly becoming the management of choice in patients with small, polar, exophytic renal tumours (1–3). Clamping of hilar vessels can result in ischaemic nephropathy, causing long term decline in renal function. We assessed functional and oncological outcomes of laparoscopic partial nephrectomy in our institution.

Methods: 43 consecutive patients underwent laparoscopic partial nephrectomy. All cases were performed by a single surgeon. Operative technique in our institution has evolved over the duration of the study, with the first 16 cases being carried out using a thulium laser. The subsequent 27 cases were carried out using the LigaSure vessel sealing device and argon beam plasma coagulation. All patients underwent pre-operative cross sectional imaging.

Results: 18 patients were female. Mean age at diagnosis was 55.4 years (34–76 years). 22 cases (47.8%) were right sided tumours. The mean tumour diameter on preoperative imaging was 28.2 mm (12–49 mm). Median PADUA score was 8. Mean operative time was 165.9 minutes. Mean blood loss was 347 ml. All cases were zero-ischaemia. Mean estimated glomerular filtration rate (eGFR) was 72.5 pre-operatively vs 71.3 post-operatively. One patient had positive surgical margins. No cases were converted to open surgery. 37 cases were malignant tumours on histological analysis. Mean postoperative stay in hospital was 5 days (2–17).

Conclusions: Partial nephrectomy is the gold standard for surgical management of small renal lesions suspicious for malignancy. Zero ischaemia laparoscopic partial nephrectomy is a safe and oncologically satisfactory procedure for the management of small localised renal tumours.

References

Patient outcomes following open partial nephrectomy for renal tumours

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Introduction: With improvements in modern imaging techniques the detection rate of incidental small renal masses (SRMs) has increased. Nephron sparing surgery offers similar oncological outcome as radical nephrectomy for SRMs whilst preserving renal function.

Methods: Between January 2012 and April 2015, 48 open partial nephrectomies were performed. The median age at diagnosis was 55.4 years (34–76 years). 22 cases (47.8%) were right sided tumours. The mean tumour diameter on preoperative imaging was 28.2 mm (12–49 mm). Median PADUA score was 8. Mean operative time was 165.9 minutes. Mean blood loss was 347 ml. All cases were zero-ischaemia. Mean estimated glomerular filtration rate (eGFR) was 72.5 pre-operatively vs 71.3 post-operatively. One patient had positive surgical margins. No cases were converted to open surgery. 37 cases were malignant tumours on histological analysis. Mean postoperative stay in hospital was 5 days (2–17).

Conclusions: Partial nephrectomy is the gold standard for surgical management of small renal lesions suspicious for malignancy. Zero ischaemia laparoscopic partial nephrectomy is a safe and oncologically satisfactory procedure for the management of small localised renal tumours.

References
performed. All data was collected prospectively.

Results: Mean age of patients was 58.7 years (range = 32–80). Regarding tumour position; seven were upper pole, 12 inter-polar and 16 lower pole. Mean tumour size was 3.1 cm (range 1.5–7 cm). Warm ischaemia time (WIT) was 0 minutes in 22 patients while the remaining 26 patients, which had the renal vessels clamped prior to excision of renal tumour, had a mean warm ischaemia time (WIT) of 12.1 minutes (range = 5–20). No patients required ureteric stenting. Mean estimated blood loss was 441.5 mls (range = 100–1825). Mean operative time was 138 minutes (range = 90–180). Mean length of stay was 7.5 days (range 5–18). Post operative complications include pneumonia (n = 1), perinephric abscess (n = 1), urinoma requiring stenting (n = 2), wound infection (n = 1), 1 patient and preoperative cardiac arrest. However, there is so far 0 mortality rate. Histologically, all resected tumours had negative surgical margins for tumour. On patients with 1 year follow up, no patients had significant deterioration in renal function. Of all the patients followed up so far, for upto 30 months, non of these patients has tumour recurrence.

Conclusion: Partial nephrectomy is technically challenging, however in carefully selected cases, in expert and well trained hands, having necessary equipment available at tertiary care centre, it is feasible with good oncological as well as functional (nephron sparing) outcomes.

Preventing urethral trauma by inadvertent inflation of catheter balloon within the urethra during catheterisation: Evaluation of a novel safety syringe after correlating trauma with urethral distension and catheter balloon pressure

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Introduction: We aimed to investigate urethral diametric strain and threshold maximum inflation pressure for rupture during inadvertent inflation of a catheter’s anchoring balloon in the urethra. We also evaluated a novel safety device for preventing trauma based on these parameters.

Methods: Inflation of a urethral catheter’s anchoring balloon was performed in the bulb urethra of ex vivo porcine models (n = 21) using 16 French catheters. Urethral trauma was assessed with retrograde urethrography. Urethral rupture was correlated with internal urethral diametric strain and maximal urethral pressure threshold values (kPa). Urethral catheters were then inflated in the bulb urethras of fresh male cadavers (n = 7) using both a standard syringe and a ‘prototype’ syringe. The plunger of the standard syringe was depressed until opposing resistance pressure generated by the urethra prevented further inflation of the anchoring balloon. The plunger of the ‘prototype safety syringe’ was depressed until sterile water within the syringe decanted through an activated safety threshold pressure valve.

Results: Retrograde urethrography demonstrated that porcine urethral rupture consistently occurred at an internal urethral diametric strain >40% and a maximum inflation pressure >150 kPa. The maximum human urethral threshold inflation pressure required to activate the safety prototype syringe’s ‘pressure valve’ was 153 ± 3 kPa. In comparison, the maximum inflation pressure was significantly greater with a standard syringe compared to the activated prototype syringe (452 ± 188 kPa); P < 0.001.

Conclusion: Internal urethral diametric strain and threshold maximum inflation

Total penile glans resurfacing to maximize penile form and function in penile cancer: Mi-pecans

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Introduction: The traditional treatment of malignant penile lesions has traditionally been with radical surgery (2 cm margins). Radical surgery has demonstrated excellent local control rates, although associated with significant psychological morbidity and sexual dysfunction. Total glans resurfacing is suitable for the treatment of Ta and T1 lesions of the foreskin and glans. This results in a good cosmetic appearance and maximum phallic length with preservation of sexual and urinary function, and importantly without compromising oncological control.

Methods: A consecutive series referred for the treatment of penile malignancy were prospectively analysed over 12 months. After clinical staging and grading, those patients offered glans-preserving surgery were analysed for oncological and functional outcomes.

Results: 21 patients were referred with penile malignancies during the study period, of which 12 (57%) underwent total glans resurfacing. There was 100% graft take using STSG anterior thigh (median 1.8 mm thickness). 17% lesions were CIS on final pathology, one revealed Kaposi’s disease, one was metastatic colorectal cancer and 66% were Ta/T1 squamous cell carcinoma. No local recurrences were encountered.

Conclusion: This study contains one of the world’s largest cohorts for this procedure. Careful tumour risk assessment and appropriate patient choice is necessary. The need for close observation is also essential as the long-term recurrence rates for these techniques are still unknown. However, the advances in penile preserving surgery, in conjunction with other techniques such as dynamic sentinel lymph node biopsy, has transformed the approach to management of penile cancer, and reduced the physical and psychological morbidity associated with treatment.

References
Introduction: Acute urinary retention (AUR) is a common urological emergency managed by catheterization. If suitable, patients who fail a trial without catheter (TWOC) despite medical treatment are scheduled for surgical treatment. Prolonged catheterization is associated with increased morbidity. In our institution we admit all patients who present with AUR.

Methods: Retrospective analysis was performed of all male patients admitted with AUR (January to December 2014). Data was obtained from Hospital Inpatient Enquiry (HIPE) database and patient records. Outcomes following TWOC were analyzed.

Results: In total, there were 130 admissions for AUR. Of these, 74/130 (56.9%) were due to progressive LUTS, 20.8% due to clot retention, 9.2% on a background of prostate cancer and 13% other. Mean age of LUTS patients was 72 years. All LUTS patients had a TWOC after 48 hours. Overall 34/74 (45.9%) had a successful TWOC with a median length of stay (LOS) of 4 days. In the failed TWOC group, 13/74 (17.6%) underwent TURP on the same admission (median LOS of 9 days), 11/74 (14.9%) were discharged with a long term catheter due to their comorbidities, 7/74 (9.5%) patients underwent TURP on a different admission (median waiting time 55 days). A further 6/74 (8.1%) patients are still awaiting TURP, whilst a definitive treatment decision for 3/74 (4%) patients has yet to be made.

Conclusion: Admission of patients with AUR allows a definitive management strategy to be put in place. Early TWOC and early surgery for those who fail TWOC reduces prolonged catheterization.


Self-reported aetiology and rates of self-reported surgical burnout amongst U.K. and Irish urologists

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Introduction: Burnout has an effect on personality, fatigue and an stress, which can be detrimental towards performance and can impair technical skills as well as vigilance and memory. Whilst many surgeons may believe that they are less susceptible to the effects of burnout, the traits that define some of their success place them in a vulnerable position. These findings place an onus on the healthcare institution to determine the aetiology, and to engage in secondary prevention.

Methods: A joint collaborative questionnaire was sent by the Irish Society of Urology (ISU) and the British Association of Urological Surgeons (BAUS). The questionnaire comprised of two parts: the first encompassed sociodemographic data collection and identifying risk factors for burnout, the second utilized the Maslach Burnout inventory (MBI) to quantify workplace burnout. Statistical analysis was performed using GraphPad Prism Version 6.0b for Mac OS X.

Results: 575 urologists responded to the online survey (40%). The median age was 45 years, with males representing 87.5% of respondents. There were statistically significant differences in grade, location and contract type. However, most commonly given reasons were an excessive administrative workload, a high volume of work, a lack of institutional resources, a poor work-life balance, and inadequate support/communication with institutional management.

Conclusions: This is the first study to address the issue of burnout across both health systems in the UK and Ireland, and lends itself to the creation of risk stratification for urologists, and an opportunity to provide educational resources, training/development programs, and collegial and administrative support pathways.

References


Geriatric urology: An evolving subspecialty with increasing workload

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Introduction: The population over 65 will more than double over the next 30 years with evident implications for health service planning and delivery. Urology is one of the surgical specialties that has been most affected by the growing demographic of older adults. The aim of our study was to assess the extent and nature of hospital work load related to older patients.

Methods: Hospital Inpatient Enquiry (HIPE) database was used to explore urology patient admission between January 2014 to June 2014. All urology admissions over 65 years were included and demographics, primary diagnosis and length of inpatient stay were recorded.

Results: There were a total of 485 urology admissions. 30% patients were 65 years or over with mean age of 75.9 years (65–92 years). Urological malignancies with or without metastasis constituted 31.8%, urinary stone disease 17%, bladder outlet obstruction 11.1%, urinary infections...
Is testicular pain and vomiting pathognomonic for testicular torsion in pubertal boys?

**Implications for lay and medical education**

ASLAM A¹, YAP LC¹, NASON GJ², KELLY N³, DOMANSKA K⁴, GIRI SK¹ and FLOOD HD¹

¹University Hospital Limerick; ²Beaumont Hospital, Dublin; ³University of Limerick

**Introduction:** Delay in the diagnosis of testicular torsion (TT) is common and usually pre-hospital. Our experience suggests that the trifecta of acute scrotal pain and vomiting in a pubertal boy is highly predictive of testicular torsion.

**Methods:** A retrospective review was conducted of all patients who presented with acute scrotal pain to University Hospital Limerick (UHL) from July 2013 to December 2014. The parameters assessed were, age, pubertal status, symptoms and signs, presenting times, operative findings and testis outcome at 3 months.

**Results:** Of 102 boys 31 (30.4%) were explored. TT was seen in 22/31 (71%). Mean duration of scrotal pain was 37 (range 1–240) hours with mean time interval from 1st presentation of pain to 1st medical review being 38.6 (range 2.2–241.5) hours and from initial medical review to surgical exploration being 116.9 (5–445) mins. Orchidectomy was performed in 9 (29%) boys and peroperative testicular viability was demonstrated in 13 (59%) boys. Vomiting was 77.3% sensitive and 88.9% specific for the diagnosis with a PPV of 94.4% and NPV of 61.5%. Vomiting in pubertal boys with TP had 68% sensitivity and 100% specificity for the diagnosis of TT. The PPV and NPV were 100% and 56.2% respectively. 2/13 (15.4%) testes were atrophic at 12 weeks follow-up.

**Conclusion:** Vomiting in association with testicular pain in a pubertal boy is highly suggestive of TT. This fact could be the basis for an effective lay and medical education programme.

**Selection of patients for eswl in the era of flexible ureteroscopy (FURS). Can hounsfield units predict successful outcome?**

HAROON UM, SIDDQUI R, BOLTON E, KELLY T and JAFFRY SG

Galway University Hospital, Galway

**Introduction:** There is a number of variables for the success of Extracorporeal shockwave lithotripsy (ESWL) which include type of stone, type of machine and stone density on CT. ESWL was upgraded at our hospital in the form of STORZ-Medical modulith SLK lithotripter. We assessed trends of the patients treated and the density of the stone in hounsfield units (HU) for predicting ESWL success.

**Methods:** We prospectively evaluated the patients referred to the lithotripsy department from January 2014 to March 2015. Patients were enrolled for ESWL via out patient referral which were reviewed by our consultant-in-charge. All patients had a CT KUB confirmed renal or ureteric stone. Patient age, sex, stone size, stone location, stone laterality, stone attenuation (HU), presence of JJ-stent and number of sessions were studied as potential predictors. ESWL success was defined as patients being stone-free with remaining stone fragments of <3 mm, which were considered as clinically insignificant residual fragments (CIRF).

**Results:** 147 patients were referred over 14 months for ESWL of which 119 were deemed suitable for treatment. 63% were male and 37% female. Median age was 53 years (range 19–76 years), median stone-size was 7 mm (range 3 mm–14 mm) 63% patients were stone-free and 37% failed treatment.

**Conclusion:** We can conclude that larger stones with greater distance to skin and greater HU are correlated with failed ESWL and multiple sessions. With the introduction of more effective forms of ureteroscopy, it may be worth proceeding directly to flexible ureteroscopy and stone fragmentation rather than attempting ESWL.

<table>
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<tr>
<th>ESWL</th>
<th>Mean stone size (mm)</th>
<th>Median stone density (150–1670 HU)</th>
<th>Median stone-to-skin distance (4.7–22 cm)</th>
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<tr>
<td>Successful</td>
<td>6 mm</td>
<td>840 HU (P&lt;0.05)</td>
<td>9.6</td>
</tr>
<tr>
<td>Unsuccessful</td>
<td>9 mm</td>
<td>1100 HU (P&lt;0.05)</td>
<td>11.5</td>
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