

70th ANNUAL JAMES C. KIMBROUGH UROLOGICAL SEMINAR



2024 PROGRAM BOOK

January, 17-21, 2024
Hilton Norfolk The Main
Norfolk, Virginia



Society of Government Service Urologists

2024 PROGRAM BOOK



www.govurology.org

Scientific Program Directors:

Col Timothy Baumgartner, MC, USAF

Col Necia Pope, MC, USAF

Col Christopher Allam, MC, USAF

Disclosure: The views and opinions expressed in this program book are those of the authors and do not necessarily reflect the official policy or position of the US Navy, Army, Air Force, the Department of Defense, or the U.S. Government.



Welcome from the President, COL (Ret.) Timothy Phillips, MC, USAF

Dear SGSU Members,

Welcome to Norfolk, Virginia and the 70th Annual Kimbrough Seminar. It is a distinct honor to serve as the President of the Society of Government Service Urologists. Dr. Timothy Baumgartner, Dr. Necia Pope and Dr. Christopher Allam have put together an outstanding academic and social program, and the DeSantis Management Group continues to provide exceptional administrative leadership and support. We look forward to a fabulous meeting. As the field of Urology, military medicine, and VA medicine evolve, the Kimbrough Seminar will likewise change with the times. The meeting remains a foundation for Urologists in the service of our government, an excellent forum for education and training, and a wonderful opportunity to socialize and network with one another. The leadership and dedication of our active duty, VA and retired membership ensures that the wonderful tradition of the Kimbrough meetings will continue to support the mission and camaraderie that is unique to military and VA urology. Enjoy the meeting and your time in this beautiful city. I look forward to seeing you all.

With Best Regards,

COL (Ret.) Timothy Phillips, MC, USAF

Welcome from the Program Chairs



Col Timothy S. Baumgartner, MC, USAF



Col Necia Pope, MC, USAF



Col Christopher Allam, MC, USAF

Dear SGSU Members,

A warm welcome all to the 70th Annual Society of Government Service Urologists, James C. Kimbrough Urological Seminar in Norfolk, Virginia. We have an exciting and robust academic program planned while maintaining our important SGSU traditions. We will have three full meeting days and again providing the highly valued Mock Oral Boards and Military Preparations Course on Sunday for a total of 19 hours of CME (including separate CME symposiums).

Our Scientific Program provides every resident and staff the opportunity to present original research at podium and poster sessions. We are also honored to have a distinguished group of visiting faculty that will focus on state-of-the art discussions and highlight best practices and new research in urology. Special topic lectures and industry programs will round out our meeting. We will also include ample time for audience questions and discussions.

In addition to a power-packed scientific program, we are planning a number of exciting social activities including our Wednesday evening Welcome Reception, on Friday evening, will feature the entertaining and traditional GU Bowl followed by a Casino Royale Night. Saturday late afternoon will feature our Poster Session with a Reception and The Littrell Awards Ceremony.

We look forward, as always, to renewing old friendships and making new ones.

Best Regards,

Col Timothy Baumgartner, MC, USAF

Col Necia Pope, MC, USAF

Col Christopher Allam, MC, USAF

San Antonio Medical Military Center

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SGSU LEADERSHIP

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JBSA Ft. Sam Houston, San Antonio, TX

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Robert Steckler, MD
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Erik T. Grossgold, MD
Naval Medical Center Portsmouth, VA

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USAV

The **Urological Society for American Veterans (USAV)** is established to enable its members to review and deliberate on topics and opportunities unique to federal urologic practitioners. The purpose of the organization is to initiate, discuss, and develop ideas, in an evidenced-based manner, which will improve the care of the Veteran patients with urologic disease(s) and the welfare of the federal urologic practitioner members. Learn about USAV's missions and the benefits of membership by visiting USAV website: <https://govurology.org/usav/>



govurology.org/usav/

**Please join the USAV
in San Antonio
at the
AUA Annual Meeting**

**USAV Annual Meeting
Sunday, May 5, 10:00 am- 2:30 pm
Grand Hyatt Hotel, San Antonio, TX**

JAMES CLAUDE KIMBROUGH, MD

Colonel, Medical Corps, United States Army -1887-1956



Colonel Kimbrough was the “Father of U.S. Army Urology”. A native of Madisonville, Tennessee, he graduated from Vanderbilt University School of Medicine in 1916 and entered the U.S. Army Medical Corps in July 1917. He served a total of forty-one months in Europe during World Wars I and II. His career from 1921, was spent almost exclusively as Chief Urologist in many Army hospitals and included four tours, totaling eighteen years, at Walter Reed General Hospital where he initiated the urology residency program in 1946. His military awards include a MOS prefix of “A”, Bronze

Star, Legion of Merit, Purple Heart, and a Meritorious Service Citation from General Pershing. He was immediately recalled to active duty after his statutory retirement in 1948. In 1953 an Act of Congress appointed him a Permanent Consultant in urology at Walter Reed. In addition, COL Kimbrough was a Diplomat of the American Board of Urology, a member of the American Urological Association (AUA), a Fellow of the American College of Surgeons, and a member of the American Medical Association. He served as President of the Mid-Atlantic Section of the AUA from 1955 to 1956. From 1949 to 1950 he was President of the Washington, D.C. Urologic Society. He held honorary memberships in the Western Section of the AUA, Royal Society of Medicine of London, Academic de Chirurgie of Paris and Alpha Omega Alpha. Colonel Kimbrough was a 32d degree Mason and Shriner. His intense interest and enthusiasm in Urology made him an authority in the field of urologic oncology; he contributed fifty-eight papers to the urological literature. In 1953 this seminar was established in his honor. In 1957, after his death, the official name became the James C. Kimbrough Urological Seminar. On 29 June 1961, Kimbrough Army Hospital, Fort George G. Meade, was dedicated to his memory.

JAMES C. KIMBROUGH MEMORIAL AWARDS - PREVIOUS WINNERS (cont.)

In 1957, Mrs. Pauline Kimbrough established the Kimbrough Memorial Award for the best presentation by a military resident. Starting in 1972, first place awards began to be presented to the two armed forces urology residents making the best presentations in clinical urology and basic science research. The competition was expanded to include all residents in government service affiliated urology residency programs in 2007. A plaque is given to each award winner.

PREVIOUS AWARD WINNERS

1957	MAJ Gerald Mahaffey, USAF	Letterman Gen Hospital
1958	MAJ A.A. Borski, USA	Fitzsimons Gen Hospital
1959	LT Carter E. Carlton, USN	Baylor U. College of Medicine
1959	CPT Frank E. Ceccarelli, USA	Brooke Gen Hospital
1960	CPT Herbert Levin, USA	Walter Reed Gen Hospital
1961	CPT Richard C. Macure, USA	Brooke Gen Hospital
1962	LCDR R.M. Busch, USN	San Diego Naval Hospital
1963	CPT Richard Finder, USA	Walter Reed Gen Hospital
1964	MAJ Mauro P. Gangai, USA	Walter Reed Gen Hospital
1965	MAJ Thomas Shown, USA	Letterman Gen Hospital
1966	LCDR Robert E. Julian, USN	US Naval Hospital, PA
1967	MAJ Robert Wright, USA	Brooke Gen Hospital
1968	MAJ John C. Wurster, USA	Tripler Gen Hospital
1969	MAJ Joseph A. Bruckman, USA	Tripler Gen Hospital
1970	MAJ Davis F. Gates, USA	Tripler Gen Hospital
1971	MAJ Charles T. Swallow, USA	Brooke Gen Hospital
1972	CPT Tarver B. Bailey, USA	Walter Reed AMC
1972	MAJ Peter A. Leninger, USA	Walter Reed AMC
1973	MAJ George E. Deshon, Jr., USA	Walter Reed AMC
1973	MAJ Gerald L. Levisay, USA	Fitzsimons AMC
1974	MAJ H. David Cox, USA	Walter Reed AMC
1974	LTC Jan Hull, USA	Brooke AMC
1975	MAJ Shannon McMillen, USA	Madigan AMC
1975	LCDR Clifford J. Nemeth, USN	National Naval Med Ctr
1976	MAJ Phillip H. Beck, USA	Letterman AMC
1976	MAJ Patrick W. Kronmiller, USA	Madigan AMC
1977	MAJ William D. Belville, USA	Walter Reed AMC
1977	MAJ David W. Bentley, USA	Fitzsimons AMC
1978	MAJ Victor J. Kiesling, USA	Letterman AMC
1978	Torrence M. Wilson, USA	Fitzsimons AMC
1979	MAJ Jack R. Pence II, USAF	Wilford Hall MC
1979	MAJ Rene Sepulveda, USA	Walter Reed AMC
1980	MAJ George G. Mygatt, USA	Tripler Army AMC
1980	MAJ Jack R. Pence II, USAF	Wilford Hall MC
1981	LCDR Kathryn S. Buchta, USN	Naval Med Ctr, San Diego
1981	MAJ Gary A. Wikert, USA	Brooke AMC
1982	MAJ Louis R. Cos, USA	Univ of Rochester MC
1982	CPT August Zabbo, USAF	Cleveland Clinic Foundation
1983	CPT Robert G. Ferrigni, USAF	Wilford Hall MC
1983	CPT Ian M. Thompson Jr., USA	Brooke AMC
1984	CPT Stephen M. Dresner, USAF	WA Univ, St. Louis, MO
1984	CPT Julius L. Teague, USA	Brooke AMC
1985	LCDR Thomas F. Huisman, USN	Naval Medical Ctr, San Diego
1985	CPT Thomas A. Rozanski, USA	Madigan AMC
1986	CPT Judd W. Moul, USA	Walter Reed AMC

JAMES C. KIMBROUGH MEMORIAL AWARDS - PREVIOUS WINNERS (cont.)

1986	CPT Thomas A. Rozanski, USA	Madigan AMC
1987	LCDR Thomas J. Stilwell, USNR	Mayo Clinic, Rochester, MN
1987	LT Harold A. Frazier II, USNR	Nat'l Naval Med. Ctr.
1988	CPT Anurag K. Das, USAFR	Duke Univ Med Ctr
1988	LT Jeffrey Twidwell, USNR	Naval Medical Ctr, San Diego
1989	MAJ Kurt L. Hansberry, USA	Brooke AMC
1989	CPT Leonard G. Renfer, USA	Madigan AMC
1990	<u>Cancelled</u> (Desert Shield/Storm)	
1991	CPT Wilfred S. Kearsce, Jr. USAF	Wilford Hall MC
1991	MAJ Timothy K. Dixon, USA	Brooke AMC
1992	CPT Richard W. Knight, USA	Madigan AMC
1992	MAJ Donald J. Lewis, USA	Walter Reed AMC
1993	MAJ M. David Bomalaski, USAF	Wilford Hall MC
1993	MAJ Thomas M. Seay, USAF	Wilford Hall MC
1994	CPT R. Duane Cespedes, USAF	Wilford Hall MC
1994	MAJ Joseph Y. Clark, USA	Brooke AMC
1995	CPT Jay T. Bishoff, USAF	Wilford Hall MC
1995	PT Ted O. Morgan, USA	Walter Reed AMC
1996	CPT Jay T. Bishoff, USAF	Wilford Hall MC
1996	CPT Raymond S. Lance, USA	Madigan AMC
1997	MAJ John G. Anema, USAF	Wilford Hall MC
1997	LTC Rhonda Cornum, USA	Brooke AMC
1998	MAJ John G. Anema, USAF	SAUSHEC*
1998	MAJ George B. Stackhouse, USA	Walter Reed AMC
1999	LT Melody A. Denson, USN	University of Iowa
1999	CPT Kyle J. Weld, USAF	University of Tennessee
2000	LCDR Prodromos G. Borboroglu, USN	Naval Medical Ctr, San Diego
2000	CPT Michael L. Gallentine, USAF	SAUSHEC*
2001	MAJ Kevin J. Gancarczyk, USA	Walter Reed AMC
2001	CPT Barak Perahia, USAF	SAUSHEC*
2002	CPT Ann S. Fenton, USAF	SAUSHEC*
2002	CPT Kenneth H. Ferguson, USAF	SAUSHEC*
2004	CPT Eric J. Hick, USAF	SAUSHEC*
2004	MAJ Stacey G. Koff, USA	Walter Reed AMC
2005	MAJ Mark Noller, USA	SAUSHEC*
2005	CPT Thomas Novak	Walter Reed AMC
2006	MAJ Inger Rosner, USA	Walter Reed AMC
2006	LT R. Chanc Walters, USN	Naval Medical Ctr, San Diego
2007	LT Alison M. Lake, USN	University of Michigan
2007	LT R. Chanc Walters, USN	Naval Medical Ctr, San Diego
2008	LT Alison M. Lake, USN	University of Michigan
2008	CPT L. Andrew Evans	SAUSHEC*
2009	CPT Chad DeRosa, MC, USA	Walter Reed AMC
2009	CPT Forrest C. Jellison, MC, USAF	Loma Linda Medical Center
2012	CPT Timothy Tausch, MC USA	Madigan AMC, WA
2012	MAJ Patrick McDonough, MC, USA	Madigan AMC, WA
2013	CPT Nicholas J. Kuntz, MC, USA	Duke University
2013	CPT Mark R. Anderson, MC, USA	Duke University
2014	CPT Ryan W. Speir, MC, USA	Madigan Army Medical Center
2014	CPT Nicholas J. Kuntz, MC, USA	Duke University

JAMES C. KIMBROUGH MEMORIAL AWARDS - PREVIOUS WINNERS (cont.)

2015	CPT Raffaella DeRosa, MC, USA	Tripler Army Medical Center
2015	CPT Nicholas J. Kuntz, MC, USA	Duke University
2016	MAJ Stephen Overholser, MC, USA	Univ. of TX Hlth. Sci. Ctr.
2016	LT Travis C. Allemang, MC, USN	Naval Medical Center Portsmouth
2017	CPT Tara K. Ortiz, MC, USA	Duke University Medical Center
2017	CPT Jonathan Wingate, MC, USA	Madigan Army Medical Center
2018	LT Chad Pusateri, MC, USN	Naval Medical Center San Diego
2018	Capt Theodore R. Saitz, MC, USAFR	Oregon Health & Sci. Univ. Urology
2019	CPT Bradley Potts, MC, USA	Duke University Medical Center
2019	CPT Alexandria Hertz, MC, USA	Madigan Army Medical Center
2020	LCDR Nathan Oehrlein, MC, USN	Walter Reed Nat'l Military Med. Ctr.
2020	CPT Bradley A. Potts, MC, USA	Duke University Medical Center
2021	CPT Bradley A. Potts, MC, USA	Duke University Medical Center
2022	LT Chloe Michel, MC, USN	Naval Medical Center San Diego
2023	CPT Gina T. Baaklini, MC, USA	San Antonio Military Medical Center

*San Antonio Uniformed Services Health Education Consortium

PRINCE D. BEACH, MD

Colonel, Medical Corps, United States Army -1918-1992



Colonel Beach was a native of New Bedford, Massachusetts, a graduate of Colby College and Jefferson Medical College, and was commissioned in the US AMEDD in 1945. Over the next several years he served as a battalion surgeon and medical officer with varied and multiple commands of dispensaries and station hospitals, primarily in Europe. During the Korean War he received the Bronze Star while commanding officer and division surgeon of the 24th Medical Battalion. After completion of his urology residency in 1955 at Brooke Army Medical Center, he was the Assistant Chief of Urology at Fort Carson and Brooke, and Chief of Urology, 2nd General

Hospital, Landstuhl, Germany. He returned to Brooke General Hospital in 1963 and was Chief of Urology from 1965 until his retirement in 1968, after 23 years of active service. Subsequently, he became an Associate Professor in the Department of Urology at Baylor College of Medicine, Chief of Urology at the VA Hospital in Houston, Texas, and Co-chairman of the VA Cooperative Urological Research Group. He was Executive Secretary of the Society of Government Service Urologists (SGSU) from its inception until his death in 1992. He was known for his great sense of humor, administrative expertise, wise counsel and sound clinical acumen.

PRINCE D. BEACH AWARD PREVIOUS WINNERS

Established in 1992 for the best paper presented by a Society Member Staff Physician, as judged by Chief Residents attending the Seminar.

PREVIOUS AWARD WINNERS

1993	MAJ Samuel Peretsman, USAF, MC	Wilford Hall Medical Center
1994	MAJ J. Brantley Thrasher, MC, USA	Madigan Army Medical Center
1995	MAJ J. Brantley Thrasher, MC, USA	Madigan Army Medical Center
1996	MAJ Allen F. Morey, MC, USA	UCSF San Francisco Gen. Hospital
1997	MAJ Ronald S. Sutherland, MC, USA	Tripler Army Medical Center
1998	LTC Burkhardt H. Zorn, MC, USA	Walter Reed Army Medical Ctr.
1999	COL Rhonda Cornum, MC, USA	Eisenhower Army Medical Center
2000	LCDR Stephen V. Jackman, MC, USN	Naval Medical Ctr. Portsmouth
2001	COL Thomas A. Rozanski, MC, USA	Brooke Army Medical Center
2002	MAJ(P) Douglas W. Soderdahl, MC, USA	Eisenhower Army Medical Center
2004	LCDR Brian Auge, MC, USN	Naval Medical Center San Diego
2005	COL Edward Mueller, MC, USA (Ret.)	San Antonio, TX
2006	LCDR Emily Cole, MC, USNR	Naval Medical Center San Diego
2007	MAJ R. Clay McDonough, III, USAF, MC	University of Iowa Hosp. & Clinics
2008	James A. Brown, M.D.	Medical College of Georgia
2009	LTC Andrew Peterson, MC, USA	Madigan Army Medical Center
2010	LCDR Douglas W. Storm, MC, USN	Naval Medical Center San Diego
2011	MAJ Steven Hudak, MC, USA	San Antonio Military Med. Ctr.
2012	LCDR Joe Miller, MC, USN	Univ. of California, San Francisco
2013	LTC Timothy Brand MC, USA	Madigan Army Medical Center
2014	LCDR Douglas W. Storm, MC, USN	University of Iowa Hosp. & Clinics
2015	Col (Ret) Drew Peterson, MC, USA	Duke University
2016	LCDR Eric T. Grossgold, MC, USN	Washington Univ. Medical Ctr.
2017	LCDR Eric T. Grossgold, MC, USN	Washington Univ. Medical Ctr.
2018	Thomas Rozanski, MD	UT Hlth. Sci. Ctr. San Antonio
2019	Stephen A. Boorjian, MD	Mayo Clinic, Rochester, MN
2020	Ranjith Ramasamy, MD	University of Miami
2021	No recipient	
2022	Rachel Rubin, MD	Georgetown University Hospital
2023	Sue & Irwin Goldstein, MD	San Diego Sexual Medicine

H. GODWIN STEVENSON

SGSU Administrator - 1920-1992



H. Godwin Stevenson, a native of Philadelphia, graduated from Cornell University with a B.S. in zoology. He was a naval aviator and flight instructor during World War II. In 1946 he joined Eaton Laboratories as their first salesman and was in charge of government sales from 1952 until his retirement in 1982. He was a naturalist throughout his life, an expert in falconry, an avid birdwatcher, and published authority on moths. Known affectionately as "Tibbie," he was a trusted friend, confidant, and supporter of all Armed Forces and VA urologists. His numerous contributions to government service urology remain his legacy, and include: administrator of the SGSU from its inception in 1972 until his death in 1992, organization and

publication of the "Proceedings of the Kimbrough Seminar," solicitation of multiple corporate sponsors for the annual James C. Kimbrough Urological Seminar, resident grants to professional meetings, SGSU Membership Directory, and hotel conference agreements for the yearly Kimbrough meeting.

H.G. STEVENSON AWARD PREVIOUS WINNERS

In 1992 the Society established this award, which is presented annually for outstanding support and dedicated service to the Society. The recipient of this award can be a Corporate Member, physician, or other individual as determined by the Board of Directors.

PREVIOUS AWARD WINNERS

1992	COL Evan Lewis, MC, USA (Ret)
1994	Preston N. Littrell
1995	COL John N Wettlaufer, MC, USA (Ret)
1996	COL Leonard Maldonado, MC, USA (Ret)
1997	F. Kash Mostofi, M.D.
1998	Lester Persky, M.D.
1999	Charles A. Hulse, M.D.
2000	COL Donald E. Novicki, USAF, MC (Ret)
2001	Harry Tarr
2002	COL Martin L. Dresner, MC, USA (Ret)
2004	COL Robert M. Dobbs, MC, USA (Ret)
2005	COL Ian M. Thompson, MC, USA (Ret)
2006	Kathryn S. Littrell
2007	COL Howard E. Fauver, MC, USA (Ret)
2008	COL David G. McLeod, MC, USA (Ret)
2009	COL David McLeod, MC, USA (Ret)
2010	COL Thomas A. Rozanski, MC, USA (Ret)
2011	Isabel Sesterhenn, MD
2012	John Weigel, MD
2013	BGEN James T. Turlington, MC, USAF (Ret)
2014	John M. Barry, MD
2015	DeSantis Management Group
2016	MAJ GEN Thomas P. Ball, USAF, Ret.
2017	George W. Kaplan, MD
2018	Gerald Jordan, MD
2019	COL Joseph Y. Clark, MC, USA (Ret)
2020	Col Steve Lynch, USAF, MC (Ret)
2021	No recipient
2022	CAPT Harold (Hal) A. Frazier, II, MC, USN (Ret)
2023	CAPT (Ret.) Jeffrey Jones, MC, USNR

CHRISTINE MANTHOS

Major, Medical Corps, United States Army - 1961-1999



Major Manthos, a native of Leesburg, Virginia, commissioned in the USAR in 1985, was a graduate with distinction of University of Virginia and the Uniformed Services University of the Health Sciences from which she received the Army Surgeon General Award. She did her surgical internship at Fitzsimons AMC followed by a one year assignment in Korea as Troop Medical Clinic Commander. She returned to Fitzsimons to complete her Urology residency in 1996 as the last graduating urology resident prior to the closure of Fitzsimons. Among her accomplishments throughout her life were fluency in Russian, participation in an early Hanta

virus study, experience as a country music disc jockey, selection by her peers in 1996 as Outstanding Teaching Resident and below zone promotion to Major. An outstanding physician, she was known for her genuine compassion, excellent teaching abilities and superb surgical skills. Chris was lovingly devoted to her children, family and many friends. Her ever-present infectious smile touched all who knew her. The annual luncheon will be held in memory of Christina Manthos, a member of the society who died of breast cancer. We hope her memory and love for residents will live on during the annual Manthos Resident and Young Urologist Luncheon.

CLARE SCANLON

1941-2005



Clare Scanlon was just as much a member of the Army as was her husband, retired judge advocate Wally. A native of Long Island, New York, Clare graduated from Marymount College in Arlington, Virginia. While raising a family and moving from post to post, Clare worked tirelessly to enrich the lives of those around her. She received the Military Wife of the Year award at Fort Dix, NJ in 1971, and in 1974 was a recipient of the Molly Pitcher award for distinguished service as an officer's wife in the community at Ft. Sill, OK. While at West Point, Clare instructed cadets on finer points of decorum and protocol, launching many young men and women into successful Army careers.

After Wally's career took him to Fort Sam Houston, she served as the medical editor for Brooke Army Medical Center, shepherded many manuscripts into prestigious journals and textbooks of international renown, and began a decade of service to the SGSU. Even into the last year of her life, Clare dedicated countless hours to planning the Kimbrough Urological Seminar, editing and assembling the program book.

CLARE SCANLON AWARD - PREVIOUS WINNERS

CLARE SCANLON AWARD

In 2006, to express our deep gratitude for her devoted service, the Society established the Clare Scanlon Award, to be "presented annually for outstanding administrative support and service to the Society, specifically in regards to the annual Kimbrough Seminar, as determined by the Course Director".

PREVIOUS AWARD WINNERS

2006 Teresa Clark & Sharon Mason
2007 Janie N. Garcia
2008 Patricia A. Harrison
2009 Toni Dominci
2011 Verna Munroe
2016 Maria Salazar
2017 LTC Joseph R. Sterbis, MC,

2018 Inger Rosner, MD
2019 COL Robert C. Dean, MC, USA
2020 Pierce Irby, MD
2021 No recipient
2022 CDR Erik Grossgold, MC, USN
2023 Jeannie DeSantis, MBA

HONORARY LIFETIME MEMBERSHIP

Presented annually to an individual who has distinguished him or herself as a long-time supporter who is dedicated to the society.

HONORARY LIFETIME MEMBERSHIP AWARD PREVIOUS WINNERS

2015	Brendan Fox, MD
2016	COL (Ret.) Martin L. Dresner, MD
2017	Mitchell Edson, MD
2018	John M. Barry, MD
2019	COL (Ret.) Noah S. Schenkman, MD
2020	Al Squitieri, MD, FACS, COL, MC, USA (Ret.)
2021	No recipient
2022	CAPT Sean P. Stroup, MC, USN
2023	COL (Ret) James Jezior, MD

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	
1	1953	Walter Reed General Hospital COL Jack W. Schwartz, MC, USA
2	1954	Walter Reed General Hospital COL Jack W. Schwartz, MC, USA
3	1955	Brooke General Hospital COL Claude C. Dodson, MC, USA
4	1956	Walter Reed General Hospital LTC Kryder E. Van Buskirk, MC, USA
5	1957	Walter Reed General Hospital COL John F. Patton, MC, USA
6	1958	Brooke General Hospital COL Louis K. Mantell, MC, USA
7	1959	Brooke General Hospital COL Louis K. Mantell, MC, USA
8	1960	Brooke General Hospital LTC Clarence B. Hewitt, MC, USA
9	1961	Brooke General Hospital COL Louis K. Mantell, MC, USA
10	1962	Letterman General Hospital COL Kryder E. Van Buskirk, MC, USA
11	1963	Walter Reed General Hospital COL Clarence B. Hewitt, MC, USA
12	1964	Brooke General Hospital COL Prince D. Beach, MC, USA
13	1965	Letterman General Hospital LTC Charles A. Moore, MC, USA
14	1966	Walter Reed General Hospital COL Kryder E. Van Buskirk, MC, USA
15	1967	Brooke General Hospital COL Prince D. Beach, MC, USA
16	1968	Walter Reed General Hospital COL Kryder E. Van Buskirk, MC, USA
17	1969	Letterman General Hospital COL Leonard Maldonado, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	
18	1970	Brooke General Hospital LTC Robert M. Dobbs, MC, USA
19	1971	Letterman General Hospital LTC Ray E. Stutzman, MC, USA
20	1972	Fitzsimons General Hospital COL Evan L. Lewis, MC, USA
21	1973	Walter Reed Army Medical Center COL Anthony A. Borski, MC, USA CAPT Mitchell Edson, MC, USN
22	1974	Brooke Army Medical Center COL Mauro P. Gangai, MC, USA
23	1975	Madigan Army Medical Center COL John N. Wettlaufer, MC, USA
24	1976	Naval Hospital, NRMHC, San Diego, CA CAPT C.R. Sargent, MC, USN
25	1977	Fitzsimons Army Medical Center COL Robert M. Dobbs, MC, USA
26	1978	Wilford Hall USAF Medical Center COL Thomas P. Ball, MC, USAF COL Carl H. Weber, MC, USAF
27	1979	Walter Reed Army Medical Center COL Ray E. Stutzman, MC, USA
28	1980	Naval Regional Med Center, San Diego CAPT Michael R. McCarthy, MC, USN CDR John P. Sands, MC, USN
29	1981	Fitzsimons Army Medical Center COL Howard E. Fauver, MC, USA
30	1982	Wilford Hall USAF Medical Center COL Donald E. Novicki, USAF, MC LT COL Richard A. Airhart, USAF, MCP
31	1983	Letterman Army Medical Center COL Robert E. Agee, MC, USA
32	1984	Naval Hospital, Oakland, CA CDR George J. Gavrell, MC, USN

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	
33	1985	Madigan Army Medical Center COL William D. Belville, MC, USA
34	1986	Wilford Hall USAF Medical Center COL Alvin L. Sago, USAF, MC LTC John D. Maldazys, MC, USAF
35	1987	Walter Reed Army Medical Center/USUHS COL David G. McLeod, MC, USA LTC Steven J. Skoog, MC, USA
36	1988	Naval Hospital Portsmouth CAPT Gordon MacDonald, MC, USA
37	1989	Brooke Army Medical Center COL Francisco R. Rodriguez, MC, USA
38	1990	Fitzsimons Army Medical Center COL Michael J. Raife, MC, USA
39	1991	National Naval Medical Center-Bethesda s CAPT Kevin J. O'Connell, MC, USN LCDR Harold A. Frazier, II, MC, USN
40	1992	Madigan Army Medical Center Four Seasons Olympic Hotel, Seattle, WA COL John N. Wettlaufer, MC, USA
41	1993	Naval Medical Center San Diego Bahia Hotel, San Diego, CA CAPT John P. Sands, MC, USN
42	1994	Naval Medical Center Portsmouth Omni at Charleston Place, Charleston, SC CAPT James R. Auman, MC, USN
43	1995	Walter Reed Army Medical Center/USUHS L'Enfant Plaza, Washington, DC COL David G. McLeod, MC, USA LTC Pierce B. Irby, MC, USA
44	1996	Wilford Hall USAF Medical Center Scottsdale Plaza Hotel, Scottsdale, AZ MAJ Steven C. Lynch, MC, USAF MAJ Edmund S. Sabanegh, MC, USAF

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	
45	1997	Tripler Army Medical Center The Fairmont Hotel, San Francisco, CA COL George E. Deshon, MC, USA
46	1998	National Naval Medical Center-Bethesda Ft. Magruder Inn, Williamsburg, VA CAPT Paul J. Christenson, MC, USN CDR Harold A. Frazier, II, MC, USN
47	1999	Brooke Army Medical Center Hilton Palacio Del Rio, San Antonio, TX LTC Thomas A. Rozanski, MC, USA LTC John P. Foley, MC, USA
48	2000	Naval Medical Center San Diego Wyndam Emerald Plaza, San Diego, CA CAPT James L. Roberts, MC, USN LCDR Christopher J. Kane, MC, USN
49	2001	Madigan Army Medical Center Four Seasons Olympic Hotel, Seattle, WA LTC(P) Raymond A. Costabile, MC, USA
50	2002	Walter Reed Army Medical Center Crystal City Marriott Hotel, Arlington, VA COL Dennis S. Peppas, MC, USA
51	2004	Wilford Hall USAF Medical Center Hilton Palacio Del Rio, San Antonio, TX MAJ Edith Canby-Hagino, MC, USAF LT COL Steven C. Lynch, MC, USAF
52	2005	Tripler Army Medical Center Sheraton Waikiki Hotel, Honolulu, HI COL Ronald S. Sutherland, MC, USA
53	2006	Naval Medical Center Portsmouth & Eastern Virginia Medical School Savannah Marriott Riverfront, Savannah, GA CAPT Leo Kusuda, MC, USN Gerald H. Jordan, MD
54	2007	Brooke Army Medical Center Westin Galleria, Houston, TX LTC Douglas W. Soderdahl, MC, USA COL Allen F. Morey, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	
55	2008	Naval Medical Center San Diego Wyndam Emerald Plaza, San Diego, CA CDR Brian K. Auge, MC, USN LCDR Donald S. Crain, MC, USN
56	2009	Walter Reed Army Medical Center & National Naval Medical Center-Bethesda Hyatt Regency Capitol Hill, Washington DC COL James R. Jezior, MC, USA COL Robert C. Dean, MC, USA
57	2010	Wilford Hall Medical Center Westin Hotel, San Antonio, TX LT COL Kyle J. Weld, MC, USAF
58	2011	Madigan Army Medical Center Seattle Sheraton, Seattle, WA MAJ Timothy C. Brand, MC, USA
59	2012	Naval Medical Center Portsmouth Charleston Marriott, Charleston, SC CAPT Paul D. McAdams, MD, FACS
60	2013	Tripler Medical Center, Honolulu Marriott Waikiki Beach Hotel, Honolulu, HI COL (Ret.) USA, Richard S. Stack, MD MAJ Joseph Sterbis, MC, USA CDR Tammy L. Bloom, MC, USN
61	2014	Naval Medical Center San Diego Sheraton Harbor Island Hotel, San Diego, CA CDR Sean P. Stroup, MC, USN CDR Jamey Sarvis, MC, USN
62	2015	Madigan Army Medical Center Sheraton Harbor Island Hotel, San Diego, CA LTC Timothy C. Brand, MC, USA LTC Jack R. Walter, MC, USA
63	2016	San Antonio Military Medical Center Westin Hotel, San Antonio, TX MAJ Steven J. Hudak, MC, USA LT COL Timothy M. Phillips, MC, USAF

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	
64	2017	Naval Medical Center, Portsmouth, VA Sheraton Harbor Island Hotel, San Diego, CA CDR R. Chanc Walters, MC, USN LCDR Paul R. Womble, MC, USN
65	2018	Walter Reed National Military Medical Center The Scottsdale Resort at McCormick Ranch, Scottsdale, Arizona COL Robert C. Dean, MC, USA
66	2019	Tripler Army Medical Center Sheraton Kona Hotel, Kona, Hawaii LTC Joseph Sterbis, MC, USA & LTC John Musser, MC, USA
67	2020	Brooke Army Medical Center San Antonio Military Medical Center Hilton Charlotte University Place, Charlotte, NC LTC Christopher Allam, MC, USAF LTC George Kallingal, MC, USA
68	2021	Naval Medical Center San Diego USNR / MEDVAMC / Baylor College of Medicine Virtual One-Day Meeting CDR Justin DeGrado, MC, USN, CAPT Jeffrey Jones, MC, USNR
68	2022	Naval Medical Center San Diego USNR / MEDVAMC / Baylor College of Medicine Westin Mission Hills, Rancho Mirage, CA CDR Justin DeGrado, MC, USN, CAPT (Ret.) Jeffrey Jones, MC, USNR
69	2023	Madigan Army Medical Center, Tacoma, WA El Conquistador Hilton, Tucson, AZ LTC Ryan Speir, MC, USA, LTC RJ Caras, MC, USA
70	2024	JBSA Ft Sam Houston, San Antonio, TX Hilton Norfolk The Main Col Timothy Baumgartner, MC, USAF, Col Christopher Allam, MC, USAF

GENERAL INFORMATION

Registration:

Registration is required in order to obtain Continuing Medical Education credits. Attendees will be given badges at registration. It is required that you wear your badges to gain entry into the scientific sessions, exhibits, social events, breakfasts, and breaks. Should you wish to bring your spouse to any of these events, you must register them for a badge.

Registered Spouses/Guests are welcome to attend the morning breakfasts and breaks in the exhibit hall. Spouse/Guest badge is required.

Overview/Highlights:

Topics featured at the Kimbrough Annual Seminar will feature state of the art lectures in various urologic topics - including: Sexual Medicine, Prostate Cancer, Transgender Surgery, Pediatric Urology, Stones, Bladder Cancer, Reconstruction, Testicular Cancer, GU Cancer, Diversity, Equity & Inclusion, Leadership and Military Preparedness. In addition, the program will include the traditional Resident Research Competition, Research Papers, Poster Session and Mock Oral Boards - for those preparing for the ABU certifying examination.

Special Assistance/Dietary Needs: The SGSU complies with the Americans with Disabilities Act §12112(a). If any participant is in need of special assistance or has any dietary restrictions, please see the registration desk.

Dress Code:

Service Dress on Thursday (Business for civilians) for picture, and any time when presenting or moderating. All other times will be business casual (collared shirt and slacks or female equivalent).

Attention Presenters:

Go to slide preview area to make changes/update slides. Updates must be made at least three hours in advance of your presentation.

Slide Preview Hours:

WED: 2:00 PM - 6:00 PM

THURS - SAT: 7:00 AM - 5:00 PM

SUN: 7:00 AM - 9:00 AM

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Acknowledgement of Financial Commercial Support

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Acknowledgement of In-Kind Commercial Support

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Satisfactory Completion

Learners must complete an evaluation form to receive a certificate of completion. Your chosen sessions must be attended in their entirety. Partial credit of individual sessions is not available. If you are seeking continuing education credit for a specialty not listed below, it is your responsibility to contact your licensing/certification board to determine course eligibility for your licensing/certification requirement.

Joint Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by Amedco LLC and Society of Government Service Urologists. Amedco LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. Amedco Joint Accreditation #4008163.



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Objectives - After Attending This Program You Should Be Able To:

1. Examine and discuss challenges in Treatment of Post-Prostatectomy Incontinence.
2. Review updates in Testicular Cancer and discuss Military Threats and Opportunities.
3. Utilize new techniques and procedures alternate Treatments of Benign Prostatic Hyperplasia.

Disclosure of Conflict of Interest

The following table of disclosure information is provided to learners and contains the relevant financial relationships that each individual in a position to control the content disclosed to Amedco. All of these relationships were treated as a conflict of interest, and have been resolved. (C7 SCS 6.1--6.2, 6.5)

All individuals in a position to control the content of CE are listed in the program book. If their name is not listed below, they disclosed that they had no financial relationships with a commercial interest.

NAME	COMMERCIAL INTEREST
Lori Lerner	BSCI, AMBU: Consultant, Janssen: Research Grant Site Principal Investigator
Peter Pinto	Philips: Patent Holder
Keith Rourke	Cook Medical, A.M.I.: Consultant
Shaw Wan	Well Lead Medical Co: Patent Holder

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Questions? Email Certificate@AmedcoEmail.com

Thank you!

PROGRAM-AT-A-GLANCE

Special Note: Meal service for all daytime functions is in the first hour.

WEDNESDAY, JANUARY 17

TIME	EVENT	ROOM
2:00 PM - 6:00 PM	Registration	Main Ballroom Foyer
2:00 PM - 6:00 PM	Slide Preview	Main Ballroom Foyer
2:00 PM - 4:00 PM	Board of Director's Mtg.	Main Ballroom GF
2:00 PM - 6:00 PM	Exhibits Set Up	Main Ballroom ABC
6:30 PM - 8:30 PM	Welcome Reception	Grain Restaurant, 5th Fl

THURSDAY, JANUARY 18

TIME	EVENT	ROOM
7:00 AM - 2:40 PM	Exhibits Open	Main Ballroom ABC
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 4:00 PM	Registration	Main Ballroom Foyer
7:00 AM - 5:00 PM	Slide Preview	Main Ballroom Foyer
8:15 AM - 8:35 AM	Opening Ceremonies	Main Ballroom
8:35 AM - 8:45 AM	AUA Keynote Address	Main Ballroom
8:45 AM - 9:00 AM	Group Picture	Main Ballroom
9:00 AM - 9:20 AM	Resident Competition 1	Main Ballroom
9:20 AM - 9:40 AM	Resident Competition 2	Main Ballroom
9:40 AM - 10:10 AM	Resident Competition 3	Main Ballroom
10:10 AM - 11:15 AM	Network Break	Exhibits/Expo Lab Area
11:15 AM - 11:45 AM	Resident Competition 4	Main Ballroom
12:00 PM - 1:40 PM	Manthos Lunch Program	Main Ballroom
12:00 PM - 1:40 PM	Lunch in Exhibits Area	Exhibits/Expo Lab Area
1:40 PM - 2:15 PM	Resident Competition 5	Main Ballroom

PROGRAM-AT-A-GLANCE

Special Note: Meal service for all daytime functions is in the first hour.

THURSDAY, JANUARY 18 (cont.)

TIME	EVENT	ROOM
2:15 PM - 3:00 PM	Educational Symposium	Main Ballroom
3:00 PM - 3:30 PM	Resident Competition 6	Main Ballroom
3:30 PM - 5:00 PM	USAV Program	Main Ballroom

FRIDAY, JANUARY 19

TIME	EVENT	ROOM
7:00 AM - 2:00 PM	Exhibits Open	Main Ballroom
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 3:00 PM	Registration	Main Ballroom Foyer
7:00 AM - 4:00 PM	Slide Preview	Main Ballroom Foyer
8:15 AM - 9:15 AM	Prostate /Sexual Med.	Main Ballroom
9:15 AM - 10:00 AM	Navy Presentation	Main Ballroom
10:00 AM - 11:15 AM	Network Break	Exhibits/Expo Lab Area
11:15 AM - 11:55 AM	Sexual Medicine	Main Ballroom
12:00 PM - 1:15 PM	CME Lunch Program	Main Ballroom
1:25 PM - 2:05 PM	Transgender	Main Ballroom
2:05 PM - 2:20 PM	Pediatric Urology	Main Ballroom
2:20 PM - 2:35 PM	Military Applications	Main Ballroom
2:35 PM - 2:50 PM	Prostate	Main Ballroom
5:00 PM - 5:30 PM	GU Bowl/Tailgate Party	Main Ballroom Foyer
5:30 PM - 6:30 PM	GU Bowl	Main Ballroom
6:30 PM - 9:30 PM	Casino Royale Night	Main Ballroom

PROGRAM-AT-A-GLANCE

Special Note: Meal service for all daytime functions is in the first hour.

SATURDAY, JANUARY 20

TIME	EVENT	ROOM
7:00 AM - 5:00 PM	Registration	Main Ballroom Foyer
7:00 AM - 5:00 PM	Slide Preview	Main Ballroom Foyer
7:15 AM - 2:00 PM	Exhibits Open	Main Ballroom
7:15 AM - 8:30 AM	Networking Breakfast	Exhibits/Expo Lab Area
8:30 AM - 9:00 AM	Consultant Updates	Main Ballroom
9:05 AM - 9:40 AM	Stones	Main Ballroom
9:40 AM - 10:15 AM	Educational Symposium	Main Ballroom
10:15 AM - 11:15 AM	Network Break	Exhibits/Expo Lab Area
11:15 AM - 12:00 PM	Reconstruction	Main Ballroom
12:00 PM - 1:15 PM	CME Lunch Program	Main Ballroom
1:20 PM - 2:25 PM	SGSU Business Meeting	Main Ballroom
2:25 PM - 2:45 PM	Testicular Cancer	Main Ballroom
2:45 PM - 4:00 PM	GU Cancer/Gen.Urology	Main Ballroom
4:00 PM - 5:30 PM	Poster Session/Happy Hour	Main Ballroom

SUNDAY, JANUARY 21

TIME	EVENT	ROOM
7:00 AM - 11:00 AM	Registration	Granby Blrm. Foyer
7:00 AM - 9:30 AM	Slide Preview	Momentum Room
7:00 AM - 8:00 AM	Continental Breakfast	Granby Ballroom
7:15 AM - 7:35AM	DEI Session	Granby Ballroom
7:35 AM - 9:00 AM	Military Preparedness	Granby Ballroom
8:00 AM - 11:00 AM	Mock Oral Boards	Granby Ballroom E

INVITED SPEAKERS

Clint Bahler, MD

Associate Professor of Urology, Adjunct
Associate Professor of Radiology & Imaging
Sciences – Indiana University

Heather DiCarlo, MD

Johns Hopkins, Director, Pediatric Urology
Research Assistant Professor of Urology

Tracy M. Downs, MD

Chief Diversity & Community Engagement
Officer, Univ. of Virginia Physicians Group

Robert Dreicer, MD, MS, MACP, FASCO

Section Head Medical Oncology, Deputy
Director, University of Virginia
Comprehensive Cancer Center, Associate
Director for Clinical Research, Co-Director
Paul Mellon Urologic Cancer Institute
Professor of Medicine and Urology
University of Virginia School of Medicine

Leonard Gomella, MD

Chair, Department of Urology, Medical
Thomas Jefferson Univ., Philadelphia, PA

LTC Sean Kern, MC, USA

Founding Director, Testicular Cancer
Enterprise for Survivorship, Treatment,
Investigational Sciences TESTIS Program,
Murtha Cancer Center, USU, Urologic
Oncologist, Uniformed Services Univ.- Health
Sciences & Walter Reed National Military
Med. Ctr., Program Director, NCC/Walter
Reed Residency Program

Mohit Khera, MD, MBA, MPH

SMSNA President, Baylor College of
Medicine, Temple, TX

Frances M. Martin, MD, FACS

Urology of Virginia

Kurt A. McCammon, MD, FACS

Devine Chair, Genitourinary
Reconstructive Surgery, Program Director,
Urology Residency Program, Eastern
Virginia Medical School

Edward M. Messing, MD, FACS

AUA Immediate Past President
Professor of Urology & Oncology,
University of Rochester

Tony Minter

Veterans Prostate Cancer Awareness Inc.

Peter A. Pinto, MD

Senior Investigator, Urologic Oncology
Branch, NIH

Rachel Rubin, MD

Urologist/Sexual Medicine Specialist,
Bethesda, MD, Education Committee
Chair, ISSWSH

Keith F. Rourke, MD, FRCSC,

President Elect, GURS, Professor, Division
of Urology, University of Alberta, Urology
Site Chief, University of Alberta Hospital,
Alberta Health Services

James Smith, MD

Chief Medical Officer at Fellow

Mark D. Sawyer, MD

Rocky Mountain Regional Veterans
Administration Medical Center

Tamarie Wheat, APRN, FNP-BC

Nurse Practitioner, VA Boston Health Care.

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Hours:

Thur.: 7:00am - 2:40pm

Fri: 7:00am - 2:00pm

Sat: 7:15am - 2:00pm

Thursday ExpoLab Events:

Breakfast: 7:00am

Refreshment Break: 10:10am

Lunch Break: 12:00pm

Friday ExpoLab Events:

Breakfast: 7:00am

Refreshment Break: 10:10am

Saturday Expo Lab Events:

Breakfast: 7:15am

Refreshment Break: 10:15am

**Visit with the Expo Lab during the Breakfasts,
Refreshment Breaks & Thursday Lunch**

Use your Prize Card & get Scratcher Cards to win prizes!

EXHIBITORS

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Sexual Health

American Urological Association

WEDNESDAY, JANUARY 17

Outline of Scientific Program

70th Kimbrough

Annual Seminar * Hilton Norfolk The Main * Norfolk, VA

TIME	EVENT	ROOM
2:00 PM - 6:00 PM	Registration	Main Ballroom Foyer
2:00 PM - 6:00 PM	Slide Preview	Main Ballroom Foyer
2:00 PM - 4:00 PM	Board of Director's Mtg.	Main Ballroom GF
2:00 PM - 6:00 PM	Exhibits Set Up	Main Ballroom ABC
6:30 PM - 8:30 PM	Welcome Reception	Grain Restaurant, 5th Fl

Welcome
Reception

6:30pm - 8:30pm
Grain Roof-Top Garden
Restaurant, 5th Floor

Welcome to the 70th Kimbrough Meeting!
Join friends & colleagues while enjoying
food stations, hosted libations,
craft beers and fun vibes overlooking
the Elizabeth River.



Dress is cocktail attire.

Bring your
Green Drink Tickets

BADGE & TICKET REQUIRED

THURSDAY, JANUARY 18

Outline of Scientific Program

70th Kimbrough

Annual Seminar * Hilton Norfolk The Main * Norfolk, VA

TIME	EVENT	ROOM
7:00 AM - 2:40 PM	Exhibits Open	Main Ballroom ABC
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 4:00 PM	Registration	Main Ballroom Foyer
7:00 AM - 5:00 PM	Slide Preview	Main Ballroom Foyer
8:15 AM - 8:35 AM	Opening Ceremonies	Main Ballroom
8:35 AM - 8:45 AM	AUA Keynote Address	Main Ballroom
8:45 AM - 9:00 AM	Group Picture	Main Ballroom
9:00 AM - 9:20 AM	Resident Competition 1	Main Ballroom
9:20 AM - 9:40 AM	Resident Competition 2	Main Ballroom
9:40 AM - 10:10 AM	Resident Competition 3	Main Ballroom
10:10 AM - 11:15 AM	Refreshment Break	Exhibits/Expo Lab Area
11:15 AM - 11:40 AM	Resident Competition 4	Main Ballroom
12:00 PM - 1:40 PM	Manthos Lunch Program	Main Ballroom
12:00 PM - 1:40 PM	Lunch in Exhibits Area	Exhibits/Expo Lab Area
1:40 PM - 2:15 PM	Resident Competition 5	Main Ballroom
2:15 PM - 3:00 PM	Educational Symposium	Main Ballroom
3:00 PM - 3:30 PM	Resident Competition 6	Main Ballroom
3:30 PM - 5:00 PM	USAV Program	Main Ballroom



**Rise &
Shine**

7:00 am

**Head to the EXPO LAB (Exhibits Areas) this morning
for the Networking Breakfast & hot coffee!**

THURSDAY, JANUARY 18, 2024

OPENING CEREMONIES

8:15 AM - 9:00 AM - Main Ballroom

8:15AM - 8:30AM

Welcome & Announcements

Program Chairmen: Col Timothy Baumgartner,
MC, USAF & Col Christopher Allam, MC, USAF
President: COL (Ret.) Timothy Phillips, MC, USAF

8:30AM - 8:35AM

National Anthem

1.

8:35 AM - 8:45 AM

AUA Keynote Address

Edward M. Messing, MD, FACS

**Immediate Past President,
American Urological Association**

8:45AM

Stay for Group Picture (All)

THURSDAY, JANUARY 18, 2024

RESIDENTS COMPETITION 1

Pediatric Urology

9:00 AM - 9:20 AM - Main Ballroom DE

(Papers are seven minutes)

**Moderators: Col Timothy Baumgartner, MC, USAF &
COL (Ret.) Timothy Phillips, MC, USAF**

**Judges: COL (Ret.) Timothy Brand, MC, USA, Harold (Hal) Frazier, II, MD,
Joseph Clark, MD, Edward Messing, MD**

- 2 9:00AM SO1 (vet.) Shane Kronstedt, MC, USN**
Pediatric Genitourinary Trauma In Afghanistan And Iraq.
- 3 9:07AM CPT Trevor J Maloney, DO**
Clinical Evaluation Of A Suspicious Bladder Mass In A 5-year-old
Boy – A Case Report.
- 9:14AM Discussion (6 minutes)**
- 9:20AM End of Session**

THURSDAY, JANUARY 18, 2024

RESIDENTS COMPETITION 2

Oncology

9:20 AM - 9:40 AM - Main Ballroom DE

(Papers are seven minutes)

Moderator: LTC Sean Q. Kern, MC, USA

**Judges: COL (Ret.) Timothy Brand, MC, USA, Harold (Hal) Frazier, II, MD,
Joseph Clark, MD, Edward Messing, MD**

- 4 9:20AM SO1 (vet.) Shane Kronstedt, MC, USN**
Early Adjuvant Chemotherapy Improves Survival In Muscle Invasive
Bladder Cancer: A Systematic Review And Meta-Analysis.
- 5 9:27AM SO1 (vet.) Shane Kronstedt, MC, USN**
Oncologic Outcomes Of Extent Of Pelvic Lymph Node Dissection
During Radical Prostatectomy: A Systematic Review, Meta-Analysis,
And Network Analysis.
- 9:34AM Discussion (6 minutes)**
- 9:40AM End of Session**

THURSDAY, JANUARY 18, 2024

RESIDENTS COMPETITION 3

Voiding Dysfunction

9:40 AM - 10:10 AM - Main Ballroom DE
(Papers are seven minutes)

**Moderators: CAPT Erik T. Grossgold, MC, USN &
CDR Nathan Oehrlein, MC, USN**

**Judges: COL (Ret.) Timothy Brand, MC, USA, Harold (Hal) Frazier, II, MD,
Joseph Clark, MD, Edward Messing, MD**

- 6 9:40AM CPT Timothy W. Brandt, MC, USA**
Clinically Adequate Uroflowmetry Data: Implementation of MyUroflow Home Testing.
- 7 9:47AM T. Max Shelton, MD**
Assessment Of Bladder Botulinum Toxin Injection Risk Factors Following Holmium Laser Enucleation Of The Prostate.
- 8. 9:54AM LT Hannah M. Johnson, MC, USN**
Evaluating Decision Regret in Sacral Neuromodulation Patients.

10:01AM Discussion (9 minutes)

10:10AM End of Session

VENDOR-BLENDER - FUEL UP!

10:10 AM - 11:15 AM



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Win Great Prizes!!!

**Visit & chat with the vendors
to complete your PRIZE CARD!**

**Exhibitors will give out the
SCRATCHER CARDS at their discretion.**

THURSDAY, JANUARY 18, 2024
RESIDENTS COMPETITION 4

Education

11:15 AM - 11:40 PM - Main Ballroom DE
(Papers are seven minutes)

Moderators: LTC Ryan Speir, MC, USA & COL Joseph Kuebker, MC, USAF

Judges: COL (Ret.) Timothy Brand, MC, USA, Harold (Hal) Frazier, II, MD,
Joseph Clark, MD, Edward Messing, MD

9 11:15AM CPT Brianna Walter, MC, USA
Low Cost, Low Fidelity Urethroplasty Model.

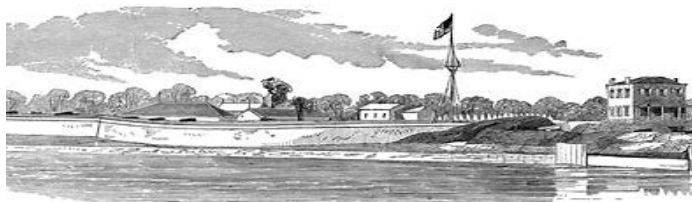
10 11:22AM CPT Trevor J. Maloney, DO
Microsurgical Training In A High-volume Academic Infertility
Practice; Assessment Of Trainee Improvement.

**11:29AM Treatment of Anterior Urethral Strictures With the
Optilume Drug-Coated Balloon.**

Cassandra C. Lyons, MD; Michelle E, Koski, MD; Donald S. Crain,
MD: San Diego, CA.

11:37AM Discussion (3 minutes)

11:40PM End of Session



Courtesy Reminder

SET PHONES TO VIBRATE

**Please take your calls outside the
meeting room.**

Thank You

LUNCH PROGRAMS

THURSDAY, JANUARY 18, 2024

11

12:00 PM - 1:40 PM - Main Ballroom DE

Moderator: CAPT Erik T. Grossgold, MC, USN

Manthos Resident & Young Urologist Lunch Program

**“Experiences with and Benefits of
Global Surgery for the Young Urologist”**

Kurt A. McCammon, MD, FACS

Devine Chair in Genitourinary Reconstructive Surgery
Program Director, Urology Residency Program
Eastern Virginia Medical School

~ Meet & Greet with Industry ~

12:00 PM - 1:40 PM

**Lunch provided by SGSU
in the Expo Lab**

(Food service until 1:15pm)

Visit the exhibitors to complete your **PRIZE CARD** for the drawing.
Chat with the exhibitors - they will give out the **SCRATCHER CARDS**
at their discretion for instant prizes!

THURSDAY, JANUARY 18, 2024

RESIDENTS COMPETITION 5

Infertility

1:40 PM - 2:15 PM - Main Ballroom DE
(Papers are seven minutes)

Moderator: Amanda Reed-Maldonado, MD

Judges: COL (Ret.) Timothy Brand, MC, USA, Harold (Hal) Frazier, II, MD
Joseph Clark, MD, Edward Messing, MD

- 12 1:40PM Tamarie Wheat, ARNP**
Mail-in Semen Analysis Improves Processes, Compliance And Cost.
- 13 1:47PM LT Paolo Rigo, MC, USN**
A Pilot Study To Evaluate The Efficacy Of Vasovasostomy
Anastomosis Techniques.
- 14 1:54PM LCDR Benjamin Baker, MC, USN**
Sperm Preservation Ensured by Regulations/Mandates: a
Qualitative Analysis (S.P.E.R.M. Q.A.).
- 15 2:01PM CPT Meleighe Sloss, MC, USA**
Non-Ischemic Priapism As An Initial Presenting Symptom of
Multiple Sclerosis In A Young Active Duty Soldier.
- 2:08PM Discussion (7 minutes)**
- 2:15PM End of Session**

EDUCATIONAL SYMPOSIUM

16. 2:15 PM - 3:00 PM

**Fellow Mail-in Semen Analysis Delivers Improved Compliance,
Cost Savings, and Better Patient Satisfaction at VA Boston.**

James Smith, MD, Chief Medical Officer at Fellow

Tamarie Wheat, APRN, FNP-BC, Nurse Practitioner,
VA Boston Health Care.

Non CME Program - Supported by Fellow

THURSDAY, JANUARY 18, 2024
RESIDENTS COMPETITION 6
Kidney

3:00 PM - 3:30 PM- Main Ballroom DE
(Papers are seven minutes)

Moderators: CDR Gregory Chesnut, MC, USN / LCDR Alexander Doudt, MC, USN

Judges: COL (Ret.) Timothy Brand, MC, USA, Harold (Hal) Frazier, II, MD,
Joseph Clark, MD, Edward Messing, MD

- 17 3:00PM Maj Cassandra C. Lyons MC, USAF**
Extensive Bilateral Renal Tumor Burden In A Patient With SDH-Deficient Renal Cell Carcinoma Managed With Concurrent Bilateral Open Partial Nephrectomies.
- 18 3:07PM SO1 (vet.) Shane Kronstedt, MC, USN**
Ureterectomy Vs. Endoscopic Resection Vs. Radical Nephroureterectomy For Upper Tract Urothelial Carcinoma: A Systematic Review And Network Meta-analysis.
- 19 3:14PM T. Max Shelton MD**
Comparative Outcomes In Patients With Pre-existing Nephrostomy Tube Prior To Percutaneous Nephrolithotomy (PCNL): Retrospective Analysis Of Tract Reutilization Vs New Intraoperative Access.
- 20 3:21PM Capt Clinton Yeaman, MD, MS, MC, USAF**
Impact Of Spy Fluorescence Angiography On Incidence Of Ureteroenteric Stricture After Urinary Diversion.
- 3:28PM Discussion (2 minutes)**
- 3:30PM End of Session**

CLAIM YOUR CME - DAILY EVALUATIONS
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govurology.org -> 2024 Meeting
click on "Daily Evaluations"

THURSDAY, JANUARY 18, 2024

USAV Program

3:30 PM - 5:00 PM- Main Ballroom DE

Moderator:

Robert L. Grubb, III, MD, President, USAV

- 21 3:30PM Robert L. Grubb, III, MD, President, USAV, Medical University of South Carolina**
Welcome and USAV Report
- 22 3:35PM Robert L. Grubb, III, MD, Frances Martin, MD, FACS**
Moderator: Tracy M. Downs, MD
Expert Panel - Case Discussion - Integrating New Bladder Cancer Therapies into Practice.
- 23 4:00PM Mark D. Sawyer, MD, Rocky Mountain Regional Veterans Administration Medical Center**
Hybrid Room.
- 24 4:20PM Tracy M. Downs, MD, Chief Diversity & Community Engagement Officer, Univ. of Virginia Physicians Group**
Diversity, Equity and Inclusion.
- 25 4:35PM Peter A. Pinto, MD, Senior Investigator, Urologic Oncology Branch, NIH**
MRI & Prostate Cancer.
- 26 4:55PM Tony Minter, Retired US Army Flight Paramedic**
Veterans Prostate Cancer Awareness Update.
- 5:00PM End of Session**



FRIDAY, JANUARY 19

Outline of Scientific Program

70th Kimbrough

Annual Seminar * Hilton Norfolk The Main * Norfolk, VA

TIME	EVENT	ROOM
7:00 AM - 2:00 PM	Exhibits Open	Main Ballroom
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 3:00 PM	Registration	Main Ballroom Foyer
7:00 AM - 4:00 PM	Slide Preview	Main Ballroom Foyer
8:15 AM - 9:15 AM	Prostate /Sexual Med.	Main Ballroom
9:15 AM - 10:00 AM	Navy Presentation	Main Ballroom
10:00 AM - 11:15 AM	Refreshment Break	Exhibits/Expo Lab Area
11:15 AM - 11:55 AM	Sexual Medicine	Main Ballroom
12:00 PM - 1:15 PM	CME Lunch Program	Main Ballroom
1:25 PM - 2:05 PM	Transgender	Main Ballroom
2:05 PM - 2:20 PM	Pediatric Urology	Main Ballroom
2:20 PM - 2:35 PM	Military Applications	Main Ballroom
2:35 PM - 2:50 PM	Prostate	Main Ballroom
5:00 PM - 5:30 PM	GU Bowl/Tailgate Party	Main Ballroom Foyer
5:30 PM - 6:30 PM	GU Bowl	Main Ballroom
6:30 PM - 9:30 PM	Casino Royale Night	Main Ballroom



7:00 AM

Get energized at the

Network Breakfast in the Expo Lab

Bring your **PRIZE CARD**

Power Up!



FRIDAY, JANUARY 19, 2024

PROSTATE / SEXUAL MEDICINE

8:15 AM - 9:15 AM - Main Ballroom

Moderators:

CDR Nathan Oehrlein, MC, USN / LCDR Alexander Doudt, MC, USN

- 27 8:15AM ENS Cedrick B. Chiu, BS, USN**
Should Veterans Be Classified as High Risk for Prostate Cancer Screening: A Review of Current Literature.
- 28 8:20AM ENS Nathaniel McLaughlan, SM, USN**
Prostate Specific Antigen Screening Patterns By Age, Race, and Veteran Status: A U.S. National Behavioral Analysis.

8:25AM Discussion (5 minutes)

29 8:30AM

STATE OF THE ART LECTURE

**SUPPORTED BY
SEXUAL MEDICINE SOCIETY OF NORTH AMERICA
(SMSNA)**

**Changing Paradigms in the Diagnosis and Management of
Erectile Dysfunction.**

Mohit Khera, MD, MBA, MPH, SMSNA President

Baylor College of Medicine, Temple, TX

9:05AM Discussion (10 minutes) / 9:15 AM End of Session.

FRIDAY, JANUARY 19, 2024

NAVY PRESENTATION

9:15 AM - 10:00 AM - Main Ballroom

Medical Corps Career Development Board Program.

CAPT Erik Grossgold, MC, USN

Navy Urology Liaison
Naval Medical Center, Portsmouth, Virginia

SEE WHAT'S  **IN THE EXPO LAB**

Refreshment & Network Break
10:00am - 11:15am

VISIT OUR EXHIBITORS
2 WAYS TO WIN!

PRIZE CARD



SCRATCH CARD

Get one from each Exhibitor



WIN BIG



FRIDAY, JANUARY 19, 2024

SEXUAL MEDICINE

11:15 AM - 11:55 AM - Main Ballroom

Moderators:

Amanda Reed-Maldonado, MD & CDR Jonathan Berger, MC, USN

30 11:15AM

**STATE OF THE ART LECTURE
SUPPORTED BY
INTERNATIONAL SOCIETY FOR THE STUDY OF
WOMEN'S SEXUAL HEALTH (ISSWSH)**

How Treating a Female Patient Can Cure Your Male Patient.

Rachel Rubin, MD

Education Committee Chair, ISSWSH, Assistant Clinical Professor in
Department of Urology at Medstar Georgetown University
Clinical Instructor in Department of Urology at George Washington

11:45 AM Discussion (10 minutes) / 11:55 AM End of Session.

CME LUNCH SYMPOSIUM

31 12:00 PM - 1:15 PM - Main Ballroom

**Intensifying Care: Elevating Treatment of Hormone-
Sensitive Prostate Cancer for Federal Urologists.**

Leonard Gomella, MD

Chair, Department of Urology
Thomas Jefferson University
Philadelphia, PA

*This activity is supported by medical education grants
from Astellas and Pfizer, Inc. and Janssen Biotech, Inc. administered by
Janssen Scientific Affairs, LLC.*

FRIDAY, JANUARY 19, 2024

TRANSGENDER SURGERY

1:25 PM - 2:05 PM - Main Ballroom

32 1:25PM

STATE OF THE ART LECTURE

**Updates in Gender Affirmation Bottom Surgery -
The Role of the Urologist.**

Heather DiCarlo, MD

Johns Hopkins, Baltimore, MD

1:55PM Discussion / 2:05PM End of Session

FRIDAY, JANUARY 19, 2024

PEDIATRIC UROLOGY

2:05 PM - 2:20 PM - Main Ballroom

Moderator: Heather DiCarlo, MD & LTC Matthew Kasprenski, MC, USA

- 33 2:05PM CPT Victoria A. Maxon, MC, USA**
Prenatal Diagnosis In The Exstrophy-epispadias Complex: Spectrum Of Success.
- 34 2:10PM CPT Victoria A. Maxon, MC, USA**
A Rocky Road: Bladder Stones In The Exstrophy-Epispadias Complex.
- 2:15PM Discussion (5 minutes)**
- 2:20PM End of Session**

**CLAIM YOUR CME - DAILY EVALUATIONS
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**govurology.org -> 2024 Meeting
click on "Daily Evaluations"**

FRIDAY, JANUARY 19, 2024

MILITARY APPLICATIONS

2:20 PM - 2:35 PM - Main Ballroom

Moderators:

Col Timothy Baumgartner, MC, USAF & Col Necia Pope, MC, USAF

- 35 2:20PM 2LT Madeline Chaput, USAF; CAPT (ret.)**
Additive Manufacturing in Austere Environments: Urological Applications.
- 36 2:25PM 2LT Madeline Chaput, USAF; CAPT (ret.)**
The Final Frontier: The United States Air Force and Urological Contributions to the Space Race.
- 2:30PM Discussion (5 minutes)**
- 2:35PM End of Session**

FRIDAY, JANUARY 19, 2024

PROSTATE

2:35 PM - 2:55 PM - Main Ballroom

Moderators:

CDR Gregory Chesnut, MC, USN & LCDR Chad Pusateri, MC, USN

- 37 2:35PM David C. Dalton, MD**
Impact Of Anticoagulation On Operative Efficiency In HOLEP Patients.
- 38 2:40PM T. Max Shelton, MD**
Patient Awareness Of Holmium Laser Enucleation Of The Prostate And Alternative Treatments Of Benign Prostatic Hyperplasia.
- 39. 2:45PM COL (Ret) Judd W. Moul, MC, USA**
Real-world Analyses Of Mortality Risk After Androgen Deprivation Therapy Initiation In Black Vs. White Prostate Cancer Patients.
- 2:50PM Discussion (5 minutes) / 2:55PM End of Session**

ENJOY THE AFTERNOON BREAK UNTIL 5:00 PM

FRIDAY, JANUARY 19, 2024

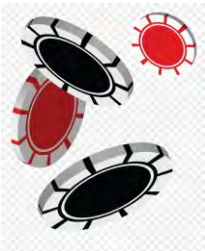


**Cheer
on your
team!**



5:00 PM: Official Tailgate Party - Ballroom Foyer

5:30 PM: GU Bowl - Main Ballroom



Followed by

An Evening at Casino Royale
*Casino games, prizes, dinner,
hosted drinks, magician, and fun!!*



SATURDAY, JANUARY 20

Outline of Scientific Program

70th Kimbrough

Annual Seminar * Hilton Norfolk The Main * Norfolk, VA

TIME	EVENT	ROOM
7:00 AM - 5:00 PM	Registration	Main Ballroom Foyer
7:00 AM - 5:00 PM	Slide Preview	Main Ballroom Foyer
7:15 AM - 2:00 PM	Exhibits Open	Main Ballroom
7:15 AM - 8:30 AM	Networking Breakfast	Exhibits/Expo Lab Area
8:30 AM - 9:00 AM	Consultant Updates	Main Ballroom
9:05 AM - 9:40 AM	Stones	Main Ballroom
9:40 AM - 10:15 AM	Educational Symposium	Main Ballroom
10:15 AM - 11:15 AM	Refreshment Break	Exhibits/Expo Lab Area
11:15 AM - 12:00 PM	Reconstruction	Main Ballroom
12:00 PM - 1:15 PM	CME Lunch Program	Main Ballroom
1:20 PM - 2:25 PM	SGSU Business Meeting	Main Ballroom
2:25 PM - 2:45 PM	Testicular Cancer	Main Ballroom
2:45 PM - 4:00 PM	GU Cancer/Gen.Urology	Main Ballroom
4:00 PM - 5:30 PM	Poster Session/Happy Hour	Main Ballroom

7:15 AM

**Get Energized in the Expo LAB
this Morning!**



SATURDAY, JANUARY 20, 2024

CONSULTANT UPDATES

8:30 AM - 9:00 AM - Main Ballroom

- 40 8:30AM COL Joseph Sterbis, MC, USA**
State of the Army.
- 41 8:37AM Col Christopher Allam, MC, USAF**
State of the Air Force.
- 42 8:44AM CDR Erik Grossgold, MC, USN**
State of the Navy.
- 43 8:51AM Robert L. Grubb, III, MD**
State of the USAV.
- 9:00 AM End of Session**

SATURDAY, JANUARY 20, 2024

STONES

9:05 AM - 9:40 AM - Main Ballroom

Moderator:

Col Christopher Allam, MC, USAF

- 44 9:05AM Maj Amy M. Reed, MC, USAF**
Cystinuria and Pregnancy: Clinical Course and Outcomes in Patients From 2000-2020.
- 45 9:15AM David C. Dalton, MD**
Analysis Of Seasonal Variations In 24-hour Urine Studies.
- 46 9:25AM Shaw P. Wan, MD, COL (Ret.), USA**
What is ClearPetra® and Why I invented it.
- 9:35AM Discussion (5 minutes)**
- 9:40AM End of Session**

SATURDAY, JANUARY 20, 2024

EDUCATIONAL SYMPOSIUM

9:40 AM - 10:15 AM, Main Ballroom

Illuccix® for 68Ga-PSMA-11 PET Imaging of Prostate Cancer.

Clint D. Bahler, MD

Associate Professor of Urology, Adjunct Associate Professor of Radiology & Imaging Sciences, Indiana University

Non CME Program - Supported by Telix Pharmaceuticals

**Expo LAB Networking
Refreshment Break
10:15 AM**

Coffee - Sodas - Beverages

Enjoy the Exhibits & win great prizes



Complete your Prize Card

Engage with exhibitors to get a Scratcher Card

(Physicians & APP/NPs only)

SATURDAY, JANUARY 20, 2024

RECONSTRUCTION

11:15 AM - 12:00 PM - Main Ballroom

Moderators:

CAPT Erik T. Grossgold, MC, USN, CPT Danielle Stackhouse, MC, USA

47 11:15AM

STATE OF THE ART LECTURE SUPPORTED

GENITOURINARY RECONSTRUCTIVE SURGEONS (GURS)

**Treatment of Post-Prostatectomy Incontinence: Current
Challenges and Future Directions.**

Keith F. Rourke, MD, FRCSC

President of GURS, University of Alberta, Canada

11:50AM Discussion / 12:00PM End of Session

CME LUNCH SYMPOSIUM

48

12:00 PM - 1:15 PM - Main Ballroom

**New Immunotherapy Approaches for Veterans and Service
Members with Bladder Cancer.**

Robert Dreicer, MD, MS, MACP, FASCO

Section Head Medical Oncology, Deputy Director, University of Virginia

Comprehensive Cancer Center, Associate Director for Clinical Research

Co-Director Paul Mellon Urologic Cancer Institute, Professor of Medicine/Urology,
University of Virginia School of Medicine

This activity is supported by an education grant from AstraZeneca and SeaGen.

SGSU MEMBERS



BUSINESS MEETING



1:20pm - 2:25pm - Main Ballroom

SATURDAY, JANUARY 20, 2024

TESTICULAR CANCER

2:25 PM - 2:45 PM - Main Ballroom

**Moderators: LTC Sean Q. Kern, MC, USA &
CDR Gregory Chesnut, MC, USN**

49 2:25PM

STATE OF THE ART LECTURE

Testicular Cancer: Military Threats and Opportunities.

LTC Sean Kern, MC, USA

Uniformed Services University of the Health Sciences / Walter Reed National
Military Medical Center

2:40PM Discussion (5 minutes) / 2:45PM End of Session

SATURDAY, JANUARY 20, 2024

GU CANCER & GENERAL UROLOGY

2:45 PM - 3:50 PM - Main Ballroom

Moderators:

LTC Ryan Speir, MC, USA & CPT Timothy Wright, MC, USA

GU CANCER

- 50 2:45PM Robert M. Smith, MD**
Exploring Racial Differences In Administration Of Neoadjuvant
Chemotherapy Prior To Radical Cystectomy.
- 51 2:50PM Capt Tarah Woodle, MC, USA**
Intravesical Therapy in Bladder Cancer During Pregnancy: A Case
Report and Review of the Literature.
- 52 2:55PM SO1 (vet.) Shane Kronstedt, MC, USN**
Comparison Of Peritoneal Interposition Flaps And Sealants For
Prevention Of Lymphocele After Radical Prostatectomy And Pelvic
Lymph Node Dissection: A Bayesian Network Meta-analysis And
Meta-regression.

- 53 3:00PM CPT Jeremy Kurnot, MC, USA**
Physician Perspectives On The Non-clinical Factors That Contribute To Decision-making For Advanced Prostate Cancer Care: A Qualitative Study.

3:05PM Discussion (5 minutes)

GENERAL UROLOGY

- 54 3:10PM CPT Zachary R. Seymour, MC, USA**
Routine Neonatal Circumcision: A Quality Improvement Project.
- 55 3:15PM LT Hannah Johnson, MC, USN**
Early Testicular Torsion on CT: The Swirl Sign.
- 56 3:20PM CPT Kayla Turner, MC, USA**
Cremasteric Muscle Thickening: The Anatomic Difference In Men With Testicular Retraction Due To Hyperactive Cremaster Muscle Reflex.
- 3:25PM Discussion (5 minutes)**
- 57 3:30PM David C. Dalton, MD**
Comparison Of Fluoroscopic Radiation Exposure Between Standard, Mini, And Ultramini Percutaneous Nephrolithotomy.
- 58 3:35PM Capt Daniel P. Pierce, MC, USAF**
Evolution And Effects Of Caffeine Utilization Throughout Medical And Surgical Training.
- 59 3:40PM Katherina Y. Chen, MD**
The Burden Of Superfluous Information In Outside Medical Records.

3:45PM Discussion (5 minutes)

3:50PM End of Session

**CLAIM YOUR CME - DAILY EVALUATIONS
USE LINK
govurology.org -> "2024 Meeting"
click on "Daily Evaluations"**

4:00 PM
HAPPY & POSTER
HOUR SESSION

Followed by Littrell Awards Ceremony

SATURDAY, JANUARY 20, 2024

4:00 PM - 5:30 PM - Main Ballroom

(5 minutes poster viewing, followed by 2 minute podium presentations)

Moderators/Judges:

**Col Christopher Allam, MC, USAF / Col Necia Pope, MC, USAF /
LTC Ryan Speir, MC, USA**

- 60 2LT Ananya Tripathi, Ms3**
MyUroFlow Home Uroflowmetry Cost Savings and Improved Access to Care.
- 61 2LT Sung Alexander, BS**
Impact of Seasonality and Geography on Testicular Torsion, Testicular Pain, and Groin Pain Using Search Interest.
- 62 Maj Cassandra C. Lyons MC, USAF**
Traumatic Dislocation Of An Inflatable Penile Prosthesis: A Case Report.
- 63 LT Colin Lucas Smith, DO, MC, USN**
Obstructive Uropathy Secondary To Childhood Schistosomiasis Infection, A Case Report.
- 64 CPT Victoria A. Maxon, MC, USA**
Novel Use Of Intravesical N-Acetylcysteine In Recurrent Bladder Stone Formers Of The Exstrophy-Epispadias Complex.
- 65 Muqsit Buchh**
Rates of Retained Ureteral Fragments Following Mini and Ultra Mini Percutaneous Nephrolithotomy.

- 66 T. Max Shelton, MD**
Increased Oscillation Rate Improves Morcellation Efficiency In Holmium Laser Enucleation Of The Prostate.
- 67 CPT Lucien R. McBeth, MC, USA**
Sarcomatoid Urothelial Carcinoma found during an Anterior Urethroplasty.
- 68 Capt Marilyn E. Jones, MC, USAF**
Case report of Vesical Fungal Bezoar: Do's and Don't of Endoscopic Management.
- 69 LT Josiah K. Low, MC, USN**
Robot-Assisted Resection of a Retroperitoneal Schwannoma.
- 70 MAJ Vladimir Mezhiritsky, MC, USA**
Adrenal Cyst Presenting With Clinical Features Of A Pheochromocytoma.
- 71 CPT Rahul Jayakrishnan, MC, USA**
Cannulation of the Renal Vein: An Uncommon Urologic Complication of Thoracostomy Tube Placement.
- 72 LCDR Ben Baker, MC, USN**
Non-Traumatic Testicular Rupture as a Sequelae of Epididymorchitis.
- 73 CPT Leah Williams, MC, USA**
International Mission Trip for Residents Promotes Military Readiness: Resident Experience in Tegucigalpa, Honduras.

In Dedication to Kathy & Preston Littrell



**Littrell Awards
Ceremony**



FREE EVENING - ENJOY

SUNDAY, JANUARY 21

Outline of Scientific Program

70th Kimbrough

Annual Seminar * Hilton Norfolk The Main * Norfolk, VA

PLEASE NOTE: WE ARE MOVING TO THE 3RD FLOOR TODAY.

TIME	EVENT	ROOM
7:00 AM - 11:00 AM	Registration	Granby Ballroom Foyer
7:00 AM - 9:30 AM	Slide Preview	Momentum Room
7:00 AM - 8:00 AM	Hasta La Vista Breakfast	Granby Ballroom
7:15 AM - 7:35 AM	DEI	Granby Ballroom
7:35 AM - 9:00 AM	Military Preparedness	Granby Ballroom
8:00 AM - 11:00 AM	Mock Oral Boards	Granby Ballroom E



FOR CME CREDIT CERTIFICATE

**Go to the SJSU Website at
govurology.org -> 2024 Meeting Tab**

**Click on “Print CME Certificate”
&
Click on “Daily Evaluations”**

SUNDAY, JANUARY 21, 2024

7:00 AM



Hasta La Vista
Full Breakfast in
Granby Ballroom,
3rd Floor

SUNDAY, JANUARY 21, 2024

DIVERSITY, EQUITY & INCLUSION

7:15 AM - 7:35 AM - Granby Ballroom, 3rd Fl.

Moderator:

CPT Timothy Wright, MC, USA

- 74 7:15AM Maj Amy M. Reed, MC, USAF**
Diversity, Equity, and Inclusion in Urolithiasis Clinical Trials:
Representative Enrollment by Race, Ethnicity and Sex.
- 75 7:22AM David C. Dalton, MD**
Analysis Of 24-Hour Urine Studies In Hispanic Stone Formers.
- 7:29AM Discussion**
- 7:35AM End of Session**



SUNDAY, JANUARY 21, 2024

**MILITARY READINESS &
PREPAREDNESS COURSE**

7:35 AM - 9:00 AM - Granby Ballroom, 3rd Fl.

**Moderators: Col Christopher Allam, MC, USAF,
Col Necia Pope, MC, USAF**

SUNDAY, JANUARY 21, 2024

MOCK ORAL BOARDS

8:00 AM - 11:00 AM - Granby Ballroom E, 3rd Fl.

Director: LTC Sean Q. Kern, MC, USA

GET PREPPED FOR THE BOARDS!

Be sure to sign up for this session at the Registration Desk.

Attendees will circulate through examiner stations and be asked board questions.

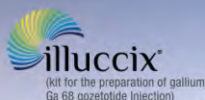


for attending the meeting!

Go to the SCSU Website at

govurology.org -> 2024 Meeting Tab

to print your CME certificate and complete evaluations.



Iluccix® for Ga68-PSMA-11 PET Imaging of Prostate Cancer

Presented by Dr. Clint Bahler

Society of Government Service Urologists
Kimbrough Annual Seminar



January 20th
9:40 - 10:15 AM



Main Ballroom



Clint Bahler, MD
Associate Professor, Urology - IU Health

INDICATIONS AND USAGE

ILLUCIX, after radiolabeling with Ga 68, is indicated for positron emission tomography (PET) of prostate-specific membrane antigen (PSMA) positive lesions in men with prostate cancer:

- With suspected metastasis who are candidates for initial definitive therapy
- With suspected recurrence based on elevated serum prostate-specific antigen (PSA) level
- For selection of patients with metastatic prostate cancer, for whom lutetium Lu 177 vipivotide tetraxetan PSMA-directed therapy is indicated

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Risk for Misinterpretation

Image interpretation errors can occur with ILLUCIX PET. A negative image does not rule out the presence of prostate cancer, and a positive image does not confirm the presence of prostate cancer. Gallium Ga 68 gozetotide uptake is not specific for prostate cancer and may occur with other types of cancer as well as non-malignant processes such as Paget's disease, fibrous dysplasia, and osteophytosis. Clinical correlation, which may include histopathological evaluation of the suspected prostate cancer site, is recommended.

Important safety information continued on next page.



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ABSTRACTS

PAPER #2

PEDIATRIC GENITOURINARY TRAUMA IN AFGHANISTAN AND IRAQ

Shane Kronstedt, MD; David Barham, MD; David E. Hinojosa-Gonzalez*, MD; Gal Saffati*, MD; Andrew D. Fisher*, MD, MPAS; Michael D. April*, MD, DPhil, MSc; Zachary Mucher*, MD, Andrew C. Peterson, MD, MPH, FACS; Paul F. Austin*, MD, FAAP; Steven G Schauer*, DO, MS.

Houston, TX

(Presentation to be made by Dr. Shane Kronstedt)

Objectives: Deploying surgeons frequently train, prepare, and bring equipment to manage adult trauma patients without sufficient planning and consideration for pediatric populations. Urological trauma in adult combat casualties occurs at an incidence of 5-7%. Pediatric urotrauma in this setting remains undefined yet may require immediate, lifelong, and transitional care.

Materials and Methods: We retrospectively analyzed the prospectively maintained Department of Defense Trauma Registry between 2007 and 2016. We used predefined search criteria to identify pediatric casualties that arrived at a military treatment facility with urological-based injuries.

Results: The registry contained 42,790 casualties, of which 3,439 (8.0%) were pediatric by documented or estimated age. Within that, 430 (13%) had at least one urological diagnostic or procedural code (Table 1). Ages and the proportion of males were similar across the two groups. More urological injuries were seen in Afghanistan (79%). Explosive (48%) and firearm (24%) injuries predominated. The median injury severity score was 16 (IQR 9-22). The urological injury group was more likely to have severe injuries to the abdomen and extremities (27%). Pelvic fractures were seen in 11% of patients with urotrauma. Most patients survived to hospital discharge (92%). Massive transfusion protocols were activated in 31% of patients with urologic wounds compared to 14% in the group without urologic injury. The most common procedures were surgical interventions to the bladder (70%). Renal injuries comprised 20%; 41% required operative intervention, with 60% of them being nephrectomies (Figure 1).

Conclusions: Pediatric patients experience and compensate for trauma differently. Pediatric urotrauma occurs in a higher proportion, with more severe wounds than adults in combat; one in eight pediatric casualties during the recent wars sustained an injury to the GU system, with most undergoing at least one surgical procedure. Pediatric patients sustained higher rates of kidney injuries with high operative intervention rates.

Source of Funding: None.

PAPER #3

CLINICAL EVALUATION OF A SUSPICIOUS BLADDER MASS IN A 5-YEAR-OLD BOY – A CASE REPORT

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(Presentation to be made by Dr. Trevor Maloney)

Background: Bladder masses are rare amongst the pediatric urologic population. Although rare, appropriate evaluation and management is still warranted. We aim to present a unique case of a 5-year-old male with a suspicious bladder mass.

Case: A 5-year-old male with autism and prior urologic history of bilateral ureteral reimplantation for vesicoureteral reflux presented with ultrasound findings of a small bladder mass with internal doppler flow. He was nonverbal, therefore unable to provide any subjective history. He was not potty trained, but mom denied any history of gross hematuria, and his urinalysis in clinic did not demonstrate any hematuria. He underwent cystoscopic evaluation, which revealed a ~1.5cm fingerlike-papillary mass along the anterior bladder wall. A complete transurethral resection and fulguration of the mass was performed, and expert pathologic analysis was consistent with a nephrogenic adenoma.

Discussion/Conclusions: There is a wide differential for bladder masses in the pediatric population to include benign and malignant neoplastic processes, with one of the most worrisome being rhabdomyosarcoma. Nephrogenic adenoma is a benign proliferation of glands that can occur at several sites within the urogenital tract, including calyx, pelvis, ureter, bladder and urethra. Nephrogenic adenoma of the bladder is rare with less than 35 cases reported in the literature. Risk factors such as chronic inflammation, trauma, or similar urothelial mucosal injuries such as prior urologic surgery, have been described. Typical presentation includes gross hematuria, urgency, and stranguria. On imaging and grossly, it is hard to distinguish from malignant pathology. Treatment involves transurethral resection and fulguration. Fortunately, these masses are benign, and when treated with local resection, requires only periodic cystoscopy.

Source of Funding: None

PAPER #4

EARLY ADJUVANT CHEMOTHERAPY IMPROVES SURVIVAL IN MUSCLE INVASIVE BLADDER CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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(Presentation to be made by Dr. Shane Kronstedt)

Objectives: Muscle-invasive bladder cancer (MIBC) necessitates a comprehensive treatment approach, typically commencing with neoadjuvant cisplatin-based chemotherapy followed by radical cystectomy and pelvic lymph node dissection. However, there are scenarios where upfront cystectomy and adjuvant chemotherapy (AC) may be considered. We sought to evaluate whether earlier administration of adjuvant chemotherapy can significantly augment survival rates in this specific patient population.

Methods: A PRISMA-compliant systematic review was for full-text articles that addressed whether the timing of AC affected survival in patients with MIBC after a radical cystectomy and pelvic lymph node dissection. The inclusion criteria encompassed studies that examined the relationship between the timing of adjuvant therapy and oncologic outcomes, including overall survival (OS) and progression-free survival (PFS). Data was extracted independently by two authors and analyzed using Review Manager 5.41. The results are presented as Hazard Ratios (HR) with 95% confidence intervals. Statistical significance was set at $P < 0.05$. Subgroup analyses were performed to control for confounders. The first subgroup analysis involved stratifying studies based on a 90-day cutoff for initiating AC, while the second subgroup analysis utilized a 45-day cutoff.

Results: A total of 4 studies met the inclusion criteria, totaling 3,750 patients, of which 3,466 were in the 90-day cutoff subgroup while 284 were in the 45-day cutoff. Meta-analysis of all included studies revealed increased OS with immediate AC compared to delayed (HR 1.27 [1.13, 1.47]). When analyzing studies stratified by timing of the therapy (90-day cutoff vs. 45-day cutoff), the 90-day cutoff had a pooled HR of 1.27[1.06,1.52], while the 45-day cutoff had a HR of 1.27[1.10, 1.47] for OS. Progression-free survival (PFS) was reported in only 2 of the included trials. Meta-analysis of these two trials revealed increased PFS with immediate AC (HR 1.77 [1.37, 2.28]).

Conclusion: A survival benefit was seen with an earlier administration of AC. A safe and ethical approach at this time would be to administer adjuvant chemotherapy as early in the postoperative period as possible, given the known survival benefit of such therapy. Further investigations into the timing of adjuvant immunotherapy will be needed.

Source of Funding: None

ONCOLOGIC OUTCOMES OF EXTENT OF PELVIC LYMPH NODE DISSECTION DURING RADICAL PROSTATECTOMY: A SYSTEMATIC REVIEW, META-ANALYSIS, AND NETWORK ANALYSIS

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(Presentation to be made by Dr. Shane Kronstedt)

Objectives: Some authors propose extended PLND (ePLND) to enhance diagnostic and therapeutic outcomes in patient with localized prostate cancer. However, recent evidence found no difference in biochemical recurrence (BCR). The purpose of this study is to stratify and analyze available evidence on ePLND and its impact on BCR in patients with localized prostate cancer.

Materials and Methods: We performed a systematic review of the literature according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to identify studies up to December 2022. We identified original articles that presented statistical comparisons through cox regressions reported as Hazard Ratio (HR) or survival curve data reported as Kaplan-Meier curve differences in BCR in patients undergoing radical prostatectomy and stratified by the extent of lymph node dissection for localized prostate cancer.

Results: We identified 11 studies with 2 of them being randomized controlled trials (RCTs). The RCTs showed no benefit of ePLND with a HR of 1.03 [0.92, 1.14], $p=0.61$. A combined analysis of nine retrospective studies revealed a notable reduction in BCR with an HR of 0.67 [0.51, 0.89], $p=0.005$. Subgroup analysis based on the extent of dissection demonstrated that studies focusing on the limited template of dissection did not show significant BCR benefit (HR 0.97 [0.72, 1.32], $p=0.86$), while dissections that expanded the anatomical extent showed decreased BCR (HR 0.56 [0.40, 0.79], $p=0.005$). Bayesian network analysis highlights significant differences in BCR reduction between different dissection approaches, indicating potential benefits of specific dissection templates.

Conclusions: Available literature on the extent of PLND is limited in quality, quality and varying definitions of the template defining ePLND. Dissection of the common iliac nodes may be beneficial.

Source of Funding: None

PAPER #6

CLINICALLY ADEQUATE UROFLOWMETRY DATA: IMPLEMENTATION OF MYUROFLOW HOME TESTING

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(Presentation to be made by Dr. Timothy Brandt)

Objectives: At our institution, we have noted that many of our clinic uroflowmetry tests provide inadequate voided volumes during the evaluation, rendering the test non-diagnostic. Multiple reasons have been attributed to these issues, such as shy voiding, poor single void attempt in the clinical setting, and limitation on number of attempts due to clinic resources. In our search for a solution to this issue, novel technologies have been explored. Among these technologies, MyUroflow, an FDA-approved (510k) app for at-home uroflowmetry for adult males was evaluated and implemented. This analysis focuses on the use of this novel technology at Madigan Army Medical Center, and its diagnostic prowess compared to the conventional standard clinic uroflowmetry.

Materials and Methods: Retrospective data was collected in men 18 years or older who required uroflowmetry testing at our institution. In office uroflowmetry data was collected from 1JUN2022-1DEC2022 while data from the MyUroflow app was collected from 1DEC2022-1JUN2023. We selected different date ranges to reduce selection bias, since once the app was implemented, mostly elderly men continued to prefer in-office testing. The main outcome measured was adequacy of the test, as defined by a voided volume of ≥ 200 mL. A chi-square test of independence was performed to compare the techniques.

Results: 232 men underwent uroflowmetry testing: 178 in-person and 54 MyUroflow patients. 49.4% of clinic patients compared to 81.5% of MyUroflow patients had sufficient voided volume to render diagnostic results ($p < 0.001$).

Conclusions: MyUroflow is able to capture more useable data compared to in-office testing, with significantly more men having diagnostic volumes. This approach effectively overcomes several of these challenges inherent to in-office uroflowmetry, especially the limitation of a single low-volume void that is insufficient for an accurate flow rate.

Source of Funding: None

ASSESSMENT OF BLADDER BOTULINUM TOXIN INJECTION RISK FACTORS FOLLOWING HOLMIUM LASER ENUCLEATION OF THE PROSTATE

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(Presenting author is Dr. Shelton)

Introduction/Objective:

Holmium laser enucleation of the prostate (HoLEP) is a size independent surgical option for patients with symptomatic prostatic enlargement. A significant proportion of patients experience lower urinary tract symptoms (LUTS) following outlet procedures. This study analyzed a retrospective cohort of HoLEP patients to determine risk factors for bladder botulinum toxin therapy (BTT) following HoLEP.

Methods:

2482 patients underwent HoLEP at a single institution between 7/1/2019 and 10/1/2022. 13 patients underwent BTT following HoLEP. We randomly assigned 13 age-matched non-catheter-dependent post-HoLEP patients and compared outcomes.

Results:

Average prostate volume of the non-BTT group was 114.3 vs. 58.8 g in the BTT group ($p=0.02$). Average enucleation times were 49.2 vs. 37.2 minutes for non-BTT and BTT patients ($p=0.15$). Energy per gram enucleated was 2.2 kJ/gram vs. 4.1 kJ/gram in non-BTT and BTT patients ($p=0.04$). Significance was reached for higher preoperative tamsulosin ($p=0.03$) and lower anticholinergic usage ($p=0.03$) in non-BT patients. Mean time to BTT was 13.6 months following HoLEP. No differences were found in pre-operative PSA, presence of median lobe, diabetes mellitus, or neurological disorders. The average number of BTT treatments was 1.1 with mean time to treatment of 13.6 months. All BTT patients failed at least 1 non-invasive medical treatment prior to BTT.

Conclusion:

Prostate size, enucleated volumes, and energy used per gram of tissue resected were notably different in BTT and non-BTT patients. Preoperative tamsulosin usage was significantly lower and anticholinergic usage was higher in BTT patients. Future studies are warranted to analyze risk factors for post-HoLEP LUTS.

PAPER #8

EVALUATING DECISION REGRET IN SACRAL NEUROMODULATION PATIENTS

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(Presentation to be made by Dr. Hannah Johnson)

Objectives: This study aimed to evaluate whether patients regret their decision to undergo sacral neuromodulation. Secondary objectives were to identify if patient's symptom relief from the device correlated to their decision regret, if a patient's complication rate correlated with their decision regret, or if their need to have the device removed correlated with their decision regret.

Methods: A telephone survey was administered to all patients who underwent sacral neuromodulation at Naval Medical Readiness Training and Command (NMRTC) San Diego between the years 2012 and 2022. Patient's decision regret was assessed using a validated decision regret scale and regret scores were calculated. Additional questions about device functionality, complications, and active-duty status were also asked.

Results: One hundred and nineteen patients who answered the full telephone survey were enrolled in our study. The average age of our study participants was 49.8 years and 59.7% of the participants were female. The study participants had their sacral neuromodulation devices in place for an average of 57.5 months. The average regret score for patients who felt that they had greater than 50% symptom improvement with the device was 5.49.2 versus 44.127.6 for those who did not have greater than 50% symptom improvement ($p < 0.001$). Regret scores for patients who had device complications were significantly higher than those who did not (29.432.4 versus 17.323.3, $p = 0.04$). Lastly, those patients who underwent device explant had significantly higher regret scores than those who did not (48.231.4 versus 14.521.1, $p < 0.001$). Of the patients who underwent a military deployment with the device in place, there was no significant difference in their decision regret scores (12.519.2 versus 21.6 27.2, $p = 0.34$).

Conclusion: Our study shows that patients who have significant symptom improvement, no complications, and have not had the device removed, have significantly lower decision regret scores. Whether or not patients underwent a military deployment with the device had no bearing on their decision regret.

Source of Funding: None

PAPER #9

LOW COST, LOW FIDELITY URETHROPLASTY MODEL

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(Presentation to be made by Dr. Walter)

Objectives: Reconstructive urologic surgery is complex and can have lower case volume in MTFs than at civilian training centers. Simulation has been shown in multiple disciplines to decrease learning curve and enhance learner comfort during procedures. Our goal was to develop a model for dorsal onlay graft urethroplasty.

Materials and Methods: Using a 9x12" sheet of felt this was clipped to a clipboard and alligator clamps used to secure the edges. A strip of felt 9" in length at 2" in width was then tubularized and secured with glue to make a simulated urethra. The urethra was then secured on top of the other piece of felt using binder clips.

Learners then simulated rotating the urethra to visualize the dorsal surface of the urethra. A 15-blade was used to incise the simulated urethra. The length of simulated stricture was then measured. The learner then cut a "graft" from additional felt to this measurement.

The "graft" was then spread-fixed to the back-piece on the clipboard using 4-0 vicryl. The anastomosis was then performed between the simulated graft and urethra using 4-0 or 5-0 PDS. A Foley catheter could be placed midway through the repair.

De-identified surveys were taken from learners at the end of the exercise.

Results: This model in total cost approximately \$10 for all these easily accessible, commercially available supplies. For this amount you could simulate approximately 10 urethroplasties. 100% of learners (3/3) felt that the simulation was valuable. 100% (3/3) said they would repeat the exercise and recommend it to another learner. Some comments from the surveys were: "Very realistic. Great exercise for conceptualization," and "Love felt urethras".

Conclusions: We present a low-cost, low fidelity model for urethroplasties. Given that it requires minimal supplies, it offers a portable, accessible option for resident learning.

Source of Funding: None

PAPER #10

MICROSURGICAL TRAINING IN A HIGH-VOLUME ACADEMIC INFERTILITY PRACTICE; ASSESSMENT OF TRAINEE IMPROVEMENT

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(Presentation to be made by Trevor J. Maloney)

Introduction and Objective(s):

Surgical education has been traditionally rooted in the apprenticeship model, where the experts teach the surgeons-in-training during real-time surgeries. Current administrative demands focused on operating room time efficiency and patient safety outcomes often conflict with needs of the surgical training program. With increased application of microsurgical skills in many surgical subspecialties, there is a significant need to investigate and objectively evaluate surgical trainees via a standardized system. The goal of this study is to present the applicability of a scoring rubric in urologic microsurgical training which can be used to evaluate trainee performance.

Method(s):

A structured resident male infertility microsurgical training program was devised and implemented under the direction of a fellowship trained microsurgeon. The devised rubric was applied to real-time surgeries at the beginning and end of the training period. All aspects of the assessment were evaluated on the scale of 1-5, with 1 being the lowest and 5 the highest. According to the individual improvement, the difficulty of the skills and steps of the procedure were advanced accordingly. The scores of the trainees at the initiation and conclusion of the training were then compared and assessed for improvement.

Result(s):

A total of 108 microscopic vasectomy reversal surgeries were performed by one staff surgeon and six consecutive resident surgeons between January 2020 and May 2023. All residents were in their 2nd year of Urology training (PGY-2). On average, each of the trainees participated in 18 vasectomy reversals (14-22), with similar elapsed surgical time (about 3-4 hrs/ case). At initiation of their training, each individual had similar basic and microscopic surgical skills, procedure knowledge, economy of motion and tissue/ instrument/ needle handling ability (scores of 2-3 out of 5). All residents improved in their overall microsurgery skills by the end of their time in the training program. Notably, trainees with subjectively higher interest and willingness to correct their actions based on real-time feedback had greater overall improvement at the end of the training.

Conclusion(s):

While a structured microsurgical training program is of utmost importance, competing professional and personal interests of the resident-surgeons may affect its full execution. With the advent of simulation and virtual reality training programs, this study aims to demonstrate the feasibility and success of a structured, hands-on, microsurgery training program by use of careful observation and an objective scoring assessment.

Source of Funding: none

PAPER #12

MAIL-IN SEMEN ANALYSIS IMPROVES PROCESSES, COMPLIANCE, AND COST

Tamarie Wheat, ARNP* and Lori B. Lerner, MD: Boston, MA

Presentation to be made by Ms. Wheat*

Objectives: As our Veterans Affairs (VA) hospital has no semen analysis (SA) capabilities, contracts with outside laboratories are necessary. Patients throughout New England travel to Boston labs willing to contract with VA. SA testing is costly and inconvenient, and attaining outside results is difficult. To improve patient experience, compliance, and fiscal responsibility, a pilot program with mail-in SA was explored. We hoped to improve our post-vasectomy SA (PVSA) compliance, cost of infertility evaluations, and patient convenience and satisfaction.

Methods: In October 2022, an interdisciplinary team was created to find a solution. Given VA regulations, a Clinical Laboratory Improvement Amendments (CLIA) accredited lab vendor was mandatory. Only one company met VA standards, Fellow, who created mail-in PVSA test kits. Ten kits were ordered as a pilot process. First, kits were sent directly to the Urology clinic instead of the lab. Logs were created to track the reference numbers associated with each kit. At the time of visit, a corresponding lab order was placed in the electronic medical record and the appropriate kit (infertility vs post-vasectomy) was given to the patient. Nurses guided patients in “activating” their Fellow kit electronically prior to leaving the office, which logs the patient into the Fellow system for tracking and testing reminders. For PVSA patients, Fellow reminded patients to test starting 11 weeks post-vasectomy, with interval reminders out to 16 weeks. For fertility semen analysis (FSA), patients received several reminders over 2-weeks. Patients mailed their semen to Fellow in prepaid boxes. Emails indicating resulted studies were sent to the patient and provider. If sperm was still present in the PVSA, up to two additional tests were sent to the patient at no cost. For internal tracking and documentation, VA staff signed into the Fellow portal at regular intervals to upload results into the medical record and notify patients via phone or letter.

Results: For PVSA kits activated from Dec 2022 - Mar 2023 (those meeting the window for post procedure testing), 70% have been completed, with 12% requiring a PVSA re-test secondary to persistent sperm. Prior to mail-in, only 32% of patients completed a PVSA. For FSA kits activated from Nov 2022 - Aug 2023, 80% have been returned. There was a 39-54% cost reduction for FSA with mail in as compared to VA contracted labs. PVSA was up to 56% less expensive than 3 contracted hospitals, but significantly more expensive than a 4th (\$64 difference per test). The biggest mail in drawback is kits are given to patients that are never returned and money is lost. However, this is offset by overall lower costs with nearly all labs and tests, and 2 free retests per PVSA. Patient ease of semen submission, not needing a full infertility consult at the contracted hospitals (an additional cost), accessible results to patients and clinical team, decreased dollar cost of most tests, and improved tracking has increased overall satisfaction.

Conclusions: Utilizing Fellow mail-in SA has improved patient tracking, access to results, patient satisfaction, and reduced cost to both the VA system and the patient. While Fellow mail-in SA will not completely negate the need for referral and testing in specialized fertility centers with some patients, it addresses the majority of patients seen in the VA system.

Source of Funding: None

PAPER #13

A PILOT STUDY TO EVALUATE THE EFFICACY OF VASOVASOSTOMY ANASTOMOSIS TECHNIQUES

Paolo Rigo, MD; Daniel Armstrong, BS; Kathryn Lipscomb, MD;
Chad Pusateri, DO: Portsmouth, VA
(Presentation to be made by Dr. Paolo Rigo)

Background: Microsurgical vasovasostomy stands as the established method for vasectomy reversal. Various microsurgical techniques have been documented, yet none has achieved consensus as the superior approach. Most commonly, single-layer and two-layer anastomosis techniques are practiced, with recent investigations exploring the application of fibrin glue. The prevalent hypothesis posits that both vas deferens patency and the creation of a watertight anastomosis are pivotal to achieving success. Nevertheless, no studies to date have directly scrutinized the rates of patency and anastomotic leakage between different techniques.

Objectives: To systematically assess and compare the effectiveness of four unique vasovasostomy techniques, with a specific focus on evaluating both patency and anastomotic leakage rates.

Methods: Patients from our Urology clinic who have undergone vasectomy to be recruited for this study. A total of 20 pairs of vas deferens segments are aseptically excised and preserved in saline solution. Subsequently, these segments underwent anastomosis using one of four surgical techniques: single-layer anastomosis, two-layer anastomosis, exclusive use of fibrin glue, and fibrin glue combined with three full-thickness sutures. Each surgical technique was applied to 5 segment pairs. The duration required for vasovasostomy was meticulously recorded. After completing the vasovasostomy, the integrity of the anastomosis was assessed for both patency and leakage. This evaluation was conducted by cannulating the anastomosed vas with a 24-gauge angiocatheter connected to a bag of dyed saline positioned 40 cm above the anastomosis site. Saline is collected and measured, and the time is recorded. Flow rates are calculated, and compared between groups using ANOVA.

Results: Data will be analyzed following completion of the study. Participant recruitment currently underway. Upon completion of data collection, a thorough analysis of the gathered data will be conducted.

Conclusions: Our evaluation of microsurgical anastomosis techniques for patency and leakage using a standardized test will serve as a foundation for future studies on vasovasostomy anastomosis techniques.

PAPER #14

SPERM PRESERVATION ENSURED BY REGULATIONS/MANDATES: A QUALITATIVE ANALYSIS (S.P.E.R.M. Q.A.)

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Ricardo E. Flores, MPH*; Sara B. McMenamin, PhD, MPH*; H. Irene Su, MD,
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(Presentation to be made by Dr. Baker)

Objectives: The inherent complexities of the U.S. medical system render it impossible for policymakers to fully understand the impact new healthcare laws/regulations until those new policies are tested in a real-world setting. We sought to investigate the impact of state insurance mandates for fertility preservation for individuals facing iatrogenic infertility due to cancer treatment.

Materials and Methods: From July 2022 to May 2023, representatives from sperm banks across three states (California, Illinois, and New York) were contacted to participate in semi-structured interviews regarding their experiences with patients accessing fertility preservation benefits. An interview guide based on the Exploration Preparation Implementation Sustainment (EPIS) framework was employed to complete videoconference interviews which were recorded and transcribed. Qualitative data was analyzed with MaxQDA (VERBI Software, Berlin, Germany) for thematic analysis. Code summaries were developed by two independent coders (one urologist, one policy analyst). Triangulation with quantitative data was pursued through “secret shopper” contact of sperm banks to inquire regarding billing practices (direct to insurance versus patient). Descriptive data are reported and chi-square testing was completed to compare billing practices between sperm located within a state with mandated fertility coverage and those which were not.

Results: Seven sperm bank interviews were conducted. Thirteen code summaries were generated. Common identified themes included: Those sperm banks who did not participate in direct insurance billing do so for concern of intense time/resource allocation for ultimately low reimbursement. The responsibility of interacting with the insurance company was often shifted to the patient. Sperm banks who did directly bill insurance were part of larger organizations with dedicated collections departments. Templated information sheets for cost expectations insurance company interactions were thought to be a helpful resource. Of the 636 clinics identified in a national review, billing practices were discussed with 155 (41 in “mandate” states, 114 in “non-mandate” states). Sperm banks in mandate states were not significantly more likely to participate in direct insurance billing versus those in non-mandate states—31.7% v 21.9%, respectively ($p=0.3$).

Conclusions: The intended impact of preservation mandates may be limited by compensation levels offered by insurance companies. Time/effort of interacting with insurance companies may be passed along to patients. Standardized information sheets may benefit patient counseling. State mandates regarding fertility preservation coverage may not affect sperm bank billing practices.

PAPER #15

NON-ISCHEMIC PRIAPSIM AS AN INITIAL PRESENTING SYMPTOM OF MULTIPLE SCLEROSIS IN A YOUNG ACTIVE DUTY SOLDIER

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(Presentation to be made by Dr. Sloss)

Objective: This case study aims to report a rare presentation of multiple sclerosis (MS) in a young male with non-ischemic priapism as the initial presenting symptom.

Methods: We present a case of a 28-year-old otherwise healthy male who presented to the emergency department with a persistent, painful erection that lasted for more than four hours. Detailed medical history, physical examination, and laboratory investigations were performed to assess potential causes of priapism.

28 yo AD M presents for evaluation on non-ischemic priapism as presenting symptom for multiple sclerosis. While on leave in Wisconsin in early July 2023, he reported onset of painful persistent erection for which he was evaluated and treated for at a civilian Emergency Department (ED). He was given 250mcg of phenylephrine without resolution. He returned to the same ED the following day with persistent symptoms and was subsequently started on pseudoephedrine which he took 60 mg every 6 hours for weeks without improvement in symptoms. He presented to Tripler Army Medical Center Emergency Department (TAMC ED) 7/18/23 due to worsening pain and persistent erection despite conservative measures to alleviate his pain. He was found to have a partially erect penis without any other findings. No history of genital trauma, genitourinary surgery, erectogenic medications, blood dyscrasia or recreational drug use. Pseudoephedrine was discontinued. On 7/20/23 he presented to an ophthalmologist for vision change and was recommended he proceed to the ED for further evaluation. On 7/22, he re-presented to TAMC ED with double vision. There was concern for ocular nerve palsy from demyelinating process versus a neuromuscular junction disorder. A Magnetic resonance imaging study of the brain and orbits was obtained and showed findings concerning for demyelinating disease with both enhancing and non-enhancing lesions. He was found to have strong family history of MS in multiple family members. Neurology evaluated the patient after his new vision changes. He was given 3 days of 1000 mg IV solumedrol and noted improvement but not resolution of diplopia but did not have resolution of his priapism. He was otherwise neurologically intact except for mild oculomotor findings. He was evaluated in Urology clinic and his exam demonstrated painless penile fullness. A point of care Doppler ultrasound was performed confirming the presence of high arterial flow (PSV of 20cm/s, EDV <5). He noted normal on-demand erections with persistent penile fullness that was slowly resolving. Due to high burden of radiological disease Neurology recommended early aggressive treatment with Ocrelizumab infusions which was started on 8/18/23.

Results: No apparent underlying causes of priapism were identified upon initial evaluation, including drug-related factors and systemic diseases. Later, after presentation with diplopia, magnetic resonance imaging (MRI) of the brain revealed multiple demyelinating lesions consistent with the diagnosis of multiple sclerosis.

Conclusion: Non-ischemic priapism is an unusual and atypical initial presentation of multiple sclerosis, especially in a young, healthy male. This case highlights the importance of considering MS as a potential underlying cause in patients presenting with uncommon manifestations, even in the absence of typical neurological symptoms. Early recognition and diagnosis of MS are crucial for initiating appropriate management and preventing potential neurological complications. Further studies are warranted to explore the mechanisms linking priapism to demyelinating lesions in multiple sclerosis.

PAPER #17

EXTENSIVE BILATERAL RENAL TUMOR BURDEN IN A PATIENT WITH SDH-DEFICIENT RENAL CELL CARCINOMA MANAGED WITH CONCURRENT BILATERAL OPEN PARTIAL NEPHRECTOMIES

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San Diego, CA

Objectives/Introduction: Succinate dehydrogenase (SDH)- deficient renal cell carcinoma (RCC) is a manifestation of a rare neoplastic syndrome linked to a germline mutation involving the Krebs cycle. The syndrome has an autosomal dominant inheritance pattern and is often associated with pheochromocytomas (PCC), paragangliomas (PGL), gastrointestinal stromal tumors (GIST), and pituitary tumors. Fewer than 60 cases of SDH-RCC exist in the literature, only two of which describe bilateral tumor burden. Here we present a case of extensive bilateral renal tumor burden in an adult male that was managed by concurrent bilateral open partial nephrectomies.

Methods/Case Presentation: An otherwise healthy 42-year-old Iraqi male presented to the emergency department with complaints of vague abdominal pain and right abdominal bulging. A CT scan revealed three large renal masses, two of which affected the upper and lower pole of the right kidney, and one in the lower pole of the left kidney. Each of the tumors was noted to be peripherally enhancing and greater than 8cm in size. The patient underwent a percutaneous biopsy of the right lower pole mass that revealed an unclassified oncocytic neoplasm. The remainder of the work-up was negative for metastatic disease. The patient reported a family history of RCC in his father but denied any other relevant cancers or syndromes.

Results: The patient was taken to the operating room where a midline incision was made from the xyphoid to two centimeters above the pubic symphysis. The peritoneum was entered, and the bowel mobilized to gain access to the right kidney where the two large masses were easily identified. The right kidney was noted to have 3 veins and two arteries, which were clamped prior to a 10min ice bath. The upper and lower pole masses were excised and oversewn with 3-0 Vicryl suture, followed by multiple 0-Vicryl renorrhaphy stitches. Cold ischemia time of the right kidney was 89 minutes and approximately 40% of the renal parenchyma remained. Attention was turned to the left kidney which was noted to have two arteries and one vein. The left kidney had one large lower pole tumor which was excised in a similar fashion, with a warm ischemia time of 40 minutes. Hemostasis was excellent at the end of the case and the abdomen was closed in the usual fashion.

On pathology, margins were found to be negative and associated lymph nodes were without evidence of disease. Histologically the tumors were comprised of round monomorphic cells with eosinophilic cytoplasm and abundant vacuoles with pink secretions. The morphology is noted to be highly suspicious for SDH sub-types which was confirmed by absence immunohistochemical staining for SDHB. The patient was referred to a genetic counselor and underwent subsequent germ line testing. A mis-sense mutation was identified in the B sub-unit of the succinate dehydrogenase complex rendering the patient SDH deficient. The patient had an uncomplicated post-operative course and surveillance imaging has been negative for reoccurrence to date.

Conclusions: SDH-deficient RCC is a rare neoplasm that has not been widely studied since its identification in 2004, primarily due to its low incidence. While the SDH gene is well known for its critical role in energy conversion, it also acts as an important tumor suppressor. Mutations in one or more of the four subunits of the succinate dehydrogenase complex lead to decreased enzymatic activity and an increased risk of tumorigenesis. Previous studies estimate a 10-15% lifetime risk of developing RCC in patients with an SDH mutation with an average age of presentation between 37-40 years of age, and male predominance (1.7:1). This case highlights the importance of testing for familial syndromes in patients who present with bilateral RCC at a young age. While surgical excision with wide surgical margins is usually curative, these patients remain at risk for PCCs, PGLs, and GISTs. Annual surveillance imaging for recurrence of RCC or development of an associated neoplasm is recommended. To our knowledge, this is the largest SDH deficient RCC tumor burden to be reported.

URETERECTOMY VS. ENDOSCOPIC RESECTION VS. RADICAL NEPHROURETERECTOMY FOR UPPER TRACT UROTHELIAL CARCINOMA: A SYSTEMATIC REVIEW AND NETWORK META-ANALYSIS

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(Presentation to be made by Dr. Shane Kronstedt)

Objectives: The upper urinary tract is an infrequent location for urothelial carcinoma. Accurate staging has long faced challenges and has led to radical nephroureterectomy (RNU) being considered the standard of care. Kidney-sparing surgery (KSS) such as ureterectomy or endoscopic resection have been proposed as possible adequate therapies for patients with unifocal, low-grade disease with <15mm tumor volume. This study aims to compare the oncologic outcomes of KSS modalities vs RNU using a Bayesian network framework.

Methods: On February 2023 a PRISMA compliant systematic review was performed. Studies providing overall survival, disease specific survival and/or recurrence between ureterectomy, radical nephroureterectomy and endoscopic resection with either ureteroscopy or percutaneous nephroscopy were included. When Hazard Ratios (HR) were not provided, Tierney's method was used to estimate the HR from the survival curve. Data was analyzed in R Studio using the gemtc package where the results from analyzed studies was used to build a 3-arm network, which was used to model 200,000 Markov chains with Montecarlo sampling every 10 iterations. Results are presented in HR and 95% credible interval.

Results: Thirty-three studies provided 19,072 patients, of which 4,336 underwent ureterectomy, and 727 underwent endoscopic resection. Overall survival was similar between ureterectomy and RNU (HR 0.99 [0.91, 1.1]) and endoscopic resection and RNU (HR 1.0 [0.91, 1.1]). Disease-specific survival was not different between ureterectomy and RNU (HR 1.1 [0.83, 1.4]) or endoscopic resection and RNU (HR 1.1 [0.79, 1.6]). Recurrence rates were higher in ureterectomy and endoscopic resection.

Conclusion: Aggregate analysis of available evidence suggests kidney-sparing approaches such as endoscopic resection or ureterectomy may provide similar survival to RNU at the cost of increased recurrence, necessitating surveillance. The available literature is highly heterogeneous, with significant pollution of high-grade or multifocal disease groups.

Source of Funding: None

PAPER #19

COMPARATIVE OUTCOMES IN PATIENTS WITH PRE-EXISTING NEPHROSTOMY TUBE PRIOR TO PERCUTANEOUS NEPHROLITHOTOMY (PCNL): RETROSPECTIVE ANALYSIS OF TRACT REUTILIZATION VS NEW INTRAOPERATIVE ACCESS

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(Presenting Author: Dr. Shelton)

Introduction and Objective:

Percutaneous nephrolithotomy (PCNL) is indicated for the treatment of large renal calculi. At our institution, percutaneous access into the kidney is performed by urologists the majority of the time, however, in some instances, patients already have a percutaneous nephrostomy (PCN) tube placed by interventional radiology (IR) prior to the PCNL surgery. This study aimed to evaluate outcomes of PCNLs in patients with pre-existing nephrostomy tubes and focused on pre-existing PCN tract utilization versus new urology-obtained intraoperative access.

Methods:

A retrospective study was performed to identify patient who underwent unilateral PCNL with preoperative nephrostomy tube placement by interventional radiology at a single institution from 2017 to 2022. Patient demographic data, surgical outcomes and 30-day postoperative data was analyzed.

Results:

A total of 79 patients met inclusion criteria. In 63 patients (79.7%), the existing nephrostomy access was used to perform PCNL, while in 16 (20.3%) patients new intraoperative access was obtained. No differences were noted in postoperative stent or nephrostomy tube placement, residual stone burden, same-day discharge rate, or ipsilateral secondary surgery at 90 days. 30-day complication rates and emergency department visits were higher in the PCN tract set at 29 (46.03%) vs 1 (6.25%).

Conclusions:

Our findings reveal a statistically significant increase in the 30-day complication rate when the PCN tract was reused compared to when new intraoperative access was obtained (46% vs. 6.3%, respectively). This observation suggests a potential advantage in establishing new intraoperative access during PCNL in patients with a pre-existing nephrostomy tubes. Further studies are warranted to substantiate these results and to identify the underlying factors responsible for the increased complication rate.

Source of Funding: None

PAPER #20

IMPACT OF SPY FLUORESCENCE ANGIOGRAPHY ON INCIDENCE OF URETEROENTERIC STRICTURE AFTER URINARY DIVERSION

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(Presentation to be made by Dr. Clinton Yeaman)

Introduction/Objective: Ureteroenteric strictures (UES) are a common and morbid complication of radical cystectomy and urinary diversions. UES occurs in 4-25% of all patients undergoing urinary diversion and anastomotic ischemia is implicated in the formation of stricture. SPY fluorescence angiography is a technology that can be employed during open surgery that allows for evaluation of ureteral perfusion.

Methods: We conducted a prospective single-institution study of intraoperative use of SPY for ureteral perfusion assessment with a primary outcome of ureteroenteric stricture incidence compared with a cohort of historic controls prior to the use of SPY during urinary diversion at our institution. Chart abstraction was conducted to determine the presence of confirmed stricture in these patients, defined as endoscopic diagnosis or definitive imaging findings. Statistical analysis was performed in SAS using chi squared test, t-test, and Wilcoxon Rank-Sum Test.

Results: 332 patients underwent urinary diversion during the study period. UES occurred in 31 of 277 patients (11.1%) in the control group compared with 1 of 55 patients (1.8%) enrolled in the SPY arm to date ($p=0.03$). The per ureter UES rate was 6.7% (33/582) in the control group compared with 0.09% (1/106) in the SPY group. Median follow-up in the SPY group was 17.5 months and 58.6 months in the control group. Median CCI was 5 in the SPY group and 4 in the control group. There were no other significant demographic differences between the study groups. 26/55 (47.2%) had additional ureteral length excised based on SPY perfusion results, indicating that SPY changed management in those cases.

Conclusion: SPY fluorescent angiography can be used during open urinary diversion to ensure perfusion to ureteroenteric anastomosis. Our study suggests that intraoperative ureteral perfusion assessment decreases UES rate.

Source of Funding: N/A

PAPER #27

SHOULD MILITARY VETERANS BE CLASSIFIED AS HIGH RISK FOR PROSTATE CANCER SCREENING: A REVIEW OF CURRENT LITERATURE

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(Presentation to be made by Cedrick B. Chiu)

Objectives: Prostate cancer ranks among the most prevalent malignancies affecting males worldwide and stands as the most commonly diagnosed cancer among U.S. veterans. Furthermore, the incidence of prostate cancer is notably higher among veterans, affecting 1 in 5, as opposed to the general population where it impacts 1 in 8 individuals. The American Urological Association (AUA) established guidelines for risk assessment and screening of prostate cancer, but these lack consideration for active-duty military personnel and veterans, who may have unique risk profiles due to their military experiences.

The purpose of this study is to examine these particular risks, raise awareness, and advocate for change to ensure the best care possible for those who have served their nation. **Materials and Methods:** Google Scholar, PubMed, and Medline using the Ovid interface were searched for studies published between 1990 and 2023 investigating prostate cancer in veterans. Search terms: “veteran”, “military”, “molecular markers”, “prostate cancer”, “prostate cancer risk”, and “military exposure” were used. Additional studies were identified from reference lists of included articles. Two reviewers (CBC, GS) assessed the selected studies for inclusion and exclusion criteria as well as quality. A third reviewer (DOR) resolved any disagreement. Included articles were analyzed and the data was then summarized.

Results: The initial search yielded 381 articles, but after excluding duplicates and following full-text review and examination of article references, 82 articles were used in the final analysis. These papers collectively shed light on exposures that disproportionately affect military personnel and their consequential impact on prostate cancer outcomes. The review finds evidence both in case-control and epidemiological studies of the relationship between Agent Orange exposure and prostate cancer to suggest that veterans who have served in Vietnam have increased risk. The review also suggests that Bisphenol A (BPA), found in military equipment and gear, dental sealants, thermal paper, and canned rations, induces prostate cancer cell migration and elevates carcinogenic risk. Cohort, epidemiological, and case-control studies suggest cadmium exposure increases the risk of prostate cancer. Cadmium is found in aircraft components, munitions, electrical equipment, paints, and welding materials. Likewise, there is some evidence to suggest Per- and polyfluoroalkyl substances (PFAS) exposure, mostly through contamination by aqueous film-forming foams, increases prostate cancer risk through metabolism, endocrine disruption, and epigenetic perturbation. While some evidence suggests an association between Camp Lejeune and prostate cancer risk in retrospective cohort studies, a logistical regression analysis study did not entirely substantiate this relationship. Despite limited studies on burn pits found in forward operating bases, as well as the presence of benzene in fuel and solvents, styrene in fiberglass, paints, and composite material, and xylene in adhesives, degreasers, and laboratories, preliminary findings have associated these exposures with an increased risk of prostate cancer.

Conclusions: This review identified several exposures, including Agent Orange, BPA, cadmium, PFAS that significantly elevate prostate cancer risk. Preliminary findings point to potential association between prostate cancer risk and exposures such as Camp Lejeune, burn pits, benzene, styrene, and xylene. However, further research is warranted to strengthen these associations, as the current evidence remains limited. These findings underscore the unique risks faced by veterans due to their military service, highlighting the importance of considering the reclassification of veterans as a high-risk group for early prostate screening within the AUA guidelines.

Source of Funding: None

PAPER #28

PROSTATE SPECIFIC ANTIGEN SCREENING PATTERNS BY AGE, RACE, AND VETERAN STATUS: A U.S. NATIONAL BEHAVIORAL ANALYSIS

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(Presentation to be made by ENS Nathaniel R. McLauchlan)

Objectives: Prostate cancer (PCa) remains a prevalent and burdensome disease in the United States, with an estimated 288,000 new diagnoses annually. This burden has historically been disproportionately borne by non-Hispanic Black (NHB) men, who are at increased risk of developing PCa. While guidelines for prostate specific antigen (PSA) screening have recognized this increased risk and encouraged early routine screening for NHB men, evidence shows decreased prevalence of PSA screening in the general population for NHB men when compared to non-Hispanic White (NHW) men. However, veteran status has been shown to generally mitigate this racial disparity in PSA screening, suggesting this disparity is likely due to systemic differences in access to care. To further understand the effect of veteran status on PSA screening, we investigated the effect of age and race amongst veterans and non-veterans on PSA screening patterns, hypothesizing that screening uptake differs significantly for each age group in the context of race and veteran status.

Methods: Using the 2018 BRFSS survey cycle, we analyzed NHW and NHB men aged between 55 and 69 who responded to the PSA screening questionnaires with the exclusion of those with a history of PCa. BRFSS provides weight variables to calculate nationally representative estimates. Using those variables, we fitted a multivariable complex-weighted Poisson regression model to calculate the adjusted national predicted PSA screening prevalence by race, veteran status, and age group (55-59, 60-64, and 65-69), the model was adjusted for the following covariates: reported health status, health coverage, income, education attainment, marital status, and personal doctor. We utilized a 3-way interaction to assess the inter-relationship between race, veteran status, and age category. Further, we calculated the adjusted risk difference (ARD) estimate the marginal effects.

Results: A total of 120,377 were included in the study, of those 14,403(12.54%) were veterans, and 105,974(87.46%) were non-veterans. Adjusted mean predicted PSA screening prevalence in the US by veteran status was calculated as follows: veterans 0.428, [95%CI;0.41,0.445], non-veterans 0.407, [95%CI;0.397,0.416], when further stratifying by race: NHW non-veteran 0.403 [95%CI; 0.393,0.413], NHW veteran 0.415 [95%CI; 0.397,0.434], NHB non-veteran 0.439 [95%CI; 0.397,0.481], and NHB veteran 0.533 [95%CI; 0.479,0.587]. Further stratification by age group is available in Figure 1. An Adjusted Wald test for the 3-way interaction between race, veteran status, and age category was statistically significant $P_{int} = <0.001$. Adjusted risk difference showed that in 55-59 age group NHB have a significant higher prevalence difference by 14.7% compared to NHB non-veterans (55-59 NHB veteran vs. 55-59 NHB non-veteran, ARD; 0.147 [95%CI;0.024,0.271], $P=0.019$), and significant higher prevalence by 18.0% when comparing NHB veterans to NHW veterans in same age group (55-59 NHB veteran vs 55-59 NHW veteran, ARD; 0.18 [95%CI;0.066,0.294], $P=0.002$). In the 65-69 age group, we found a significant 9.3% higher PSA screening prevalence in NHB veterans compared to NHW veterans (65-69 NHB veteran vs. 65-69 NHW Veteran, ARD; 0.093 [95%CI; 0.001,0.186], $P=0.047$). Moreover, we found a significant incremental increase in NHW veterans with every age group increase, similarly for NHW non-veterans, and NHB non-veterans. However, NHB veterans remained having a high screening prevalence at all age groups without any statistically significant difference as the age group increase. See Figure1.

Conclusion: PSA screening is highest in Black military veterans as estimated in BRFSS. In addition, PSA screening prevalence significantly increases as age groups become older. Compliance with national screening guidelines and information provided to Black veterans may explain improved rates of PSA screening in this population. Additional studies are needed to better understand the factors associated with the observed differences among identified racial groups and ultimately prostate cancer outcomes.

Source of Funding: None

**PRENATAL DIAGNOSIS IN THE EXSTROPHY-EPISPADIAS COMPLEX:
SPECTRUM OF SUCCESS**

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(Presentation to be made by Dr. Victoria Maxon)

Objectives: Bladder exstrophy-epispadias complex is a spectrum of genitourinary malformations encompassing classic bladder exstrophy (CBE) and cloacal exstrophy (CE) that requires surgical repair after birth. Repairs are ideally performed by a pediatric urologist in concert with general pediatric surgery, orthopedics, and even neurosurgery. Earlier presentation to a high-volume exstrophy center leads to improved outcomes, but patients are often diagnosed at birth due to poor prenatal screening. The authors hypothesize that increased prenatal diagnosis of CE and CBE are associated with increased rates of delivery at high-volume centers and improved success rates of primary closure.

Materials and Methods: An institutional database of 1504 exstrophy-epispadias patients (165 CE, 1084 CBE) was reviewed retrospectively for patients with prenatal diagnostics who underwent primary closure at an identifiable institution since 2000. Gestational age at diagnosis, ultrasound findings, confirmatory fMRI, institution of closure, and outcome of primary closure attempt were recorded. Results were compared between diagnostic groups.

Results: The cohort included 280 CBE patients and 37 CE patients. 73% (27) of the CE patients and 39% (110) of the CBE patients were diagnosed prenatally. The median gestational age at diagnosis was 20 weeks (inter-quartile range [IQR]: 8 – 36.5) for CE patients and 22 weeks (IQR: 18 – 24.5) for CBE patients. Both CE and CBE patients were significantly more likely to undergo primary closure at exstrophy centers of excellence when diagnosed prenatally ($p=0.049$ and $p=0.0004$, respectively). When diagnosed prenatally, primary closures were successful more often in both CE (75% vs. 57%) and CBE patients (74% vs. 69%), but neither comparison was statistically significant ($p=0.38$ and $p=0.78$, respectively).

Conclusions: Both CE and CBE patients are often undiagnosed at birth, and rates of prenatal diagnosis are worse for CBE than CE patients. When successfully diagnosed before birth, patients with either CE or CBE are more likely to undergo closure at a high-volume exstrophy center and may have an improved chance of successful primary closure. These results illustrate the importance of specific prenatal imaging protocols to improve rates of prenatal diagnosis in this population.

Source of Funding: None

PAPER #34

A ROCKY ROAD: BLADDER STONES IN THE EXSTROPHY-EPISPADIAS COMPLEX

Victoria A. Maxon DO, Chloe A. Michel MD, Alexander M Hirsch* MD, Ahmad Haffar* MD, Chad B. Crigger* MD, Heather N. DiCarlo* MD, John P. Gearhart* MD: Baltimore, MD

(Presentation to be made by Dr. Victoria Maxon)

Objectives: We hypothesize that bowel segment choice influences the rate of stone formation after bladder augmentation and the rate of complications from bladder stone surgery.

Materials and Methods: An IRB approved institutional database of 1512 exstrophy-epispadias patients was reviewed retrospectively. Patients that had a history of bladder augmentation and were seen at our institution between 2003 and 2023 were included. We reviewed patient demographics, comorbidities, type of augmentation, time from augmentation to first stone surgery, treatment modality, stone composition, time to first and second recurrence and complications.

Results: Bladder stones developed in 18% (74/409) of patients. Bowel segment used in the augment was known in 249 patients, (colon 147, Ileum 29, Ileum & colon 12). Stones formed in 19.72% of Colon augments compared to 29% ileal augments, however this was not statistically significant. No stones formed in the 12 ileum and colon combined augments. The most common primary stone component was dahllite, followed by struvite for all augments. The median time to stone treatment after augmentation was 4.14 years (0.75-31). 74% of patients had a recurrence that required a second surgery. The median time from first to second surgery and second to third surgery was 1.4 years and 2.22 years, respectively. Stone surgery complications occurred in 16% of patients, vesicocutaneous fistula being the most common, and complications did not differ by augment type. Median follow up after first stone intervention was 6.07 years (0-19.5).

Conclusions: The treatment of bladder stones in the exstrophy-epispadias complex remains challenging. Interventions to prevent recurrence are crucial as the majority of patients will require two or more stone surgeries.

Source of Funding: None

ADDITIVE MANUFACTURING IN AUSTERE ENVIRONMENTS: UROLOGICAL APPLICATIONS

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(Presentation to be made by Madeline Chaput)

Objectives: Additive manufacturing, aka 3D printing, is a fast-advancing method of creating three-dimensional forms using thin layers of successively bonded material. Interest in the medical and surgical applications of additive manufacturing technologies has increased over the last decade. This study examines the available applications of 3D printing for urological concerns in low-resourced or remote environments.

Materials and methods: Relevant literature was identified using keyword term searches using Boolean operators via PubMed and Google Scholar search engines. Keywords included the following: austere environments, aerospace medicine, spaceflight, military, urology, 3D printing, and additive manufacturing. The specific search in PubMed and Google Scholar is as follows: ("Space Flight" OR "space medicine" OR "aerospace medicine" OR "austere environments" OR "military") AND ("urology") AND ("additive manufacturing" OR "3D printing"). We applied the English filter and analyzed indexed articles between 1980-2023; this resulted in 446 publications. A combination of organizational publications, review articles, and scientific papers was then selected for inclusion in this comprehensive review based on relevance, quality, and clarity of the publication.

Results: Additive manufacturing has been shown to be a viable technology for the manufacture of surgical tools, instruments, and implants, including trocars and ureteral stents. Printer weight and cost continues to decrease as recyclability increases. Advances in bioprinting promise to improve wound healing and even, in the future, print complex tissues and organs. Numerous urological complaints that have substantial morbidity and mortality in low-resourced settings, from nephrolithiasis to urinary retention, may benefit from on-site additive manufacturing.

Conclusions: With the ten-year anniversary of the first 3D printer on the International Space Station approaching, it is clear that additive manufacturing is in space to stay, but the increasing portability and efficiency of material extrusion, DED, and bioprinters have implications for human health in all austere environments. 3D printing can change the status of many possible urological conditions requiring intervention from "should" treat to "shall" treat by decreasing supply burden and averting or delaying medical evacuation. Evolution in the 3D printing capability onboard the ISS is expected soon, which will expand the array of useful spaceflight necessities and provide additional proof of concept for exploration class missions. Additive manufacturing will be an integral part of the medical planning for any long-duration mission with supply challenges, whether it is occurring in space, undersea, or on a remote logistics station or distant battlefield.

THE FINAL FRONTIER: THE UNITED STATES AIR FORCE AND UROLOGICAL CONTRIBUTIONS TO THE SPACE RACE

Madeline B. Chaput B.A.* , Jeffrey Jones M.D.:
Houston, TX

(Presentation to be made by Madeline Chaput)

Objectives: The lunar surface landing in 1969 was a massive feat for all humankind and proved that the inhospitable environment of space could be tamed with the assistance of the fledgling field of space medicine. While rightly considered one of the crowning achievements of the National Aeronautics and Space Administration (NASA), work on solving the physiological problems of space travel had begun at multiple United States Air Force (USAF) bases before NASA's founding in 1958. The purpose of this study is to shed light on the impact that USAF / Department of Defense urological research had on the success of the United States' space program in putting the first men on the moon.

Materials and methods: Relevant literature was identified using keyword and Mesh term searches using Boolean operators via PubMed and Google Scholar search engines. Keywords included the following: aerospace medicine, spaceflight, space medicine, urology, and air force. We applied the English filter and analyzed indexed articles between 1940-2023; this resulted in 395 publications. Relevant sources were also selected by searching within cited references. A combination of organizational publications, review articles, books, and scientific papers was then selected for inclusion in this comprehensive review based on relevance, quality, and clarity of the publication.

Results: The findings of this review show that throughout the history of the US space program (from the Space Task Group and formation of NASA to present day) all three military branches contributed to aerospace medicine operations and research. Early military space medicine pioneers included: for the Navy- Capt. Ashton Graybiel, USN (MC), Director of Medical Research for the Naval School of Aviation Medicine, Dr. Robert B. Voas, psychologist; for the Army- Capt William Augerson, aeromedical consultant to Project Mercury from Army Ballistic Missile Agency, Redstone arsenal; and for the Air Force Medical Corps- LTC Stanley C. White, chief of Crew Systems Branch, STG, and his proteges LTC William Douglas, and LTC James Henry, Flight Surgeons, assigned to the astronauts, Col. George M. Knauf, AFMT, Asst. for Bioastronautics and DOD Representative for Project Mercury Support, Col. Harold V. Ellingson, Commander of the Gunter Branch of the School of Aerospace Medicine and Col. Rufus Hessburg, at Holloman AFB.

The newly minted Air Force became the predominant driver of the future space program, with its Aeromedical Field Laboratory in Alamogordo, NM and the School of Aerospace Medicine in San Antonio, TX; spearheaded by USAF notables such as LTC Charles Berry, WPARB, LTC William Turner, Maj. Julian E. Ward, Maj. C. Kratochvil, USAF flight surgeons and board certified in Aviation Medicine. It was at these sites that early urological investigations into space medicine took place, some of which were helmed by future AUA president and Air Force Captain, Dr. Abraham T. K. Cockett.

Conclusions: The scientific and medical advancements of Air Force physicians and researchers in the field of aerospace urology helped to reveal that space travel was possible while contributing to the safety and health of astronauts. In addition, luminaries such as Dr. Cockett laid the foundation for the decades of urological space medicine research that have continued to advance the field.

PAPER #37

IMPACT OF ANTICOAGULATION ON OPERATIVE EFFICIENCY IN HOLEP PATIENTS

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Presenting author: Dr. David C Dalton

Introduction: Anticoagulant usage raises questions about these medications' impact on hemostasis during Holmium Laser Enucleation of the Prostate (HoLEP). We performed a retrospective review of HoLEP patients on anticoagulant (AC) or antiplatelet (AP) medications to examine their impact on operating efficiency during HoLEP.

Methods: We performed a retrospective review of our institutional HoLEP database including patients with no AC/AP usage, holding AC/AP, or continuing AC/AP through surgery. Hemostasis time was calculated as analogous to OR time not dedicated to enucleation or morcellation. Grams enucleated per minute, total laser-energy usage (kJ), and laser-energy per gram of tissue enucleated were also analyzed to evaluate operative efficiency.

Results: We included 621 patients who underwent HoLEP from July 2018 to August 2022; 49 continued AC/AP through surgery, 101 held preoperatively, and 471 had no AC/AP usage. There was no difference in hemostasis time between those continuing AC/AP, patients holding these medications, and non-anticoagulated patients (19.12 vs. 18.16 vs. 18.93; $p=0.825$). There was no difference in mean total energy used (120.25 vs. 120.25 vs. 121.09; $p=0.992$) or kJ/gram enucleated among the groups (3.58 vs. 2.47 vs. 2.71; $p=0.092$). However, mean enucleated grams/minute was different among the groups (1.25 vs. 1.44 vs. 1.64; $p=0.016$). OR specimen weight was different in those who continued AC/AP and those with no AC/AP usage (54.29 vs. 77.46; $p=0.017$).

Conclusion: HoLEP is safe and equally efficient for patients who require AC or AP therapy. While enucleation efficiency was different between the groups, there was no statistically significant difference in operative efficiency in those who continued or discontinued AC/AP.

Funding: None

Conflict of Interest: Dr. Rivera is a consultant for Boston Scientific and Cook Medical. Dr. Slade is a consultant for Cook Medical.

PAPER #38

PATIENT AWARENESS OF HOLMIUM LASER ENUCLEATION OF THE PROSTATE AND ALTERNATIVE TREATMENTS OF BENIGN PROSTATIC HYPERPLASIA

T. Max Shelton*, Rachel M. Gross*, Mariah L. Thomas*, Saveda K. Majety*, RJ Caras, Austen Slade*, David Dalton*, Marcelino Rivera*

(Presentation to be made by Dr. Shelton)

Introduction and objective: Patient literacy in medical treatment is essential to providing quality patient-centered care. Holmium laser enucleation of the prostate (HoLEP) was first described in the 1990s and has established itself as a durable and cost-effective surgical treatment for benign prostatic hyperplasia (BPH). This study aims to evaluate patient knowledge of HoLEP among patients who underwent this procedure at Indiana University Health between 2019 and 2022.

Methods: This retrospective cohort study included a survey of eight multiple choice questions which was sent via SMS text message to 2322 patients who previously underwent HoLEP at Methodist Hospital. Data was collected using research electronic data capture (REDCap). A total of 59 patients responded to the survey.

Results: Of those contacted, 59 patients responded to the survey (% of total). The average age was 69.5 years at the time of surgery. 93% of patients did not have any BPH surgical treatments prior to HoLEP. The average time between surgery date and survey response was 31 months. A total of 69.5% of patients were referred by local urologists and 15% by their primary care physician (PCP). Less than a third of patients sought out multiple opinions on treatment options and even less (13.6%) traveled from out of state for treatment. Of those who did travel, 75% were from neighboring states. Outside of HoLEP, TURP and Urolift were the most well-known procedures with 58% and 36% of respondents respectively hearing of the procedures preoperatively. 88% of patients who underwent HoLEP reported satisfaction and would recommend the procedure to a friend or family member. The most common reasons listed for the 7 patients who would not recommend the procedure were prolonged leakage and affected sexual performance.

Conclusions:

Patients were more likely to be referred by their urologist than hear of HoLEP from their PCP, online source, or friend. Over half of patients had knowledge of other BPH surgical procedures preoperatively, but most patients did not seek out multiple opinions or undergo any surgical treatments prior to HoLEP. Overall patient satisfaction remained high after an average of 2.5 years post-operatively. Further studies are warranted to analyze PCP HoLEP awareness and referral practices.

PAPER #39

REAL-WORLD ANALYSES OF MORTALITY RISK AFTER ANDROGEN DEPRIVATION THERAPY INITIATION IN BLACK VS. WHITE PROSTATE CANCER PATIENTS

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Presentation to be made by Dr. Judd W. Moul

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Objectives: Two studies found significantly longer overall survival in Black vs. White patients with metastatic castration-resistant prostate cancer (PCa): a 2019 meta-analysis of nine phase III trials (n=8,820)¹ and a 2020 registry study (n=1,902)² Our real-world data study compared all-cause mortality risk for Black vs. White PCa patients. In contrast to the prior studies mentioned, our study encompasses a broader scope and is not exclusively centered on men with castration-resistant PCa.

Methods: Data were collected from the Decision Resources Group (DRG, now Clarivate) Real World Evidence repository, which links medical claims, prescription claims, and US Electronic Healthcare Records (EHR) to provide historical, longitudinal patient-level data. The DRG repository covered the majority of entities in the US healthcare system, including >300 million patients' medical and pharmacy claims and EHR data. The analysis set included PCa patients who received at least one injection of ADT between 1991-2020 (99% of patients started ADT within 2010-2020). Cox regression was used to compare all-cause mortality rates between White and Black patients. The multivariable regression model took into account the following variables: baseline metastasis, BMI, oncology vs. urology setting, antagonist vs. agonist, personal major adverse cardiovascular event (MACE) history, tobacco history, baseline PSA (>4 vs. ≤4 ng/mL), race (White vs. Black), statin use, increasing age per year, ethnicity (non-Hispanic vs. Hispanic), increasing ADT exposure per year, diabetes, hypertension, and family MACE history.

Results: 34,762 patients with PCa treated with ADT who met the inclusion/exclusion criteria were analyzed. Of the 34,762 patients, 5,817 and 28,945 were Black and White patients, respectively. Overall, mortality risk was 2.6% and 17% at 1 and 4 years after ADT initiation, respectively. The mortality risk after ADT initiation was 1.6% and 2.6% at 1 year and 11.7% and 18.1% at 4 years for Black and White patients, respectively. Both unadjusted (HR=1.66, 95% CI 1.53-1.80, p<0.05) and adjusted (HR=1.24, 95% CI 1.01-1.52, p<0.05) mortality risks were higher for White vs. Black patients.

Conclusions: Our analysis found that all-cause mortality incidence was higher in White vs. Black patients. Adding to the body of evidence for men with CRPC, our research also reveals that Black race is associated with a protective effect on survival for all-cause mortality in men undergoing treatment with ADT. Potential hypotheses for higher mortality in White vs. Black patients include survival bias to MACE (i.e., Black patients may have died from PCa before having a MACE), survival bias to get to PCa (i.e., Black patients may have had a higher rate of CV death and kidney failure prior to PCa diagnosis), and protective effects of higher BMI in Black patients against cancer cachexia. The large size (~45,000 patients from a database containing >300 million patients), long follow-up (10 years for some patients), recent clinical experience (99% from 2010-2020), and diversity of the dataset give weight to the results being an accurate representation of current clinical experience. Future studies should confirm our findings that White PCa patients are at a higher risk of mortality and investigate the hypotheses provided above.

Source of Funding: Tolmar, Inc.

PAPER #44

CYSTINURIA AND PREGNANCY: CLINICAL COURSE AND OUTCOMES IN PATIENTS FROM 2000-2020

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(Presentation to be made by Dr. Amy Reed)

Objectives: Cystinuria is a rare disease which limits the understanding of its impact on pregnancy. We sought to characterize stone disease and management of patients with cystinuria during pregnancy at a single institution.

Materials and Methods: We completed a retrospective chart review of cystinuria patients at a single institution from 2000-2022. Patients were identified by ICD-10 codes (E72.01) and then included for childbearing potential. Charts were reviewed for urologic history as well as baseline medical and surgical treatment history. We evaluated imaging studies, stone episodes, stone surgeries and complications during pregnancy.

Results: Of the 45 female patients with cystinuria, 15 had confirmed pregnancies. Of note, there were no transgender patients in this cohort. There were 39 pregnancies and 28 successful live births. Pre-pregnancy management included medical (tiopronin (5), urinary alkalinization (7) or fluid alone (7)) and surgical (total of 92 prior surgeries). Comorbidities included chronic pain (2), chronic kidney disease (1) and multiple sclerosis (1). Renal colic occurred in 8 (21%) of pregnancies which resulted in 25 additional imaging studies. Confirmed stone events in 5 (13%) pregnancies and 3 (20%) patients. Two of these patients (63%) underwent a total of 10 surgeries (PCN (2), stent (6), ureteroscopy (2)). One pregnancy was complicated by a post-ureteroscopy ureteral stricture that required reconstruction. No obstetrical complications were reported.

Conclusions: During pregnancy, cystinuria patients are more likely to experience stone events and undergo additional imaging but can be safely managed surgically without an increase in complications. Given the high rate of stone formation during pregnancy, these patients should be followed with postpartum imaging. To better understand this patient population, further multi-institutional and prospective studies are warranted.

Funding: None.

ANALYSIS OF SEASONAL VARIATIONS IN 24-HOUR URINE STUDIES

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Presenting Author: Dr. David Dalton

Introduction and Objective: Nephrolithiasis is a common medical issue affecting an estimated 1 in 11 people in the United States. Inadequate fluid intake has been shown to play a role in stone development. There is a lack of consensus regarding seasonal variations in urine volumes and little published on seasonal variations in urine electrolytes. This study evaluates seasonal variations in 24-hour urine parameters among a large cohort of stone-formers at a single institution.

Methods: Data from 2,779 24-hour urine tests from 2017-2022 was used to calculate seasonal averages for urine testing variables. Subsequently, an ANOVA single factor test was used to determine the statistical significance of the results using a p-value of 0.05.

Results: Urine volumes, urine chemistries and super-saturations were analyzed for a total of 2,779 24-hour urine studies. Urine sodium and chloride were statistically lower during summer months (June-August) at 154.6 vs. 170.5 mmol/d ($p=0.00003$) and 157.2 vs. 170.4 mmol/d ($p=0.0008$). This seasonal variation was also reflected with urine urea nitrogen ($p=0.0346$), magnesium ($p=0.0357$), and phosphorus ($p=0.0266$). The remainder of analyzed factors showed no statistically significant difference.

Conclusion: This study shows statistically significant decreases in urine sodium, chloride, magnesium, and phosphorus during the summer season compared to other yearly averages. The decreases in these parameters may be due to electrolyte losses from perspiration, although other dietary factors warrant study. Interestingly, no significant seasonal variations were noted in urine volumes, super-saturations, or other urine electrolytes.

Funding: None

Conflict of Interest: Dr. Rivera is a consultant for Boston Scientific and Cook Medical. Dr. Slade is a consultant for Cook Medical.

PAPER #46

WHAT IS CLEARPETRA AND WHY I INVENTED IT

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(Presentation to be made by Col. Shaw P. Wan)

Abstract

Introduction: ClearPetra® is a novel access sheath to accomplish the concept of vacuum assisted endoscopic lithotripsy.

Material: ClearPetra® has several components: sheath, obturator, sealing cap, collection bottle, and connection tubing. The sheath has a straight tube and a 45° oblique side branch with a longitudinal pressure adjusting air vent that can be connected to a vacuum source, Figure 1. Nephrostomy, ureteral access, and cystoscopic sheaths are available.

Method: ClearPetra® can be introduced into the urinary tract either percutaneously or through a natural orifice, usually over a guide wire. An endoscope is inserted through an airtight seal to visualize the stone. Irrigation is delivered through the scope and egress of fluid is between the scope and sheath. Lithotripsy can be performed using any available lithotripter. Tiny stone fragments will exit between the scope and the sheath. Larger fragments that are small enough to enter the sheath but too large to pass between the sheath and the scope; the scope can be withdrawn to proximal of the takeoff of the side branch to allow the evacuation of the larger fragments. Throughout the procedure, the vacuum pressure can be ergonomically and precisely controlled using the air vent.

Result: Several published laboratory and clinical studies on intrarenal pressure and operative outcomes using the vacuum assisted sheath are summarized with the permission of the coauthors.

Conclusion: The concept of vacuum assisted lithotripsy has been validated to reduce intraluminal pressure, decrease operative time, and increase stone extraction rate.

PAPER #50

EXPLORING RACIAL DIFFERENCES IN ADMINISTRATION OF NEOADJUVANT CHEMOTHERAPY PRIOR TO RADICAL CYSTECTOMY

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(Presentation to be made by Dr. Robert Smith)

Introduction: Cisplatin based neoadjuvant chemotherapy (NAC) therapy has been shown to improve survival outcomes in patients with muscle invasive bladder cancer (MIBC), however contraindications to cisplatin, including chronic kidney disease (CKD), limit its use. Although African American (AA) patients are less likely to develop bladder cancer, they have historically experienced higher mortality. We sought to understand whether rates of NAC administration differed based on demographic characteristics, including race, and to assess if intrinsic characteristics of patient populations preclude the use of NAC.

Methods: We performed a retrospective cohort study of all cystectomies including partial, radical, and simple performed at a single institution from 2000-2018. Inclusion criteria included age >18 years and radical cystectomy (RC). Variables of interest included patient characteristics, surgical indications, intraoperative complications, post-operative course as well previous systemic or intravesical therapies. 498 patients met inclusion criteria for analysis during this time.

Results: At time of analysis, our database included 498 radical cystectomies performed for cancer (MIBC or recurrent high risk non-MIBC). Of those, there were 420 white patients and 76(AA) patients. AA patients had a higher rate of CKD compared to whites (11% to 3%). Despite the higher percentage of CKD in AA, there was a non-significant trend where more AA patients (34%) received NAC than white patients (28%), $p=0.24$.

Conclusions: Receipt of NAC did not differ between AA and white patients in our study. There was a trend towards AA patients receiving NAC at a higher rate than white patients despite higher incidence of CKD among AA patients. Our overall rate of NAC is higher than found in other published studies. Further study is needed to determine how sociodemographic characteristics affects the administration of NAC and if this affects cancer outcomes.

	White (N= 420)	African American (N= 76)	P value (: 2)
History of CKD (n, %)?			<0.05
Yes	12 (2.9)	8 (10.5)	
No	408 (97.1)	68 (89.5)	
Received Neoadjuvant chemotherapy (n, %)			0.242
Yes	116 (27.6)	26 (34.2)	
No	304 (72.4)	50 (65.8)	

INTRAVESICAL THERAPY IN BLADDER CANCER DURING PREGNANCY: A CASE REPORT AND REVIEW OF THE LITERATURE

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Introduction/Background: Urothelial carcinoma during pregnancy is an exceedingly rare condition affecting 13 in 1,000,000 pregnancies and is difficult to manage secondary to limited data and concerns about the safety of interventions. In patients with non-muscle invasive bladder cancer (NMIBC), intravesical therapy in the perioperative setting has been shown to significantly reduce recurrence rates, however, its use in pregnant patients remains poorly understood. We report the first case of intravesical gemcitabine in a pregnant patient with urothelial carcinoma and provide a review of the existing literature on intravesical therapy in this unique population.

Methods/materials: We present the case of a 36-year-old woman at 14 weeks gestation who underwent transurethral resection of a bladder tumor (TURBT) with post-operative instillation of intravesical gemcitabine for a 3 centimeter papillary bladder mass on the right lateral wall. A literature review was conducted to explore the available evidence on intravesical therapy in pregnant patients with bladder cancer. Electronic databases were searched for relevant studies using specific keywords. The search aimed to identify studies on the management of bladder cancer during pregnancy, particularly focusing on intravesical therapy. Additionally, studies on the management of other malignancies during pregnancy were reviewed for insights and lessons learned.

Results: A TURBT was successfully performed without complications, and the patient and her fetus were closely monitored throughout the surgical and postoperative period. Surgical pathology revealed papillary urothelial neoplasm of low malignant potential. Review of the literature revealed two previous cases that implemented the use of intravesical therapy: one using an induction course of BCG during the second trimester and one using intravesical mitomycin in the perioperative setting. In both cases there was no evidence of fetal harm or complications. Furthermore, the use of systemic gemcitabine in gallbladder cancer during the second and third trimester of pregnancy has been shown to be effective and safe, further justifying the use of intravesical therapy that has been shown to have minimal systemic penetration.

Conclusion: Bladder cancer during pregnancy presents unique challenges, and the optimal management approach requires careful consideration of the risks and benefits to both the mother and fetus. The literature on intravesical therapy in pregnant patients with bladder cancer is limited, but lessons can be learned from studies on other malignancies during pregnancy. This case report highlights the successful surgical resection of a bladder tumor during the second trimester with instillation of intravesical gemcitabine and provides insights into the management of bladder cancer in pregnant patients. Further research is warranted to establish evidence-based guidelines for intravesical therapy in this population.

COMPARISON OF PERITONEAL INTERPOSITION FLAPS AND SEALANTS FOR PREVENTION OF LYMPHOCELE AFTER RADICAL PROSTATECTOMY AND PELVIC LYMPH NODE DISSECTION: A BAYESIAN NETWORK META-ANALYSIS AND META-REGRESSION

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(Presentation to be made by Dr. Shane Kronstedt)

Objectives: A lymphocele is the abnormal collection of lymphatic fluid and is one of the most common complications after robot-assisted laparoscopic prostatectomy (RALP). Multiple authors have proposed the use of vessel sealants and/or various peritoneal interposition techniques as preventive strategies without increased morbidity. Various interposition techniques exist and haven't been directly compared. This study aimed to aggregate and analyze the available literature on multiple interventions which seek to prevent lymphocele through a Bayesian Network.

Materials and Methods: In February 2023, a systematic review was performed to identify prospective studies evaluating strategies for lymphocele prevention after RALP + pelvic lymph node dissection (PLND). Data was extracted independently by two authors and used to build a network in R Studio. These networks were used to model 200,000 MarkovChains via MonteCarlo sampling. The results are expressed as odds ratios with 95%CrI. Cumulative incidences of lymphocele for each cohort were estimated using weighted percentages. Meta-regression was used to determine coefficient of change and adjust for PLND extent.

Results: Eleven studies providing data from 1,837 patients were included. The overall weighted incidence of lymphocele was 49.03% in the control cohorts of sealant studies and 22% in the control cohorts of the interposition studies. Four studies tested sealants or patches in 150 patients, six studies tested peritoneal interposition techniques in 741 patients, and one study tested interposition with fenestration in 50 patients. Odds of developing any lymphocele were significantly decreased using perivesical fixation (OR 0.47 [0.32,0.69]), partial pelvic bone fixation (OR 0.42 [0.25,0.71]), sealant/patches (OR 0.47 [0.29,0.76]), and was the lowest in interposition with fenestration (OR 0.14 [0.04,0.50]). None of the interventions showed significant reductions in symptomatic lymphocele; however, every method analyzed had an OR < 1, suggesting these may reduce symptomatic lymphoceles with larger datasets. All techniques showed an OR < 1 for developing asymptomatic lymphoceles, only perivesical fixation (OR 0.57 [0.37,0.87]) and sealant/patch (OR 0.57 [0.34,0.95]) reached statistical significance. Meta-regression revealed non-significant ratios of change associated with variations of PLND extent.

Conclusions: Sealants, Interposition flaps and Fenestration appear to be effective interventions for reducing the overall incidence of lymphocele.

Source of Funding: None

PHYSICIAN PERSPECTIVES ON THE NON-CLINICAL FACTORS THAT CONTRIBUTE TO DECISION-MAKING FOR ADVANCED PROSTATE CANCER CARE: A QUALITATIVE STUDY

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(Presentation to be made by Dr. Jeremy Kurnot)

Objectives: Promising new treatments exist for advanced prostate cancer. Decision-making is complicated: there is minimal comparative effectiveness data; differing routes of administration, drug mechanisms of-action and side effects; and significant price differences. These challenges contribute to variations in care and quality, treatment disparities, and lack of concordance with patient values. The aim of this study was to examine physician perspectives of factors influencing decision-making for first-line advanced prostate cancer treatments.

Materials and Methods: We conducted a qualitative descriptive study of physicians who treat patients with advanced prostate cancer from 09/2021-06/2022. Participants were purposively sampled from across the United States.

Results: Twenty-seven physicians participated. We identified seventeen domains and three overarching themes affecting physician decision-making for advanced prostate cancer care. The overarching themes were: 1) physician and practice factors impact prescribing decisions, 2) health practice resource availability affects the likelihood that patients will receive the recommended treatment, and that the treatment will be in line with patients' values and 3) patient non-clinical factors influence physician decision-making, but patient values could be better incorporated into prescribing decisions. Based upon the analyses, we constructed a preliminary framework of clinician decision-making for advanced prostate cancer treatments.

Conclusions: Physicians perceive that non-clinical patient, physician, and practice factors impact decision-making. These factors, therefore, must be considered when implementing programs to optimize a physician's ability to provide quality cancer care, reduce health care disparities and patient financial burden and provide patient goal-concordant care. The preliminary theoretical model of clinician decision-making for advanced prostate cancer care may also be used to inform these efforts.

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ROUTINE NEONATAL CIRCUMCISION: A QUALITY IMPROVEMENT PROJECT

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Presentation to be made by: Dr. Zachary R. Seymour

Objectives: Routine neonatal circumcision is frequently performed by obstetricians, pediatricians, or family medicine providers while urologists manage complications or complex cases due to anatomic abnormalities. It is important that performing providers be able to accurately identify contraindications and be well versed in proper surgical technique. As part of a quality improvement endeavor, we created and distributed an anonymous online questionnaire to assess comfortability, training, and basic knowledge regarding routine neonatal circumcision within the National Capital Region (NCR).

Materials and Methods: A 13 item online anonymous questionnaire was created and distributed to medical students, residents, and staff who participate in routine neonatal circumcision in the NCR. Descriptive statistics were used to present survey results.

Results: There were 72 responses comprised of 18 medical students (25%), 20 residents (28%), and 34 staff (47%). Only 5 medical students (27%) and 7 residents (35%) reported having received any type of formal didactic training while most received some combination of pre-procedural briefing or hands-on training. All medical students and 70% of residents reported direct staff supervision. All trainees reported utilizing either the Mogen or Gomco clamp technique. Of the staff, 68% reported feeling comfortable, whereas 24% reported being uncomfortable performing newborn circumcision. Within the trainees, 50% of residents reported being comfortable while 30% reported being uncomfortable. 71% of staff and 45% of residents reported being comfortable with newborn penile exam while 12% and 20% reported being uncomfortable respectively. Medical students averaged 81% correct on the contraindication knowledge assessment, while residents and staff both averaged 84% correct. Commonly missed contraindications included micropenis, buried penis, and chordee. Many respondents also incorrectly identified physiologic phimosis as a contraindication.

Conclusions: Overall, there appears to be room to improve trainee and faculty comfortability with performing routine neonatal circumcision and neonatal penile exam. A minority of learners reported receiving formal didactic training, and many missed several common contraindications on the knowledge assessment. This survey highlights the potential benefit of a formal structured training program which could be the target of future quality improvement efforts.

Source of Funding: none

PAPER #55

EARLY TESTICULAR TORSION ON COMPUTERIZED TOMOGRAPHY: THE SWIRL SIGN

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(Presentation to be made by Dr. Hannah Johnson)

Introduction/Background:

Testicular torsion is a clinical diagnosis and often associated with nausea and vomiting, a sudden onset of severe testicular pain, a high-riding testicle, or palpable twist in the spermatic cord on physical examination. In these cases, it is imperative to proceed directly to the operating room.¹ In instances where the diagnosis is questionable, a scrotal ultrasound might be performed to visualize either the absence of blood flow within the testicle, consistent with torsion, or the presence of blood flow, which then requires no further testing.^{1,2} Only one other case has been published where the diagnosis of testicular torsion was made on computed tomography (CT) imaging with what they coined as the “whirl” sign.³ Here we present a case of testicular torsion which was ultimately diagnosed on ultrasound, but earlier CT imaging demonstrated concerning findings, which could have been suggestive of early testicular torsion.

Clinical Case: Here we present a case of right lower quadrant abdominal pain in a young male. A CT scan was completed to evaluate for appendicitis, which demonstrated an area of concern in the right scrotum that the radiologists described as “swirling of the right spermatic cord and adjacent vessels...concerning for torsion, recommend testicular ultrasound”. Given the lack of presenting testicular pain, an ultrasound was performed which demonstrated present arterial and venous waveforms in the right testicle. The patient was discharged from the emergency room with strict return precautions. He presented the following night with sudden onset right testicular pain and this time his ultrasound demonstrated a lack of blood flow to the right testicle. He was taken back to the operating room where a 360° torsion of the right testicle was observed. The operative note reflects that on initial inspection, the right testicle was blue and dusky on inspection. It was covered with warm gauze while the left orchidopexy was performed. Inspection of the right testicle after this was completed then demonstrated a slight improvement in the color, so an incision was made into the right testicle. This relieved some of the pressure within the testicle and healthy seminiferous tubules were noted. A tunica vaginalis flap was then rotated to cover the incision into the testicle. The right orchidopexy was then completed.

Conclusion/Case Discussion: This is the second reported case where testicular torsion or early testicular torsion was noted on a CT scan completed for abdominal pain. This uncommon finding might help guide future clinical decision making and warrant proceeding to the operating room sooner if a “whirl” is visualized on CT imaging.

PAPER #56

CREMASTER MUSCLE THICKENING: THE ANATOMIC DIFFERENCE IN MEN WITH TESTICULAR RETRACTION

DUE TO HYPERACTIVE CREMASTER MUSCLE REFLEX

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(Presentation to be made by Dr. Kayla Turner)

Objectives: The objective was to assess whether men suffering from testicular retraction secondary to hyperactive cremaster muscle reflex have an anatomic difference in the thickness of the cremaster muscle in comparison to men who do not have retraction.

Materials and Methods: From March 2021 to December 2021, 21 men underwent microsurgical subinguinal cremaster muscle release (MSCMR) on 33 spermatic cord units, as 12 of them had bilateral surgery, at Surgicare of South Austin Ambulatory Surgery Center in Austin, TX, USA. During that same time frame, 36 men underwent subinguinal microsurgical varicocele repair on 41 spermatic cord units, as 5 were bilateral for infertility. The thickness of cremaster muscles was measured by the operating surgeon in men undergoing MSCMR and varicocele repair. Comparison was made between the cremaster muscle thickness in men with testicular retraction due to a hyperactive cremaster muscle reflex undergoing MSCMR and the cremaster muscle thickness in men undergoing varicocele repair for infertility with no history of testicular retraction, which served as an anatomic control.

Results: The mean cremaster muscle thickness in men who underwent MSCMR was significantly greater than those undergoing varicocele repair for infertility, with a mean cremaster muscle thickness of 3.9 (standard deviation [s.d.]: 1.2) mm vs 1.0 (s.d.: 0.4) mm, respectively.

Conclusions: Men with testicular retraction secondary to a hyperactive cremaster muscle reflex demonstrate thicker cremaster muscles than controls, those undergoing varicocele repair. An anatomic difference may be a beginning to understanding the pathology in men who struggle with testicular retraction.

Source of Funding: None

**COMPARISON OF FLUOROSCOPIC RADIATION EXPOSURE BETWEEN
STANDARD, MINI, AND ULTRAMINI PERCUTANEOUS NEPHROLITHOTOMY**

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(Presenting author is Dr. David Dalton)

Introduction and Objective: Advances in endoscopic technology have broadened surgical treatment options for patients with large renal stone burdens. In addition to standard percutaneous nephrolithotomy (PNL), more minimally invasive approaches with mini (MPL) and ultra mini PCNL (UPL) have gained favor. This study evaluates differences in intraoperative fluoroscopic radiation exposure between these three procedures in a retrospective single institution analysis.

Methods: A retrospective review of a all MPL and UPL procedures performed at a single institution between January 2021 and January 2023 was performed. Bilateral surgeries and cases performed with ultrasound guidance or incomplete fluoroscopy records were excluded. In total, 36 MPL and 10 UPL cases were identified. An additional 36 age and gender matched PNL patients were also identified within this same period. Radiation exposure was compared between all 3 procedures using two-tailed T-tests.

Results: Among the age and gender-matched cohort, no significant difference was noted between the average radiation exposure in SPL 69.8 mGy, MPL 90.6 mGy, and UPL 48.8 mGy ($p=0.5622$). Although there were marked differences in exposure averages—wide variations in standard deviation limited significance.

Conclusions: There appears to be no difference in radiation exposure between SPL, MPL, and UPL in this retrospective cohort. Future prospective studies focusing on procedural radiation exposure are warranted to evaluate for comparison among these techniques.

Source of Funding: None

Conflict of Interest and Disclosure Statement: Dr. Rivera is a consultant for Boston Scientific and Cook Medical. Dr. Slade is a consultant for Cook Medical.

PAPER #58

EVOLUTION AND EFFECTS OF CAFFEINE UTILIZATION THROUGHOUT MEDICAL AND SURGICAL TRAINING

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(Presentation to be made by: Dr. Daniel Pierce)

Objectives: Caffeine is a naturally occurring psychostimulant consumed globally in various forms for its stimulant properties and mood-enhancing effects, as well as part of cultural practices. Due to its mass availability in coffees, teas, and energy drinks, caffeine consumption is a mainstay in the medical profession. Many medical students and residents cope with the demanding lifestyle and long work hours with caffeine, but their patterns and consequences of use have yet to be widely studied. Current research focuses on individual groups within medical training and has not examined how caffeine consumption may change throughout education or vary based on specialty.

Materials and Methods: The current study utilized a questionnaire-based survey among medical students and residents nationwide. Its purpose was to investigate trainees' relationships with caffeine with respect to the amount of caffeine consumed, when it is most consumed, and associated effects on sleep and concentration. We further analyzed how caffeine consumption may evolve during training and the differences in caffeine use over time as individuals move throughout medical school and into residency. Data was analyzed using SPSS.

Results: A total of 211 medical students and 42 residents nationwide participated in the cross-sectional survey. Of these respondents, 86% consumed caffeine with the most popular forms being coffee and tea. Interestingly, the difference between surgical residents and nonsurgical residents in caffeine consumption was not statistically significant ($p = 0.12$). Approximately 69% of respondents consumed less than the accepted amount of caffeine during pregnancy of 200mg with a mean consumption of 152-183mg of caffeine. There was not a significant difference in amount of caffeine consumption between medical students and residents ($p = 0.10$). Only 13% of participants reported less than adequate sleep. There is a correlation between caffeine use and decreased hours of sleep, feeling tired, and difficulty concentrating in medical students; however, no relationships were established in residents. The evolution of caffeine consumption from the first year of medical school to first-year residency increased throughout medical school but remained relatively stable during both surgical and medical residency. A significant difference was found on sleep quality based on year in training ($p < 0.05$). There was no effect on year of training or residency specialty on timing of caffeine intake, with most of the caffeine consumed in the morning.

Conclusions: In conclusion, most medical students and residents nationwide consume caffeine in the morning in the form of tea and coffee. Among them, approximately one third consume more than 200gm caffeine per day. The amount consumed increased during medical school training and remained stable during residency; there is not a significant difference in consumption in medical versus surgical residents. The amount of caffeine consumption correlates with the quality of sleep, daytime fatigue, and concentration difficulties in medical students but does not appear to have a relationship with residents.

Source of Funding: None

PAPER #59

THE BURDEN OF SUPERFLUOUS INFORMATION IN OUTSIDE MEDICAL RECORDS

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(Presentation to be made by Dr. Katherina Chen)

Objectives: At the end of 2021, nearly 63% of physicians reported symptoms of burnout. Poor electronic medical record usability and time-consuming data entry are large contributors to professional dissatisfaction. When patients are referred to a tertiary medical center, outside medical records (OMR) provide important information regarding their care. These records, however, are usually compiled by non-clinical personnel and often contain information that is extraneous or redundant. Our study aims to quantify and classify the superfluous portions of the OMR sent to urologists at an academic referral center.

Materials and Methods: The OMR for all initial visits seen by two urologists in a subspecialty clinic over a 6-month-period were reviewed. From the OMR, the number of pages relevant to the consult was recorded. The superfluous portions of the OMR were classified as: 1. Clinical-but-not-relevant 2. Non-clinical, and 3. Duplicate. Whether the consult came from a urologist or non-urologist was also noted.

Results: During the study period, 111 patients had OMR that met inclusion criteria. Patients without OMR were excluded from analysis. Patients with OMR had a median of 12 pages of OMR (range 1 - 239); a median of 27.3% of those pages contained information relevant to the consult. Of the remaining pages, a median of 33.3% were non-clinical and 27.3% were clinical-but-not-relevant. There were no duplicates. When referring providers were divided between urologists and non-urologists, urologists were more likely to send OMR that contains more relevant information (41.0% versus 31.2%, $p=0.048$).

Conclusions: In our study less than one third of the OMR that accompanied a referral contained relevant clinical information, and most of the superfluous information was non-clinical. Searching through extraneous and redundant OMR can lead to wasted time and effort, likely increasing mental workload, and negatively impacting patient care. There is a need for improvement in how OMR are processed in order to improve clinical efficiency, decrease provider burnout, and reduce medical errors.

MYUROFLOW HOME UROFLOWMETRY COST SAVINGS AND IMPROVED ACCESS TO CARE

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(Presentation to be made by Ananya Tripathi)

Objectives: Multiple advancements in technology have made diagnostic testing in medicine more patient centric and accessible, while providing more robust data collection. These technologies can reduce both time and cost to the patient and the clinic. At our institution, we have employed a novel uroflowmetry test which utilizes the patient's smart phone for at-home testing. The MyUroflow application is FDA (510k) approved for adult males and is provided to our patients at no cost to them. The focus of this analysis is to evaluate the potential cost savings and improved access to care by employing this technology at Madigan Army Medical Center (MAMC).

Materials and Methods: Retrospective data was collected in men 18 years or older who required uroflowmetry testing at MAMC. We collected data on time required for in-clinic uroflowmetry over a 6-month period, prior to utilization of the app (1Jun2022-1DEC22), and from implementation of the app (12DEC2022-11OCT2023). Time analysis was completed by evaluating appointment slots dedicated to in-clinic uroflowmetry, which take 30-minute technician appointments and compared to the number of visits avoided using the app. Cost analysis was conducted using Current Procedural Terminology (CPT) code 51741 (Complex Uroflowmetry using calibrated electronic equipment) and regional reimbursements for out of network (\$150) in the Tacoma area. The main outcomes evaluated were reduced technician visits and potential cost savings.

Results: Six months prior to the utilization of the app, there were 179 in-clinic uroflowmetry appointments completed. A total of 89.5 clinic hours were used during this time for uroflowmetry. Since the implementation of the app, 107 men underwent uroflowmetry testing using MyUroflow, with a total appointment time savings of 53.5 hrs. This would be a total out of network cost of \$16,050. MyUroflow subscription is \$6,600.

Conclusions: MyUroflow can save clinic time and resources while providing greater access to care to our patients. The results of this study demonstrate a significant reduction in technician visits after implementation of the app. Cost savings are modest but do not reflect the true savings, since of the 107 patients using the app, the majority have completed multiple voids (average 31) and not just a single void. Even with the app subscription (\$6,600), out of network cost in resource scarce locations without in-clinic uroflowmetry is significant. The use of this technology has demonstrated utility and may provide cost and appointment reductions in the appropriate clinical setting.

Source of Funding: None

IMPACT OF SEASONALITY AND GEOGRAPHY ON TESTICULAR TORSION, TESTICULAR PAIN, AND GROIN PAIN USING SEARCH INTEREST

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(Presentation to be made by Sung Alexander)

Objectives: Testicular torsion is a urological emergency that is most common in adolescent males, with cold weather being one of the known risk factors. In some cases, patients with testicular torsion may simply search for general terms such as testicular pain or groin pain because they are unaware of the condition and may delay diagnosis and treatment. 35% of U.S. adults search for information about a specific medical condition they or someone they know has, such as their children. Google Trends (GT) analyzes the popularity of top search queries in Google search across various regions over time. The purpose of this study is to find correlations of search interest for testicular torsion, testicular pain, and groin pain with seasonality and geography to investigate if cold weather affects the increase in search.

Materials and Methods: From 2004 to 2021 in the United States, GT analysis was performed for “testicular torsion”, “testicular pain” and “groin pain” under the “Health” category. This analysis was compared with 2016-2019 nationwide testicular torsion diagnosis from the Healthcare Cost and Utilization Project Database (HCUP) (ICD-10-CM code N44.0) using the Nationwide Inpatient Sample (NIS). Their analyses were performed for seasonality and geographic significance in the U.S.

Results: A strong positive correlation exists between testicular torsion search interest and its diagnosis ($R^2=0.8637$). Seasonality was indicated for increased testicular torsion, testicular pain, and groin pain in January ($p=0.0423, p=0.0151, p=0.0001$). Seasonality was also indicated for decreased testicular torsion in August ($p=0.0003$). Search interests for all three diagnoses were increased in West Virginia ($p=0.0011, p=0.0038, p=0.0026$). Search interest for testicular torsion was also increased in Kentucky ($p=0.0054$), and testicular pain interest was increased in Vermont ($p=0.0133$). Search interests for testicular torsion and testicular pain were decreased in Hawaii ($p=0.0083, p=0.0336$).

Conclusions: The strong positive correlation between testicular torsion search interest and diagnosis demonstrates the utility of Google Trends. The presence of seasonality and geographic search interest differences in Google Trends reinforces cold temperature being a risk factor for testicular torsion, testicular pain, and groin pain.

Source of Funding: None

TRAUMATIC DISLOCATION OF AN INFLATABLE PENILE PROSTHESIS: A CASE REPORT

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Objectives/Introduction: Penile fractures are one of the few urologic emergencies and are defined as traumatic rupture of the tunica albuginea of an erect penis. Clinical signs include penile pain, rapid detumescence, with subsequent swelling and bruising due to extravasation of blood through the corporal defect. Immediate surgical intervention is indicated in an attempt to preserve erectile function, but what if the patient already has erectile dysfunction managed by an inflatable penile prosthetic(IPP)? Here we describe a curious case of traumatic corporotomy and dislocation of a cylinder in a patient with an IPP.

Methods/Case Presentation: A 55 year old male with a history of erectile dysfunction (ED) due to low testosterone presented to the Urology clinic with decreasing response to intracavernosal injection (ICI) therapy. The patient elected to pursue IPP placement and was initially taken to the operating room where he underwent an infrapubic approach IPP placement. During the case the patient was noted to have corporal dilation of the left mid-shaft, which made distal dilation difficult and resulted in a urethral injury. The case was aborted, and the patient recovered from the failed placement attempt. Once healed, the patient returned to the operating room where he underwent a successful IPP placement via a penile-scrotal approach. After an appropriate recovery interval, the patient reported satisfaction with his device and was able to cycle the device without issue. Ten months later the patient presented to the clinic for a new penile deformity over the left shaft that appeared after a vigorous and prolonged sexual encounter the night before. Attempts made by the patient to cycle the device were limited by pain. On exam, the deformity appeared to be a knuckle of folded cylinder that was no longer contained by the tunica albuginea. There was no apparent swelling or bruising. The patient was voiding at baseline and UA was negative for hematuria.

Results: The patient was taken to the operating room for urgent exploration. The previous penoscrotal incision was reopened and the left corporal cylinder was discovered ventral to the corpora at the penoscrotal junction at approximately the location of the original corporotomy. There was no thinning of the corpora or capsule to suggest erosion. The left corpora was sounded with brooks dilators and was found to seat nicely proximally and distally in the glans. The glans extent of the dilators was perfectly symmetric to the intact right cylinder consistent with adequate sizing. The wound was irrigated, and the cylinder was replaced. The device was cycled and found to be in good working condition. The corporal defect was closed with a combination of interrupted and running 2-0 Vicryl.

Conclusions: The complications of penile prosthetic surgery are well described in the literature. While rare, impending cylinder erosion or extrusion can be a devastating complication that can severely affect patients' quality of life. Risk factors for cylinder extrusion include aggressive dilation, corporal fibrosis, and chronic mechanical pressure from the cylinder. The literature reports a mean time to extrusion of ~8.5 years, with most occurring distally or laterally. In our case, the traumatic extrusion and subsequent dislocation of the cylinder occurred at the location of the prior corporotomy within a short postoperative interval. While the inciting event for the reopening of the corporotomy can be attributed to the patient's sexual encounter, the previously noted corporal fibrosis and failed implant attempt were likely contributing factors. To our knowledge, this is the only case of traumatic extrusion of a penile prosthetic.

OBSTRUCTIVE UROPATHY SECONDARY TO CHILDHOOD SCHISTOSOMIASIS INFECTION, A CASE REPORT

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(Presentation to be made by Dr. Colin L. Smith)

Objectives: Schistosomiasis is a trematode infection endemic to 78 countries worldwide, many of which the United States Military has sustained presence in, and has been identified by the World Health Organization as one of twenty neglected tropical diseases. Adult worms from the *Schistosoma haematobium* species reside in the bladder venous plexuses producing eggs that are subsequently excreted in the urine. Urogenital manifestations from this parasitic disease result from the host's inflammatory response; ranging from flu-like illness and hematuria in acute infection, to fibrosis, calcification, and obstructive uropathy with chronic infections. Here we discuss the presentation and functional evaluation of a 39-year-old male with distal ureteral and bladder calcifications attributed to parasitic egg deposition and granulomatous inflammation from a distant, untreated childhood schistosomiasis infection.

Methods: An otherwise healthy 39-year-old active duty male presented to the emergency department with severe lower abdominal pain associated with nausea and vomiting of a few hours duration. The patient was noted to be hemodynamically stable and afebrile, but in obvious distress secondary to his lower abdominal pain. Computed tomography was significant for areas of calcification in the bladder wall and distal ureters with mild hydroureter and hydronephrosis. Further urologic history acquisition revealed that, as a child, he frequently swam in a river in Sub-Saharan Africa known to be contaminated with schistosomes and experienced a self-resolving episode of hematuria at age 10.

Results: The presumptive diagnosis of genitourinary schistosomiasis was made based on the suggestive history and imaging findings in this case. Further evaluation with cystoscopy identified streaky calcifications under smooth mucosa, corresponding with the hyperdense areas on CT, along with minimal mobility of bilateral ureters. Given the location of calcification there was concern for obstructive uropathy. Functional evaluation with radioisotope renography surprisingly showed nonobstructive flow through the kidneys, ureters, and bladder. Metabolic urolith studies were performed to optimize the patient's risk of developing a stone which would undoubtedly be difficult to pass through his poorly compliant ureters which may have been responsible for his acute pain episodes.

Conclusions: This case sheds light on the complications, functional evaluation, and proposed management of chronic sequelae from genitourinary schistosomiasis. Our findings accentuate the importance of early detection and treatment to mitigate the development of complications from this neglected tropical disease.

Source of Funding: none

**NOVEL USE OF INTRAVESICAL N-ACETYLCYSTEINE IN RECURRENT
BLADDER STONE FORMERS OF THE EXSTROPHY-EPISPADIAS COMPLEX**

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(Presentation to be made by Dr. Victoria Maxon)

Objectives: N-Acetylcysteine (NAC) has a wide range of clinical applications. Most commonly, it is used to treat acetaminophen toxicity and as a mucolytic agent in the respiratory tract. It works by breaking disulfide bonds within the mucous, making the mucous less viscous and easier to clear. It has also been established to have anti-biofilm properties and has been safely used as an intravesical agent after bladder augmentation^{1,2}. Accumulation of mucous and urinary stasis in augmented bladders can lead to recurrent urinary tract infections (UTI) and bladder stones. Daily saline bladder irrigation remains the mainstay of treatment for recurrent stone formers, however many patients exhibit non-compliance with irrigation regimens. The authors present an initial case series on the use of daily intravesical n-acetylcysteine instillation to prevent bladder stones in patients with a history of bladder augmentation in the exstrophy-epispadias complex.

Materials and Methods: NAC instillation was implemented in 4 patients who were considered high-risk for recurrent bladder stone formation (defined as having >4 prior stone surgeries) or at high-risk for complications from repeat stone surgery (history of vesicocutaneous fistula or pre-existing CKD). Patients were instructed to dilute 10ml of 20% NAC with 50ml of NS and then instill the solution into the bladder and allow to dwell for 30-60 minutes twice daily. Patients continued their current irrigation schedule with normal saline in addition to the dwell time with NAC. Patients were followed with renal bladder ultrasound at 6-12 month intervals to determine stone recurrence.

Results: All four patients had a history of an ileal augmentation and continent urinary stoma. Three patients had a history of at least 4 prior stone surgeries, 2 patients had a history of vesicocutaneous fistula after cystolitholapaxy and the remaining patient had a history of a transplant kidney prior to starting NAC instillations. The four patients had an average of 0.92 stone surgeries per year (range 0.38-1.2) prior to starting NAC. The mean follow up was 25.9 months (range 12.4-41). Three patients have remained stone free on ultrasound. One patient had a recurrence of a 7mm bladder stone 6 months after a previous stone surgery and is awaiting treatment. No adverse reactions to NAC instillations have been reported.

Conclusions: NAC instillation may be useful as an adjunct to prevent bladder stone formation in high-risk stone formers. Further research will be needed to determine long-term efficacy.

Source of Funding: None

**RATES OF RETAINED URETERAL FRAGMENTS FOLLOWING MINI AND
ULTRA MINI PERCUTANEOUS NEPHROLITHOTOMY**

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(Presentation to be made by Muqsit Buchh)

Objectives: Percutaneous nephrolithotomy (PCNL) is the gold standard for treatment of large intrarenal stones. Advances in equipment and technique have allowed for progressively smaller access sheaths to treat kidney stones with less morbidity for patients with mini and ultra mini PCNL (mPCNL and UMP). Similar outcomes in selected patients have been demonstrated between different sized access sheaths for PCNL. The purpose of this study is to evaluate the rates of antegrade migration of ureteral fragments mPCNL and UMP.

Methods: This retrospective study included all identifiable patients undergoing PCNL with <24fr sheath between July of 2019 and September of 2022 at a single tertiary referral center for complex stone cases. Patients with incomplete follow-up records were excluded. All patients with close interval follow-up CT scans were re-read to evaluate for retained renal and ureteral fragments. Charts were reviewed for complications and return to the OR. The Fisher's exact and ANOVA tests were used to estimate the differences in outcomes between sheath size. All statistical analyses were performed using SAS 9.4.

Results: A total of 84 cases met inclusion for study. Antegrade migration rate was 7.2%. The ureteral stone free rate of mPCNL and UMP were 94.1% and 90% respectively, $p=0.879$. ANOVA analysis demonstrated no statistically significant difference when stratifying by sheath-size, 13 and 15 fr (10%), vs 17.5 (7.1%), vs. 22fr (3.6%) $p=0.751$.

Conclusions: mPCNL, and UMP are excellent options for the treatment of renal stones. The risk of antegrade ureteral fragment migration remains low despite smaller sheath size.

Source of Funding: None

**INCREASED OSCILLATION RATE IMPROVES MORCELLATION EFFICIENCY IN
HOLMIUM LASER ENUCLEATION OF THE PROSTATE**

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Slade*, RJ Caras, Deepak Agarwal*, Tim Large*, Marcelino Rivera*
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(Presenting author is Dr. Shelton)

Introduction and Objective: Tissue morcellation has become increasingly efficient, yet remains a rate limiting step in holmium enucleation of the prostate (HoLEP). Limited data exists on how the rate of oscillation by the morcellator blades affects morcellation efficiency (ME).

Methods: A retrospective review was performed of our HoLEP procedures performed by two surgeons from 7/1/2019 to 8/25/2022. All morcellation was performed with the Wolf Piranha device and enucleation was performed with Moses 2.0 technology. Surgeon 1 routinely uses 1500 oscillations/min (low rate) and Surgeon 2 uses a rate of 6000 oscillations/min (high rate). The primary endpoint was morcellation efficiency (grams/minute). Secondary endpoints include enucleation efficiency, mean tissue specimen weight, and preoperative prostate volume. The data was also subgrouped into small and large specimen weights (<150 gms and >150 gms) to delineate any differences based on amount of tissue.

Results: 894 HoLEPs were analyzed, 302 by Surgeon 1 and 592 by Surgeon 2. Surgeon 2 had larger preoperative prostate volumes (126 vs 101; $p<0.001$) and specimen tissue weights (86.0 vs 61.1; $p<0.001$). Morcellation time was longer in the low rate group (11.3 vs 6.1 min, $p<0.001$) and ME was lower in the low rate group (9.3 vs 12.1 g/min, $p<0.001$). The difference in ME was inversely proportional to specimen weight. When the data was subgrouped by specimen weight (<150 gms and >150 gms), there was a significant difference below 150 gms (9.3 vs 12.3; $p<0.001$) in ME, yet no significant difference in the large tissue group (8.8 vs 9.4; $p=0.42$).

Conclusion: Increased oscillation rate during morcellation leads to a decrease in morcellation time and increased morcellation efficiency during prostate enucleation. Future prospective studies will serve to evaluate this finding across a larger numbers of institutions, and evaluate ways to increase ME in large prostate cohorts (i.e. >150 gms).

Source of Funding: None

SARCOMATOID UROTHELIAL CARCINOMA FOUND DURING AN ANTERIOR URETHROPLASTY

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Eric C Umbreit, M.D.: San Antonio, TX
(Presentation to be made by: Dr. Lucien R. McBeth)

Objectives: Sarcomatoid urothelial carcinoma (SUC) of the urethra is a rare malignancy with only two cases reported in the literature. We describe the case of a patient who was diagnosed with SUC found during an excision and primary anastomosis urethroplasty for an obliterative anterior urethral stricture. The purpose of this presentation is to describe this uncommon malignancy and discuss our management of this patient.

Conclusions: SUC is a rare condition with two published case reports. Guidelines do not exist for its management. We add our findings to the body of literature. Our patient presented with obstructive lower urinary tract symptoms and was diagnosed with a urethral stricture. A cystoscopy and retrograde urethrogram showed an obliterative bulbar urethral stricture with urethral stones. A suprapubic tube was placed for bladder decompression. The patient underwent an excision and primary anastomotic urethroplasty. During the procedure, an obliterative one cm stricture was encountered and the spongiosal tissue was noted to be abnormal in appearance as is seen with spongiofibrosis. He was also noted to have significant trilobar prostatic hypertrophy and a severely trabeculated bladder. The remainder of the case was uncomplicated. His recovery was complicated by persistent urinary retention and has remained suprapubic tube dependent. His pathology results returned after second opinion showing spindle cell proliferation, consistent with SUC. Staging imaging showed local disease without evidence of metastasis. He began neoadjuvant gemcitabine and cisplatin. He was counseled on the recommendation for a cystoprostatectomy and urethrectomy versus bladder preservation with prostatectomy and urethrectomy. He preferred to undergo bladder sparing surgery. At the time of this abstract submission, the patient was completing neoadjuvant chemotherapy and is pending repeat staging imaging with a penile MRI and surgical planning.

Source of Funding: None

CASE REPORT OF VESICAL FUNGAL BEZOAR: DO'S AND DON'T OF
ENDOSCOPIC MANAGEMENT

Marilyn Jones, MD

Background: Vesical fungal balls or fungal bezoars are rare in clinical practice and most associated with pre-disposing factors such as immunocompromise, diabetes mellitus and chronic obstruction. [1] [2] Several techniques for the treatment have been described though generally focus on patients with ureteral obstruction and impending urosepsis.[3]

Case Description: This is the case of a 45-year-old male patient who underwent extensive excisional debridement with diverting loop colostomy due to Fournier's gangrene followed by skin grafting and prolonged hospitalization. Given worsening necrosis and dry gangrene of the patient's phallus, a suprapubic tube was placed for long-term bladder management. Intra-operatively there was noted posterior bladder wall sloughing versus possible fungal ball. As there was no ureteral involvement, hydronephrosis or systemic infection, no further management was initiated at that time. In the weeks following suprapubic tube placement, the patient began to experience intermittent obstruction of his catheter prompting attempts at operative management of the fungal ball. Given newly grafted skin spanning the abdomen and pelvis, endoscopic management was preferred, and several techniques were attempted to include use of the resectoscope, stone graspers and CyberWand.

Conclusion: We found that the resectoscope worked best for removal of the fungal ball tissue, but this was a meticulous and time-consuming process. Given the density of the necrotic tissue, the CyberWand was unable to piece-meal the fungal ball and did not provide enough suction to pull the adherent tissue from the bladder wall. Given the large size of the fungal bezoar, we were unable to clear the patient's bladder and ultimately, he was referred for open cystotomy. Though endoscopic management techniques have been described, this case demonstrates that they are not feasible for the treatment of large adherent fungal balls and we would recommend consideration of open management as primary treatment strategy in patient's with large and adherent fungal balls. [4] [2]

PAPER #69

ROBOT-ASSISTED RESECTION OF A RETROPERITONEAL SCHWANNOMA

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(Presentation to be made by Dr. Josiah Low)

Objectives: Schwannomas are benign nerve sheath neoplasms composed entirely of Schwann cells. While some are associated with a concomitant pathologic process, they predominantly present in sporadic and solitary fashion. Most are asymptomatic and incidentally found in the upper limbs, head, trunk, and flexor surfaces of the lower extremities. We present a case of rare retroperitoneal schwannoma that was resected successfully using a robot-assisted approach.

Case/methods/results: A 23-year-old male presented to the ER with one day of nausea and vomiting. CT demonstrated a para-aortic lesion measuring 1.5x1.5x1.7cm. Germ cell tumor was suspected given its location but serum tumor markers and scrotal ultrasound were unremarkable. Pathology from IR biopsy supported classification as a peripheral nerve sheath tumor, schwannoma favored. The patient initially elected surveillance; however, follow-up CT demonstrated interval growth to 1.6x1.6x1.8cm and he ultimately requested surgical excision. The patient underwent robot-assisted retroperitoneal exploration. The descending colon was mobilized and the retroperitoneum was exposed. The left ureter, gonadal vein and left common iliac artery were visualized. Dissection was carried towards the renal hilum along the lateral border of the aorta. A firm, smooth mass was encountered caudal to the hilum and completely excised alongside 11 benign lymph nodes. EBL was 10ml. The patient recovered well and was discharged the same day. Final pathology demonstrated cellular schwannoma, 2x2x2cm.

Conclusions: Retroperitoneal schwannomas are rare. Discovery is often incidental as ample retroperitoneal space allows for growth without compressive symptoms. Definitive treatment is surgical excision as radiotherapy and chemotherapy are ineffective. The size and location of this lesion allowed for robot-assisted excision to be performed without difficulty. Although they are overwhelmingly benign, rare reports exist of malignant transformation to neurofibrosarcoma. Continued growth can also cause local symptoms and complicate future resection. Post-operative surveillance imaging can be considered to monitor for recurrence or malignancy, especially if incomplete resection is suspected.

Source of Funding: None

**ADRENAL CYST PRESENTING WITH CLINICAL FEATURES OF A
PHEOCHROMOCYTOMA**

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Presentation to be made by Dr. Vladimir Mezhiritsky

Background: Benign adrenal cysts are uncommon variants of adrenal incidentalomas. When identified, most adrenal cysts are asymptomatic, which differentiates them from other functional adrenal lesions. There are various types of adrenal cysts, the most common being a benign endothelial cyst. Ultimately, evaluation and management are aimed at ruling out a functional adrenal mass and management of symptoms if needed. We present a unique case of an otherwise healthy male with a large incidental adrenal cyst, later identified as a benign endothelial cyst, who presented with classic symptoms of catecholamine excess.

Case: A healthy 30M presented to the ED with recurrent episodes of tachycardia, lightheadedness, chest tightness, and nausea following a large meal. Evaluation revealed a large adrenal cyst. The patient had a negative hormonal evaluation and ultimately decided to undergo surgical excision of the lesion. Pathology was consistent with a benign endothelial cyst and the patient's symptoms resolved after his post-operative recovery.

Discussion/Conclusions: Adrenal cysts are rare and generally asymptomatic. Typically, evaluation and management of an adrenal cystic mass follows the standard pathway for all adrenal masses. This evaluation includes contrast-enhanced cross-sectional imaging, hormonal studies, and possible surgical excision. Though cystic adrenal masses can be hormonally active, sequelae of chronic inflammatory processes, or even malignant, in this patient, a benign endothelial cyst seemingly caused symptoms of catecholamine excess mimicking a cystic pheochromocytoma. We suggest that given the size and mass effect on the adrenal medulla with gastric distention, this patient experienced transient increases in circulating catecholamines causing symptomatic episodes. This case report and brief review provides valuable insight into the evaluation and management of a unique clinical scenario.

Source of funding: None

**CANNULATION OF THE RENAL VEIN: AN UNCOMMON UROLOGIC
COMPLICATION OF THORACOSTOMY TUBE PLACEMENT**

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(Presentation to be made by Dr. Rahul Jayakrishnan)

Introduction: According to the Eastern Association for the Surgery of Trauma guidelines, consideration of drainage of traumatic hemothoraces via tube thoracostomy is standard of care. The percutaneous use of a small caliber pigtail catheter, as opposed to the use of a large caliber chest tube, has been shown to be effective in the drainage of hemothoraces with improved patient reported outcomes (1). Complications are typically categorized as insertional, positional, removal or infectious in nature. Insertional injuries can result in vascular or solid organ injury of the thorax or abdomen with reported rates as high as 15% (2).

Case Presentation: We present the case of a 59-year-old male who presented after a traumatic bicycle accident with subsequent evidence of a small left hemothorax on initial chest x-ray and CT imaging. After 24 hours of observation, repeat imaging showed expansion of the hemothorax resulting in the decision to percutaneously place a bedside pigtail catheter. After significant sanguineous output and the development of hemodynamic instability, an emergent chest CT revealed placement of the pigtail catheter into the left renal vein. The location of the catheter in the renal vein was further confirmed on by interventional radiology with a renal artery angiogram. The catheter was removed under fluoroscopic guidance, without the need for embolization, and the patient regained hemodynamic stability. The patient was then transferred to the surgical intensive care unit for further resuscitation.

Conclusion: Insertional complications for tube thoracostomies in the setting of hemothorax are rare. We describe the first case report of percutaneous placement of a pigtail catheter in the setting of left hemothorax into the left renal vein and the safe removal without need for embolization with interventional radiology.

Source of Funding: None

NON-TRAUMATIC TESTICULAR RUPTURE AS A SEQUELAE OF EPIDIDYMO-ORCHITIS

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Presentation to be made by Dr. Johnson

Introduction: Epididymo-orchitis in the adult population is routinely treated with antibiotics and typically responds well to management without additional complications. There have been only a handful of reported case in the literature of non-traumatic testicular rupture following epididymo-orchitis

Case Report: Here we present the case of a 66-year-old male with a past medical history significant for hypertension, hyperlipidemia, gastroesophageal reflux, and exercise-induced asthma who presented to the emergency department with a history of one week of right testicular swelling with associated nausea and vomiting. Patient was found to have a leukocytosis to 21.2 and a urine analysis notable for positive nitrites, leukocyte esterase, and > 50 WBC/HPF. He was also febrile on presentation. A scrotal ultrasound was completed which demonstrated right epididymo-orchitis and a complex right hydrocele. He was admitted to the hospital for treatment of epididymo-orchitis and was given doses of levofloxacin and rocephin in the emergency room but transitioned to oral levofloxacin 500mg every 24 hours for 10 days and was discharged home three days later. His urine culture from admission grew 100,000 CFU/mL *klebsiella pneumoniae*, appropriately sensitive to levofloxacin. He had a follow up ultrasound approximately two weeks following discharge which demonstrated “persistent right testicular enlargement and heterogenous echotexture without hyperemia may represent resolving orchitis”. He then re-presented to the emergency department approximately one month following his first visit with complaints of bleeding and pus drainage from his right testicle. A scrotal ultrasound demonstrated “right testicular rupture through the tunica albuginea, with testicular contents extending to the skin surface”. On physical exam the patient was noted to have extrusion of pink seminiferous tubules through an opening in the right hemiscrotum overlying the testicle. There was devitalized and necrotic tissue surrounding the area of extrusion and loss of the rugae of the scrotum. Due to these concerning findings, the patient was taken to the operating room and an ellipsoid incision was made around the devitalized tissue and large amounts of pus were expressed from within the right hemiscrotum. There were no definitive planes in the medial and inferior portions of the right hemiscrotum. The testicle appeared to be ruptured near the medial aspect with extrusion of seminiferous tubules and abscess material. Laterally, normal tunica albuginea, the remainder of the testicle, and spermatic cord were identified and ultimately the spermatic cord was ligated, and the small remaining portion of the testicle was removed. The edges of the wound were debrided until bleeding edges were noted. A drain was placed, and the patient was discharged home on post-operative day 2 and his drain was subsequently removed on post-operative day 5 when the patient was seen in clinic for a wound check. He was noted to have significantly improved swelling and no concerning findings on exam.

Conclusion: Here we present a case of non-traumatic testicular rupture secondary to epididymo-orchitis complicated by extrusion of the testicular contents through the scrotum on presentation. Our patient was managed with orchiectomy due to the abscess contents surrounding and involving the testicle.

INTERNATIONAL MISSION TRIP FOR RESIDENTS PROMOTES MILITARY READINESS: RESIDENT EXPERIENCE IN TEGUCIGALPA, HONDURAS

Leah E Williams M.D. Timothy Baumgartner MD: San Antonio, TX

(Presentation to be made by Dr. Leah Williams)

Background: North American residents have demonstrated increasing interest in exposure to international medicine. International rotations and mission trips can help physicians gain a better understanding of global medicine, epidemiology of disease, and disparities within global healthcare. Working within the healthcare system of developing nations helps physicians to operate with often more limited capabilities. International travel can help develop cross-cultural competency and understanding. This cross-cultural sensitivity is especially important for military physician readiness when working with international partners, allies, and in foreign nations. This readiness could be obtained through global health training and international trips or rotations.

Mission: Air Force staff Pediatric Urologist and an Army Urology Resident participated in a pediatric urology surgical mission trip to Hospital Escuela in Tegucigalpa, Honduras. Due to the lack of a pediatric urologist in Honduras, there is a significant volume of children who have untreated surgical congenital anomalies. While pediatric surgeons within the country are comfortable with more straightforward pathology, there is an increasing number of children with complex pathology who require surgical intervention. This nation currently relies on its international partners to provide urologic care to its pediatric patients.

One week of intensive surgery was performed at Hospital Escuela which provided multiple opportunities to see advanced pathology and practice complex reconstructive surgical skills. Surgical techniques were taught to local pediatric surgeons and pediatric surgery residents. Local surgeons demonstrated daily, how to provide quality care for patients in the setting of limited resources.

Local Impact: 11 surgeries performed in 4 days. Participated in complex case conferences and surgical morning reports. Reviewed pediatric urology lectures within their educational curriculum.

Educational Benefits: Residents were able to learn how to function optimally with limited resources, gained experience with operative pathology not seen frequently in the United States, exposure to a new culture, and established collaborative relationships with local counterparts.

Conclusion: International mission trips offer residents the opportunity to learn within an intense, high-volume environment which reinforces surgical skills and exposure to endemic pathology seldom seen in the United States. International training can prepare military physicians with the skills to work with limited resources and develop cross-cultural competencies that will serve them both in country and abroad.

PAPER #74

DIVERSITY, EQUITY, AND INCLUSION IN UROLITHIASIS CLINICAL TRIALS: REPRESENTATIVE ENROLLMENT BY RACE, ETHNICITY AND SEX

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(Presentation to be made by Dr. Amy Reed)

Objectives: To assess whether study populations in urolithiasis clinical trials are representative to the urolithiasis population, we sought to characterize trends in patient enrollment by race, ethnicity and sex.

Materials and Methods: PubMed was queried for urolithiasis US clinical trials published from 2000-2022. Trials were evaluated for reporting patient race, ethnicity and sex enrollment data. This was then compared to the stone prevalence reported by the National Health and Nutrition Examination Survey (NHANES) from 2015-2018. We calculated a representation quotient (RQ) to describe enrollment of patients and then stratified by overall enrollment, study type (surgical, dietary, medical or imaging), geographic location and funding source.

Results: Of 182 eligible trials, 40 (21.9%) were included for analysis after excluding trials that did not report race, ethnicity or sex of enrolled patients. Among eligible studies, Hispanic and mixed-race patients are underrepresented while Black patients are overrepresented (RQ 0.46 and 0.34 versus 1.84, respectively; $p=.02$). When stratified by study type, dietary intervention trials had the least proportional enrollment by race and ethnicity while imaging trials had the most proportional enrollment (mean RQ difference -0.66 versus -0.38, respectively). Of the 77 surgical intervention trials, only five trials reported enrollment data (6.5%). When stratified by funding source, industry sponsored trials had more proportional enrollment by race and ethnicity compared to academic and government funded trials (mean RQ difference -0.58 versus -0.86 and -0.63, respectively). When stratified by AUA section, trials completed in Western Section reported more proportional race and ethnicity enrollment compared to studies completed in the Southeast Section and Northeast Section (mean RQ difference -0.51 v -0.99 and -0.57, respectively). Male and female patients are proportionally represented (RQ 1.0).

Conclusions: Only 1 in 4 published US urolithiasis trials report race or ethnicity enrollment. Surgical intervention trials have the lowest rates of reported enrollment of Hispanic, Asian and mixed-race patients. Almost all trials report binary sex. Investigators should work to improve enrollment of more representative cohorts, increase reporting of enrollment data, and utilize centralized public trial databases.

Funding: None.

PAPER #75

ANALYSIS OF 24-HOUR URINE STUDIES IN HISPANIC STONE FORMERS

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(Presentation to be made by Dr. David Dalton)

Introduction/Objective

24-hour urine testing provides valuable feedback on risk factors affecting kidney stone formers. This study focused on variations in 24-hour urine study parameters in Hispanic patients to identify unique risk factors among this patient population to support preventive strategies and tailored clinical interventions.

Methods

A retrospective analysis of self-identified Hispanic patients was performed at two separate hospital systems within a single academic institution. Patients with 24-hour urine testing were included in the study. An age and sex matched non-Hispanic patient cohort was used for comparison. 24-hour urine data variables analyzed included: volume, calcium, chloride, citric acid, creatinine, magnesium, oxalate, urine pH, phosphorus, potassium, sodium, and uric acid. Two-tailed T-tests were performed to analyze differences between these groups.

Results

A total of 118 patients were included in this study, 59 Hispanic and 59 were non-Hispanic who were sex and age matched in comparison to the Hispanic group. Significant differences in 24-hour urine calcium and uric acid levels were identified ($P < 0.05$). No significant difference in urine volume, chloride citric acid, creatinine, magnesium, oxalate, urine pH, phosphorus, potassium, or sodium.

Conclusion

Hispanic patients in this cohort demonstrated statistically significant elevations in 24-hour urine calcium and uric acid levels when compared to an age and sex matched non-Hispanic population. These differences may be due to factors such as dietary patterns, genetic predisposition, and metabolic abnormalities; however, further study is needed to investigate these differences.

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Conflict of Interest: Dr. Rivera is a consultant for Boston Scientific and Cook Medical. Dr. Slade is a consultant for Cook Medical.

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