72nd ANNUAL JAMES C. KIMBROUGH UROLOGICAL SEMINAR

2026 PROGRAM BOOK

January, 28 - February 1, 2026
Hilton Hotel
Long Beach, California

Society of Government Service Urologists

2026
PROGRAM BOOK

www.govurology.org

Scientific Program Directors:

LTC Matthew Kasprenski, MC, USA
LTC Thomas Gerald, MC, USA

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.) Bradley Schwartz, MC, USA

Dear SGSU Members,

Welcome to Long Beach California and the 72nd Annual Kimbrough Seminar. It is a distinct honor to serve as the President of the Society of Government Service Urologists. Dr. Matthew Kasprenski and Dr. Thomas Gerald 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.) Bradley Schwartz, MC, USA

Welcome from the Program Chairs

 

LTC Matthew Kasprenski, MC, USA
LTC Thomas Gerald, MC, USN

Dear SGSU Members,

A warm welcome all to the 72nd Annual Society of Government Service Urologists, James C. Kimbrough Urological Seminar in Long Beach, California. 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, Military Preparations & Leadership Course, and much more for a total of 18.75 hours of CME.

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, Thursday evening outing to the Queen Mary (optional event) and on Friday evening, will feature the traditional GU Bowl. Saturday late afternoon will feature our Poster Session with a Reception and The Littrell Awards Ceremony, after enjoy a free evening to explore the town.

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

Best Regards,

LTC Matthew Kasprenski, MC, USA
LTC Thomas Gerald, MC, USA

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SGSU LEADERSHIP

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DeSantis Management Group
1950 Old Tustin Avenue, Santa Ana, CA 92705
T: 714.550.9155 / E: info@sgsu.org
www.sgsu.org

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 Washington DC at the 2026 AUA Annual Meeting

USAV Annual Meeting

Sunday, May 17, 2026

8:00 am- 12:00 pm

Marriott Marquis Hotel

(includes meeting sessions & exhibits)

HISTORY OF THE SGSU

In the early years of the annual military urology seminar, which was named after James Kimbrough in 1957, the standard practice for decades was that the SGSU leader for that particular year was the chairman of Urology at the sponsoring military institution for the upcoming Kimbrough meeting. This individual, who functioned as "the President", was called the "Course Director", although occasionally there were "Co-Course Directors". This tradition continued until approximately 2010. It was around this time that the broader military leadership became concerned about the public appearance of military individuals soliciting from sponsoring corporations, to fund scientific meetings. Ultimately the decision was made to change the structure of the SGSU leadership, creating a Board of Directors (BOD), that was composed entirely of civilian, rather than military, urologists; although usually retired military. The SGSU BOD made the decision to separate the military "Course Director" away from leading the formal activities of the SGSU board. At this point, the elections included a military course director and a civilian (typically non-active duty military) President. The decision was made to place civilians within the formal SGSU leadership to minimize the exposure of the military urologists to potential financial conflicts of interest. When the Urological Society for American Veterans was brought into the SGSU as an affiliate organization in 2017, then USAV VA representatives were also allowed to be included in consideration for the Course Director(s) and President positions. Thus, the current SGSU BOD is able to execute the business and financial considerations of the organization with full transparency. In the earlier years of the SGSU, commonly the person who signed the tax return was the treasurer, however it could have been the incoming course director, or another member of the SGSU Board of Directors, but not necessarily the course director. During the years the SGSU was managed by Tibby Stevenson, and to a lesser degree by Preston Littrell, the organizational processes were less rigorous than the current ones, especially related to financial matters, like the signature on the annual IRS filings. Preston Littrell began working with the SGSU in 1961 and attended more than 40 Kimbrough Urological Seminars. In 1992 he became the Administrator for the SGSU and served in that capacity until 2009, when the Weiser Group took over the administration. The DeSantis Management Group replaced the Weiser Group in 2014 and continue to serve in that capacity as of 2025.

Of note- Meeting #38 in 1990 was cancelled at the last minute due to the mobilization for Desert Storm. Meeting #42 was run by Dr James Auman in Charleston SC in January 1995 (as it was supposed to be the 1994 meeting, but had to be delayed due to a scheduling challenge with the hotel). A second meeting was held in 1995 as meeting #43, run by Dr David McLeod, and was held in Washington DC in November 1995. The November 2003 meeting was moved to January of 2004, so there was not a meeting in 2003. After this Kimbrough meeting time change, it was decided to always have the meeting in early winter to reduce any potential scheduling conflicts with AUA section meetings which typically are in the fall, and with the main AUA meeting always being in the spring.

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 Chirugie 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	Cancelled (Desert Shield/Storm)	
1991	CPT Wilfred S. Kearse, 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
2024	Capt Clinton Yeaman, MD, MS, MC, USAF	University of Virginia Health System
2025	CPT Daniel Bender, MC, USA	Madigan Army 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
2024	Col (Ret.) Judd Moul, MC, USA	Duke University, Durham, NC
2025	CAPT (Ret.) Timothy Donahue, MC, USN	Mem. Sloan Kettering Cancer Ctr

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
2024 COL (Ret.) Bradley Schwartz, MC, USA
2025 COL (Ret.) Robert Dean, MC, USA

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”.

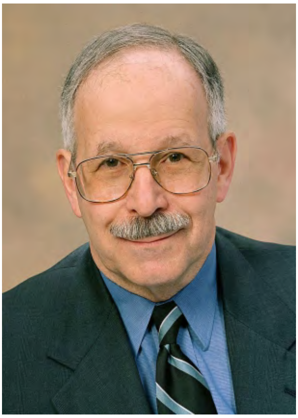
PREVIOUS AWARD WINNERS

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
2024	CAPT Erik Grossgold, MC, USN

(This award has been shuttered)

COL (RET.) MARTIN L. DRESNER, MD

1940-2020



Marty, Dr. Jazz, was a lifelong active member of our society and had a deep passion for resident education. He served on the SGSU Board of Directors for many years, was bestowed as an Honorary Member in 2016 and was a fixture as judge for the Annual Kimbrough Seminar Resident Competition. Dr. Dresner served as the President of the Western Section AUA and on the American College of Surgeons Board of Governors, received the AUA Presidential Citation, and was a tireless advocate for military medicine, always promoting the talent and caliber of military urologists. Marty was an outstanding clinician and surgeon; he enjoyed teaching and mentoring many of our members while on active duty and after his transition to civilian practice. Marty loved his family (and considered us part of his family), music, tennis and enforcing the rules of proper grammar. Dr. Dresner retired from the Army as Colonel, was a decorated Vietnam War Veteran having served with the First Air Cavalry Division, received the Legion of Merit, Bronze Star, and many other distinguished awards. Marty was proud to have introduced the DeSantis family management to our Society. His presence and impact will forever be felt and appreciated at all future Kimbrough Seminars.

MARTIN DRESNER GRAND PRIZE POSTER AWARD PREVIOUS WINNERS

In 2024, the SGSU established this award to be given in memory of Dr. Dresner for his love to support resident education and research, and for his dedicated service to the SGSU.

2024 Max Shelton, MD
2025 Victoria Maxon, MC, USA

HONORARY LIFETIME MEMBERSHIP

Presented 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
2024	COL (Ret.) Robert Dean, MC, USA
2025	COL (Ret) Timothy Brand, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

#	YEAR	PLACE/COURSE DIRECTORS
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	PLACE/COURSE DIRECTORS
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, NRMC, 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 President: CDR Elliott L. Cohen, MC, USPHS
31	1983	Letterman Army Medical Center COL Robert E. Agee, MC, USA President: COL Mauro P. Gangsai, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	COURSE DIRECTOR(S) / PRESIDENT
32	1984	Naval Hospital, Oakland, CA CDR George J. Gavrell, MC, USN President: CDR Michael P. McCarthy, MC, USN
33	1985	Madigan Army Medical Center COL William D. Belville, MC, USA President: Lt.Col. Donald E. Novicki, MC, USAF
34	1986	Wilford Hall USAF Medical Center COL Alvin L. Sago, USAF, MC LTC John D. Maldazys, MC, USAF President: COL C.R. Spence, MC, USA
35	1987	Walter Reed Army Medical Center/USUHS COL David G. McLeod, MC, USA LTC Steven J. Skoog, MC, USA President: COL Robert E. Agee, MC, USA
36	1988	Naval Hospital Portsmouth CAPT Gordon MacDonald, MC, USA President: COL William D. Belville, MC, USA
37	1989	Brooke Army Medical Center COL Francisco R. Rodriguez, MC, USA President: COL Alvin L. Sago, MC, UCSF
38	1990	Fitzsimons Army Medical Center COL Michael J. Raife, MC, USA President: COL David G. McLeod, MC, USA (Meeting cancelled due to Desert Storm)
39	1991	National Naval Medical Center-Bethesda CAPT Kevin J. O'Connell, MC, USN LCDR Harold A. Frazier, II, MC, USN President: COL John N. Wetlaufer, MC, USA
40	1992	Madigan Army Medical Center Four Seasons Olympic Hotel, Seattle, WA COL John N. Wettlaufer, MC, USA President: CAPT John P. Sands, MC, USN
41	1993	Naval Medical Center San Diego Bahia Hotel, San Diego, CA CAPT John P. Sands, MC, USN President: CAPT James R. Auman, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	COURSE DIRECTOR(S) / PRESIDENT
42	1994	Naval Medical Center Portsmouth Omni at Charleston Place, Charleston, SC CAPT James R. Auman, MC, USN President: COL David G. McLeod, MC, USA
43	1995	Walter Reed Army Medical Center/USUHS L'Enfant Plaza, Washtington, DC COL David G. McLeod, MC, USA LTC Pierce B. Irby, MC, USA President:MAJ Steven C. Lynch, MC, USAF
44	1996	Wilford Hall USAF Medical Center Scottsdale Plaza Hotel, Scottsdale, AZ MAJ Steven C. Lynch, MC, USAF MAJ Edmund S. Sabanegh, MC, USAF President: COL George E. Deshon, MC, USA
45	1997	Tripler Army Medical Center The Fairmont Hotel, San Francisco, CA COL George E. Deshon, MC, USA President: CAPT P.J. Christenson, MC, USN
46	1998	National Naval Medical Center-Bethesda Ft. Magrudder Inn, Williamsburg, VA CAPT Paul J. Christenson, MC, USN CDR Harold A. Frazier, II, MC, USN President: LTC Thomas A. Rozanski, MC, USA
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 President: COL (Ret.) Ian M. Thompson, 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 President: LTC(P) Raymond A. Costabile, MC, USA
49	2001	Madigan Army Medical Center Four Seasons Olympic Hotel, Seattle, WA LTC(P) Raymond A. Costabile, MC, USA President: COL Dennis S. Peppas, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	COURSE DIRECTOR(S)/PRESIDENT
50	2002	Walter Reed Army Medical Center Crystal City Marriott Hotel, Arlington, VA President: Lt.Col (Sel.) Edith D. Canaby-Hagino, MC, USAF
	2003	No Meeting President: Lt.Col (Sel.) Edith D. Canaby-Hagino, MC, USAF
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 President: COL R.S. Sutherland, MC, USA
52	2005	Tripler Army Medical Center Sheraton Waikiki Hotel, Honolulu, HI COL Ronald S. Sutherland, MC, USA President: CPT Leo Kusuda, MC, USN
53	2006	Naval Medical Center Portsmouth & Eastern Virginia Medical School Savannah Marriott Riverfront, Savannah, GA CAPT Leo Kusuda, MC, USN Gerald H. Jordan, MD President: COL Allen F. Morey, MC, USA
54	2007	Brooke Army Medical Center Westin Galleria, Houston, TX LTC Douglas W. Soderdahl, MC, USA COL Allen F. Morey, MC, USA President: CDR James L. Roberts, MC, USN
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 President: COL Douglas E. Soderdahl, MC, USA
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 President: MAJ Steven C. Lynch, MC, USAF

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	COURSE DIRECTOR(S)/PRESIDENT
57	2010	Wilford Hall Medical Center Westin Hotel, San Antonio, TX LT COL Kyle J. Weld, MC, USAF President: MAJ (Ret) Steven C. Lynch, MC, USAF
58	2011	Madigan Army Medical Center Seattle Sheraton, Seattle, WA MAJ Timothy C. Brand, MC, USA President: CPT (Ret) James L. Roberts, MC, USN
59	2012	Naval Medical Center Portsmouth Charleston Marriott, Charleston, SC CAPT Paul D. McAdams, MD, FACS President: CAPT (Ret) James R. Auman, MC, USN
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 President: COL (Ret) Richard S. Stack, MC, USA
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 President: CAPT (Ret) Christopher J. Kane, 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 President: CAPT (Ret) Brian K. Auge, MC, USN
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 President: CAPT (Ret) Thomas A. Rozanski, MC, USA
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 President: CAPT (Ret) Harold (Hal) A. Frazier, II, MC, USN

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	COURSE DIRECTOR(S)/PRESIDENT
65	2018	Walter Reed National Military Medical Center The Scottsdale Resort at McCormick Ranch, Scottsdale, Arizona COL Robert C. Dean, MC, USA President: CAPT (Ret) Timothy F. Donahue, MC, USN
66	2019	Tripler Army Medical Center Sheraton Kona Hotel, Kona, Hawaii LTC Joseph Sterbis, MC, USA LTC John Musser, MC, USA President: COL (Ret) Gregory P. Thiault, 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 President: Debora Moore, MD
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 President: COL (Ret.) Robert Dean, MC, USA
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 President: COL (Ret.) Robert Dean, MC, USA
69	2023	Madigan Army Medical Center, Tacoma, WA El Conquistador Hilton, Tucson, AZ LTC Ryan Speir, MC, USA, LTC RJ Caras, MC, USA President: COL (Ret.) Timothy Brand, MC, USA

PREVIOUS JAMES C. KIMBROUGH SEMINARS

NUMBER	YEAR	COURSE DIRECTOR(S)/PRESIDENT
70	2024	JBSA Ft Sam Houston, San Antonio, TX Hilton Norfolk The Main, Norfolk, VA Col Timothy Baumgartner, MC, USAF Col Necia Pope, MC, USAF Col Christopher Allam, MC, USAF President: COL (Ret.) Timothy Phillips, MC, USAF
71	2025	Naval Medical Center San Diego / USAV The Peabody Hotel, Memphis, TN CDR Jonathan Berger, MC, USN LCDR Alexander Doudt, MC, USN Robert Grubb, III, MD (USAV) President: CAPT (Ret.) Jeffrey Jones, MC, USNR
72	2026	Tripler Army Medical Center Hilton Hotel, Long Beach, CA LTC Matthew Kasprenski, MC, USA LTC Thomas Gerald, MC, USA President: COL (Ret.) Bradley Schwartz, MC, USA

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, , Pediatric Urology, Stones, Voiding Dysfunction, Reconstruction, Oncology/Stone Disease, Female Pelvic Medicine, USAV Program, Leadership/ Military Preparedness & Leadership. In addition, the program will include the traditional Resident Research Competition, Case Reports, 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: 4:00 PM - 6:00 PM

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

CONTINUING MEDICAL EDUCATION

2026 Society of Government Service Urologists
72nd Annual Meeting, January 28 - February 1, 2026, Long Beach, CA

Acknowledgement of Financial Commercial Support
No financial commercial support was received for this educational activity.

Acknowledgement of In-Kind Commercial Support
No in-kind commercial support was received for this educational activity.

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

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

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.

Physicians (ACCME) Credit Designation
Amedco LLC designates this live activity for a maximum of 18.75 *AMA PRA Category 1 Credits*™ for physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Objectives - After Attending This Program You Should Be Able To:
1. Critique and implement new therapies in the management of pelvic reconstructive surgery.
2. Review and discuss updates in sexual medicine including; urinary problems, sexual dysfunction, testosterone therapy.
3. Evaluate the automation of robotic skills assessment using artificial intelligence.

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.

Roger Dmochowski: Blue Wind: Consultant
Andrew Hung: Intuitive Surgical: Consultant / Teleflex: Consultant
John Leppert: Telix: Scientific/Medical Advisory Board Member
Faysal Yafi - Coloplast: Scientific/Medical Advisory Board Member / Vertica: Research Grant Site Principal Investigator

CONTINUING MEDICAL EDUCATION

For CME Credit:

1. Submit daily evaluations
2. After meeting, print your certificate

1. Complete your daily evaluations electronically

Go to >> govurology.org

Click on >> 2026 Daily Evaluations

2. Print Your CME Certificate

Go to >> www.govurology.org

Click on >> Print 2026 CME Certificate

Please print all pages of your certificate for your record.
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 28

TIME	EVENT	ROOM
2:00 PM - 6:00 PM	Registration	Int'l Ballrm Foyer
4:00 PM - 6:00 PM	Slide Preview	Caribbean Room
2:00 PM - 4:00 PM	Board of Director's Mtg.	Atlantic Room
2:00 PM - 6:00 PM	Exhibits Set Up	Int'l Ballroom I/II
6:30 PM - 8:30 PM	Welcome Reception	Catalina Room

THURSDAY, JANUARY 29

TIME	EVENT	ROOM
7:00 AM - 2:40 PM	Exhibits Open	Int'l Bllrm / Promenade
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 4:30 PM	Registration	Int'l Ballrm Foyer
7:00 AM - 5:00 PM	Slide Preview	Caribbean Room
8:15 AM - 8:40 AM	Opening Ceremonies	International Ballroom
8:40 AM - 8:50 AM	AUA Keynote Address	International Ballroom
8:50 AM - 9:00 AM	Group Picture	International Ballroom
9:00 AM - 9:20 AM	Resident Competition 1	International Ballroom
9:20 AM - 9:40 AM	Resident Competition 2	InternationalBallroom
9:40 AM - 10:15 AM	Resident Competition 3	International Ballroom
10:15 AM - 11:00 AM	Network/Refreshmt. Break	Exhibits/Expo Lab Area
11:00 AM - 11:20 AM	Resident Competition 4	International Ballroom
11:20 AM - 12:00 PM	Educational Symposium	International Ballroom
12:00 PM - 1:40 PM	Manthos Lunch Program	International Ballroom
12:00 PM - 1:40 PM	Lunch in Exhibits Area	Exhibits/Expo Lab Area
1:40 PM - 2:10 PM	Resident Competition 5	International Ballroom

PROGRAM-AT-A-GLANCE

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

THURSDAY, JANUARY 29 (cont.)

TIME	EVENT	ROOM
2:10 PM - 2:40 PM	Educational Program	International Ballroom
2:45 PM - 3:30 PM	Resident Competition 6	International Ballroom
3:30 PM - 5:30 PM	USAV Program	International Ballroom
5:30 PM	Queen Mary Event	Optional Event

FRIDAY, JANUARY 30

TIME	EVENT	ROOM
7:00 AM - 2:00 PM	Exhibits Open	Exhibits/Expo Lab Area
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 3:00 PM	Registration	Int'l Ballrm Foyer
7:00 AM - 4:00 PM	Slide Preview	Caribbean Room
8:15 AM - 9:20 AM	Sexual Medicine Part 1	International Ballroom
9:20 AM - 10:00 AM	Educational Symposium	International Ballroom
10:00 AM - 11:15 AM	Network/Refreshmt. Break	Exhibits/Expo Lab Area
11:15 AM - 11:55 AM	Sexual Medicine Part2	International Ballroom
12:00 PM - 1:15 PM	Symposium Lunch	International Ballroom
1:20 PM - 1:45 PM	FPRMS	International Ballroom
1:45 PM - 2:30 PM	Reconstruction	International Ballroom
2:35 PM - 3:00 PM	Video Session	International Ballroom
3:00 PM - 3:30 PM	AF Urology Readiness	International Ballroom
5:00 PM - 5:45 PM	GU Bowl Tailgate Party	Int'l Bllrm Promenade
5:45 PM - 6:30 PM	GU Bowl	International Ballroom

PROGRAM-AT-A-GLANCE

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

SATURDAY, JANUARY 31

TIME	EVENT	ROOM
7:00 AM - 5:00 PM	Registration	Int'l Ballrm Foyer
7:00 AM - 5:00 PM	Slide Preview	Caribbean Room
7:15 AM - 2:00 PM	Exhibits Open	Exhibits/Expo Lab Area
7:15 AM - 8:30 AM	Networking Breakfast	Exhibits/Expo Lab Area
8:15 AM - 9:15 AM	Military Updates	International Ballroom
9:15 AM - 9:45 AM	Pediatric Urology	International Ballroom
9:45 AM - 10:15 AM	Transplant Surgery	International Ballroom
10:15 AM - 11:15 AM	Network/Refreshmt. Break	Exhibits/Expo Lab Area
11:15 AM - 12:00 PM	Urology Leadership	International Ballroom
12:00 PM - 1:15 PM	Lunch Symposium	International Ballroom
1:20 PM - 2:25 PM	SGSU Business Meeting	International Ballroom
2:30 PM - 3:00 PM	Leadership	International Ballroom
3:00 PM - 3:20 PM	Case Reports 1	International Ballroom
3:20 PM - 3:40 PM	Case Reports 2	International Ballroom
3:40 PM - 4:40 PM	Educational Symposium	International Ballroom
4:40 PM - 5:30 PM	Posters/Awards/Reception	International Ballroom

SUNDAY, FEBRUARY 1

TIME	EVENT	ROOM
7:00 AM - 9:00 AM	Registration	Int'l Ballrm Foyer
7:00 AM - 8:00 AM	Hasta La Vista Breakfast	International Ballroom
7:10 AM - 7:30 AM	Meeting Highlights	InternationalBallroom
7:30 AM - 10:00 AM	Mock Oral Boards	Pacific Room I/II

INDEX OF PARTICIPANTS

INVITED SPEAKERS

Tony Abraham, DO, MPA
Chief of Nuclear Medicine & Theranostics, New York Imaging Specialists.

Major General John Borling (USAF-ret)
Honored Manthos Speaker

Karim Chamie, MD
Associate Professor of Urology, UCLA Health

Timothy Daskivich, MD
Urologic Oncologist & Director, Health Services, Cedars-Sinai Urology

Paul Dato, MD
Director, Cancer Center of Excellence, Unio Health, San Diego, CA

Jose De La Cerda, MD
Urology San Antonio

Roger Dmochowski, MD
Associate Surgeon in Chief, Vanderbilt University Medical Center

Ryan Forrey, PharmD, MS, BCSCP, FASHP
Associate Director, Market Development and Training for the hazardous drug solutions platform at BD

Stephen Freedland, MD
Director, Center for Integrated Research in Cancer/Lifestyle; Associate Director for Training and Education,Samuel Oschin Comp. Cancer Institute, Cedars Sinai

Sue Goldstein, CCRC, CSE, IF
Past President - ISSWSH, AASECT Certified Sexuality Educator, San Diego Sexual Medicine

Irwin Goldstein, MD, IF
Past President - ISSWSH, San Diego Sexual Medicine

Christopher Gonzalez, MD
President of GURS, Department Chair, Urology, Loyola Medicine, Maywood, IL

Andrew Hung, MD
Surgeon Scientist, Cedars Sinai Urology

John Leppert, MD
Professor of Urology, Stanford Univ.

Jessica Lusche, RN, BSN
Regional Business Manager, Gov. Accounts, BD

Nima Nassiri, MD
Transplant Surgery/Urology, UCLA Health

Yaw Nyame, MD, MS, MBA
University of Washington Urolgy

Lane S. Palmer, MD,
AUA President (presentation by video)

Jeffrey Proctor, MD (US Navy LCMDR, vet.), Georgia Urology

Ronald Sutherland, MD
Hawaii Pacific Health

Dan Wiener, MD, (US Army MJR, vet)
Boston VA Chief of Thoracic Surgery, Mesothelioma Veterans Center & Assistant Professor of Surgery, Harvard Med. School

Faysal A. Yafi , MD
Secretary of SMSNA, Medical Director, Men’s Health Program, UCI Urology

INDEX OF PARTICIPANTS

EXHIBITOR ACTIVITIES

Visit the Expo Lab / Exhibitors

Located in the International Ballroom

Join us in the The ExpoLAB for a mix of discovery, opportunity, lively network breaks, and good cheer!

EXPO LAB SCHEDULE

Thursday, Jan. 29:

Hours: 7:00am - 2:40pm

Network Breakfast: 7:00am
Refreshment Break: 10:15am
& "Prize Card" Drawings
Lunch in Exhibits Room: 12:00pm

Friday, Jan. 30:

Hours: 7:00am - 2:00pm

Network Breakfast: 7:00am
Refreshment Break: 10:00am
& "Prize Card" Drawings

Saturday, Jan. 31:

Hours: 7:15am - 2:00pm

Network Breakfast: 7:15am
Refreshment Break: 10:15am
& "Prize Card" Drawings

Visit the Expo Lab to complete your Prize Card to be eligible to win prizes and

Engage with the exhibitors to receive a Scratcher Card.

EXHIBITORS

We thank our commercial exhibitors for their support of the Kimbrough Annual Meeting. Please be sure to visit them during the meeting.

Alnylam
AMBU
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Boston Scientific
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Cook Medical
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Del Medical
Dornier MedTech
Exact Imaging
Fellow Health
Immunity Bio
Johnson & Johnson
KARL STORZ Endoscopy
Lantheus
Mdxhealth
Merck
Novartis
Pfizer Inc.
Photocure
Sagent Urology
Sonablate
Sumitomo Pharma America, Inc.
Telix Pharmaceuticals
Uro-1, Inc.
UroGen
UroMedica
UrologyLocums.com

Please visit and Thank our Exhibitors in the Expo Lab
and see what's new and exciting.
Win prizes! Say "Hello".

THANK YOU SUPPORTERS

The SGSU thanks the following companies for their outstanding support!

THANK YOU SUPPORTERS

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Johnson & Johnson
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BD
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Telix Pharmaceuticals
Uro-1

Emerald

Sexual Medicine Society of North America
Society of Genitourinary Reconstructive Surgeons
Int'l Society for the Study of Women's Sexual Health
American Urological Association
Boston Scientific

VIP Exhibitor Supporters

Alnylam
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WEDNESDAY, JANUARY 28

Outline of Scientific Program

72nd Kimbrough

Annual Seminar * Long Beach Hilton Hotel, California

TIME	EVENT	ROOM
2:00 PM - 6:00 PM	Registration	Int'l Ballrm Foyer
4:00 PM - 6:00 PM	Slide Preview	Caribbean Room
2:00 PM - 4:00 PM	Board of Director's Mtg.	Pacific Room
2:00 PM - 6:00 PM	Exhibits Set Up	Int'l Ballroom I/II
6:30 PM - 8:30 PM	Welcome Reception	Catalina Room

Wed., Jan. 28 - 6:30pm - 8:30pm
Catalina Room

Welcome to the 72nd Kimbrough Meeting! Join friends & colleagues while enjoying food stations, hosted libations and fun vibes.

Dress is cocktail attire.

Bring your Green Drink Tickets

BADGE & TICKET REQUIRED

THURSDAY, JANUARY 29

Outline of Scientific Program

72nd Kimbrough

Annual Seminar * Long Beach Hilton Hotel, California

TIME	EVENT	ROOM
7:00 AM - 2:40 PM	Exhibits Open	Int'l Bllrm / Promenade
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 4:30 PM	Registration	Ballroom Promenade
7:00 AM - 5:00 PM	Slide Preview	Caribbean Room
8:15 AM - 8:40 AM	Opening Ceremonies	International Ballroom
8:40 AM - 8:50 AM	AUA Keynote Address	International Ballroom
8:50 AM - 9:00 AM	Group Picture	International Ballroom
9:00 AM - 9:20 AM	Resident Competition 1	International Ballroom
9:20 AM - 9:40 AM	Resident Competition 2	InternationalBallroom
9:40 AM - 10:15 AM	Resident Competition 3	International Ballroom
10:15 AM - 11:00 AM	Network/Refreshmt. Break	Exhibits/Expo Lab Area
11:00 AM - 11:20 AM	Resident Competition 4	International Ballroom
11:20 AM - 12:00 PM	Educational Symposium	International Ballroom
12:00 PM - 1:40 PM	Manthos Lunch Program	International Ballroom
12:00 PM - 1:40 PM	Lunch in Exhibits Area	Exhibits/Expo Lab Area
1:40 PM - 2:10 PM	Resident Competition 5	International Ballroom
2:10 PM - 2:45 PM	Educational Symposium	International Ballroom
2:45 PM - 3:30 PM	Resident Competition 6	International Ballroom
3:30 PM - 5:30 PM	USAV Program	International Ballroom
5:30 PM	Queen Mary Event	Optional Event

Good Morning

7:00 am

Rise & Shine

Network Breakfast in the Expo Lab

Bring your **PRIZE CARD**

OPENING CEREMONIES

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

8:15AM - 8:30AM **Welcome & Announcements**
Program Chairmen: LTC Matthew Kasprenski, MC, USA; LTC Thomas Gerald, MC, USA
President: COL (Ret.) Bradley Schwartz, MC, USA

8:30AM - 8:40AM **National Anthem**

1. **8:40 AM - 8:50 AM**

AUA Keynote Address

(Video Presentation)

Lane S. Palmer, MD

President, American Urological Association

8:50AM **Stay for Group Picture (All)**

RESIDENTS COMPETITION 1
Bladder / Urethra

9:00 AM - 9:20 AM - International Ballroom

Moderators: MAJ Felicia Balzano, MC, USA

(Papers are seven minutes)

Resident Competition 1-6 Judges:
John Barry, MD, Harold (Hal) Frazier, II, MD, Joseph Clark, MD

2 **9:00AM LT Paolo Rigo, MC, USN**
The Effect of Pudenal Nerve Blocks On Acute Pain Reduction After Urethroplasty.

3 **9:07AM LT Caitlin Cooley, MC, USN**
Ischemic Priapism After IPP Placement.

9:14AM Discussion (6 minutes) / 9:20AM End of Session

RESIDENTS COMPETITION 2
Incontinence

9:20 AM - 9:40 AM - International Ballroom

Moderators:
Sue W. Goldstein, CCRC, CSE, IF / Irwin Goldstein, MD, IF,
MAJ Felicia Balzano, MC, USA

(Papers are seven minutes)

4 **9:20AM CPT Evalyn George, MC, USA**
Development Of A Novel Natural Orifice Thermoregulatory Device For The Treatment Of Chronic Pelvic Pain.

5 **9:27AM CPT Alexis Eastburn, MC, USA**
Lower Urinary Tract Symptoms and Pelvic Disorders in Female Military Servicemembers.

9:34AM Discussion (6 minutes) / 9:40AM End of Session

RESIDENTS COMPETITION 3

Stones

9:40 AM - 10:15 AM - International Ballroom

Moderators:
LTC Ronald Caras, MC, USA

(Papers are seven minutes)

6 **9:40AM LCDR Douglas Trask, MC, USN**
Reducing Opioid Prescriptions After Ureteroscopy: A Quality Improvement Initiative.

7 **9:47AM LCDR Bryan Kaps, MC, USN**
GLP-1 Agonist Use Associated with Reduced Risk of Repeat Kidney Stone Events in a Nationally Representative Cohort.

8 **9:54AM Capt Colten Juell, MC, USAF**
Reporting of 24-Hour Urine Composition for Urinary Stone Prevention by Commercial Laboratories.

9 **10:01AM Capt Nicholas Moll, MC, USAF**
Cystinuria: Epidemiology And Management Of A Rare Cause Of Nephrolithiasis Using A Collaborative Global Network.

10:08AM Discussion (7 minutes) / 10:15AM End of Session

Vendor-Blender - fuel up!

10:15 AM - 11:00 AM

REFRESHMENT BREAK IN THE EXPO LAB

Win Great Prizes!!!
Visit & chat with the vendors to complete your PRIZE CARD!
Exhibitors will give out the SCRATCHER CARDS
at their discretion.

Coffee, Sodas, Beverages served

RESIDENTS COMPETITION 4

Sexual Medicine

11:00 AM - 11:20 AM - International Ballroom

Moderators:
COL Andrew Medendorp, MC, USA
(Papers are seven minutes)

10 **11:00AM CPT Marilyn Jones, MC, USAF**
Google searches for Selective Androgen Receptor Modulators are higher than average on or around military installations.

11 **11:07AM Capt Ryan Frazier, MC, USAF**
Intraoperative And Postoperative Practice Patterns Among Penile Prosthesis Surgeons.

11:14AM Discussion (6 minutes) / 11:20AM End of Session

EDUCATIONAL SYMPOSIUM

12. 11:20 AM - 12:00 PM - International Ballroom

Optimizing Prostate Biopsy for Better Outcomes

Part 1: Jeffrey Proctor, MD (US Navy LCMDR, vet.),
Georgia Urology, Canton, GA
Obtaining Bigger Better Core Needle Biopsies

Part 2: Dan Wiener, MD, (US Army MJR, vet),
Boston VA Chief of Thoracic Surgery & Harvard Medical School
Optimizing Prostate Biopsy Specimens for Improved Pathological Diagnosis

Non CME Program - Supported by URO-1

LUNCH PROGRAMS

THURSDAY, JANUARY 29, 2026

13. **12:00 PM - 1:40 PM - International Ballroom**

Moderator: CDR Jonathan Berger, MC, USN

Manthos Resident & Young Urologist Lunch Program

"250, Now What"
Celebration and pursuit of purpose with some war stories for seasoning.

Leadership and Faculty Development

Major General John Borling (USAF-ret)

~ 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.
Engage with the exhibitors to receive a SCRATCHER CARD at their discretion for instant prizes!

RESIDENTS COMPETITION 5
Sexual Medicine
1:40 PM - 2:10 PM - International Ballroom
Moderators: COL Amanda Reed-Maldonado, MC, USA
(Papers are seven minutes)

14 1:40PM CPT Isabel Gibson, MC, USA
Infertility Rates By Occupation Of Active-duty Service Members.

15 1:47PM CPT Rahul Jayakrishnan, MC, USA
Multicenter Evaluation on the Use of Down-sized Cylinders in Penile Prosthesis Surgery.

16 1:54PM CPT Zachary Seymour, MC, USA
Wildfire Smoke Exposure Among Men Purusing Mail-in Semen Analysis Testing In The Contiguous United States.

2:01PM Discussion (9 minutes) / 2:10PM End of Session

THURSDAY, JANUARY 29, 2026

EDUCATIONAL SYMPOSIUM

2:10 PM - 2:45 PM, International Ballroom

Advancing Home Care Options for Veterans: BD® PureWick® Innovations in Urinary Incontinence Management

Ryan Forrey, PharmD, MS, BCSCP, FASHP &
Jessica Lusche, RN, BSN

Non CME Program - Supported by BD

RESIDENTS COMPETITION 6

Testis and Prostate

2:45 PM - 3:30 PM- International Ballroom

Moderators: LTC Matthew Banti, MC, USA

(Papers are seven minutes)

17 2:45PM LT James Hoang, MC, USN
Comparative Analysis of Proton Therapy vs. IMRT for Localized Prostate Cancer: A Retrospective Study on Side Effect Profiles.

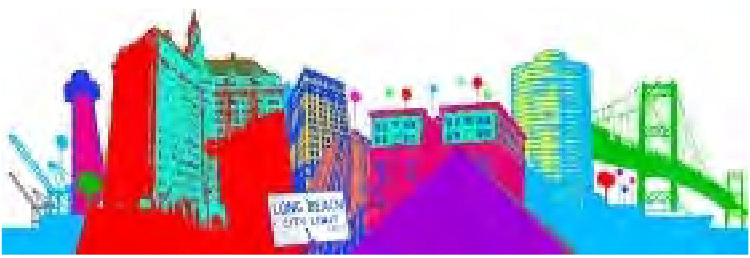
18 2:52PM CPT Evalyn George, MC, USA
Early Longitudinal Outcomes Of Black Men Undergoing Prostate-specific Antigen(psa) Screening Following Implementation Of A Psa-based Stratification Algorithm.

19 2:59PM CPT Eric Adams, MC, USA
Image-guided Multiparametric Magnetic Resonance Imaging-transrectal Ultrasound Fusion Biopsy Augmented With A Sextant Versus An Extended Template Random Biopsy: Comparison Of Cancer Detection Rates, Complication, And Functional Outcomes.

20 3:06PM LT Josiah Low, MC, USN
Natural History of PSMA-positive Lesions Equivocal For Metastasis In Newly-diagnosed And Biochemically-recurrent Prostate Cancer.

21 3:13PM LT Josiah Low, MC, USN
Primary Retroperitoneal Lymph Node Dissection for Clinical Stage II Seminoma: Comparative Analysis Against Established Paradigms Using the National Cancer Data Base.

3:20PM Discussion (10 minutes) / 3:30PM End of Session



USAV Program

3:30PM - 5:30 PM- International Ballroom

22 3:30PM Mark Sawyer, MD, President, USAV
Welcome and Introduction

23 3:35PM John Leppert, MD
Geographic Variation in Urinary Stone Disease: The “Stone Belt” 30 Years Later.

24 4:00PM Yaw Nyame, MD, MS, MBA
Eliminating Racial Disparities in Prostate Cancer Death: Lessons Learned from Engagement and Partnership with Black Prostate Cancer Survivors.

25 4:30PM Tim Daskivich, MD
Improving Physician Communication in Prostate Cancer Treatment Consultations.

26 5:00PM Andrew Hung, MD
Automation of Robotic Skills Assessment with AI.

5:30PM End of Session

CLAIM YOUR CME - DAILY EVALUATIONS USE LINK
govurology.org -> 2026 Meeting
click on “Daily Evaluations”

THURSDAY EVENING

Night Aboard the Queen Mary

Elegant and classic, the legendary Queen Mary is the most unique and distinct event venue in Southern California. The Queen Mary's remarkable ballrooms and salons are adorned with original 1930's artwork on luxuriously appointed walls, rich polished wood paneling, and Art Deco décor, setting the stage for a magical night.

This is an optional event. A ticket is required for entry and must be purchased prior to the event, no sales at the door.
Limited to 70 pp. Cost $70.00 pp
Ticket price includes: Admission, Dinner, Drinks (during reception/dinner), Private Tour & Transportation
(Bus begins departing from hotel at 5:00pm)

FRIDAY, JANUARY 30

Outline of Scientific Program

72nd Kimbrough

Annual Seminar * Long Beach Hilton Hotel, California

TIME	EVENT	ROOM
7:00 AM - 2:00 PM	Exhibits Open	Exhibits/Expo Lab Area
7:00 AM - 8:15 AM	Networking Breakfast	Exhibits/Expo Lab Area
7:00 AM - 3:00 PM	Registration	Int'l Ballrm Foyer
7:00 AM - 4:00 PM	Slide Preview	Caribbean Room
8:15 AM - 9:20 AM	Sexual Medicine Part 1	International Ballroom
9:20 AM - 10:00 AM	Educational Symposium	International Ballroom
10:00 AM - 11:15 AM	Network/Refreshmt. Break	Exhibits/Expo Lab Area
11:15 AM - 11:55 AM	Sexual Medicine Part2	International Ballroom
12:00 PM - 1:20 PM	Symposium Lunch	International Ballroom
1:20 PM - 1:45 PM	FPRMS	International Ballroom
1:45 PM - 2:30 PM	Reconstruction	International Ballroom
2:35 PM - 3:00 PM	Video Session	International Ballroom
3:00 PM - 3:30 PM	AF Urology Readiness	International Ballroom
5:00 PM - 5:45 PM	GU Bowl Tailgate Party	Int'l Bllrm Promenade
5:45 PM - 6:30 PM	GU Bowl	International Ballroom

7:00 AM

Get energized at the

Network Breakfast in the Expo Lab

Bring your PRIZE CARD

SEXUAL MEDICINE - PART 1

8:15 AM - 9:20 AM - International Ballroom

Moderators:

COL Amanda Reed Maldonado, MC, USA / Faysal Yafi, MD /
MAJ David Barham, MC, USA

27 8:15AM LTC Daniel Kim, MC, USA
Predictors Of Clomiphene Citrate Response In The Treatment Of Men With Testosterone Deficiency.

28 8:20AM LTC Daniel Kim, MC, USA
Testosterone Therapy In Men On Active Surveillance For Prostate Cancer.

29 8:25AM ENS Andrew Goulian, MC, USN
Unmasking Masculinity: Biological, Behavioral, and Social Determinants of Testosterone Deficiency in U.S. Men.

8:30AM Discussion (5 minutes)

30 8:35AM

STATE OF THE ART LECTURE SUPPORTED BY
SEXUAL MEDICINE SOCIETY OF NORTH AMERICA (SMSNA)

Regenerative Therapies for ED - Are They Ready for Primetime?

Faysal A. Yafi, MD, SMSNA Secretary

Associate Professor & Vice-Chair, Director of Men's Health & Newport Urology,
Chief, Division of Men's Health and Reconstructive Urology
Department of Urology, University of California, Irvine

9:15AM - 9:20AM Discussion (5 minutes)

EDUCATIONAL SYMPOSIUM

31 9:20 AM - 10:00 AM - International Ballroom

PYLARIFY® (piflufolastat F 18) Injection for PET/CT Imaging in Prostate Cancer Combining Clear Diagnostic Performance With Clear Availability

Tony Abraham, DO, MPA,
New York Imaging Specialists

Non CME Program - Supported by Lantheus

CRUISE INTO THE EXPO LAB

see whats new

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

VISIT OUR EXHIBITORS

2 WAYS TO WIN!

- PRIZE CARD
- SCRATCH CARD

Get one from each Exhibitor

Enjoy coffee, sodas, beverages
& prize drawings!

SEXUAL MEDICINE - PART 2

11:15 AM - 11:55 AM - International Ballroom

Moderator:
LTC Thomas Gerald, MC, USA

32 11:15AM

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

Urinary Problems Triggered From Sexual Dysfunctions.

Sue Goldstein, CCRC, CSE, IF, Past President, ISSWSH &

Irwin Goldstein, MD, IF - Past President, ISSWSH
San Diego Sexual Medicine

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

EDUCATIONAL LUNCH SYMPOSIUM

12:00 PM - 1:20 PM - International Ballroom

INLEXZO: An Innovative Intravesical Drug Releasing System

Karim Chamie, MD, UCLA Health

Jose De La Cerda, MD, Urology San Antonio

Non CME Program - Supported by Johnson & Johnson

FEMALE PELVIC MEDICINE & RECONSTUCTIVE SURGERY (FPMRS)

1:20 PM - 1:45 PM - International Ballroom

Moderator:
COL Andrew Medendorp, MC, USA

33 1:20PM MAJ Lauren Muramoto, MC, USA
Group Medical Visits in Urogynecology and Reconstructive Pelvic Surgery (URPS).

34 1:25PM MAJ Lauren Muramoto, MC, USA
A Proposed Template for Virtual Group Medical Visits in Urogynecology and Reconstructive Pelvic Surgery (URPS).

35 1:30PM LT Alec Basterrechea, MC, USN
Novel Technique for Transcorporal Artificial Urinary Sphincter Placement: The Gullwing Method.

36 1:35PM 2LT Gabriel Rodrigues, MC, USA
The Economics Of Innovation: Cost Outcomes In Bladder Cancer Clinical Trials.

1:40PM Discussion (5 minutes) / 1:45PM End of Session

RECONSTRUCTION

1:45 PM - 2:30 PM - International Ballroom

Moderator:
MAJ David Barham, MC, USA

37 1:45PM

STATE OF THE ART LECTURE

SUPPORTED BY
GENITOURINARY RECONSTRUCTIVE SURGEONS (GURS)

Management of Failed Pediatric Hypospadias Repair.

Christopher Gonzalez, MD
GURS President, Loyola Univ. Medical Ctr., IL

2:20PM Discussion / 2:30PM End of Session

VIDEO SESSION

2:35 PM - 3:00 PM - International Ballroom

Moderators:

LTC Danielle Stackhouse, MC, USA, Alexandria Hertz, MD

MAJ David Barham, MC, USA / Christopher Gonzalez, MD

38 2:35PM Capt Audra Garrigan, MC, USAF
Single Port Total Urinary Tract Reconstruction After Crush Injury.

39 2:42PM CPT Jonathan Yu, MC, USA
Immediate Robotic Intervention of Iatrogenic Ureteral injuries: A Case Series.

40 2:49PM CPT Zachary Seymour, MC, USA
Transurethral Ventral Inlay Buccal Mucosa Graft Urethroplasty: Technique and Short-Term Outcomes.

2:55PM Discussion (5 minutes) / 3:00PM End of Session

AF Urology Readiness / CMRP Discussion

3:00 PM - 3:30 PM, International Ballroom

ENJOY THE AFTERNOON BREAK UNTIL 5:00 PM

Friday Evening

U.S. AIR FORCE

UNITED STATES NAVY

U.S.ARMY

5:00 PM:
Official Hawaiian Tailgate Party
Ballroom Foyer

Followed by the
GU ALOHA Bowl
International Ballroom

Bring your
Green Drink Tickets
Wear your Hawaiian Attire!

SATURDAY, JANUARY 31

Outline of Scientific Program

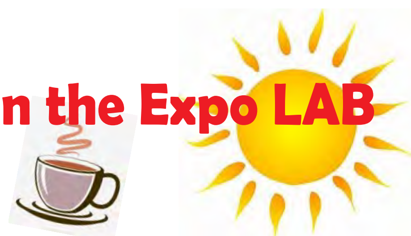
72nd Kimbrough

Annual Seminar * Long Beach Hilton Hotel, California

TIME	EVENT	ROOM
7:00 AM - 5:00 PM	Registration	Int'l Ballrm Foyer
7:00 AM - 5:00 PM	Slide Preview	Caribbean Room
7:15 AM - 2:00 PM	Exhibits Open	Exhibits/Expo Lab Area
7:15 AM - 8:30 AM	Networking Breakfast	Exhibits/Expo Lab Area
8:15 AM - 9:15 AM	Military Updates	International Ballroom
9:15 AM - 9:45 AM	Pediatric Urology	International Ballroom
9:45 AM - 10:15 AM	Transplant Surgery	International Ballroom
10:15 AM - 11:15 AM	Network/Refreshmt. Break	Exhibits/Expo Lab Area
11:15 AM - 12:00 PM	Urology Leadership	International Ballroom
12:00 PM - 1:15 PM	Lunch Symposium	International Ballroom
1:20 PM - 2:25 PM	SGSU Business Meeting	International Ballroom
2:30 PM - 3:00 PM	Leadership	International Ballroom
3:00 PM - 3:20 PM	Case Reports 1	International Ballroom
3:20 PM - 3:40 PM	Case Reports 2	International Ballroom
3:40 PM - 4:40 PM	Educational Symposium	International Ballroom
4:40 PM - 5:30 PM	Posters/Awards/Reception	International Ballroom

7:15 AM

Get Energized in the Expo LAB this Morning!



CONSULTANT UPDATES/ MILITARY UROLOGY

8:15 AM - 9:15 AM - International Ballroom

41 8:15AM LTC Ryan Speir, MC, USA
State of the Army.

42 8:27AM Lt Col Ted Saitz, MC, USAF
State of the Air Force.

43 8:39AM CDR Gregory Chesnut, MC, USN
State of the Navy.

44 8:51AM Justin DeGrado, MD, USNR
State of the Reserves

45 9:05AM Mark Sawyer, MD, USAV President
State of the USAV.

9:15AM End of Session

PEDIATRIC UROLOGY

9:15 AM - 9:45 AM - International Ballroom
Moderators:
MAJ Victoria Maxon, MC, USA / LTC Matthew Kasprenski, MC, USA

47 9:15AM

STATE OF THE ART LECTURE

Urological Opportunities in Under-Resourced Communities.

Ronald Sutherland, MD

Hawaii Pacific Health Med. Grp./The Queen’s Health Syst.

9:35AM - Discussion (10 Minutes) / 9:45AM End of Session

TRANSPLANT SURGERY

9:45 AM - 10:15 AM - International Ballroom

Moderator:

LTC Thomas Gerald, MC, USA

48 9:45AM

STATE OF THE ART LECTURE

Bladder Transplantation

Nima Nassiri, MD

UCLA David Geffen School of Medicine

10:05AM - Discussion (10 Minutes) / 10:15AM End of Session

UROLOGY LEADERSHIP

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

Moderators:
LTC Matthew Kasprenski, MC, USA

49 11:15AM

UROLOGY LEADERSHIP & CAREER TRAJECTORY PANEL

Panelists: COL (Ret) Bradley Schwartz, MC, USA, Randy Sulaver, MD, COL Andrew Medendorp, MC, USA, Roger Dmochowski, MD, Alexandria Hertz, MD

12:00PM End of Session

LUNCH SYMPOSIUM

50 12:00 PM - 1:15 PM - International Ballroom

High-risk Biochemical Recurrence: How To Identify And Latest In Treatment Strategies.

Stephen Freedland, MD

Cedars Sinai Medical Center

Non-CME Symposium Supported by Pfizer

51

★ SGSU MEMBERS BUSINESS MEETING ★

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

LEADERSHIP

2:30 PM - 3:00 PM - International Ballroom
Moderator:
COL (Ret) Bradley Schwartz, MC, USA

52 2:30PM

STATE OF THE ART LECTURE

Leadership and Lessons Learned

Roger Dmochowski, MD

Vanderbilt University Med. Ctr.

2:50PM - Discussion (10 Minutes) / 3:00PM End of Session

CASE REPORTS - PART 1

3:00 PM - 3:20PM - International Ballroom
Moderator:
MAJ Timothy Wright, MC, USA / CPT Jonathan Yu, MC, USN
(Papers are 2 minutes)

53 3:00PM CPT Brittney Murray, MC, USA
Assessing Abnormal Voiding In Young Active Duty Males.

54 3:02PM LT Nate McLauchlan, MC, USN
Rock Bottom: An Unusual Case Of Multi-system Complications From A Large Bladder Stone.

3:04PM Discussion (6 minutes)

55 3:10PM CPT Reilly Carr, MC, USA
End Stage Bladder Secondary To Dysfunctional Voiding: A Unique Indication For Simple Cystectomy.

56 3:12PM CPT Zachary Seymour, MC, USA
A Case of Spontaneous Subepithelial Pelvic Hematoma (Antopol-Goldman Lesion) in a Patient with Suspected Hemophilia A.

3:14PM Discussion (6 minutes) / 3:20PM End of Session

CASE REPORTS - PART 2

3:20 PM - 3:40 PM - International Ballroom

Moderators:
MAJ Victoria Maxon, MC, USA / CDR Paul Campbell, MC, USN / Maj Helal Syed, MC, USAF

(Papers are 2 minutes each)

57 3:20PM LT James Berry, MC, USN
Case Report of Pediatric Penile Amputation Following Plastibell Circumcision.

58 3:22PM LT Kailey Davis, MC, USN
Neonatal Adrenal Hemorrhage Presenting As Suspected Testicular Torsion: A Case Report.

59 3:24PM Capt Brayden Payne, MC, USAF
Navigating Neurogenic Bladder in a Military Aviator: A Case of Tethered Cord Syndrome Presenting with Pelvic Floor Dysfunction.

3:26PM Discussion (4 minutes)

60 3:30PM LT Alec Basterrechea, MC, USN
In Vitro Fertilization Egg Retrieval and Urologic Complications: A Case Series.

61 3:32PM CPT Monica Van Shufflin, MC, USA
A Common Urologic Complaint from an Uncommon Source: A Case of Bilateral Spermatic Vein Thrombi.

62 3:34PM 2nd LT Ryan Colby, MC, USAF
Masson's Tumor of the Scrotum Case Report.

3:36PM Discussion (4 minutes) / 3:40PM End of Session

EDUCATIONAL SYMPOSIUM

3:40 PM - 4:40 PM - International Ballroom

68-Ga-PSMA-11 PET/CT Imaging for the Detection of Prostate Cancer

Paul Dato, MD

Director, Cancer Center of Excellence, Unio Health, San Diego, CA

Non CME Program - Supported by Telix

(Bring your Green Drink Tickets)

Poster Session

Followed by

The Littrell Awards Ceremony & Reception

4:40 PM - 5:30 PM - International Ballroom

Moderators/Judges:

COL (Ret) Bradley Schwartz, MC, USA / COL (Ret) Timothy Brand, MC, USA / COL (Ret) Robert Dean, MC, USA

(Poster viewing, followed by 2 minute presentation at each poster)

63 **CPT Jae Woo Shin, MC, USA**
Management Of A Large Symptomatic Cowper's Duct Cyst In A Young Male: Open Excision With Concomitant Urethroplasty.

64 **LT Samuel Shalov, MC, USN**
Pediatric Zinner Syndrome.

65 **LT Jack Stensland, MC, USA**
Assessment of the Quality of Resources on BPH Surgery Across Major Search Engines.

66 **CPT Monica Van Shufflin, MC, USA**
Bilateral Orchiectomy: An Uncommon Result of Tertiary Syphilis.

67 **CPT Evalyn George, MC, USA**
Financial Toxicity Interventions In Cancer Patients: A Systematic Review.

68 **CPT Isabel Gibson, MC, USA**
Hypogonadism Rates By Occupation Of Active-duty Service Members.

69 **CPT Alexis Eastburn, MC, USA**
One Year Follow Up: Retrospective Data and Lessons Learned from the First Year Utilizing Steerable Vacuum Stone Extraction.

Continued on next page

70 **ENS Maximilliano Buckner, MC, USN**
Very Low Rates of Adequate Evaluation of Adrenal Incidentaloma by Both Urologists and Endocrinologists: A Single Institution Experience.

71 **LCDR Bryan Kaps, MC (UMO), USN**
Opioids Prescribed for Kidney Stones Not Associated with Risk of Opioid Use Disorder in a Nationally Representative Cohort.

72 **LTC Tino Wilke, MC, GER**
The Influence of Surgical Approach on Patient Quality of Life: A Comparative Analysis of Laparoscopic versus Robot-Assisted Adrenalectomy.

In Dedication to Kathy & Preston Littrell

Littrell Awards Ceremony

SUNDAY, FEBRUARY 1

Outline of Scientific Program

72nd Kimbrough

Annual Seminar * Long Beach Hilton Hotel, California

TIME	EVENT	ROOM
7:00 AM - 10:00 AM	Registration	Int'l Ballroom Foyer
7:00 AM - 8:00 AM	Hasta La Vista Breakfast	International Ballroom
7:10 AM - 7:30 AM	Meeting Highlights	International Ballroom
7:30 AM - 10:00 AM	Mock Oral Boards	Pacific Room I/II

FOR CME CREDIT CERTIFICATE

Go to the SGSU Website at govurology.org -> 2026 Meeting Tab

Click on "Print CME Certificate"
&
Click on "Daily Evaluations"

7:00 AM

Hasta La Vista
Breakfast in Grand Ballroom

MOCK ORAL BOARDS PREP

7:30 AM - 10:00 AM - Pacific Room

Moderator: 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 SGSU Website at govurology.org -> 2025 Meeting Tab to print your CME certificate and complete evaluations.

Johnson & Johnson Portfolio

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(apalutamide) 60 mg tablets 240 mg tablet

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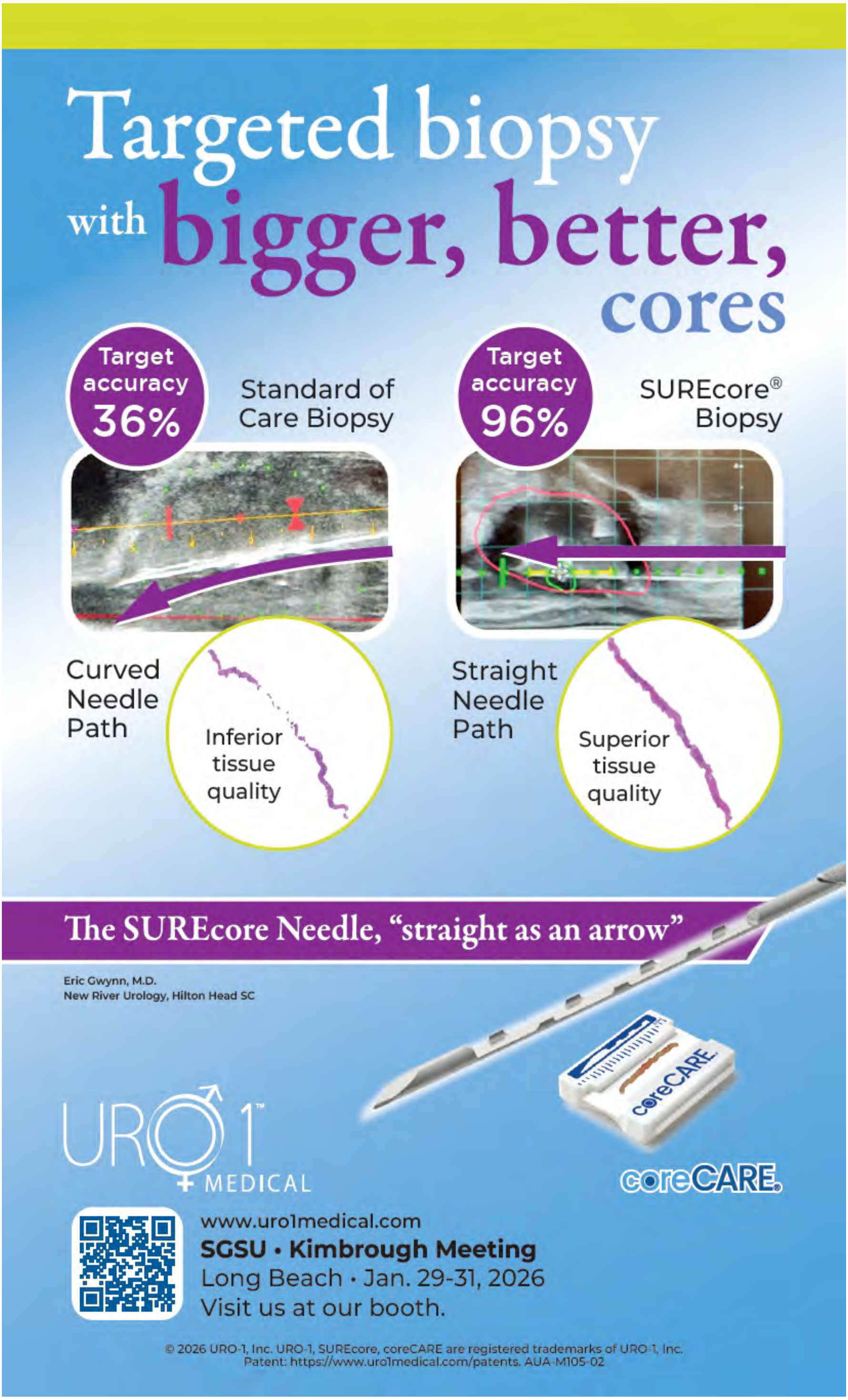
Johnson&Johnson



ABSTRACTS

PAPER #2

THE EFFECT OF PUDENAL NERVE BLOCKS ON ACUTE PAIN REDUCTION AFTER URETHROPLASTY

Paolo Rigo, MD; Alice Grant, MD; Nima Baradaran, MD; Kurt McCammon, MD
Norfolk, VA
(Presentation to be made by Dr. Paolo Rigo)

Background: Pudendal nerve block (PNB) provides regional anesthesia to the perineum and has reduced postoperative pain and opioid consumption in obstetric, anorectal and some urologic procedures. Its utility after perineal urethral reconstruction (urethroplasty) has not been systematically evaluated in comparative cohorts. This pilot study evaluates bilateral pudendal nerve block (PNB) as an adjunct to general anesthesia for perineal urethroplasty. This analysis is presented as an exploratory pilot intended to evaluate preliminary analgesic and opioid-sparing responses and to guide the design of future prospective trials.

Objectives: To assess whether addition of bilateral PNB to standard anesthesia for perineal urethroplasty reduces acute postoperative pain (PACU and postoperative day 1) and decreases postoperative opioid use.

Methods: Retrospective pilot cohort of evaluable patients (N = 18) undergoing perineal urethroplasty. Exposure was bilateral pudendal nerve block (PNB) performed transperineal anatomic technique: after general anesthesia was induced, patient placed in lithotomy, surgeon's index finger inserted into the rectum to palpate the ischial spine. The skin entry point was selected ~2.5 cm posteromedial to the ischial tuberosity; a spinal/needle was advanced lateral to the clinician's finger in a posterolateral direction to the ischial spine and then through the sacrospinous ligament approximately 1 cm medial and inferior to the ischial spine. After negative aspiration, local anesthetic (10 mL of 0.5% bupivacaine per side in this cohort) was injected.

Results: In this small pilot (evaluable N = 18; PNB n = 6, No-PNB n = 12), VAS scores trended lower in the PNB group. In PACU mean VAS was 2.83 ± 2.71 for PNB versus 4.73 ± 2.15 for No-PNB (mean difference ≈ −1.9 points). On POD1 mean VAS was 3.17 ± 2.79 for PNB versus 4.45 ± 2.73 for No-PNB (mean difference ≈ −1.3 points). Documented postoperative opioid use was common: 5/6 (83%) in the PNB group versus 9/12 (75%) in the No-PNB group. Overall, point estimates favored decreased pain with PNB but differences did not reach statistical significance in this limited sample.

Conclusions: As a pilot, this retrospective cohort signals a clinically meaningful reduction in early postoperative pain associated with bilateral pudendal nerve block after urethroplasty, with moderate-to-large effect size at PACU and a smaller effect at POD1; however, differences were not statistically significant in this small, nonrandomized sample and documented opioid use was not reduced. These preliminary results support feasibility and provide effect-size estimates that justify a prospective, randomized trial with standardized analgesic protocols and precise opioid dosing (converted to morphine-milligram equivalents) to definitively assess analgesic and opioid-sparing benefits.

PAPER #3

ISCHEMIC PRIAPISM AFTER IPP PLACEMENT

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(Presentation to be made by Dr. Caitlin Cooley)

Introduction: Priapism, a urologic emergency characterized by prolonged penile erection, is prevalent in sickle cell disease (SCD) due to vaso-occlusion, affecting up to 42% of patients and risking erectile dysfunction (ED) from recurrent ischemic episodes. Initial management includes hydration, analgesia, aspiration and phenylephrine injection, but refractory cases may necessitate inflatable penile prosthesis (IPP) placement to restore function and prevent further episodes. Priapism following IPP placement is a rare complication that typically involves either high-flow (non-ischemic) priapism due to iatrogenic arteriocavernosal fistula formation during surgery, or ischemic (low-flow) priapism. This case examines a patient with SCD with an IPP initially placed for recurrent ischemic priapism who continued to have ischemic priapism following surgery.

Case description: 26-year-old male with history of SCD on Hydroxyurea and recurrent ischemic priapism s/p multiple aspirations and shunts who underwent IPP placement in 2021 at Naval Medical Center Portsmouth. In 2024, he again started having recurrent episodes of ischemic priapism which were managed conservatively with exchange transfusion and pain control. He has been managed since that time with daily Cialis without much improvement. He can cycle the device without issue but reports almost daily pain and frequent ED visits. In January 2025, he was admitted for a week for sickle cell crisis and persistent priapism without improvement of symptoms. Given symptoms were not improving with medical management of SCD, we discussed explant and reimplant. A penoscrotal incision was utilized and the existing implant was excised which was an 18 cm 3-piece IPP with 3 cm rear tip extenders, incised the capsule and re-dilated the corporal bodies. At this time, we implanted an AMS 700 IPP measuring 21 cm without rear extenders. Since that time, patient's pain has since resolved and he has not had any further episodes of priapism.

Discussion: This case demonstrates that although ischemic priapism following IPP placement is extremely rare, it poses significant management challenges, particularly in patients with sickle cell disease. The patient's recurrent ischemic priapism post-IPP, despite Hydroxyurea and daily Tadalafil highlights the complexity of managing priapism in SCD, where vaso-occlusive tendencies persist despite surgical intervention. Literature reports suggest post-IPP priapism is more commonly high-flow, resulting from iatrogenic arteriocavernosal fistulae, but ischemic cases, as seen here, are exceptional and may stem from persistent corporal ischemia or device-related factors like capsule formation. The patient's frequent ED visits and pain, despite device functionality, underscore the limitations of conservative measures in such cases. The decision to explant and reimplant the IPP, with corporal capsule incision and re-dilation, likely addressed fibrotic changes or suboptimal device positioning, resolving the patient's pain. Challenges include the risk of infection or injury during reimplantation and emphasizes the need for individualized treatment plans for this patient population.

Conclusion: This case of a 26-year-old male with SCD and recurrent ischemic priapism post-IPP placement illustrates the rare but significant challenge of managing persistent priapism after prosthesis surgery. Ischemic priapism following IPP may be secondary to compromised venous outflow secondary to capsule formation or device obstruction. Explantation and reimplantation with capsule incision and corporal re-dilation successfully resolved the patient's symptoms, highlighting the efficacy of surgical revision in refractory cases.
Source of Funding: None

PAPER #4

DEVELOPMENT OF A NOVEL NATURAL ORIFICE THERMOREGULATORY DEVICE FOR THE TREATMENT OF CHRONIC PELVIC PAIN

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(Presentation to be made by Dr. George)

Background and Objectives: Chronic Pelvic Pain is a challenging disease process that significantly impacts sexual health, quality of life, and can result in potential self-harm. It burdens patients, families, and caregivers. Cryoanalgesia has been previously prescribed for patients with chronic perineal pain and led to the development of our novel device. Our objective is to evaluate the safety of our intraluminal thermal cycling probe designed for the treatment of pelvic pain.

Methods: We designed a phase 0 trial using porcine animal models. Through a midline laparotomy incision, thermal sensing probes were sutured in place in the spaces posterior to the rectum, anterior to the rectum, anterior to the vagina, and anterior to the bladder. A Foley catheter was inserted through a cystotomy along with a temperature sensor in the bladder. The probe was inserted vaginally or rectally, and temperature monitoring of the tissues and bladder was collected and analyzed. At the completion of data collection, the animal was euthanized and rectal, vaginal, and bladder tissue were collected for pathologic evaluation.

Results: Studies were completed on 5 porcine models. Tissue perfusion and temperature regulation demonstrated a depth of penetration of approximately 30mm with temperature minimums of 21C and maximums of 42C in sensors adjacent to tissue. Pathologic specimens demonstrated no evidence of thermal damage on histologic staining.

Conclusions: Thermal cycling using a natural orifice intraluminal probe showed no evidence of thermal damage while cooling and heating adjacent structures. Future research will need to be conducted via phase 2 trials to determine safety in humans.

Source of Funding: Funding provided by NIH heal initiative grant Ref#: 1R43HD112219-01A1.

PAPER #5

LOWER URINARY TRACT SYMPTOMS AND PELVIC DISORDERS IN FEMALE MILITARY SERVICEMEMBERS

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Tacoma, WA
(Presentation to be made by Dr. Alexis Eastburn)

Objectives: Prior research has shown de novo urinary incontinence and pelvic organ prolapse in young nulliparous women after military training. However, the data is limited, and these conditions are thought to be under reported. The purpose of this study was to evaluate the rates of lower urinary tract symptoms (LUTS) and pelvic dysfunction in active-duty females using diagnosis codes from the military electronic medical record.

Materials and Methods: Data was pulled from the Military Health System Data Repository from 2017-2024. We limited it to active-duty women. Extracted data included age, race and number of women with LUTS and pelvic dysfunction. These diagnoses were determined via International Classification of Diseases codes for general, stress, urge, mixed and sexual urinary incontinence. We also evaluated urinary frequency or urgency, urinary tract infection (UTI), dyspareunia, pelvic floor dysfunction and pelvic organ prolapse (POP).

Results: The average population size across all months of the study period was 277,572. The most common diagnosis evaluated was UTI with a prevalence of 28.22% of active-duty women. This was followed by pelvic floor dysfunction (7.76%), stress urinary incontinence (7.60%), urinary urgency (5.60%) general incontinence (4.17%), mixed urinary incontinence (3.02%) and urge urinary incontinence (2.27%). POP of any type was diagnosed in 1.77% of active-duty women. Dyspareunia was less common at 0.97%.

Conclusion: LUTS and pelvic dysfunction are rare in active-duty female servicemembers. However, we suspect these conditions may be underreported either due to embarrassment and/or lack of understanding that these conditions can be treated. Our next step will be to prospectively evaluate a large number of female servicemembers to better ascertain true rates of these conditions.

S
ource of Funding: None

PAPER #6

REDUCING OPIOID PRESCRIPTIONS AFTER URETEROSCOPY: A QUALITY IMPROVEMENT INITIATIVE

Douglas Trask MD, Jonathan Berger MD: San Diego, CA
(Presentation to be made by Dr. Trask)

Objectives: There is wide variation in opioid prescriptions across urologic procedures, especially ureteroscopy. Opioids are frequently prescribed “just in case” to prevent unplanned postoperative encounters or emergency department visits for pain. However, overprescribing opioids increases the risk of diversion and persistent opioid use in opioid-naïve patients. This quality improvement initiative aimed to reduce opioid prescriptions after ureteroscopy by implementing an opioid-free discharge protocol while comparing unplanned encounters for postoperative pain before and after the intervention.

Materials and Methods: This single-institution, institutional review board-exempt quality improvement project used the Plan-Do-Check-Act (PDCA) framework to implement an opioid-free ureteroscopy protocol. During a department meeting, a standardized opioid-free discharge protocol was developed for outpatient ureteroscopy. While opioids could still be prescribed at the surgeon's discretion in select cases, non-opioid medications became the default. Mean oral morphine equivalent (OME) doses prescribed before and after the intervention were retrospectively compared, along with “bounce backs” for pain, broadly defined as any unplanned clinic visit, emergency department encounter, or phone call for postoperative pain within 30 days.

Results: In the three months prior to the intervention, the mean OME dose at discharge following outpatient ureteroscopy was 36 mg. In the four months after implementation of opioid-free ureteroscopy, excluding the intervention month as a washout period, the mean OME dose dropped to 13 mg, representing a 65% decrease in opioids prescribed at discharge ($P < 0.001$). There was no statistically significant change in the rate of bounce backs for pain: 9% before the intervention versus 10% after ($P = 0.14$).

Conclusions: Opioid therapy, given its potential for harm, should be optimized and data-driven. This initiative demonstrates that opioid prescriptions can be safely reduced following outpatient ureteroscopy, without increasing the burden of unplanned patient encounters. The PDCA quality improvement cycle is an effective framework for implementing change within an institution.

Source of Funding: None

PAPER #7

GLP-1 AGONIST USE ASSOCIATED WITH REDUCED RISK OF REPEAT KIDNEY STONE EVENTS IN A NATIONALLY REPRESENTATIVE COHORT

Bryan C. Kaps M.D., Jonathan H. Berger, MD: San Diego, CA
(Presentation to be made by Dr. Bryan C. Kaps)

Objectives: Kidney stone disease is often mediated by diet and metabolic risk. We sought to evaluate the use of GLP-1 agonists as an independent predictor of kidney stone recurrence in known stone formers.

Materials and Methods: Using the National Health and Nutrition Examination Survey (NHANES, 2011–2020), we included only those indicating a positive history of kidney stones. We analyzed the relationship between GLP-1 agonist use and stone event (recent or recurrent). Analyses incorporated survey weights and multivariable logistic regression for cross-sectional associations.

Results: 26,280 participants represented 233,118,491 U.S. adults. Overall, 131 participants were GLP-1 users; 2,465 reported a history of kidney stones (representing 23,302,919), including 22 GLP-1 users. Among stone formers, 539 reported events (recent or current), including 1 GLP-1 user. The weighted prevalence of ever having kidney stone was 9.9% (95% CI 9.34–10.53) in non-GLP-1 users vs 26.5% (95% CI 12.61–47.36) in GLP-1 users. Among stone formers, the prevalence of stone event was 26.5% (95% CI 23.68–29.44) in non-GLP-1 users vs 2.8% (95% CI 0.02–77.51) in GLP-1 users. In models, GLP-1 use was associated with higher odds of ever having a kidney stone in univariate (OR 3.27, 95% CI 1.38–7.78, p=0.008) but not multivariate (OR 1.74, 95% CI 0.65–4.65, p=0.266) models. Among stone formers, GLP-1 use was associated with lower odds of stone event in both univariate (OR 0.08, 95% CI 0.01–0.74, p=0.027) and multivariate (OR 0.06, 95% CI 0.01–0.60, p=0.018) models.

Conclusions: Within a nationally representative cohort, GLP-1 agonist use is associated with reduced odds of repeat kidney stone events (recent and recurrent) in known stone formers. While this study is limited by the cross-sectional design, it is the first to suggest the GLP-1 agonist may independently reduce the risk of kidney stones in a nationally representative sample.

Source of Funding: None

PAPER #8

REPORTING OF 24-HOUR URINE COMPOSITION FOR URINARY STONE PREVENTION BY COMMERCIAL LABORATORIES

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(Presentation to be made by Dr. Juell)

Objectives: Prior work has demonstrated variability in reporting stone composition by commercial laboratories. In this study, we sought to evaluate the precision of 24-hour urine reporting by two commercial laboratories.

Methods: At home 24-hour urine collections were submitted by two participants to two commonly used, U.S.-based commercial laboratories. Labs were blinded to participants and collection days. For each collection day, urine was collected for 24-hours and divided into equal parts for each void. The two collections were added to each lab collection jug and stored as instructed. At the end of the 24-hour collection, two separate tests were sent from each jug. Intra-lab and inter-lab comparisons for 24-hr urine parameters were analyzed using a paired t-test.

Results: Ten collections were submitted to Lab A and 8 collections were submitted to Lab B. Intra-laboratory precision was evaluated by comparing test results from the same lab sent from urine collected on the same day. There were no statistically significant intra-lab differences between reported results for either lab. For Lab A, the average percent difference between results was 3% (0.3%-8.2%). For Lab B, the average percent difference between results was 3.2% (0.8%-6.8%). Interlaboratory accuracy was evaluated by comparing test results from Lab A and Lab B from urine collected on the same day. When examining inter-lab precision, there was a significant difference between Lab A and Lab B in reporting calcium (141.2 vs. 157.7 mg/day, $p<0.05$), oxalate (29.1 vs. 23.5 mg/day, $p<0.05$), citrate (480.9 vs. 516.6 mg/day, $p<0.05$), uric acid (0.76 vs. 0.67 g/day, $p<0.05$) and creatinine (1590.9 vs. 1725.6 mg/day, $p<0.05$). The average percent difference between results were 8.87% (4.34%-14.41%) (Figure 1). Oxalate results had the greatest variability between Lab A and Lab B with an average difference of 24.6% (13.6%-40.4%).

Conclusion: There are minor differences in 24-hour urine reporting when using the same laboratory. However, when comparing results between commercial laboratories, there are greater differences, most notably for urine oxalate.

Source of Funding: Supported by Bob Kenworthy.

PAPER #9

CYSTINURIA: EPIDEMIOLOGY AND MANAGEMENT OF A RARE CAUSE OF NEPHROLITHIASIS USING A COLLABORATIVE GLOBAL NETWORK

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(Presentation to be made by: Dr. Nicholas Moll)

Background: To date, estimates of cystinuria's burden of disease and its implications have been absent in the literature. Cystinuria is an autosomal recessive, rare source of nephrolithiasis that can lead to aggressive and recurrent kidney stones, characterized by impaired transport of cystine. Published data has been largely limited to single institution and small multi-institutional case series. Demographics are not well defined and clinical applicability on a national scale is lacking. We leveraged a large collaborative network to develop the largest cystinuric cohort to date and provide insights into epidemiology and management.

Methods: We used the TriNetX, LLC Global Collaborative Network which drew from deidentified electronic medical records of over 176 million patients from 148 health care organizations across 17 countries in North and South America, Europe, Africa, and Asia, including academic medical centers, insurance providers, and private practice groups between 2004-2025. Demographics, diagnosed comorbidities, prescribed medications, laboratory values, and procedures were queried. This study was exempted from International Review Board approval as it only used deidentified patient information.

Results: Of 176 million patients seen at 148 health care organization across the world, 2.8 million had stones and 2,087 had stones and an ICD diagnosis of cystinuria. The cohort had a mean age of 51 (age range 2-90). 49.35% were male, 75.08% were white, 8.09% were black, 4.22% were Hispanic or Latino. Life-time prevalence of moderate to severe CKD (stage III-V) was 29% and prevalence of acute kidney failure was 27%. 37% had required ureteroscopy at any time point and 22% had required PCNL. 26% had been prescribed tiopronin, and 45% had been prescribed potassium citrate.

Conclusions: While cystinuria may be a rare cause of nephrolithiasis in the general community, our data provide improved understanding of the burden of the disease on a global scale. Moderate to severe CKD affects 29%, and surgical interventions are often required. A significant portion, 27% of patients, will present in acute kidney failure at some point. Almost half of patients receive urinary alkalinization, but less than a quarter receive tiopronin in spite of it being a recommend treatment according to AUA guidelines. Such data from a multi-center data network provides an overview of the largest cohort of cystinurics to date and helps inform future targets to improve quality of care and patient outcomes.

PAPER #10

GOOGLE SEARCHES FOR SELECTIVE ANDROGEN RECEPTOR MODULATORS ARE HIGHER THAN AVERAGE ON OR AROUND MILITARY INSTALLATIONS

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Presentation to be made by Capt Marilyn Jones, MD

Objective: Selective Androgen Receptor Modulators (SARMs) are a class of compounds that interact with androgen receptors in the body (similar to testosterone and anabolic steroids) but are designed to be more selective in their effects. There is ongoing clinical research into their use in the treatment of osteoporosis or cachexia, but currently there are no FDA approved SARMs. Despite this, they are widely marketed as “legal steroids” and used by athletes and fitness enthusiasts. Our objective was to evaluate geographical and temporal patterns of public interest in SARMs using Google search trends.

Methods: Google Trends is a publicly accessible tool that allows users to observe the relative popularity of search terms on Google over time on a scale from 0 to 100. It also provides regional data at the state, metropolitan, and city levels, which can be used to evaluate geographic disparities in public interest. This study utilized Google Trends to assess public interest in selective androgen receptor modulators (SARMs) across the United States over a 5-year period from June 2020 to June 2025.

Geographic clusters of SARM interest were determined by comparing interest in military-associated regions with non-military metropolitan areas. Multivariable regression analysis was used to identify associations between normalized SARM search interest and potential predictive variables such as proximity to military bases, seasonality, and local temperature variation.

Results: Over the study period, SARM search interest across the United States, normalized to the control term “news,” accounted for a median of 5.1% (range: 1.86%–16.6%) of control search volume, with a peak of 16.6% observed in January 2024. SARM search interest had an initial increase through 2021, followed by a gradual decline and stabilization at a lower baseline after the January 2024 spike. Slight seasonal fluctuations were observed with higher interest during the winter.

Geographic analysis revealed that the top 10 areas for SARM search interest were predominantly military-associated cities. SARM search interest was notably higher in military-associated regions compared to non-military metropolitan areas. The mean normalized SARM search interest among military areas was 8.3%, compared to 2.6% in non-military regions.

Conclusion: Our Google Trends analysis reveals a measurable and growing interest in SARMs across the United States, based on search activity. Stratification by city confirmed elevated search traffic in military-associated areas. These findings align with known concerns regarding SARM awareness and their use in military populations, despite the Department of Defense's official prohibition and the implementation of the Operation Supplement Safety initiative. We must note that Google Trends data reflects search interest and not actual usage. High search frequency may indicate curiosity, concern, or educational intent, and should not be interpreted as direct evidence of SARM consumption. In summary, while not indicative of confirmed SARM use, the elevated search interest in specific regions, particularly military-affiliated areas, highlights the need for targeted educational outreach, monitoring efforts, and further research into public awareness and behavior regarding SARMs.

PAPER #11

INTRAOPERATIVE AND POSTOPERATIVE PRACTICE PATTERNS AMONG PENILE PROSTHESIS SURGEONS

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(Presentation to be made by Dr Ryan Frazier)

Objective: Penile prosthesis (PP) surgery has been an effective and reliable treatment for erectile dysfunction (ED) for over 50 years. It is presumed that there are significant variations in intraoperative techniques and postoperative management strategies among prosthetic urologists. These authors aimed to evaluate the perioperative practice patterns of penile prosthesis surgeons.

Materials and Methods: An anonymous web-based survey was sent to members of the Sexual Medicine Society of North America (SMSNA), the Society for Urologic Prosthetic Surgeons (SUPS), and the Society of Genitourinary Reconstructive Surgeons (GURS). Twenty-seven questions were asked regarding the perioperative practice patterns of the respondents. Descriptive statistics were performed.

Results: 189 responses were received from surgeons that perform PP. Most respondents (82.6%) were fellowship trained in andrology, reconstruction, or prosthetics. The majority of respondents perform PP placement via the penoscrotal (76.7%) compared to infrapubic approach (23.3%). Corporotomies were most commonly closed with preplaced sutures compared to running closure (89.4% vs 9.5%). PDS (43.9%) and Vicryl (36.5%) sutures (both Ethicon, Raritan, NJ, USA) were the most frequently used for corporotomy closure.

Slightly over half (55.6%) of respondents routinely use a closed suction drain postoperatively, with 45.2% of those surgeons leaving for 2 or more days. Clinical data influenced 54.3% of respondents' drain duration, with drain output the most common basis for duration (91.2%). Mummy wrap (73.5%) with scrotal support (78.8%) was the most common postoperative dressing. Of the 56.1% of respondents who leave a Foley catheter postoperatively, the majority remove it on postoperative day one (92.5%).

Same day discharge is routinely performed by 61.4% while 23.3% prefer 23-hour observation. Most surgeons (65.6%) leave the device inflated, with 51.6% inflating >50% and 44.4% <50%. There was wide variability in timing of first postoperative visit and initiating device cycling. 26.5% of surgeons clear the patient to use the implant for sexual activity at 4 weeks while 55.6% clear at 6 weeks.

Conclusions: Our results demonstrate great variability in practice patterns for PP surgery most notably with drain use, Foley catheter management, and patient disposition. Additionally, postoperative follow-up, device cycling, and implant use varied widely between surgeons. These results on different management strategies will help guide future studies to better understand the implications of these practices on patient outcomes and experiences.

Source of Funding: None

PAPER #14

INFERTILITY RATES BY OCCUPATION OF ACTIVE-DUTY SERVICE MEMBERS

Isabel Gibson, MD; Michael Fredericks, MS*; Carolyn A. Salter, MD
Tacoma, WA
(Presentation to be made by Dr. Gibson)

Objective: Endurance athletes are known to be at risk for infertility due to exercise-hypogonadal male condition characterized by hypogonadism and reduced spermatogenesis. Given the intense physical and psychological demands of certain military occupations (MOS), we hypothesize that elite forces have higher rates of infertility.

Methods: The Military Health System Data Repository from 2017-2024 was queried for active-duty men limited to an active-duty age range (18-64 years-old). Age, rank category, race, and presence or absence of infertility were evaluated. Male infertility was defined using International Classification of Diseases (ICD) codes for infertility due to varicocele, azoospermia, oligospermia, asthenospermia, teratospermia, hypospermatogenesis, testicular hypoplasia, systemic disease, extratesticular cause, obstruction, and/or drug therapy. Due to triangulation concerns, we excluded MOS with <10 men. The 20 MOS with the highest percentages of men with infertility were evaluated.

Results: 2,840,566 men were included. 50,704 had a diagnosis of infertility (1.78%). Men with infertility were older (30.50±7.16 years versus 25.74±8.21 years; $p<0.001$). Junior Enlisted soldiers made up 64% of the total and 28% of those with infertility diagnoses. Warrant officers and NCOs had nearly 5:1 odds of having infertility compared to Junior Enlisted. Field-Grade Officers and Company Grade officers had approximately 4x and 3x higher odds of all-cause infertility respectively. General Officers had over 2:1 odds compared to Junior Enlisted. All odds ratios reached statistical significance ($p<0.05$). By MOS, healthcare jobs were disproportionately represented. Nine of the top 20 MOS were healthcare-related with an average age of 36. Interestingly, Special Forces of any branch were not represented among MOS with highest rates of infertility.

Conclusions: Given an approximate prevalence of 7% in the general population, male-factor infertility is generally uncommon in the military. This may be due to disproportionate representation of a younger cohort. More investigation is needed to identify average age of special forces, how many patients were tested for infertility or generally interested in family planning, and causative factors for increased fertility in certain MOS.

PAPER #15

MULTICENTER EVALUATION ON THE USE OF DOWN-SIZED CYLINDERS IN PENILE PROSTHESIS SURGERY

Jeffrey Lee, Rahul Jayakrishnan, Elia Abou Chawareb, Muhammed Hammad, Jake Miller, Babak Azad, Daniel Swerdloff, Daniar Osmonov, Hossein Sadeghi-Nejad, Arthur Burnett, Ian Pearce, Aaron C Lentz, Kelli Gross, James Hotaling, Maxime Sempels, Sung Hun Park, Koenraad van Renterghem, Georgios Hatzichristodoulou, Robert Andrianne, James A Jones, Tung-Chin Hsieh, Vaibhav Modgil, Adam Jones, J Nicholas Warner, , Matthew Ziegelmann, Alfredo Suarez-Sarmiento Jr, Paul Perito, Jay Simhan, Martin S Gross, Faysal A Yafi, David W Barham: San Antonio, TX

(Presentation to be made by Dr. Rahul Jayakrishnan)

Objectives: Down-sized inflatable penile prosthesis (IPP) cylinders are used in challenging penile fibrosis scenarios, such as after priapism or prior implant infection. Their role in primary penile prosthesis surgery, however, is not well studied. This study aims to identify factors associated with the use of down-sized cylinders in men undergoing primary IPP placement.

Materials and Methods: We conducted a multicenter, retrospective study on men undergoing primary IPP surgery, categorizing them into a down-sized cylinder group (AMS 700 CXR and Coloplast NB) and a standard cylinder group (AMS 700 CX, AMS 700 LGX, and Coloplast Titan). We collected demographic, intraoperative, and postoperative variables and performed a multivariable analysis.

Results: 4,389 men were included in the study with a mean age of 62.3 ± 10.3 years. Overall, 1,485 (34%) men had diabetes, and 2,131 (49%) had hypertension. Downsized cylinders were placed in 406 men (174 CXRs, 232 NBs), while standard cylinders were placed in 3,983. Multivariable analysis indicated that downsized cylinders were more commonly used in men with diabetes (OR 2.6 [1.9, 3.7], $p<0.001$) and less frequently in men with hypertension (OR 0.5 [0.4, 0.7], $p<0.001$). A history of priapism did not significantly impact the use of down-sized cylinders ($p\geq0.152$). Sequential dilation was performed more often with the use of down-sized cylinders (OR 4.0 [2.8, 5.7], $p<0.001$). Down-sized cylinders were associated with an increased rate of non-infectious complications (OR 1.9 [1.3, 2.9], $p<0.001$), however, there was no significant association with implant infection (OR 2.1 [0.9, 4.6], $p=0.07$). Non-infectious complications occurred in 44 (25%) men with down-sized cylinders. In the down-sized group, hematomas occurred in 10 (2.5%) men and wound-related complications occurred in 7 (1.7%) men. Cylinder-related complications occurred in 7 (1.7%) men with down-sized cylinders. Device-related malfunctions were seen in 8 (2%) men.

Conclusions: This study demonstrates that down-sized cylinders are more frequently used in men with diabetes and surgeons should be prepared to place down-sized cylinders in these men. Prosthetic urologists are also more likely to use down-sized cylinders in men requiring sequential dilation likely due to fibrosis or more challenging dilations. Down-sized cylinders are associated with a low overall complication rate.

Source of Funding: None

PAPER #16

WILDFIRE SMOKE EXPOSURE AMONG MEN PURUSING MAIL-IN SEMEN ANALYSIS TESTING IN THE CONTIGUOUS UNITED STATES

Trevor J. Maloney DO, Lillian Xie Lindell MD*, Daniel Nolte*, Christine T. Loftus PhD*, James F. Smith MD*, Tristan M. Nicholson MD*: Seattle, Washington

(Presentation to be made by Trevor Maloney)

Objective(s): Wildfire smoke (WFS) is a growing contributor to fine particle pollution (PM2.5), which has well-documented adverse impacts on human health. Recent years have seen increased, and more widespread, WFS exposure in the contiguous United States. The impact of WFS on male fertility is still largely unknown. Our objective was to characterize WFS exposure among a cohort of men pursuing mail-in semen analysis (SA) testing in the contiguous United States (US).

Materials and Methods: Our study cohort consisted of participants utilizing mail-in SA testing (Fellow Health, Inc). Participant addresses were converted to zip code and WFS exposure in the 90 days prior to SA testing (a biologically relevant timeframe for spermatogenesis) was estimated using a national spatiotemporal model of WFS-specific PM2.5 (Childs et al. [2022]). A smoke day was defined as average WFS PM2.5 >10ug/m3.

Results: We included 14,315 participants with mean age 34.6 (range 18-82) who underwent mail-in SA testing from 2020-2023. Participants were located in all Census Bureau Divisions in the contiguous US with considerable heterogeneity in socioeconomic distress and urbanicity. In the 90 days prior to SA participants experienced 3.15 average smoke days. 48.7% of the cohort were exposed to at least one smoke day, and 21.3% experienced 5 or greater smoke days. Geographic variation of WFS exposure was observed, most notably near nationwide increased WFS exposure from July-September 2023 corresponding to a large Canadian wildfire event.

Conclusions: WFS exposure was widespread in a cohort of men undergoing mail-in SA testing in the contiguous US, with half of our cohort experiencing at least 1 smoke day, and 1 in 5 greater than 5 smoke days in the 90 days prior to SA. This is the first nationwide study to characterize WFS exposure in a cohort of men undergoing fertility testing. Given emerging evidence that WFS and air pollution may affect male fertility, more investigation is needed to better understand this relationship.

Source of Funding: This project was supported by the National Institute of Environmental Health Sciences of the National Institutes of Health under Award Number K12ES033584.

PAPER #17

COMPARATIVE ANALYSIS OF PROTON THERAPY VS. IMRT FOR LOCALIZED PROSTATE CANCER: A RETROSPECTIVE STUDY ON SIDE EFFECT PROFILES

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(Presentation to be made by Dr. James H Hoang)

Objectives: This retrospective study compares side effect profiles of proton therapy (PT) versus intensity-modulated radiation therapy (IMRT) for localized prostate cancer. We previously demonstrated equivalent oncologic outcomes between PT and IMRT, with no differences in biochemical recurrence, metastasis, or overall survival rates.

Materials and Methods: We analyzed electronic medical records from Urology of Virginia spanning January 1, 2010, to December 15, 2023. Inclusion criteria comprised men with localized prostate cancer who underwent definitive PT or IMRT without brachytherapy, yielding 2,446 patients (566 PT, 1,880 IMRT) with mean follow-up of 4.13 years. Primary endpoints included lower urinary tract symptoms (LUTS), Radiation Therapy Oncology Group (RTOG) genitourinary (GU) toxicity grade ≥2, new or worsened erectile dysfunction (ED), gross hematuria (GH), urethral strictures, fistulas, and rectal toxicity.

Results: Preliminary analysis of 110 PT patients revealed: LUTS 51.82%, RTOG GU toxicity grade ≥2 19.09%, ED 30%, GH 14.55%, urethral stricture 3.64%, and rectal toxicity 1.82%. No fistulas occurred. These rates compare favorably with published IMRT toxicity data showing RTOG GU toxicity grade ≥2 10-25%, ED 30-60%, urethral stricture 1-5%, GH 11-16%, and rectal toxicity 5-15%. Complete comparative analysis of the full PT and IMRT cohorts is ongoing.

Conclusions: Preliminary data demonstrate comparable side effect profiles between PT and IMRT for localized prostate cancer, including RTOG grade ≥2 GU toxicity, erectile dysfunction, gross hematuria, urethral stricture, and rectal toxicity. Complete analysis comparing the full PT cohort to the IMRT cohort is forthcoming.

Source of Funding: None

PAPER #18

EARLY LONGITUDINAL OUTCOMES OF BLACK MEN UNDERGOING PROSTATE-SPECIFIC ANTIGEN(PSA) SCREENING FOLLOWING IMPLEMENTATION OF A PSA-BASED STRATIFICATION ALGORITHM IN A HEALTH SYSTEM-WIDE INITIATIVE

Evalyn I George, Sriram Deivasigamani*, Eric S Adams, Akash Hemanth*, Mahdi Mottaghi*, Melissa Lowe*, Donna Niedzwiecki*, Anthony Sorrentino*, Anand Shah*, John Anderson*, Andrew J Armstrong*, Rajan T Gupta*, Steven Patierno*, Nadine J Barrett*, Daniel J George*, Glenn M. Preminger*, Judd W Moul, Cary N Robertson, Kevin C Oeffinger, Kevin Shah, Thomas J Polascik*: Durham, NC

Presentation to be made by Dr. Evalyn George

Background: PSA test is a valuable screening tool but requires balancing the risks of overdiagnosis with detecting clinically significant prostate cancer (csPCa). The Duke Cancer Institute, in collaboration with the Primary Care network, created a PSA-based screening algorithm for patient risk stratification, considering PSA, age, and race. This study aimed to report the outcomes of PSA screening among Black men following the implementation of the algorithm.

Methods: The patient cohort included Black men age 40-75 with a serum PSA measurement following the initiation of an electronic health record (EHR) screening algorithm from 02/02/2017-02/21/2018. Duke's algorithm cut-points for PSA at ages 40-49, 50-69, and 70-75 years were ≥1.5, ≥3, and ≥6.5 ng/ml, respectively. The clinical outcomes, including referral rate, biopsy, overall, and csPCa diagnosis, were evaluated through 02/2023.

Results: 480 Black men with sufficient follow-up were included. A total of 331 men (69%) were referred to urologists. The median age, PSA, and positive family history were 57 vs. 50 years (p=0.01), 4.1 vs. 3.0 ng/mL (p=0.13), and 21% vs. 9.6% (p=0.001) for referred vs. non-referred men, respectively. Of 331 PCP-referred Black men, 73 (22%) had mpMRI. Black men who underwent mpMRI, compared to those who did not, had comparable PSA [mean(SD): 6.4(17.5) vs. 5.7(3.2),p=0.6], but significantly higher chances of having a PCa family history (30% vs. 19%,p=0.049), a prior biopsy(s) history (18% vs. 5%,p<0.001), and were more likely to be diagnosed with overall (47% vs. 19%,p<0.001) and csPCa (30% vs. 14%,p<0.001). Of 122 (37%) men who underwent prostate biopsy, 83/122 (68%) returned positive for PCa, where csPCa was detected in 59/122 (48%). Compared to screening alone, the model using multiple variables (including PSA, repeat PSA exceeding cut-point criteria, prostate health index (PHI), and multiparametric MRI) had a higher diagnostic accuracy for PCa detection (AUC 0.56 vs. 0.93) and csPCa detection (AUC 0.52 vs. 0.75), respectively.

Conclusion: Implementing a system-wide, structured EHR-based PSA screening algorithm among Black men facilitated the identification of PCa across all age brackets. Additionally, using a combination of PSA, family history, PHI, and mpMRI have demonstrated efficacy in enhancing cancer detection among this under-represented population.

Source of Funding: Duke population science grant

PAPER #19

IMAGE-GUIDED MULTIPARAMETRIC MAGNETIC RESONANCE IMAGING-TRANSRECTAL ULTRASOUND FUSION BIOPSY AUGMENTED WITH A SEXTANT VERSUS AN EXTENDED TEMPLATE RANDOM BIOPSY: COMPARISON OF CANCER DETECTION RATES, COMPLICATION, AND FUNCTIONAL OUTCOMES.

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(Presentation to be made by Dr. Adams)

Objectives: To compare the efficacy of a novel fusion template “reduced six-core systemic template and multiparametric magnetic resonance imaging/transrectal ultrasound (mpMRI/TRUS) fusion targeted biopsy” (TBx+6c), with mpMRI/TRUS fusion-targeted biopsy and 12-core systematic biopsy template (TBx+12c) in the diagnosis of prostate cancer (PCa).

Materials and Methods: This is an institutional review board approved single-center observational study involving adult men undergoing fusion-targeted biopsies for the diagnosis of PCa. Patients were sorted into cohorts of TBx+6c or TBx+12c based on the systematic biopsy template used. The study's main objective was to determine the cancer detection rate (CDR) for overall PCa and clinically significant PCa (csPCa) and the secondary objectives were to compare complication rates and functional outcome differences between the cohort.

Results: A total of 204 patients met study's inclusion criteria. TBx+6c group had 120 patients, while TBx+12c cohort had 84 patients. The groups had similar baseline characteristics and overall CDR in the TBx+6c cohort was 71.7% versus 79.8%, compared to the TBx+12c ($p = 0.18$) whereas, the csPCa detection rate in the TBx+6c group was 50.8% versus 54.8% in the TBx+12c group ($p = 0.5$). TBx+6c cohort had lower overall complication rate of 3% versus 13%, ($p = 0.01$) and ≥ grade 2 complication rates (1 (1%) vs. 3(4%), $p = 0.03$) compared to the TBx+12c cohort. There were no differences in IIEF-5 ($p = 0.5$) or IPSS ($p = 0.1$) scores at baseline and 2-weeks and 6-weeks post-biopsy.

Conclusions: TBx+6c cohort, when compared to the TBx+12c cohort, demonstrated comparable diagnostic performance along with similar functional outcomes and lower complication rates. These results suggest the importance of further exploring the clinical implications of adopting a TBx+6c schema for PCa diagnosis in comparison to the widely used TBx+12c schema through a multicenter randomized controlled trial.

Source of Funding: The Josiah Charles Trent Memorial Foundation Endowment Fund

PAPER #20

NATURAL HISTORY OF PSMA-POSITIVE LESIONS EQUIVOCAL FOR METASTASIS IN NEWLY-DIAGNOSED AND BIOCHEMICALLY-RECURRENT PROSTATE CANCER

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(Presentation to be made by Dr. Josiah Low)

Objectives: Prostate-specific membrane antigen PET (PSMA-PET) has superior sensitivity and specificity for detection of micrometastatic prostate cancer (CaP) compared to conventional imaging (CT, F-18 FDG-PET). False positives remain possible, however, and recommended treatment differs drastically depending on whether a PSMA-PET-positive lesion truly reflects metastasis. We report our experience of patients with PSMA-PET-positive lesions equivocal for metastasis who were initially managed as presumed false positives.

Materials and Methods: We reviewed patients who received PSMA-PET ([18F]DCFPyL and [68Ga]Ga-PSMA-11) at Naval Medical Center San Diego for either newly diagnosed or biochemically recurrent (BCR) CaP. Patients had one or more PSMA-PET-positive, equivocally-metastatic lesions. Patients who elected to immediately undergo treatment for presumed metastatic disease were excluded. Patient-level variables collected included baseline demographics, disease characteristics, and initial treatment modality. Lesion-level variables included location, SUV, and presence of CT correlate. Primary outcome was diagnosis of metastatic CaP.

Results: One-hundred and eighty-five studies were performed from March 10, 2022 to March 6, 2025. Forty patients had at least one lesion. Seventeen patients had newly diagnosed CaP, from which 30 lesions were identified (median follow-up 16.3 months, IQR 9.7 – 27.8). Median age was 67 (58 – 74). Median PSA was 8.4 (5 – 15.8). Most patients were at least high-risk and elected for primary radiation. Median lesion SUV was 3.65 (2.6 – 4.75). Most were bony lesions without CT correlate. No metastasis occurred. One death occurred from metastatic urothelial carcinoma. Twenty-three patients had BCR, yielding 58 lesions (27.3mo, 13.3 – 33.8). Median age was 71.4 (66.1 – 78.9). Median PSA was 0.93 (0.45 – 3.00). Metastasis was diagnosed in 14 patients. One patient died (cause unknown). Patients who developed metastasis had significantly greater median lesion SUV than those who did not (with metastasis - 9.1, 4.0-15.5; without metastasis - 3.25, 3.1-4.2; p=0.006). CT correlate was present in one lesion in the metastatic cohort and none in the non-metastatic cohort (p=0.032).

Conclusions: Equivocally-metastatic lesions appear more likely to be false positives in newly-diagnosed CaP.

PAPER #21

PRIMARY RETROPERITONEAL LYMPH NODE DISSECTION FOR CLINICAL STAGE II SEMINOMA: COMPARATIVE ANALYSIS AGAINST ESTABLISHED PARADIGMS USING THE NATIONAL CANCER DATA BASE

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(Presentation to be made by Dr. Josiah Low)

Objectives: While primary retroperitoneal lymph node dissection for clinical stage II seminoma can reduce chemotherapy and radiation burden, no comparative analyses of this approach currently exist. We utilized a national oncologic data registry to perform the first comparative analysis of outcomes after primary retroperitoneal lymph node dissection for stage II seminoma.

Materials and Methods: Using the National Cancer Data Base, we identified patients with stage II germ cell tumors between 2004 to 2022. Cox regression was used for survival analyses. Primary analysis examined overall survival for patients with stage II seminoma. Sensitivity analysis after energy-balancing weighting was performed. Secondary analyses were performed for overall survival in patients who underwent primary retroperitoneal lymph node dissection for stage II germ cell tumor generally and for salvage-chemotherapy-free survival after primary retroperitoneal lymph node dissection for stage II seminoma.

Results: Primary analysis included 4,661 patients (median follow-up 6.8 years, IQR 3.6-10.5yr). Overall survival did not differ by primary treatment (versus chemotherapy – HR1.34, 95% CI 0.93-1.93, p=0.12; versus radiation – 1.02, 0.65-1.59, p=0.95). Sensitivity analysis results were similar. Secondary analysis showed increased mortality with nonseminomatous germ cell tumor (HR2.63, 1.07-6.49, p=0.036) and increased salvage chemotherapy with cN2 (HR3.88, 1.87-8.03, p=0.00027) and cN3 (HR6.03, 2.1-17.3, p=0.00083) compared to cN1.

Conclusions: Overall survival after primary retroperitoneal lymph node dissection for stage II seminoma appears comparable to alternatives and possibly improved in favor of seminoma compared to nonseminomatous germ cell tumor. Risk of needing salvage chemotherapy increases with clinical disease extent.

Source of Funding: None

PAPER #27

PREDICTORS OF CLOMIPHENE CITRATE RESPONSE IN THE TREATMENT OF MEN WITH TESTOSTERONE DEFICIENCY

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(Presentation by Dr. Kim)

Objectives: Clomiphene citrate (CC) is an established treatment for men with low testosterone (T), but predictors of treatment response are poorly defined. This study aims to identify factors associated with clinically meaningful increases in serum testosterone levels during CC therapy.

Methods: This study analyzed men diagnosed with low T and treated with CC between 2008 and 2024. We included men with (i) a diagnosis of low T based on a documented total testosterone (TT) ≤300 ng/dL with symptoms or borderline low TT with TT ≤400 ng/dL with objective signs of TD (low bone density or elevated HbA1c), (ii) documented lab follow-up within 12-weeks from initiation, and (iii) no prior T therapy. Initial CC dosing was 25 mg every other day (QOD), with escalation to 50 mg QOD if labs showed persistent TT <400 ng/dL. Labs were redrawn every 4 weeks following changes in dosing until at goal or alterations in treatment were made. TT measurements were performed using liquid chromatography-mass spectrometry. Multivariable models were used to assess predictors of treatment success. The primary outcome was achievement of treatment response, defined as TT ≥400 ng/dL on treatment plus an increase in TT ≥200 ng/dL from baseline.

Results: 182 men met64 ng/dL (IQR 219, 314) and median baseline LH of 3.5 mU/mL (IQR 2.6, 5.1). Comorbidities included diabetes (18%), hyperlipidemia (46%), hypertension (44%), prior radical prostatectomy (41%), prostate radiotherapy (34%), and ADT (4.5%). Treatment response was achieved in 136 of 292 (47%) patients; the remaining 156 (53%) failed to achieve response. Multivariable analysis identified baseline LH (increase per mu/mL) (OR 0.82, 95% CI 0.71, 0.95, p=0.008) as a significant negative predictor for treatment success. Likewise, prior ADT was predictive for poor response (OR 0.11, 95% CI 0.01-0.6, p=0.039). Baseline TT and age at start of CC treatment were not found to be predictive.

Conclusion: In men with low T, higher baseline LH and history of prior ADT predicted worse response to CC therapy.

Source of Funding: None

PAPER #28

TESTOSTERONE THERAPY IN MEN ON ACTIVE SURVEILLANCE FOR PROSTATE CANCER

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(To be presented by LTC Kim)

Objectives: Testosterone therapy (TTH) in men with prostate cancer (PCa) remains controversial, with limited data on cancer specific outcomes for patients on TTH available, particularly for men on Active Surveillance (AS). This study aims to assess progression-free survival (PFS) in AS patients receiving TTH.

Materials and Methods: Patients with Grade Group (GG) 1 and 2 PCa on AS were examined, including a subset of patients who were concurrently treated with TTH. Institutional protocols for AS consisted of lab work and exam every 6 months, MRI every 18 months, and biopsy every 36 months. Men on TTH had total testosterone and PSA labs drawn within 2-4 weeks of TTH initiation and every 3-6 months when stable on dosing. The primary outcome was time to progression, defined as a rise in GG on biopsy. A secondary outcome used an alternate definition for progression which incorporated progression to definitive treatment.

Results: The study included 3,324 AS patients, with 79 on TTH. 1,256 patients had progression on biopsy. On multivariable analysis, TTH did not significantly impact the risk of disease progression (HR 0.99; 95% CI: 0.67,1.48; p>0.9), with adjusted survival curves failing to demonstrate clinically meaningful differences in event rates. Similarly, TTH did not impact progression-free survival when also incorporating progression to definitive treatment (HR 0.94; 95% CI: 0.64, 1.38; p=0.8).

Conclusions: Utilization of TTH in the setting of AS did not significantly impact progression-free survival or treatment-free survival for patients receiving treatment when compared to patients who did not receive TTH.

Source of Funding: None

PAPER #29

UNMASKING MASCULINITY: BIOLOGICAL, BEHAVIORAL, AND SOCIAL DETERMINANTS OF TESOSTERONE DEFICIENCY IN U.S. MEN

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(Presentation to be made by Andrew J. Goulian, MPH)

Objectives: Testosterone deficiency is often viewed as a biological or age-related condition, yet hormone levels may also mirror broader social and behavioral influences. As a hormone linked to male identity, testosterone may serve as both a physiological signal and a social barometer. This study applied the Healthy People 2030 social determinants of health framework to identify biological, behavioral, and contextual predictors of testosterone deficiency among U.S. men.

Materials and Methods: Data were drawn from four cycles of the National Health and Nutrition Examination Survey (NHANES, 2011–2016 and 2021–2023). The analytic sample included 10,357 men aged 18 years or older with valid testosterone levels; men using exogenous testosterone were excluded. Testosterone deficiency was defined as total serum testosterone <300 ng/dL. Predictor variables included body mass index, fasting glucose, sedentary time, sleep, depressive symptoms, smoking, income-to-poverty ratio, education, employment, health insurance, usual source of care, marital status, and race or ethnicity. Multivariable logistic regression models adjusted for age and survey design.

Results: The prevalence of testosterone deficiency was 25.7%, declining from 28.1% in 2011–2012 to 20.3% in 2021–2023 (p-trend <0.01). Obesity (AOR 2.69, 95% CI 2.36–3.06), impaired fasting glucose (AOR 1.55, 95% CI 1.27–1.90), diabetes-range glucose (AOR 2.92, 95% CI 2.03– 4.21), and sedentary behavior ≥8 h/day (AOR 1.39, 95% CI 1.14–1.70) increased odds of deficiency. Lack of a usual source of care raised odds (AOR 1.27, 95% CI 1.05–1.54), while current smoking lowered odds (AOR 0.79, 95% CI 0.65–0.97). Never-married men had significantly lower odds than married men (AOR 0.70, 95% CI 0.57– 0.86).

Conclusions: Testosterone deficiency in U.S. men reflects intersecting metabolic, behavioral, and social factors. Beyond obesity and glycemic status, healthcare access and relational context play key roles. These findings support viewing testosterone as a biopsychosocial marker shaped by both physiology and the lived experience of masculinity.

Source of Funding: None

PAPER #33

GROUP MEDICAL VISITS IN UROGYNECOLOGY AND RECONSTRUCTIVE PELVIC SURGERY (URPS)

Lauren P.K. Muramoto M.D., M. Lynn Stothers M. D.*
(Presentation to be made by Dr. Lauren Muramoto)

Objectives: Alternatives to the traditional in person clinic visit model have become more utilized as the healthcare delivery systems have become more overburdened including the shared medical appointment (SMA) or group medical visit (GMV). There have been positive results published in the primary care, chronic pain and diabetes literature regarding productivity, access and patient centered outcomes (PROMs) in various SMA/GMV settings. Though there are recent studies regarding individual telehealth appointments in the urology setting, there have been no studies to date on telehealth in the URPS setting – particularly regarding virtual GMVs. Thus, aimed to determine if the virtual group medical visit (GMV) expands access to care, patient education and satisfaction allowing more dedicated time towards counseling and education without requiring burdensome travel to an in person appointment.

Methods: This was a single center prospective study. Virtual GMVs were created based on a common but URPS topic: recurrent urinary tract infection (rUTI) prevention. English speaking, female, established clinic patients were recruited. A pre-test was administered to all participants to establish baseline knowledge. Participants then attended one hour long GMV that included a didactic portion followed by question and answer session. Sessions were limited to 10 participants each. Participants then completed a post-test, validated Telehealth Usability Questionnaire (TUQ) and answered a survey assessing travel time or travel distance. A paired t-test was used to compare pre and post test scores.

Results: 317 patients were screened having met initial eligibility criteria. Of the 36 that were recruited to the study, 33 attended their visit, 25 completed the TUQ, 21 completed both the pre and post test and 19 completed all three components. Most participants reported high satisfaction with the visit and agreed that it was an acceptable method for receiving healthcare. Almost all participants agreed that the visit improved access to care. There was a statistically significant average improvement in pre and post test scores (1.52, 95% CI 0.73-2.32, $p < 0.05$) with some participants seeing an improvement by up to 5 points after attending the group visit session. Subjectively, participants offered positive feedback and enjoyed the additional information without needing to leave their homes. Limiting the size of the session allowed providers to answer individual questions during the question and answer portion.

Conclusions: The virtual GMV is an effective and well received inclusion to the regular patient care algorithm being easy to adopt in a busy URPS practice. Further research is needed to determine whether this format of non-individualized counseling is beneficial for other common but straightforward urogynecologic conditions, such as overactive bladder, genitourinary syndrome of menopause or stress urinary incontinence to name a few.

PAPER #34

A PROPOSED TEMPLATE FOR VIRTUAL GROUP MEDICAL VISITS IN UROGYNECOLOGY AND RECONSTRUCTIVE PELVIC SURGERY (URPS)

Lauren P.K. Muramoto M.D., M. Lynn Stothers M. D.*
(Presentation to be made by Dr. Lauren Muramoto)

Objectives: Group medical visits have become increasingly more utilized since the 1990s. Several studies have been published int he primary care, chronic pain and diabetes literature offering potential group visit templates either in live, virtual or mixed formats to help guide other clinicians in implementing these practices. However, there is little to be found in the literature regarding implementation of group medical visits in the URPS setting, particularly in a virtual format. Here we aim to present our virtual group visit template proposed as a potential format that could be adopted by other urology clinics and scaled to fit the needs of individual practices.

Methods: This was a single center prospective study. Virtual GMVs were created based on a common but URPS topic: recurrent urinary tract infection (rUTI) prevention. English speaking, female, established clinic patients were recruited. Patients were given instructions prior to the visit how to access the video platform through MyChart. GMV format involved and hour long templated appointment with approximately 30 minutes of didactics followed by a question and answer session in the remaining time. Participation was limited to 10 patients for each session. Patients were allowed to ask questions using the chat feature built into the video visit platform but were required to keep microphones muted for the duration of the visit to limit background noise. We used the screen share feature to display our presentation. The provider giving the talk had their video camera turned on. A scribe was present to aid with admitting patients to the visit and monitoring the chat function. While participants were encouraged to keep their cameras on, this was not a requirement. Participants were also not required to identify themselves by name, in fact there was a method to remain anonymous within MyChart's video platform.

Results: 317 patients were screened having met initial eligibility criteria. Of the 36 that were recruited to the study, 33 attended their visit. Most participants welcomed the group video format. Most sessions ended at least 15 minutes early as there was a natural conclusion to the visit once there were no further questions being answered in the chat feature. Some common questions included those regarding specific UTI symptoms, when to contact providers, medication related questions including methenamine which is not mentioned in current guidelines and dosages of common UTI prevention supplements. One participant remarked in the comment section they were unable to change their name after logging on. Another participant had sound issues related to their own personal headphones. A few participants had wished they could verbally ask questions rather than using the cumbersome chat feature.

Conclusions: The virtual GMV hosted through Epic's video visit platform is feasible to implement within a busy URPS practice. While there were some technical difficulties associated with both hardware and software, the system was intuitive and easy for providers to adapt to. Further work would be necessary to determine whether virtual GMVs are feasible in the military setting.

PAPER #35

NOVEL TECHNIQUE FOR TRANSCORPORAL ARTIFICIAL URINARY SPHINCTER PLACEMENT: THE GULLWING METHOD

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(Presentation to be made by Dr. Alec Basterrechea)

Objective: A fragile or compromised urethra can be difficult for traditional placement of the artificial urinary sphincter (AUS) in the proximal bulbar urethra for men with stress urinary incontinence. Transcorporal placement of the AUS provides an alternative approach although it has poor circumferential reinforcement of the urethra and occasionally omits future penile prosthetic placement. We discuss a variation of the transcorporal AUS placement with the gullwing method via case report. An 82-year-old male with history of robot assisted radical prostatectomy (2010) subsequent development of stress urinary incontinence (SUI) with sling placement (2013). SUI persisted and AUS was placed (2016). AUS cuff revision with cuff removal and replacement (2022). Erosion of cuff (2024) explanted with suprapubic tube placement cystoscopy showed a pale urethra at area of prior cuff placement. Patient was counseled on transcorporal AUS placement (2025).

Results: Transcorporal AUS Placement with Gullwing Method
The corporal bodies were exposed from the level of the penoscrotal junction to proximal of crura of the corporal bodies. Corporal wings were marked and cut. Wings were approximated over the ventral urethra with 4-0 chromic. Cuff size was measured to be 5.5cm which is upsized by 0.5 cm; therefore, a 6cm cuff is to be placed. The porcine graft was secured to close the corpora prior to passing the cuff with running 3-0 PDS.

Conclusions: The gullwing method for AUS placement is an approach involving two important aspects. Ventral corporal flaps allow for circumferential reinforcement of the urethra while dorsal placement of porcine graft allows for consideration of future penile prosthetic placement.

PAPER #36

THE ECONOMICS OF INNOVATION: COST OUTCOMES IN BLADDER CANCER CLINICAL TRIALS

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(Presentation to be made by Gabriel F Rodrigues, BS)

Objectives: On a per-patient basis, the lifetime cost of managing bladder cancer exceeds that of any other malignancy. Novel therapeutics and interventions have improved outcomes however contribute to rising costs of care. Despite the need to improve value-based care, little is known regarding cost inclusion in US clinical trials end points. Herein, we sought to determine the prevalence of cost considerations in bladder cancer clinical trial designs and describe characteristics of these trials.

Materials and Methods: Using ClinicalTrials.gov, all bladder cancer trials including cost in either the trial description, primary secondary or exploratory outcomes, were identified. Characteristics of these trials were evaluated, including study type, duration, completion status, enrollment, funding type, cost outcomes, and inclusion of cost-effectiveness analyses.

Results: Of 2,105 bladder cancer trials, 74 (3.5%) mentioned cost. Of these, 34 (45.9%) included cost as an outcome, including 2 as the primary outcome (5.9%), 25 as a secondary outcome (73.5%), and 7 as an exploratory (20.6%) outcome. Cost-effective analyses were performed in 5 (14.7%) trials. Most of these trials were interventional (79.4%) with the most common interventions being surgery (20.6%) and pharmacological (20.6%). Trials including costs were most commonly conducted in the USA (39.2%), United Kingdom (14.7%) and the Netherlands (11.8%). The majority of these (64.7%) included 100-499 participants, and 14 studies (41.1%) were completed.

Conclusions: Bladder cancer clinical trials rarely include cost considerations despite the increasing financial burden associated with management of this disease. Broader inclusion of costs in clinical trial design can potentially improve understanding of financial implications of novel treatments, enhance value-based care, and mitigate patient financial toxicity.

Source of Funding: None

PAPER #38

Single Port Total Urinary Tract Reconstruction After Crush Injury

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(Presentation to be made by Dr. Audra Garrigan)

Objectives: The objective of this video is to demonstrate a total urinary tract reconstruction including bilateral ureteral reimplantation and posterior urethroplasty using the da Vinci Single Port Robot System.

Material and Methods: The procedure was performed on a male patient presenting three months following pelvic crush injury.

Results: Successful urinary tract reconstruction

Conclusion: The Single Port system is an effective tool in total urinary tract reconstruction.

PAPER #39

IMMEDIATE ROBOTIC INTERVENTION OF IATROGENIC URETERAL INJURIES: A CASE SERIES

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Presentation to be made by CPT Jonathan S. Yu

INTRODUCTION
Ureteral injury during gynecologic surgery occurs at an estimated rate of 0.08 -1.3%, with a higher incidence attributed to laparoscopic hysterectomy. Approximately 62-70% of ureteral injuries are identified in the post-operative period. In the delayed setting the traditional recommendation for management includes urinary diversion with retrograde ureteral stent versus percutaneous nephrostomy placement, with consideration for immediate repair if identified within one week. In this case series we demonstrate the safety and feasibility of several techniques for early robotic intervention of iatrogenic ureteral injuries.

METHODS
From July to October of 2025 five patients with iatrogenic ureteral injury during a gynecologic procedure were transferred urgently from outside medical centers for urologic evaluation and intervention.

RESULTS
Every patient underwent percutaneous nephrostomy (PCN) tube placement at the time of injury diagnosis, prior to operative repair. The time to robotic repair after diagnosis of injury ranged from 1-8 days. PCNs were removed on day of surgery in all but one patient. A variety of reconstructive techniques were employed including Heineke Mikulicz ureteroplasty, ureteroureterostomy, ureteroneocystostomy, and augmented anastomotic ureteroplasty with buccal graft onlay. Two injuries were caused by suture ligation of the ureter. In both cases, after removal of the suture, IV indocyanine green confirmed excellent perfusion at the injury site, so further reconstruction was deferred. Average EBL was 43ml (5-100ml). Average operative time was 121min (15-260 min). The average time of post-operative admission was 1 day (0-2 days). Ureteral stents were removed without issues within 2-6 weeks of surgery. There were no post operative complications within 30 days of surgery.

CONCLUSION
This case series demonstrates that immediate robotic intervention of iatrogenic ureteral injuries due to gynecologic procedures is safe and feasible utilizing different robotic reconstructive techniques. This series also suggests that diagnosis of ureteral injury after 1 week from the index surgery should not necessarily preclude a patient from early surgical repair. Long term follow up is needed to determine the outcomes and perceived benefits of early intervention of iatrogenic ureteral injuries.

PAPER #40

TRANSURETHRAL VENTRAL INLAY BUCCAL MUCOSA GRAFT URETHROPLASTY: TECHNIQUE AND SHORT-TERM OUTCOMES

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

Objectives: Treatment options for anterior urethral stricture disease include dilation, direct visual internal urethrotomy (DVIU), and urethroplasty. Urethroplasty remains the gold-standard treatment as recurrence rates are significantly less than endoscopic modalities. For pendulous urethral strictures specifically, endoscopic management is not recommended due to exceedingly high recurrence rates. Despite this, urethroplasty remains underutilized due to both patient and provider related factors. Here we describe a novel technique for minimally invasive transurethral urethroplasty with buccal graft inlay. This minimally invasive technique could help address the current discrepancy in urethroplasty utilization due to its ease of adaptation and more benign post-operative recovery.

Materials and Methods: This is a case report of a singular case of pendulous urethral stricture treated with a novel transurethral ventral inlay buccal mucosa graft urethroplasty. The technique involves transurethral DVIU, balloon dilation, followed by endoscopic placement of two PDS sutures that are used to deliver and secure the proximal end of the buccal graft. These anchoring sutures are tied down on the ventral surface of the penis. The remainder of the graft is secured with externally placed quilting sutures and distal sutures at the meatus. The patient underwent peri-cath retrograde urethrogram prior to catheter removal and was followed post-operatively to observe for recurrence. IPSS and QOL, Q-max, and PVR were obtained at subsequent post-operative visits.

Results: Our patient presented with an approximately ____cm stricture involving nearly the entire pendulous urethra. His pre-op Q-max and PVR were 4.9 ml/s and 192cc respectively. The surgical time was 140 minutes. Post-operative Q-max and PVR will be obtained at the 6-week post-operative appointment.

Conclusions: This novel minimally invasive transurethral urethroplasty is a promising treatment option for urethral stricture disease. If proven durable, it would offer the superior outcomes of traditional urethroplasty with the less invasive and more benign recovery of endoscopic modalities. It may also be more easily adopted in the armamentarium of urologists without formal reconstructive training.

Source of Funding: none

PAPER #53

ASSESSING ABNORMAL VOIDING IN YOUNG ACTIVE DUTY MALES

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(Presentation to be made by Dr. Brittney Murray)

Objectives: Urethral stricture disease is a complex disease process with a variety of etiologies, clinical presentations, and treatment options. The objective of this case presentation is to detail a unique urethral stricture presentation and emphasize the importance of maintaining flexibility in treatment planning for this diverse patient population.

Materials and Methods: This is a case report detailing the clinical course of a patient ultimately diagnosed with a distal urethral stricture. This patient's atypical presentation and initial reluctance to pursue evaluation and treatment contributed to delays in both diagnosis and definitive management.

Results: The patient was an otherwise healthy 21 year old male with a history of an unknown childhood inguinal surgery who initially presented to an outside hospital with a painful left testis October 2022. He was diagnosed with a left scrotal abscess and underwent scrotal exploration and washout. His symptoms briefly resolved but he began to notice pain with ejaculation and new climacturia one month following his surgery. A CT with IV contrast completed at our institution in November 2022 showed heterogenous fluid in the right hemiscrotum and left inguinal canal as well as a cystic structure along the right posterior bladder. The patient completed several courses of antibiotics for bilateral epididymoorchitis before he reestablished urologic care and completed a CT Urogram in April 2024. This study redemonstrated the cystic structure in the right spermatic cord with extension into the right inguinal canal and a second cystic structure posterior to the bladder. Both structures were noted to follow the course of the right vas deferens. An attempt was made to complete an office cystoscopy in August 2024. This procedure was aborted due to the patient's inability to tolerate dilation past the fossa navicularis. His post-void residual (PVR) was 96cc at that time. Cystoscopic evaluation and retrograde urethrogram under anesthesia the following month significant for a tight, 2-3cm pendulous urethral stricture which was balloon dilated to 24Fr. The remainder of the patient's urethra, prostate, and bladder were normal. A right retrograde ureterogram was also normal. The patient initially had improved urinary flow and resolution of his climacturia following urethral dilation. His symptoms slowly returned over a month. A low, flat curve and 107cc of retained urine on uroflow with PVR were concerning for obstruction so the decision was made to place a suprapubic tube in January 2025. A retrograde urethrogram completed at the time of suprapubic tube placement reveal contrast reflux into a severely dilated right seminal vesicle. After a period of urethral rest, the patient underwent a transurethral ventral inlay urethroplasty in July 2025. The patient has continued to have a patent urethra.

Conclusions: This patient experienced a complex clinical course prior to diagnosis and surgical repair of his urethral stricture. A history of an undocumented childhood surgery and recurrent episodes of epididymoorchitis served as key indicators, but his diagnosis required a high index of suspicion. The patient's pendulous urethral stricture led to persistent reflux into his seminal vesicles and epididymal duct, resulting in repeated infections. Additionally, pooling of urine in the markedly dilated seminal vesicles contributed to his climacturia. This case underscores the need for urologists to consider further investigation in young patients presenting with atypical voiding symptoms or recurrent epididymal infections.

Source of Funding: None

PAPER #54

ROCK BOTTOM: AN UNUSUAL CASE OF MULTI-SYSTEM COMPLICATIONS FROM A LARGE BLADDER STONE

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(Presentation to be made by Dr. Nathaniel McLauchlan)

OBJECTIVES: To describe a rare presentation of a large bladder stone contributing to obstructive uropathy, renal failure, bacteremia, and rectal prolapse in an otherwise healthy adult male.

METHODS: Single case report detailing a 42-year-old man presenting with abdominal pain, constipation, and intermittent rectal prolapse.

RESULTS: The patient presented with a chief complaint of rectal prolapse. Labs revealed leukocytosis (23.8 K/mcL), anemia (Hgb 9.2 g/dL), elevated creatinine (8.9 mg/dL), and initial blood cultures demonstrated Enterococcus faecalis bacteremia. CT imaging identified a 6 cm bladder calculus with severe bilateral hydroureteronephrosis, bladder wall thickening, and a left inguinal hernia. Initial foley catheterization was unsuccessful. Open cystolithotomy revealed the stone adherent to the bladder neck and bathed in purulent fluid. The patient was treated with broad spectrum antibiotics and improved clinically before discharging home.

CONCLUSIONS: Rectal prolapse as an initial symptom of a massive vesical calculus is extraordinarily rare, with no prior reports of association with bacteremia. This case underscores the importance of considering obstructive uropathy in patients with rectal complaints, the anatomic interplay between pelvic organs, and the need for prompt multidisciplinary management to prevent long-term renal sequelae.

Funding: None.

PAPER #55

END STAGE BLADDER SECONDARY TO DYSFUNCTIONAL VOIDING: A UNIQUE INDICATION FOR SIMPLE CYSTECTOMY

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Presentation to be made by Dr. Reilly Carr

Objectives: Simple cystectomy is a potential management option for patients with non-malignant causes of bladder dysfunction such as interstitial cystitis, neurogenic bladder, radiation cystitis, hemorrhagic cystitis, and infectious disease. This is typically considered a last resort for management of the aforementioned conditions. The purpose of this case report is to provide an example of a rare etiology of end-stage bladder which was managed with simple cystectomy and urinary diversion for the purpose of renal preservation.

Materials and Methods: With patient's documented consent, the electronic medical record was used to provide de-identified information and images to discuss this case.

Results: The patient is a 64-year-old male with a history of type II diabetes mellitus and stage IV chronic kidney disease who was referred to urology for evaluation of bilateral hydroureteronephrosis on a non-contrasted CT scan. Cystoscopy and retrograde ureteropyelography demonstrated grade III bladder trabeculation with severe hydroureteronephrosis bilaterally down to the level of the intramural ureter. There was no evidence of significant BPH or urethral stricture to explain his hostile bladder consistent with chronic, severe obstruction. There were no masses evident on cystoscopy and an MRI pelvis was normal, without masses and a prostate volume of 32cc. In the absence of alternative etiologies to explain development of end-stage bladder, dysfunctional voiding was the most likely cause, and it appeared that physical obstruction of the ureters from severe trabeculations had been causing his deteriorating renal function. Management options were discussed with him including CIC or indwelling foley with routine stent exchanges, bilateral nephrostomy tubes, or simple cystectomy with urinary diversion. The patient ultimately elected for simple cystectomy with ileal conduit. His surgery was completed without complications, and recovered uneventfully, with discharge on postoperative day 6. Postoperatively he continued to progress well postoperatively with stable renal function and no physical deficits.

Conclusions: Though radical cystectomy has been included in the urologist's surgical competencies for some time in the management of bladder malignancy, simple cystectomy is a rarely used tool in the management of end-stage bladder disease. Though simple cystectomy has multiple potential indications, this case illustrates a patient with a unique cause of end-stage bladder. In this patient, voiding dysfunction alone appeared to contribute to severe trabeculations which resulted in bilateral chronic obstructive uropathy. Simple cystectomy was an appropriate management choice in this situation, providing the patient with an opportunity to preserve his remaining renal function while avoiding repeated procedures and the potential complications of an end-stage bladder en-vivo.

PAPER #56

A CASE OF SPONTANEOUS SUBEPITHELIAL PELVIC HEMATOMA (ANTOPOL-GOLDMAN LESION) IN A PATIENT WITH SUSPECTED HEMOPHILIA A

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

Objectives: Spontaneous subepithelial hemorrhage and hematoma of the renal pelvis is a rare clinical entity first described by Antopol and Goldman in their 1948 case series. There are less than 50 cases reported in the literature. Although the etiology is unclear, it has been associated with trauma, congenital renal anatomic abnormalities, hypertension, NSAID use, anticoagulant use, amyloidosis, and hemophilia. Patients typically present with intermittent flank pain and gross hematuria. CT findings include pre-contrast hyperdensity with mural thickening and a filling defect of the renal pelvis and proximal ureter, with non-enhancement on post-contrast images. Given that malignancy is often included on the differential, diagnostic ureteroscopy can be performed to confirm the diagnosis. Conservative management with correction of any underlying coagulopathy and interval imaging has also been described as an appropriate management strategy.

Materials and Methods: In this case report we present a patient with spontaneous hematoma of the right renal pelvis (Antopol-Goldman lesion) with concurrent suspected hemophilia A. Patient presentation, diagnostics, management, and outcomes are reviewed alongside the relevant literature.

Results: Our patient is a 73-year-old male with history of Parkinson's disease who initially presented with bilateral lower extremity deep vein thrombosis, spontaneous bruising, and several weeks of reported gross hematuria. Initial diagnostic work-up revealed elevated PTT, D-dimer, and Fibrinogen along with undetectable haptoglobin and decreased factor VIII activity concerning for acquired hemophilia A versus lupus anticoagulant syndrome. CT urogram demonstrated a circumferential hyperdense filling defect of the right renal pelvis and proximal ureter concerning for malignancy versus subepithelial hematoma. The patient would later undergo diagnostic ureteroscopy, which confirmed the diagnosis of subepithelial hematoma.

Conclusions: Antopol-Goldman lesions (AGL) are a rare clinical entity with known risk factors but unclear etiology. There is only one other instance of AGL with concurrent hemophilia reported in the literature.

Source of Funding: none

PAPER #57

CASE REPORT OF PEDIATRIC PENILE AMPUTATION FOLLOWING PLASTIBELL CIRCUMCISION

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(Presentation to be made by Dr. James Berry)

Objectives: While circumcision is a common procedure, amputation of the glans penis is a rare but serious potential complication. Factors such as circumcision technique and practitioner experience have been associated with variable rates of complication and penile injury in pediatric circumcision. We report a case of penile amputation during Plastibell (Hollister Incorporated, IL, USA) circumcision and subsequent re-anastomosis.

Materials and Methods: A 6-year-old boy with unremarkable past medical history underwent attempted Plastibell circumcision in a pediatrics clinic. Vigorous bleeding was noted during the procedure after which he presented to the emergency department for evaluation. The severed tissue had been wrapped in gauze and placed on ice in a specimen cup, and the penis was dressed with gauze. When dressing over external genitalia was taken down, immediate pulsatile bleeding was noted which obscured the wound and precluded proper examination. A compressive penile tourniquet of gauze and Coban was applied, and he was taken to the operating room for exploration and repair. Exam under anesthesia revealed complete amputation of the distal glans and complete transection of the fossa navicularis. Decision was made to proceed with primary replantation. An 8Fr catheter was placed across the transected fossa and into the native urethra. Re-anastomosis of the distal glans and fossa navicularis was performed over the catheter with 6-0 PDS in a directed, simple interrupted fashion circumferentially around the glans. The remaining proximal circumcision line was re-approximated in a directed, simple interrupted fashion.

Results: On post-op day one, the patient's pain was adequately controlled with acetaminophen, and he was discharged with catheter to drainage bag. On post-op day seven, patient was seen in clinic for wound check and was noted to be healing well with minimal swelling and intact stitches. On post-op day 13, he was seen again for follow up where he was noted to be healing with a good cosmetic result and his catheter was removed.

Conclusions: Penile amputation is a rare yet potentially devastating complication of pediatric circumcision. Careful primary repair often results in good cosmetic outcomes and may be performed with or without microvascular re-anastomosis of the amputated tissue.

Source of Funding: None

PAPER #58

NEONATAL ADRENAL HEMORRHAGE PRESENTING AS SUSPECTED TESTICULAR TORSION: A CASE REPORT

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(Presentation to be made by Dr. Kailey Davis)

Introduction and Objectives: Neonatal adrenal hemorrhage (NAH) is a rare but documented occurrence with an incidence of ~2 per 1000 live births. Most cases occur on the right side, thought to be due to venous drainage emptying directly into the inferior vena cava, and thus being more affected by mechanical pressure. Generally, NAH is asymptomatic and self-resolving, but there are case reports describing anemia, jaundice, adrenal insufficiency, or scrotal swelling as the presenting symptom. This case study describes a case of neonatal adrenal hemorrhage identified after initial presentation as suspected testicular torsion.

Methods: Patient was a 38+4 week male born via spontaneous vaginal delivery to 31-year old G7P4 mother with pregnancy notable only for gestational diabetes. Right scrotal ecchymosis and swelling was noted raising suspicion for testicular torsion. Scrotal ultrasound showed a complex mass adjacent to the right testis but normal blood flow bilaterally. Repeat examination demonstrated ecchymosis over the right groin after which urology team recommended abdominal ultrasound, revealing large right adrenal hematoma with likely congenital adrenal hemangioma and extension of hematoma through a patent processus vaginalis.

Results: Given normal vitals and normal hemoglobin, conservative management was employed which entailed observation and serial hemoglobin checks. Vitals and hemoglobin remained stable for several days and resolution of scrotal and groin ecchymoses was seen, after which he was discharged with plans for future outpatient follow up.

Conclusion: This case highlights neonatal adrenal hemorrhage as a rare cause of scrotal swelling and edema in a newborn which would otherwise suggest testicular torsion. More importantly, it underscores the need to avoid premature closure and maintain an appropriate differential diagnosis, especially when findings are discordant from the initial working diagnosis. This practice allows for identification of other possible pathology – for instance, a strangulated inguinal hernia – and facilitates appropriate coordination with specialists to provide optimal patient care.

Source of Funding: None o CIC selectively, mostly before strenuous activity or overnight, and notes

PAPER #59

NAVIGATING NEUROGENIC BLADDER IN A MILITARY AVIATOR: A CASE OF TETHERED CORD SYNDROME PRESENTING WITH PELVIC FLOOR DYSFUNCTION

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(Presentation to be made by Dr. Brayden Payne)

Objectives: Tethered cord syndrome (TCS) is a rare but significant spinal cord disorder often diagnosed in childhood, and even more rarely in previously asymptomatic adults. This case discusses a 31-year-old active duty F-15 pilot who presented with urinary and fecal incontinence during high-G maneuvers and was ultimately diagnosed with adult-onset tethered cord syndrome. His condition progressed despite surgical intervention, requiring a multidisciplinary approach including two tethered cord releases, urodynamic testing, and pelvic floor therapy, with eventual recovery of near-baseline voiding function.

Materials and Methods: The patient, initially developed saddle anesthesia and urinary/fecal incontinence in October 2020. Lumbar MRI demonstrated a low-lying conus medullaris at S1, lipoma of the filum terminale, and transitional lumbosacral anatomy. EMG revealed lower sacral polyradiculopathy. Urodynamics demonstrated dysfunctional voiding and a post-void residual (PVR) of 120 cc. He underwent S1-S2 laminectomy with tethered cord release in January 2021, and a second release at Stanford Medical Center in September 2022 due to worsening symptoms.

Results: Following his initial surgery, the patient experienced worsening bladder and bowel symptoms, including urge and stress incontinence, and persistent saddle anesthesia. CIC (clean intermittent catheterization) was initiated 3x daily, which improved symptoms. Post-second tethered cord release, he experienced marked improvement in continence and sensory function. At follow-up in August 2024 and again in August 2025, renal bladder ultrasounds showed stable upper tracts, no hydronephrosis, and PVRs improved from 100 cc (2024) to 25 cc (2025). He continues to CIC selectively, mostly before strenuous activity or overnight, and notes only mild climacturia or urgency if he does not self-cath. He has regained nearly complete control of voiding with no lower extremity neurologic deficits.

Conclusions: This case highlights the diagnostic and management challenges of tethered cord syndrome in an adult with high physical demands and atypical presentation. The patient's occupation as an F-15 pilot likely led to symptom exacerbation during high-G maneuvers, a unique context that underscores the importance of occupational history in urologic evaluation. TCS should remain on the differential in adult patients presenting with saddle anesthesia, neurogenic bladder, or bowel dysfunction, especially with supportive imaging findings. Successful management requires a coordinated neurosurgical, urologic, and rehabilitative approach. Furthermore, this case reinforces the value of long-term urologic follow-up in optimizing continence and preserving upper tract function.

Source of Funding: None

PAPER #60

IN VITRO FERTILIZATION EGG RETRIEVAL AND UROLOGIC COMPLICATIONS: A CASE SERIES

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(Presentation to be made by Dr. Alec Basterrechea)

Objectives: In the United States in vitro fertilization (IVF) has almost doubled in the past 10 years. Rarely does IVF egg retrieval lead to serious complications. Specifically, urologic complication rates such as ureteral or bladder injuries are around 0.01%. This case series presents two urologic complications related to IVF egg retrieval.

Ureteral injury: A 36-year-old female presented to the ER four days after IVF egg retrieval with right flank pain. A CT abdomen pelvis with contrast revealed mild right hydronephrosis and delayed nephrogram.

Bladder injury: A 41-year-old female presented to the ER five days after IVF egg retrieval with one day of hematuria and downtrending hemoglobin. CT hematuria showed large clot burden in the bladder and small volume hemoperitoneum.

Results: Ureteral injury: Cystoscopy with retrograde pyelogram and right ureteral stent placement revealed extensive edema at right ureteral orifice. Retrograde pyelogram did not show extravasation of contrast although it was performed 2 cm proximal to ureterovesical junction, so distal extent of ureter was not visualized. A double J ureteral stent was placed (for four weeks) along with a foley (for two days).

Bladder injury: Cystoscopy with clot evacuation, fulguration, retrograde pyelogram and stent placement revealed residual clot and pulsatile bleeding near the left ureteral orifice. Clot was evacuated and pulsatile bleeding was fulgurated. Retrograde pyelogram performed without evidence of ureteral injury. A double J ureteral stent was placed in the left ureter (for one week) along with a foley (for one day). 2upRBC were intraoperatively.
Conclusions: Urologic complications after IVF egg retrieval are rare; however, urologists should be aware of these urologic complications. These cases may provide management strategies for ureteral or bladder injuries after IVF egg retrieval.

PAPER #61

A COMMON UROLOGIC COMPLAINT FROM AN UNCOMMON SOURCE: A CASE OF BILATERAL SPERMATIC VEIN THROMBI

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Presentation to be made by Monica Van Shufflin, M.D.

Objective: In this review, we present and discuss a rare case of spontaneous bilateral spermatic vein thrombosis

Introduction: Acute testicular pain is a frequent urological complaint in the emergency department commonly attributed to testicular torsion, epididymo-orchitis, complicated or incarcerated hernias and varicocele of the spermatic cord1,2. Spermatic vein thrombosis, though rare, should be considered in differential diagnosis, particularly when typical causes have been excluded. Most reported cases of spermatic vein thrombosis involve unilateral involvement, with the most common site being on the left side3; isolated bilateral spontaneous cases are exceedingly uncommon. Etiological factors include intense physical exertion, indirect inguinal hernias, structural defects, trauma and hypercoagulable states5. Doppler ultrasound remains the primary diagnostic tool for accurate identification of thrombosis in the spermatic veins.

Methods: This case report demonstrates a common urologic complaint with an uncommon etiology; bilateral spermatic venous thrombi.

Results: The patient was referred to hematology/oncology for further work up and management. Further work up included coagulopathy lab work and CT abdomen/pelvis to rule out intrapelvic or intraabdominal pathology. He was treated with anticoagulation with repeat ultrasound with resolution of his bilateral thrombi.

Conclusions: Bilateral spermatic vein thrombosis is rare but should be considered in differential diagnosis of scrotal pain.

Source of funding: None

PAPER #62

MASSON'S TUMOR OF THE SCROTUM CASE REPORT

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(Presentation to be made by Ryan Colby)

Objectives: Intravascular papillary endothelial hyperplasia (Masson's tumor) is a benign vascular proliferation which causes raised skin lesions. Although its exact cause remains unclear, it is often associated with prior vascular injury, thrombosis, or malformations. Masson's tumor typically occurs in soft tissues of the head, neck, and extremities. We describe a rare case arising in the left hemiscrotum that clinically resembled a cutaneous horn, ultimately excised due to possible malignant potential. This case underscores the importance of maintaining a broad differential for scrotal skin lesions, and performing oncologic excision due to potential abnormal presentations which could represent malignancy in rare cases.

Materials and Methods: Patient consent was obtained prior to data collection. The electronic medical record was used to document and present the patient's case and relevant images. Results: A 27-year-old healthy male with a history of mild bilateral hydroceles and small epididymal cysts presented with a gradually enlarging, firm, dark scrotal nodule. This lesion was preceded by a "blood-blister" which he attempted to treat on his own by crushing. Physical examination revealed a solitary exophytic, dark, horn-like, 1cm lesion on the left scrotum without tenderness, discharge, or lymphadenopathy. The lesion's horn-like morphology raised concern for a cutaneous horn or keratoacanthoma. Complete surgical excision at the base was performed in the operating room and closed primarily. Histopathologic examination of the excised specimen demonstrated organizing thrombus with proliferation of vascular channels. The findings favored a diagnosis of a Masson's tumor, with benign hemangioma considered in the differential. No features of dysplasia or malignancy were identified. The postoperative course was uncomplicated, and no recurrence was observed on 1 month follow-up.

Conclusion: This case illustrates the importance of maintaining a broad differential in the workup of atypical scrotal lesions. Although rare, recognition of these entities can prevent misdiagnosis of malignant or pre-malignant lesions as benign. Clinicians should remain vigilant for uncommon presentations, as accurate histopathologic evaluation is essential to ensure proper diagnosis and appropriate treatment.

Source of Funding: Non

PAPER #63

MANAGEMENT OF A LARGE SYMPTOMATIC COWPER'S DUCT CYST IN A YOUNG MALE: OPEN EXCISION WITH CONCOMITANT URETHROPLASTY

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(Presentation to be made by Dr. Jae Woo Shin)

Objective: Cowper's duct cysts (syringoceles) are rare lesions of the male genitourinary tract. Although often asymptomatic and incidentally detected, they may cause pain, lower urinary tract symptoms (LUTS), infection, or acute urinary retention. Reported management strategies include observation, endoscopic marsupialization or unroofing, and open excision with or without urethroplasty. This case report describes the management of a large, symptomatic Cowper's duct cyst in a young male and highlights key considerations when urethral involvement necessitates open surgical intervention, an area where limited data are available.

Results: A 19-year-old otherwise healthy male presented with progressive left groin, scrotal and perineal pain, worsening LUTS, and an episode of acute urinary retention complicated by Enterobacter urinary tract infection. Imaging revealed a 5 cm periurethral cyst consistent with a Cowper's duct syringocele. Intraoperatively, the cyst measured 5–6 cm, was septated, and densely adherent to a thin urethral mucosa. Complete excision of the cyst was not practical without excising a large segment of ventral urethral mucosa. The cyst was drained, cyst walls not adherent to the urethral mucosa were excised and the residual edges were fulgurated and oversewn. A small urethrotomy was repaired primarily with a two-layer urethroplasty. He recovered without immediate complications. A postoperative peri-catheter retrograde urethrogram (RUG) performed at three weeks demonstrated no extravasation, confirming a watertight urethral repair, and the Foley catheter was removed.

Conclusion: This case highlights the spectrum of Cowper's duct cyst management. While endoscopic approaches are effective for smaller, communicating lesions, large, septated, and urethra-adherent cysts may necessitate open excision and urethroplasty. Preoperative imaging and intraoperative findings should guide surgical decision-making to optimize outcomes and minimize recurrence.

Source of Funding: None

PAPER #64

PEDIATRIC ZINNER SYNDROME

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(Presentation to be made by Dr. Samuel Shalov)

Introduction/Objectives: Zinner Syndrome (ZS) is a rare congenital anomaly characterized by unilateral renal agenesis with an ipsilateral seminal vesicle cyst (SVC) and ejaculatory duct obstruction. The disorder occurs due to abnormal development of the mesonephric duct during the fifth week of gestation. Symptomatic patients typically present between twenty to forty years of age with common complaints including perineal/abdominal pain, dysuria, pain with ejaculation, epididymo-orchitis, infertility, and hematospermia. In the pediatric population, ZS is often detected incidentally due to the routine use of pre and postnatal renal/bladder ultrasound imaging. The most common presentations for symptomatic pediatric patients include recurrent urinary tract infections and epididymo-orchitis. For those with findings suspicious for ZS, MRI serves as the gold standard for confirming the diagnosis. Due to the risk of damaging nearby structures in the deep pelvis, treatment in asymptomatic patients is not pursued routinely. For those that are symptomatic, treatment options include excision or unroofing of the SVC, vesiculectomy, and/or resection of Wolffian structure remnants.

Case Presentation: We report the case of a 15-year-old male with history of right renal agenesis detected prenatally. He was initially referred to Gastroenterology after multiple Emergency Room presentations secondary to severe rectal pain. A workup for Inflammatory Bowel Disease was negative and he was ultimately referred to Pediatric Urology after a temporal relationship between ejaculations and symptom onset was identified by the patient. He denied a history of urinary tract infections, hematuria, stranguria, or hematospermia. A scrotal ultrasound was negative for abnormalities. Due to his history of right renal agenesis, an MRI of the abdomen and pelvis was obtained to evaluate for additional anatomic abnormalities. Imaging was notable for his known right renal agenesis, a significantly dilated right seminal vesicle, and a likely dilated distal right ureter with the appearance of seminal fluid within these structures. This constellation of findings is characteristic of ZS. Treatment options included continued monitoring of his symptoms, ultra-sound guided seminal vesical aspiration with vesiculography, or robot-assisted laparoscopic vesiculectomy. A semen analysis was offered to the patient prior to any procedure which was declined. After deliberation, the patient and family have elected for robotic vesiculectomy scheduled for October 7th, 2025 with operative findings to be discussed at the time of case presentation.

Conclusions: Zinner Syndrome is a rarely occurring congenital condition often discovered incidentally in the pediatric population. In select instances, operative intervention may be desired by patients and their families to relieve bothersome symptoms.

Source of Funding: None

PAPER #65

ASSESSMENT OF THE QUALITY OF RESOURCES ON BPH SURGERY ACROSS MAJOR SEARCH ENGINES

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'- Kiran Patel College of Osteopathic Medicine, Nova Southeastern University, Davie, Fl, US, *- Desai Sethi Urology Institute, University of Miami, Miami, Fl, US

Background: Many patients turn to the internet for information about managing medical conditions and their complications. Identifying high-quality sources is crucial. While quality evaluations of online health information are emerging in other specialties, urology lacks similar studies. This study provides the first evaluation of the quality of patient information across multiple search engines, focusing on resources related to prostate surgeries.

Methods: In October 2024, we conducted searches across ten search engines—Google, Bing, Yahoo, Baidu, Yandex, DuckDuckGo, Ask, Naver, AOL, and Seznam—using the keywords “TURP,” “Prostate Resection,” “Prostate Surgery,” “HoLEP,” “Aquablation,” and “Urolift.” The first two pages of search results were compiled, reviewed independently by two authors (J.S. and A.R.), and evaluated using the Quality Evaluation Scoring Tool (QUEST), which scores articles on a scale of 0 to 28, with a higher score indicating better quality. We performed a Kruskal-Wallis test to determine if there were statistically significant differences between search engines or between the first and second pages of results.

Results: The mean QUEST score across all search results was 16.25 (SD=5.08). DuckDuckGo had the highest average QUEST score of 17.15 (SD = 4.65), while Ask had the lowest average score of 9.15 (SD = 5.02). However, the Kruskal-Wallis test revealed no statistically significant differences between the search engines (p = 0.7179) (Figure 1). The average Although the average QUEST score was higher for 2nd page results (16.54 vs 15.93) the difference was not statistically significant (figure 2).

Discussion: This study found consistent quality in the information regarding prostate surgeries across different search engines and between the first and second pages of search results. Despite some variation in scores, the overall quality of prostate surgery-related information appears comparable across search engines and pages.

PAPER #66

BILATERAL ORCHIECTOMY: AN UNCOMMON RESULT OF TERTIARY SYPHILIS

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Presentation to be made by Monica Van Shufflin, M.D.

OBJECTIVES: To describe an atypical cause of bilateral testicular masses.

INTRODUCTION: Syphilis is a relatively common sexually transmitted infection caused by Treponema pallidum, a gram-negative spirochete that often manifests with minimal physical symptoms. Primary syphilis typically presents with a painless chancre at the site of inoculation. If untreated, the infection may progress to secondary syphilis, characterized by a non-pruritic rash (often involving the palms and soles) and mucosal lesions. Tertiary syphilis may occur more than 10 years after the initial infection and can involve multiple organ systems, most commonly the cardiovascular system and central nervous system (neurosyphilis), though any organ can be affected. Pathologically, syphilitic lesions can be challenging to diagnose, as they often demonstrate nonspecific inflammatory changes. Special stains, such as silver staining, may aid in the detection of spirochetes but have a high false-negative rate (30–70%)[1]. Testicular involvement is also rare and can mimic neoplastic processes both clinically and radiographically.

CASE REPORT: A 27-year-old HIV-positive male (treatment non-compliant) presented with a 3-month history of bilateral testicular pain and palpable masses. Work up, in addition to detailed H&P: Ultrasound: Bilateral heterogeneous testicular masses measuring 2.4 × 2.2 × 2.2 cm (right) and 3.4 × 2.6 × 3.2 cm (left). Additionally, a 3.4 × 3.2 × 3.0 cm heterogeneous paratesticular mass was noted along the right epididymis. Vascularity was preserved bilaterally. CT abdomen/pelvis: Mildly enlarged retroperitoneal lymph nodes, none overtly pathologic. Serum tumor markers: LDH 178, β-hCG <3, AFP <3.6. Given his age and presentation, bilateral germ cell tumors were the leading differential diagnosis. The paratesticular lesion was thought to be an inflammatory process or possible sarcoma. The patient subsequently underwent uncomplicated bilateral orchiectomy.

RESULTS: Pathology was sent for outside consultation. Prior to those results, the patient was discussed in multidisciplinary tumor board which raised concern for other, non-malignant causes such as syphilis or vasculitis based on local pathologic findings. Two days later, the patient was seen in follow up and shared that he had prior history of syphilis that was reportedly treated. Histopathology ultimately revealed extensive necrotizing orchitis bilaterally. Both specimens demonstrated tissue necrosis and a mixed inflammatory infiltrate composed of CD20-positive B cells, CD3-positive T cells, and CD138-positive plasma cells. No evidence of germ cell neoplasia in situ or malignancy was identified. Syphilis serology at the time of diagnosis: RPR titer 1:128.

DISCUSSION: Bilateral testicular tumors are rare. The differential diagnosis includes: Primary testicular lymphoma (more common in middle-aged men), synchronous bilateral germ cell tumors, metastatic disease from extratesticular primaries, and adrenal rest tumors. Testicular involvement from syphilis is an uncommon but important consideration, especially in patients with known risk factors such as HIV infection, high-risk sexual behavior, or prior history of syphilis. In this case, the clinical and radiographic findings mimicked malignancy, but pathology confirmed syphilitic orchitis.

CONCLUSIONS: Testicular syphilis, though rare, should be considered in the differential diagnosis of bilateral testicular masses, particularly in patients with significant risk factors. Early recognition is important to potentially avoid unnecessary surgery and to guide further medical therapy.

SOURCE OF FUNDING: None.

PAPER #67

FINANCIAL TOXICITY INTERVENTIONS IN CANCER PATIENTS: A SYSTEMATIC REVIEW

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(Presentation to be made by Dr. Evalyn George)

Objectives: Rising costs in healthcare, prolonged treatment courses, and increasing survivorship have all amplified financial hardship amongst oncologic patient populations. Financial toxicity is an emerging area of interest in cancer research, which describes the costs and burdens of both diagnosis and treatment to the patient. This systematic review aims to comprehensively evaluate the current literature on interventions targeting financial toxicity in cancer care.

Methods: A systematic search was conducted through February 2024 using key terms encompassing cancer, financial toxicity, and financial interventions, guided by the 2009 American Society of Clinical Oncology Guidance Statement. Articles were screened and selected in Covidence, with inclusion determined by agreement of two independent reviewers; a third reviewer served as a tiebreaker when necessary. Studies were assessed for intervention type, target population, and outcome measures.

Results: The search criteria identified 4364 unique articles, 178 of which met the inclusion criteria; however, many were early pilot programs without significant follow up or implementation. The most predominant themes are detailed in Figure 1. Direct financial assistance emerged as the most frequently reported intervention, primarily addressing objective indicators of financial toxicity, including out-of-pocket expenses, work-related disruptions, and risk of bankruptcy. Other commonly reported interventions included patient navigation programs, which facilitate the identification of individualized patient needs and available resources, psychosocial support initiatives, and multidisciplinary care approaches, however many interventions were met with only mixed success.

Conclusions: This review highlights that financial toxicity is a critical determinant of cancer care delivery, yet interventions to mitigate have demonstrated variable effectiveness. Although many studies included in this review are small-scale pilot investigations, a range of potential strategies exist to reduce financial burden and address systemic barriers. Despite promising efforts, gaps remain in standardization and evaluation of these interventions, underscoring the need for rigorous, patient-centered research to optimize strategies that reduce financial hardship and improve equitable cancer outcomes.

Source of Funding: National Cancer Institute Funding K08 CA267062 04

PAPER #68

HYPOGONADISM RATES BY OCCUPATION OF ACTIVE-DUTY SERVICE MEMBERS

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(Presentation to be made by Dr. Gibson)

Objectives: Testosterone has been shown to decline following military training/missions, likely due to the high physical demands, low energy intake, psychologic stress, and sleep deprivation. We aimed to evaluate rates of hypogonadism per military occupational specialty (MOS). We hypothesized that elite forces like special operations would have higher rates of hypogonadism.

Methods: Military Health System Data Repository (MDR) from 2017-2024 was queried. Active-duty men ages 18-64 years-old were included. Extracted data included age, rank category, race, and presence or absence of hypogonadism by ICD code. Analysis was narrowed to the 20 MOS's with the highest rates of hypogonadism.

Results: Of 2,840,511 men included, 12,112 had a diagnosis of hypogonadism (0.43%). Men with hypogonadism were older (38.21±7.53 years) than men without a diagnosis (25.75± 8.19 years); $p<0.001$. Hypogonadism was diagnosed in general officers (2.14%), warrant officers (2.09%), and field-grade officers (1.74%) at rates 4x higher than the study population. 1.21% of non-commissioned officers were affected. Lower than average rates were found in company-grade officers (0.38%) and junior enlisted servicemembers (0.05%); $p<0.001$. Racial differences were noted with highest rates in American Indian/Alaskan native (0.67%), followed by White (0.47%), Asian/Pacific Islander (0.38%), and Black/African American (0.22%); $p<0.001$.

Hypogonadism was found in a preponderance of cyberspace operations to include Navy general cyberspace operations (64.70%) and Air Force general cyberspace operations (13.07%). 13.44% Navy explosive ordinance disposal (EOD) had a diagnosis of hypogonadism compared to 10.08% Marine EOD. As hypothesized, Navy Special Forces (27.53%) and Army Special Forces (7.93%) had exceptionally high rates of hypogonadism.

Conclusions: Overall rates of hypogonadism are low in the active-duty military population with higher rates seen in cyberspace operations, special forces, and EOD compared to the general military population. Further conclusions are limited by reliance on an ICD code without access to lab levels or prescriptions as this data is unreliable in MDR. Additionally, there may be significant selection bias if certain MOS's are more inclined to inquire about testosterone or certain unit providers are more likely to evaluate for hypogonadism. Further research prospectively evaluating all servicemembers is needed to remove this potential selection bias.

PAPER #69

ONE YEAR FOLLOW UP: RETROSPECTIVE DATA AND LESSONS LEARNED FROM THE FIRST YEAR UTILIZING STEERABLE VACUUM STONE EXTRACTION

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(Presentation to be made by Dr. Alexis Eastburn)

Objectives: Present data derived from the first year of cases at Madigan Army Medical Center utilizing the Calyxo® steerable vacuum stone extraction system (CVAC), including patient demographics, average stone size, stone composition, and stone free rates, as well as discuss lessons learned from a full year of utilizing CVAC in our clinic.

Methods: A retrospective chart review was performed on all cases within the Madigan Urology Department during which CVAC was used, from August 2024 to September 2025 totaling 35 cases. For each case the following information was recorded: patient age, stone size, unilateral vs bilateral, stone composition, anticoagulation use, other significant comorbidities, whether they were presented, intra- or post-op complications, and whether they were stone free at the standard post-ureteroscopy renal bladder ultrasound at 6-8 weeks post-operative.

Results: The average age of patients for which CVAC was employed was 62.09. The average stone size was 2.11cm, excluding 2 cases for which CVAC was utilized to clear significant debris, not formed calculi. Majority of cases were unilateral (68.5%). 22 patients (62.9%) were presented. The most common stone composition was calcium oxalate (55.7%), followed by uric acid (15.7%), calcium phosphate (7.1%), and brushite (4.3%). Of the 35 cases, 7 patients (20%) were on chronic anticoagulation. Significant comorbidities amongst the patients included history of MI, CAD, PE, DVT, and/or atrial fibrillation. Four complications were recorded, including a UPJ perforation, a parenchymal perforation, a post-operative DVT, and post-operative pyelonephritis. Of the patients who had post-operative imaging completed at the time of data collection (n=28), 12 patients (42.8%) were stone-free, and 16 patients (45.7%) had residual stones, as measured by standard 6-8 weeks post-op renal bladder ultrasound or alternative equivalent imaging.

Conclusions: The Calyxo® steerable vacuum stone extraction system (CVAC) remains a valuable tool for ureteroscopy, allowing the Urologist to treat large stone burdens that would otherwise require PCNL or staged ureteroscopy. From this retrospective review, we demonstrate the ability to get patients stone-free with a single procedure using CVAC over 40% of the time. The patient demographics noted in this retrospective review highlight the role of CVAC for patients who are poor candidate for PCNL due to chronic anticoagulation use or other significant medical comorbidities. Furthermore, the 68.5% of cases where the patient was presented highlights the importance of considering the larger 11.9Fr overall diameter of the device, one of the notable lessons we learned over the first year utilizing CVAC in our practice.

Source of Funding: None

PAPER #70

VERY LOW RATES OF ADEQUATE EVALUATION OF ADRENAL INCIDENTALOMA BY BOTH UROLOGISTS AND ENDOCRINOLOGISTS: A SINGLE INSTITUTION EXPERIENCE

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(Presentation to be made by Maximilliano Buckner)

Objectives: The incidence of adrenal incidentalomas (AIs) continues to rise with the increasing utilization of cross-sectional imaging. However, adequate endocrinological evaluation and radiologic follow up of AIs remains variable, and, in some cases, omitted. We sought to understand the follow-up management and referral patterns of urologists and endocrinologists.

Methods: A retrospective study was conducted, including all patients who were found to have an AI between 2018 and 2022 at our institution. An AI was defined as an incidental finding of an adrenal mass, lesion, nodule, or adenoma greater than 1cm in an imaging report. Data collection included clinical characteristics, referral details, and laboratory, radiological, and pathological evaluations within a two-year follow-up period. Descriptive statistics and statistical analyses were performed.

Results: A total of 555 patients were included in this study with 192 and 55 patients having a first referral to endocrinology and urology for AI workup, respectively. There was a statistically significant difference in time to first evaluation between urologists and endocrinologists, with average times of 3.4 and 4.8 months, respectively (t-test, $p = <0.0001$). Notably, 74.5% of endocrinology patients were new patients compared to 59.2% of urology patients (t-test, $p = 0.0478$). Moreover, 27.3% of urology patients underwent a hormonal workup as dictated by the Boston Medical Center Adrenal Incidentaloma (BMCAI) algorithm, as compared to 31.3% of endocrinology patients (Fisher's exact test, $p = 0.6211$). The median lesion sizes were 2.2cm and 2.1cm for urology and endocrinology patients, respectively (Mann-Whitney test, $p = 0.1044$). Of the 44.5% of patients who were not referred to a specialist, 1.1% of patients underwent a hormonal workup indicated by the BMCAI algorithm with an average time to lab evaluation of 12.3 months.

Conclusion: Unsurprisingly, referrals to urologists for AI evaluation are much less common than referrals to endocrinologists. A minority of all patients diagnosed with AI are referred to either specialty for evaluation. Notably, for those patients referred to either urologists or endocrinologists, most patients are not adequately evaluated for hormonal hypersecretion, and no difference in rate of evaluation was detected between the specialties. However, referral to either specialty increases workup rate greatly. While this study is limited to a single institution, it may signify a potential broader gap in care; multi-institutional studies are needed to validate and strengthen these findings.

Sources of funding: None

PAPER #71

OPIOIDS PRESCRIBED FOR KIDNEY STONES NOT ASSOCIATED WITH RISK OF OPIOID USE DISORDER IN A NATIONALLY REPRESENTATIVE COHORT

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(Presentation to be made by Dr. Bryan C. Kaps)

Objectives: Concerns regarding opioid prescribing for kidney stone pain center on the potential risk of subsequent opioid use disorder (OUD). We sought to evaluate the risk of OUD following opioid prescriptions specifically for kidney stone in a national standardized survey.

Materials and Methods: Using the Medical Expenditure Panel Survey (MEPS, 2010–2019), we identified opioid prescriptions attributable strictly to kidney stone treatment. We assessed the odds of future OUD as well as subsequent non–stone-related opioid prescriptions. Analyses incorporated survey weights and multivariable logistic regression for both cross-sectional and temporal models.

Results: 238,048 participants represented 245 million U.S. adults annually; 3.15% had kidney stones and 0.36% had OUD. Kidney stone diagnosis was associated with OUD (OR 1.82, 95% CI 1.28-2.59), however, after controlling for non–stone-related opioid prescriptions the association disappeared (OR 1.04, 95% CI 0.72–1.50). Temporal analyses showed that opioids prescribed for stones were not associated with subsequent opioid prescriptions (OR 1.14, 95% CI 0.78–1.68). In contrast, opioids prescribed for non-stone indications were strongly associated with both OUD (OR 2.93, 95% CI 2.22–3.89) and subsequent opioid prescriptions (OR 4.58, 95% CI 3.88–5.40). Notably, 0 of 294 patients prescribed opioids for stones developed OUD, compared with 118 of 12,791 prescribed opioids for other reasons.

Conclusions: Although kidney stone diagnosis correlates with OUD, this association appears to be confounded by opioid prescriptions for non-stone conditions. Temporal analysis suggests that short-term opioid prescriptions for acute stone pain do not increase risk of OUD or future non-stone opioid prescribing. While limited to two years of follow-up, these findings support the relative safety of appropriately targeted, short-duration opioid use for kidney stones.

Source of Funding: None

PAPER #72

THE INFLUENCE OF SURGICAL APPROACH ON PATIENT QUALITY OF LIFE: A COMPARATIVE ANALYSIS OF LAPAROSCOPIC VERSUS ROBOT-ASSISTED ADRENALECTOMY

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Kiel, Germany, Berlin, Germany
(Presentation made by Major Tino Wilke MD)

Introduction: Adrenal tumors can be successfully removed using minimally invasive techniques. At the University Medical Center Schleswig-Holstein, Campus Kiel, minimally invasive adrenalectomies have been performed since 2008, with a shift toward predominantly robot-assisted procedures since 2014. This patient cohort was assessed for health-related quality of life using the internationally validated instrument EORTC QLQ-C30.

Materials and Methods: Patients who underwent laparoscopic (LA) or robot-assisted (RA) adrenalectomy at UKSH Campus Kiel between 2008 and 2019 were included. A total of 102 patients were contacted via questionnaire, of which 39 responses were eligible for analysis. The EORTC data as well as peri- and postoperative clinical parameters were evaluated.

Results: The overall cohort showed minimal impairments in functional scores compared to the European reference population, while global health status was rated higher. Patients in the RA group reported significantly more nausea (p=0.025), fatigue (p=0.013), dyspnoea (p=0.012), insomnia (p=0.002), appetite loss (p=0.022), and financial difficulties (p=0.026), with no significant differences in functional scores between groups. In addition to surgical technique, side of surgery and approach— transperitoneal (TP) vs. retroperitoneal (RP)—were analyzed. Left-sided adrenalectomy was associated with reduced social functioning (p=0.039). Patients in the RP group reported lower levels of nausea (p=0.011), insomnia (p=0.016), appetite loss (p=0.001), constipation (p=0.001), and financial difficulties (p=0.007). Other symptom scores followed similar trends but did not reach statistical significance.

Conclusion: Patients undergoing adrenalectomy showed some limitations in daily and social functioning compared to normative data. However, in terms of symptom burden measured by the EORTC QLQC30, they were comparable to the general population. Overall, adrenalectomy appears to be a safe procedure with no significant impairment in quality of life. Surgical approach and tumors side had no relevant impact on functional outcomes. Robot-assisted adrenalectomy may be considered a safe gold standard in adrenal surgery, showing no inferiority to conventional laparoscopy.

NOTES

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Dear SGSU member,

As most of you know, the Kimbrough and SGSU have a rich tradition and have given rise to numerous Urologists who have contributed extensively to the carbon footprint of human kind. Since the first Kimbrough in 1953 in Washington, DC to this 2026 conference in Long Beach, the organization has adhered to several tenets:

1. Excellence in Government Service Urology to help our service members, their families and those who have served.
2. Promote ethical and robust research.
3. Stimulate fraternity and friendship amongst the membership and guests.
4. Prioritize resident and medical student education, development and leadership.

It is bullet #4 that is the spirit of this letter. I was recently and humbly nominated to be President of the SGSU for 2026. At the 2025 Board Meeting there was tremendous and healthy discussion regarding the future of this meeting and the ability to have residents participate because of broad Medical Education funding cuts across all services (Army, Navy, Air Force and VA).

Everyone has a story as to why they dedicated time to Government Service. For me personally, it made the difference between success and failure professionally as a Urologist and as a person. I will always be indebted to Army Urology for what they did for my career and how it shaped me as a physician.

I am asking you to give back to an organization that has helped you somewhere along the way and made a difference in your life. Because of the organizational structure of the SGSU, the donations given to the general fund and earmarked for resident support are NOT tax deductible as charitable contributions for federal income tax purposes.

Please do not hesitate to reach out to me (bschwartz@siumed.edu) or anyone on the Board for further comments or questions.

Thank you,
Brad Schwartz, COL, USA, Ret, President, SGSU

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