



Hong Kong Urological Association

The 26th Annual
Scientific Meeting
2021

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Hong Kong Urological Association

The 26th Annual Scientific Meeting 2021

Date : 17th October 2021 (Sunday)

Time : 0830 – 1700

Venue : Kerry Hotel
38 Hung Luen Road,
Hung Hom,
Kowloon, Hong Kong
(MTR Whampoa Station, Exit C2)

Scan to join the
Q&A session





Hong Kong Urological Association

INTRODUCTION

Hong Kong Urological Association (HKUA) was founded in 1988. Since its commencement, the association has operated with the objectives to facilitate advancement and academic discussion within the Urology profession, as well as to equip the general public in Hong Kong with a better understanding of urological diseases.

The main objectives of the Association are:

- To promote the interest in and a better understanding of urological problems in Hong Kong;
 - To provide a venue for discussion of problems related to urology;
 - To improve and set the standard of urological care in Hong Kong;
 - To provide a means of liaison with workers in urology in other parts of the world;
 - To advise and provide information on postgraduate urological training;
 - To collect and disseminate information regarding members of the association and information of any event or happening.
-

To achieve the objectives, monthly council meetings are held to plan, organize, implement, and review the activities of the association. Regular academic meetings, which include case presentations, topic discussions and talks by invited speakers, are held monthly. Renowned overseas speakers have been invited to deliver lectures on subjects of special interest. Seminars, workshops, education programmes and talks to the public, general practitioners and other associations have been organized to enhance communication with the community and other medical specialties.

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WELCOME MESSAGE FROM PRESIDENT

After a challenging year of 2020, I am delighted to welcome you all to participate in the 26th Annual Scientific Meeting of Hong Kong Urological Association.

Last year, it was our first-ever hybrid scientific meeting which was held successfully under the social distancing situation. Today, we are genuinely excited to invite our members to attend our physical meeting for fraternity; while the virtual lectures are also available for colleagues who are engaged at work.

This year, we are pleased to have featured leaders from our international partners, Urological Association of Asia Congress (UAA), BJU International (BJUI) and Société Internationale d'Urologie (SIU) to present keynote lectures on the latest updates on various urological diseases, as well as distinguished local speakers to present a COVID-19 lecture and to share a consensus statement collaborated with Hong Kong Society of Uro-oncology. The nursing chapter symposium serves as an excellent platform for sharing knowledge among our allied health members.

I would like to express our heartfelt appreciation to our members, colleagues and industrial partners who provide us impetus to advance cutting-edge urology development and nurture our young urologists. May I wish everyone participating in today's meeting a most fruitful and enjoyable one.



Dr. James C.M. LI
President
Hong Kong Urological Association

HKUA COUNCIL (2020-2022)



Dr. James Cheuk-man LI
President



Dr. Peter Ka-fung CHIU
Honorary Secretary



Dr. Raymond Wai-man KAN
Honorary Treasurer



Dr. Eddie Shu-yin CHAN
Ex-Officio



Dr. Chun-ki CHAN
Council Member



Dr. Phoebe Man-hung CHEUNG
Council Member



Dr. Justin Kin-man Lam
Council Member



Dr. Clarence Lok-hei LEUNG
Council Member



Dr. Eric Siu-kei LI
Council Member

CO-OPT MEMBERS



Dr. Marco Tsz-yeung CHAN



Dr. Wilson Hoi-chak CHAN



Dr. Franklin Kwok-leung HO



Dr. Wai-kit MA



Dr. Samuel Chi-hang YEE

SUBCOMMITTEE MEMBERS (2020-2022)

Education

Dr. Marco Tsz-yeung CHAN
Dr. Phoebe Man-hung CHEUNG
Dr. Franklin Kwok-leung HO
Dr. Raymond Wai-man KAN
Dr. Clarence Lok-hei LEUNG

External Affairs

Dr. Justin Kin-man LAM
Dr. Marco Tsz-yeung CHAN
Dr. Bryan Kwun-chung CHENG
Dr. Phoebe Man-hung CHEUNG
Dr. Peter Ka-fung CHIU
Dr. Terence Chun-ting LAI
Dr. Ting-kit LO
Dr. Donald Chi-ho IP

Member's Benefit

Dr. Wilson Hoi-chak CHAN
Dr. Phoebe Man-hung CHEUNG

Publicity

Dr. Peter Ka-fung CHIU
Dr. Chun-ki CHAN
Dr. Wilson Hoi-chak CHAN
Dr. Eric Siu-kei LI
Dr. Trevor Churk-fai LI
Dr. Chang-chung NGO
Dr. Samuel Chi-hang YEE

Social Media

Dr. Clarence Lok-hei LEUNG
Dr. Samuel Chi-hang YEE

Young Urologist Section

Dr. Chun-ki CHAN
Dr. Wilson Hoi-chak CHAN
Dr. Samuel Chi-hang YEE

UROLOGY NURSING CHAPTER COUNCIL MEMBERS (2020 – 2022)

- **Chairperson** : Mr. Kevin Chi-chiu TANG
- **Honorary Secretary** : Ms. Irene Pui-hing WU
- **Honorary Treasurer** : Mr. Gilbert Ka-lok LUI
- **Ex-Officio** : Mr. Benny Kwok-kin LEUNG

SUBCOMMITTEE MEMBERS

- **Educational** : Ms. Mondy Man-yee LIU
Ms. Amy Yi-ying LO
Ms. Helen Kit-ling YAU
- **IT** : Mr. Alan IP
- **Welfare** : Mr. Jan Lok-sang CHING
Ms. Hilda Sze-wan KWOK
Ms. Crystal Suk-yin LI

HONG KONG UROLOGICAL ASSOCIATION YOUNG UROLOGISTS SECTION (2020 – 2022)

- **Chairlady** : Dr. Chun-ki CHAN
- **Honorary Secretary** : Dr. Vincent POON
- **Treasurer** : Dr. Steffi YUEN
- **Subcommittee members** : Dr. Henry CHOW

Dr. Alex NG

Dr. Chi Man NG

Dr. Chang Chung NGO

Dr. Chris LEE

Dr. Christy MAK

Dr. Terence LAI

PAST PRESIDENTS

- 2018 – 2020 ● Dr. Eddie Shu-yin CHAN
 - 2016 – 2018 ● Dr. Lap-yin HO
 - 2014 – 2016 ● Dr. Chi-wai FAN
 - 2012 – 2014 ● Dr. Steve Wai-hee CHAN
 - 2010 – 2012 ● Dr. Peggy Sau-kwan CHU
 - 2008 – 2010 ● Dr. Ming-kwong YIU
 - 2006 – 2008 ● Dr. Wai-sang WONG
 - 2004 – 2006 ● Dr. Chi-wai MAN
 - 2002 – 2004 ● Dr. Rudolph Loi-cheong NGAI
 - 2000 – 2002 ● Dr. Bill Tak-hing WONG
 - 1998 – 2000 ● Dr. Tim-fuk YIU
 - 1996 – 1998 ● Dr. John FENN
 - 1994 - 1996 ● Dr. Andrew Yau-tung CHAN
 - 1987 - 1994 ● Dr. Che-hung LEONG
-

MEMBERS' PUBLICATIONS FROM OCT 2020 – PRESENT

Publications

1. Liu SY, Yee CH, Chiu PK, Lam CC, Wong SK, Ng EK, Ng CF. The effect of bariatric surgery on the improvement of lower urinary tract symptoms in morbidly obese male patients. *Prostate Cancer Prostatic Dis.* 2021 Jun;24(2):380-388.
2. Yee CH, Yuen-Chun J, Chan ES. Current evidence for robotic surgery in radical cystectomy. *Turk J Urol.* 2021 Feb;47(Supp. 1):S1-S8.
3. Yee CH, Wong HF, Tam MHM, Yuen SKK, Chan HC, Cheung MH, Yu ATO, Chiu Y, Chan NH, Leung LH, Ng ATL, Law DMC, Ng TL, Teoh JYC, Chiu PKF, Ng CF. Effect of SARS and COVID-19 outbreaks on urology practice and training. *Hong Kong Med J* 2021 Aug;27(4):258–65
4. Yee CH, Chan BLH, Gudar K, Wong HF, Tam MHM, Teoh JYC, Chiu PKF, Hou SM, Ng CF. Robotic radical cystectomy and bilateral nephrectomy in a renal transplant patient: the indocyanine green technique. *Cent European J Urol .* 2021;74(2):272-273.
5. Chu PSK, Leung CLH, Cheung MH, Woo SWS, Lo TK, Chan TNH, Wong WKK. Hong Kong Geriatrics Society and Hong Kong Urological Association consensus on personalised management of male lower urinary tract symptoms in the era of multiple co-morbidities and polypharmacy. *Hong Kong Med J .* 2021 Apr;27(2):127-139.
6. Huang, J., Leung, D. K., Chan, E. O., Lok, V., Leung, S., Wong, I., et al. (2021). A Global Trend Analysis of Kidney Cancer Incidence and Mortality and Their Associations with Smoking, Alcohol Consumption, and Metabolic Syndrome. *European urology focus*, S2405-4569(21)00001-8. Advance online publication. <https://doi.org/10.1016/j.euf.2020.12.020>
7. Leung, D. K., Chiu, P. K., Ng, C. F., & Teoh, J. Y. (2021). Novel Strategies for Treating Castration-Resistant Prostate Cancer. *Biomedicines*, 9(4), 339. <https://doi.org/10.3390/biomedicines9040339>
8. Leung, D. K., Chiu, P. K., Ng, C. F., & Teoh, J. Y. (2021). Role of pre-biopsy multiparametric MRI in prostate cancer diagnosis: Evidence from the literature. *Turkish journal of urology*, 47(Supp. 1), S65–S70. <https://doi.org/10.5152/tud.2020.20360>
9. Lee, H. Y., Chan, E. O., Li, C. C., Leung, D., Li, W. M., Yeh, H. C., et al. (2021). How to manage patients with suspected upper tract urothelial carcinoma in the pandemic of COVID-19?. *Urologic oncology*, S1078-1439(21)00266-0. Advance online publication. <https://doi.org/10.1016/j.urolonc.2021.06.007>

10. Leung, D. K., Yuen, S. K., Lo, K. L., Ng, C. F., & Teoh, J. Y. (2021). eLearning and transurethral prostate surgery: virtual tools for a real training. *Current opinion in urology*, 10.1097/MOU.0000000000000914. Advance online publication. <https://doi.org/10.1097/MOU.0000000000000914>
11. Ashok Agarwal, Renata Finelli, Manesh Kumar Panner Selvam, ..., Chak-Lam Cho, et al. A global survey of reproductive specialists to determine the clinical utility of oxidative stress testing and antioxidant use in male infertility. *The World Journal of Men's Health* 2021;39(3):470-488. doi:10.5534/wjmh.210025
12. Rafeal Ambar, Ashok Agarwal, Ahmad Majzoub, Sarah Vij, Nicholas Tadros, Chak-Lam Cho, Neel Parekh, Edson Borges Jr., Sidney Glina. The use of testicular sperm for ICSI in patients with high sperm DNA damage: a systematic review. *The World Journal of Men's Health* 2021;39(3):391-398. doi:10.5534/wjmh.200084
13. Ahmad Majzoub, Chak-Lam Cho, Sandro C Esteves. Testicular sperm retrieval: indications, surgical protocol, and outcomes. In: *Manual of sperm retrieval and preparation in human assisted reproduction*. Ashok Agarwal, Ahmad Majzoub, Sandro C Esteves (eds.). Cambridge University Press. Book ISBN: 978-1-108-79215-8. pp36-43. doi:10.1017/9781108867245.007
14. Ashok Agarwal, Kristian Leisegang, Ahmad Majzoub, ..., Chak-Lam Cho, et al. Utility of antioxidants in the treatment of male infertility: clinical guidelines based on systematic review and analysis of evidence. *The World Journal of Men's Health* 2021;39(2):233-290. doi:10.5534/wjmh.200196
15. Ashok Agarwal, Neel Parekh, Saradha Baskaran, Chak-Lam Cho, Ralf Henkel, Sarah Vij, Mohamed Arafa, Manesh Kumar Panner Selvam, Rupin Shah. Male Infertility. *The Lancet* 2021 Jan 23;397(10271):319-333. doi:10.1016/S0140-6736(20)32667-2
16. Sandro C Esteves, Francesco Lombardo, Nicolás Garrido, ..., Chak-Lam Cho, et al. SARS-CoV-2 pandemic and repercussions for male infertility patients: a proposal for the individualized provision of andrological service. *Andrology* 2021;9(1):10-18. doi:10.1111/andr.12809
17. CL Cho, CK Shiu. Megacalycosis: a rare radiological finding. *Hong Kong Medical Journal* 2020;26(6):539.e1-2. doi:10.12809/hkmj208463
18. Chak-Lam Cho. Improved arterial preservation achieved by combined use of indocyanine green angiography and Doppler detector during microsurgical subinguinal varicocelectomy. *Journal of Investigative Surgery* 2020;33(10):948-949. doi:10.1080/08941939.2019.1580324
19. Chak-Lam Cho. A knotted ureteral stent. *Urology Case Reports* 2020;33:101327. doi:10.1016/j.eucr.2020.101327
20. Ashok Agarwal, Ahmad Majzoub, Saradha Baskaran, ..., Chak-Lam Cho, et al. Sperm DNA fragmentation: a new guideline for clinicians. *The World Journal of Men's Health* 2020;38(4):412-471. doi:10.5534/wjmh.200128

The backbone in PCa treatment that:

Sustainably suppresses testosterone <20ng/dL¹

Is preferred by physicians and patients²

Offers 6-month formulation³

Abbreviation: PCa, prostate cancer

References: 1. Bieul J, et al, Adv Ther 2017;34(2):513-523. 2. Shore ND, et al, Urol Nurs 2013;33(5):236-244. 3. DIPHERELINE® 22.5mg Hong Kong Package Insert.

DIPHERELINE® Hong Kong Abridged Package Insert (Refer to full prescribing information before prescribing)

Trade Name: DIPHERELINE® PR, 3.75mg/11.25mg/22.5mg. **INN:** Triptorelin. **Presentations:** Powder and solvent for intramuscular injections, 28-day or 3 months or 6-month prolonged release form. This pack contains a glass vial of powder, an ampoule of 2 ml solvent, 1 syringe and 2 needles. **Posology & Administration:** Prostate Cancer: one intramuscular injection every 4 weeks (PR 3.75) or every 3 months (PR 11.25) or every 6 months (PR 22.5). Endometriosis: one intramuscular injection every 4 weeks (PR 3.75) or every 3 months (PR 11.25) – treatment must be initiated in the first 5 days of the menstrual cycle and should not be administered for more than 6 months. Uterine fibromyomas prior to surgery (PR 3.75): one intramuscular injection every 4 weeks – treatment must be initiated in the first 5 days of the menstrual cycle, treatment must not exceed 3 months. Precocious puberty (PR 3.75): before 8 years in girls and 10 years in boys – children under 20kg: half the dose of DIPHERELINE PR 3.75 every 28 days; children more than 20kg: one intramuscular injection of DIPHERELINE PR 3.75mg every 28 days. Female infertility (PR 3.75): supplementary treatment in combination with gonadotrophins, one injection of DIPHERELINE PR 3.75mg on the 2nd day of the cycle – gonadotrophins should be started generally 15 days after the injection. **Contraindications:** Hypersensitivity to GnRH, its analogues or to any of the excipients; pregnancy. **Special Warnings & Precautions:** Non-pregnancy should be confirmed before prescription. Treatments may cause reduction in bone mineral density; may reveal the presence of a previously unknown gonadotroph cell pituitary adenoma; mood changes, incl. depression has been reported. Caution should be given to patients treated with anti-coagulants. In men: DIPHERELINE causes a transient increase in serum testosterone levels, which should be checked periodically. Caution should be given to patients with prostate cancer: special metastases; urinary tract obstruction; additional risk factors of osteoporosis, diabetes and certain cardiovascular diseases. In women: Every 4 weeks administration results in constant hypogonadotrophic amenorrhoea, if genital haemorrhage occurs after the first month, plasma oestradiol levels should be measured and if levels are below 50 pg/ml, possible organic lesions should be investigated. In female infertility, the follicular retrieval induced by the injection combined with gonadotrophins may increase markedly in some predisposed patients and particularly in cases of polycystic ovarian disease. The induced ovulation should be monitored closely. **Interactions:** When triptorelin is used in combination with drugs that modify the secretion of pituitary gonadotrophins, special precautions must be taken and it is recommended to close monitored with hormone assays. **Undesirable Effects:** In men: urinary symptoms, bone pain of metastatic origin and symptoms associated with mediullary compression from spinal metastases, hot flushes, decreased libido, impotence, paraesthesia in lower limbs, hyperhidrosis, asthenia, back pain. In women: exacerbation of endometriosis symptoms, metrorrhagia, hot flushes, vaginal dryness, decreased libido and dyspareunia. In both: allergic reactions such as urticarial, rash, pruritus, nausea, vomiting, weight gain, hypertension, mood disorders, visual disturbances, pain at the injection site and fever.

Revision date: 07/09/2020

More Information available upon request

AGENDA

Date : 17th October 2021 (Sunday)

Time : 0830 – 1700

Venue : Kerry Hotel, 38 Hung Luen Road, Hung Hom, Kowloon, Hong Kong

Scientific Programme

Location: Main Lecture Hall

Time	Duration	Rundown
0830 – 0845	15 mins	Welcome Speech by Dr. James C.M. Li, President of HKUA
0845 – 0900	15 mins	Disruptions in Urological Care Globally Amid the COVID-19 Pandemic Speaker: Prof. Jeremy YC Teoh
0900 – 0915	15 mins	HKUA-HKSUO Consensus Statement – Genomic Testing on Prostate Cancer Speaker: Dr. Peter KF Chiu
0915 – 0945	30 mins	UAA Lecture: Azoospermia: Current and Future Perspectives Speaker: Dr. Lim Kok Bin Moderator: Dr. Fan Chi Wai
0945 – 1045	60 mins	Oral Presentation I Adjudicators: Dr. Simon Leung & Dr. Eddie Chan
1045 – 1115	30 mins	Break
1115 – 1145	30 mins	A Paradigm Shift in the Management of Metastatic Prostate Cancer – Positioning of Novel Hormonal Therapy - Supported by Astellas Speaker: Prof. Arnulf Stenzl Moderator: Dr. Ma Wai Kit
1145 – 1215	30 mins	State-of-art Management of nmCRPC – Who, When and How - Supported by Bayer Speaker: A/Prof Ravindran Kanesvaran Moderator: Dr. Chan Wai Hee
1215 – 1330	75 mins	Lunch
1330 – 1500	90 mins	Oral Presentation II Adjudicators: Dr. Simon Leung & Dr. Eddie Chan
1500 – 1530	30 mins	Break
1530 – 1600	30 mins	SIU Lecture: Reconstruction Speaker: Dr. Sanjay B. Kulkarni Moderator: Prof. Wayne Lam
1600 – 1630	30 mins	BJUI Lecture: Novel Minimally Invasive BPH Treatment Speaker: Mr. Toby Page Moderator: Dr. Ho Lap Yin
1630 – 1700	30 mins	Closing Remarks and Award Presentation

Scientific Programme

Location: Nursing Hall

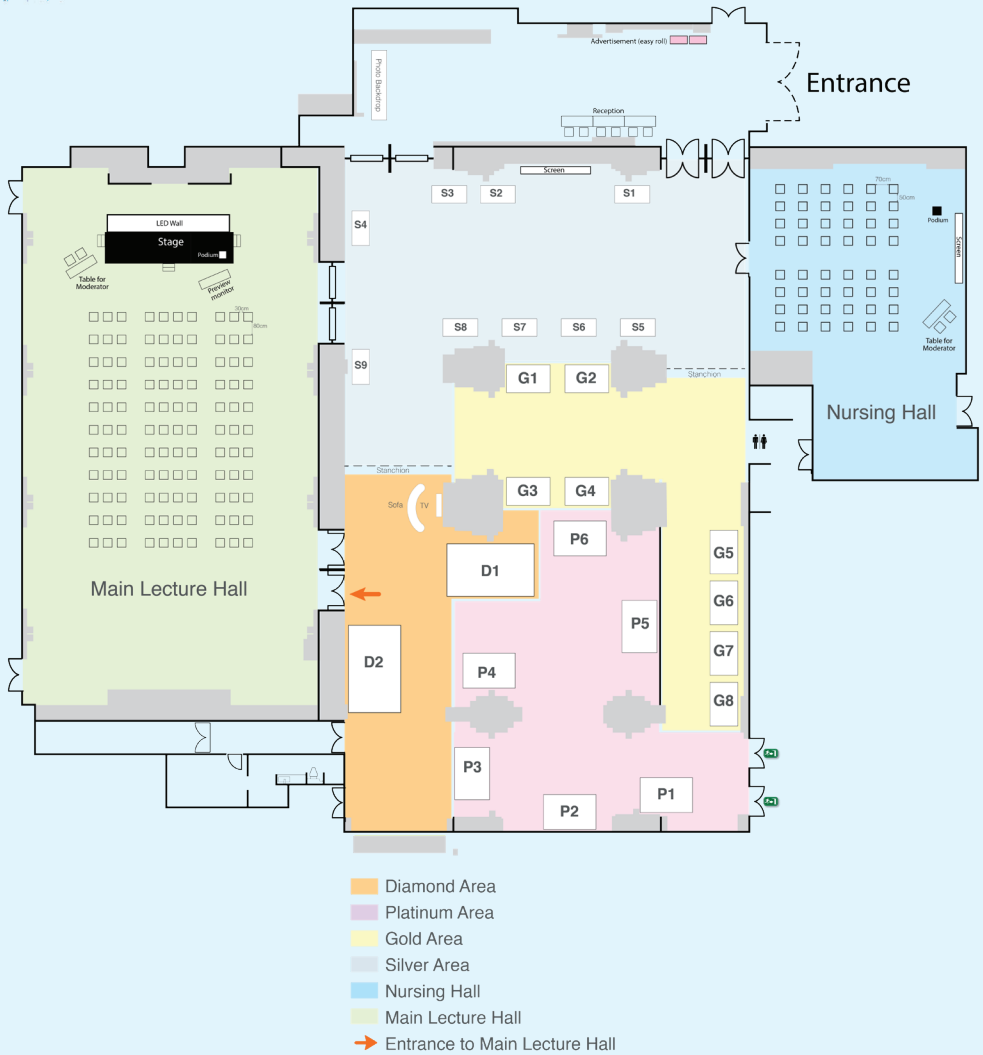
0945 – 1045	60 mins	Moderated Poster Adjudicators: Dr. Ng Man Tat & Dr. Sidney Yip
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Nursing Session

Location: Nursing Hall

Time	Duration	Rundown
1330 – 1335	5 mins	Opening Speech by Dr. James CM Li, President of HKUA
1335 – 1435	60 mins	Fencing in Urology: MRI fusion Prostate Biopsy Speaker: Dr. Ringo WH Chu Moderators: Ms. Irene Wu & Ms. Helen Yau
1435 – 1505	30 mins	Sharing on Urology Nursing Care in Macau and Hong Kong during COVID-19 Speakers: Ms. Angela Fong & Mr. Ching Lok Sang Jan Moderators: Ms. Irene Wu & Ms. Helen Yau
1505 – 1520	15 mins	Oral Presentation Adjudicators: Dr. Ringo WH Chu Moderators: Ms. Irene Wu & Ms. Helen Yau
1520 – 1525	5 mins	Closing Remarks by Mr. Kevin Tang, Chairperson of UNC

VENUE FLOOR PLAN



EXHIBITORS

DIAMOND

- D1 Olympus Hong Kong and China Ltd.
- D2 Astellas Pharma HK Co. Ltd.

PLATINUM

- P1 Karl Storz Endoscopy China Ltd.
- P2 Da Hon Enterprises Co., Ltd. / Becton Dickinson Asia
- P3 Janssen, a division of Johnson & Johnson (HK) Ltd.
- P4 Glaxo Smith Kline Ltd.
- P5 Beaufour Ipsen International (Hong Kong) Ltd.
- P6 Intuitive Surgical-Fosun (Hongkong) Co., Ltd.
- G5 Medtronic Hong Kong Medical Ltd.

GOLD

- G1 Chindex Hong Kong Ltd.
- G2 B. Braun Medical (H.K.) Ltd.
- G3 Boston Scientific Hong Kong Ltd.
- G4 Takeda Pharmaceuticals (Hong Kong) Ltd.
- G6 Ferring Pharmaceuticals Ltd.
- G7 Merck Sharp & Dohme (Asia) Ltd.
- G8 Teleflex Medical Asia Pte. Ltd.

SILVER

- S1 A. Menarini Hong Kong Ltd.
- S2 Viatris Healthcare Hong Kong Ltd.
- S3 Bayer HealthCare Ltd.
- S4 Associated Medical Supplies Co., Ltd.
- S5 Synmosa Biopharma (HK) Co., Ltd.
- S6 Tronda Electronics Ltd.
- S7 Chavon Medical Systems Ltd.
- S8 Baxter Healthcare Ltd.
- S9 AstraZeneca Hong Kong Ltd.

“Azoospermia: Current and Future Perspectives”



Dr. Lim Kok Bin

• MBBS (S'pore), FRCS (Edin), FAMS (Urology)

Dr. Lim Kok Bin graduated from the National University of Singapore and obtained his Fellowship Diploma from the Royal College of Surgeons, Edinburgh in 1999. He became a fellow of the Academy of Medicine, Singapore in 2006.

Dr. Lim sat on the executive committee of the Singapore Urological Association for many years and was the immediate past president. He was the Convenor for the Urology Residents' Course in 2008, a course meant to prepare graduating residents in Asia for their professional exit examination. He was the scientific co-chair for Urofair 2011 and the overall chairman for Urofair 2012, a regional meeting organized by Singapore Urological Association for urologists in the Asia Pacific countries. He was also appointed scientific co-chair for the 12th Biennial Meeting of the Asia Pacific Society for Sexual Medicine held in Singapore in 2009. Dr Lim is the current vice dean of the Academy for Men's Health, Singapore.

Dr. Lim has won a few regional awards for his research including best poster at the Asian Congress in Urology 1998 for his work on urinary stone disease and best free paper at the first Asia Pacific Congress of Uro-oncology in 2002 for his work on BPH.

In 2005, under the Singapore Health Service's Health Manpower Development Programme, he undertook a Clinical Fellowship in Andrology and Sexual Medicine at the University of Western Ontario, London, Canada. During his fellowship, Dr. Lim won the Prize Essay for best clinical paper for his research on Peyronies' disease at the 61st annual meeting of the Canadian Urological Association.

“A paradigm shift in the Management of Metastatic Prostate Cancer- Positioning of Novel Hormonal Therapy”



Prof Arnulf Stenzl

- Director of the Department of Urology, University of Tuebingen Medical School

Professor Arnulf Stenzl is the Director of the Department of Urology, University of Tuebingen Medical School. Professor Stenzl is the author or co-author on more than 700 publications and scientific papers in peer-reviewed journals, is the member of innumerable public and privately initiated steering committees and advisory boards on all kind of urologic topics. He holds 2 international patents. He has been the Chairman of the Scientific Congress Office of the European Association of Urology since 2012 and is now the Adjunct Secretary Science in EAU. Furthermore, he is a Board member of the European Cancer Organization and the president of the German Association of Urology. He is the member of various national and international urological associations. He is on the Editorial Board of several journals.

His major research interests are bladder and prostate cancer and reconstructive urology. He has been awarded the Jackson Hole Award of Excellence, USA. Additionally, he is the investigator of numerous clinical trials and organized numerous national and international symposiums related to uro-oncology, - in particular prostate and bladder cancer – as well as other urologic subjects. In May 2017 he was granted the position of "DOCTOR HONORIS CAUSA" because of his worldwide recognition and contribution to the development in the field of Urology.

“State-of-art Management of nmCRPC- who, when and how”



Dr. Ravindran Kanesvaran

- BSc (Hons), MD, MRCP (UK), FAMS (Med Onco)
- Associate Professor, Duke-NUS Medical School Singapore
- Deputy Chair and Senior Consultant, Division of Medical Oncology, National Cancer Centre Singapore
- Program Director, Singhealth Medical Oncology Senior Residency Program
- President, International Society of Geriatric Oncology (SIOG)

Dr. Ravindran Kanesvaran is the Deputy Head and Senior Consultant in the Division of Medical Oncology of the National Cancer Centre Singapore. He is also an Associate Professor at Duke-NUS Medical School and clinical senior lecturer at the Yong Loo Lin School of Medicine, National University of Singapore. He is actively involved in graduate medical education and is the Program Director of the Medical Oncology Senior Residency Program. He completed his medical oncology specialty training in the National Cancer Centre Singapore. After completion of that training he followed up with a fellowship in genitourinary oncology (GU) and geriatric oncology in Duke Cancer Institute in North Carolina, USA on a Healthcare Manpower Development Program (HMDP) scholarship awarded by the Ministry of Health Singapore. His research interests include GU oncology and geriatric oncology. He has published over 100 peer-reviewed articles, including in well-known peer-reviewed journals such as the Journal of Clinical Oncology and Lancet Oncology. He is also the author of textbook chapters in the field of geriatric oncology.

He has also been awarded a number of awards including the American Society of Clinical Oncology (ASCO GU) Merit Award 2009, American Association for Cancer Research (AACR) scholar-in-training Award 2010 and the European Society of Medical Oncology (ESMO) fellowship award 2012. He is currently the immediate past President of the Singapore Society of Oncology (SSO) and the Singapore Geriatric Oncology Society. He has been appointed as European Society of Medical Oncology (ESMO) Faculty 2015-2016 in Geriatric Oncology and 2016-2018 in GU Oncology. He has been the voting/ panel member for Advanced Prostate Cancer Consensus Conference (APCCC) since 2018. He is the President-Elect, on the Board of Governance and the National Representative for Singapore in the International Society of Geriatric Oncology (SIOG). He was awarded National Representative of the Year SIOG 2014 award. He was awarded the SingHealth Excellent Service Quality Award in 2018 (Silver) and 2019 (Gold).

“What’s New in Urethroplasty”**Dr. Sanjay B. Kulkarni**

- Director Kulkarni Reconstructive Urology Center, Pune, India
- President of the Society International de Urology, SIU

Sanjay B. Kulkarni, MD, MS, Diploma Urology (London), FRCS (Glasgow), Hon. FRCS(London) is a nationally and internationally recognized expert in urethral reconstruction. He underwent Urology training in England from 1981 to 1986. He was trained by Mr Richard Turner Warwick, considered as the father of urethral reconstruction. Dr. Kulkarni returned to motherland India to serve the people of his country. His wife Dr. Jyotsna Kulkarni and Sanjay were pioneer in introducing Laparoscopy in India. They started India's first animal lab for Laparoscopy training. Dr. Kulkarni established Centre for Reconstructive Urology in 1995. The centre performs one of the largest number of Genito-Urinary Reconstructive Surgeries in the world today. The centre is ethical and no patient is denied surgery for economic grounds. Kulkarni School of Urethral Surgery was established in 2006. The centre is engaged in permanent educational activities for urologists who are interested in the in-depth training in reconstructive urethral surgery. They conduct an operative workshop on a weekend once every month where about 8-10 Urologists from India and abroad attend inside the OR and watch surgeries LIVE. Kulkarni School of Urethral Surgery is very popular amongst the urologists. This is a purely academic activity with no registration fees. Dr. Kulkarni invented many techniques of reconstruction. The “Kulkarni Urethroplasty” for pan urethral stricture is popular around the world.

He was awarded “President’s Gold Medal” by the Urology Society of India for outstanding contribution to Urology in India in 2011. Dr. Kulkarni was the President of the society of Genito Urinary Reconstructive Surgeons in 2014. In 2016 Dr. Sanjay Kulkarni was awarded “Dr BC Roy” award by the President of India for developing new speciality. In 2017 he was conferred Honorary membership of the Royal College of Surgeons of England and made Honorary member of the British Association of Urological Surgeons. He currently serves as the President of the Society International de Urology, SIU (2019-20).

“Novel minimally invasive BPH Treatment”



Mr. Toby Page

- Consultant Urological Surgeon and Associate Editor, BJUI Knowledge

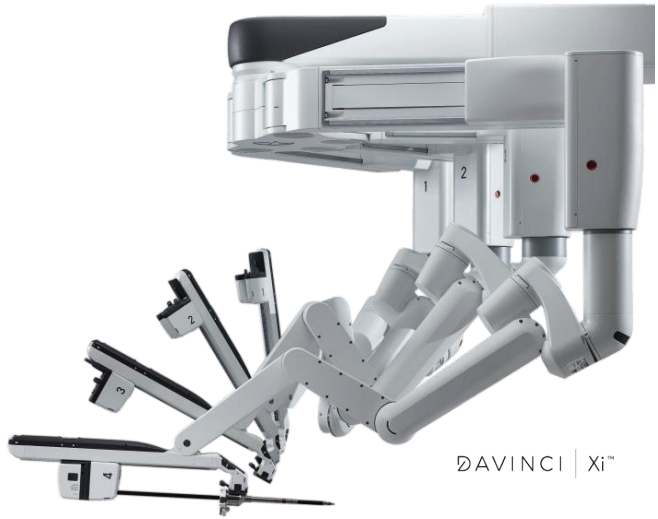
Toby Page did his medical school training at University College London. He was awarded a PhD in Molecular genetics of kidney cancer from Exeter university in 2005. He trained in Urology at the Freeman hospital and has been a consultant at The Freeman hospital for over a decade.

He runs a high-volume bladder outlet surgery service offering, a large range on treatments. He has trained in HOLEP/ THUVARP/ THULEP/ Urolift /Rezum/ aqua- ablation and leads the regional PAE service in collaboration with interventional radiology colleagues. He is also a high-volume kidney surgeon and has set up numerous new services. He sets up and regularly runs the first described multi-modality laser training course using fresh cadavers and has trained many surgeons in HOLEP. He has performed in the region of a thousand HOLEP procedures with a high rate of day case and low post-op incontinence and receives referrals from both around the UK and internationally.

His specialist interest is clinical research in BPH and bladder outlet surgery and was part of the applicant team for the UNBLOCS study team, Primary investigator for the PULSAR urolift trial and co-investigator for the Goliath trial.

He is currently leading new clinical trials in the assessment of BOO procedures and minimally invasive treatments. He has published widely, including publications in the Lancet, BJUI, Eur Urol and many other journals as well as being a Cochrane database author and reviewer and expert advisor.

Toby has been a Royal College of Surgeons Clinical tutor and has just stepped down as the national lead for medical students for the British association of Urology Surgeons (BAUS) and member of BAUS education Committee. He is currently the BJUI Knowledge associate editor leading the BPH and LUT dysfunction section.



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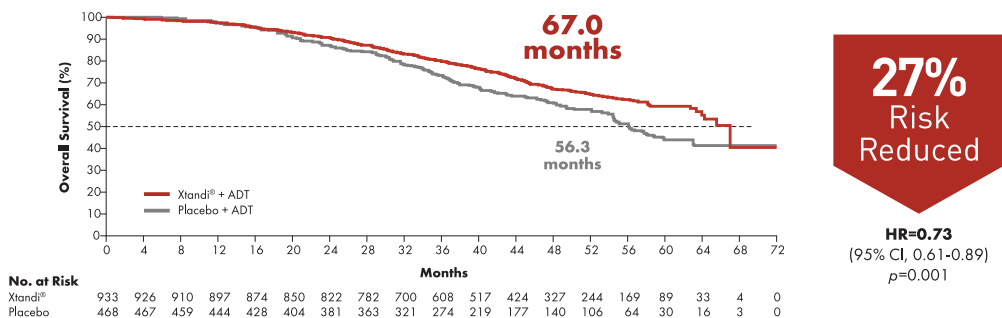
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Abbreviation: ADT, androgen deprivation therapy; CI, confidence interval; HR, hazard ratio; nmCRPC, non-metastatic castration-resistant prostate cancer; OS, overall survival
References: 1. Xianli® Hong Kong Prescribing Information. Astellas. 2. Sternberg CN et al. *N Engl J Med*. 2020;382(23):2197-2206.

[illegible]

patients treated with placebo plus ADT.
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Start Betmiga® for your elderly patients, a well-tolerated¹ and highly persistent
avenue for OAB without compromising cognitive function.^{2,3}

Day Time Frequency ≥ 8 times

Nocturia ≥ 1 time

Urgency



Abbreviations: LUTS, lower urinary tract symptoms; OAB, overactive bladder

References: 1. Viaggi A, et al. Efficacy, safety, and tolerability of mirabegron in patients aged ≥ 65 yr with overactive bladder: wet, a phase IV, double-blind, randomised, placebo-controlled study (PILLAR). *Eur Urol*. 2020;77(2):211-20. 2. Gledhill TL, et al. Effect of mirabegron on cognitive function in elderly patients with overactive bladder: MCA results from a phase 4 randomised, placebo-controlled study (PILLAR). *EMC: Genar*. 2020;20(1):1-3. 3. Chapple CR, et al. Persistence and adherence with antimuscarinic agents in patients with overactive bladder: a retrospective observational study in UK clinical practice. *Eur Urol*. 2017;72(3):389-99.

Abbreviated prescribing information of Betmiga® prolonged-release tablets

Version: 003 Composition: Mirabegron Indication: Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Dosage:** Adult including elderly 50 mg once daily with or without food. **Administration:** Swallow whole with liquids. Do not chew/dissolve/discard. **Contraindications:** Mirabegron is contraindicated in patients with: - Hypertension (systolic blood pressure ≥ 160 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg). **Special warnings and precautions for use:** (Rital treatment) Betmiga has not been studied in patients with stage renal disease (GFR < 15 mL/min/1.73 m²) or patients requiring haemodialysis and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m²) based on a pharmacokinetic study a dose reduction to 25 mg is recommended in this population. Betmiga is not recommended for use in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m²) concomitantly receiving strong CYP3A4 inhibitors. Hepatic impairment Betmiga has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. Betmiga is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A4 inhibitors. Hypertension Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with Betmiga, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg and/or diastolic blood pressure ≥ 100 mm Hg). Patients with concomitant or acquired QT prolongation Betmiga, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies. However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking anticholinergics: medications for OAB Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking anticholinergic medications for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with Betmiga; however, Betmiga should be administered with caution to patients with clinically significant BOO. Betmiga should also be administered with caution to patients taking anticholinergic medications for the treatment of OAB. **Undesirable effects:** Summary of the safety profile The safety of Betmiga was evaluated in 6,433 patients with OAB, of which 3,644 received at least one dose of mirabegron in the phase 2/3 clinical program, and 632 patients received Betmiga for at least 1 year (OOS days). In the three 12-week phase 3 double-blind, placebo-controlled studies, 86% of the patients completed treatment with Betmiga, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for patients treated with Betmiga 50 mg during the three 12-week phase 3 double-blind, placebo-controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 12% in patients receiving Betmiga 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving Betmiga 50 mg. The frequency of urinary tract infections was 2.3% in patients receiving Betmiga 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving Betmiga 50 mg. Serious adverse reactions included initial Irritation (0.2%). Adverse reactions observed during the 1-year (long-term) active-controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double-blind, placebo-controlled studies. List of adverse reactions: The table below reflects the adverse reactions observed with mirabegron in the three 12-week phase 3 double-blind, placebo-controlled studies. The frequency of adverse reactions is defined as follows: very common (≥ 10%), common (≥ 1% to < 10%), uncommon (≥ 0.1% to < 1%), rare (≥ 0.01% to < 0.1%), very rare (< 0.01%). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Infections and infestations: Common: Urinary tract infections. Uncommon: Vaginal infection. Cystitis. Psychiatric disorders: Not known (cannot be estimated from the available data). Inconvin: Eye disorders: Rare: Eyelid oedema. Cardiac disorders: Common: Tachycardia. Uncommon: Palpitation. Initial Irritation Vascular disorders: Very rare: Hypertensive crisis. Gastrointestinal disorders: Common: Nausea, Constipation, Diarrhoea. Uncommon: Dyspepsia, Gastritis. Rare: Lip oedema Skin and subcutaneous tissue disorders: Uncommon: Urticaria, Rash, Rash macular, Rash papular. Pruritus. Rare: Livedoid dermatitis, vasculitis, Purpura, Angioedema Musculoskeletal and connective tissue disorders: Uncommon: Joint swelling Reproductive system and breast disorders: Uncommon: Vulvovaginal pruritus. Investigations: Uncommon: Blood pressure increased, GGT increased, ALT increased, ALT increased Renal and urinary disorders: Rare: Urinary retention Nervous system disorders: Common: Headache, Dizziness* observed during post-marketing experience Full prescribing information is available upon request.

ORAL PRESENTATION SESSION 1

Time: 09:45 – 10:45 **Venue:** Main Lecture Hall

09:45 – 09:52

[OP. 1-1]

Technique, Outcome and Changes in Prostate Dimensions in Patients with Urinary Retention after Aquablation

CH Yee, WHB Siu, SF Tang, SKK Yuen, CK Chan, JYC Teoh, PKF Chiu, CF Ng
S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

09:52 – 09:59

[OP. 1-2]

A review of 18-year surgical experience in laparoscopic assisted Tenckhoff catheter insertion for peritoneal dialysis: Is it worth the effort?

CH Tam, TCT Lai, CF Tsang, BSH Ho, W Lam, ATL Ng, JHL Tsu
Division of Urology, Department of Surgery, The University of Hong Kong, Queen Mary Hospital, Hong Kong

09:59 – 10:06

[OP. 1-3]

High-Intensity Focused Ultrasound (HIFU) focal therapy for localized prostate cancer with MRI-US fusion platform

CH Yee, PKF Chiu, JYC Teoh, CF Ng, CK Chan, SM Hou
S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

10:06 – 10:13

[OP. 1-4]

Post TRUS versus Post TPUS Radical Prostatectomy: Different Distribution of Positive Surgical Margins

DKW Leung, JYC Teoh, HM Tam, KM Li, SKK Yuen, SYS Chan, KL Lo, PKF Chiu, SM Hou, CF Ng
S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital and North District Hospital, Hong Kong

10:13 – 10:20

[OP. 1-5]

Effect of Neoadjuvant chemotherapy in ASA1-2 patient undergoing Radical Cystectomy for muscle-invasive CA bladder: Retrospective, Single-institutional study

SF Ma, TO Yu, YK Lee, TY Chan, CH Cheng, H Chau, CW Man, SK Chu
Division of Urology, Department of Surgery Queen Elizabeth Hospital, Hong Kong
Division of Urology, Tuen Mu Hospital, New Territories West Cluster

10:20 – 10:27

[OP. 1-6]

The first prospective external validation of the novel urine Spermine risk score for high grade prostate cancer detection.

PK Chiu¹, WH Lui¹, YP Wong¹, YH Fung², CH Leung¹, RT Tse¹, TH Tsoi², JY Teoh¹, KL Lo¹, CF Ng¹, KL Wong²

¹SH Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong, Hong Kong

²Department of Chemistry, Hong Kong Baptist University, Hong Kong

10:27 – 10:34

[OP. 1-7]

Health-related quality of life of prostate cancer patients on Androgen deprivation therapy(ADT)

CH Ko¹, J Lim², CF Ng¹, Y Wei³, TA Ong², PSK Chu⁴, W Chan⁵, CY Huang⁶, KK Feng⁶, J Teoh¹, X Ning³, P Chiu¹, CH Yee¹, S Leung²

¹SH Ho Urology Centre, The Chinese University of Hong Kong, Hong Kong, China

²Urology Unit, Department of Surgery, University of Malaya, Kuala Lumpur, Malaysia

³The First Affiliated Hospital, Fujian Medical University, Fuzhou, China

⁴Division of Urology, Tuen Mun Hospital, Hong Kong, China

⁵Division of Urology, Kwong Wah Hospital, Hong Kong, China

⁶Department of Urology, National Taiwan University Hospital, Taipei, Taiwan

10:34 – 10:41

[OP. 1-8]

The additional value of PSA density in detection of prostate cancer among PIRADS 2 and 3 lesions with PSA <10ng/mL: A multicenter evaluation

A Mok¹, JJ Leow², CH Chiang³, PF Hsieh⁴, W Lam⁵, WC Tsang⁶, HC Chan⁷, CF Li⁸, MC Law⁹, CLH Leung¹⁰, CM Li¹¹, HS So⁷, PL Liu⁹, WH Au⁸, YH Fan¹², TP Lin¹², CH Leung¹, JY Teoh¹, JHL Tsu⁵, CF Ng¹, HC Wu⁴, TW Tan², E Chiong⁶, CY Huang³, PK Chiu¹

¹SH Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong

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³Department of Urology, National Taiwan University Hospital, Taipei, Taiwan

⁴Department of Urology, China Medical University Hospital, Taichung, Taiwan

⁵Division of Urology, Department of Surgery, University of Hong Kong, Hong Kong

⁶Department of Urology, University Surgical Cluster, National University Health System, Singapore

⁷Division of Urology, Department of Surgery, United Christian Hospital

⁸Division of Urology, Department of Surgery, Queen Elizabeth Hospital

⁹Division of Urology, Department of Surgery, Caritas Medical Centre

¹⁰Division of Urology, Department of Surgery, Kwong Wah Hospital

¹¹Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital

¹²Department of Urology, Taipei Veterans General Hospital, Taipei, Taiwan

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

13:30 – 13:37

[OP. 2-1]

A randomized study to compare different focal zone size on treatment outcomes in patients undergoing ESWL for renal stones: An interim analysis

Ho SC¹, Ng CF¹, CH Yee¹, PK Chiu¹, Kong A¹, Lau B¹, Wong KT², Chu W².

¹SH Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

²Department of Imaging and Interventional Radiology, Prince of Wales Hospital, The Chinese University of Hong Kong

13:37 – 13:44

[OP. 2-2]

Sectoral Distribution of Prostate Cancer in a Cohort of Fusion Prostate Biopsy: Implication on the Systematic Biopsy Template

YC Chan, TK Lo, HL Wong, TO Yu, TT Law, YK Lee, CH Cheng, TY Chan, H Chau, CW Man, SK Chu

Division of Urology, Department of Surgery

Tuen Mun Hospital, Hong Kong

13:44 – 13:51

[OP. 2-3]

Transperineal Targeted Microwave Ablation(TMA) for localized prostate cancer: a report of the first 10 cases

CH Chan¹, SY Lau¹, CH Yee¹, JY Teoh¹, HF Wong¹, KL Lo¹, EHY Hung², CCM Cho², CF Ng¹, PK Chiu¹.

¹SH Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

²Department of Imaging and Interventional Radiology, Prince of Wales Hospital, The Chinese University of Hong Kong

13:58 – 14:05

[OP. 2-4]

Transurethral convective radiofrequency water vapour thermal therapy of the prostate (Rezüm) for men with lower urinary tract symptoms related to benign prostatic hyperplasia at a single institution: a pilot study and initial outcomes

W Lam^{1,2}, CH Tam¹, S Chun², JHL Tsu¹

¹Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong SAR

²Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR

14:05 – 14:12

[OP. 2-5]

Prostate cancer detection, tolerability and safety of transperineal prostate biopsy under local-anaesthesia versus standard transrectal biopsy in biopsy-naïve men: a pragmatic, parallel group, randomized-controlled study

Wayne Lam^{1, 2}, Albert Wong¹, Stacia Chun², Thomas Wong¹, Wilson Hung¹, Henry Lie¹, Chiu-Fung Tsang¹, Brian SH Ho¹, Ada TL Ng¹, James HL Tsu¹

¹Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong SAR

²Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR

14:12 – 14:19

[OP. 2-6]

Risks of metabolic diseases and androgen deprivation therapy for prostate cancer in an Asian population: a prospective multi-centre cohort study

Chris Wong¹, Y Wei², TA Ong³, Peggy Chu⁴, Jeremy Teoh¹, Peter Chiu¹, CH Yee¹, Helen Wan¹, Steven Leung¹, CF Ng¹

¹SH Ho Urology Centre, The Chinese University of Hong Kong, Hong Kong, China

²The First Affiliated Hospital, Fujian Medical University, Fuzhou, China

³Urology Unit, Department of Surgery, University of Malaya, Kuala Lumpur, Malaysia

⁴Tuen Mun Hospital, Hong Kong, China

14:19 – 14:26

[OP. 2-7]

Robotic ureteric reconstruction using buccal mucosa grafts for long proximal strictures: our initial experience and outcome

MSY Mak¹, BSH Ho¹, TCT Lai¹, CF Tsang¹, ACL Ng¹, JHL Tsu¹, W Lam^{1, 2}

¹Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong SAR

²Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR

14:26 – 14:33

[OP. 2-8]

Standard pre-operative ureteric stenting in retrograde intrarenal surgery (RIRS)

LY Yeung, MH Cheung

Division of Urology, Department of Surgery, Tseung Kwan O Hospital

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

14:33 – 14:40

[OP. 2-9]

Chinese validation of urethral stricture surgery specific patient-reported outcome measure (USS-PROM) and evaluation of the outcome of urethroplasty for anterior urethral strictures at a single institution

TF Wong¹, S Chun², ATL Ng¹, JHL Tsu¹, W Lam^{1,2}

¹Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong SAR

²Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR

14:40 – 14:47

[OP. 2-10]

Retzius-sparing Robotic Augmentation Cystoplasty Using the Modified Hautmann Reconstruction Technique

CH Yee, CH Ko, MHM Tam, PKF Chiu, JYC Teoh, CK Chan, CF Ng

S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

14:47 – 14:54

[OP. 2-11]

A Pioneer Multidisciplinary Urology Service for Exstrophy in Hong Kong

JYY To, LCS Hsu, HCK Lau, DLS Chan, MKH Chan, JHK Ngan.

Exstrophy Team of MedArt China Orphan Outreach and Dr John Ngan Adult and Paediatric Urology

14:54 – 15:01

[OP. 2-12]

10 year review of urethroplasty outcome and risk factor for recurrence: a single center experience

K.S. Tam, T. O. Yu, H. Chau, S. K. Chu, C. W. Man

Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong



The **ONLY** fixed-dose combination in relieving BPH symptoms and reduce risk of AUR or BPH-related surgery

DUAL ACTION:

- Superior symptoms improvement¹ (adjusted mean change in IPSS from baseline to year 4 was **-6.3** points for combination therapy versus **-3.8** points for tamsulosin)

DUAL PROTECTION:

Reduce relative risk of

- Reduce prostate size up to **27%^{1#}**

AUR by 68%

• BPH related surgery by 71%

vs tamsulosin monotherapy¹



BPH: Benign Prostatic Hyperplasia
AUR: Acute Urinary Retention

DUODART Safety Information: Renal Impairment: Patients with creatinine clearance of less than 10 mL/min should be approached with caution as these patients have not been studied. **Hypotension:** Patients being treated with Duodart should be cautioned to sit or lie down at the first signs of orthostatic hypotension until the symptoms have resolved. Concomitant use of α -blockers and PDE5 inhibitors can lower blood pressure and cause symptomatic hypotension. **Fertility and sexual function in men:** Dutasteride has been reported to affect semen characteristics (reduction in sperm count, semen volume and sperm motility) in healthy men. The possibility of reduced male fertility cannot be excluded. Effects of tamsulosin hydrochloride on sperm counts or sperm function have not been evaluated.

DUODART (Dutasteride-tamsulosin) abbreviated prescribing information: **Indications** Treatment of moderate to severe symptoms of benign prostatic hyperplasia (BPH). **Doseage and Administration** The recommended dose of DUODART (Dutasteride-tamsulosin) is one capsule (0.5 mg/0.4 mg) taken once daily. The capsules should be swallowed whole and not chewed or opened. **Contraindications** Treatment of the prostate capsule may result in irritation of the oropharyngeal mucosa. **Contraindications** Patients with known hypersensitivity to dutasteride, other α -1 adrenoceptor antagonists, tamsulosin (including tamsulosin-induced angioedema), soap, peanut or any of the excipients; history of orthostatic hypotension; with severe hepatic impairment; women and children and adolescents. **Warnings and Precautions** Cardiac Failure In two 4-year clinical study, the incidence of cardiac failure (a composite term of reported events, primarily cardiac failure and congestive cardiac failure) was higher among subjects taking the combination of dutasteride and α -1 adrenoceptor antagonist, primarily tamsulosin, than it was among subjects not taking the combination. In these two trials, the incidence of cardiac failure was low (1%) and variable between the studies. **Effect on prostate-specific antigen (PSA) and prostate cancer detection** Serum prostate-specific antigen (PSA) concentration is an important component in the detection of prostate cancer. DUODART causes a decrease in mean serum PSA levels by approximately 50% after 6 months of treatment. Patients receiving DUODART should have a new PSA baseline established after 6 months of treatment with DUODART. It is recommended to monitor PSA values regularly thereafter. Any confirmed increase from lowest PSA level with on DUODART may signal the presence of prostate cancer or noncompliance to therapy with DUODART and should be carefully evaluated, even if these values are still within the normal range for men not taking a 5- α -reductase inhibitor. In the interpretation of a PSA value for a patient taking dutasteride, previous PSA values should be sought for comparison. **Treatment with DUODART does not interfere with the use of PSA as a tool to assist in the diagnosis of prostate cancer after a new baseline has been established.** Total serum PSA levels return to baseline within 6 months of discontinuing treatment. The ratio of the total PSA remains constant even after the influence of DUODART. It indicates that to test prostate PSA as an aid in the detection of prostate cancer in men undergoing DUODART therapy, no adjustment to its value appears necessary. **Digital rectal examination, as well as other evaluations for prostate cancer or other conditions which can cause the same symptoms as BPH, must be performed on patients prior to initiating therapy with DUODART and periodically thereafter.** Prostate cancer and high grade tumors **THE REDUCE study** a 4-year, multicenter, randomized, double-blind, placebo-controlled study investigated the effect of dutasteride 0.5 mg daily on patients with a high risk for prostate cancer (including men 50 to 75 years of age with PSA levels of 2.5 to 10 ng/mL and a negative prostate biopsy 9 months before study enrollment) compared to placebo. Results of this study revealed a higher incidence of Gleason 8–10 prostate cancers in dutasteride treated men ($n=29$, 0.9%) compared to placebo ($n=19$, 0.6%). The relationship between dutasteride and Gleason 8–10 prostate cancers is not clear. Thus, men taking Avodart should be regularly evaluated for prostate cancer. **Renal impairment** The treatment of patients with severe renal impairment (creatinine clearance of less than 10 mL/min) should be approached with caution as these patients have not been studied. **Hypotension** Orthostatic As with other α -1 adrenoceptor antagonists, a reduction in blood pressure can occur during treatment with tamsulosin. As a result of which, risk, syncope can occur. Patients beginning treatment with DUODART should be cautioned to sit or lie down at the first signs of orthostatic hypotension (dizziness, weakness) until the symptoms have resolved. **Symptomatic** Caution is advised when α -1 adrenoceptor blocking agents including tamsulosin are co-administered with PDE5 inhibitors. **Alpha-1 adrenoceptor antagonists and PDE5 inhibitors** are both vasodilators that can lower blood pressure. Concomitant use of these two drug classes can potentially cause symptomatic hypotension. **Intraoperative floppy iris syndrome (IFIS)** a variant of small pupil syndrome has been observed during cataract surgery in some patients on or previously treated with tamsulosin. IFIS may increase the risk of eye complications during and after the operation. The initiation of therapy with DUODART in patients for whom cataract surgery is scheduled is therefore not recommended. During pre-operative assessment, cataract surgeons and ophthalmic teams should consider whether patients scheduled for cataract surgery are being or have been treated with DUODART in order to ensure that appropriate measures will be in place to manage the IFIS during surgery. **Discontinuing tamsulosin** 1–2 weeks prior to cataract surgery is anecdotally considered helpful, but the benefit and duration of stopping therapy prior to cataract surgery has not yet been established. **Leaking Capsule** Dutasteride is absorbed through the skin, therefore women, children and adolescents must avoid contact with leaking capsules. If contact is made with leaking capsules, the contact area should be washed immediately with soap and water. **Inhibitors of CYP3A4 and CYP2D6** Concomitant administration of tamsulosin hydrochloride with strong inhibitors of CYP3A4, or to a lesser extent, with strong inhibitors of CYP2D6 can increase tamsulosin exposure. Tamsulosin hydrochloride is therefore not recommended in patients taking a strong CYP3A4 inhibitor and should be used with caution in patients taking a moderate CYP3A4 inhibitor, a strong or moderate CYP2D6 inhibitor, a combination of both CYP3A4 and CYP2D6 inhibitors, or in patients known to be poor metabolizers of CYP2D6. **Hepatic impairment** DUODART has not been studied in patients with liver disease. Caution should be used in the administration of DUODART to patients with mild to moderate hepatic impairment. **Excipients** This medicinal product contains the colouring agent Sunset Yellow (E110), which may cause allergic reactions. **Breast neoplasia** There have been rare reports of male breast cancer in men taking dutasteride in clinical trials and during the post-marketing period. However, epidemiological studies showed no increase in the risk of developing male breast cancer with the use of 5- α -reductase inhibitors. Physicians should instruct their patients to promptly report any changes in their breast tissue such as lumps or ridge changes. **Interactions** Tamsulosin Concomitant administration of tamsulosin hydrochloride with drugs which can reduce blood pressure, including antihypertensive agents, PDE5 inhibitors and other α -1 adrenoceptor antagonists could lead to enhanced hypotensive effects. Dutasteride-tamsulosin should not be used in combination with other α -1 adrenoceptor antagonists. Concomitant administration of tamsulosin hydrochloride and ketoconazole (a strong CYP3A4 inhibitor) resulted in an increase of the Cmax and AUC (44%) of tamsulosin hydrochloride by a factor of 2.2 and 2.8 respectively. Concomitant administration of tamsulosin hydrochloride and paroxetine (a strong CYP2D6 inhibitor) resulted in an increase of the Cmax and AUC of tamsulosin hydrochloride by a factor of 1.2 and 1.5 respectively. A similar increase in exposure is expected in CYP2D6 poor metabolizers as compared to extensive metabolizers when co-administered with a strong CYP3A4 inhibitor. The effects of co-administration of both CYP3A4 and CYP2D6 inhibitors with tamsulosin hydrochloride have not been evaluated directly, however there is a potential for significant increase in tamsulosin exposure. Concomitant administration of tamsulosin hydrochloride (0.4 mg) and cimetidine 400 mg every six hours for six days resulted in a decrease in the clearance (26%) and an increase in the AUC (44%) of tamsulosin hydrochloride. Caution should be used when dutasteride-tamsulosin is used in combination with cimetidine. A definitive drug-drug interaction study between tamsulosin hydrochloride and warfarin has not been conducted. Results from limited in vitro and in vivo studies are inconclusive. **Diclofenac and warfarin** however, may increase the elimination rate of tamsulosin. Caution should be exercised when concomitant administration of warfarin and tamsulosin hydrochloride on sperm counts or sperm function have not been evaluated. The effects of dutasteride (0.5 mg) on sperm characteristics were evaluated in healthy volunteers aged 18 to 52 ($n=27$). Dutasteride, $n=23$ (placebo) throughout 52 weeks of treatment and 24 weeks of post-treatment ($n=20$). At 52 weeks, the mean percent reduction from baseline in total sperm count, semen volume and sperm motility were 23%, 28% and 18%, respectively. In the dutasteride group when adjusted for changes from baseline in the placebo group. Sperm concentration and sperm morphology were unaffected. After 24 weeks of follow-up, the mean percent change in total sperm count in the dutasteride group remained 25% lower than baseline. While the values for all parameters at all time points remained within the normal ranges and did not meet the predefined criteria for a clinically significant change (20%). two subjects in the dutasteride group had decreases in sperm count of greater than 90% from baseline at 52 weeks with partial recovery at the 24 week follow-up. The possibility of reduced male fertility cannot be excluded. It is not known whether dutasteride or tamsulosin are excreted in human milk. **Adverse Reactions** **Clinical Trial Data** (Dutasteride and tamsulosin combination therapy): Impotence, altered (decreased) libido, ejaculation disorders, breast disorders (includes breast tenderness and breast enlargement), dizziness and cardiac failure, (Dutasteride monotherapy): Dizziness, altered (decreased) libido, ejaculation disorders, breast disorders (includes breast tenderness and breast enlargement), alopecia (primarily body hair loss), hyperhidrosis, tamsulosin monotherapy: BPH, urinary retention, palpitations, constipation, diarrhoea, vomiting, arthralgia, rhinitis, rash, pruritus, urticaria, orthostatic hypotension, syncope, headache, nausea, angioedema, pruritus, Stevens-Johnson syndrome, Drug rash with systemic symptoms, disorders of Intraoperative floppy iris syndrome (IFIS), a variant of small pupil syndrome, during cataract surgery have been associated with α -1 adrenoceptor antagonists, including tamsulosin. In addition **allergic reactions**, urticaria, tachycardia, dyspnoea, epistaxis, vision blurred, visual impairment, erythema multiforme, dermatitis exfoliative, allergic disorder, retropulsion, ejaculation failure and dry mouth have been reported in association with tamsulosin use. The frequency of events and the role of tamsulosin in their causation cannot be reliably determined. **Abbreviated PI based on H027017/G0251541vM02021702628.** Please refer to the full prescribing information before prescribing. Full prescribing information is available upon request.

At 14 month 48, the adjusted mean percentage change from baseline in total prostate volume was -27.3% for combination therapy, -4.6% ($p<0.001$) for tamsulosin, and -28.0% ($p=0.42$) for dutasteride.

References: 1. Rothermundt CB, et al. *Eur Urol* 2010;57(1):129-41. 2. DUODART Hong Kong Full Prescribing Information. Version number: H027017/G0251541vM02021702628.

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1. Based on Medtronic report, FY20 market model: procedural volume data.

2. Average calculated using data from Intuitive Surgical 2019 Annual Report.

3. Based on internal report prepared by Consumer Dynamics: quantitative research with U.S. and European surgeons and hospital executives, March 21, 2020.

4. Fitch K, Engel T, Bochner A. Cost differences between open and minimally invasive surgery. *Managed Care*. 2015;24(9):40–48.

5. Tiwari MM, Reynoso JF, High R, Tsang AW, Oleynikov D. Safety, efficacy, and cost effectiveness of common laparoscopic procedures. *Surg Endosc*. 2011;25(4):1–10.

6. Roumm AR, Pizzi L, Goldfarb NI, Cohn H. Minimally invasive: minimally reimbursed? An examination of six laparoscopic surgical procedures. *Surg Innovation*. 2010;13(2):155–161.

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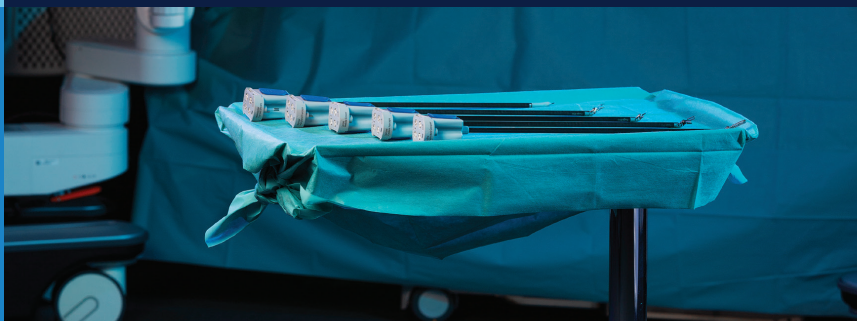
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127-1135.

05;12(3);261-287.

MODERATED POSTERS

Time: 09:45 – 10:45 Venue: Nursing Hall

09:45 – 09:50

[MP. 1]

Sexual counselling service in a Men's Health Clinic for men with erectile dysfunction: A multidisciplinary clinic model

DF Poon¹, JLS Ching², BKC Cheng³, NH Chan⁴, HS So³, SSW Ng¹

¹Community Rehabilitation Service Support Center, Queen Elizabeth Hospital, Hong Kong.

²Nursing Services Division, United Christian Hospital, Hong Kong.

³Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong.

⁴Division of Urology, Department of Surgery, Tseung Kwan O Hospital

09:50 – 09:55

[MP. 2]

Early experience of supine percutaneous nephrolithotomy (PCNL) under regional anesthesia.

SF Ma, HL Wong, KS Tam, YC Chan, TO Yu, TT Law, TK Lo, YK Lee, CH Cheng, TY Chan, LH Chau, CW Man, PSK Chu

Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

09:55 – 10:00

[MP. 3]

Prostatic Arterial Embolization for Benign Prostatic Enlargement in High-Risk Men with Indwelling Urethral Catheters - Our four-year experiences

KC Cheng¹, HM Lam¹, HC Chan¹, MH Cheung², SM Yu³, SK Kei⁴, NH Chan², HS So¹

¹Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

²Division of Urology, Department of Surgery, Tseung Kwan O Hospital, Hong Kong

³Department of Radiology, United Christian Hospital, Hong Kong

⁴Department of Radiology, Tseung Kwan O Hospital, Hong Kong

10:00 – 10:05

[MP. 4]

Transperineal prostate biopsy under Ginsberg protocol: Is it a better approach?

WL Chan, TCF Li, CF Kan, HY Ngai, WH Au

Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong SAR

10:05 – 10:10

[MP. 5]

Effect of Intravesical Hyaluronic Acid Instillation on Ketamine-induced Cystitis

SF Tang, CH Yee, CYL Hong, FPT Lai, YH Tam, CF Ng

Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong

10:10 – 10:15

[MP. 6]

Evaluation of patient characteristics undergoing PAE on effect of clinical outcome

LG Chui, WM Kan, HY Ngai, WH Au

Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong

10:15 – 10:20

[MP. 7]

Acute Scrotal Pain, Are We Exploring Too Much?

YH Fan, D Wen, H Lie, F Wong, MH Yu, CC Ngo, KW Wong, SK Li, CM Li

Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital

10:20 – 10:25

[MP. 8]

Evaluation of the learning curve for bipolar enucleation of the prostate (BipoLEP): Experience from the first 50 patients

JSL Leung, VYK Poon, CY Ng, KK Lo, CH Ip, Y Chiu, TY Chu, YC Lam, WK Ma

Division of Urology, Department of Surgery

Princess Margaret Hospital, Hong Kong

10:25 – 10:30

[MP. 9]

One-year voiding and symptoms outcomes after HoLEP and TURP

KC Cheng, KC Wong, WC Lam, LF Lee, HC Chan, HS So

Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

10:30 – 10:35

[MP. 10]

How Accurate Is Targeted Biopsy Alone? A Prospective Comparative Study of Targeted Versus 24-Core Mapping Transperineal Prostate Biopsy Using Robot-Assisted Software Fusion Platform

TF Wong, CH Ip, ACY Ng, H Chow, AKK Lo, YK Poon, TY Chu, Y Chiu, YC Lam, WK Ma

Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong SAR

10:35 – 10:40

[MP. 11]

Can patients with low suspicion on multi-parametric magnetic resonance imaging of the prostate safely avoid prostate biopsy? A single-institution retrospective cohort analysis

HHY Lie¹, TT Chun², TCT Lai¹, CF Tsang¹, BSH Ho¹, ATL Ng¹, JHL Tsu¹, W Lam²

¹*Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong SAR*

²*Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR*

10:40 – 10:45

[MP. 12]

Bipolar enucleation of prostate (BipoLEP) for benign prostatic obstruction

KL Lo, PY Au-Yeung, SY Chow, TC Lam, CSJ Yeung, SCM Ng, SH Ng, AQ Liu, CH Yee, JY Teoh, KM Li, HM Wong, CF Ng, PK Chiu.

SH Ho Urology Centre, NTEC Urology, The Chinese University of Hong Kong

UNMODERATED POSTERS

[UMP. 1]

Predictive Factors of Stone-Free Rate in Ureteroscopic Laser Lithotripsy - Does the S.T.O.N.E. score matter?

CHT Yu¹, KC Cheng¹, NH Chan², HS So¹

¹Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

²Division of Urology, Department of Surgery, Tseung Kwan O Hospital, Hong Kong

[UMP. 2]

Thulium-Fibre Laser : the cutting edge technology in modern urological practice

Chan TC Timothy, TCF Li, HY Ngai, WH Au

Division of Urology, Department of Surgery

Queen Elizabeth Hospital, Hong Kong

[UMP. 3]

Evaluation of a Multi-disciplinary Trial Without Catheter Protocol for Geriatric Hip Fracture Patients Suffering from Acute Retention of Urine

CW Wu, CM Ng, HY Ngai, WH Au

Division of Urology, Department of Surgery, Queen Elizabeth Hospital

[UMP. 4]

Urachal anomalies: their clinical presentation and management

NS Yeung, CLH Leung, KW Chan

Division of Urology, Department of Surgery

Kwong Wah Hospital, Hong Kong

[UMP. 5]

Sepsis rate after transrectal versus transperineal prostate biopsy: a single centre experience

KW Chan, LH Leung, TH Leung

Division of Urology, Department of Surgery

Kwong Wah Hospital, Hong Kong

[UMP. 6]

From Fluoroscopic-guided Prone PCNL to Free-hand Ultrasonographic-guided Supine PCNL: a safe and feasible transformation.

CHM Wong, JKM Li, KL Lo, SYS Chan, JHF Wong, SCH Yee, PKF Chiu, JYC Teoh, SKK Yuen, CK Chan, TCK Ng, DKW Leung, HM Tam, KL Chui, SK Mak, HY Cheung, JHM Wong, SSM Hou, CF Ng

Division of Urology, Department of Surgery

North District Hospital and Prince of Wales Hospital, New Territories East Cluster

SH Ho Urology Centre,

Department of Surgery, the Chinese University of Hong Kong

[UMP. 7]

Risk factors for recurrence of paraumbilical hernia in End-Stage Renal Failure patients on Peritoneal dialysis

HHY Lie¹, TT Chun², TCT Lai¹, CF Tsang¹, W Lam², ATL Ng¹, JHL Tsu¹, BSH Ho¹

¹*Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong SAR*

²*Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR*

[UMP. 8]

Pain score comparison between patients undergoing MRI fusion targeted transperineal biopsy versus systematic transperineal prostate biopsy under local anaesthesia

YM Kwok, HC Chan, WC Lam, LF Lee, KC Cheng, HS So, HM Lam, HT Yiu

Division of Urology, Department of Surgery, United Christian Hospital



UROLOGY NURSING SYMPOSIUM

Time: 15:05 – 15:20 **Venue:** Nursing Hall

15:05 – 15:10

[UNS. 1]

Urinary Catheter Dependent Loops as a Potential Contributing Cause of Incomplete Drainage: An Observational Study

Sy YW, Lau KY, Lui KL, Kung WC, Ngo CC, Wong KW, Li SK, Li CM, Lai CH

Department of Surgery, Pamela Youde Nethersole Eastern Hospital

15:10 – 15:15

[UNS. 2]

Nursing perspectives for management of stent irritative symptoms-initial experience with removal of magnetic ureteral double J stenting

Kung WC, Lau KY, Lui KL, Sy YW, Wong CH, Yu MH, Li SK, Wong KW, Ngo CC, Li CM, Lai CH

Department of Surgery, Pamela Youde Nethersole Eastern Hospital

15:15 – 15:20

[UNS. 3]

A prospective pilot study on patient's voiding experience in using the new Urinal-Uroflowmeter

Au WKL (1), Chiu PK (1,2), Kwok SW (1), Chan CK(1,2), Ng CF(1,2), Li SY(1).

¹*Department of Surgery, PWH.*

²*SH Ho Urology Centre, Department of Surgery, the Chinese University of Hong Kong.*

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References: 1. ERLEADA™ Hong Kong prescribing information. 2. Chi KN, et al. N Engl J Med. 2019;81(1):13-24. 3. Chi KN, et al. N Engl J Med. 2019;81(1):13-24. Supplementary information.

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ORAL PRESENTATION SESSION 1

Time: 09:45 – 10:45 **Venue:** Main Lecture Hall

[OP. 1-1]

Technique, Outcome and Changes in Prostate Dimensions in Patients with Urinary Retention after Aquablation

CH Yee, WHB Siu, SF Tang, SKK Yuen, CK Chan, JYC Teoh, PKF Chiu, CF Ng
S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

Objectives:

Aquablation was first introduced as a robotic procedure for the management of benign prostatic obstruction (BPO). This study aimed to investigate the functional and urodynamic outcome of Aquablation in patients with retentions on catheters.

Patients & Methods:

Men aged 50-70 who failed medical treatment of BPO with retentions failing to wean off urethral catheter were recruited to undergo Aquablation. Individuals were assessed pre-operatively and at 3 and 6 months after surgery. The primary outcome was defined by success rate of trial without catheter (TWOC), while secondary outcomes were measured by change in prostate size, symptom scores and urodynamic parameters.

Results:

Twenty patients underwent Aquablation between June 2019 and September 2020. Mean duration of urethral catheter in-situ was 5.9 weeks and mean prostate size pre-operatively was 60.8cc. A second pass Aquablation treatment was performed in 14 patients. Five patients failed TWOC on first attempt after surgery, requiring another attempt 1 week later which were all successful. At 3 months after operation, significant reduction in prostate volume was observed (60.8cc vs 24.9cc, $p<0.001$). No change in international index of erectile function (IIEF) was found (baseline: 16.1; 3-month:14.9; $p=0.953$). Mean bladder outlet obstruction index was 14.2 at 6 months upon urodynamic assessment with 75% of patients had resolution of detrusor overactivity. Reduction in prostate length was found to be more significantly than reduction in width and height after Aquablation ($R=0.693$, $p=0.039$).

Conclusion:

Aquablation provided a consistent improvement in symptoms, uroflowmetry and urodynamic parameters in patient with retentions.

[OP. 1-2]

A review of 18-year surgical experience in laparoscopic assisted Tenckhoff catheter insertion for peritoneal dialysis: Is it worth the effort?

CH Tam, TCT Lai, CF Tsang, BSH Ho, W Lam, ATL Ng, JHL Tsu
*Division of Urology, Department of Surgery, The University of Hong Kong,
Queen Mary Hospital, Hong Kong*

Objectives:

Laparoscopic Tenckhoff catheter insertion (TKI) is routinely performed for patient with non-virgin abdomen or prior dialysis related peritonitis in our centre. This review aims to determine the extent of adjunct procedures performed during these laparoscopies and their associated catheter outcomes.

Patients & Methods:

Laparoscopic TKI between 1st January, 2003 and 30th April, 2021 in Queen Mary Hospital and Tung Wah Hospital were retrospectively reviewed. Patient demographics, medical history, operative and dialysis outcome were analysed.

Results:

182 patients were recruited with mean follow-up 97 ± 80 weeks. Indications for laparoscopy included history of abdominal surgery (45.1%) and dialysis-related peritonitis (64.8%).

86.3% patients had diagnostic laparoscopy only, while 13.2% and 2.2% patients had adhesiolysis and omentectomy performed respectively. Tenckhoff catheter was not inserted in 10 patients due to dense adhesions.

Although prior surgical history increased risk of intraperitoneal adhesions (66.0% vs 46.3%, $p=0.008$), both abdominal surgery and dialysis-related peritonitis did not correlate with need for adjunct procedure during laparoscopy ($p=0.909$ & $p=0.419$ respectively). Even in presence of adhesions, performing adhesiolysis and omentectomy did not reduce catheter failure ($p=0.120$) yet significantly increase operative time (59min vs 37min, $p=0.001$). Catheter anchoring also did not improve Tenckhoff survival ($p=0.538$).

Conclusion:

Laparoscopic TKI requires general anaesthesia with longer operative time. Our study demonstrated that majority of patients did not require adjunct procedure even with prior surgical history or dialysis-related peritonitis. Prospective study is warranted to assess the feasibility of open TKI under local anaesthesia in this group of patients.

ORAL PRESENTATION SESSION 1

Time: 09:45 – 10:45 **Venue:** Main Lecture Hall

[OP. 1-3]

High-Intensity Focused Ultrasound (HIFU) focal therapy for localized prostate cancer with MRI-US fusion platform

CH Yee, PKF Chiu, JYC Teoh, CF Ng, CK Chan, SM Hou

S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

Objectives:

To investigate the outcome of prostate HIFU focal therapy using the MRI-US fusion platform for localization and treatment delivery.

Patients & Methods:

It is a prospectively designed case series. Inclusion criteria include (i) clinical tumor stage \leq T2; (ii) visible index lesion on multi-parametric MRI less than 20mm in diameter; (iii) absence of Gleason 5 pattern on biopsy; and (iv) PSA \leq 20ng/ml. HIFU ablation was performed in the conventional manner in the initial 50% of the series, whereas the other cases were with a MRI-US fusion platform. Treatment failure, tumor recurrence, PSA change, peri-operative complications and functional outcomes were measured.

Results:

Twenty patients underwent HIFU focal ablation. HIFU on a MRI-US fusion platform had a trend of a longer total operative time (124.2 mins vs 107.1 mins, $p=0.066$). There was no difference in the mean ablation volume to lesion volume ratio between the two. The mean PSA percentage change from baseline to 6-month is more significant in the conventional group (63.3% vs 44.6%, $p=0.035$). No suspicious lesion was seen at 6-month mpMRI in all 20 patients. Two patients, one from each group, eventually underwent radical treatment because of the presence of clinically significant prostate cancer in the form of out-of-field recurrences during follow-up biopsy. No significant difference was observed before and after HIFU concerning uroflowmetry, SF-12 score and EPIC-26 score. It was observed that energy used per volume was positively correlated with PSA density of the patient ($r=0.6364$, $p=0.014$).

Conclusion:

In conclusion, HIFU with conventional or MRI-US fusion platform provided similar oncological and functional outcome.

[OP. 1-4]
Post TRUS versus Post TPUS Radical Prostatectomy: Different Distribution of Positive Surgical Margins

DKW Leung, JYC Teoh, HM Tam, KM Li, SKK Yuen, SYS Chan, KL Lo, PKF Chiu, SM Hou, CF Ng
S.H. Ho Urology Centre, Department of Surgery
Prince of Wales Hospital and North District Hospital, Hong Kong

Objectives:

Given the advent of transperineal biopsy(TP) and its different trajectories from transrectal biopsy(TR), this study aims to compare the histopathological and clinical outcomes of robotic assisted radical prostatectomy(RARP) after TP versus TR biopsy.

Patients & Methods:

Retrospective analysis was performed to consecutive RARP cases after prostate biopsy(TRUS/TPUS) in NTEC in 2016-2020. Multiple biopsies were excluded. Statistical comparisons of demographics, perioperative and functional outcomes, pathology results, particularly rates and distribution of positive surgical margins(PSM) were performed between the TP and TR groups.

Results:

A total of 260 RARP cases (64 TP and 196 TR) were included. Their demographics were as follows: age (TP65.8 vs TR67.4), mean prostate size (TP42.9cc vs TR38.7cc), PSA (TP20.4ng/mL vs TR15.8ng/mL) and median number of cores (TP18 vs TR10). There was no statistically significant difference in PSM rates [37.5%(24/64) for TP group and 31.1%(61/196) for TR group; p=0.89]. However, there were significantly more anterior PSM in the TP group (TP35.5% vs TR13.3%, p=0.007). There was no significant difference in PSM distribution at other locations or functional outcomes.

PSM sites	Anterior	Posterior	Basal	Lateral	Apex	Unclassified
TP	35.5%	25.8%	9.68%	0%	29.0%	0%
TR	13.3%	22.7%	10.7%	4%	42.7%	6.67%
p-values	0.007	0.752	0.879	0.258	0.190	-

Conclusion:

There was no difference in overall PSM rates. When present, PSM was more likely to be located anteriorly in TP compared to TR, compatible with current understanding of prostate anatomy.

ORAL PRESENTATION SESSION 1

Time: 09:45 – 10:45 **Venue:** Main Lecture Hall

[OP. 1-5]

Effect of neoadjuvant chemotherapy in patient undergoing radical cystectomy for muscle-invasive CA bladder: A retrospective, single-institutional study

SF Ma, TO Yu, YK Lee, TY Chan, CH Cheng, H Chau, CW Man, SK Chu

Division of Urology, Department of Surgery Queen Elizabeth Hospital, Hong Kong

Division of Urology, Tuen Mu Hospital, New Territories West Cluster

Objectives:

To evaluate the effect of neoadjuvant chemotherapy on overall survival in patients with American Society of Anaesthesiologists Classification (ASA) 1-2 undergoing radical cystectomy for muscle-invasive urothelial bladder cancer.

Patients & Methods:

We retrospectively examined consecutive patients of ASA 1 or 2 with muscle invasive bladder cancer (clinical stage T2-T4, N0/1, M0) who underwent radical cystectomy with or without neoadjuvant chemotherapy at single institution (Tuen Mun Hospital) between Aug 2011 to Oct 2016. Patients were categorized into the neoadjuvant chemotherapy group; n=16 and the non-neoadjuvant chemotherapy group; n=7. The primary outcome was 5-year overall survival.

Results:

The 5-year overall survival rates were 81.3% and 42.9% in the neoadjuvant chemotherapy and non-neoadjuvant chemotherapy groups respectively ($P=0.137$). As for subgroup analysis, among patients with cT3-4N0-1 disease, the 5-year overall survival rate were 81.8% and 25% in the neoadjuvant chemotherapy and non-neoadjuvant chemotherapy groups respectively ($P=0.077$). For patients who have undergone neoadjuvant chemotherapy, the 5-year overall survival rate of responder (downstaging of pathological grading; n=11) and non-responder (upstaging/ same staging of pathological grading; n=5) are 90.9% and 60% respectively ($p=0.214$).

Conclusion:

Among patients with ASA1-2 undergoing radical cystectomy for muscle-invasive bladder cancer, neoadjuvant chemotherapy group has higher 5-year survival rate than non-neoadjuvant chemotherapy group and the responders to neoadjuvant chemotherapy has a higher survival rate than non-responders; although the results are not statistically significant.

[OP. 1-6]

The first prospective external validation of the novel urine Spermine risk score for high grade prostate cancer detection.

PK Chiu¹, WH Lui¹, YP Wong¹, YH Fung², CH Leung¹, RT Tse¹, TH Tsoi², JY Teoh¹, KL Lo¹, CF Ng¹, KL Wong²

¹SH Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong, Hong Kong

²Department of Chemistry, Hong Kong Baptist University, Hong Kong

Objectives:

To externally validate the novel urine Spermine Risk Score in a cohort of Chinese men.

Patients & Methods:

Out of 922 consecutive men with transperineal prostate biopsy performed in 2 hospitals, men with PSA 4-20ng/mL, no prior diagnosis of prostate cancer, and non-prostate massage urine collected for urine spermine test before biopsy were included. A previously internally validated Spermine Risk Score to predict high grade PCa (HGPCa, ISUP grade group 2 or above) including urine Spermine, age, PSA, DRE finding, and prostate volume was prospectively applied to this independent new cohort. Analyses including Area-under-curve (AUC) and calibration plots were used.

Results:

595 consecutive men were included. The median age, PSA, Prostate volume and biopsy cores taken were 68 years, 8.4ng/mL, 49ml, and 18 cores respectively, with 8% men having abnormal DRE. Pre-biopsy MRI prostate was performed in 41%(242/595) men, in which 65%(157/242) had PI-RADS score ≥ 3 . In HGPCa prediction, AUCs of PSA, PSA density, and Spermine Risk score were 0.52, 0.72, and 0.79 respectively. Excellent calibration was demonstrated (Figure 1).

Conclusion:

The newly developed Spermine risk score for HGPCa showed excellent discrimination and calibration in an external validation cohort.

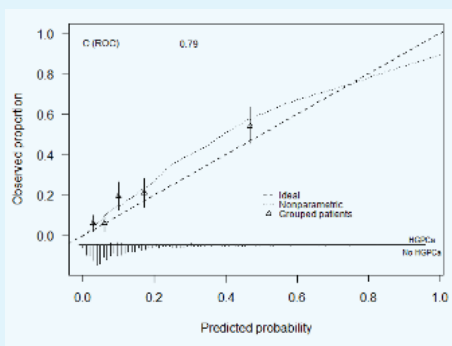


Figure 1. Calibration plot of HGPCa prediction using Spermine Risk Score

ORAL PRESENTATION SESSION 1

Time: 09:45 – 10:45 **Venue:** Main Lecture Hall

[OP. 1-7]

Health-related quality of life of prostate cancer patients on Androgen deprivation therapy (ADT)

CH Ko¹, J Lim², CF Ng¹, Y Wei³, TA Ong², PSK Chu⁴, W Chan⁵, CY Huang⁶, KK Feng⁶, J Teoh¹, X Ning³, P Chiu¹, CH Yee¹, S Leung²

¹SH Ho Urology Centre, The Chinese University of Hong Kong, Hong Kong, China

²Urology Unit, Department of Surgery, University of Malaya, Kuala Lumpur, Malaysia

³The First Affiliated Hospital, Fujian Medical University, Fuzhou, China

⁴Division of Urology, Tuen Mun Hospital, Hong Kong, China

⁵Division of Urology, Kwong Wah Hospital, Hong Kong, China

⁶Department of Urology, National Taiwan University Hospital, Taipei, Taiwan

Objectives:

To study the effect of ADT on health-related quality of life (HRQoL) amongst Asian prostate cancer patients.

Materials & Methods:

We conducted a prospective multicenter observational study involving prostate cancer patients decided for ADT in 6 centers from Hong Kong, Fuzhou, Taiwan and Malaysia. Baseline clinical characteristics, HRQoL(EQ-5D-5L) and 100-point visual analogue scale (VAS) were collected. Analyses of 5 different dimensions in the EQ-5D-5L questionnaire was performed at baseline, 6-months and 12-months after ADT initiation.

Results:

442 patients(mean age 72) were recruited in 2016-2020. Approximately half of the patients were diagnosed with metastatic prostate cancer. In EQ-5D-5, the majority reported no problem with mobility(76.7%), self-care(87.3%), performing usual activities (83.0%), no pain or discomfort (68.3%) and was not anxious or depressed (72.6%) at baseline. Baseline median VAS was 80(interquartile range 70-90), indicating good overall health on average during ADT initiation. The baseline HRQoL was significantly different between Taiwan, Hong Kong, Fuzhou and Malaysia populations($p < 0.05$). There was significant increase of anxiety / depression ($Z = -4.212$, $p < 0.01$) after 6 months of ADT. Comparing to month 6, a higher proportion of patients encountered certain degrees of problem with mobility ($Z = -2.051$, $p = 0.04$) and performing usual activities ($Z = -2.584$, $p = 0.01$) after 12 months of ADT.

Conclusion:

ADT is associated with worsening HRQoL amongst Asian prostate cancer patients.

[OP. 1-8]

The additional value of PSA density in detection of prostate cancer among PIRADS 2 and 3 lesions with PSA <10ng/mL: A multicenter evaluation

A Mok¹, JJ Leow², CH Chiang³, PF Hsieh⁴, W Lam⁵, WC Tsang⁶, HC Chan⁷, CF Li⁸, MC Law⁹, CLH Leung¹⁰, CM Li¹¹, HS So⁷, PL Liu⁹, WH Au⁸, YH Fan¹², TP Lin¹², CH Leung¹, JY Teoh¹, JHL Tsu⁵, CF Ng¹, HC Wu⁴, TW Tan², E Chiong⁶, CY Huang³, PK Chiu¹

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Objectives:

To evaluate the additional value of PSA density in predicting prostate cancer among PIRADS 2 and 3 lesions with low PSA levels.

Patient & Methods:

The analysis included men in a multicenter MRI-guided biopsy database of 12 centers in Hong Kong, Singapore, and Taiwan. Each men underwent MRI-targeted and systematic biopsy. The role of PSA density (PSAd) in various PIRADS and PSA levels in predicting clinically significant prostate cancer (csPCa; ISUP≥2) was evaluated.

Result:

1881 patients with MRI-guided biopsy were included. 5.3%, 42.3%, 36.2% and 16.2% patients had highest PIRADS 2, 3, 4 and 5 lesions respectively. The median PSA and PSA density were 8.8 and 0.17 respectively. 32.3% patients had csPCa. In PIRADS 2 patients, csPCa was diagnosed in 1.8% (PSA<10) and 9.3% (PSA≥10). In PIRADS 3 patients with PSA<10, csPCa was diagnosed in 9.5% (PSAd<0.15) and 26.4% (PSAd≥0.15). PSAd increased csPCa detection in PIRADS 4 and 5 patients also, but csPCa rate was 22.5% and 44.6% respectively, even in PSAd<0.15. (Table 1)

Conclusion:

Prostate biopsy should be offered for men with PIRADS 4 and 5 lesions, and PIRADS 3 lesions with PSAd≥0.15, but should be avoided in men with PIRADS 2 lesion with PSA <10ng/mL.

Table 1. PIRADS score and csPCa detection rates.

	PSA ≥ 10		PSA < 10		PSA < 10 + PSA _d $\geq 15\%$		PSA < 10 + PSA _d $< 15\%$	
ISUP	≥ 1	≥ 2	≥ 1	≥ 2	≥ 1	≥ 2	≥ 1	≥ 2
PIRADS2	16.28%	9.30%	8.77%	1.75%	6.67%	0.00%	9.52%	2.38%
PIRADS3	25.42%	15.25%	31.39%	14.89%	43.57%	26.43%	26.49%	9.52%
PIRADS4	62.08%	47.50%	57.86%	35.54%	75.00%	52.13%	44.67%	22.54%
PIRADS5	90.86%	76.88%	76.27%	59.32%	89.83%	74.58%	64.29%	44.64%

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ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

[OP. 2-1]

A randomized study to compare different focal zone size on treatment outcomes in patients undergoing ESWL for renal stones: An interim analysis

Ho SC¹, Ng CF¹, CH Yee¹, PK Chiu¹, Kong A¹, Lau B¹, Wong KT², Chu W².

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²Department of Imaging and Interventional Radiology, Prince of Wales Hospital, The Chinese University of Hong Kong

Objectives:

The small focal zone size of modern lithotripters was one of the suspected reasons for the poorer treatment efficacy compared to HM3 lithotripter. This study aims to compare single-treatment success rates of standard and extended focal zones for shock wave lithotripsy (SWL) of renal stones.

Methods:

In this prospective study conducted between April 2018 and Jan 2021, adult patients with solitary radio-opaque renal stones were randomized to receive SWL using either narrower standard (S, 6x28 mm) or wider extended (W, 9x50 mm) focal zones (Storz Modulith SLX-F2). Treatment was delivered with a maximum of 3000 shocks at 1.5Hz under analgesics. The primary outcome was treatment success at 12 weeks after one SWL session, defined as no stone or stone fragment <4mm on CT. Secondary outcome measures included the incidence of perinephric hematoma by cross-sectional imaging on day-2, and changes in urinary levels of acute renal injury markers.

Result:

154 patients were randomized to S-group (n=78) and W-group (n=76). Baseline parameters, total energy and treatment times were similar in the 2 groups. The overall treatment success at 3 months for S-group and W-group were 80.0% and 64.3%, respectively (p=0.038). The imaging-detected haematoma rate for S-group and W-group were 39.7% and 41.9%, respectively (p=0.788). Both groups had similar unplanned hospital admission rates and exhibited statistically significant increases in urinary acute renal injury markers levels after SWL. However, no inter-group differences in urinary markers were observed.

Conclusion:

In this interim analysis, treatment success rate was better by using smaller standard focal zone, with similar complication rates.

[OP. 2-2]

Sectoral Distribution of Prostate Cancer in a Cohort of Fusion Prostate Biopsy: Implication on the Systematic Biopsy Template

YC Chan, TK Lo, HL Wong, TO Yu, TT Law, YK Lee, CH Cheng, TY Chan, H Chau, CW Man, SK Chu

Division of Urology, Department of Surgery

Tuen Mun Hospital, Hong Kong

Objectives:

To review the sectoral distribution of cancer in the systematic biopsy in a cohort of fusion biopsy

Patients & Methods:

The pathology of all fusion prostate biopsies performed in a single center were reviewed. Targeted biopsy (TBx) was performed first followed by systematic biopsy (SBx). A modified version of Ginsburg protocol with number of cores ranged from 16-20 was used as the SBx template. The sectoral distribution and grade group of cancer were evaluated. Unifocal cancer was defined no more than two adjacent sectors positive for cancer and consistent location with positive target lesion.

Results:

117 patients were identified. Mean age was 66.8. Mean PSA was 13.0ng/ml. Mean prostate volume was 59.4ml. The cancer detection rates were 55.6% for TBx+SBx, 50.4% for TBx and 51.3% for SBx. The sectoral distributions of the 65 patients with cancer were: Anterior – Right 44.6%, Left 47.7%; Midgland – Right 30.8%, Left 44.6%; Base – Right 12.3%, Left 16.9%; Posterior – Right 46.1%, Left 46.1%. 23 (19.7%) patients had unifocal cancer. The sectoral distributions of the 23 patients with unifocal cancer were: Anterior – Right 26.1%, Left 21.7%; Midgland – Right 13.0%, Left 13.0%; Base – Right 0%, Left 0%; Posterior – Right 30.4%, Left 17.4%. No patient had isolated base sector positive for cancer.

Conclusion:

Most of the prostate cancer had multi-sectoral distribution. Base sector biopsy contributes the least in the detection of prostate cancer irrespective of multi-sectoral or unifocal disease. Omission of base sector biopsy in the systematic template can be considered.

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

[OP. 2-3]

Transperineal Targeted Microwave Ablation(TMA) for localized prostate cancer: a report of the first 10 cases

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²Department of Imaging and Interventional Radiology, Prince of Wales Hospital, The Chinese University of Hong Kong

Objectives:

To investigate the safety and efficacy of transperineal Targeted Microwave Ablation(TMA) as focal therapy for localized prostate cancer(PCa).

Methods:

This report included the first 10 cases in the first clinical trial of transperineal multi-needle TMA treatment for PCa(Clinicaltrials NCT04113811). This is a single-centre prospective phase 2 trial to investigate the efficacy of TMA guided by Koelis Trinity MRI-Ultrasound fusion navigation system in 30 men. Men aged 45-75 and diagnosed with focal low to intermediate risk PCa≤15mm on MRI-targeted biopsy were recruited. The primary outcome was any cancer detected in each ablated area at 6-month biopsy.

Results:

10 men(mean age 70) were treated with TMA under general or spinal anaesthesia. 7 of them had intermediate risk PCa. A total of 18 lesions(mean size 10mm) were ablated. The mean number of needle ablations, ablation time and operative time was 4.8, 18.8 mins, and 80 mins respectively. All patients were discharged on day 0-1. Median duration of Foley's catheter was 6 days. The only complications included 2 cases of hematuria(grade 1, resolved in 1 day) and 1 case of perineal hematoma(grade1). 1-week MRI showed treatment zones corresponding well to predicted zones. Upon 6-month biopsy of treated areas, 83.3%(15/18) had no cancer and 16.7%(3/18) had Gleason 3+3 PCa. Mean PSA dropped from 8.1 to 3.3ng/mL at 6 months. There was no change in IPSS, Uroflowmetry, and quality of life(EQ5D). IIEF-5 dropped from 10.1 to 5.6 at 6 months(p=0.002).

Conclusion:

Transperineal TMA for localized PCa appeared to be safe and effective in the initial series.

[OP. 2-4]

Transurethral convective radiofrequency water vapour thermal therapy of the prostate (Rezum) for men with lower urinary tract symptoms related to benign prostatic hyperplasia at a single institution: a pilot study and initial outcomes

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²Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR

Objectives:

Rezum is a new minimally-invasive surgical technology, which utilizes radiofrequency-generated water vapour to ablate prostate tissue for benign prostatic hyperplasia (BPH). This study evaluates its safety and efficacy in Hong Kong.

Patients & Methods:

A prospective cohort of BPH patients treated with Rezum at a single institution between January 2020 to July 2021 was analysed. Efficacy was evaluated using international prostate symptom score (IPSS), quality-of-life score (IPSS-QoL), uroflowmetry and post-void residual (PVR) volumes, Overactive Bladder Questionnaire-Short Form (OAB-q SF), international index of erectile function (IIEF-5) questionnaire, male sexual-health questionnaire for ejaculatory dysfunction. All patients had transrectal-ultrasound prostate volume estimation. Patients with maximum flow-rate (Qmax) <15ml/s, IPSS ≥13, PVR<250ml and prostate volume 30-120cc were eligible.

Results:

Thirty-three patients were eligible with a median follow-up of 8 months. Mean age was 65.7. Mean prostate volume was 59.8cc. 21(68%) carried out under sedation. Mean operative time was 14 minutes (range 6 – 28). Thirty-one (94%) patients were discharged on the same day. Post-operative median catheter-indwelling time was 6 days (range 1 – 10). Rezum significantly improved IPSS by mean of -12.13 (56%), IPSS-QoL of -2.2 (49%), Qmax of 5.5ml/s (68%). None of the 18 sexually-active men reported erectile or ejaculatory dysfunction. 9.1% reported transient dysuria. One patient required re-admission for haematuria. 2 (6%) had post-op UTI. One patient had to resume alpha-blocker, and one required redo-Rezum.

Conclusion:

Rezum is a feasible option for men with significant LUTS caused by BPH. This study demonstrated its excellent short-term efficacy, safety and functional outcomes in Hong Kong.

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

[OP. 2-5]

Prostate cancer detection, tolerability and safety of transperineal prostate biopsy under local-anaesthesia versus standard transrectal biopsy in biopsy-naïve men: a pragmatic, parallel group, randomized-controlled study

Wayne Lam^{1, 2}, Albert Wong¹, Stacia Chun², Thomas Wong¹, Wilson Hung¹, Henry Lie¹, Chiu-Fung Tsang¹, Brian SH Ho¹, Ada TL Ng¹, James HL Tsu¹

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Objectives:

Local-anaesthetic transperineal biopsy (LATPB) of prostate is an alternative to TRUS biopsy (TRUSB) to investigate men at risk of prostate cancer (PCa). This study evaluated LATPB against TRUSB in PCa detection, complication rates and patient tolerability.

Patients and Methods:

A parallel group, randomized study of men suspected with PCa were allocated in a 1:1 ratio to LATPB systematically according to modified-Ginsburg protocol, or standard 12-core TRUSB. Inclusion-criteria: biopsy-naïve, age 40-80, PSA \leq 20ng/mL, suspected tumour clinical stage \leq T2 on DRE. Exclusion-criteria: known history of PCa. Primary endpoint: difference in proportion of patients with clinically significant PCa on histology. Secondary endpoints: patient tolerability comparison measured by visual analogue scale (VAS) and health-related QoL questionnaires at <24 hours and <1 month, and post-biopsy sepsis rates.

Results:

266 patients underwent randomisation. 47/134 (35.1%) in LATPB arm had PCa vs 33/132 (25.0%) in TRUSB arm ($p<0.05$). No significant difference in detecting clinically significant PCa between the two arms (16.4% vs 14.4%, $p=0.74$). There was no statistically significant difference in VAS ($p=0.14$), IPSS change ($p=0.18$), or post-biopsy retention ($p=0.107$). Post-biopsy reduction in IIEF-5 was more significant in LATPB arm ($p<0.05$). 11 (8.3%) patients in TRUSB arm developed sepsis but none following LATPB. Study was terminated early following interim analysis on ethical grounds due to significant difference in sepsis rates.

Conclusion:

This study demonstrated statistically higher PCa detection rate with LATPB in biopsy-naïve men at clinical risk for PCa, although clinically significant PCa detection rates were equivalent between the two techniques. LATPB was tolerated as well as TRUSB, but was not associated with any sepsis. This study provided a high-level evidence that LATPB should be the current standard prostate biopsy choice of technique.

[OP. 2-6]

Risks of metabolic diseases and androgen deprivation therapy for prostate cancer in an Asian population: a prospective multi-centre cohort study

Chris Wong¹, Y Wei², TA Ong³, Peggy Chu⁴, Jeremy Teoh¹, Peter Chiu¹, CH Yee¹, Helen Wan¹, Steven Leung¹, CF Ng¹

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²The First Affiliated Hospital, Fujian Medical University, Fuzhou, China

³Urology Unit, Department of Surgery, University of Malaya, Kuala Lumpur, Malaysia

⁴Tuen Mun Hospital, Hong Kong, China

Objectives:

Androgen deprivation therapy (ADT) use in prostate cancer has seen a rising trend. We are looking into the relationship between ADT and development of metabolic diseases in Asian patients.

Patients & methods:

This is a prospective multi-centre cohort yielded from the READT database (Real-life experience of ADT in Asia). Patients from centres in Hong-Kong, China and Malaysia diagnosed of prostate cancer and offered ADT were recruited from 2016. It is compared to a control cohort of prostate cancer patients in Hong Kong (HK-Cap database) collected prospectively and retrieved retrospectively. Patient outcomes are followed-through 2 years. We compared between the groups the new diagnoses of metabolic diseases and the initiation of related medication for these conditions. Baseline characteristics including pre-treatment comorbidities, medications and tumour characteristics are documented.

Results:

151 patients receiving ADT (from READT database) and 447 patients not receiving ADT (from HK-Cap database) were analysed. ADT is related to higher risks of developing new onset DM (10.6% vs 3.4%, $p < 0.001$), metabolic syndrome (21.9% vs 11.9%, $p = 0.002$) and cardiovascular accident (4% vs 1.3%, $p = 0.046$). Initiation of new medications is also more common in ADT patients. New antihypertensives (37.8% vs 12.5%), oral hypoglycemic agents (12.6% vs 4.9%), insulin (4.0% vs 0.05%) and statin (15.2% vs 8.7%) are more commonly started in ADT cohort.

Conclusion:

Asians receiving ADT are exposed to increased risks of metabolic syndrome, and a higher likelihood of stepping up pharmaceutical control for pre-existing comorbidities. This highlights physicians' role to monitor metabolic profiles in at-risk men upon offering ADT.

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

[OP. 2-7]

Robotic ureteric reconstruction using buccal mucosa grafts for long proximal strictures: our initial experience and outcome

MSY Mak¹, BSH Ho¹, TCT Lai¹, CF Tsang¹, ACL Ng¹, JHL Tsu¹, W Lam^{1,2}

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Objectives:

Management of long ureteric strictures in the mid-proximal segments often requires ileum transposition or autotransplantation of kidney. Robotic buccal graft ureteroplasty (RBU) have recently been described to reduce morbidity in treating these patients. This study aims to present our initial experience of RBU in patients with long proximal ureteric strictures.

Patients & Methods:

A retrospective study was conducted at Queen Mary Hospital between December 2018 and July 2021. Patients with proximal ureteric strictures who were symptomatic or ureteral-stent / percutaneous nephrostomy dependent and subsequently treated with RBU were eligible for the study. All patients had pre-operative MAG-3 imaging and reassessment at 3 months after RBU in measuring differential renal function (DRF). Peri-operative outcomes were assessed.

Results:

Six patients were eligible. Median age was 56 years. Two patients had stricture on the right. Mean length of stricture was 4.5cm (range 3.5 – 7). Causes of stricture were previous ureteric stones in 5 patients (83%), and ketamine-related in one. All RBU were carried out with an onlay buccal graft and omental reinforcement. Three patients required concurrent flexible ureterorenoscopic laser lithotripsy. Mean operative time was 289 minutes (range 271—305). There were no peri-operative complications at a median follow-up of 8 months. Median length of stay was 2 days (range 1-3). All patients remained asymptomatic, with follow-up MAG-3 demonstrating stable DRF with no obstruction.

Conclusion:

RBU is a feasible technique in managing proximal-mid ureteric strictures with excellent short-term efficacy. It may be offered to well-selected patients as an alternative to ileal ureter or autotransplantation.

[OP. 2-8]

Standard pre-operative ureteric stenting in retrograde intrarenal surgery (RIRS)

LY Yeung, MH Cheung

Division of Urology, Department of Surgery, Tseung Kwan O Hospital

Objectives:

Pre-stenting before RIRS increases the success rate of ureteric access sheath (UAS) placement and reduce ureteric injury but resulted in additional procedure and stent related complication. The purpose of this review is to evaluate the effect of pre-stenting on the access; peri-operative outcomes and its complication.

Patients & Method:

We retrospectively analyzed the patients who underwent RIRS between Jan 2018 to April 2021 in Kowloon East Cluster (KEC). The demographic data of patients, characteristics of stones, duration of pre-stenting, pre-stenting related complications and outcomes were recorded.

Results:

A total of 75 cases were analyzed. Thirteen patients (18.6%) underwent RIRS without pre-stenting. Among the 62 patients with pre-stenting, around half of them were emergency operation due to sepsis or impaired renal function. Median duration of elective stent placement ranged was 10 days. Around 20% of patients with JJ stents required emergency admission with the most common cause being fever.

When compared the electively stented group (29 patients) and the non-stented group (13 patients), there is no statistically significant difference in the size of the stone (8.8mm Vs 10.8mm; $p=0.08$); OT time (81min Vs 65min; $p=0.15$); and hospital stay (3.4 days Vs 3.6 days; $p=0.00$). Post-operative fever (9.3%) and bleeding (4%) were all from the stented group.

Only one patient failed ureteric access sheath insertion after pre-stenting for 10 days while all patients without pre-stenting had successful ureteric access sheath insertion.

Conclusion:

In our series, the success rate of passing the UAS was high even among the non-stented group. The correlation between stenting and post-operative morbidities could not be demonstrated. Pre-stenting is associated with morbidities and emergency re-admission.

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

[OP. 2-9]

Chinese validation of urethral stricture surgery specific patient-reported outcome measure (USS-PROM) and evaluation of the outcome of urethroplasty for anterior urethral strictures at a single institution

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²*Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR*

Objectives:

To validate a Chinese language version of USS-PROM in men undergoing urethroplasty for anterior urethral stricture, and to evaluate outcomes at a single institution.

Patients & Methods:

A Chinese version of USS-PROM was carried out using double-forward translation by two independent translators. Patients were asked to complete the PROM with uroflowmetry assessment before (baseline) and 3 to 6 months after urethroplasty. The PROM was evaluated for internal consistency, test-retest reliability, criterion validity, and responsiveness. Non-Chinese speaking men, aged <18, catheterised patients and posterior urethroplasty patients were excluded.

Results:

Thirty-five urethroplasties were carried out between October 2017 and July 2021, including 13 bulbar urethroplasties and 22 distal urethroplasties or salvage hypospadias repair. 20 patients were eligible for the study. Cronbach's alpha was 0.80. Mean total-LUTS score improved from 13.4 at baseline to 5.08 at 6 months after surgery ($p = 0.004$, 95% CI 3.18 – 13.4). Mean Peeling's picture score improved from 3.15 to 2.00 ($p = 0.003$, 95% CI 0.46 – 1.84). Mean Qmax improved from 12.5ml/s to 23.2ml/s ($p = 0.001$). Mean RU improved from 71.3ml to 20.5ml ($p = 0.098$). The mean EQ-VAS score was increased from 63.8 to 77.1 ($p = 0.046$). The erectile function score remains similar (2.50 vs 2.42, $p = 0.586$). Overall, 95% were satisfied or very satisfied with urethroplasty. One patient required revision urethroplasty.

Conclusion:

The Chinese version of the USS-PROM has adequate psychometric properties and is a valid instrument to assess PROM in men undergoing anterior urethroplasty. This study also demonstrated that urethroplasty is able to provide excellent outcomes.

[OP. 2-10]

Retzius-sparing Robotic Augmentation Cystoplasty Using the Modified Hautmann Reconstruction Technique

CH Yee, CH Ko, MHM Tam, PKF Chiu, JYC Teoh, CK Chan, CF Ng

S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong

Objectives:

Anterior clamp cystoplasty technique has been the conventional technique for bladder augmentation. However, disruption of Retzius-space by this approach can create difficulty for future bladder intervention, and concomitant bilateral ureteric stricture would be difficult to be managed. The current study investigated the feasibility and early outcome of Retzius-sparing robotic augmentation cystoplasty using the modified Hautmann technique.

Patients and Methods:

Patients with a contracted bladder due to cystitis were arranged with robotic augmentation cystoplasty. Robot setup was per conventional robotic cystectomy configuration. Contrary to conventional clamp cystoplasty technique, the bladder was left attached to the anterior abdominal wall. A U-shaped cystostomy flap was created which was followed by a M-configuration augmentation pouch. Bilateral chimneys could be extended to accommodate coexisting ureteric stricture requiring interposition. Early peri-operative outcome was collected for analysis.

Results:

Between December 2020 and April 2021, 6 patients underwent robotic augmentation cystoplasty using the modified Hautmann technique. Five cases were ketamine-associated uropathy and one was interstitial cystitis. Two patients had additional procedures for bilateral ureters in the same operating session, namely bilateral ureteric reimplantation, and ileal interposition plus ureteric reimplantation. Mean operative time was 272 mins +/- 114 mins and mean blood loss was 141ml +/- 97ml. Mean hospital stay was 9 days +/- 9 days. Mean follow-up time was 4.5 months. Mean functional bladder capacity before and after operation at 3 months were 52ml +/- 37ml and 322ml +/- 62ml ($p < 0.001$). No complication was documented in the early post-operative period.

Conclusion:

Retzius-sparing robotic augmentation cystoplasty with the modified Hautmann technique is a safe and feasible alternative to conventional clamp cystoplasty for complex urinary tract reconstruction.

ORAL PRESENTATION SESSION 2

Time: 13:30 – 15:00 **Venue:** Main Lecture Hall

[OP. 2-11]

A Pioneer Multidisciplinary Urology Service for Exstrophy in Hong Kong

JYY To, LCS Hsu, HCK Lau, DLS Chan, MKH Chan, JHK Ngan.

Exstrophy Team of MedArt China Orphan Outreach and Dr John Ngan Adult and Paediatric Urology

Objectives:

Bladder (1:50,000 livebirths) and cloacal exstrophy (1:400,000 livebirths) are among the rarest and most difficult conditions to treat in urology. In 2004, MedArt established Hong Kong's first exstrophy programme. We conducted a feasibility audit of the programme, hoping to guide similar future endeavours.

Patients & Methods:

19/22 children with exstrophy (age=1y4mo; M:F=13:6; bladder:cloacal=17:2) received one-staged bladder closure, epispadias repair and bilateral pelvic innominate osteotomy at Hong Kong Sanatorium and Hospital, 2008-2019. 9 (M:F=6:3) failed previous closures (8 persistent exstrophies; 6 epispadias, 1 urethral stricture), despite 9 attempts of bladder closure, 1 epispadias repair and 4 osteotomies. Comorbidities included omphalocele (3), inguinal hernia (14), myelodysplasia (2), imperforate anus (2), rectal prolapse (2), obstructive megaureter, cryptorchidism, ureterocoele, factor VIII deficiency, renal insufficiency (2), and Wolff Parkinson White syndrome. Our team consisted of 1 urologist, 2 orthopaedic surgeons, 1 anaesthesiologist and 1 paediatric nephrologist. Effectiveness of care delivery was assessed in terms of anaesthetic, urological, orthopaedic and paediatric outcomes.

Results:

Success was achieved in 17/19 (89%) children. 2 boys receiving redo-surgeries failed. Boys had more blood losses (M:F=311:127ml), procedures performed (M:F=8.9:6.3) and longer operating times (M:F=10h40m:8h15m). There were 1 bladder calculus and 2 meatal stenoses, requiring lithotripsy and meatoplasty. Minor complications occurred in 16 patients: febrile UTI (12), temporary vesicocutaneous fistula (5), temporary recurrent inguinal hernia (2), and wound infection/ superficial dehiscence (10). None required surgical correction.

Conclusions:

Our results are comparable to major exstrophy centres of excellence. Obstacles identified are redo-surgeries, blood loss and male genital anatomy. Fistulas and hernias after closure heal spontaneously.

[OP. 2-12]

10 YEAR REVIEW OF URETHROPLASTY OUTCOME AND RISK FACTOR FOR RECURRENCE: A SINGLE CENTER EXPERIENCE

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Objectives:

To review the result of urethroplasty performed in our center and identify potential risk factors for recurrence.

Patients & Methods:

We retrospectively review urethroplasty performed between 2011 and 2020 in our center. Primary outcome was stricture recurrence which defines as need of intervention or radiological/endoscopic confirmation of stricture. Baseline demographic data including age, comorbidity, smoking, site and length, etiology, previous intervention was compared. Postoperative erectile dysfunction and incontinence were also analyzed.

Results:

There was total 49 male patients with 61 urethroplasty procedures performed. The mean age was 56. The predominant stricture etiologies were post TUR related (32.7%, N=16) and trauma (24.5%, N=12). Patient had stricture length less than 2cm and those more than 2cm were 49% (N=24) and 51% (N=25) respectively. Most strictures were located at bulbous (32.7%, N=16), penile (30.6%, N=15) and penobulbar region (20.4%, N=10). 10 cases (20.4%) had previous urethroplasty performed. 17 cases (34.7%) had previous sounding or dilatation or urethrotomy. 30 cases (61.2%) had suprapubic cystostomy prior to urethroplasty.

Urethroplasty performed included anastomotic urethroplasty (22) and substitutional urethroplasty (27). Overall stricture recurrence rate was 12/49 (24.5%).

Higher re-stricture rates were observed in those with previous urethral sounding/dilatation/urethrotomy (47.1%:12.5%), previous urethroplasty (40%:20.5%), without suprapubic cystostomy prior to surgery (36.8%:16.7%).

Conclusion:

Urethroplasty is an effective treatment for urethral stricture with successful rate of 75.5%. Patients who had prior sounding or dilatation or urethrotomy, previous urethroplasty and those without prior suprapubic cystostomy had greater odds of developing a recurrence following urethroplasty.

MODERATED POSTERS

Time: 09:45 – 10:45 Venue: Nursing Hall

[MP: 1]

Sexual counselling service in a Men's Health Clinic for men with erectile dysfunction: A multidisciplinary clinic model

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²Nursing Services Division, United Christian Hospital, Hong Kong.

³Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong.

⁴Division of Urology, Department of Surgery, Tseung Kwan O Hospital

Objectives:

1. Describe the model and participants characteristics of a Multi-disciplinary (MD) clinic for men with erectile dysfunction in Men's Health Clinic in KEC.
2. Discuss the benefit of this model from the patient's perspective.

Patients & Methods:

A two-tier service model was established with collaboration from Men's Health Clinic, KEC and Community Rehabilitation Services Support Center (CRSSC), QEH.

SS(Specific Suggestion) IT(Intensive Therapy)	Tier 2 Intensive sexual counseling (ISC) at CRSSC Integrate sexual communication, nondemanding pleasuring, erotic scenarios and psychosexual skills. Overcome performance anxiety by Cognitive Behavioral sex therapy Utilize their sexual strength by Solution focus brief therapy
P(Permission) LI(Limited Information)	Tier 1 Brief sexual counseling (BSC) at Men's Health Clinic, TKOH Screen clients about psychosocial sexual issues by Urologist or Nursing Consultant and triage to sex therapist Recognize clients' sexual distress and how does it impact on himself, his partner and their relationship. Coach about lifestyle modifications for sexual wellness, couple intimacy, adaptive strategies and sexual script.

Figure 1 Sexual therapy guided by PLISSIT Model

Results:

Between Dec 2020 and June 2021, 61 patients were intervened by MD team. 77% received BSC only, 22% further received ISC. Among the respective groups, mean age 58 vs 52; mean age different with partner 6.4 vs 5.6; IIEF-5 scoring mean 9.4 vs 10.1; person with fertility plan 0 vs 2. Accumulated attendance 47 vs 42.

Conclusion:

Cultural dominance is observed in traditional double standard and pass-fail performance beliefs over female-male sexual equity and Good Enough Sex belief. Aged patients attribute sexual difficulties to health deterioration rather than psychosocial factors. The unspoken sexual self-image and dyadic disengagement due to sexual dysfunction are addressed. One stop service favor sexual health help-seeking behavior among men.



MODERATED POSTERS

Time: 09:45 – 10:45 **Venue:** Nursing Hall

[MP. 2]

Early experience of supine percutaneous nephrolithotomy (PCNL) under regional anesthesia.

SF Ma, HL Wong, KS Tam, YC Chan, TO Yu, TT Law, TK Lo, YK Lee, CH Cheng, TY Chan, LH Chau, CW Man, PSK Chu

Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

Objectives:

Supine Percutaneous Nephrolithotomy (PCNL) has the advantages of better stone drainage, feasible for endoscopic combined intrarenal surgery and better for patient with poor lung condition / obese patient. The General Anaesthesia (GA) is the standard modality for PCNL. There are studies concluded that Spinal Anaesthesia (SA) is safe and can be considered. We report our experience on the supine percutaneous nephrolithotomy (PCNL) performed under regional anesthesia.

Patients and Method:

There were total of 31 supine PCNL performed under combined spinal epidural anaesthesia (CESA) between Dec 2020 to June 2021. We retrospectively collected data from the patient's medical records. The morbidity, complication and transfusion rate are the primary objective, while the operative time, conversion to GA and mean length of stay are the secondary objectives.

Results:

The mean age of patients was 60 years old. The mean stone size was 2.6 cm. For the Guy's Stone score grading, grade 1 had 11 cases (35.5%). Grade 2 had 15 cases (48.4%). Grade 3 had 2 case (6.5%) and grade 4 had 3 cases (9.7%). There were 5 cases of morbidity and the morbidity rate was 16.1%. All the morbidity belonged to Clavein I/II complications. The transfusion rate was 0%. For the secondary objective, the mean operative time was 110 minutes (55 to 168). The conversion to general anaesthesia was 0% and the mean length of stay was 4.3 days.

Conclusion:

Supine PCNL under combined spinal epidural anaesthesia is technically feasible and safe. This provide an additional choice for anaesthetist and surgeon for managing high risk patient.

[MP. 3]

Prostatic Arterial Embolization for Benign Prostatic Enlargement in High-Risk Men with Indwelling Urethral Catheters - Our four-year experiences

KC Cheng¹, HM Lam¹, HC Chan¹, MH Cheung², SM Yu³, SK Kei⁴, NH Chan², HS So¹

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Objectives:

To investigate the success rate of voiding trial after prostatic artery embolization (PAE) in high-risk men with indwelling urethral catheters.

Patients & Methods:

This is a prospective, multicenter single arm study. High-risk men with prostate size more than 50cc, ASA class 3 or 4, with either refractory retention or obstructive uropathy were recruited. CT angiogram of pelvis was performed after recruitment to determine feasibility for PAE. Voiding trials were scheduled on week 1, week 2, week 4 and week 12 after PAE. Clinical follow-up is arranged every 3 months for two years after intervention. Primary outcome was the success rate of voiding trial within 12 weeks after PAE. Secondary outcomes included complications, change in prostate size, change in serum PSA, postoperative flow rate and IPSS/QoL questionnaire score.

Results:

68 patients were recruited from 1 April 2017 to 1 April 2021. 48 (70.6%) were deemed fit for PAE after CTA assessment. 45 PAE sessions were performed in 41 men. 26 PAE sessions were bilateral while 19 PAE sessions were unilateral. 75.6% of men who received PAE had successful voiding trials. There were decrease in PSA level, reduction in prostate gland volume and improvement in the maximum flow rate after PAE. The mean reduction in PSA and prostate size at 12 months after PAE were $15.4\% \pm 50\%$ and $33.5\% \pm 17.5\%$ respectively.

Conclusion:

PAE is an effective treatment for high-risk men with indwelling urethral catheter who are not fit for conventional transurethral prostatectomy.

MODERATED POSTERS

Time: 09:45 – 10:45 Venue: Nursing Hall

[MP. 4]

Transperineal prostate biopsy under Ginsberg protocol: Is it a better approach?

WL Chan, TCF Li, CF Kan, HY Ngai, WH Au

Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong SAR

Objectives:

To compare the cancer detection rate (CDR) of systematic Ginsburg transperineal prostate biopsy (sTPPB) with systematic 12 core transrectal prostate biopsy (sTRPB) under local anaesthesia in biopsy naïve patients.

Patients & Methods:

This was a retrospective matched case study comparing patients with sTPPB performed with freehand trocar method under Modified Ginsberg protocol in 10/2018 to 6/2021, compared to a historical cohort of TRPB performed in 1-12/2016. Those with pre-biopsy PSA ≤ 20 , biopsy naïve, without pre-biopsy magnetic resonance imaging of the prostate were included. Demographic data, pathology results and complications of prostate biopsy were retrospectively reviewed.

Results:

137 patients were included in the sTPPB group while 261 patients in the sTRPB group. Both groups had comparable PSA, prostate volume and PSA density. The mean biopsy core number was 24.6 for sTPPB vs 12 in sTRPB group. CDR was significantly higher for sTPPB group (36% vs 26%, $p=0.037$). Superior CDR in sTPPB was also found for those with PSA ≤ 10 (34% versus 22%, $p=0.024$). There was no significant difference in detecting Gleason grade group ≥ 2 in sTPPB and sTRPB (57% versus 45%, $p=0.8$). No sepsis was recorded in the sTPPB group, and the sepsis rate was 1.9% in sTRPB (5/261). The pain visual analogue scale in sTPPB and sTRPB were 1.9 and 2.9 respectively ($p=0.026$).

Conclusion:

sTPPB achieved a superior cancer detection rate as compared to sTRPB in biopsy naïve settings without procedure-related sepsis.

[MP. 5]

Effect of Intravesical Hyaluronic Acid Instillation on Ketamine-induced Cystitis

SF Tang, CH Yee, CYL Hong, FPT Lai, YH Tam, CF Ng

Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong

Objectives:

Chronic abuse of ketamine leads to ketamine-associated uropathy. The actual mechanism is unknown. It is believed that ketamine and its metabolites would disrupt the proliferation of bladder epithelial cells. Bladder instillation of hyaluronic acid was observed to be an effective glycosaminoglycan (GAG) layer replacement therapy for interstitial cystitis. This study aimed to investigate the clinical effect of hyaluronic acid instillation in ketamine-induced cystitis.

Patients & Methods:

This is a prospective case series of patients with ketamine-associated uropathy. Patients failing the initial tiers of treatment, namely anti-inflammatory or anti-cholinergic drugs, and opioid analgesics or pregabalin, were offered to undergo 8 intravesical instillations of hyaluronic acid. Outcome was assessed with functional bladder capacity, pelvic pain and urgency or frequency (PUF) symptom scale, and the EuroQoL visual analogue scale. Non-steroidal anti-inflammatory drug (NSAID) and analgesic consumption was also assessed before and after treatment.

Results:

Between 11/2012 to 11/2020, 39 patients underwent intravesical hyaluronic acid instillation with a mean age of 27. 27 patients were able to complete the whole course of treatment. After treatment, significantly less patients experienced perineal/suprapubic pain. There were statistically significant improvement in PUF symptom score (15.2 ± 4.4 vs 14.1 ± 5.6 , $p=0.049$), QoL self-assessment score (47.8 ± 19.5 vs 53.9 ± 22.2 , $p=0.028$), mean functional bladder capacity (83.7 ± 71.9 ml vs 111.4 ± 105.8 ml, $p=0.005$) and mean voiding interval (47.5 ± 33.4 minutes vs 60.4 ± 43.2 minutes, $p=0.035$). Multivariate analysis revealed that patients of a longer ketamine abuse history and age are significant variable that contribute to the decrease in NSAID/analgesic use.

Conclusion:

Intravesical hyaluronic acid significantly improved pain and lower urinary tract symptoms in patients with ketamine-induced cystitis.

MODERATED POSTERS

Time: 09:45 – 10:45 Venue: Nursing Hall

[MP. 6]

Evaluation of patient characteristics undergoing PAE on effect of clinical outcome

LG Chui, WM Kan, HY Ngai, WH Au

Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong

Objectives:

Prostatic artery embolization (PAE) is a treatment beneficial to patients with benign prostatic hyperplasia (BPH) and refractory hematuria of prostatic origin. This study aimed to evaluate the characteristics of patients undergoing PAE on the effect of clinical outcome.

Patients & Methods:

26 patients who underwent PAE in our centre between April 2017 and July 2021 were evaluated. Their age ranged from 59 to 93 (mean 78.2). Indications for PAE included obstructive uropathy (42.3%), refractory retention of urine (ROU)(26.9%), hematuria(15.4%), lower urinary tract symptoms (LUTS) refractory to medical treatment (11.5%) and BPH with bladder stone (3.8%). Patients were evaluated on their age, pre- and post-PAE prostate volume, international prostate symptom score (IPSS), quality of life(QOL), peak flow rate (Qmax), post-void residual volume (PVR), comorbidities and time to successful self-void.

Results:

22 patients underwent PAE successfully. Mean time to successful self-void was 16.8 days. 60% with obstructive uropathy or refractory ROU were able to self-void. 66.7% with hematuria did not experience hematuria after PAE. 66.7% with LUTS refractory to medical treatment had improvement in IPSS and QOL. Mean of pre- and post-PAE prostate volume was 92.72 g and 58.26 g respectively ($p < 0.001$). All 4 patients who failed PAE had cardiovascular disease (CVD). 72.7% patients with successful PAE had CVD. Mean IPSS decreased from 17 to 8.83 post-PAE ($p = 0.043$). Mean QOL decreased from 3.5 to 2.2 ($p = 0.103$). Qmax increased from 7.63 ml/s to 10.3 ml/s ($p=0.178$). PVR decreased from 107.8 ml to 77.7 ml ($p=0.129$).

Conclusion:

PAE appeared to be an effective treatment alternative for patients who were otherwise not fit for procedure under general anesthesia.

[MP. 7]

Acute Scrotal Pain, Are We Exploring Too Much?

YH Fan, D Wen, H Lie, F Wong, MH Yu, CC Ngo, KW Wong, SK Li, CM Li

Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital

Objectives:

In this retrospective review, we aim to explore the relationship between patient's factors, physical examination and scrotal exploration findings in order to reduce unnecessary operations and raise awareness of healthcare staff to identify high risk cases for testicular torsion (TT).

Patients & Methods:

All patients admitted for acute scrotal pain with scrotal exploration done from August 2017 to August 2021 were included. Parameters including age, duration of symptoms, physical examination and intra-op findings were reviewed. Data of 72 patients with a median age of 17-year-old were reviewed. Scrotal explorations done for scrotal abscess/testicular injury from scrotal trauma were excluded.

Results:

8 patients (11%) had genuine TT. 20 cases (28%) were torsion appendix testis; and 20 cases were epididymitis/orchitis; no pathology was found in the remaining patients. The median age for TT is 20-year-old, which is the same for patients with epididymitis/orchitis. Patients with torsion appendix testis were found to be younger, with a median age of 10-year-old. 75% of patients with TT had abnormal PE findings (swelling/high lying of testis). However, our data failed to demonstrate a significant correlation between abnormal PE findings and TT ($p=0.053$). Median duration of symptoms for TT is 4 hours; whilst that of torsion appendix testis and inflammation are 24 hours and 12 hours respectively.

Conclusion:

Time of onset remains an important factor to predict TT. Although not proven to have significant correlation, abnormal PE should still raise awareness of medical staff. A well designed risk system combining patient's age, duration of symptoms and physical findings may aid identifying patients with high risk of torsion and reduce frequency of scrotal exploration.

MODERATED POSTERS

Time: 09:45 – 10:45 Venue: Nursing Hall

[MP. 8]

Evaluation of the learning curve for bipolar enucleation of the prostate (BipolEP): Experience from the first 50 patients

JSL Leung, VYK Poon, CY Ng, KK Lo, CH Ip, Y Chiu, TY Chu, YC Lam, WK Ma

*Division of Urology, Department of Surgery
Princess Margaret Hospital, Hong Kong*

Objectives:

To map out the learning curve for performing BipolEP, and its associated efficacy and safety.

Patients & Methods:

Between June 2018 to July 2021, 50 patients who underwent BipolEP +/- concomitant cystolithotripsy with endoscopic morcellation by a single surgeon who was new to this technique were retrospectively reviewed. Patients were chronologically arranged into five groups of ten (Group 1 to 5), and the peri-operative and post-operative parameters were compared.

Results:

Group	Operative time, mean (mins)	Preoperative prostate size, mean (g)	Prostate size reduction, mean (%)	PSA decline, mean (%)	Enucleation Efficiency, mean (g/min)	Morcellation Efficiency, mean (g/min)
1	99	67	36	63	0.26	0.67
2	152	117	49	82	0.48	1.48
3	124	112	49	90	0.51	1.89
4	132	123	60	86	0.53	2.76
5	142	121	50	89	0.54	3.38

The largest improvements in key peri-operative outcomes can be observed between Groups 1 and 2, but efficiency and percentage PSA decline reached a steady state starting from Group 3 (after performing 20 operations). A trend in longer operative times is explainable by the inclusion of patients with larger prostate sizes. Post-operative maximum flow rates improved with case accumulation (from 19.3 ml/s to 30 ml/s). Enucleation failure rate was 10%, all occurring within the first 20 cases. 1-month readmission for haematuria (6%) or urinary tract infections (4%) were low. There were no Clavien-Dindo IIIa or above complications.

Conclusion:

Operative outcomes in BipolEP reach a steady state after 20 procedures. The strive for top technique lies in refining both enucleation and morcellation effectiveness, handling larger-sized prostates while maintaining low complication profiles.

[MP. 9]

One-year voiding and symptoms outcomes after HoLEP and TURP

KC Cheng, KC Wong, WC Lam, LF Lee, HC Chan, HS So

Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

Objectives:

To evaluate the voiding outcomes and symptoms improvement at one-year after HoLEP and TURP.

Patients & Methods:

This is a prospective cohort included men underwent HoLEP and TURP since 2018. HoLEP was performed with two-lobes or three-lobes technique by a single surgeon. Clinical follow-up was arranged at one year post-operation for all cases to assess the IPSS/QoL questionnaire scores, uroflowmetry results and blood tests for PSA.

Results:

Total 309 men were recruited (HoLEP n=124; TURP n=185). Majority of men underwent surgery for refractory retention (n=97, 31.4%). Mean age was 74 +/- 8 and 76 +/- 9 for HoLEP and TURP. Pre-operatively, men underwent HoLEP had a larger prostate volume (93.3 +/- 42.9cc vs 59.2 +/- 30.5cc; p<0.01) and a higher PSA (15.6 +/- 25.9 ug/L vs 9.4 +/- 13.4 ug/L; p<0.01). At one year after surgery, men underwent HoLEP had a significantly higher peak flow rate compared with TURP (19.3 +/- 9.4ml/s vs 15 +/- 7.4 ml/s; p<0.01). One-year IPSS score (IQR) were 7 (4-13) and 5 (3-12) (p=0.25); QoL score (IQR) were 2 (1-3) and 2 (1-3) (p= 0.29) for HoLEP and TURP respectively. Greater PSA reduction was achieved by HoLEP at one-year (81% +/- 22% vs 43% +/- 65%; p<0.01).

Conclusion:

HoLEP resulted in a significantly higher peak flow rate at one-year after operation compared with TURP.

MODERATED POSTERS

Time: 09:45 – 10:45 **Venue:** Nursing Hall

[MP: 10]

How Accurate Is Targeted Biopsy Alone? A Prospective Comparative Study of Targeted Versus 24-Core Mapping Transperineal Prostate Biopsy Using Robot-Assisted Software Fusion Platform

TF Wong, CH Ip, ACY Ng, H Chow, AKK Lo, YK Poon, TY Chu, Y Chiu, YC Lam, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong SAR

Objectives:

To review the outcomes of patients undergoing both targeted and mapping biopsy using robot-assisted software fusion platform (Artemis; Eigen, USA) in an office setting.

Patients & Methods:

All patients with suspicious lesion on MRI (PIRADS 3 or above) who underwent both targeted and mapping transperineal biopsy under local anaesthesia in our centre from October 2020 to June 2021 were included. Mapping biopsy was taken under modified Ginsburg protocol with 24 cores for each prostate. Statistical analysis was performed using Fisher's exact test, McNemar's test and T-test. Outcomes including cancer detection rate and complications were reported.

Results:

A total of 148 patients with 268 suspicious MRI lesions underwent the procedure. 73 (49.3%) were diagnosed of prostate cancer, in which 65.8% were clinically significant. Targeted biopsy was non-inferior to mapping biopsy in detection of all cancers (42.6% vs 47.3%, $p=0.082$) and clinically significant cancer (29.1% vs 27%, $p=0.064$). For the 46 patients with clinically significant cancer, 10 (17.4%) were detected by targeted biopsy only and 5 (10.9%) by mapping biopsy only. Targeted biopsy managed to detect ISUP grade 1 cancer in all the latter 5 patients, and these positive targets were at the ipsilateral side of significant cancer yielded from mapping biopsy. Targeted biopsy has superior sampling efficiency for cancer detection (30.5% vs 10.6%, $p<0.001$). No patient developed procedure-related sepsis, while 21 (14.3%) patients developed urinary retention after biopsy.

Conclusions:

Targeted biopsy efficiently detects a substantial number of clinically significant cancer. This procedure can be performed in an office setting with a good safety profile.

[MP. 11]

Can patients with low suspicion on multi-parametric magnetic resonance imaging of the prostate safely avoid prostate biopsy? A single-institution retrospective cohort analysis

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²*Division of Urology, Department of Surgery, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong SAR*

Objectives:

Elevated prostate-specific antigen (PSA) is the commonest reason for having a prostate biopsy, which remains to date the only intentional means of diagnosing prostate cancer (CaP). Multiparametric magnetic resonance imaging (mpMRI) has emerged as a valuable tool to stratify risk of having clinically significant prostate cancer (csCaP) graded by the Prostate Imaging-Reporting and Data System (PI-RADS) score. The aim of this study is to determine the rate of false negative mpMRI in our patients in identification of CaP, and thus mpMRI's potential to guide clinical decision to avoid prostate biopsy.

Patients & Methods:

Analysis of our prospective prostate biopsy database of patients who underwent prostate biopsy between the period of January 2017 and August 2021 was performed. Patients suspicious of CaP with PI-RADS category 1 or 2 on mpMRI with systematic prostate biopsy and a PSA level within 4-20ng/mL were included. Patient characteristics and biopsy results were evaluated using univariate and multivariate regression analysis.

Results:

92 cases were identified. Median PSA and PSA density (PSAD) for the cohort were 7.4 ng/mL and 0.155ng/mL². 6.5% (6/92) of the patients were diagnosed with CaP, none of them was csCaP. Logistic regression analysis did not identify any statistically significant predictive factors for CaP, including PSA ($p=0.058$), PSAD <0.15 ($p=0.945$) and PHI ($p=0.299$).

Conclusion:

The false negative rate of mpMRI in predicting csCaP in our locality is very low at 0%. The results suggest patients with PI-RADS category 1 or 2 can consider not having prostate biopsy as a shared clinical decision between the patient and urologist.

MODERATED POSTERS

Time: 09:45 – 10:45 **Venue:** Nursing Hall

[MP. 12]

Bipolar enucleation of prostate (BipoLEP) for benign prostatic obstruction

KL Lo, PY Au-Yeung, SY Chow, TC Lam, CSJ Yeung, SCM Ng, SH Ng, AQ Liu, CH Yee, JY Teoh, KM Li, HM Wong, CF Ng, PK Chiu.

SH Ho Urology Centre, NTEC Urology, The Chinese University of Hong Kong

Objectives:

To review the post-operative outcomes of bipolar enucleation of prostate (BipoLEP) for benign prostatic obstruction.

Methods:

A retrospective review of BipoLEP cases performed in 2 hospitals between April 2018 and June 2021 was done. Peri-operative outcomes were compared between different time periods.

Results:

194 patients with mean age 73 (+/-11.6) years were included. 68.6% patients had refractory retention. 87.1% was performed under spinal anaesthesia. 28.4% and 65.5% patients were ASA 3 and ASA 2 respectively. 74.1% cases were performed by one surgeon. Mean operative, enucleation, and morcellation times were 84 (+/-35), 36 (+/-16), and 21 (+/-12)mins. Median bladder irrigation time was 6(interquartile range 6-12) hours. Median catheter-removal time was day 1(interquartile range 1-2) days. Mean change of Hb was 0.73 (+/-1.5) g/dL, and 1.5% (3/194) required 1-2 units of packed cells transfusion. Mean prostate tissue removed was 59 (+/-39)g. PSA dropped by a median of 90% (interquartile range 75-95%). The mean maximal flow rate (Qmax) at 6-12 months was 22.0 (+/-15.4) ml/s. 13.6% (22/162) had *de novo* post-operative stress urinary incontinence (SUI), including 4.9% (8/162) lasting 6-12 months and 1.9% (3/162) lasting more than 12 months.

Dividing the patients into 2 treatment periods(first phase 100 and second phase 94), independent sample t-test showed shorter mean bladder irrigation time (13 vs 7 hours, $p=0.003$), and shorter mean time of SUI (2.3 vs 0.2 months, $p<0.001$) in second phase, while post-op Hb change, PSA change and Qmax had no significant difference.

Conclusions:

This review demonstrated the safety and efficacy of BipoLEP. Post-op SUI was reduced with increased operative experience.



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UNMODERATED POSTERS

[UMP. 1]

Predictive Factors of Stone-Free Rate in Ureteroscopic Laser Lithotripsy – Does the S.T.O.N.E. score matter?

CHT Yu¹, KC Cheng¹, NH Chan², HS So¹

¹Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

²Division of Urology, Department of Surgery, Tseung Kwan O Hospital, Hong Kong

Objectives:

To investigate the association of S.T.O.N.E. score and other factors in predicting stone-free rate (SFR) in ureteroscopic laser lithotripsy (URSL).

Features	1	2	3
(S)ize	<5mm	5-10mm	>10mm
(T)opography	Distal to mid ureter	Proximal ureter to mid and upper pole kidney	Lower pole
(O)bstruction	Preoperative stenting or no hydronephrosis	Grade 1-2 hydronephrosis	Grade 3-4 hydronephrosis
(N)umber	1 stone	2 stones	>=3 stones
(E)valuation of Hounsfield units	<750HU	750-1000HU	>1000HU

Table: S.T.O.N.E. score

Patients & Methods:

Patients who underwent URSL between 1 January 2018 to 31 December 2018 in United Christian Hospital and Tseung Kwan O Hospital were included. Patients with no pre-operative CT scan, anatomical abnormalities, sepsis and those who underwent ureteroscopy with additional procedures were excluded.

Results:

134 ureteroscopies were included. Overall SFR was 90.3%. The overall S.T.O.N.E. score showed no correlation with SFR. Multivariable logistic regression showed higher SFR in females ($p=0.035$), those presenting with no hematuria ($p=0.049$), and those with a lower S.T.O.N.E. obstruction score ($p=0.052$).

Conclusion:

Female patients and those presenting with no hematuria have a higher successful SFR with URSL. Overall S.T.O.N.E. score did not correlate with SFR.

[UMP. 2]

Thulium-Fibre Laser : the cutting edge technology in modern urological practice

Chan TC Timothy, TCF Li, HY Ngai, WH Au

Division of Urology, Department of Surgery

Queen Elizabeth Hospital, Hong Kong

Objectives:

Our objective is to review and explore the clinical applications of Thulium-fibre laser (TFL) in our local unit, and to evaluate the operative efficacy in daily practice.

Patients & Methods:

We collected several patients for the trial of TFL in early 2021 within Queen Elizabeth Hospital, ranging from RIRS to mini-PCNL, from *en bloc* TURBT to Thulium-laser enucleation of prostate (ThuFLEP). Operative videos were recorded for analysis. Patients' data, including histopathological data and imaging results, were retrospectively collected to evaluate the operative outcome.

Results:

For the patient undergoing *en bloc* TURBT and ThuFLEP, good hemostasis could be achieved with the Thulium-fibre laser, which also facilitates early discharge and minimize the duration of bladder irrigation in post-operative period.

In the patients undergoing Thulium-fibre laser lithotripsy, excellent stone dusting quality and minimal stone retropulsion was noted in intraoperative handling. Fluoroscopic and endoscopic stone clearance was successfully achieved. The benefit of using TFL permits the usage of smaller caliber instruments, while at the same time achieving surgical safety and short operative time.

Conclusion:

Thulium-fibre laser is an effective and powerful tool in our daily urological surgeries, with impressive clinical outcome in terms of stone clearance or hemostatic efficacy. It helps in expanding the indication for stone surgeries, in terms of larger stone load or more technically challenging anatomy. It has a great potential in future operative applicability. Further research is needed to look for the optimal setting in different operative scenarios.

UNMODERATED POSTERS

[UMP. 3]

Evaluation of a Multi-disciplinary Trial Without Catheter Protocol for Geriatric Hip Fracture Patients Suffering from Acute Retention of Urine

CW Wu, CM Ng, HY Ngai, WH Au

Division of Urology, Department of Surgery, Queen Elizabeth Hospital

Objectives:

To evaluate the outcomes of multi-disciplinary trial without catheter (TWOC) protocol in geriatric patients suffering from acute retention of urine (AROU) during recovery from hip fracture.

Patients & Methods:

Geriatric patients suffering from AROU during their admissions for hip fracture had TWOCs after optimization following a multi-disciplinary protocol. The demographics, clinical parameters and TWOC outcomes of those attending the follow-up clinic from January 2020 to July 2021 were evaluated.

Results:

52 patients attended the follow-up clinic in the period. Their mean age was 87 ± 7.2 and the mean 1st catheterized volume was 509 ± 192.8 ml. The overall success rate of was 100% (77% in the rehabilitation hospital and 23% after discharge). The median time from AROU to TWOC was 14 days. The first catheterized volume positively correlated with the time to successful TWOC ($r(50) = .402$, $p < .01$).

Conclusion:

This multi-disciplinary protocol is a successful approach for managing geriatric hip fracture patients suffering from AROU. This may limit the consultation number and shorten the catheterization time.

[UMP. 4]

Urachal anomalies: their clinical presentation and management

NS Yeung, CLH Leung, KW Chan

Division of Urology, Department of Surgery

Kwong Wah Hospital, Hong Kong

Objectives:

To assess the clinical manifestations, management and outcomes of urachal anomalies in our unit.

Patients & Methods:

We performed a retrospective study of all cases of congenital anomalies of the urachus requiring operation in our unit over a ten-year period.

Results:

Thirteen cases of urachal anomalies were included.

The mean age of presentation was 50-year-old (range: 17-84). 61.5% were male.

Clinical manifestations included abdominal pain, umbilical discharge, fever, haematuria, mucosuria and dysuria. Diagnostic tests were ultrasound, computed tomography and flexible cystoscopy.

Indications of surgery included infected urachal cyst, infected urachal sinus, urachal abscess and bladder adenocarcinoma.

Laparoscopic excision of urachus and partial cystectomy were conducted. Mean operation time was 146 minutes (range: 70 – 227 minutes).

Post-operative complications included hernia defect and wound gapping.

None had recurrence so far.

Two cases had adenocarcinoma of the bladder while one had mucinous cystic tumour of uncertain malignant potential.

Conclusion:

Urachal anomalies become symptomatic when complicated. They can present at different ages and in various ways. Surgical outcomes in this single-centre study are favourable with no recurrence so far.

[UMP. 5]

Sepsis rate after transrectal versus transperineal prostate biopsy: a single centre experience

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Division of Urology, Department of Surgery

Kwong Wah Hospital, Hong Kong

Objectives:

Transrectal ultrasound-guided prostate biopsy (TRPBx) has long been considered the standard of care for detection of prostate cancer since its introduction in 1989.

However, in light of evidence of non-inferior cancer detection rates and post-TRPBx urinary tract infections (UTI) rates of 1.9% in our locality, the safer Transperineal approach (TPPBx) has quickly gained widespread acceptance and adoption.

Our institution has transitioned to preference of TPPBx since September 2020 and the aim of this presentation was to compare the rates of hospital re-admission for sepsis after TRPBx and TPPBx.

Patients & Methods:

140 TPPBx performed at our centre between September 2020 and June 2021 were compared with 137 TRPBx performed between September 2019 and August 2020.

Patient information including patient age, 30-day readmission and complications rates were retrieved from patient records.

Sepsis was defined according to the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).

Results:

Mean age did not significantly differ between the groups. (68.2 vs 68.9)

20 (14.3%) patients in the TRPBx group required admission within 30 days of biopsy, compared to 2 (1.4%) patients in the TPPBx group.

In the TRPBx group, 17 patients (12.1%) had urinary tract infections (UTI), of which 3 developed sepsis and 1 required ICU admission. 3 patients had acute retention of urine (AROU).

In the TPPBx group, 1 patient had gross haematuria and 1 patient developed AROU. Neither had fever or positive urine cultures.

Conclusion:

The transperineal approach of prostate biopsy is a safer procedure with fewer potentially life-threatening infective complications, supporting its widespread adoption.

[UMP. 6]

From Fluoroscopic-guided Prone PCNL to Free-hand Ultrasonographic-guided Supine PCNL: a safe and feasible transformation

CHM Wong, JKM Li, KL Lo, SYS Chan, JHF Wong, SCH Yee, PKF Chiu, JYC Teoh, SKK Yuen, CK Chan, TCK Ng, DKW Leung, HM Tam, KL Chui, SK Mak, HY Cheung, JHM Wong, SSM Hou, CF Ng

Division of Urology, Department of Surgery

North District Hospital and Prince of Wales Hospital, New Territories East Cluster

SH Ho Urology Centre,

Department of Surgery, the Chinese University of Hong Kong

Objectives:

To compare the safety and clinical outcome of different positioning of PCNL.

Patients & Methods:

Patients who had undergone primary PCNL to urinary stones in the North District Hospital and Prince of Wales Hospital from January 2017 to July 2021 were included. Demographic of patients including the body mass index and comorbidities, as well as the stone characteristics were retrospectively collected. The intraoperative parameters like operative time, position of patient during PCNL and puncture method were included in the analysis. The clinical outcomes included the stone-free rate at 6 months and complication rate. Secondary outcomes including rate of combined endourological procedure and mean length of hospital stay were also included.

Results:

There were a total of 379 PCNL performed in the above-mentioned period. There were 128 procedures done as supine PCNL and 151 done as prone PCNL. There were no differences in the patient characteristics. There were more staghorn stones in the prone PCNL group and stones were significantly larger in the prone PCNL group. Ultrasonographic-guided (USG-guided) puncture was almost done in all supine PCNL procedures. The stone-free rate was significantly higher in the supine PCNL group with similar complication rates. The supine PCNL group also showed shorter operative time, shorter length of hospital stay and had more combined endourological procedure.

Conclusion:

Supine PCNL with USG-guided puncture is a safe and feasible technique as alternative to fluoroscopic-guided prone PCNL with a potential better stone free rate and comparable complication rate. Further prospective study is required.

[UMP. 7]

Risk factors for recurrence of paraumbilical hernia in End-Stage Renal Failure patients on Peritoneal dialysis

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Objectives:

To study the risk factors associated with recurrent paraumbilical hernia in End-Stage Renal Failure (ESRF) patients on Peritoneal Dialysis (PD)

Patients & Methods:

Retrospective analysis of ESRF and PD patients who had undergone paraumbilical hernia repair in the period of May 2011 to May 2020 in Hong Kong West Cluster was performed. In total 38 patients were identified, including elective or emergency repair of paraumbilical hernia in Queen Mary Hospital or Tung Wah Hospital. Patients characteristics, operative details and clinical outcome were evaluated.

Results:

Median follow-up for the cohort was 30 months. Size of defect of the paraumbilical hernia ranges from 1cm to 4cm. 16 patients (42.1%) had mesh repair with either Prolene mesh or biological mesh, 22 patients had primary closure (57.9%). 6 patients in the primary repair group had recurrent hernia (18.8%) while none had recurrence in the mesh repair group. The higher risk of recurrence in primary repair group was statistically significant ($p=0.03$). The complication rates for both group of patients are very low. Further statistical analysis with t -test, Chi-square test and Fisher's exact test failed to show other significant risk factors for recurrence, including age ($p=0.587$), size of defect ($p=0.829$), duration of PD ($p=0.269$) and diabetes mellitus ($p=0.239$).

Conclusion:

Our study echoes with current evidence that the use of mesh for paraumbilical hernia repair carries lower risk of recurrence. Mesh repair for paraumbilical hernia in ESRF patients on PD provide a better clinical outcome without an increased risk of wound complication.

[UMP: 8]

Pain score comparison between patients undergoing MRI fusion targeted transperineal biopsy versus systematic transperineal prostate biopsy under local anaesthesia

YM Kwok, HC Chan, WC Lam, LF Lee, KC Cheng, HS So, HM Lam, HT Yiu
Division of Urology, Department of Surgery, United Christian Hospital

Objectives:

To compare the pain score between MRI-fusion targeted transperineal prostate biopsies versus systematic transperineal prostate biopsies in UCH

Materials and methods:

Fourteen and twenty patients undergoing MRI fusion biopsy and systematic biopsy respectively were included between October 2020 and August 2021 in United Christian Hospital. For MRI-fusion biopsy, one to four lesions are found in MRI, in which median PI-RADS is 4. Three to six cores are taken in targeted biopsies and 12 cores systematic template-guided biopsies are included. For systematic biopsy, modified Ginsburg protocol is applied by freehand and co-axial needle. Pain score by visual analogue score (ranging 0-10) during local skin infiltration, probe insertion, peri-prostatic nerve block and biopsy was compared between two groups. Statistical analysis was performed by SPSS.

Results:

Mean 28.5ml and 24.2ml 1% lignocaine was used in MRI-fusion biopsy group and systematic biopsy group respectively. Pain score during probe insertion was statistically significantly lower in systematic biopsy group than MRI fusion biopsy group (median 3.5 vs 6.5, $p < 0.05$; mean 5.36 vs 3.55, $p < 0.05$). Pain scores during local skin infiltration and biopsy were statistically lower in systematic biopsy group than MRI fusion biopsy group. Pain score during peri-prostatic nerve block was statistically higher in systematic biopsy group than MRI fusion biopsy group. Sepsis rate was zero in both groups. A case in MRI-fusion biopsy group was admitted due to gross haematuria and urinary retention after biopsy. Limitation of this study is small sample size. Pain score was documented since October 2020.

Conclusion:

Systematic biopsy is associated with lower pain score during probe insertion when compared with MRI fusion biopsy.



UROLOGY NURSING SYMPOSIUM

Time: 15:05 – 15:20 **Venue:** Nursing Hall

[UNS. 1]

Urinary Catheter Dependent Loops as a Potential Contributing Cause of Incomplete Drainage: An Observational Study

Sy YW, Lau KY, Lui KL, Kung WC, Ngo CC, Wong KW, Li SK, Li CM, Lai CH

Department of Surgery, Pamela Youde Nethersole Eastern Hospital

Objectives:

To determine the prevalence of indwelling catheter dependent loops and the changes in retained urine within an inpatient hospital setting.

Patients & Methods:

An observational study was conducted over a one-week period. Patients with Fr.14 silicone coated latex Foley with standard urine drainage bag in inpatient ward were enrolled. Inclusion criteria included presence of an indwelling urinary catheter for at least 24 hours, visibly clear urine without blood clots, sediment/tissue or calculi, absence of extrinsic tubing obstruction, and recorded mean urinary output of at least 30ml per hour within 12 hours of evaluation. Patients were excluded if they had a suprapubic catheter, impaired renal function or other factors affecting measurement of residue urine like ascitic fluid, ovarian cyst or on CAPD. Bedside bladder ultrasound were performed between 0700 and 0800, before first ambulation after sleep.

Results:

A total of 141 patients were recruited. The majority (85%) of observed urine drainage systems contained dependent loops in the drainage tubing and 93.8% of the dependent loops contained urine. Mean residual volume was 96ml (range 4ml to 226ml) without dependent loops in the drainage tubing and the mean residual volume was 136ml (range 22ml to 237ml) contained dependent loops in the drainage tubing ($p<0.05$).

Conclusion:

We find that dependent loops are extremely common in urinary drainage systems among hospitalized patients. Contrary to long-held assumptions, traditional Foley catheter drainage does not consistently or completely evacuate the bladder. The presence of dependent loops is associated with a statistically significant increase in retained urine volume in the bladder of patients.

[UNS. 2]

Nursing perspectives for management of stent irritative symptoms-initial experience with removal of magnetic ureteral double J stenting

Kung WC, Lau KY, Lui KL, Sy YW, Wong CH, Yu MH, Li SK, Wong KW, Ngo CC, Li CM, Lai CH

Department of Surgery, Pamela Youde Nethersole Eastern Hospital

Objectives:

To evaluate the efficacy of this new device and service with regard to its applicability, safety and side effects.

Patients & Methods:

Patients with conventional double J stent and new magnetic double J stent inserted after ureteroscopic lithotripsy (URSL) between Jan 2019 to June 2021 were recruited. Patient demographics, stent irritative symptoms and time to stent removal were analysed retrospectively.

Results:

A total of 186 patients (108 with magnetic double J stent & 78 with conventional double J stent) were recruited. There was no significant difference for patient demographics with median age: 55.3 (Magnetic J) & 58.2 (Conventional J) ($P>0.05$). However, significant difference was found regarding the median waiting time to stent removal was 8 days in magnetic J group & 35 days in conventional J group ($P<0.05$) & the median time for stent removal in endoscopy unit was 6 mins for conventional stent and 2 mins for stent removal in nurse clinic for magnetic stent. ($P<0.05$). In addition, the median visual analogue score (VAS) for magnetic stent removal was 3.3 and 4.4 for conventional removal ($P<0.05$) and the International prostate symptoms score (IPSS) showed statistically significant difference between 2 groups 5.2 (Magnetic J) v.s. 10.7 (Conventional J) ($P<0.05$).

Conclusion:

Our early experience in magnetic double J stent showed that the device was convenient and tolerable. The technique for stent removal is easy to perform by urology nurse and applicable in nurse clinic of surgical day ward. Moreover, patients can benefit with the early removal of stent for reducing stent associate urinary symptoms.



UROLOGY NURSING SYMPOSIUM

Time: 15:05 – 15:20 **Venue:** Nursing Hall

[UNS. 3]

A prospective pilot study on patient's voiding experience in using the new Urinal-Uroflowmeter

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Introduction:

Male patients are required to urinate into a small funnel-shaped urine collector. This is quite different from the usual toilet setting and may not be able to replicate patient's usual voiding. A newly designed uroflowmeter using a urinal design was used to facilitate voiding at uroflowmetry.

Objectives:

To prospectively assess patient's voiding experience in using the new urinal-uroflowmeter compared with the usual uroflowmeter.

Patients & Methods:

This is a non-randomized prospective study recruiting male patients who need to undergo uroflowmetry in the Lithotripsy & Uro-investigation Centre, allocating them urinal or funnel-shaped uroflowmeter groups. A questionnaire was completed by the patient to determine (1) to what extent the flow study replicate usual voiding on a visual analogue scale(VAS) of 0-10, (10 = perfect resemblance of usual voiding), and (2) patients' preference in using which type of uroflowmeter.

Results:

92 male patients had completed the questionnaire. The mean age using the new urinal-uroflowmeter and the funnel-shaped uroflowmeter was 65.9 +/- 9.5 and 69.3 +/- 8.6 years respectively ($p=0.093$). The mean VAS score on resemblance of usual voiding was 8.1 +/- 1.9 in urinal-uroflowmetry group and 6.9 +/- 2.6 in funnel-shaped uroflowmeter group respectively ($p= 0.01$). In a subgroup of 32 men with prior experience of using the funnel-shaped uroflowmeter and who used the new urinal type uroflowmeter in this study, 90.6% (29/32) preferred using the urinal-uroflowmeter.

Conclusion:

This pilot study suggests that the new urinal-uroflowmeter can better replicate usual voiding than usual funnel-shaped uroflowmeter, and was preferred by most male patients.

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