



KUACON 2020

Virtual Annual Conference of Karnataka Urology Association

KUA President's message,

Dear members,

Dear esteemed colleagues,

Warm greetings from the KUA office.



Hope you and your family are keeping good health in these tiring times of COVID-19. I am sure that you are continuing to provide services despite the challenges posed by the global pandemic.

Though we had plans for grand celebration of the 25th anniversary of our association at the scenic place of Shivamogga, it is not possible to do so this year. The council has decided to have a virtual annual conference this year and postpone the silver jubilee celebrations to next year.

You are aware that due to the global pandemic the activities of the association were limited. We had a successful Urogynecology workshop held at Mysuru before the lockdown. We also conducted a virtual mock exam for the postgraduates in May.

As we had a tsunami of webinars in all sub-specialities of Urology conducted by USI, the KUA council deferred from conducting virtual meets and webinars.

We look forward for active participation of all our members in the upcoming virtual KUACON and make it a grand success.

On a personal note, I sincerely thank all the members of KUA for providing me an opportunity to serve the association. I also thank Dr Kumar Prabhu, the Hon. Secretary and other council members for their valuable support.

Let us all stay safe and healthy.

Long live Karnataka Urology Association

Regards

Dr. Siddalingeshwar Neeli

President KUA



Org. Secretary's Message,

Dear members,

Greeting's from Bangalore,

The Shivamogga team were planning to have a grand 25th KUACON and wanted to plan physical conference even if it is postponed to April 2021. But looking at broader issue, we will be delaying handing over the council to new team and they in turn will have shorter term. Due to Covid-19, KUA Council planned to have virtual conference and we went ahead with schedule dates of 7th and 8th November, 2020.

Doing a virtual conference has newer challenges as this was never done before. In organising this conference we are limiting to 3 hours each day considering the screen time limitation. KUA Council is making all efforts to have all the mandatory KUA programs including online quiz and virtual GBM.

I humbly request KUA members, who are all around the globe, to join us during Karnataka Rajyotsava month and make this 25th KUACON a success.

Jai Karnataka

Regards

Dr. Kumar Prabhu M

Hon. Secretary KUA &

Organising Secretary KUACON



PROGRAM SCHEDULE

DAY 1: November 7th 2020, Saturday

(Platinum media sponsor: Sun Pharma)

6 pm to 6.05 pm: Welcome to virtual conference by Dr. Siddalingeshwar Neeli,
President KUA

6.05 pm to 6.40 pm: Davangere PG Symposium.

(8 minutes per speaker and 5 minutes discussion at the end of 4 talks)

Topic: From Knife to Pill: A Paradigm Shift in Uro-oncology?

Moderator: Dr. Rajeev Thekke Puthalath, Mangaluru

1. Targeted therapy in RCC: current status.
Dr. Prashant Kumar Chauhan, INU, Bengaluru
2. Chemotherapy in advanced TCC: emerging trends.
Dr. Suraj J, KMC Manipal
3. Sequential management of HRPC: recent advances.
Dr. Priyabrata Adhikari, JN Medical College, Belgavi
4. Novel biomarkers & molecular targets in urological malignancies: an update.
Dr. Kamal Sachdeva, NU Hospitals, Bengaluru

6.40 pm to 7.00 pm: Inauguration Ceremony

7 pm to 7.30 pm: Dr.MP Raju MYSOGUS Endowment Lecture

Topic: My experience of Endovascular intervention - Nephrology and Urology

Speaker: Dr. Mohan M Rajapurkar, Director and Nephrologist, Nadiad

Moderators: Dr. Bharath Kshatri and Dr. Kumar Prabhu M

7.30 pm to 8 pm: Prof. P. Venugopal Oration

Topic: Laparoscopic Partial Nephrectomy

Speaker: Dr. Mallikarjuna C, President Elect USI.

Moderators: Dr. Siddalingeshwar Neeli and Dr. Kumar Prabhu M



8 pm to 8.20 pm: 1st KUACON Revisited.

Speakers: 1st KUA EC office bearers

8.20 pm to 8.50 pm: Bijapur Uro Quiz (for all KUA members)

Moderator: Dr. Jaideep Ratkal, KIMS, Hubballi

8.50 pm to 9.05 pm: Devon Travelling Fellowship (only for PG's)

Moderator: Dr. Vinod Kumar P, NU Hospitals, Bengaluru

DAY 2: November 8th 2020, Sunday

8.30 am to 9 am: **BMC Best Poster Prize**

(Silver media sponsor: IPCA laboratories)

(3 min presentation and 2 min discussion)

Moderators: Dr. Anant Kamath J, Dr. Amrith Raj Rao, Dr. Ranganath MS

1. [A case report on penile fracture.](#)

Dr. Sriramadasu Yashwanth, Dr Amruthraj Gowda, Dr Vijay Kumar R, Dr Sachin D, Dr Ravikumar B R, Dr Manjunath V

2. [A rare case of desmoid tumour with bladder invasion.](#)

Dr. Abhilash Gautham Ramesh, Dr. Amruth Raj Gowda, Dr. Vijaya Kumar R, Dr Ravikumar B R, Dr. Sachin D, Dr. Manjunath V

3. [Tuberculosis of Glans Penis: A Case Report](#)

Dr. Suresh Babu Mahadevappa Kagalkarreddy

4. [Prostate artery embolisation as a palliative care in a patient with prostate cancer: A case report](#)

Dr. Priyabrata Adhikari, Dr. RB Nerli

5. [A rare prostatic tumour masquerading clinically as BPH](#)

Dr. Abhijit Samal, Dr. Abishai J, Dr. Anuj Jain, Dr. Santosh Patil, Dr. Vinay S. Kundargi, Dr. Basavesh S. Patil, Dr. S.B. Patil

6. [Symptomatic bilateral single system ureterocoele in adults.](#)

Dr. Vivek Jayakumar, Dr. Manasa T, Dr. Puvvada Sandeep, Dr. Prasad Mylarappa, Dr. Ramesh D



9 am to 9.50 am Dileep Adappa Best Paper Award (6 min talk + 2 min Q & A)
(Gold media sponsors: Dr. Reddy's Laboratories)

Moderators: Dr. Vinay S Kundargi, Dr. H B Shivakumar,
Dr. Sanjay Parachuru

1. [5-ALA-induced fluorescent cytology in the diagnosis of bladder cancer.](#)
Dr. Priyabrata Adhikari, Dr. RB Nerli. J N Medical College, Belagavi.
2. [Prognostic significance of the combination of preoperative hemoglobin and albumin levels and lymphocyte and platelet counts \(HALP\) in patients with renal cell carcinoma after radical nephrectomy: A Fact or Fallacy?](#)
Dr. Ravi Kumar Jha, Dr. Manohar C S, Dr. Navneeth Shreenidhi. INU Bengaluru.
3. [Evaluation of urinary incontinence after robot assisted radical prostatectomy.](#)
Dr. Anand Shankargouda Patil. Manipal Hospital, Bengaluru
4. [Peri-operative, functional, quality of life, and oncological outcomes after robot-assisted radical cystectomy and intra-corporeal orthotopic ileal neobladder - Our experience.](#)
Dr. Preetham Dev, Dr. T B Yuvaraja, Dr. Santosh Waigankar, Dr. Abhinav Pednekar, Dr. Varun Agarwal.
Kokilaben Dhirubhai Ambani Hospital, Mumbai
5. [Comparison of Robotic Assisted Laparoscopic Partial Nephrectomy and Laparoscopic Partial Nephrectomy in localized renal tumours.](#)
Dr. Manjunath Kempegowda, Dr. Mihir Jitendra Karathia, Dr. Pradeep Singh, Dr. Kumar Pankaj, Dr. Jagadish Kaushik, Dr. Prashanth Kulkarni. Narayana Hrudayalaya Hospital, Bengaluru.
6. [Prediction of upper urinary tract obstruction and renal function using ultrasound.](#)
Dr. Pulkit Rakesh Gupta, Dr. Siddalingeshwar Neeli. J N Medical College, Belagavi.

9.50 am – 10.30 am: NU Hospital Best Video Prize (6 + 2 min)
(Silver media sponsors: Intas Pharmaceuticals)

Moderators: Dr. Nitin Kekre, Dr. Nagbhushana M, Dr. Vikram Prabha

1. [Transpubic urethroplasty for pelvic fracture urethral injury: Still relevant today.](#)
Dr. Abheesh Varma Hegde, Dr. Sandesh Parab, Dr. Tarun Jain, Dr. Mukund Andankar, Dr. Hemant Pathak.
TNMC & Nair Ch. Hospital, Mumbai



2. [Gracilis to the rescue: Operative management of recurrent rectobulbar fistula.](#)
Dr. Abheesh Varma Hegde, Dr. Sandesh Parab, Dr. Tarun Jain, Dr. Mukund Andankar, Dr. Hemant Pathak.
TNMC & Nair Ch. Hospital, Mumbai
3. [Minimizing warm ischemia time in minimal invasive partial nephrectomy.](#)
Dr. Jeevan Kumar Vuppalapati, Dr. Mujeeburahiman. Yenepoya Medical College, Mangaluru
4. [Complex ureteric strictures following major urological surgeries, and the robot.](#)
Dr. Nischith D'Souza, Dr. Mujeeburahiman, Dr. Altaf Khan, Dr. Raghu Sarath, Dr. Jeevan Kumar. Yenepoya Medical College, Mangaluru
5. [Robot assisted Complex Vesico-vaginal fistula repair with Novel technique of ureteric re-implantation!!](#)
Dr. Preetham Dev, Dr. T B Yuvaraja, Dr. Santosh Waigankar, Dr. Abhinav Pednekar. Kokilaben Dhirubhai Ambani Hospital, Mumbai

10.30 am - 11.30 am: General body meeting

11.30 am to 11.40 am: Valedictory function

KUA COUNCIL

| | |
|--------------------------|----------------------------|
| President | Dr. Siddalingeshwar Neeli |
| President Elect | Dr. Bharath Kshatri |
| Hon. Secretary | Dr. Kumar Prabhu M |
| Treasurer | Dr. Chandrashekar Rao V |
| Council members | Dr. Sanman KN |
| | Dr. Naveen H N |
| | Dr. Sharanabasavesh B Alur |
| | Dr. Govardhan Reddy H.S. |
| Immediate Past President | Dr. Girish Nelivigi |
| Immediate Past Secretary | Dr. Nischit D'Souza |



BMC Best Poster Award Abstracts

1. A case report on penile fracture

Aim: Penile fracture is a rare condition. Penile fracture occurs due to blunt trauma to an erect penis. Urethral injury occurs in 28% of cases. Corpora cavernosum is most commonly involved in penile fracture. Involvement of corpora spongiosum is rare. This case shows a complete urethral tear with corpora spongiosum and partial bilateral corpora cavernosum.

Materials and methods: A 55 year old male patient came to casualty with sudden onset penile and scrotal oedema after blunt trauma to his penis during sexual intercourse. Patient also gave history of acute retention of urine. USG Doppler of the penis showed features suggestive of penile fracture involving corpora spongiosum and left corpora cavernosa with breach in tunica albuginea, Bucks fascia with adjacent hematoma. Patient underwent suprapubic catheterization in view of distended bladder. Patient was taken up for penile fracture repair and intraoperatively complete urethral and corpora spongiosum tear with bilateral partial corpora cavernosa tear were noted. Corpora spongiosum and cavernosum repair with primary urethral anastomosis was done. Circumcision procedure was also performed. Patient was discharged with suprapubic catheter and urethral Foley's in situ on POD 3. On POD 10 suprapubic catheter was removed.

Results: Patient regained nocturnal erections in 7 days and patient is voiding well after Foley was removed.

Conclusion: Penile fractures being rare condition, complete urethral tear is even more uncommon. Immediate surgical treatment should be given with urethral repair to regain the voiding characters.

2. A rare case of desmoid tumour with bladder invasion

Introduction: Desmoid tumor also known as aggressive fibromatosis, is a rare, locally invasive, non-metastasizing soft tissue tumor. They arise from the connective tissues. Infiltration of bladder is rare and very few cases reported till date.

Case report: 35 year female with mass in the suprapubic region and lower abdominal pain since 1 month. She had total abdominal hysterectomy 8 years ago through pfannenstiel incision.

On abdominal examination there was a soft, mass 5x6cm, palpable over the lower abdomen in the suprapubic region with tenderness. FNAC showed features suggestive endometriosis of bladder wall. CECT revealed ? Ca bladder/endometriosis of bladder.

Cystoscopy - mucosal edema in right lateral wall, no mass in bladder with normal findings. Diagnostic laparoscopy and biopsy from the mass and right lateral bladder wall was performed.

Histopathology - collagen forming fibrous lesion suggestive of fibromatosis.

Complete excision of the mass with sufficient margins of anterior rectus sheath, deroofting of the tumor with bladder wall was done. Final HPR - fibromatosis with no evidence of endometriosis/epithelial malignancy.

Discussion: Desmoid a rare tumor, with incidence of 2-4/million population, accounts for 0.03% of all neoplasms. Desmoid tumor arises from myofibroblast, lacks a true capsule, infiltrates into adjacent muscles. But the infiltration of the bladder is rare. The etiopathogenesis is multifocal. Mutation in APC or beta-catenin genes is seen. Complete excision of the mass with wide margins is required.

Conclusion: The course is unpredictable, with spontaneous regression, long-lasting mass and/or progression of disease can occur. Currently for asymptomatic cases "wait and see" approach is preferred, Tumour's showing increase in size causing symptoms require active management.



3. Tuberculosis of glans penis: A case report, a rare case.

Introduction: Tuberculosis (Tb) is a bacterial infectious disease in *Mycobacterium tuberculosis*, Genitourinary Tb is a common site for extra pulmonary Tb. But Tb of the penis is an extremely rare entity with few cases described in the literature.

Clinical Case: Tb of penis is a very rare entity. It may present as primary or secondary to Pulmonary Tb. We present the case of a 43-year-old male patient who presented to us with nodular growth over glans penis, biopsy of the lesion showed evidence of Tb.

Penile Tb; A genital ulcer is rare presentation. He presented with complaint of painless and non-healing lesion over genitalia for last 12 months. He had no history of any loss of weight in the recent past. He denied extramarital sexual contact or dysuria. The patient had tried different treatment modalities without any response. Dermatological examination of the penis found multiple nodular lesion involving prepuce. The rest of the clinical examination revealed bilateral, mobile inguinal lymph nodes. Haematological and biochemical examination did not reveal any abnormality.

Treatment; A Laboratory tests for syphilis, HIV and Viral Hepatitis B and C were negative. The histological examination of the ulceration revealed intense granulomatous infiltrate with Langhans giant cells and caseation necrosis, first evolving Tb. Radiological investigations including X-ray chest and ultrasound of the abdomen, to find any collateral evidence of Tb, were normal. The patient was treated with anti-bacillary drugs: rifampicin (R), isoniazid (H), pyrazinamide (Z) and ethambutol (E) during two months relayed by a dual therapy combining R and H during four months. The healing of genital ulcer was complete.

Conclusion: Any chronic non-healing ulcer or nodular over the penis should arouse a suspicion of Tb, especially in an endemic country like India.

4. Prostate artery embolisation as a palliative care in a patient with prostate cancer: A case report

Introduction: Prostate artery embolization is an emerging technique that appears to be a promising option in the management of benign prostatic hyperplasia for patients unsuitable for surgery. Prostate artery embolization, similar to all other interventions, is not a suitable treatment for all patients with this disease. It is indicated as a minimally invasive option in patients unfit to undergo transurethral resection of prostate.

Case Report: A 78 year old male suffering from castrate resistant prostate cancer and on treatment with Abiraterone plus prednisolone presented to the Uro-oncological services of the hospital with difficulty to void, incomplete voiding and sense of incomplete voiding. He had other medical co-morbidities which included Diabetes mellitus, hypertension and ischaemic heart disease. His cardiac ejection fraction was 25% and was advised not to undergo any surgical procedure. Serum creatinine on admission was 2.2 mg% and serum PSA was 26.5 ng/ml. Under local anesthesia, using retrograde Seldinger's technique right common femoral arterial access was obtained and 6F vascular introducer sheath was placed. Bilateral pelvic angiogram was performed, each of the prostatic arteries was superselectively catheterized and the prostatic gland was embolized using PVA (polyvinyl alcohol) particles 200 micrometer. Post catheter removal the patient voided well with a maximum flow of 14.5 ml/sec.

Conclusions: Prostate artery embolization can successfully treat complications associated with prostate cancer such as LUTS, urinary retention and haematuria with a low risk of serious adverse events.



5. A rare prostatic tumour masquerading clinically as BPH

Introduction: Prostatic tumors are usually benign. Malignant tumors are usually adenocarcinoma. Rare benign tumors of prostate include Inflammatory Myofibroblastic Tumors (IMT), which can be found in various parts of the body and are frequently identified in the lung or abdominal cavity of children and young adults. IMT of the urinary tract present more often in kidneys. Prostatic IMT are extremely rare.

Case report: A 44 years old male presented in emergency room with complaints of gross hematuria since 15 days with recurrent retention of urine. He also gave history of obstructive lower urinary tract symptoms since a couple of months. Per rectal examination revealed grade II prostate enlargement which was firm in consistency. Patient was catheterized and further evaluated. PSA was mildly raised (4.4ng/ml). USG abdomen showed enlarged prostate with irregular margins and heterogeneous echo-texture showing increased flow on color Doppler. TRUS guided biopsy was done in lieu of suspicious ultrasound findings and marginally raised PSA levels. On cystoscopy, large pedunculated growth was present over the left lateral prostatic lobe. Endoscopic transurethral resection was done and a prostate chip on histopathology was suggestive of inflammatory myofibroblastic pseudo tumour of prostate.

Conclusion: Inflammatory pseudotumors have also been observed in various other organs throughout the body, such as the ureter, vagina, and urethra. Etiopathogenesis of pseudosarcomatous fibromyxoid tumors is unknown. In most of the reported cases, common associated factors were smoking, previous instrumentation, and surgery. IMT is considered as benign tumor with local recurrence but rarely metastases to the distant locations. It is important for urologists and pathologists to recognize it using immunohistochemistry and to be aware of its benign course in order to avoid unnecessary radical procedures.

6. Symptomatic bilateral single system ureteroceles in adults

Introduction & Objectives: Although bilateral single system ureteroceles are a known entity in adults, it is often diagnosed incidentally due to insignificant obstruction. We present a series of symptomatic bilateral single system ureteroceles in 8 adult men with varied presentation.

Methods: We retrospectively analysed all patients with the diagnosis of ureterocele and underwent surgery between January 2010 and January 20 from our hospital database. All case sheets were reviewed for age, sex, symptoms at presentation, imaging characteristics including unilateral/bilateral, single or duplex system, intravesical, extravesical or combined, intraoperative characteristics, presence or absence of stones and the mode of management. All paediatric ureteroceles were excluded from our study. All patients were traced, telephonically contacted and questioned for persistence/improvement in symptoms.

Results: 23 adult patients had undergone ureterocele incision during the time frame studied of whom 12 were female and 11 were male. Mean age at presentation was 41.2yrs and LUTS was the most common presentation (43.5%). All ureteroceles were orthotopic with 4 male and all females having either unilateral or bilateral duplex system ureterocele. Remaining 7 adult males had a bilateral single system orthotopic ureterocele of whom 2 presented with LUTS, 2 with flank pain, 1 with acute urinary retention and 1 with gross haematuria. 3/7 patients had associated



renal/ureteric stones which were completely cleared with no recurrence till date. All 7 patients underwent transurethral incision of the ureterocele with complete resolution of symptoms.

Conclusion: Bilateral orthotopic single system ureterocele in adult men can present with a wide range of symptoms. Transurethral incision of ureterocele is safe and effective in relieving symptoms.

Dileep Adappa Best Paper Award Abstracts

1. 5-ALA-induced fluorescent cytology in the diagnosis of bladder cancer

Abstract: Introduction and objective: 5-aminolevulinic acid (ALA) - induced fluorescence cystoscopy has established itself in the detection of flat and / or small lesions that are barely visible under white-light cystoscopy. This is explained by the simple fact that there is increased uptake of ALA, altered activity of certain enzymes and altered intracellular redistribution and storage of Protoporphyrin IX (PPIX) in the malignant cells. Intracellular PPIX allows red fluorescence detection at an excitation wavelength of approximately 400 nm and an emission wavelength at 635 nm. In this preliminary study, the efficacy of 5-ALA-induced fluorescent urine cytology was compared with conventional cytology in the diagnosis of bladder tumors.

Methods: In this prospective study, patient's ≥ 18 years of age, admitted to the department of urology with non-malignant conditions formed the controls and patients ≥ 18 years of age with imaging confirmed bladder tumors formed the study group. Freshly voided urine sample was collected from these patients and divided into two samples of 50 cc each. One of these samples was sent in for conventional cytology examination whereas the other sample was sent in for 5-ALA fluorescent photodynamic diagnosis. Conventional cytology and 5-ALA-induced fluorescent cytology was evaluated by the same pathologist.

Results: A total of 100 patients were included in the study of which 75 patients were controls and the remaining 25 were patients with bladder tumors. The sensitivity of conventional cytology and 5-ALA-induced fluorescent cytology was 64% and 100% respectively, whereas the specificity was 96% and 98.67% respectively. The sensitivity of conventional cytology was 61.19% in low grade cancers as compared to 75% in high grade cancers, whereas the sensitivity was 100% with 5-ALA-induced fluorescent cytology both in low as well as high grade cancers.

Conclusions: Our study shows that 5-ALA-induced fluorescent cytology is highly sensitive test to diagnose bladder cancer and shows a significant difference especially in low grade bladder cancer when compared to conventional cytology.

2. Prognostic significance of the combination of preoperative hemoglobin and albumin levels and lymphocyte and platelet counts (HALP) in patients with renal cell carcinoma after radical nephrectomy: A Fact or Fallacy?

Abstract: Aims & objective: Renal cancer accounts for 2% to 3% of all cancers, approximately 90% of renal cancer is RCC, and surgery is the only curative treatment. About 20% of RCC patients have advanced stage disease, and for those with localized RCC, nearly 30% show recurrence after tumor resection. Therefore, we need better prognostic models to improve prognosis. Hence we conducted a study to evaluate the prognostic significance of the novel



index combining preoperative hemoglobin and albumin levels and lymphocyte and platelet counts (HALP) in renal cell carcinoma (RCC) patients.

Method: We included 203 patients retrospectively with histologically confirmed RCC who had undergone radical nephrectomy in the Department of Urology, Institute of Nephrourology between 2007 and 2020. The cut-off values for HALP were determined by using X-tile v3.6.1. Various statistical analyses were done with SPSS v 27 software. Multivariate Cox proportional-hazards model was used to evaluate the prognostic significance of HALP for RCC.

Results: In a sample of 203 patients, 144 were male and mean age was 55 (45-65 IQR). 189 patients had clear cell RCC and right-sided (118) was the mostly affected. 11 patients had hypoalbuminemia & 38 patients had anemia. 30 patients had lymphocytosis, 12 patients had thrombocytosis, 8 patients had metastasis. HALP score was calculated and stratified into high (>33.4) and low (<33.4) which included 98 & 105 patients respectively. Kaplan-Meier and log-rank tests revealed that HALP was strongly correlated with cancer-specific survival ($P < 0.001$) and Cox multivariate analysis demonstrated that preoperative HALP was an independent prognostic factor for cancer-specific survival (HR= 1.838, 95%CI:1.260-2.681, $P = 0.002$).

Conclusions: Low HALP was closely associated with worse clinico-pathologic features and was an independent prognostic factor of cancer-specific survival for RCC patients undergoing radical nephrectomy. A nomogram based on HALP independently & accurately predicts prognosis of RCC.

3. Evaluation of urinary incontinence after robot-assisted radical prostatectomy

Introduction and Objectives: Prostate cancer is the most common malignant neoplasm diagnosed in men. Urinary incontinence is the most prevalent complaint after robot-assisted radical prostatectomy (RARP), with rates varying from 4 to 31%. A prospective study was carried out to assess urinary incontinence after robotic-assisted radical prostatectomy for prostate cancer and factors predictive for postoperative urinary incontinence.

Methods: Fifty patients who underwent robotic-assisted radical prostatectomy during the study period (April 2018 - August 2019). Post-RP the frequency of incontinence was evaluated by using Follow-up and Questionnaire at 1 month, 6 months, 12 months using Number of pads used per day and by ICIQ-SF.

Results: In our study, 50 cases of localized prostate cancer between April 2018 and August 2019 underwent Robot-assisted radical prostatectomy. Clinical variables including age, BMI, medical comorbidities, preoperative PSA, grade, stage of tumour, prostatic volume, nerve sparing or non-nerve sparing surgery were recorded. 65.2 ± 5.32 yrs was the mean age of the patients. 16(32%) of patients had Diabetes mellitus, 41(82%) of patients had hypertension, Mean BMI was 26.4 ± 3.31 kg/m², Mean PSA was 12.1 ± 6.23 , Mean Prostate Volume (ml) was 42.1 ± 12.74 ml. 46% had non-nerve sparing surgery, whereas 54% had nerve sparing surgery in 34% had B/L nerve sparing and 20% had U/L nerve sparing.

In our study, urinary continence after 12 months of surgery using a no pad as Continence definition is 78%.

Conclusion: The prevalence of urinary incontinence after RARP is influenced by preoperative patient characteristics like increasing age, the presence of comorbidities, high BMI, high PSA value, increasing prostate size, higher grade of tumor, stage of disease and on nerve sparing procedure.



We feel the number of pads used is an insufficient indicator for evaluating incontinence after RARP. Incontinence after RARP should be evaluated using a combination of noting the number of pads used and ICIQ-SF questionnaires.

4. Peri-operative, functional, quality of life, and oncological outcomes after robot-assisted radical cystectomy and intra-corporeal orthotopic ileal neobladder - Our experience.

Introduction: Robot-assisted radical cystectomy (RARC) and intracorporeal orthotopic neobladder (OINB) is technically a challenging surgery due to the involvement of prolonged console time and higher level of surgical skills. Therefore, standardizing technique and testament of good functional and oncological outcomes is required to increase its acceptance among surgeons. We report our experience of RARC with OINB and analyse the perioperative, functional, quality of life, and survival outcomes.

Materials and Methods: Single surgeon experience of over 22 OINB after RARC is done, which includes 21 male and one female patients, was done retrospectively. Modified Karolinska Studer technique of neobladder creation was followed. Intraoperative findings, post-operative complications, and follow-up information were recorded for analysis.

Results: The patients' median age was 50.5 years (IQR, 41.25-55.50), and the median follow-up period was 45.5 months (IQR, 26.75-68). Median console time was 447.5 minutes (IQR, 347.5-500), blood loss was 225 ml (IQR, 200-250), and hospital stay was 12 days (IQR, 11-15). Most of the complications were Clavien-Dindo grade-I and II. Longer surgery time and more complications were noted in the first 10 cases compared to the next 12 cases. Day and night-time urinary continence is 95% and 77% at 12 months, respectively. Two patients died of disease, and overall-survival at 5-year was 84%.

Conclusion: Our experience supports OINB as a feasible option after RCIC with acceptable complications, good functional and survival outcomes, with better quality of life. With experience, surgical morbidity and operative-time decreases. This surgery should be undertaken after gaining experience with an intracorporeal ileal conduit and has a steep learning curve.

5. Comparison of Robotic Assisted Laparoscopic Partial Nephrectomy and Laparoscopic Partial Nephrectomy in localized renal tumours.

Introduction & objectives: Robotic Assisted Laparoscopic Partial Nephrectomy (RALPN) is being performed more frequently for the minimally invasive management of localized renal tumours.

However, it's unclear whether Robotic Assisted Laparoscopic Partial Nephrectomy is more efficacious than the standard Laparoscopic Partial Nephrectomy (LPN) as literature wise there is great heterogeneity. The objective of this study is to compare Robotic Assisted Laparoscopic Partial Nephrectomy and Laparoscopic Partial Nephrectomy in terms of perioperative, functional and oncological outcomes in management of renal tumor considering various factors.

Materials & methodology: Prospective and Retrospective - Observational study consisting of 70 patients 32 in LPN group and 38 in RALPN group. All patients according to inclusion and exclusion criteria are evaluated between the period from January 2017 and January 2020. Surgical outcome-, warm ischemia time operative time, hospital stay, blood loss, complications and oncological outcome i.e surgical margin were compared between the groups. Chi-square test (for 2x2 tables only) was used as test of significance for qualitative data. Independent t test was used as test of significance to identify the mean difference between two quantitative variables. P value of <0.05 was considered as statistically significant.

Results: Total 70 patients, 32 in LPN group and 38 in RALPN group were evaluated. The mean age was 50-55 years, both the groups were comparable with the baseline characteristics i.e age,



gender, ASA class, tumour size and RENAL nephrometry score in our study. Mean Warm Ischemia Time was significantly low in RALPN group (23.54 min) compared to LPN group (30.73 min). Length of stay in hospital was also significantly higher in LPN group. Rate of complete resection (tumour free margin) and preservation healthy renal tissue was better with RALPN.

Conclusion: Robot assisted partial nephrectomy is a safe and viable alternative to laparoscopic partial nephrectomy, providing equivalent good oncological outcomes and comparable morbidity to a traditional laparoscopic approach. Moreover robot assisted partial nephrectomy appears to offer the advantages of decreased hospital stay, shorter warm ischemia time, and also to provide maximal preservation of renal reserve (saving more healthy marginal tissue). Finally operative parameters for robot assisted partial nephrectomy appear to be less affected by tumor complexity (advanced degrees of freedom) compared to laparoscopic partial nephrectomy.

6. Prediction of upper urinary tract obstruction and renal function using ultrasound.

Abstract: Introduction: Ultrasound is commonly used to detect hydronephrosis in upper urinary tract obstruction. Conventional ultrasonography does not estimate renal function, for which nuclear renal scan is the gold standard. In this study we aim to predict the split renal function (sGFR) using ultrasound.

Material and Methods: Patients >18 years age presenting with unilateral upper tract obstruction from June 2019 to July 2020 were included. Nuclear renal scan was done to detect obstruction and sGFR. Renal parenchymal thickness (RPT), renal parenchymal volume (RPV) and resistive index (RI) were assessed using ultrasound and colour Doppler. Pearson's correlation test was used to find correlation between sGFR and RPT, RPV & RI. p values <.05 were considered significant. Simple regression model was used to estimate GFR from RPT, RPV and RI. R software (version 3.6.1) was used for analysis.

Results: Total 49 patients with mean age of 31.12±15.80 years (18-90yrs) were analysed. There was significant positive correlation between RPT (+0.60), RPV (+0.66) and sGFR and strong negative correlation between RI (-0.84) and sGFR in obstructed system while there was no significant correlation in unobstructed system. Using this model obstruction can be predicted with 83.67% accuracy, 93.9% sensitivity and 73.5% specificity. Estimation of sGFR in obstructed kidney is best done by RI with 71.77% R squared value, 26.72% error. The regression equation for sGFR estimation from RI is also suggested.

Conclusion: Ultrasound with colour Doppler can predict the obstruction and sGFR on the basis of RPT, RPV and RI.

NU Hospital Best Video Prize Abstracts

1. Transpubic urethroplasty for Pelvic fracture urethral injury: Still relevant today

Introduction: Complex posterior urethral strictures secondary to pelvic floor urethral injuries (PFUI) are challenging to manage. Although majority of these can be managed through progressive perineal urethroplasty, concomitant bladder neck repair, repeat urethroplasty and PFUI complications can be managed better using the transpubic perineal urethroplasty.

This technique is largely abandoned in developed countries but continues to be used in our country due to the nature of PFUI here. We demonstrate this technique in a patient with PFUI

Case: A 30 year old male had a road traffic accident after which he underwent laparotomy and colostomy with supra pubic catheterization with right femur fixation. He presented to us a month later. An ascending urethrogram and voiding cystogram showed cut off at the proximal bulbar urethra and bladder neck respectively with bladder neck displacement. Top down scopy showed only the proximal prostatic urethra and blind ending bulbar urethra. With the progressive perineal approach, the defect was large and proximal urethra not reachable. A



Transpubic urethroplasty was done. Post op period was uneventful. Continence and erection were maintained and he is doing well at 18 months of follow up.

Conclusion: The Transpubic approach provides excellent exposure, tension and scar free bulboprosthetic urethral anastomosis especially for those with long urethral gap or complex PFUI with intra-abdominal complications. A progressive perineal approach should be utilized first. An omental wrap may be included with good success rates.

2. Gracilis to the rescue: Operative management of recurrent rectobulbar fistula

Introduction: Rectourethral fistulae can be congenital or acquired. Congenital fistulae persisting after anoplasties can be missed fistulae or due to iatrogenic injury. Urine leakage per rectum during micturition, pneumaturia, fecouria and persistent urinary tract infections are the various presentations. Small fistulae heal spontaneously. When fistulae persist, they need operative intervention. We present an operated case of recurrent rectobulbar fistula and demonstrate its surgical correction using gracilis interposition flap

Case Report: A 22 year old male who had undergone PSARP for anorectal malformation in infancy presented with pneumaturia, fecaluria and passage of urine per rectally since 6 years. He had undergone a fistula repair with ASARP ten years back for rectobulbar fistula. A supra pubic catheter was inserted and an ascending urethrogram and voiding cystourethrogram was done. Urethroscopy also confirmed a diagnosis of rectobulbar fistula. Pre operatively a diversion colostomy was done. After 6 weeks, patient underwent fistula repair through perineal approach. Urethra was dissected away from the rectum and primary closure was done over a Foleys catheter. The Plastic surgery team then did a Gracilis muscle interposition flap. Post operatively, colostomy reversal was done after imaging confirmed no fistula following removal of Foleys and SPC. He is symptom free at 1 year of follow up.

Conclusion: Rectourethral fistula is a rare and complex entity. There are several approaches used for surgical correction. Surgery is technically demanding and requires a collaborative effort by the operating team comprising of urologists, colorectal surgeons and plastic surgeons. When local repairs fail, muscle transposition procedures must be utilized for best outcomes.

3. Minimizing warm ischemia time in minimal invasive partial nephrectomy

The partial nephrectomy is the new standard of care for small renal mass whenever feasible. The main goal of partial nephrectomy is to preserve as much of normal parenchyma as possible to maintain adequate GFR. This can be augmented by minimizing the warm ischemia time as much as possible. In our video we are demonstrating the methods to minimize the warm ischemia time by using laparoscopic satinsky clamp to achieve hilar control and early releasing of clamp immediately after medullary stitch and then completing the further renorrhaphy.

4. Complex ureteric strictures following major urological surgeries, and the robot.

We present a video of some of the complex ureteric strictures after major urological surgeries i.e., renal transplantation and radical cystectomy with ileal conduit and their management with the daVinci robot.

5. Robot assisted complex vesico-vaginal fistula repair with novel technique of ureteric re-implantation!!

Introduction: Pelvic radiation is one of the leading causes of Vesico-vaginal fistula(VVF). To mitigate the limitations of open surgical approach, and difficulties encountered with laparoscopic technique like prolonged learning curve and difficult suturing, robotic approach has been described. We hereby describe our technique of managing a post radiation VVF robotically.



Methods: 49-year-old female diagnosed as carcinoma cervix, underwent chemotherapy followed by external beam radiotherapy (RT) with brachytherapy boost. Two months later, she developed continuous urinary leak. She was placed on continuous catheterization for last 6 months. Present PET-CT shows no evidence of disease.

Cystoscopy revealed 2.5 cm VVF just above the level of trigone. Robot assisted VVF repair was done using Xi system. Trans-peritoneal approach, vagina is opened, and fistula is assessed, cystotomy done and plane is created between them. Adequate dissection was not possible due to post RT status, hence hysterectomy done. Due to close proximity of right ureteric orifice, modified Heineke-Mikulicz re-implantation was done. Fistula is closed in layers with interposition on omentum and round ligament.

Results: Console time was 295 minutes, with blood loss of 200ml. Drain was removed on fourth post-operative day and discharged after seven days. SPC was clamped and PUC removed on post-operative day 21. Patient voided well without incontinence, so SPC was removed after 3 days after confirming by a cystogram. DJ stent was removed after 6 weeks. Currently patient is voiding well without incontinence

Conclusion: Good technique, appropriate interposition flap and adequate post-operative drainage are extremely essential for a successful VVF repair. This video establishes the feasibility of robotic technique in management of post radiation VVF.