AUA-2023
CHICAGO ✶ APR 28-MAY 1
SATURDAY | APRIL 29, 2023
DAILY NEWS

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Urologists must start the conversation about genitourinary syndrome of menopause

Genitourinary syndrome of menopause (GSM), a spectrum of symptoms and signs caused by hypoestrogenic changes in urogenital tissues typically occurring during menopause, affects up to 87% of postmenopausal women. The discomfort, pain and irritation in symptomatic women can greatly impact their quality of life, including their sexual function and interpersonal relationships. Yet fewer than 6% of women with GSM signs and symptoms are being treated.

"An unfortunate barrier to treatment is that women believe symptoms of GSM are a normal consequence of aging they must accept," said Melissa R. Kaufman, MD, PhD, FACS, chair of urological surgery at Vanderbilt University Medical Center. "As a result, women rarely discuss symptoms with their health care provider, and providers do not consistently ask about symptoms."

It's time for urologists to start the conversation.

"Urologists need to stand up and get really loud about GSM and educate patients and other providers about it," said Rachel S. Rubin, MD, during Friday's Instructional Course, "Navigating Genitourinary Syndrome of Menopause: Path to Patient Satisfaction." The course synthesized the totality of evidence available on the benefits and harms of screening, diagnosing and treating GSM to inform decision-making for health care professionals and clinicians. "We have a unique opportunity to make this about the bladder," said Dr. Rubin, who is a board-certified urologist with fellowship training in sexual medicine.

The deficit of estrogen in menopause creates a cascade of effects, including a change in the microbiota and in the anatomy of the vagina, that can increase the risk of infection in the urinary tract, said Una J. Lee, MD, head of urology and renal transplantation and urology physician lead at Virginia Mason Franciscan Health.

Symptoms of GSM may include vulvovaginal dryness, pain during intercourse, vaginal irritation/discomfort, itching, pain during exercise, tenderness and bleeding related to intercourse. Urinary symptoms include urgency, dysuria, recurrent urinary tract infections, urge incontinence and stress incontinence. Signs can include decreased moisture and elasticity, labia minora resorption, loss of vaginal rugae and urethral eversion or prolapse.

Localized vaginal estrogen creams, inserts and rings are Food and Drug Administration-approved treatment options that are safe and effective.

"Vaginal hormones are the foundation of treatment," Dr. Rubin said. "Patient education is essential for adherence." GSM is progressive. To maintain healthy vaginal tissue, patients will need to refill their vaginal estrogen prescription indefinitely.

The AUA is in the process of developing a clinical practice guideline based on an independent systematic review of the evidence.

"GSM guidelines will change the landscape," Dr. Kaufman said. "We have to own it." ●

American Urological Association

2023 AUA ANNUAL BUSINESS MEETING

HELD AT AUA2023

Monday, May 1 | 12 PM
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Everyone is invited to attend the AUA's Annual Business Meeting. The agenda includes reports of the President, Secretary, Treasurer, Bylaws Committee and Audit Subcommittee.

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Reaching success in urologic oncology clinical trials

Clinical trials provide evidence for determining and improving on the standards of care across urologic oncology. The Urologic Oncology Research Symposium explored the ingredients and strategies that help build a successful clinical trial.

Much depends on the type of trial.

"With an investigator-initiated trial (IIT), it is your idea and you have the broadest control," said Viraj A. Master, MD, PhD, professor, chair of clinical urological research and director of integrative oncology and survivorship at Winship Cancer Institute of Emory University.

IITs tend to be smaller, proof-of-concept studies with smaller budgets.

Industry-sponsored trials give the principal investigator less flexibility than an ITT but larger budgets.

Federally funded trials can be more flexible than industry trials but may carry other restrictions.

National Cancer Institute Trials Network trials give principal investigators little flexibility but offer access to larger resources and populations than industry-sponsored trials.

"No matter the type of trial, all viable clinical trials start with a strong hypothesis," said Ana Aparichio, MD, professor of genitourinary medical oncology at the University of Texas MD Anderson Cancer Center.

Start with a clear and specific question that addresses a clinically relevant gap in knowledge. Next, define the independent and dependent variables that can affect the answer to the question. Formulate a clear and precise hypothesis, a declarative statement that if this is done, then that specific change will be seen.

The strongest trials incorporate PICO methodology: population, intervention, comparison, and outcome. PICO creates a clear, focused, answerable research question using a transparent and reproducible process.

"The ideal trial is a comparison of a new therapy to the accepted standard of care," said Stephen A. Boorjian, MD, Carl Rosen Professor and chair of urology at Mayo Clinic.

Daniel Wei Lin, MD, and Juan Javier-DesLoges, MD

"PICO is the equivalent of the methods section of the trial report."

Populations matter, too. Lack of diversity in trial data means lack of valid data for Asian, Black, Hispanic, Native American and other patient populations that were not included in trials.

"Every trial has a gatekeeper," said Juan Javier-DesLoges, MD, MS, assistant professor of urology at the University of California, San Diego. "You have to get in the door of a hospital or cancer center that offers the trial to even be offered the opportunity to participate. The patient and their caregiver are left on their own to figure the system out, if they can even get in the door."

University of California, San Diego, has focused on hiring a more diverse staff, including language- and culture-specific navigators, language and cultural training for providers and staff, and other steps to increase access to clinical trial information and participation. Hispanic participation in clinical trials has jumped to 21%.

"We need to bring precision medicine principles to clinical trials," Dr. Javier-DesLoges said. "The right approach to the right patient at the right time, to bring more diversity to our trials." •

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DAILY NEWS

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New approaches to understanding and treating pelvic pain

Aaron D. Mickle, PhD

The AUA's first basic science symposium devoted entirely to chronic pelvic pain focused on the peripheral nervous system, the central nervous system and neuroinflammation pathways and biomarkers.

One of the key gaps in knowledge is the role urothelial cells play in bladder pain.

"There are differences in urothelial receptors, gene expression, cell differentiation and cell signaling in individuals with and without chronic pain," said Aaron D. Mickle, PhD, assistant professor of neuroscience at the University of Florida.

The P2X receptor pathway plays a role in pain perception, but it is not yet clear what types of neurons are involved, how the brain interprets these signals or how bladder disease or dysfunction might affect signaling.

Pain signals from the bladder are transmitted via the rostral ventromedial medulla to the spinal cord, continued Vijay K. Samineni, PhD, assistant professor of anesthesiology in the department of biology and biomedical sciences at Washington University in St. Louis.

Endogenous analgesic pathways in rats and in humans suggest the possibility of chronic pelvic pain analgesic pathways.

Neurostimulation of the dorsal root ganglia is one potential approach to pain management.

"If the signal does not reach the brain, the patient will not feel the pain," said Bin Feng, PhD, assistant professor of bioengineering at the University of Connecticut.

Dorsal root ganglia neurostimulation in the 50- to 100-hertz range blocks afferent neural transmission, he said, and is completely reversable.

Manipulating peripheral glia signaling is another approach. Glial fibrillary acidic protein positive glia can reduce pressure and pain sensations, said Xiaoqiao Xie, PhD, assistant professor of surgery-urology at the University of Colorado School of Medicine.

Chronic pelvic pain is a broad and highly variable condition that encompasses both organ-centric and systemic disease.

"A nonlinear system is not the sum of its parts," said Jennifer DeBarry, PhD, assistant professor of anesthesiology and perioperative medicine at the University of Alabama at Birmingham. "What is happening in the pain-free state is not the same as in the chronically painful state. We need a truly complete picture built from many different angles." ●

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Kirtishri Mishra
@KirtishriM
@CaseUrology is well represented at **#AUA2023** this year. One of our rock star med students **@mloria13** from **@CWRUSOM** presenting our work on prostate cancer screening in transgender females! Take away point, it does not occur at the same rate as it does in cis men.

Ranjith Ramasamy
@ranjithramamd
Excited to present findings from our clinical trial using **#VR** to reduce pain and anxiety in patients undergoing in-office vasectomy **@FarhanQureshi30 @farahrahman23 @AkhilMuthigi @RussellSaltzman #IAUA #AUA2023**

@akronurology
Kicking off AUA Conference with iTind reps at Roka Akur! Who is the most skilled at using chopsticks? #AUA2023

Scott Lundy MD PhD
@ScottLundyMDPhD
Superstar fellow and soon-to-be partner **@raevti** giving a masterclass on sperm DNA fragmentation for male infertility.
The student has truly become the master.
@CleClinicUro @PBajicMD @SarahLacyC @NeelParekhMD #AUA2023

Emilie Johnson
@eekayjay
Kicking off **#AUA2023** at the **@UChicagoUrology** peds robotic course with **@pgargollo**! Looking forward to seeing more friends **@SPU_Urology** tomorrow! **@LurieUrology @NM_Urology**

GeSRU
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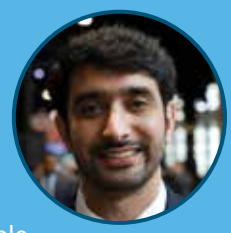
Career Success Outside of Clinical Urology is speaking about work balance. Go in open-minded! Thanks for this amazing and inspiring panel discussion as part of **#AUA #Residents Forum #AUA2023**

QUESTION OF THE DAY

How are you promoting diversity, equity, inclusion and accessibility in the workplace and/or in urology?

I actually interviewed at three university hospitals where women of color were underrepresented, so I chose to be at a facility where there was more diversity and there were women in higher levels of medicine. So now, when we are interviewing newcomers, I'm a part of that process and we do everything we can to ensure it's a mix of color and gender in our practice.

Belinda Fugalli, PA-C
Fayetteville, North Carolina



Historically, there was an eGRF equation that used a race factor for African Americans, and the American Kidney Foundation and the American Society of Nephrology Task Force removed the race factor, which precludes previously eligible patients for certain bladder cancer treatments. I am advocating at my hospital that this factor shouldn't be removed.

Amir Khan, MBBS, MPH
Baltimore, Maryland

I work in a unit where we practice diversity. In New Zealand, we're in a multicultural society, so we are sure to acknowledge the different ethnicities that we have and are also respectful of women and in our acknowledgement of the sexual orientations of our patients.

Michael Rice, MD
Auckland, New Zealand

As a woman in urology, I can say we are definitely underrepresented. As a whole, though, we are beginning to have more of a presence in urology. I have really incredible mentors of both genders who have been very intentional about lifting me up and promoting me as a strong female within surgery and within urology to become a leader in the field. I think that's really key. Find mentors who will not hold you back because of gender, race or anything you identify with and who really try to promote you as a person.

Kelly Harris, MD
Denver, Colorado

Managing upper tract urothelial carcinoma in the real world


Surena F. Matin, MD

In conjunction with the 2023 release of "Diagnosis and Management of Non-Metastatic Upper Tract Urothelial Carcinoma: AUA/SUO Guideline," Surena F. Matin, MD, the Monteleone Family Foundation Distinguished Professor in the department of urology at MD Anderson Cancer Center in Houston, led a distinguished panel of urologists whose clinical practice focuses on the treatment of upper tract urologic cancers (UTUC) in Friday's session, "Management of Upper Tract Urothelial Carcinoma." The discussion featured select topics on managing UTUC, which coincides with the release of the new guidelines.

Using patient case vignettes to integrate the new treatment guidelines into real-world scenarios, panelists discussed their treatment recommendations for cases of low-grade UTUC, and high-grade, high-risk UTUC with good glomerular filtration rate. Panelists included Jay D. Raman, MD, FACS, professor and chair of the department of urology at Penn State Health Milton S. Hershey Medical Center; Sima P. Porten, MD, FASC, MPH, an associate professor in the department of urology at University of California, San Francisco; and Tomonori Habuchi, MD, an associate professor in the department of urology at Akita University in Japan.

The panelists debated the use of endoscopic therapy, neoadjuvant chemotherapy, bladder cuff dissection, laser selection for endoscopic UTUC management and lymphadenectomy. Summarizing the general recommendations for managing UTUC that emerged from the presented case studies, Dr. Matin offered these take-home tips:

- Consider mitomycin hydrogel for low-grade recurrent UTUC disease
- Intravesicular chemotherapy with nephroureterectomy (NU) is supported by level 1 data
- Intravesicular chemotherapy after ureteroscopic biopsy is supported by a preponderance of circumstantial data

For high-risk UTUC disease:

- Use risk stratification of upper tract tumor
- Estimate post-NU kidney function to counsel between initial NU or neoadjuvant chemotherapy
- Consider lymphadenectomy.

Panelists also discussed the appropriate use of Lynch syndrome testing. UTUC is the third most common Lynch syndrome cancer, affecting 9% to 10% of patients with UTUC.

Strong, moderate or conditional recommendations were made where sufficient evidence existed. To learn more, visit https://www.auanet.org/guidelines-and-quality/guidelines/non-metastatic-upper-tract-urothelial-carcinoma. ●

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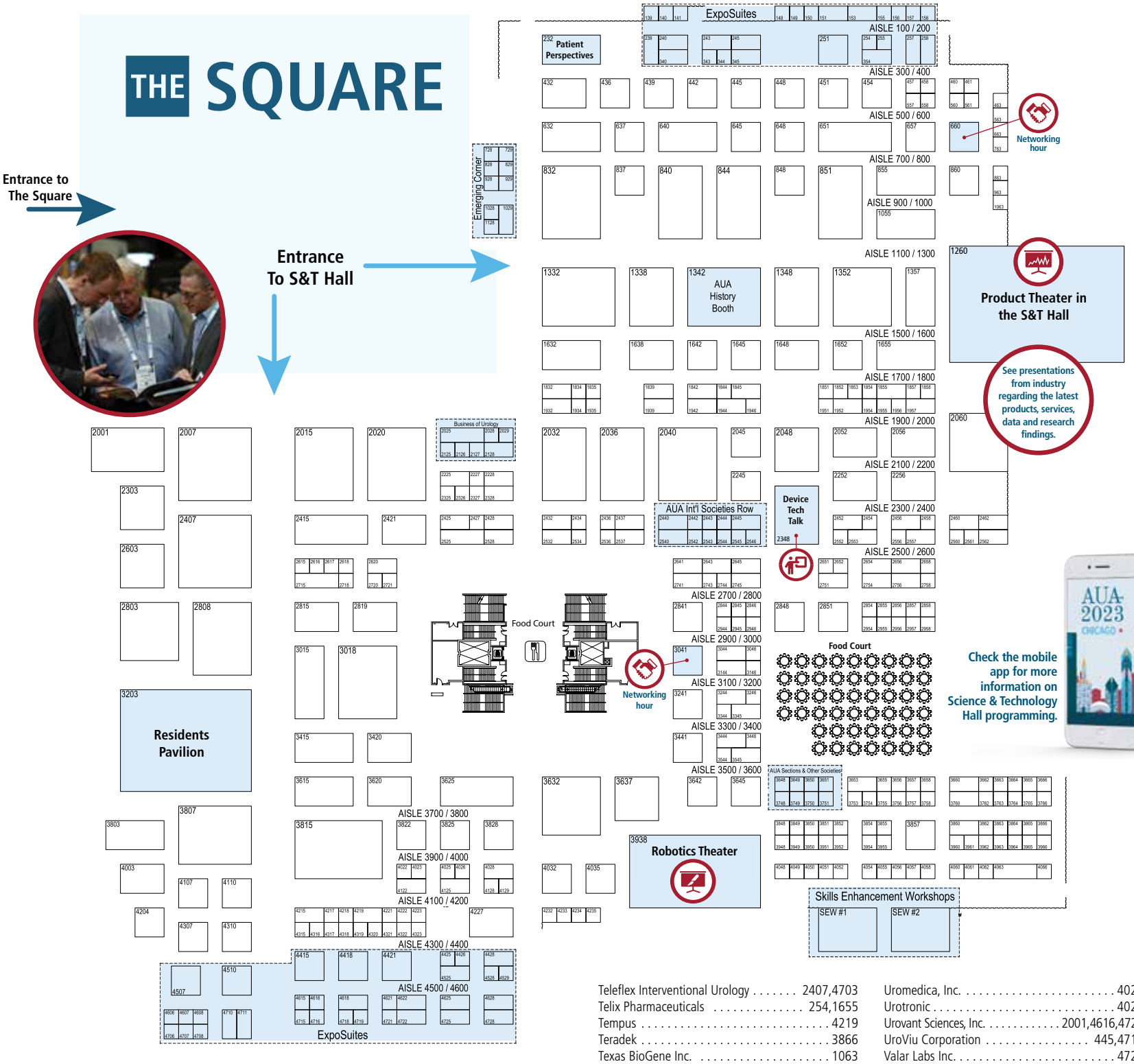

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