AUA2024 San Antonio MAY 3-6

SUNDAY | MAY 5, 2024

DAILY NEWS

SEE THE DAILY SCHEDULE FOLLOWING PAGE 8

P2s Paradigm-Shifting, Practice-Changing Clinical Trials in Urology

These sessions are designed to showcase the exceptional, groundbreaking studies that are expected to change the day-to-day practice of urology.

8:20-8:30 a.m.
Plenary, Stars at Night Ballroom

1-1:40 p.m.
Plenary, Stars at Night Ballroom

NEW! Learning Lab

These important clinical trials are expected to influence practice when they are ultimately reported and/or published.

Clinical Trials in Progress: Bladder Cancer
10 a.m.-noon
AUA Square: Learning Lab

Clinical Trials in Progress: Cancer
1-3 p.m.
AUA Square: Learning Lab

AUA Robotics Theater

Don't miss today's moderated session with live narration of robotic procedure videos and a panel discussion.
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Kidney and Upper Tract Procedures
9:30-11:30 a.m.
S&T Hall, Booth #2425

Prostate artery embolism is a new alternative for BPH

The 2023 amendment to the AUA guideline on benign prostatic hyperplasia added a new approach: prostate artery embolism. The concept is simple: Inject an embolic agent into the prostatic arteries to block blood supply, shrinking the prostate to allow better urinary flow.

"PAE is a great example of urology of the future, interventional urology," said Timothy McClure, MD, assistant professor of urology at Weill Cornell Medicine in New York. "My entire practice is interventional urology."

Dr. McClure opened the afternoon Plenary on Saturday with an explanation of PAE and some of the clinical trials leading to its inclusion in the AUA guideline. The prior guideline, published in 2021, recommended against PAE for lack of evidence showing more benefit than risk.

PAE is a straightforward interventional procedure. Using cone-based computerized tomography and angiography, the clinician locates the prostatic arteries and threads a 22-French catheter through either the femoral or radial artery into one lobe of the prostate. Once the proper location is confirmed by imaging, an embolic agent is injected into the artery, blocking it. The catheter is repositioned into the other lobe, and the embolization is repeated. Then the catheter is removed, and the procedure is complete.

Interventional procedures are commonplace in radiology, cardiology and other specialties, Dr. McClure said, but have yet to find broad use in urology. He is among the few urologists who are board certified in both urology and interventional radiology with practical experience in urology and vascular and interventional radiology.

Early attempts at PAE had had roughly similar clinical results to transurethral resection of the prostate, with reported complication rates as high as 52%. What were termed complications included clinical failures, while urethral strictures and bladder neck stenosis rates were similar between the two procedures.

As PAE was refined, clinical outcomes for PAE and TURP converged. By 2020, the two procedures showed similar International Prostate Symptom Score improvements with fewer complications for PAE. Current analysis of randomized controlled trials comparing PAE and TURP shows similar improvement for IPSS, although PAE improvement is more variable, and with two times lower complication rates for PAE compared to TURP.


Timothy McClure, MD,

Head-to-head comparison with dutasteride/tamsulosin also showed a clear advantage for PAE. PAE had a 10-point improvement in IPSS and an eight-point improvement in International Index of Erectile Function score over medical therapy.

Duration of IPSS improvement following PAE is still an open question. A trial of PAE versus sham showed clinical improvement for PAE lasting 12 months, but there are few long-term data.

A U.K. study showed a 15-point improvement in IPSS at five years with TURP versus an 11-point improvement with PAE, and virtually identical quality-of-life scores. Nearly half of TURP patients (47.5%) reported retrograde ejaculation versus 24.1% for PAE.

Five-year recurrence for PAE is between 20% and 30%, Dr. McClure reported.

"PAE outperforms medical therapy, has a lower complication rate compared to TURP, improves IPSS similar to TURP and has far lower retrograde ejaculation," Dr. McClure said. "PAE is not a placebo effect." ●

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AUA BPH guideline amendment explained

Many of the guideline changes focus on newer techniques and technologies that were unavailable or had little evidence in prior years.

The management of benign prostatic hyperplasia (BPH) is evolving. Legacy technologies are out. Newer, less invasive approaches that are potentially more sparing of ejaculation are in.

Jaspreet S. Sandhu, MD, urological surgeon at Memorial Sloan Kettering Cancer Center in New York, discussed key changes made to the 2021 AUA guideline on the management of lower urinary tract symptoms attributed to BPH that were released in 2023. He also focused on what has not changed.

"The initial evaluation and approach remain the same," Dr. Sandhu said in his presentation on the current BPH guideline amendment during the Saturday morning Plenary. "That every patient should be counseled as an individual is extremely important. Patients should be counseled on options for intervention, including behavioral and lifestyle modifications."

Many of the changes focus on newer techniques and technologies that were unavailable or had little evidence in prior years, but pharmacotherapy remains an early option.

Alpha blockers and alpha reductase inhibitors remain mainstay medications. New evidence supports the combination of daily low-dose tadalafil with alpha blockers. The 2021 guideline had advised against the combination for lack of clinical benefit.

Low-dose daily tadalafil plus finasteride is a second new combination therapy.

Transurethral resection of the prostate (TURP) remains the leading surgical intervention. Either the familiar monopolar procedure or the newer bipolar approach is appropriate, depending on the surgeon's experience. Transurethral incision of the prostate and transurethral vaporization of the prostate are also acceptable.

Transurethral microwave therapy and transurethral needle ablation are now considered legacy technologies and are no longer recommended.

"We have seen that multiple techniques are now available, some of which are less invasive and have variable preservation of ejaculation."

—Jaspreet S. Sandhu, MD

Jaspreet S. Sandhu, MD

Laser procedures are recommended; both holmium laser enucleation of the prostate or thulium laser enucleation of the prostate should both be considered. Functional results are as good as or better than simple TURP or simple prostatectomy.

Prostate urethral lift, permanent implants placed every centimeter along each lobe to retract tissue and open the urethra, can also be considered in appropriate patients.

Two water-based techniques, water vapor thermal therapy and robotic waterjet, may also be offered to patients.

Prostate artery embolism (PAE), a technique based on interventional radiology, is now an allowable alternative surgical approach, but is not recommended. The prior 2021 guideline recommended against PAE due to lack of evidence.

Dr. Sandhu said the panel was unable to find substantial evidence to recommend PAE over minimally invasive surgical techniques, but there is evidence of at least a short-term benefit compared to observation in select patient populations.

"We have seen that multiple techniques are now available, some of which are less invasive and have variable preservation of ejaculation," Dr. Sandhu said. "All of the guideline recommendations are available at auanet.org." ●

AUA 2024 San Antonio

The AUA Daily News is the official newspaper of AUA2024 and is published by Ascend Media.

AUA Staff
Darci Berliant
Heather Corkin
Elaine Garrison
Melissa Goodman
Scott D. Morrow
Katie Phipps
Jennifer Regala
Kathleen Warshawsky

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Scan the QR code for a preview of today's session, **"What's age got to do with it?"**

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Title: A Treatment Approach for Certain Patients With High-risk, Non-muscle Invasive Bladder Cancer

Learning objectives:

- Review the cases of hypothetical patients with high-risk, non-muscle invasive bladder cancer (NMIBC)
- Present efficacy and safety data for a treatment option for certain patients with high-risk NMIBC
- Understand how to monitor and manage potential select adverse reactions

Speaker: Vahan Kassabian, MD

Dr. Vahan Kassabian is a urologic oncologist with Advanced Urology serving as the Director of the Atlanta Prostate Center and Advanced Therapeutics in Atlanta, GA. Dr. Kassabian earned his M.D. and completed his residency at the University of Montreal followed by fellowship training in urologic oncology at Baylor College of Medicine in Houston, Texas. He is a former Assistant Professor, Department of Surgery at Emory University and also served as Chief of Urology at the V.A. Hospital in Atlanta. His clinical research interests include general urologic oncology and he is a contributing editor to Reviews in Urology. His research has been featured in articles, abstracts and chapters of leading academic publications. Dr. Kassabian is an international speaker and has lectured extensively on prostate cancer and disease. He is a member of the American Urological Association, the American College of Surgeons and the Society of Urological Oncology.

Sunday, May 5, 2024

1:00 PM - 2:00 PM CT

Henry B. González Convention Center

Hemisfair Ballroom 1

Merck Medical Forums are educational meetings and do not include alcoholic beverages.

Debating the utility of TURP

Detrusor underactivity (DU) and bladder outlet obstruction (BOO) are both common troublesome causes of lower urinary tract symptoms (LUTS) and often simultaneously impact quality of life in men. When should transurethral resection of the prostate (TURP) be recommended to men with DU and BOO?

Saturday's "Crossfire: Controversies in Urology: Detrusor Underactivity in Men and Retention: To TURP or Not to TURP?" debated the rationale for recommending TURP in an index patient, a 60-year-old man who experienced two to three episodes of prostatitis yearly. The patient required clean intermittent catheterization (CIC) four times per day. He had renal insufficiency and a prostate volume of 65 centimeters. He was currently taking finasteride and tamsulosin. His previous procedure included photoselective vaporization of the prostate in 2019. Now he was in your theoretical office with voiding complaints. Would you recommend TURP so he could void without catheterization?

"To do surgery or not, think about the goals of treatment," said Nicole Miller, MD, FACS, professor of urology at Vanderbilt University in Nashville, who led the pro-TURP side of the debate. "For patients with DU, the goals include resuming spontaneous voiding, reducing postvoid residual, preventing upper tract deterioration, improving symptoms and quality of life and reducing the risk of complications."

Dr. Miller cited the literature and the AUA Whitepaper slide to support TURP surgery. "Where we clearly see obstruction, surgery will be beneficial," she said.

Christopher Tenggardjaja, MD, a urologist with Kaiser Permanente in Los Angeles, disagreed, citing evidence indicating that the risks of TURP outweighed the potential benefit. "Sexual dysfunction is a big risk. How do we counsel patients about it? We don't do so well," he said. "The patient already had bladder outflow resistance reduction surgery. Don't make the patient worse."

Ricardo Gonzalez, MD, associate professor of medicine at Houston Methodist, circled back to the goals of treatment for DU, including reducing the risk of complications, infections, renal failure, bleeding, stones and catheter use. "Offering surgery is likely to resolve retention, and postponing it risks waiting until the patient has worse dexterity and the inability to perform CIC. Operate!" he said.

Matthew Rutman, MD, associate professor of urology at Columbia University Medical Center in New York City, offered evidence supporting a rationale against TURP, including the fact that the patient didn't improve with prior surgery, didn't void between CIC and showed minimal detrusor pressure. "I know we're surgeons, but this is a guy we've got to leave alone," he said.

Christopher Tenggardjaja, MD; and Ricardo Gonzalez, MD

Overall, the audience favored TURP surgery. When session moderator Mitchell Humphreys, MD, chair and professor in the department of urology at Mayo Clinic in Arizona, asked: "How many of you would operate on this patient?" and, "If this was you, would you want the opportunity to void without catheterization?" there was a large show of hands both times. ●

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Don’t worry about ChatGPT

Instead, get in the innovation age we’re in right now, which is defined by accessible and affordable microcomputers, 3D printing and teamwork to solve problems.

Craig Niederberger, MD, FACS

From electronic medical records to devices such as neural stimulators, lasers, microscopes and robots, technology is continuing to shape various aspects of health care. Which current technological advances should urologists be concerned about now?

It’s not ChatGPT, the free generative artificial intelligence platform that uses large swaths of digital content and rearranges it according to the likelihood that words, phrases and sentences would follow.

“Don’t worry about ChatGPT,” said Craig Niederberger, MD, FACS, who presented the Ramon Guiteras Lecture on Saturday: “Modern Innovation: Promise or Peril?” Dr. Niederberger is the Clarence C. Saelhof professor and head of the department of urology in the College of Medicine at the University of Illinois at Chicago. He holds a joint appointment as professor in the department of bioengineering in the College of Engineering.

ChatGPT has the potential to identify possible research topics and help us stay abreast of updates and new developments in the field. “But the more you try to make sense of it, the more it eludes you,” Dr. Niederberger said.

“Although ChatGPT can sound like us, it doesn’t think like us,” he added. Not convinced? “Go to ChatGPT.com [and] ask it some urological questions. Put in a case and see what it says,” he said. “You’ll be comforted to know it’s not going to replace you anytime in the near future.”

Instead, focus on the innovation age that’s upon us.

“What’s going on right now in innovation is remarkable,” Dr. Niederberger said. “In the 1980s, innovation in medicine involved bringing an idea to an engineer and giving them $3 million. They would build things on the bench. Eventually (these things) would land somewhere useful, but the process was very inefficient. In the last 20 years, innovation has become more accessible and a team sport, in which medicine, engineers, learners of all kinds—from undergraduates to full professors and designers—come together to identify and solve problems.”

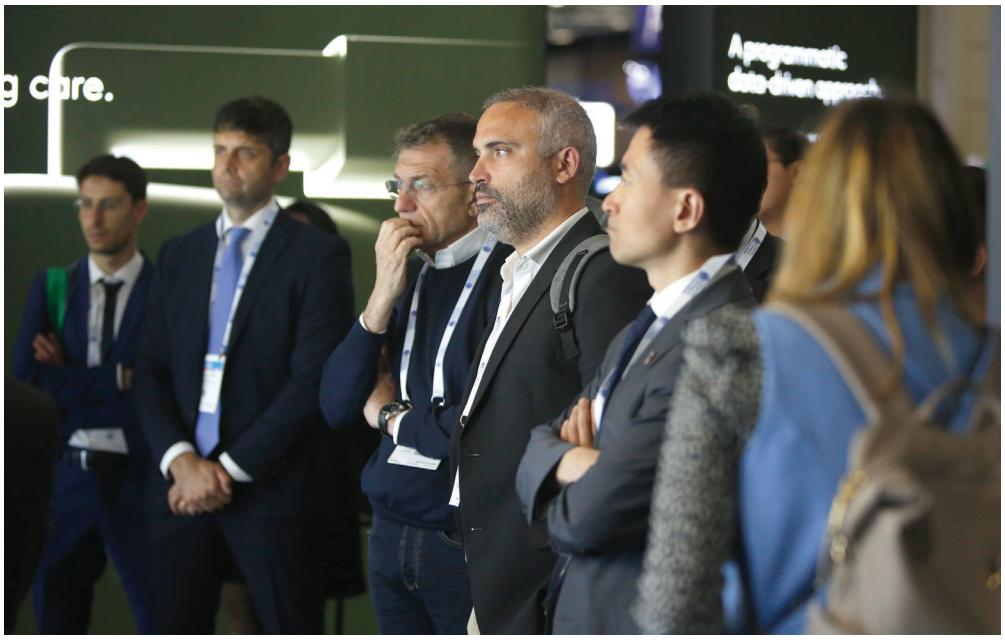
Moreover, the barrier to entry has never been lower. Dr. Niederberger cited tools such as 3D printers and small, inexpensive, easily programmed, yet highly powerful computers, such as the Arduino and the Raspberry Pi, which are available on Amazon and cost less than $50, that are making innovation easily accessible.

It all starts with identifying a problem.

“Once you realize frustrating things are problems you can solve, the world is your oyster,” Dr. Niederberger said. “As urologists, all of us are natural innovators.”

> “In the last 20 years, innovation has become more accessible and a team sport, in which medicine, engineers, learners of all kinds—from undergraduates to full professors and designers—come together to identify and solve problems.”
>
> **—Craig Niederberger, MD, FACS**

Social and scientific at AUA2024



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Title: Patient Case-Based Learning: Clinical Management of Certain Patients With VHL Disease

Learning objectives:

- Understand von Hippel-Lindau (VHL) disease through a hypothetical patient case
- Review clinical data on a management option for certain patients with VHL disease
- Discuss monitoring and management of potential adverse reactions through a patient case

Saturday, May 4, 2024

10:15 AM - 11:00 AM CT

Henry B. González Convention Center

S&T Hall, Booth #1159

Speaker: Brian Shuch, MD

Title: A Treatment Option for Certain Patients With Renal Cell Carcinoma in the Adjuvant Setting

Learning objectives:

- Review renal cell carcinoma (RCC)
- Understand clinical data supporting a treatment option for certain patients with RCC in adjuvant treatment setting
- Understand how to monitor and manage potential adverse reactions associated with this treatment option

Sunday, May 5, 2024

12:00 PM -12:45 PM CT

Henry B. González Convention Center

S&T Hall, Booth #1159

Speaker: Vahan Kassabian, MD

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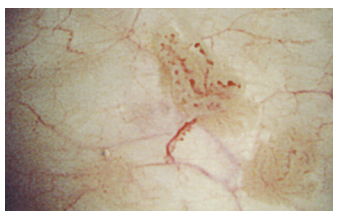

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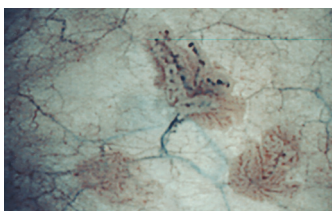

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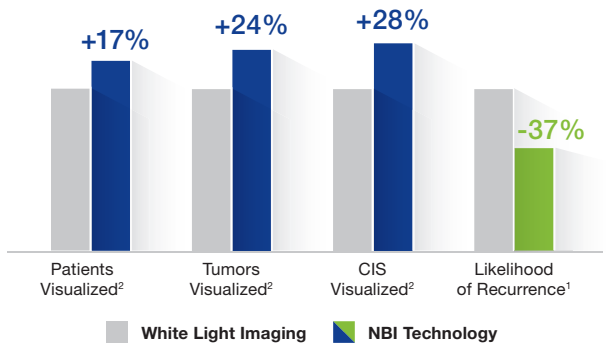

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* Derived from the hazard ratio in the study. Low certainty of evidence due to risk of bias and imprecision.

1. Lai LY, Tafuri SM, Ginier EC, Herrel LA, Dahm P, Maisch P, Lane GI. Narrow band imaging versus white light cystoscopy alone for transurethral resection of non-muscle invasive bladder cancer. Cochrane Database of Systematic Reviews 2022, Issue 4. Art. No.: CD014887. DOI: 10.1002/14651858.CD014887.pub2.
2. Li, K., Lin, T., Fan, X., Duan, Y., & Huang, J. (2013). Diagnosis of narrow-band imaging in non-muscle-invasive bladder cancer: A systematic review and meta-analysis. International Journal of Urology, 20, 602-609. www.ncbi.nlm.nih.gov/pubmed/23113702

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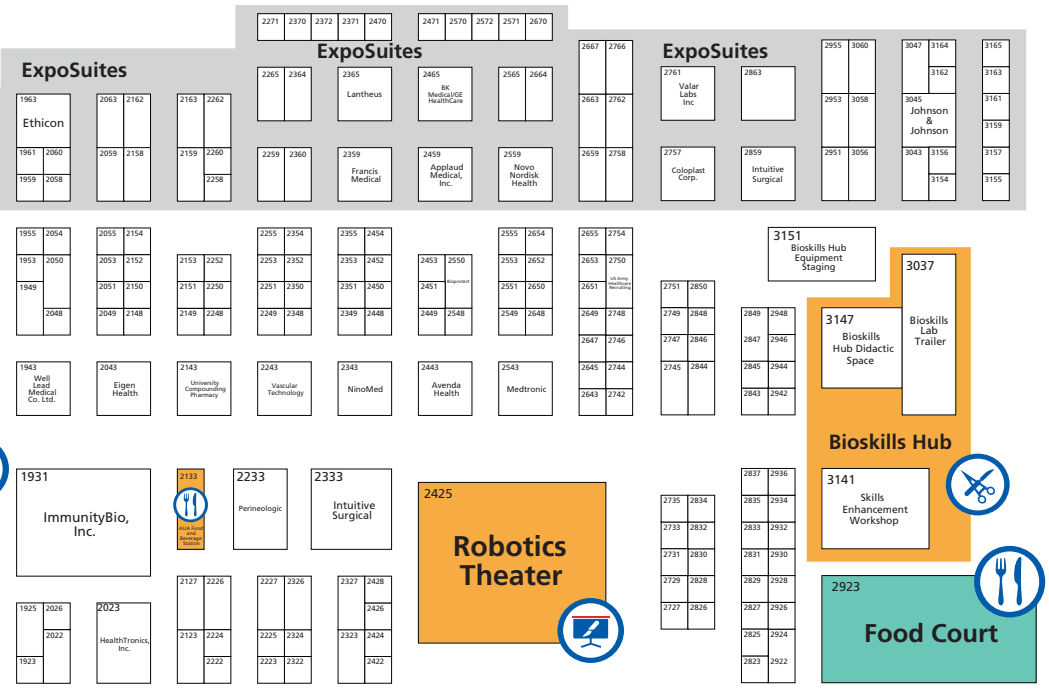

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QUESTION OF THE DAY

What have you learned at AUA2024 that you will implement into your practice back home?

I just attended a global health forum through the Societies for Pediatric Urology to learn about the different ways to get involved in global public health. … Just going for those one-week mission trips can be good, but it can be difficult to implement long-term changes in those underserved areas. They are focusing more now on education and video series so that people in underserved countries can use those to make long-term changes. In my practice, when I become an attending, I want to try to get involved in many of those organizations and see what I can do to implement long-term changes and improve urological care in underserved communities.

Nicolette Payne, MD
Phoenix, Arizona

It's kind of overwhelming how much you learn here, and you make notes for that very reason, so that when you go home, you can evaluate all the things you want to do differently in your own practice—things like lymph node dissections for cystectomies and how to handle stones and incontinence. So, I have plenty of notes!

Karin Brown, MD
Billings, Montana

I'm looking forward to implementing (transperineal prostate) biopsy into our clinical practice. There are several new models that we've been using here. I took a course and am really excited to implement quite a few of those ideas, especially with fusion and the different methods for doing things and bringing them to practice.

Andrew Tompkins, MD
Providence, Rhode Island

I would say the guidelines are especially helpful because they bring a system to the practice. Today, for example, they covered [benign prostatic hyperplasia] guidelines, so these help us really look at how we evaluate the patient. It gives us a checklist to go through. So, I really enjoy understanding the guidelines and putting those into practice.

Mandeep Singh, MD
Wexford, Pennsylvania

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VOICES & VIEWS

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USC Urology
@USC_Urology
It's always such a pleasure reconnecting with **@USCAlumni** at our annual conference **@AmerUrological @so_uro @KECKSchool_USC @EFichtenbaum @DrAAshrafi #aua24 #uscurology**

Jordan P. Malloy
@JordanPMalloy
Dr. Miles-Thomas sharing her wisdom at Peer to Peer Discussions! **#YoungUro #AUA24**

Shada Sherona Sinclair
@Shada_Sinclair
Excited to have had the opportunity to present a podium at **#AUA24** I'm very grateful for the mentorship of **@Dr_A_Dobberfuhl @StanfordUrology #uromatch2025**

Amanda North
@anorth21
All the cool kids are doing the **#AUACensus**. Be like **@MaleHealthDoc** and be a cool kid! **#AUA24**

Betsy Salazar
@BetsySalazarPhD
Excellent video presentation by **@Golenita** at **#AUA24**, offering an informative step-by-step guide on UGN-101 retrograde instillation in the clinic. Dr. Gonzalez Moncaleano, a K12 Scholar in the UroEpi Program at **@UMichUrology**, shares early outcomes from this study **#CAIRIBUatAUA**

Dr Edgar Beltrán M.H.Sc
@UrologoEdgar
Excellent first symposium of the Mexican society Urology in the AUA a completely full room. Congratulations to all the organizers **@smumexico @AmerUrological #AUA24**

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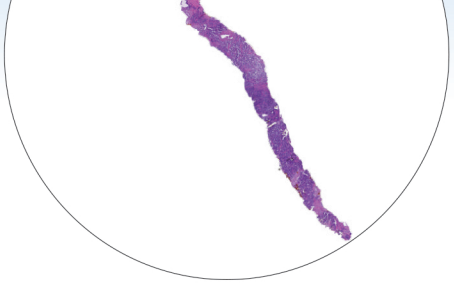

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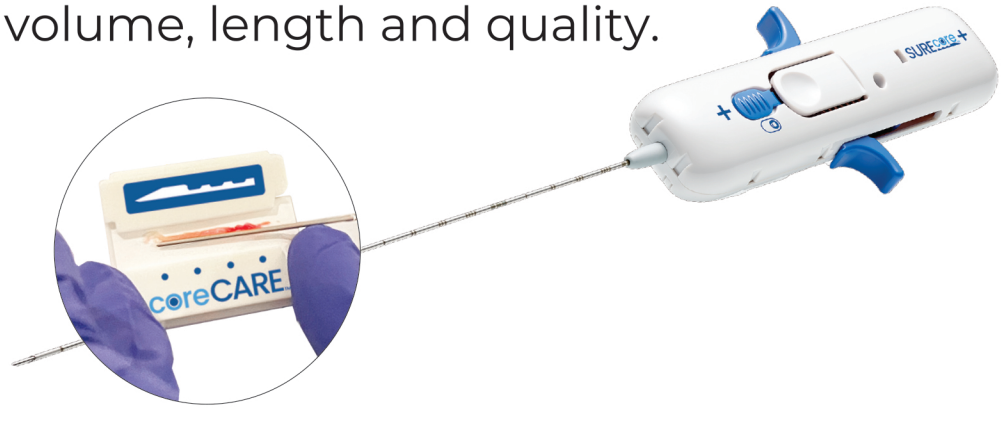

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