Welcome from the President and Program Chair

2017 – 2018 Board of Directors

Past Presidents

Mission Statement

General Meeting Information

Special Events

Educational Needs & Objectives

Accreditation Statement

2018 Resident Travel Award Winners & Contributors

Industry Support

Program Schedule

2018 Faculty Listing

Faculty Disclosure Report

Resident Podium Session

Resident Poster Session

Speaker Biosketches
WELCOME MESSAGE

Dear Colleagues,

It is with great pleasure that we welcome you to the Society of Women in Urology’s 7th Annual Clinical Mentoring Conference. We are excited to begin exploring a new location here at the Hilton Lake Las Vegas, in Henderson, Nevada. The venue is a beautiful resort meant to help facilitate the camaraderie that is an integral part of this meeting. We have assembled an all-female faculty that highlights the impressive expertise and contributions of women in the field of urology through didactic presentations, panel discussions, and, this year, a unique “tango lesson for life” presented by Dr. Jeannette Potts and her dance partner, Jorge. This will be an interactive, personal growth-oriented session, so here’s to hoping you brought your dancing shoes! Also to engage us in physical activity, Dr. Lindsey Kerr has graciously agreed to lead us in a yoga session on Saturday morning, so hopefully you brought some comfortable clothes for this wake up session as well!

The theme of this year’s meeting is “A Typical Day in the Life of the General Urologist.” What are the most common diagnoses regularly seen by general urologists? Pain conditions/syndromes (bladder, pelvic, scrotal, flank, post-op), stones, BPH, various GU malignancies, voiding dysfunction, UTI’s, geriatric patients, social media and our practices, etc. We will cover these various topics in our two and a half day conference.

The typical time allotted per visit in most office schedules is 10-15 (established patient) to 20-30 (new patient) minutes and the average attention span of most adults is about 20 minutes. Thus, our concept for this meeting is to have topics presented every 30 minutes with a didactic session of 20-25 minutes plus a few minutes for interaction/questions. It is a fast-paced and varied schedule—like a typical day in the office. We will also have panel discussions with the first covering the topic of difficult to manage patients, both male and female, with IC/CPP on Friday morning. The second panel discussion will highlight various practice models—academic urology, VAMC urology, large private practice urology and solo/small group urology. This is meant for those in training trying to decide what type of practice is best for them as well as those already in practice who may not be in a situation that is meeting their needs. How to transition from one type of practice to another will also be presented during this session on Saturday morning.

We will address leadership training/professional development with presentations on Saturday afternoon and during the President’s Banquet on Saturday evening. Our keynote speaker is Elaine S. Rosenblum, founder of ProForm U, who will address the importance of cultivating a highly effective and consistent voice: speaking voice, written voice and behavioral voice.

We have expanded the resident portion of our meeting to include not only a podium session which showcases the research efforts of residents, fellows and medical students but also a poster session coinciding with our first evening welcome
reception. This provides the participating trainees an opportunity to share their work while gaining experience in presentations and receiving constructive feedback on their presentation skills. There will also be a “mock oral boards” session for any interested parties on Sunday morning led by Dr. Melissa Kaufman. Many trainees are supported through travel awards, thanks to the generous support of our members and sponsors.

Mentoring represents another primary focus of this meeting. A formal mentoring session with pre-determined mentors and mentees will take place on Saturday afternoon. This is a new endeavor and will be fast-paced as well—like “speed dating.”

We have the unique involvement in our program this year of at least two women who are published authors, Drs. Jeannette Potts and Martha Boone. We will have an opportunity to discuss their books, publishing, etc. at our networking breakfast on Sunday morning with an informal “book club.”

As always, since the inception of our “stand alone” winter meeting, the most important aspect of this meeting is the collegial environment that allows networking with women from across the country in a variety of urology fields. You will not find a group of people in one place more willing to share ideas and listen to a clinical challenge or assist with career development. These personal interactions are important not only for our youngest members in training, but also for women at all stages of their careers. The mission of SWIU is to support women in urology! That support comes in many different forms for different people, and this meeting allows us to achieve that vision. With that in mind, the success of our meeting is dependent upon the collaborative efforts that involve you, a valued SWIU member. Your attendance represents a vital component of the experience.

Welcome to Nevada!

Suzette E. Sutherland, MD, MS, FPMRS
SWIU President

Teresa D. Beam, MD, FACS
Winter Meeting Program Chair
# BOARD OF DIRECTORS

## Officers

**President**
Suzette E. Sutherland, MD, MS, FPMRS  
University of Washington Dept. of Urology  
1959 NE Pacific, BB1106 B  
Campus Box 356510  
Seattle, WA 98195

**President-Elect**
Teresa D. Beam, MD, FACS  
Urology of Indiana  
18051 River Ave., Suite 202  
Noblesville, IN 46062

**Secretary**
Claire C. Yang, MD  
University of Washington Dept. of Urology  
1959 NE Pacific BB1106 B  
Campus Box 356510  
Seattle, WA 98195

**Treasurer**
Kathleen Kieran, MD, MS, MME  
University of Washington/Seattle Children’s Hospital  
Department of Urology PO Box 5371  
4800 Sand Point Drive NE, MS OA.6.274  
Seattle, WA 98145-5005

**Immediate Past-President**
Dolores J. Lamb, PhD, HCLD  
Baylor College of Medicine Dept. of Urology  
1 Baylor Plaza, Rm. N730 BCM382  
Houston, TX 77030

## Program Planning Committee

Teresa D. Beam, MD (Chair)  
Dolores J. Lamb, PhD, HCLD  
Anne K. Pelletier-Cameron, MD  
Suzette E. Sutherland, MD, MS  
Elizabeth A. Williams, MD

## Board of Representatives

**Board Members**
Elizabeth T. Brown, MD, MPH  
MedStar Georgetown University Hospital  
Department of Urology 3800 Reservoir Road NW, 1-PHC Washington, DC 20007

Anne P. Cameron, MD, FPMRS  
University of Michigan  
1500 E. Medical Center Drive  
3875 Taubman Center  
Ann Arbor, MI 48109-5330

Akanksha Mehta, MD, MS  
Emory University  
1365 Clifton Road NE, Bldg B  
Suite 1400  
Atlanta, GA 30309

Simone Thavaseelan, MD  
Brown University/Rhode Island Hospital Division of Urology  
2 Dudley Street, Suite 174  
Providence, RI 02905

Jannah Thompson, MD, FPMRS  
Urologic Consultants, P.C.  
2093 Health Drive, Suite 202  
Wyoming, MI 49519

Anne L. Darves-Bornoz, MD  
Vanderbilt University Dept. of Urologic Surgery  
A-1302 Medical Center North  
Nashville, TN 37232-2765

Amy N. Luckenbaugh, MD  
University of Michigan Dept. of Urology  
1500 East Medical Center Drive  
Ann Arbor, MI 48105

## Headquarters Office

WJ Weiser & Associates, Inc.  
1100 E Woodfield Road, Suite 350  
Schaumburg, IL 60173  
P: (847) 517-7225 | F: (847) 517-7229

**Associate Director**
Danielle Carrier

**Executive Director**
Wendy J. Weiser
PAST PRESIDENTS

2017  Dolores J. Lamb, PhD, HCLD
2016  Elizabeth A. Williams, MD
2015  Leslie M. Rickey, MD, MPH
2014  Jennifer L. Dodson, MD, PhD
2013  Melissa R. Kaufman, MD, PhD
2012  Nancy A. Huff, MD
2011  Tracy Cannon-Smith, MD
2010  Elizabeth R. Mueller, MD
2009  Harriette M. Scarpero, MD
2008  Elizabeth W. Bozeman, MD
2007  Cathy K. Naughton, MD
2006  Brenda S. Kinard, MD
2005  Martha K. Terris, MD
2004  Janice L. Arnold, MD
2003  Deborah J. Lightner, MD
2002  Catherine Rhu deVries, MD
2001  M’Liss A. Hudson, MD
2000  Susan J. Kalota, MD
1999  Lindsey A. Kerr, MD
1998  Gloria S. Massey, MD
1997  Nina S. Davis, MD
1996  Tamara G. Bavendam, MD
1995  Kristene E. Whitmore, MD
1994  Carole L. Gordon, MD
1993  Dana J. Weaver Osterholtz, MD
1992  Dana J. Weaver Osterholtz, MD
1991  Jean L. Fourcroy, MD, PhD, MPH
1990  Jean L. Fourcroy, MD, PhD, MPH
1989  Jean L. Fourcroy, MD, PhD, MPH
1988  Jean L. Fourcroy, MD, PhD, MPH
1987  Jean L. Fourcroy, MD, PhD, MPH
1986  Jean L. Fourcroy, MD, PhD, MPH
1985  Jean L. Fourcroy, MD, PhD, MPH
1984  Jean L. Fourcroy, MD, PhD, MPH
1983  Jean L. Fourcroy, MD, PhD, MPH
1982  Jean L. Fourcroy, MD, PhD, MPH
1981  Jean L. Fourcroy, MD, PhD, MPH

Mission Statement
To support the professional development and career advancement of women urologists and urologic researchers through education, advocacy, and mentorship.
The 7th Annual Professional Development & Clinical Mentoring Conference provides a robust scientific program with the theme, "A Typical Day in the Life of the General Urologist." The fast-paced agenda includes a variety of clinical and operational topics.

**Registration/Information Desk Hours**

*Location: Lower Level Pre-Function 1*

- Friday, January 19, 2018: 6:30 a.m. – 6:30 p.m.
- Saturday, January 20, 2018: 6:30 a.m. – 5:30 p.m.
- Sunday, January 21, 2018: 7:00 a.m. – 11:00 a.m.

**Exhibit Hall Hours**

*Location: Salon 2*

- Friday, January 19, 2018: 10:00 a.m. – 6:30 p.m.
- Saturday, January 20, 2018: 7:00 a.m. – 1:00 p.m.

**Registration Fee Includes:**

- Entrance to scientific sessions
- Breakfasts, breaks, and lunches
- Program materials
- Entrance to Networking Breakfast

**Welcome Reception with Resident/Fellow Poster Session**

*Date:* Friday, January 19, 2018  
*Time:* 5:00 p.m. – 6:30 p.m.  
*Location:* Salon 2  
*Cost:* $25.00 per person  
*Description:* The Society of Women in Urology welcomes its members to the 7th Annual Clinical Mentoring Conference. This is a great opportunity for attendees to network with colleagues and fellow members all while enjoying delicious drinks and hors d’oeuvres. New this year is the Resident/Fellow Poster Session. Make sure to take time to interact with our poster presenters.

**President’s Banquet**

*Date:* Saturday, January 20, 2018  
*Time:* 7:00 p.m. – 10:00 p.m.  
*Location:* Montelago 1  
*Cost:* $75.00 per person  
*Description:* Join fellow SWIU members for the annual President’s Banquet. The program committee is excited to announce Elaine Rosenblum, founder of ProForm U®, as our keynote speaker during the President’s Banquet. Her address, Words in the Now, looks at the importance of our word choices and how respecting the words we use influences our ability to achieve total physician and patient health.
Tango Lessons for Life: An Interactive Session
Date: Friday, January 19, 2018
Time: 3:00 p.m. – 4:30 p.m.
Location: Salons 3 & 4
Description: Using metaphors derived from Argentine Tango dance techniques, Dr. Potts will discuss and demonstrate ways to enhance communication and better appreciate our roles when leading, following or collaborating. Using tango as a tool to spark awareness, this session shows participants how to reach for meaning and happiness in a hectic world. We “dance” with many people in our daily lives and can learn to enjoy some of the more challenging steps by following certain tango rules: do not anticipate, lead from the heart, follow what you lead and more... Enjoy this interactive lecture dance workshop, featuring Argentine native, Jorge Niedas, founder of Tango21 in Chicago. Find your tango and you'll discover your bliss.

YOGA: Dr. Vinyasa - The Resilience of an Open Heart
Date: Saturday, January 20, 2018
Time: 7:00 a.m. – 7:45 a.m.
Location: Salon 1
Description: Join us for a heart opening, limb stretching Vinyassa class. No experience needed. A great warm up for the day ahead.

Mentoring Session
Date: Saturday, January 20, 2018
Time: 4:00 p.m. - 5:00 p.m.
Location: Salon 1
Description: SWIU's new mentoring session will connect mentees with multiple mentors in a “speed mentoring” format. Participants will be provided with additional mentoring instruction and contact information to continue connections post-meeting.

Networking Breakfast
Date: Sunday, January 21, 2018
Time: 8:00 a.m. – 11:00 a.m.
Location: Salon 1
Cost: Included in registration fee
Description: SWIU is happy to offer another networking opportunity at the 7th Annual Clinical Mentoring Conference. Chat with attendees and SWIU board members over a complimentary breakfast before the meeting ends.

Mock Oral Boards
Date: Sunday, January 21, 2018
Time: 8:00 a.m. - 10:00 a.m.
Location: Salons 3 & 4
Description: Mock Oral Boards session will provide participants the opportunity to independently evaluate high-yield Urologic cases from multiple disciplines in preparation for board examinations.
EDUCATIONAL NEEDS

The aging of the American population and major healthcare changes have a profound impact on urology practices. Men’s health issues, particularly the management of benign prostatic hyperplasia (BPH), warrants a greater clinical focus in new technologies for treatment. According to the AUA Guidelines for the Management of Benign Prostatic Hyperplasia, transurethral resection remains the gold standard of interventional treatment. Many patients prefer “minimally-invasive procedures” when medical therapy is insufficient to adequately control bothersome lower urinary tract symptoms. Office-based procedures are becoming more available. A need exists for the general urologist to understand the treatment options available, including new technologies, for maximum patient informed consent and preferred treatments.

Interstitial cystitis (IC) or Bladder Pain Syndrome (BPS) is a chronic, disabling condition of persistent or recurrent pain perceived in the urinary bladder region, accompanied by at least one other symptom, such as pain worsening with bladder filling and daytime and/or nighttime urinary frequency. It is becoming a more common entity. There is often overlap with chronic pelvic pain in both men and women. This condition can be extremely challenging to treat and often requires a multi-modality approach. A need exists for the general urologist to understand the evolving theories for the cause of the condition and its treatments, visceral pain pathways, viscerosomatic convergence, overlapping pain syndromes and various treatment modalities and interdisciplinary pain management strategies. We also need to discuss examples of difficult patient cases to manage.

With the advent of the Affordable Care Act in the last several years and attempts, more recently, to repeal this legislation, as well as continued changes in health care coverage and regulation, keeping abreast of health care policy issues continues to play a very important role in our medical practices. Also, understanding how best to become involved in the politics of medicine, and the necessity thereof for urologists, is in our best interest not only for our profession but also for the welfare of our patients. There is a need for the general urologist to understand these issues and the necessity for involvement.

Kidney stones are one of the most common conditions treated by the general urologist. The incidence of kidney stones has shifted to more than double in the last 20 years. This is especially true in the age group of child-bearing and child-rearing females. There has also been a rapid increase in the incidence of childhood nephrolithiasis with this patient population having a high recurrence rate. Therefore, a review is needed to determine the unique characteristics of these special patient populations and how to best treat them.

Urinary tract infections (UTIs) are common and among the most frequent medical conditions requiring outpatient treatment. Approximately 80% of all UTIs occur in women and 20 to 30% of women with UTIs will experience recurrence. These infections are a significant source of patient morbidity and health care costs. There is also a rise in antibiotic-resistance making the treatment of these infections more challenging. There is a need for general urologists to understand the contributing factors and treatments available for patients with recurrent UTIs.

As more and more women become urologists, a surgical sub-specialty, it is important to know about unique personal concerns when it comes time to begin our families. Female surgeons need to understand some issues/concerns that are special to us as women since the biological reality is that women must bear the children in families that wish to procreate.
The workforce in urology is one of the oldest in the surgical specialties. More than 50% of American urologists are over the age of 55 years old and will be retiring in the next 10 years. A large percentage of new urologists going into practice will move jobs within the first 3 years of practice. The number of job opportunities in our specialty far outnumbers the candidates to fill those spots. It would be useful to understand the different types of practice models that are most common, with pros and cons of each, for the growing number of young women who are in training and soon ready to begin their careers or in a situation that is not meeting their needs/expectations.

Voiding dysfunction, including urinary urgency, frequency and incontinence, is common in children of all ages after potty training. Confounding factors include diet, dehydration, constipation as well as volitional urine and stool holding. Schools contribute to poor bladder health with teachers and school nurses unaware of basic concepts of bladder health. Girls with voiding dysfunction may have a higher risk for pelvic floor issues in adulthood. There exists a need for the general urologist to have an understanding of these concerns and how to best deal with them when seeing children and adolescents with voiding issues.

Adolescent males have their own unique urologic issues that are often treated by general urologists. Scrotal masses need immediate attention but are usually benign with etiologies including epididymal cysts, varicoceles, hydroceles and hernias. Varicoceles are common but their management remains controversial. Scrotal pain is also common in teenage boys and has multiple etiologies including voiding dysfunction and referred musculoskeletal pain. A need exists for general urologists to have a good understanding of the evaluation and management of these various conditions found commonly in teenage males.

The aging of the American population involves many urological conditions that are addressed on a daily basis by the general urologist and often require surgical intervention for satisfactory management of these conditions. Special considerations are necessary in surgical planning in these older adults. A need exists for urologists to be able to adequately assess these patients in order to optimize good outcomes in this patient population with unique needs.

Whether trying to determine the presence of GU cancers or the best treatment options for a particular individual already diagnosed with cancer, genetic biomarkers are more and more prevalent in the discussion for decision making. A need exists for urologists to have a clear understanding of the genetic biomarkers that exist in the clinical arena today and their uses.

Whether we like it or not, we have a “social media” presence and don’t always have control over its impact on our practice. For that reason, urologists need to understand the various social media platforms and their potential uses and risks to our medical practice.

Many leaders make an effort to exhibit leadership without understanding the barriers they must first overcome. Urologists need the tools to build leadership in themselves and their organizations. We will explore various lessons to build leadership skills, explore how to reach for meaning in a hectic world and how to share the responsibility and create success.
EDUCATIONAL OBJECTIVES

At the conclusion of the meeting, attendees should be able to:

1. Explain the complex issues related to patients with interstitial cystitis/bladder pain syndrome/chronic pelvic pain, pain pathways and management of complex chronic pain patients.

2. Describe voiding dysfunction and its impact on children, adolescents and adults.

3. Describe common conditions seen by urologists in the adolescent male.

4. Identify the impact of different genetic biomarkers in the management of GU malignancies, primarily prostate and bladder.

5. Describe the impact of social media on medical practice.

6. Describe the various surgical treatment options available for BPH.

7. Describe the issues associated with being pregnant and a working surgeon.

8. Review the current health policy issues and the importance of involvement in the politics of medicine.

9. Describe the different practice models available and how to best choose a practice environment that fits your personal needs.

10. Describe the special considerations and treatment management of children and pregnant women with kidney stones.

11. Describe the treatment of patients with UTI’s, both acute and chronic.

12. Identify novel approaches used for skillful communication and personal growth.

13. Describe the assessment needed for surgical planning in the elderly population.
ACCREDITATION

Category 1
Creighton University Health Sciences Continuing Education designates this live activity for a maximum of 16.00 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AAPA accepts AMA category 1 credit for the PRA from organizations accredited by ACCME.

Accreditation Statement
In support of improving patient care, this activity has been planned and implemented by Creighton University Health Sciences Continuing Education (HSCE) and Society of Women in Urology (SWIU). Creighton University Health Sciences Continuing Education (HSCE) is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Nurses and other healthcare professionals will receive a Certificate of Attendance. For information on the applicability and acceptance of Certificates of Attendance for educational activities certified for AMA PRA Category 1 Credit™ from organizations accredited by the ACCME, please consult your professional licensing board.

General Disclaimer
The statements and opinions contained in this program are solely those of the individual authors and contributors and not of the Society of Women in Urology. The appearance of the advertisements is not a warranty, endorsement, or approval of the products or services advertised or of their effectiveness, quality, or safety. The content of this publication may contain discussion of off-label uses of some of the agents mentioned. Please consult the prescribing information for full disclosure of approved uses. The Society of Women in Urology disclaims responsibility for any injury to persons or property resulting from any ideas or products referred to in the abstracts or advertisements.

Special Assistance
We encourage participation by all individuals. If you have a disability, advance notification of any special needs will help us better serve you. Call (847) 517-7225 if you require special assistance to fully participate in the meeting.
2018 Resident Travel Award Winners

Denise Asafu-Adjei
Jessica Dai
Judy Farias
Allison Glass
Jessica Marinaro

Danica May
Kristen McAlpine
Erin Salter
Ashley Wietema
Shenelle Wilson
Rena XU

2018 Resident Travel Award Contributors

Corlis L. Archer-Goode, MD
Tamara Bavendam, MD, MS
Martha Boone, MD*
Tracy Cannon-Smith, MD
Ellura*
Lamia L. Gabal, MD*
Melissa R. Kaufman, MD, PhD*
Tamara E. Lewis, MD, FACS
Gloria S. Massey, MD*
Theresa J. McCallum, MD*
Elspeth M. McDougall, MD, FRCSC*

Mid-Atlantic Section of the AUA*
Elizabeth R. Mueller, MD, MSME*
Northeastern Section of the AUA*
Susan E. Pursell, MD
Julie M. Riley, MD
South Central Section of the AUA*
Southeastern Section of the AUA*
Kristina D. Suson, MD
Kirin K. Syed, DO
Jannah Thompson, MD
O. Lenaine Westney, MD
Elizabeth A. Williams, MD
Hadley M. Wood, MD

*Support completely funded one or more resident travel awards.
Thank You to Our 2018 Promotional Partners

Platinum Level Partner
Allergan, Inc.

Silver Level Partners
Boston Scientific
Coloplast
Ellura
Medtronic, Inc.

Thank You to Our 2018 Contributor
Ellura

Thank You to Our 2018 Exhibitors

Allergan, Inc.
Astellas Pharma US, Inc.
Avadel Pharmaceuticals
Boston Scientific
BTL
Cogentix Medical
Coloplast
Cook Medical
Ellura
Endo Pharmaceuticals
GTx, Inc
Medtronic, Inc.
KARL STORZ
Retrophin
Wellspect Healthcare

Industry listing as of 1/9/2018
SWIU 7th Annual Clinical Mentoring Conference

January 19 - 21, 2018
All sessions will be located in Salon 3 & 4, unless otherwise noted.
Speakers and times are subject to change.

Friday, January 19, 2018

OVERVIEW
6:30 a.m. - 6:30 p.m.  Registration/Information Desk Open
                        *Location: Lower Level Pre-Function 1*

10:00 a.m. - 6:30 p.m. Exhibit Hall Open
                        *Location: Salon 2*

GENERAL SESSION
8:00 a.m. - 8:05 a.m.  Welcome and Announcements
                        *Speakers: Suzette E. Sutherland, MD, MS, FPMRS
                        Teresa D. Beam, MD, FACS*

8:05 a.m. - 8:35 a.m.  Pain Pathways: Acute and Chronic
                        *Speaker: Jennifer Hah, MD, MS*

8:35 a.m. - 9:05 a.m.  How I Treat BPS/IC Patients
                        *Speaker: Jane L. Miller, MD, FPMRS*

9:05 a.m. - 9:35 a.m.  When Will Men Finally Be Treated as Well as Chickens?
                        *Speaker: Jeannette M. Potts, MD*

9:35 a.m. - 10:05 a.m. IC/CPP Panel
                        *Moderator: Teresa D. Beam, MD, FACS
                        Panelists: Jennifer Hah, MD, MS
                        Jane L. Miller, MD, FPMRS
                        Jeannette M. Potts, MD*

10:05 a.m. - 10:30 a.m. Break with Exhibitors
                        *Location: Salon 2*

10:30 a.m. - 11:00 a.m. Voiding Dysfunction in Children and Adolescents
                        *Speaker: Clare E. Close, MD*

11:00 a.m. - 11:30 a.m. Adolescent Male Urology
                        *Speaker: Clare E. Close, MD*

11:30 a.m. - 12:00 p.m. Geriatric Urology: Surgical Planning in Older Adults
                        *Speaker: Anne M. Suskind, MD, MS*
### PROGRAM SCHEDULE

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 p.m. - 1:00 p.m.</td>
<td>Lunch in Exhibit Hall</td>
<td>Salon 2</td>
</tr>
<tr>
<td>1:00 p.m. - 1:30 p.m.</td>
<td>Genomic Markers in Prostate Cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaker: Stacy Loeb, MD,MSc</td>
<td></td>
</tr>
<tr>
<td>1:30 p.m. - 2:00 p.m.</td>
<td>Social Media in Urology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaker: Stacy Loeb, MD,MSc</td>
<td></td>
</tr>
<tr>
<td>2:00 p.m. - 2:30 p.m.</td>
<td>BPH Treatment Update</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaker: Miriam Hadj-Moussa, MD</td>
<td></td>
</tr>
<tr>
<td>2:30 p.m. - 3:00 p.m.</td>
<td>Break with Exhibitors</td>
<td>Salon 2</td>
</tr>
<tr>
<td>3:00 p.m. - 4:30 p.m.</td>
<td>Tango Lessons for Life: An Interactive Session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaker: Jeannette M. Potts, MD Joined by Dancing Partner Jorge Niedas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chicago, IL</td>
<td></td>
</tr>
<tr>
<td>5:00 p.m. - 6:30 p.m.</td>
<td>Welcome Reception with Exhibitors and Resident Poster Session*</td>
<td>Salon 2 and Pre-Function Foyer 1</td>
</tr>
<tr>
<td></td>
<td>*Not CME accredited</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Poster #1</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IMPROVEMENTS IN URETEROSCOPY EFFICIENCY WHEN PERFORMED AT AN AMBULATORY SURGERY CENTER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented By: Rena Xu, MD, MBA</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Poster #2</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MALIGNANCY NEGATIVELY ASSOCIATED WITH BASELINE SEMEN PARAMETERS AMONG SPERM BANKERS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented By: Rena Xu, MD, MBA</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Poster #3</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OUTCOMES IN PATIENTS WITH KNOWN CONTRAST ALLERGY UNDERGOING CONTRAST-ENHANCED ENDOUROLOGICAL PROCEDURES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented By: Paula Domino, MD</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Poster #4</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANTERIOR URETHRAL VALVES: LONG TERM OUTCOMES FROM A SINGLE INSTITUTION</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented By: Paula Domino, MD</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Poster #5</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DISPARITIES IN ACCESS TO COMPLEX KIDNEY CANCER SURGERY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented By: Shannon Cannon, MD</td>
<td></td>
</tr>
</tbody>
</table>
Poster #6  THE FIRST FEMALE AUTHORS IN THE JOURNAL OF UROLOGY
Presented By: Kathryn Marchetti, BS

Poster #7  FACTORS INFLUENCING OVERALL SURVIVAL OF CHILDREN, ADOLESCENTS AND YOUNG ADULTS WITH HIGH RISK PEDIATRIC RENAL TUMORS
Presented By: Amanda F. Saltzman, MD

Poster #8  MULTI-CENTER PROSPECTIVE STUDY OF PROSTATE HEALTH INDEX (PHI) TESTING AS A STRATEGY FOR PROSTATE CANCER SCREENING: COLLABORATION BETWEEN UROLOGY, PRIMARY CARE AND COMMUNITY OUTREACH
Presented By: Elizabeth C. Wendel, MD

Poster #9  IMPLANT SELECTION PATTERNS AND REOPERATION RATES AMONGST SOLID ORGAN TRANSPLANT RECIPIENTS THAT UNDERWENT PENILE PROSTHESIS SURGERY
Presented By: Denise A. Asafu-Adjei, MD, MPH

Poster #10  PROSTATE MRI INTERPRETATION VARIES SUBSTANTIALLY ACROSS RADIOLOGISTS
Presented By: Nancy Wang, MPH, MD

Poster #11  EARLY VAGINOPLASTY EXPERIENCE WITHIN A MULTIDISCIPLINARY TEAM IN THE INTEGRATED HEALTHCARE SYSTEM
Presented By: Virginia Li, MD

Poster #12  THE NATIONAL RESIDENT MATCHING PROGRAM CODE OF CONDUCT: WHAT IS THE DEGREE OF COMPLIANCE DURING THE UROLOGY MATCH PROCESS?
Presented By: Elisabeth Sebesta, MD

Poster #13  SYSTEMATIC REVIEW OF OUTCOMES OF THE TRANSOBTURATOR SLING IN MEN WITH INCONTINENCE SECONDARY TO RADICAL PROSTATECTOMY AND RADIOTHERAPY FOR PROSTATE CANCER
Presented By: Divya Ajay, MD, MPH
PROGRAM SCHEDULE

Poster #14  GENDER REPRESENTATION IN UROLOGICAL SUBSPECIALTIES
Presented By: Oluwarotimi S. Nettey, MD

Poster #15  DO PATIENTS DISCONTINUE OVERACTIVE BLADDER MEDICATIONS AFTER SACRAL NEUROMODULATION?
Presented By: Katherine Amin, MD

Poster #16  EVALUATING THE CLINICAL OUTCOMES OF PRENATALLY DIAGNOSED MODERATE TO SEVERE HYDRONEPHROSIS AT A SINGLE INSTITUTION.
Presented By: Kathryn R. Trandem, MD, PhD

Saturday, January 20, 2018

OVERVIEW

6:30 a.m. - 5:30 p.m.  Registration/Information Desk Open
Location: Lower Level Pre-Function

7:00 a.m. - 8:00 a.m.  Breakfast with Exhibitors
Location: Salon 2

7:00 a.m. - 1:00 p.m.  Exhibit Hall Open
Location: Salon 2

4:00 p.m. - 5:00 p.m.  The Big Free Book Signing with Dr. Martha Boone
Location: Lower Level Pre-Function
* Not CME accredited

GENERAL SESSION

7:00 a.m. - 7:45 a.m.  YOGA*: Dr. Vinyasa - The Resilience of an Open Heart
Location: Salon 1
Instructor: Lindsey A. Kerr, MD
* Not CME accredited

8:00 a.m. - 8:05 a.m.  Welcome and Announcements
Speakers: Suzette E. Sutherland, MD, MS, FPMRS
Teresa D. Beam, MD, FACS

8:05 a.m. - 8:35 a.m.  Working as a General Urologist in Academia
Speaker: Miriam Hadj-Moussa, MD
8:35 a.m. - 9:05 a.m. The Pregnant Surgeon  
Speaker: Priyanka Gupta, MD

9:05 a.m. - 9:35 a.m. Health Policy Update  
Speakers: Christopher M. Gonzalez, MD, MBA, FACS  
Elizabeth W. Bozeman, MD

9:35 a.m. - 10:05 a.m. Career Options Panel  
Moderator: Teresa D. Beam, MD, FACS  
Panelists: Miriam Hadj-Moussa, MD  
Lindsey A. Kerr, MD  
Elizabeth A. Williams, MD  
Claire C. Yang, MD

10:05 a.m. - 10:10 a.m. The Big Free*  
Speaker: Martha B. Boone, MD  
*Not CME accredited

10:10 a.m. - 10:30 a.m. Break with Exhibitors  
Location: Salon 2

10:30 a.m. - 11:00 a.m. When Is A Child Just a Little Adult? Pediatric Nephrolithiasis for the General Urologist  
Speaker: Kristina D. Suson, MD

11:00 a.m. - 11:30 a.m. Treatment of Stones for the Pregnant Patient  
Speaker: Michelle J. Semins, MD

11:30 a.m. - 12:00 p.m. UTIs: Acute and Chronic  
Speaker: Suzette E. Sutherland, MD, MS, FPMRS

12:00 p.m. - 1:00 p.m. Lunch in Exhibit Hall  
Location: Salon 2

1:00 p.m. - 2:30 p.m. Resident Podium Session  
Moderators: Anne P. Cameron, MD, FPMRS  
Lindsey A. Herrel, MD, MS  
Michelle J. Semins, MD

1:00 p.m. #1 SERIOUS GAMES: COMPETITION VS. INCENTIVES TO ENGAGE RESIDENTS IN QUALITY IMPROVEMENT EDUCATION  
Presented By: Ashley C. Wietsma, MD

1:09 p.m. #2 GENDER-BASED DIFFERENCES ASKED OF UROLOGY APPLICANTS DURING RESIDENCY INTERVIEWS  
Presented By: Ashima Singal, MD
1:18 p.m. #3  THE PRESENCE OF GENDER BIAS IN LETTERS OF RECOMMENDATION FOR UROLOGY RESIDENT APPLICANTS
Presented By: Pauline L. Filippou, MD

1:27 p.m. #4  HUMAN PAPILLOMA VIRUS INFECTION IS ASSOCIATED WITH INCREASED IRRITATIVE LOWER URINARY TRACT SYMPTOMS IN WOMEN
Presented By: Michelle Kim, MD, PhD

1:36 p.m. #5  IMPROVEMENTS IN POST-OPERATIVE FOLEY CATHETER EDUCATION THROUGH AUDIO-VISUAL MEDIA
Presented By: Michelle Kim, MD, PhD

1:45 p.m. #6  GENDER, GEOGRAPHIC, AND PROFESSIONAL TRENDS IN THE USE OF TWITTER BY UROLOGISTS
Presented By: Arthi Satyanarayan, MD

1:54 p.m. #7  THE ROLE OF IL-10 IN UNILATERAL URETERAL OBSTRUCTION: REGULATION OF EXTRACELLULAR MATRIX AND FIBROSIS
Presented By: Bethany R. Desroches, MD, MS

2:03 p.m. #8  AMBULATORY CARE UTILIZATION AMONG PATIENTS WITH SPINA BIFIDA
Presented By: Courtney L. Shepard, MD, MS

2:12 p.m. #9  WORKPLACE BULLYING OF UROLOGY RESIDENTS: IMPLICATIONS FOR THE PATIENT AND PROVIDER
Presented By: Mashrin L. Chowdhury, DO

2:21 p.m. #10  THE ASSOCIATION OF PTSD AND CHRONIC PROSTATITIS/CHRONIC PELVIC PAIN SYNDROME IN YOUNG MALE VETERANS
Presented By: Michelle E. Van Kuiken, MD

2:30 p.m. - 4:00 p.m.  Keynote Address: Collaborative Negotiation- Colleague and Patient Relationship Management
Speaker: Elaine S. Rosenblum

4:00 p.m. - 5:00 p.m.  Mentoring Session
Location: Salon 1
Moderator: Kathleen Kieran, MD, MS, MME

6:00 p.m. - 7:00 p.m.  Past Presidents' Reception
Location: MonteLago Ballroom
PROGRAM SCHEDULE

7:00 p.m. - 10:00 p.m.  President’s Banquet and Keynote: Words in the Now  
Location: MonteLago Ballroom  
Speaker: Elaine S. Rosenblum

Sunday, January 21, 2018

OVERVIEW
7:00 a.m. - 11:00 a.m.  Registration/Information Desk Open  
Location: Lower Level Pre-Function 1

GENERAL SESSION
8:00 a.m. - 10:00 a.m.  Mock Oral Boards  
Instructor: Melissa R. Kaufman, MD, PhD

8:00 a.m. - 11:00 a.m.  Concomitant Book Discussion*/Networking Breakfast  
Location: Salon 1  
Speaker: Martha B. Boone, MD  
*Not CME accredited
Teresa D. Beam, MD, FACS
Urology of Indiana
Noblesville, Indiana

Martha B. Boone, MD
Alpharetta, Georgia

Elizabeth W. Bozeman, MD
Associated Medical Professionals of NY, PLLC
Fulton, NY

Anne P. Cameron, MD, FPMRS
University of Michigan
Ann Arbor, Michigan

Clare E. Close, MD, FAAP, FACS
Henderson, Nevada

Christopher M. Gonzalez, MD, MBA, FACS
Case Western Reserve University
Cleveland, OH

Priyanka Gupta, MD
University of Michigan
Ann Arbor, Michigan

Miriam Hadj-Moussa, MD
Ann Arbor, Michigan

Jennifer Hah, MD, MS
Pain Management Clinic
Redwood City, California

Melissa R. Kaufman, MD, PhD
Vanderbilt University
Nashville, Tennessee

Lindsey A. Kerr, MD
EMMC Pelvic Care and Continence Specialists
Bangor, Maine

Kathleen Kieran, MD, MS, MME
University of Washington/Seattle Children’s Hospital
Seattle, Washington

Stacy Loeb, MD, MSc
New York University
New York, New York

Jane L. Miller, MD, FPMRS
University of Washington
Seattle, Washington

Jeannette M. Potts, MD
San Jose, California

Elaine S. Rosenblum
ProForm U®
Atlanta, Georgia

Michelle J. Semins, MD
University of Pittsburgh
Pittsburgh, Pennsylvania

Anne M. Suskind, MD, MS
University of California, San Francisco
San Francisco, California

Kristina D. Suson, MD
Children’s Hospital of Michigan
Detroit, Michigan

Suzette E. Sutherland, MD, MS, FPMRS
University of Washington
Seattle, Washington

Elizabeth A. Williams, MD
Urology Consultants, Ltd
St. Louis, Missouri

Claire C. Yang, MD
University of Washington
Seattle, Washington
In accordance with the ACCME Accreditation Criteria, Creighton University Health Sciences Continuing Education, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. Therefore, it is mandatory that both the program planning committee and speakers complete disclosure forms. Members of the program committee were required to disclose all financial relationships and speakers were required to disclose any financial relationship as it pertains to the content of the presentations. The ACCME defines a ‘commercial interest’ as “any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients”. It does not consider providers of clinical service directly to patients to be commercial interests. The ACCME considers “relevant” financial relationships as financial transactions (in any amount) that may create a conflict of interest and occur within the 12 months preceding the time that the individual is being asked to assume a role controlling content of the educational activity.

The requirement for disclosure is not intended to imply any impropriety of such relationships, but simply to identify such relationships through full disclosure and to allow the audience to form its own judgments regarding the presentation.

<table>
<thead>
<tr>
<th>PLANNING COMMITTEE / CME ORGANIZERS</th>
<th>DISCLOSURE</th>
<th>Company</th>
<th>Role with Commercial Interest</th>
<th>Nature of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEAM, MD, FACS, Teresa</td>
<td></td>
<td></td>
<td>Nothing to disclose</td>
<td></td>
</tr>
<tr>
<td>CAMERON, MD, FPMRS, Anne</td>
<td>Medtronic</td>
<td>Grant/Research Support</td>
<td>Grant/Research Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wellspect</td>
<td>Honorarium</td>
<td>Speaker</td>
<td></td>
</tr>
<tr>
<td>LAMB, PhD, HCLD, Dolores</td>
<td>NIH</td>
<td>Grants/Research Support</td>
<td>Grants/Research Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Celmatix</td>
<td>Consultant</td>
<td>Consulting</td>
<td></td>
</tr>
<tr>
<td>SUTHERLAND, MD, MS, FPMRS, Suzette</td>
<td>Allergan, FemPulse</td>
<td>Grants/Research Support</td>
<td>Grant/Research Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axonics</td>
<td>Consultant</td>
<td>Consulting</td>
<td></td>
</tr>
<tr>
<td>WILLIAMS, MD, Elizabeth</td>
<td></td>
<td></td>
<td>Nothing to disclose</td>
<td></td>
</tr>
<tr>
<td>SPEAKERS / MODERATORS / PANELISTS / DISCUSSANTS / CO-AUTHORS</td>
<td>DISCLOSURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Company</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Role with Commercial Interest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nature of Relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEAM, MD, FACS, Teresa CME Organizer, Speaker, Moderator</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOZEMAN, MD, Elizabeth Speaker</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMERON, MD, FPMRS, Anne CME Organizer, Moderator</td>
<td>Medtronic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grants/Research Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grant/Research Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wellspect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Honorarium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHOWDHURY, DO, Mashrin Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHOWDHURY, DO, Mashrin Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLOSE, MD, Clare Speaker</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DESROCHES, MD, Bethany Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FILIPPOU, MD, Pauline Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GONZALEZ, MD, MBA, FACS, Christopher Speaker</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GUPTA, MD, Priyanka Speaker</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HADJ-MOUSSA, MD, Miriam Speaker, Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPEAKERS / MODERATORS / PANELISTS / DISCUSSANTS / CO-AUTHORS</td>
<td>DISCLOSURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Company</td>
<td>Role with Commercial Interest</td>
<td>Nature of Relationship</td>
<td></td>
</tr>
<tr>
<td>HAH, MD, MS, Jennifer Speaker, Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HERREL, MD, MS, Lindsey Moderator</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KAUFMAN, MD, PhD, Melissa Instructor</td>
<td>Cook Myosite Consultant</td>
<td>Global Principle Investigator</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Boston Scientific Corporation Honorarium</td>
<td>Faculty for Resident Cadaver Course</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KERR, MD, Lindsey Speaker, Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KIERAN, MD, MS, MME, Kathleen Moderator</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KIM, MD, PhD, Michelle Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sanofi Other Financial or Material Support</td>
<td>Reimbursed Travel to PCF Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOEB, MD, MSc, Stacy Speaker</td>
<td>Astellas Honorarium</td>
<td>Honorarium for Lectures and Reimbursed Travel</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lilly Consultant</td>
<td>Consulting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Genomic Health Consultant</td>
<td>1 consulting call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MILLER, MD, FPMRS, Jane Speaker, Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POTTS, MD, Jeannette Speaker, Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPEAKERS / MODERATORS / PANELISTS / DISCUSSANTS / CO-AUTHORS</td>
<td>DISCLOSURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROSENBLUM, Elaine Speaker</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SATYANARAYAN, MD, Arthi Abstract Presenter, Abstract Co-Author</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEMINS, MD, Michelle Jo Speaker, Moderator</td>
<td>Boston Scientific Corporation Consultant Medical Advisory Board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHEPARD, MD, Courtney Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SINGAL, MD, Ashima Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SINGAL, MD, Ashima Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUSKIND, MD, MS, Anne Speaker</td>
<td>NIDDK KURE K12 Award; NIA GEMSSTAR R03 Grants/Research Support Research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SUFU/Pfizer Grants/Research Support Research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acoustic Wave Cell Therapy Consultant Research Consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUSON, MD, Kristina Speaker</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUTHERLAND, MD, MS, FPMRS, Suzette CME Organizer, Speaker</td>
<td>Allergan, FemPulse Grants/Research Support Grant/Research Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axonics Consultant Consulting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAN KUIKEN, MD, Michelle Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPEAKERS / MODERATORS / PANELISTS / DISCUSSANTS / CO-AUTHORS</td>
<td>DISCLOSURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company</td>
<td>Role with Commercial Interest</td>
<td>Nature of Relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WIETSMA, MD, Ashley</td>
<td>Abstract Presenter</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WILLIAMS, MD, Elizabeth</td>
<td>CME Organizer, Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YANG, MD, Claire</td>
<td>Panelist</td>
<td>Nothing to disclose</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Introduction: Healthcare systems increasingly link patient safety and quality measures to outcomes. Additionally, under the aegis of the ACGME, quality improvement (QI) education is required for urology residents. Competing demands of clinical care, other curricular topics, and lack of resources and faculty expertise challenge the implementation of a QI curriculum. To enhance learner participation, we assessed engagement of urology trainees with our web-based QI learning platform in two incentive environments. Our objective was to compare the effect of team-based competition versus individual incentives on resident engagement.

Methods: We conducted a multicenter cluster randomized trial of ACGME-accredited urology residency programs stratified by size. Programs were randomized to one of two conditions: a team-based competition environment or an individual incentive environment. In both, residents participated in an identical QI program on Qstream®, a web-based, mobile-device-compatible platform. Twice weekly for 12 weeks, residents received an email link to the platform that introduced 20 clinical-scenario-based questions. After answering each question, feedback and explanations were provided. In the team-based competition environment, weekly leader boards displayed team standings. In the individual incentive arm, residents were eligible for a weekly loss-aversion lottery that required the winner be current on attempted questions. Our primary outcome was percentage of questions attempted. Secondary outcomes included participation, defined as attempt of at least 1 question, and mastery, correctly answering a question twice-in-a-row.

Results: We enrolled 453 residents from 36 accredited urology residency programs. More residents participated in the team-based competition than the individual-incentive environment (71% vs. 58%, P=0.005). Residents in the team-based competition not only attempted a greater percentage of questions than those in the individual incentive environment (60% vs. 44% P<0.001), but also mastered a greater percentage of questions (24% vs. 16% P< 0.001). Almost half of residents in the team-based competition, 45%, answered every question versus only one third of those in the individual-incentive arm, 33% (P=0.01).

Conclusion: We demonstrated that team-based competition increases engagement of urology residents in a mobile-device-friendly QI curriculum. The implementation of a standardized QI curriculum would maximize participation through team-based competition. Behavioral interventions such as team-based competition appear useful for increasing resident engagement in learning.
Podium #2
GENDER-BASED DIFFERENCES ASKED OF UROLOGY APPLICANTS DURING RESIDENCY INTERVIEWS
*Ashima Singal, MD; Mary K. Keeter, MPH; Nimali Shah, MD and Stephanie Kielb, MD
Northwestern
Presented By: Ashima Singal, MD

Introduction: Interviews are essential to the residency application process. Questions regarding marital status, child bearing, ethnicity, and religion violate employment law if asked by the interviewer. The purpose of this study was to determine rates of discriminatory questions asked during urology residency interviews and to assess for differences by applicant gender.

Methods: A 22-question anonymous survey was distributed to 340 PGY1 urology applicants at Northwestern University. Questions were asked in a two-part, stepwise fashion. If a candidate replied “no” to whether they introduced a restricted topic, they were subsequently asked how often interviewers introduced the topic.

Results: The overall survey response rate was 50% (n=170). Three individuals were excluded as they did not attend any urology interviews. Of the 167 included respondents, 127 (76.1%) were male and 40 (23.9%) were female. Overall, 35% of respondents believed they were asked an inappropriate question during urology residency interviews. This did not differ significantly by gender, with 43.2% of females reporting being asked an inappropriate question compared to 32.2% of males (p=0.2185). Of the seven restricted topics assessed by this survey, 54.5% of respondents reported being asked at least one unprompted illegal question. An overwhelming majority of females, 85% compared to 44.9% of males, reported being asked about one of the restricted topics from the survey (p<0.0001).

Conclusion: An alarming percentage of urology applicants are asked interview questions that violate employment law. Females are disproportionately questioned about age, parental status and intent for children. Education of interviewers regarding legally restricted questions is warranted.
Podium #3
THE PRESENCE OF GENDER BIAS IN LETTERS OF RECOMMENDATION FOR UROLOGY RESIDENT APPLICANTS
*Pauline L. Filippou, MD¹; Sejal Mahajan²; Allison Deal, MS²; Eric M. Wallen, MD¹; Raj S. Pruthi, MD¹; Hung-Jui Tan, MD¹ and Angela B. Smith, MD, MS¹
¹Department of Urology, University of North Carolina; ²University of North Carolina
Presented By: Pauline L. Filippou, MD

Introduction: Though changing, urology continues to be a male-dominated specialty. Multiple factors may contribute to the underrepresentation of women in urology. To determine whether implicit gender bias exists during the urology residency application process, we compared linguistic differences in letters of recommendation (LORs) submitted for male and female applicants.

Methods: From applications submitted to our urology residency program for the 2016-2017 application cycle, we abstracted LORs written by practicing urologists in the United States. To characterize linguistic patterns, we used a validated text analysis software program, Linguistic Inquiry and Word Count 2015. Analyzed LORs were compared according to gender of the applicant and letter author using two-sided student’s t-test and multivariable analysis was performed using a repeated measures model.

Results: A total of 243 males and 110 females applied to our residency program. Of 460 LORs analyzed abstracted, 420 were written by male urologists, and 40 by female urologists. When stratified by gender of letter writer, LORs written about male and female applicants contained significant differences in linguistic styles. LORs for male applicants written by male urologists were written in a more analytical and authentic while less emotional tone compared to letters written for female applicants (Table 1). Letters written for male applicants contained significantly more references to personal drive (p=0.03) and work (p=0.02) than letters written for female applicants. These differences were not observed on analysis of LORs written by women urologists. These significant differences were maintained on multivariable analysis when controlling for race and Step 1 score of the applicant.

Conclusion: Significant linguistic differences exist among LORs written for men and women applying into urology that differ based on gender of letter writer, suggesting that gender bias may permeate this aspect of resident recruitment.

<table>
<thead>
<tr>
<th>Letter Characteristics</th>
<th>Male applicant (mean, SD)</th>
<th>Female applicant (mean, SD)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Letter Writers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Words Per Letter</td>
<td>358 (140)</td>
<td>385 (129)</td>
<td>0.05</td>
</tr>
<tr>
<td>Analytic Voice (/100)</td>
<td>84.8 (9.1)</td>
<td>82.7 (9.4)</td>
<td>0.03</td>
</tr>
<tr>
<td>Authenticity (/10)</td>
<td>9.46 (7.9)</td>
<td>7.69 (7.5)</td>
<td>0.03</td>
</tr>
<tr>
<td>Emotional Tone (/100)</td>
<td>93.3 (8.2)</td>
<td>94.7 (6.0)</td>
<td>0.06</td>
</tr>
<tr>
<td>Female Letter Writers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Words Per Letter</td>
<td>360 (87)</td>
<td>358 (110)</td>
<td>0.96</td>
</tr>
<tr>
<td>Analytic Voice (/100)</td>
<td>87.5 (7.9)</td>
<td>87.4 (8.2)</td>
<td>0.95</td>
</tr>
<tr>
<td>Authenticity (/10)</td>
<td>8.88 (6.9)</td>
<td>8.68 (6.4)</td>
<td>0.92</td>
</tr>
<tr>
<td>Emotional Tone (/100)</td>
<td>92.8 (12.9)</td>
<td>93.1 (6.0)</td>
<td>0.93</td>
</tr>
</tbody>
</table>
Podium #4
HUMAN PAPILLOMA VIRUS INFECTION IS ASSOCIATED WITH INCREASED IRRITATIVE LOWER URINARY TRACT SYMPTOMS IN WOMEN
*Michelle Kim, MD, PhD¹ and Evgeniy Kreydin, MD²
¹MGH; ²USC
Presented By: Michelle Kim, MD, PhD

Introduction: Viral infections are a well-known, albeit rare, cause of voiding dysfunction. Human immunodeficiency virus and varicella zoster virus infections have both been associated with lower urinary tract symptoms (LUTS). However, the relationship between voiding dysfunction and human papillomavirus (HPV), one of the most prevalent genital viral pathogens, has not been previously assessed. Therefore, the purpose of this study was to determine whether genital infection with HPV was associated with LUTS in females.

Methods: Data were analyzed for 4520 females between the ages of 18 and 59 who underwent vaginal swab analysis for 37 HPV genotypes as part of the 2006-2012 cycles of the National Health and Nutrition Examination Survey. HPV infection was designated either low risk (if any of the 11 most common low-risk types were present) or high risk (if any of the 14 most common high-risk types were present). Associations between HPV infection and self-reported stress incontinence, urge incontinence and nocturia were assessed using weighted variance-corrected logistic regression models adjusted for age, body mass index, diabetes, race and parity.

Results: Infection with low-risk HPV genotypes was associated with increased likelihood of nocturia (OR 1.25, 95%CI 1.07-1.46) and urge incontinence (OR 1.29, 95%CI 1.04-1.60), while infection with high-risk HPV genotypes was not associated with any LUTS. No association was found between stress incontinence and HPV infection.

Conclusion: This study demonstrates a novel association between low-risk genital HPV infection and irritative LUTS in females. No association between high-risk genotypes and LUTS were found. High- and low-risk HPV genotypes have distinct tissue tropism and proliferative properties and this may account for this difference. To our knowledge, association between HPV infection and LUTS in females has not been previously described. The presence of squamous epithelium in the urethra and latency of HPV DNA in human urine suggests a site of infection and hypothetical mechanism for such an association.
Podium #5
IMPROVEMENTS IN POST-OPERATIVE FOLEY CATHETER EDUCATION THROUGH AUDIO-VISUAL MEDIA
*Michelle Kim, MD, PhD and Shahin Tabatabaei, MD
MGH
Presented By: Michelle Kim, MD, PhD

Introduction: Our objective was to assess the effects of providing AV aids in conjunction with standard forms of written instructions about urinary catheter care in terms of satisfaction, comprehension and recall of the information provided. Healthcare literacy remains an important aspect of patient care. Health illiteracy itself was found to be an independent risk factor for hospital admission among elderly managed care enrollees even after adjusting for demographics, socioeconomic status, health behavior, chronic diseases and self-reported health. This was estimated to cost $30-73 billion dollars annually. Current trends to improve literacy have focused on new modes of information delivery including the development of audio-visual (AV) aids. The development of audio-visual media that is easily comprehensible and readily available to patients during their hospitalization may be a more effective strategy to improve patient education. In informal surveys of urology patients, catheter care at home was found to be one of the most daunting aspects of a prostatectomy. Our goal was to develop a catheter audio-visual (AV) aid that could deliver pertinent and standardized instructions to patients and allow them to review the material in a visual format. This may help to answer many of the common questions asked by patients prior to discharge and reinforce the information discussed with health care professionals.

Methods: AV aids were created for patients going home with a urinary catheter based on the written instructions provided. Patients were randomized to receiving the standard catheter written instructions with nursing teaching or receiving the standard instructions with nursing teaching in addition to an AV aid. Patients were given surveys prior to discharge as well as two weeks after discharge after the catheter was removed.

Results: Eighty-one patients were enrolled in the study of which 27 were enrolled in the control arm and 54 in the experimental arm. Patient characteristics were similar between the two groups. Patient satisfaction was higher in the AV aid group relative to the control group. Patient calls were also slightly lower in the AV aid group compared to the control group. Overall patient comprehension of the information, quality of life and health care utilization was similar between the two groups.

Conclusion: Audio-visual aids are a promising avenue to improve patient literacy in surgical care. Further research should be sponsored to improve access to audio-visual aids for patients, which may improve care but also decrease health care costs.
Podium #6
GENDER, GEOGRAPHIC, AND PROFESSIONAL TRENDS IN THE USE OF TWITTER BY UROLOGISTS
*Arthi Satyanarayan, MD²; Kathryn Marchetti, BS¹; Deborah Hess, MD²; Maude Carmel, MD² and Rena Malik, MD²
¹University of Michigan Medical School; ²University of Texas Southwestern Medical Center
Department of Urology
Presented By: Arthi Satyanarayan, MD

Introduction: Twitter is a real-time social media platform used to engage in discussion worldwide on urologic topics. Our objective was to determine trends in gender, geography, professional affiliation, and quantity of urologic related information on Twitter.

Methods: We identified registered Twitter accounts from the published roster of presenters at the American Urological Association (AUA) Annual Meeting in 2017. Twitter biographies were reviewed to collect self-published data on gender, training, position, geographic, and academic affiliation. If academic affiliation was unknown on Twitter, this was cross-referenced to AUA biographies. We reviewed each subject’s most recent 10 tweets for urology-related content from August 2017 and moving chronologically back by 10 tweets. Demographic data for United States (US) based urologists were compared to the 2016 AUA Census Data.

Results: Of 432 AUA 2017 presenters with Twitter, 403 had public accounts to view and 393 (97.5%) were urologists. Of those, 12 (3.1%) were in private practice and 330 (84.0%) were academic, compared to 59.1% and 25.5%, respectively, in the AUA census. Of all registered accounts of female US-based attending/practicing urologists, 16 (34.0%) females had an academic affiliation. Urologists in training (residents and fellows) represented 60 (15.8%) of Twitter users, with 45 (11.5%) as US-based trainees. Only 9 (2.3%) were females from the US. The majority of urologists (62.1%) frequently tweeted urology related information (greater than 5 of the last 10 tweets). There was no significant difference between gender and number of urology related tweets in academic-affiliated urologists (p>0.1).

Conclusion: Trainees and practicing physicians are active on Twitter with a majority frequently tweeting urology-related content. Of those registered for AUA 2017, female academic practitioners are similarly represented, but private practice physicians and female trainees are underrepresented compared to national census data.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Individuals</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>59</td>
<td>15.0</td>
</tr>
<tr>
<td>Male</td>
<td>321</td>
<td>61.7</td>
</tr>
<tr>
<td>Unknown</td>
<td>13</td>
<td>3.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Individuals</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>223</td>
<td>56.7</td>
</tr>
<tr>
<td>International</td>
<td>108</td>
<td>27.5</td>
</tr>
<tr>
<td>Unknown</td>
<td>62</td>
<td>15.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Model</th>
<th>Number of Individuals</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic (US)</td>
<td>285</td>
<td>67.4</td>
</tr>
<tr>
<td>Academic (International)</td>
<td>65</td>
<td>16.5</td>
</tr>
<tr>
<td>Private Practice (US)</td>
<td>12</td>
<td>3.1</td>
</tr>
<tr>
<td>Unknown</td>
<td>51</td>
<td>13.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urology Related Tweets</th>
<th>Number of Individuals</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 (All)</td>
<td>85</td>
<td>21.6</td>
</tr>
<tr>
<td>Greater than 5 (Most)</td>
<td>159</td>
<td>40.5</td>
</tr>
<tr>
<td>Less than 5 (Some)</td>
<td>96</td>
<td>24.4</td>
</tr>
<tr>
<td>0 (None)</td>
<td>53</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Table 1: AUA 2017 Registered Urologists on Twitter (n=393)
THE ROLE OF IL-10 IN UNILATERAL URETERAL OBSTRUCTION: REGULATION OF EXTRACELLULAR MATRIX AND FIBROSIS
*Bethany R. Desroches, MD, MS¹; Xinyi Wang, PhD²; Pu Duann, PhD²; Meredith Rae, BS²; Hu Li, PhD²; Swathi Balaji, PhD² and Sundeep Keswani, MD²
¹Baylor College of Medicine; ²Center for Regenerative Tissue Repair, Texas Children’s Hospital, Houston, TX
Presented By: Bethany R. Desroches, MD, MS

Introduction: Even with prompt surgical intervention, unilateral ureteral obstruction (UUO) can cause significant fibrosis and kidney function impairment that currently has no treatment options. Previous reports suggest the anti-inflammatory cytokine, interleukin-10 (IL-10), attenuates fibrosis in a murine model. We have previously shown a novel role for IL-10 in dermal fibrosis, regulating the ECM - specifically hyaluronan (HA) and TGFβ isoforms, crucial for regenerative tissue repair. The roles of IL-10 and HA in renal fibrosis have not been fully elucidated. We hypothesize that IL-10 regulates renal HA and TGFβ expression and attenuates renal fibrosis in a murine UUO model.

Methods: 8 week-old C57BL/6J (WT) and IL-10 null male mice were injected with lenti-IL-10/lenti-GFP (1x10¹⁰ IU) under the renal capsule. Three days after injection, UUO was performed. 14 days after UUO, UUO/sham kidneys and serum were collected for RNA, ELISA and immunohistochemical analysis of HA synthases, hyaluronidases 1, 2 (HYAL1-2) and TGFβ-1. Fibroblasts were isolated from 8-10 week-old male WT mice. IL-10 (200 ng/ml) with or without HYAL1-2 (1.5 unit/ml) was added to cultures. HA matrices were analyzed by particle-exclusion assay at 24h. Gene expression HAS-1,2, 3, HYAL 1, 2 and TGFβ-1 were assessed by qPCR at 1, 2, 3 and 6 h. Data presented as mean±SD, n=3/treatment group. P value by ANOVA.

Results: IL-10 treatment, in vitro, resulted in an upregulation of HAS-1,2, and 3 expression at 2h after treatment and a downregulation of HYAL 1, 2 and TGFβ-1. IL-10 resulted in a 1.88-fold increase in HA-rich matrix formation at 24h, and the effect was abolished by HYAL treatment (p<0.05). In vivo, IL-10 KO mice with UUO demonstrated more fibrosis than WT mice. In both WT and IL-10 KO mice, lenti-IL-10 treatment resulted in less dilated tubules and decreased fibrosis, as and reduced α-SMA expression as compared to sham treated kidneys. In serum of lenti-IL-10 treated mice, HA level was 1.7-fold higher than that of lenti-GFP treated (p<0.05), with 3-fold increase in ratio between TGFβ-3 to TGFβ-1.

Conclusion: UUO can cause remodeled renal architecture and decrease in renal function. We have shown IL-10 regulates renal fibroblasts’ HA metabolism and TGFβ expression in vitro, and validated the effect of IL-10 in our murine UUO model. We show that endogenous IL-10 is essential for normal kidney integrity against excessive fibrosis with UUO injury. This previously unreported mechanism of the regulation of kidney ECM by IL-10 may aid in therapies to prevent or ameliorate kidney fibrosis due to ureteral obstruction.
Podium #8
AMBULATORY CARE UTILIZATION AMONG PATIENTS WITH SPINA BIFIDA
*Courtney L. Shepard, MD, MS; Ella Doerge, MD; Kate Kraft, MD; Julian Wan, MD and John Stoffel, MD
University of Michigan
Presented By: Courtney L. Shepard, MD, MS

Introduction: Effective transitional care for patients with spina bifida can help decrease preventable hospitalizations and emergency department utilization and best prepare these patients for adulthood. However, implementing transitional care is problematic, with many patients failing to transition or to follow-up altogether. A major barrier to providing successful transitional care is the lack of understanding of how the health care needs of these patients evolve as they age. The goal of this study is to evaluate the changes in ambulatory care needs of these patients with age in order to strategize for a more effective transitional care model.

Methods: Using ICD-9 codes, we identified all patients with SB who made a visit to any outpatient department within a single integrated health care system over a one-year period. Patients were categorized as pediatric (<18 years old and seen in pediatric clinics), adult (≥18 years seen only in adult clinics), and failed to transition (FT) (≥18 years but still seen in at least one pediatric clinic). We evaluated the frequency with which each group visited the various clinics.

Results: Over one year, 763 SB patients (382 pediatric, 88 FT, and 293 adult) had a total of 4,931 visits to 76 different clinics. The mean number of outpatient visits per year decreased with patient age: 7.3 for pediatric, 6.8 for FT, and 5.3 for adults (p=0.046). The type of clinic visited also changed with age, with children most commonly visiting surgery clinics (52.3% of visits) and adults most commonly visiting medical clinics (48.9%) (p<0.005). While the number of visits to neurosurgeons and orthopedic surgeons decreased over time, the number of visits to urologists remained more consistent.

Conclusion: The health care needs of SB patients change over time, with children utilizing more surgically-focused care and adults utilizing more medically-focused care. These findings indicate that SB patients may most benefit from a transition model centered on a primary care medical home. No matter the transition model used, the high utilization of urologic care across the age spectrum indicates...
Podium #9
WORKPLACE BULLYING OF UROLOGY RESIDENTS: IMPLICATIONS FOR THE PATIENT AND PROVIDER
*Mashrin L. Chowdhury, DO; Maha Husainat, MD and Kristina Suson, MD
Detroit Medical Center
Presented By: Mashrin L. Chowdhury, DO

Introduction: Workplace bullying is seen across many fields and has been extensively investigated over time. While bullying of nurses has been studied, there are few reports that evaluate resident interactions, especially with nurses. Our primary objective is to elucidate whether urology residents in the United States feel bullied and if this impacts patient care.

Methods: After receiving IRB approval, we created an online survey via Google Forms using the validated, revised Negative Acts Questionnaire (NAQ-R), which is divided into Work (total range 5-25), Person (total range 9-45), and Physical Intimidation (total range 3-15) Related bullying. Additionally, we solicited how respected residents feel by different staff on a Likert scale. ACGME and AOA urology program coordinators and directors in the United States were asked to distribute our anonymous, voluntary survey to their residents in their first year or above.

Results: A total of 102 unique responses were received (82% MD, 18% DO). The average age was 30.8±0.3 years old. Only one resident reported never experiencing bullying. The mean total bullying score was 28.9±0.9 (17-68). By category: 98.0% of residents reported at least one incident of Work Related bullying with a mean domain score of 11.3±0.4 (5-22); 82.4% reported at least one incident of Person Related bullying with mean domain score of 13.9±0.5 (9-38); 77.5% reported at least one incident of Physical Intimidation Related bullying with a mean domain score of 3.8±0.1 (3-10). DO residents reported higher mean total bullying scores than MD residents (33.7±2.2 vs 27.8±1.0, p=0.015). There was no difference in the mean total bullying score if the nurse was of the same or opposite gender (30.3±1.6 vs 29.6±1.3, p=0.753), or same or opposite race (30.1±1.4 vs 29.7±1.4, p=0.833). The impact of bullying on personal and patient outcomes is presented in the table. Residents in the top total respect score quartile had lower mean total bullying scores than those at the bottom (24.7±1.0 vs 34.9±2.2, p<0.001).

Conclusion: The vast majority of residents perceived at least some degree of bullying. In many instances, bullying negatively impacted resident performance and patient outcomes, especially those who experienced the most bullying. Programs which nurture positive nurse-resident relationships and those in which residents felt respected were associated with less perceived bullying.

---

### Table: Personal Effects/Outcomes of Workplace Bullying

<table>
<thead>
<tr>
<th>Effect</th>
<th>Yes (%)</th>
<th>Mean (SE)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you fear retaliation if you report bullying?</td>
<td>34.4±1.8</td>
<td>0.061</td>
<td></td>
</tr>
<tr>
<td>Has bullying affected your performance in residency?</td>
<td>36.6±2.0</td>
<td>0.061</td>
<td></td>
</tr>
<tr>
<td>Has an out of your control. bullying negatively affected patient outcomes?</td>
<td>36.7±1.7</td>
<td>0.061</td>
<td></td>
</tr>
<tr>
<td>Have you considered transferring residency program or specialties due to bullying?</td>
<td>30.6±1.9</td>
<td>0.061</td>
<td></td>
</tr>
<tr>
<td>Is the nature of your current one which nurtures the resident/resident relationship?</td>
<td>24.9±1.9</td>
<td>0.061</td>
<td></td>
</tr>
<tr>
<td>Have you believed in a way which some might consider bullying?</td>
<td>31.0±2.2</td>
<td>0.061</td>
<td></td>
</tr>
</tbody>
</table>

*p Mean Total Bullying Score
THE ASSOCIATION OF PTSD AND CHRONIC PROSTATITIS/CHRONIC PELVIC PAIN SYNDROME IN YOUNG MALE VETERANS

Marah Hehemann, MD²; *Michelle E. Van Kuiken, MD²; Bella Etingen, PhD¹; Frances Weaver, PhD¹ and Jeffrey Branch, MD²
¹Hines VA; ²Loyola University Medical Center
Presented By: Michelle E. Van Kuiken, MD

Introduction: Men with chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) are two times more likely to report mental health diagnoses such as anxiety and depression. Additionally, men reporting a history of sexual abuse are at increased risk for symptoms of CP/CPPS. Male veterans with mental health diagnoses are also at increased risk of lower urinary tract symptoms. We hypothesize that an association exists between CP/CPPS and post-traumatic stress disorder (PTSD) in young male veterans, and that these veterans may be more likely to report a history of sexual trauma or be subject to invasive urologic procedures.

Methods: We reviewed VA administrative data from October 1, 2010 to September 30, 2015 for male veterans, ages 18-45 diagnosed with PTSD (ICD-9 code 309.81). Medical records were then examined for pelvic pain diagnoses including chronic pelvic pain (789.09; 338.29, 625.5, 788.99, 788.99, 596.9, 599/599.8, 625.5), chronic prostatitis (601.0, 601.1, 601.9, 600.90-1, 600.0-1; 601.8, 602.8) and pain associated with voiding (788.1, 788.6). Veterans with diagnoses of spinal cord injury and neurogenic bladder were excluded. Records were examined for ICD-9 diagnoses of history of sexual trauma (general, military or any) and CPT codes for cystoscopic, urodynamic, bladder outlet and prostatic ultrasound procedures. Data were obtained for a preparatory-to-research pull.

Results: Our initial database query yielded approximately 392,000 veterans with a diagnosis of PTSD and 1.3 million veterans without documented PTSD. Veterans with PTSD were more likely to have a diagnosis of CP/CPPS than their non-PTSD counterparts (18.5% vs. 8.7%, p<0.001). Veterans with PTSD were more likely to have a history of military sexual trauma (2.8% vs. 0.5%, p<0.001) or non-military sexual trauma (0.4% vs. <0.1%, p<0.001) compared to veterans without PTSD. Young veterans with PTSD were also more likely to have a cystoscopy (0.8% vs. 0.5%, p<0.001) and/or undergo urodynamics (1.0% vs. 0.5%, p<0.001) versus those without PTSD. Rates of prostatic procedures such as transrectal ultrasound or bladder outlet procedure were not significantly different between the two groups.

Conclusion: Young male veterans with PTSD are twice as likely to carry a diagnosis of CP/CPPS. Those with PTSD and CP/CPPS are six times more likely to report a history of sexual trauma and are twice as likely to undergo a urologic procedure. We recommend improved assessment for sexual trauma and consideration of referral to mental health providers by urologists treating young male veterans with CP/CPPS.
Poster #1
IMPROVEMENTS IN URETEROSCOPY EFFICIENCY WHEN PERFORMED AT AN AMBULATORY SURGERY CENTER
*Rena Xu, MD, MBA; Timothy Batter, BA¹ and Brian Eisner, MD²
¹Boston University School of Medicine; ²Massachusetts General Hospital
Presented By: Rena Xu, MD, MBA

Introduction: Perioperative efficiency is important for both patient experience and resource allocation. We performed a retrospective review of consecutive ureteroscopic procedures performed by an academic surgeon who operates at an ambulatory surgery center (ASC) and an inpatient facility.

Methods: With IRB approval, de-identified records were obtained for ureteroscopies performed by a single surgeon from April 2016 to June 2017 at a both an ASC and an inpatient facility. Patients who were American Society of Anesthesiologists (ASA) class 1 or 2 were included in the study. Variables of interest were total time (from facility arrival to end of post-procedure care); pre-operative time; surgical time; operating room time; post-operative time; and delay (actual minus scheduled start) time. Covariates were age, sex, ASA class, body mass index, Charlson Comorbidity Index; stone size, quantity, and location; bilateral surgery; case order and ASA class of prior patient. Emergency department (ED) visits within 30 days were also assessed. Analyses were performed using Statistical Package for the Social Sciences (SPSS) software.

Results: One hundred eighty (180) procedures met inclusion criteria – 105 at ASC and 75 at the inpatient facility. Mean operative time was 25 minutes at the ASC and 36 minutes at the inpatient facility (P<0.001). On multiple linear regression, adjusting for covariates that were significant on univariate analysis (stone size, case order), all times were shorter at the ASC than at the inpatient facility (Table 1). On average, patients who underwent ureteroscopy at the ASC spent 158 fewer minutes (standard error 12.9 minutes) in facility. Using Fisher’s exact test, there was no difference in 30-day ED visits (P=0.818).

Conclusion: For the same procedure by the same surgeon, patients spent on average ~2.5 hours less in facility if the procedure was performed at an ASC. Differences in operative times accounted for 7% of the variation, suggesting that perioperative care is the key driver of the differences observed. These results suggest opportunities for process improvement as well as optimization of case allocation between ASCs and inpatient facilities.
Poster #2
MALIGNANCY NEGATIVELY ASSOCIATED WITH BASELINE SEMEN PARAMETERS AMONG SPERM BANKERS
*Rena Xu, MD, MBA; Grace Centola, PhD² and Cigdem Tanrikut, MD¹
¹Massachusetts General Hospital; ²New England Cryogenic Center
Presented By: Rena Xu, MD, MBA

Introduction: Whether various forms of malignancy are associated with diminished semen quality prior to spermatotoxic treatment remains controversial. This retrospective study investigated whether sperm bankers with different types of malignant disease have worse baseline semen parameters as compared to individuals with non-medical indications for banking.

Methods: With IRB approval, de-identified records were obtained for all episodes of sperm banking performed at the New England Cryogenic Center from January 2004 to May 2017 for one of the following reasons: “future use” (e.g., military deployment, at-risk travel, gender reassignment); infertility; benign disease; and malignancy, further categorized as testicular, other genitourinary (GU), solid non-GU, hematologic, or unspecified. Bankers with prior exposure to chemotherapy or pelvic radiation were excluded. For any banker with multiple specimens, the average of semen parameters across encounters was used. Dependent variables of interest were ejaculatory volume, sperm concentration, percent motility, and total motile sperm count (TMSC), as well as post-thaw motile count. Independent T-test and stepwise multiple linear regressions controlling for age were performed, with the “future use” group as reference for the other groups. Additional linear regressions were performed with only significant variables included and with adjustments for interaction with age where relevant.

Results: 1561 patients met the inclusion criteria. In univariate analyses, infertility was associated with age (P=0.044), motility (P=0.004), and TMSC (P=0.005). Hematologic malignancy was associated with motility (P=0.02) and TMSC (P=0.019). In stepwise multiple linear regressions, benign disease was not associated with any variables, while for the infertility group, all measured semen parameters were decreased (all P<=0.004). All subtypes of malignancy were associated with decreased TMSC (all P<=0.002). Testicular malignancy was also associated with decreased sperm concentration (P<0.001) and post-thaw motile count (P<0.001); other GU malignancy, with volume (P<0.001); and hematologic malignancy, with motility (P=0.026).

Conclusion: In addition to bankers with known infertility issues, sperm bankers with malignancy, but not benign disease, had significantly worse baseline semen parameters as compared to individuals banking for non-medical reasons. These results can help to inform patient counseling and consent prior to sperm banking and disease treatment.
Poster #3
OUTCOMES IN PATIENTS WITH KNOWN CONTRAST ALLERGY UNDERGOING CONTRAST-ENHANCED ENDouroLOGICAL PROCEDURES
*Paula Domino, MD, Justin Dersch, MD, Nitin Sharma, MD, Lawrence Caruso, MD, Susan Ford, RN and Vincent Bird, MD
University of Florida
Presented By: Paula Domino, MD

Introduction: Allergic reaction to intravenous (IV) iodinated contrast is a risk in contrast–enhanced radiologic procedures and can be mitigated by appropriate prophylaxis. A known allergy to IV iodinated contrast has not been established as a contraindication to endourologic procedures that require injection of contrast into the urinary tract. It is unclear whether steroid prophylaxis is necessary. We retrospectively evaluated allergic responses of patients with known contrast allergies that underwent endourological procedures requiring contrast and determined the effect, if any, of administering prophylaxis treatment at time of procedure.

Methods: All patients undergoing endourological procedures (2011 to 2015) requiring use of iodinated contrast were identified. Patients with known allergies to iodine, shellfish, and contrast were identified and evaluated for any clinical or hemodynamic signs of allergy during and following the procedure. Intraoperative assessment of allergy was noted by continuous anesthesia monitoring using the following parameters: otherwise unexplained mean arterial pressure < 65 mm Hg or a fall of > 30% from baseline that was sustained for > 15 minutes; otherwise unexplained fall in oxygen saturation and/or unexplained increase in peak inspiratory pressures. Allergic responses were noted along with prophylaxis treatments if used.

Results: A total of 1405 procedures were reviewed. Of these, 86 cases involving 58 patients with contrast allergies were included in our final analysis. Antihistamine and/or steroid prophylaxis was given in 39 (45%) of cases and no prophylaxis was administered in 47 (55%). No allergic responses were seen in both groups. 18 (20.1%) of these cases involved patients with history of anaphylactic reaction to IV iodinated contrast. Of these patients, 11 (61%) received steroid prophylaxis. Using the method of Hanley, the upper limit of the 95% confidence interval for the true risk of significant reaction is 3.5%.

Conclusion: No appreciable contrast allergic reactions were noted for both patients receiving steroid prophylaxis as well as those not receiving prophylaxis, including those with a history of an anaphylactic reaction to iodinated contrast.
Anterior Urethral Valves: Long Term Outcomes from a Single Institution

*Paula Domino, MD²; Kevin Birusingh, MD¹ and Romano DeMarco, MD²

¹The Iowa Clinic; ²University of Florida

Presented By: Paula Domino, MD

Introduction: Anterior urethral valves (AUV) are congenital obstructive lesions found in boys. There is little data reported in the medical literature regarding AUV, particularly in terms of long-term outcomes. We describe our experience in boys with AUV.

Methods: A retrospective review of patients diagnosed with AUV over a 20 year time period was performed. Data recorded included clinical characteristics, mode of presentation, diagnostic studies, surgical intervention, operative findings, complications, and follow-up.

Results: Seven boys were diagnosed with AUV over this time period. Age at presentation ranged from three weeks to 7 years, with an average of 20 months. Presenting signs or symptoms included antenatal hydronephrosis in 3 patients, urinary incontinence in 2, penile bulge in 1, and urinary tract infection in 1. Three patients had associated vesicoureteral reflux (VUR). One boy had grade 2 unilateral VUR, 1 had bilateral grade 3 VUR, while 1 had bilateral grade 5 VUR. Initial treatment included endoscopic ablation in 5 patients and open excision with urethroplasty in 2. At surgery all patients had a dilated urethra proximal to the level of obstruction. Six boys had an associated diverticulum. The location of the AUV was the bulbar urethra in 5, penoscrotal junction in 1, and pendulous urethra in 1. The average follow-up was 74 months (range 18 to 184 months). One patient developed an urethrocutaneous fistula following open surgery which closed spontaneously. VUR resolved in the child with unilateral low grade VUR. The patient with high grade VUR underwent successful surgical correction, while the child with bilateral grade 3 VUR is being managed with observational therapy. None have had issues with incontinence, with resolution in the 2 patients presenting with voiding issues. No child has had evidence of end-stage renal disease.

Conclusion: Patients with AUV are rare with only 7 cases diagnosed over a 20 year time span. All patients have done well no matter the method of presentation or mode of treatment. Those with long-term follow-up have had excellent results, with normal renal and bladder function and with resolution of their presenting symptoms or signs.
Poster #5
DISPARITIES IN ACCESS TO COMPLEX KIDNEY CANCER SURGERY
*Shannon Cannon, MD²; Sarah Holt, PhD²; Liam Macleod, MD, MPH¹ and John Gore, MD, MS²
¹University of Pittsburgh Medical Center; ²University of Washington
Presented By: Shannon Cannon, MD

Introduction: Technical complexity may explain the underutilization of nephron-sparing surgery (NSS) for small renal masses. Differential access to NSS may be linked to kidney cancer-related health disparities and partly explain racial disparities in kidney cancer survival. Differential utilization of NSS may impact long-term quality of life and non-cancer survival. We examined patterns of NSS and whether access to complex kidney cancer surgery for small renal masses is confounded by racial and ethnic disparities.

Methods: Using the Surveillance, Epidemiology, and End Results (SEER)-Medicare linked database, we identified patients with stage classification T1a kidney cancers from 2004-2011, with Medicare claims through 2013. Separately, we classified surgeons who perform NSS as “high-volume” or “low-volume,” based on relative annual volumes of NSS. Patients in our cohort were categorized by treatment received and by whether they were seen by a high-volume physician following diagnosis and prior to treatment. Based on prior variations studies in NSS and a priori hypotheses, we performed univariate and multivariate logistic regression adjusted for demographic, clinical, and contextual variables including age, gender, marital status, Charlson Comorbidity Index, year of diagnosis, urban/rural location and neighborhood poverty rate. We assessed the association between race/ethnicity and NSS utilization using multivariate logistic regression.

Results: Of 8908 patients identified, 828 (9%) were Black and 542 (6%) were Hispanic. 2926 patients (33%) underwent NSS, 4236 (48%) underwent radical nephrectomy, and 1524 (17%) received no surgical treatment. NSS was associated with younger age, lower comorbidity, and being married. Those who saw a high-volume surgeon were more likely to receive NSS (OR 4.88, 95%CI 4.05-5.89), independent of all other covariates. Hispanic ethnicity was associated with decreased likelihood (OR 0.68, 95%CI 0.47-0.98) of a high-volume visit in a multivariate model adjusting for age and urban/rural status. Race was not associated with decreased likelihood of a high-volume visit. White and Hispanic patients living in a high poverty area were less likely to access high-volume surgeons (OR 0.47, 95%CI 0.29-0.78, OR 0.78, 95%CI 0.65-0.94, respectively) and were also less likely to receive NSS, independent of surgeon volume (OR 0.83, 95% CI 0.75-0.93, OR 0.73, 95% CI 0.58-0.94, respectively).

Conclusion: We identified differential utilization of NSS for T1a kidney cancers among patients who saw low-volume versus high-volume surgeons. This disparity was more pronounced in White and Hispanic patients in areas with high poverty rates, suggesting a correlation with known access barriers for patients in low-income, rural areas. Although patient factors may partly explain the variations identified, discrepant referral patterns and decreased access to providers that offer NSS among historically underserved populations demand further exploration.
THE FIRST FEMALE AUTHORS IN THE JOURNAL OF UROLOGY
*Kathryn Marchetti, BS; Ted Lee, MD; David A. Bloom, MD and Julian Wan, MD
Michigan Medicine, Department of Urology
Presented By: Kathryn Marchetti, BS

Introduction: Dr. Alma Hiller became the first woman to publish in the Journal of Urology (JU). Her contribution was followed by articles from Carol Beeler and Dr. Isabel Mary Wason. Wason became the first female lead author in JU. This study explores their careers and contributions as early female scientists.

Methods: We reviewed JU articles from 1917 to 1925 and identified Hiller, Beeler, and Wason as the first three women authors. Using public records, we obtained information of their educations and careers.

Results: Hiller originally pursued training at an all-female college, which did not initially offer courses in chemistry. Passionate about the sciences, she petitioned the university director until he promised such curriculum. By 1914, she earned her degree and was soon hired at Johns Hopkins University where she conducted research leading to her JU publication. Hiller is the first female author in JU. Her article with Dr. Herman Mosenthal, “The Relation of the Non-Protein Nitrogen to the Urea Nitrogen of the Blood”, was published in 1917 in JU's inaugural issue. Beeler published in JU in 1918 with Henry Helmholtz, “Experimental Pyelitis in the Rabbit.” Soon after she traveled to Mayo Clinic where she worked with pioneering endocrinologist Russel Wilder. She contributed to innovative research on the impact of dietary modification in type 1 diabetics prior to the invention of insulin. Wason graduated from Johns Hopkins Medical School in 1917. She was then recruited by Dr. Milton Winternitz to the Yale University Pathology Department, becoming one of the first female instructors (Figure 1). In 1920, Dr. Wason published “Report of a Case of Congenital Stenosis of Both Ureteral Orifices” in JU. This article established her at the first female lead author in JU.

Conclusion: For female scientists entering the workforce in the late 1800s/early 1900s, reception was contingent upon the acceptance of male colleagues. Despite these barriers, Hiller, Beeler, and Wason contributed to novel discoveries. Today, only 37% of lead authors in the top scientific journals are women. The careers of Hiller, Beeler, and Wason demonstrate that the space for women to pursue science is earned and they highlight the ground covered by women over the last one-hundred years. Ultimately, they illustrate the importance of continued growth and acceptance in science, research, and medicine.

Figure 1: Wason with colleagues at Yale University School of Medicine in 1920.
Introduction: Renal tumors are among the most common solid malignancies in the pediatric population. Of these pediatric tumors, those considered high risk include anaplastic Wilms tumor (AWT), clear cell sarcoma of the kidney (CCSK) and malignant rhabdoid tumor (RTK). The objective of our study was to identify factors impacting overall survival (OS) in children, adolescents and young adults with these pediatric renal tumors.

Methods: The National Cancer Database was queried for patients diagnosed with AWT, CCSK, or RTK between 2004–2013. Patients >30 years old were excluded. Demographic, clinical and OS data were abstracted. Univariate and multivariate (MVA) survival analysis was performed with the log-rank test, with unadjusted Cox proportional hazards regression used to estimate hazard ratios (HR).

Results: A total of 349 patients were identified meeting study criteria; 133 (38.1%) with AWT, 120 (34.4%) with CCSK and 96 (27.5%) with RTK. Median age for AWT was 4yr, CCSK 2yr, RTK <1yr (p<0.001). Median time to last follow up was 43.3 months (range 1.3-126.2) for AWT, 49.3 months (range 0.4-125.4) for CCSK and 8.1 months (0.1-121.2) for RTK (p<0.001). AWT and CCSK tumors were associated with larger diameter than RTK (10.5cm, 12cm, 8.3cm respectively; p=0.01). Patients with RTK were less likely to undergo surgery than those with AWT or CCSK (77.1% vs. 94% vs. 99%, p<0.001). Patients with RTK were less likely than patients with AWT or CCSK to receive chemotherapy (84.4% vs. 96.2% vs. 95%, p=0.013) and radiation therapy (52.1% vs. 81.2% vs. 86.7%, p<0.001). RTK was the most likely histology to be associated with lymph node (LN) involvement (23, 34%) compared to CCSK (32, 19.1%) and AWT (34, 25.8%), p=0.013. Estimated 5yr OS was 76.1% (95% CI 67.9-84.4) for AWT, 92.7% (95% CI 87.4-97.9) for CCSK and 33.5% (95% CI 23.1-43.9) for RTK (log-rank p<0.001, with all pairwise comparisons having p<0.001). Figure 1. On MVA, AWT (HR 3.372, p=0.032) and RTK histology (HR 12.595, p<0.001) were significantly associated with worse survival, while receipt of radiation therapy (HR 0.43, p=0.006) was associated with improved OS. LN positivity, LN density, margin status and undergoing surgical resection were not.

Conclusion: While high risk pediatric renal tumors are associated with poor outcomes, RTK is worse than either AWT or CCSK. Receipt of radiation is significantly associated with improved outcomes.
Poster #8
MULTI-CENTER PROSPECTIVE STUDY OF PROSTATE HEALTH INDEX (PHI) TESTING AS A STRATEGY FOR PROSTATE CANCER SCREENING: COLLABORATION BETWEEN UROLOGY, PRIMARY CARE, AND COMMUNITY OUTREACH
*Elizabeth C. Wendel, MD¹; Dattatraya Patil, MBBS, MPH²; Brandi Weaver, BA³; Robin Leach, PhD³; Ian Thompson, MD³; Lori Sokoll, PhD³; Daniel Chan, PhD³; Jack Groskopf, PhD³; James Carter, MD, MPH³; Mersiha Torlak, MPH, CCRP² and Martin Sanda, MD²
¹Emory University; ²Emory University School of Medicine; ³Harvard Medical School; ⁴Hologic Gen-Probe; ⁵Johns Hopkins University School of Medicine; ⁶UT Health San Antonio School of Medicine
Presented By: Elizabeth C. Wendel, MD

Introduction: Our study’s primary objective was to describe PHI in a community-based screening population with ample representation of African-American men. We also evaluated PSA, [-2]proPSA (p2PSA), free PSA, and PHI to see if there were any significant associations with selected patient characteristics. Finally, we stratified the patients by normal and abnormal PHI in order to analyze and compare their relative PSA and DRE results. PHI is a promising biomarker that has demonstrated superior detection of clinically-significant prostate cancers over Prostate-Specific Antigen (PSA) in biopsy and radical prostatectomy populations. However, the data is limited on evaluating PHI (and its individual components) in community-based screening populations. Furthermore, many of the existing studies on PHI have been conducted on Caucasian and Asian patient populations and the data is limited to describe its possible role in detecting prostate cancer in African-American men. Given the increased incidence of prostate cancer and tendency towards more aggressive pathology among African-American men, there is an urgent need to assess PHI’s clinical reliability as a marker for detection among this unique patient population.

Methods: A prospective cohort of biopsy-naïve men (n=540), were enrolled, regardless of PSA results, from primary care centers and community prostate cancer screening events at different clinical sites from 2013-2015. Statistical analysis was performed to evaluate the difference in PSA, 2proPSA, free PSA, and PHI score levels between African-American and Non-African-American men. Secondary analyses were conducted to investigate the association of age, BMI, ethnicity, physical exam status, DRE findings, smoking status, and presence of symptoms of BPH with PSA, 2proPSA, free PSA, and PHI score.

Results: For PSA, 2proPSA, free PSA, and PHI, we did not find any statistically significant difference between African-American and Non-African-American participants. Median 2ProPSA values were 5 pg/mL and 5.5 pg/mL, respectively (p=0.36), and median PHI scores were 22.2 and 24.7, respectively (p=0.06). We did find, however, that there was a statistically significant difference between African-American and Non-African-American participants with regards to age, ethnicity, last complete physical exam by a physician, last rectal exam, and IPSS score. There was a statistically significant association with age for PSA, p2PSA, free PSA, and PHI. However, for DRE, there was statistical significance only for PSA, p2PSA, and free PSA.

Conclusion: Our results add to the growing body of research on new prostate cancer biomarkers and provide context in a screening population for PHI as an alternative to PSA testing. Specifically, our results will help guide how PHI may be explored in the future as a potential screening test in the community setting.
Poster #9

IMPLANT SELECTION PATTERNS AND REOPERATION RATES AMONGST SOLID ORGAN TRANSPLANT RECIPIENTS THAT UNDERWENT PENILE PROSTHESIS SURGERY

*Denise A. Asafu-Adjei, MD, MPH²; George Moran, BS³; Gen Li, PhD¹; Doron Stember, MD⁴ and Peter Stahl, MD²

¹Columbia University Medical Center/Mailman School of Public Health; ²Columbia University Medical Center/New York Presbyterian Hospital; ³Columbia University Medical School; ⁴The Mount Sinai Hospital

Presented By: Denise A. Asafu-Adjei, MD, MPH

Introduction: Patients with solid organ transplants pose unique challenges for penile implant surgeons. Immunosuppressive medications may increase infection risk, and solid organ allografts are at risk of injury during abdominal reservoir placement. Our objective was to describe practice patterns and surgical outcomes of penile prosthesis (PP) surgery in the solid organ transplant population. To our knowledge, such population-based data has not been published.

Methods: The New York Statewide Planning and Research Cooperative System (SPARCS) database was queried for ICD and CPT codes indicating insertion or replacement of malleable or inflatable penile prostheses from 1995-2014. Patients with a history of kidney, heart, liver, lung, and pancreas transplants were identified based on ICD codes. Reoperations were identified by ICD and CPT codes for prosthesis removal, repair or replacement. Analysis of implant selection patterns was performed by classifying PP cases by procedural coding as malleable, malleable or 2-piece inflatable (nonspecific CPT code 55416), 2-piece inflatable, 3-piece inflatable, or unspecified inflatable (nonspecific ICD code 6497).

Results: 14,654 patients underwent PP insertion during the study period, including 123 patients with solid organ transplants. Patients with renal transplants comprised the majority of the overall transplant cohort (101/123, 82%). 19.3% of transplant patients had malleables placed, compared to 16.5% in non-transplant patients. 2-piece inflatables were placed in 4.8% of transplant patients, compared to 6% in non-transplant patients. 3-piece inflatables were placed in 75.9% of transplant patients, compared to 77.5% in non-transplant patients. Chi-squared test showed there was no significant difference in insertion types between the two groups (p=0.614). Reoperations occurred in 18/123 (14.6%) transplant patients compared to 1826/14531 (12.6%) in non-transplant patients. The majority of the reoperations were for PP infections (specific data reporting is precluded by data agreement with SPARCS that limits investigators from reporting any n<10). PPs without abdominal reservoirs were selected more commonly than 3-piece PPs in transplant patients.

Conclusion: The overall reoperation rate in solid organ transplant patients who undergo PP surgery is acceptably low but higher than most published reoperation rates in the general population. Implant surgeons appear to more commonly select PPs without abdominal reservoirs in the transplant population.
Poster #10
PROSTATE MRI INTERPRETATION VARIES SUBSTANTIALLY ACROSS RADIOLOGISTS
Geoffrey Sonn, MD²; Richard Fan, PhD²; Pejman Ghanouni, MD, PhD²; *Nancy Wang, MD, MPH²; James Brooks, MD²; Andreas Loening, MD, PhD²; Bruce Daniel, MD²; Katherine To'o, MD¹; Alan Thong, MD, MPH² and John Leppert, MD, MS¹
¹Palo Alto Veterans Affairs, Palo Alto, CA; ²Stanford Hospital, Stanford, CA
Presented By: Nancy Wang, MPH, MD

Introduction: Multiparametric MRI is a powerful tool being used to identify and diagnose prostate cancer. Current published studies supporting its use, however, have come from centers with a few high-volume expert radiologists. Our goal was to determine whether use as a screening tool is generalizable in routine clinical care.

Methods: A prospective cohort of study participants who underwent MR-fusion biopsy performed by a single urologist between April 2014 and October 2016. Study subjects underwent in-house MRI and had not been previously treated for prostate cancer. MRIs were read by 9 radiologists using PIRADS scoring and compared to histopathology results. Using multivariable logistic regression, we evaluated the association between PIRADS score, radiologist, radiologist volume, and length of study period with the detection of all prostate cancer as well as clinically significant prostate cancer. We also assessed variability in PIRADS scoring and cancer yield amongst the 9 radiologists.

Results: A total of 409 subjects with 544 specific lesions of interest were analyzed. While the mean number of lesions assigned per patient did not differ among radiologists, there was variation in the distribution of patient PIRADS scores and cancer yield. Significant cancer detected ranged from 0-23% for PIRADS 3, 23-65% for PIRADS 4 and 40-80% for PIRADS 5 amongst the radiologists. The proportion of men with PIRADS < 3 found to have clinically significant prostate cancer varied from 7-50%. Multivariable analysis showed that PIRADS score (p<0.001) and radiologist (p=0.03) were independent predictors of all prostate cancer and significant prostate cancer. However, sensitivity analysis did not show any effects of radiologist volume or study length. Overall, the radiologists had a detection rate of 0.70 (range of 0.63-0.80) for all prostate cancers and 0.72 (range of 0.62-0.82) for clinically significant prostate cancer.

Conclusion: These findings show the variability of MRI reads and cancer yields amongst radiologist in routine clinical care.
Poster #11
EARLY VAGINOPLASTY EXPERIENCE WITHIN A MULTIDISCIPLINARY TEAM IN THE INTEGRATED HEALTHCARE SYSTEM
*Virginia Li, MD; Amanda Chi, MD; Melissa Poh, MD and Polina Reyblat, MD
Kaiser Permanente
Presented By: Virginia Li, MD

Introduction: Gender dysphoria is estimated to affect up to 0.6% of adults in the United States (US). Along with psychiatric and endocrine evaluations, gender affirmation surgery (GAS) helps patients alleviate their dysphoria by aligning their phenotypic features with their gender identity. In the past, GAS had limited insurance coverage and availability in the US, prompting transgender patients to seek operations overseas. This prevented multidisciplinary and long term follow-up. This study explores the early vaginoplasty experience within an integrated health care system.

Methods: This study includes all patients who underwent a single stage penile inversion vaginoplasty at a health maintenance organization (HMO) since its initiation in April 2017. Criteria for GAS was followed using the World Professional Association for Transgender Health (WPATH) guidelines. Several baseline characteristics were documented including age, preoperative genitourinary exam and urinary function, length of hormone therapy, and any medical or psychiatric comorbidities. Their acute postoperative course and subsequent clinical follow-ups were also reviewed for any complications. Sexual satisfaction, American Urological Association (AUA) symptom score, and urinary quality of life scores were also documented in follow-up.

Results: A total of 13 vaginoplasties were performed since April 2017. Average age was 45, (21-74). Other than a patient with prior stroke, all of them were treated with hormone therapy for at least 2 years. The most common acute complication was transient urinary retention, affecting 23% (3) of the patients; other issues included intraoperative urethral injury (1), hematoma requiring operative evacuation (1), and leukocytosis without infection prior to discharge (1). The most common complications seen on follow-up were granulation tissue intravaginally (5) and small areas of wound dehiscence (5). Some patients also experienced urinary tract infections (2) and labial abscess (1). Early GAS patients have already been able to achieve orgasm, and also perform penetrative intercourse. In terms of their urinary status, the average AUA score was 4.7, with a quality of life score of 1.7.

Conclusion: Although there were minor postoperative complications in this patient cohort, the patient response to the surgeries have been positive. Average urinary quality of life score was 1.7, reflecting that patients were pleased or mostly satisfied postoperatively. Further surveys and clinical follow-up will help to determine more long term complications and satisfaction with the surgery.
Poster #12
THE NATIONAL RESIDENT MATCHING PROGRAM CODE OF CONDUCT: WHAT IS THE DEGREE OF COMPLIANCE DURING THE UROLOGY MATCH PROCESS?
*Elisabeth Sebesta, MD; Michael Lipsky, MD; Michele Nunez; Kimberly Cooper, MD and Gina Badalato, MD
Department of Urology, Columbia University Medical Center, New York, NY
Presented By: Elisabeth Sebesta, MD

Introduction: The Urology Residency Match Program is highly competitive, with top medical students applying for limited residency spots. According to the National Resident Matching Program’s (NRMP) Code of Conduct, program directors (PDs) and associated faculty should not (1) ask illegal or coercive questions; (2) "solicit nor require post-interview contact" with applicants, particularly in a manner that is "disingenuous in influencing applicants' ranking preferences," and (3) require second-look visits nor imply that they are a decisive component of the selection process. The Urology Match states in its guidelines to programs that there should be no post-interview verbal contact from the program to applicants. Anecdotally, violations of these rules occur, but there is minimal data to substantiate such events. The goals of this survey were to assess the frequency of “illegal questions” during the interview process, to determine the incidence and type of post-interview communication, and to assess how this type of communication affected applicants’ ranking of residency programs.

Methods: We conducted a 21-question post-match survey sent to all 285 applicants to our program for the 2017 match. Questions included the following topics: illegal/coercive questions, post-interview communication, second-look visits, and the applicants’ perceived impact of these factors.

Results: A total of 166 responses were obtained and analyzed (response rate 58%), representing 39% of all candidates to submit a rank list in the 2017 Urology Match. 96/166 (58%) of applicants reported receiving follow-up communication from at least one program, of whom 79% received communication from multiple programs. 13% of those who received post-interview communication reported verbal communication from a PD or faculty. 44/96 (46%) felt communication positively influenced their ranking of the program; however, 19% felt misled to believe they had a higher chance of matching at a program based on communications. 50/166 (30%) of respondents did a second-look visit at one or more programs, and 44% reported feeling obligated to do a second-look in order to match at a particular program. Many applicants reported finances significantly affected their ability to re-visit programs. Finally, 141/166 (85%) of applicants reported that illegal questions were asked during interviews, including questions regarding personal life, rank list, and other interview locations and/or number. 32% were asked specifically which program they would rank first.

Conclusion: During the 2017 Match, a high proportion of urology applicants experienced violations of the NRMP Code of Conduct and Urology Match guidelines. Violations included illegal questions, post-interview written and verbal communication, and pressure to do second-look visits. These findings corroborate numerous anecdotal reports, and may provide the groundwork to improve the fairness of the residency application process for the future.
Poster #13
SYSTEMATIC REVIEW OF OUTCOMES OF THE TRANSOBTURATOR SLING IN MEN WITH INCONTINENCE SECONDARY TO RADICAL PROSTATECTOMY AND RADIOTHERAPY FOR PROSTATE CANCER
*Divya Ajay, MD, MPH; Bradley Potts, MD¹; Cynthia Feltner, MD, MPH² and Andrew Peterson, MD, FACS¹
¹Duke; ²UNC
Presented By: Divya Ajay, MD, MPH

Introduction: The transobturator male sling is a minimally invasive treatment option for patients with post-prostatectomy stress urinary continence. There is evidence that continence outcomes are worse in men with radiotherapy in addition to a radical prostatectomy. However, many of these studies have are inconsistent with and the data often is insufficient data to support these conclusions. The objective of this study was to conduct a systematic review of the male transobturator sling placement after radical prostatectomy and radiotherapy to examine patient reported continence outcomes, satisfaction and adverse events.

Methods: A systematic database search was conducted using keywords, according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Published series of transobturator sling placements in men with incontinence after treatment for prostate cancer were retrieved. The three key questions examined were: patient reported post-operative measure of urinary continence, patient reported post-operative satisfaction and adverse events from the surgery.

Results: There were 126 patients available for analysis of post-operative outcomes from 8 studies with sample sizes ranging from 5 to 30. Follow-up ranged from 12 to 24 months. Authors used differing definitions of post-operative success (e.g. pad-free, 0–1 pads per day, etc.). Success rates ranged from 0–55 percent across all included studies. About half of the patients reported post-operative satisfaction with the procedure. Most commonly observed adverse events with post-operative acute urinary retention and urethral injuries.

Conclusion: Men with urinary incontinence secondary to radical prostatectomy when combined with radiotherapy have poor success rates with the transobturator sling. Only 50 percent report post-operative patient satisfaction and significant number report complications including acute urinary retention and urethral erosion.
Poster #14
GENDER REPRESENTATION IN UROLOGICAL SUBSPECIALTIES
*Oluwarotimi S. Nettey, MD, MHS; Joceline Fuchs, MD; Stephanie Kielb, MD and Edward Schaeffer, MD, PhD
Department of Urology, Northwestern University Feinberg School of Medicine, Chicago, IL
Presented By: Oluwarotimi S. Nettey, MD, MHS

Introduction: To examine associations between urologic subspecialization, surgeon gender and practice patterns among certifying urologists over the last 13 years.

Methods: Demographic data of certifying and recertifying urologists (2004 to 2015) was obtained from the American Board of Urology (ABU). We investigated gender-specific trends in self-reported practice type (academic practice, private practice), subspecialization, and employment as a full-time versus part-time physician, relative to certification year and cycle.

Results: Of 9,140 urologists applying for certification or recertification over the study period, 815 (8.9%) were women. The largest proportion of female surgeon candidates (65.0% of women) were first time certifiers. Women represented 16.7% of first time certifying urologists (p<0.001). 23.6% of female surgeons identified their practice as academic compared to 13.7% of men applying for certification/recertification (p<0.001). Female surgeons identify as subspecialists in greater numbers (46.4%) than their male counterparts (23.4%) across all certification years and cycle cohorts (p<0.001). 25.4% of female surgeons requesting certification identify as subspecialists in female urology and 10.4% in pediatrics compared to 4.8% and 3.1% of their male colleagues respectively (both p<0.001). Female and male surgeon candidates request certification in equal proportion in infertility, however differ in oncology (4.5% female vs. 7.6% male surgeons), endourology and stone disease (4.0% women vs. 6.1% men).

Conclusion: A growing proportion of certifying urologists are women, with the greatest enrichment among those seeking first time certification. Since 2004, female surgeons account for a disproportionate volume of urologists who practice in the academic setting and identify as subspecialists.
Poster #15
DO PATIENTS DISCONTINUE OVERACTIVE BLADDER MEDICATIONS AFTER SACRAL NEUROMODULATION?
*Katherine Amin, MD; Dena Moskowitz, MD; Kathleen Kobashi, MD; Una Lee, MD and Alvaro Lucioni, MD
Virginia Mason Medical Center
Presented By: Katherine Amin, MD

Introduction: Overactive bladder medications (OABM) are often discontinued due to poor tolerability and recent data shows long term usage of anticholinergic OABM is associated with detrimental cognitive effects in the elderly. Therefore, utilization of 3rd line treatment options, particularly sacral neuromodulation (SNM), is attractive. However, a subset of patients continue or restart OABM while on 3rd line therapy. We explore a cohort of patients at our tertiary referral center to assess the usage of concurrent OABM in patients with SNM.

Methods: A retrospective chart review was performed on all patients who underwent SNM from 8/2014 – 6/2016. Patients were excluded if indication was urinary retention or if underwent SNM removal. We identified clinical characteristics, urodynamic parameters, and filled prescriptions of OABM queried through our electronic medical record. Concurrent therapy was defined as consecutively filling 2 anticholinergic or beta-3 agonist OABM prescriptions after SNM. We examined Patient Global Impression of Improvement (PGI-I) and percent improvement. T-test and Fishers exact were used to compare groups.

Results: 78 patients were identified. Demographic and clinical characteristics are shown in Table 1. 71% (n=55) of patients stopped and never restarted OABM (SNM alone). Median follow up was 14.5 vs. 13 months between concurrent and SNM alone groups, respectively. In the concurrent group, 78.3% of patients continued to fill OABM immediately following SNM placement and 21.7% stopped and restarted OABM at least 2 months postoperatively. Patients with concurrent use were significantly older in age (73.2 vs. 64.0 years) when compared to SNM alone patients. There was no difference seen in BMI, SNM revision, and urodynamics parameters. PGI-I and percent improvement did not differ between groups.

Conclusion: Our data reflects that >70% of patients who progress to SNM discontinue OABM and utilize this as their sole OAB treatment modality. A small portion of patients concurrently use OABM following SNM, however patient satisfaction and percent improvement do not differ between groups. Given data on OABM cognitive effects, SNM alone is an appealing treatment modality for patients.

<table>
<thead>
<tr>
<th></th>
<th>Concurrent</th>
<th>SNM alone</th>
<th>P (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>23</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Age at interstim, mean (SD)</td>
<td>73.2 (8.3)</td>
<td>64.0 (16.4)</td>
<td>0.0128 (2.0,16.4)</td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>3 (21.7)</td>
<td>3 (3.5)</td>
<td>0.0490</td>
</tr>
<tr>
<td>BMI, mean (SD)</td>
<td>21.9 (6.5)</td>
<td>26.2 (8.1)</td>
<td>0.5306 (2.65.0)</td>
</tr>
<tr>
<td>Revision, n (%)</td>
<td>2 (6.7)</td>
<td>6 (10.5)</td>
<td>1.00</td>
</tr>
<tr>
<td>UDS Capacity, mean (SD)</td>
<td>305.3 (129.1)</td>
<td>319.3 (125.5)</td>
<td>0.7970</td>
</tr>
<tr>
<td>DO present, n (%)</td>
<td>12 (76.6)</td>
<td>18 (42.9)</td>
<td>0.0040</td>
</tr>
<tr>
<td>n=17, n=42</td>
<td>3 (20.0)</td>
<td>3 (20.0)</td>
<td></td>
</tr>
<tr>
<td>Follow up, months, median (range)</td>
<td>14.3 (9-23)</td>
<td>13 (3-30)</td>
<td>0.5855</td>
</tr>
<tr>
<td>PGI-I, mean (STF)</td>
<td>2.6 (1.0)</td>
<td>2.4 (1.8)</td>
<td>0.3850</td>
</tr>
</tbody>
</table>

Table 1. Demographic and clinical factors as well as outcomes for patients who underwent SNM.
**Poster #16**

EVALUATING THE CLINICAL OUTCOMES OF PRENATALLY DIAGNOSED MODERATE TO SEVERE HYDRONEPHROSIS AT A SINGLE INSTITUTION.

*Kathryn R. Trandem, MD, PhD; Amay Singh; Sheila Ryan; Duong Tu; Chester Koh; Nicolette Janzen; Edmond Gonzales; David Roth and Abhishek Seth*

Baylor College of Medicine

Presented By: Kathryn R. Trandem, MD, PhD

**Introduction:** Over the last few decades it has been debated how to best treat neonates with prenatally diagnosed severe hydronephrosis (HN) secondary to ureteropelvic junction obstruction (UPJO). Some pediatric urologists argue that early operation is superior in protecting renal function, while others argue for a more conservative approach that only involves operation after demonstration of compromised function, worsening HN, febrile UTI or presence of symptoms. In order to define its natural history better, we examined outcomes in prenatally diagnosed moderate to severe HN.

**Methods:** A retrospective single center study involving 202 patients with prenatally diagnosed unilateral SFU grade 3 or 4 HN between 2001-2015 was conducted. Children were excluded if they had any cofounding urinary anomalies including bilateral hydronephrosis, vesicoureteral reflux, ureterectasis, ureteroceles, posterior urethral valves, neurogenic bladder, solitary or multicystic dysplastic kidneys.

**Results:** A total of 202 neonates were diagnosed with unilateral SFU grade 3 or 4 HN with renal scans consistent with UPJO. The majority of neonates were boys (71%) affecting the left kidney (63%). On initial ultrasound, 39% of children presented with SFU grade 3 HN, and (59%) presented with SFU grade 4 HN. 141 of 163 patients (87%) had early postnatal renal scans showing T1/2 emptying times > 30 minutes. With a mean follow-up of 44 months, 193 of 202 (96%) children progressed to require surgery, with the majority occurring shortly after the first year (mean 15 months, median 3 months). Indications for surgery varied widely, with worsening HN (35%) or renal differential of greater than or equal to 10% (35%) being the most common. Other indications included febrile UTI in 14.5%, severe HN in 10.8% and Dietl’s crisis/flank pain in another 4% children. Complications occurred in 12.9% of patients with a resulting urinary tract infection being most common.

**Conclusion:** The majority of children with prenatally diagnosed SFU grade 3 or 4 HN secondary to UPJO progressed to surgical correction early in their life (193 of 202, 96%). Our study may have been skewed to a higher operation rate than reported in prior studies as we only included patients with prenatally diagnosed moderate-severe (SFU grade 3 and 4) HN, many of whom presented early with poor differential function and severely impaired emptying.

**Summary Table**

<table>
<thead>
<tr>
<th>Observation vs. Surgical Correction</th>
<th>Patients advancing to surgical correction, n (%)</th>
<th>Patients failing initial observation, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>193 (90%)</td>
<td>167 (95%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indication for Surgery</th>
<th>N=193</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differential renal function &gt;10%, n (%)</td>
<td>71 (36.6)</td>
</tr>
<tr>
<td>Worsening hydronephrosis, n (%)</td>
<td>68 (34.2)</td>
</tr>
<tr>
<td>Febrile UTI, n (%)</td>
<td>24 (12.4)</td>
</tr>
<tr>
<td>&quot;Severe hydronephrosis&quot;, n (%)</td>
<td>19 (9.8)</td>
</tr>
<tr>
<td>Dietl’s crisis/flank pain, n (%)</td>
<td>6 (4.1)</td>
</tr>
<tr>
<td>Differential renal function &gt;10% &amp; Febrile UTI, n (%)</td>
<td>3 (1.6)</td>
</tr>
<tr>
<td>Hypertension, n (%)</td>
<td>1 (0.5)</td>
</tr>
<tr>
<td>Abdominal distention, poor feeding, n (%)</td>
<td>1 (0.5)</td>
</tr>
</tbody>
</table>
Teresa D. Beam, MD, FACS
Dr. Teresa D. Beam received her BA in biology from Purdue University School of Science in Indianapolis, Indiana in 1983. She later received her MD from the University of Cincinnati College of Medicine in Cincinnati, Ohio in 1991. Her residencies in general surgery (1993), urology (1996), and chief resident in urology (1997) were completed at the University of Cincinnati Medical Center. She joined Urology of Indiana in 1997. She specializes in interstitial cystitis, general urology, female urology, and kidney stones.

Martha B. Boone, MD
Dr. Martha Boone is a private practice urologist from Atlanta, Georgia. She trained at Charity Hospital in New Orleans in the eighties. She has written much about her time as one of the early women in urology. Her first published novel, The Big Free, details the humor and horror of surgical training at a time when women were not yet fully integrated into the field of urology. It is a story any women in surgery could tell. The Big Free celebrates the intimate relationship between surgeons and their patients. The proceeds from the sale at SWIU will be donated to SWIU.

Elizabeth W. Bozeman, MD
Elizabeth Wagner Bozeman received her undergraduate degree in psychobiology from Emory University. She then attended the Medical University of South Carolina earning her medical degree in 1989. She went on to do her urology residency at the same institution finishing in 1994. After 2 years of private practice in Charleston, SC, she married Dr. Gary Bozeman, a fellow urologist, and they moved to Spartanburg, SC. While there she was actively involved with the Southeastern Section, served as President of the SC Urologic, and served on the Board of the SEAUA. She is quite proud to have served SWIU as a Past President in 2007. She had a very successful practice in Spartanburg for over 18 years but left in 2013 for a new adventure. She and her husband joined Associated Medical Professionals based in Syracuse, NY. She is currently enjoying private practice in the small town of Fulton, NY. She thoroughly enjoys exploring a different area of the country, working in a rural and underserved area, and loves having four distinct seasons.

Anne Pelletier-Cameron, MD, FPMRS
Anne K. Pelletier-Cameron, MD, FRCPS(C) is a board-certified urologist. She received her undergraduate degree at the University of New Brunswick. After completing her medical degree at the University of Ottawa and residency in urology at Dalhousie University, she came to the University of Michigan for a fellowship in female pelvic medicine and reconstruction. Dr. Cameron remains at the university where she is currently a clinical associate professor in urology surgery, clerkship director, assistant fellowship director and director of the Clinical Urology Research Endeavor (CURE).

Clare E. Close, MD, FAAP, FACS
Dr. Close is a fellowship trained pediatric urologist with expertise in complex urologic reconstruction and in the treatment of congenital and acquired voiding dysfunction. Every year she treats 1,000+ children and adolescents with bladder, bowel and pelvic floor disorders that result in urinary frequency, urgency, enuresis, bed-wetting, pelvic pain, and urinary tract infections. After her urology residency at the University of Washington, Dr. Close completed a clinical and research fellowship in Pediatric Urology at Seattle Children’s Hospital. She
served as Chief of Pediatric Urology at the University of Chicago and then returned to Las Vegas to build a private practice that offers a unique and comforting environment for children with urologic problems. Dr. Close believes that there is a fundamental lack of understanding on the negative impact of poor childhood bladder, bowel and pelvic floor health on future adults’ lower urinary tract health.

She is passionate about educating her patients and families and is working toward the goal of developing school programs that will promote healthy toileting behaviors for children and adolescents during the school day. As a member of the Society of Women’s Health Research Interdisciplinary Network on Urological Health in Women, Dr. Close provides a pediatric voice to the network’s mission. She also serves as a reviewer for the Journal of Urology. Dr. Close loves living in the desert and is an avid naturalist, bird watcher and tennis player.

Christopher M. Gonzalez, MD, MBA, FACS
Chris M. Gonzalez, MD, MBA, FACS is a native of Toledo, Ohio. He graduated from Denison University in Granville, Ohio with a BS degree in 1989. Afterwards he obtained his MD degree from the University of Iowa College of Medicine in Iowa City, Iowa. Dr. Gonzalez then completed both his general surgical and urologic residency training at the McGaw Medical Center, Northwestern University in Chicago, Illinois. Dr. Gonzalez served in the US Army National Guard from January 1991 – January 2001. He joined the Northwestern University Department of Urology in 2000 following residency, and was appointed Professor of Urology in 2011. He served as Chief of Urology for the VA Lakeside from 2003 – 2006 and completed his MBA degree from the Northwestern Kellogg School of Management in 2006. He was the Director of Surgery for the Northwestern Medicine Surgical Services Department from 2014 - 2015. Dr. Gonzalez was named the Lester Persky Professor and Chairman of the Urology Institute at University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, Ohio, in September 2015.

His recent focus has been on patient reported outcome measures in the area of genitourinary reconstruction, practice patterns in reconstructive urologic surgery, practice integration of advanced practice providers, and the urology workforce shortage in the United States. His areas of clinical specialty include urethral stricture disease, salvage of failed hypospadias surgery, genitourinary fistula disease, erectile dysfunction, penile prosthetic placement, Peyronie’s disease, and penile curvature correction.

Priyanka Gupta, MD
Priyanka Gupta, MD is a Urologic Surgeon specializing in the diagnosis and management of voiding dysfunction and pelvic floor disorders. She obtained her medical degree from the Mayo Clinic College of Medicine, and then completed her urology residency at the University of Minnesota. She then completed a fellowship in female pelvic medicine and reconstructive surgery at Beaumont Health in Royal Oak, Michigan. During her fellowship she gained additional expertise in the surgical management of pelvic organ prolapse, urinary incontinence, and the use of neuromodulation and robotic technology. Dr. Gupta’s clinical practice includes both the surgical and non-operative management of pelvic organ prolapse, incontinence, pelvic pain, voiding dysfunction and pelvic floor disorders. Dr. Gupta’s research interests include outcomes of pelvic organ prolapse treatments and neuromodulation, and surgical education in the developing world.

Her clinical interests include pelvic organ prolapse (robotic sacrocolpopexy, native tissue...
repair), voiding dysfunction, incontinence (endoscopic, open surgery, neuromodulation), pelvic pain and pelvic floor disorders. She is also interested in outcomes of pelvic organ prolapse treatments and neuromodulation. She is also interested in international medicine and the use of simulation technology for improving surgical education in the developing world.

**Miriam Hadj-Moussa, MD**

Dr. Hadj-Moussa is an Assistant Professor in Urology at the University of Michigan. She studied genetics at the University of Georgia before attending medical school at the University of Alabama School of Medicine in Birmingham where she was elected to the Alpha Omega Alpha honor medical society. She completed her urology residency at the University of Michigan in 2016. Dr. Hadj-Moussa stayed at the University of Michigan for a fellowship in andrology and urologic health before joining the faculty in 2017. Her clinical practice encompasses a wide range of benign general urology, male infertility and gender confirmation surgeries. Dr. Hadj-Moussa’s academic interests are related to patient safety, quality improvement and resident education. Outside the hospital she can be found digging in her garden, knitting up a storm or loving her dogs.

**Jennifer Hah, MD, MS**

Dr. Jennifer Hah received her medical degree from Northeast Ohio Medical University in 2005. She completed her anesthesiology residency at the Cleveland Clinic and Stanford University. She then completed her pain medicine fellowship at Stanford in 2011. After completion of her clinical training, Dr. Hah simultaneously completed a postdoctoral research fellowship and obtained her master’s degree in Epidemiology at Stanford. She received a K23 career development award from the NIH National Institute on Drug Abuse in 2013. Her research has focused on psychological risk factors for persistent pain and opioid use after surgery. In addition, she has a particular interest in developing novel interventions to reduce chronic pain and opioid use after surgery.

Dr. Hah is also the director of the Pelvic Pain Program at the Stanford Pain Management Center. She is particularly interested in helping patients who experience pelvic pain caused by a multitude of conditions such as endometriosis, interstitial cystitis/painful bladder syndrome, pudendal neuralgia, peripheral nerve entrapments, vulvodynia and piriformis syndrome. The interdisciplinary approach to chronic pelvic pain management includes a team of pain medicine physicians, pain psychologists and physical therapists. Pain management centers on appropriate medication trials, interventions, psychological counseling and pelvic physical therapy.

**Melissa R. Kaufman, MD, PhD**

Dr. Melissa R. Kaufman is Associate Professor of Urologic Surgery at Vanderbilt Medical Center. She received her BA from Washington University St. Louis, and her PhD in microbial genetics at University of Tennessee. Following postdoctoral research at Stanford, and completion of medical school in her home state of Arkansas, Dr. Kaufman commenced her urology residency at Vanderbilt in 2002. She completed fellowship training in both male reconstruction and female pelvic medicine and reconstructive surgery in 2009 at Vanderbilt. Her practice focuses on female and male voiding dysfunction and incontinence, cancer survivorship, pelvic organ prolapse, neurourology, transitional care for congenital urologic conditions, urologic prosthetics, as well as reconstructive surgery for urethral stricture, fistula and trauma. She is additionally a past-president of SWIU.
Lindsey A. Kerr, MD
Dr. Lindsey Kerr is the Founder and Director of the Pelvic Care and Continence Center at Eastern Maine Medical Center. In her previous position, Dr. Kerr was an Associate Professor of Urology and Director of the Pelvic Floor Center at the University of Utah. She has served on the Board of Directors of the National Association for Continence and was their National Spokesperson. She has chaired the Not-for-profit Society for Women’s Health Research in Washington DC. Dr. Kerr received her medical degree from Duke University. She completed her urology training at the Mayo Clinic and Foundation. Dr. Kerr also completed her master’s degree in Immunology followed by a fellowship in female urology and pelvic reconstructive surgery at Harvard University.

Dr. Kerr is a member of the American Association of Clinical Urologists and the American Urological Association. She has been awarded the Eagles Cancer Research Grant, and has been an investigator on a number of National Institutes of Health Grants including the Urinary Incontinence Treatment Network and the Pelvic Floor Disorders Network.

She has written numerous articles, chapters and papers and has testified before several congressional committees on the impact of incontinence on the health and well-being of women and older Americans. She remains dedicated to the training and education of women in medicine and science. In her spare time she teaches “Yoga for Stiffs”, and is a certified RYT instructor.

Kathleen Kieran, MD, MS, MME
Dr. Kieran is a board certified pediatric urologist at Seattle Children’s Hospital and an associate professor of urology at the University of Washington. Her clinical interests include general and prenatal urology and her research interests include health care disparities, impact of public health initiatives on pediatric urologic health, and teaching and optimizing communication skills in surgeons.

Dr. Kieran received her bachelor’s and Master’s degrees from Tufts University in Medford, MA, and her M.D. from Boston University School of Medicine. She also holds a Master’s degree in Clinical Research Design and Statistics from the University of Michigan and a Master’s degree in Medical Education from the University of Iowa. She completed an internship in general surgery and a residency in urology at the University of Michigan, followed by a fellowship in pediatric urology at the University of Tennessee.

Prior to coming to Seattle, Dr. Kieran was a clinical assistant professor of urology and associate program director for the urology residency at the University of Iowa in Iowa City, IA.

She is a member of numerous local, regional, and national societies, including the American Urological Association, Society for Pediatric Urology, and Society for Fetal Urology. She is a member of the Executive Committee for the American Academy of Pediatrics, the Executive Board of the Society for Women in Urology, and the Urinary Late Effects Committee of the Children’s Oncology Group.

Stacy Loeb, MD, MSc
Dr. Stacy Loeb is an Assistant Professor of Urology and Population Health at New York University (NYU), specializing in prostate cancer. Dr. Loeb completed her urology residency training at Johns Hopkins and subsequently received a Master’s of Science in Comparative
Effectiveness Research at NYU. Dr. Loeb is an internationally recognized expert in prostate cancer with more than 285 peer-reviewed published articles and 8 book chapters. She has grants from the National Institutes of Health to study active surveillance, and from the Prostate Cancer Foundation to study digital media in prostate cancer. She is on the Editorial Board for the Journal of Clinical Oncology, British Journal of Urology International, European Urology, Nature Reviews Urology, Urology Practice, Reviews in Urology, and Urology Times. Dr. Loeb frequently gives international lectures on prostate cancer, and hosts the Men’s Health Show on US/Canadian satellite radio. She is also an active participant in social media. She is Chair of the American Urological Association Social Media Work Group and a member of the European Association of Urology Guidelines Office Social Media Committee.

Jane L. Miller, MD, FPMRS
Jane Miller is an associate professor of urology at the University of Washington where she completed her urology residency and female urology fellowship under the direction of Dr. Tamara Bavendam. Urinary incontinence and bladder pain syndrome/interstitial cystitis are her research interests; participating in the NIDDK sponsored research networks-ICCRN, MAPP, and LURN. Her clinical practice includes female urology patients, and spinal cord injury and congenitalism patients.

Jeannette M. Potts, MD
After practicing at the Cleveland Clinic’s Glickman Urological Institute for 15 years, Dr. Potts realized she needed to find a better way to provide more holistic care to men suffering from Urological Chronic Pelvic Pain Syndromes (UCPPS). During her tenure at the Cleveland Clinic she became more subspecialized, focusing her work in prostatitis, chronic pelvic pain and psychosexual well-being. For years she also had an extremely busy no scalpel vasectomy practice, and will continue to provide sensitive and compassionate care for men contemplating this safe and popular form of permanent contraception. Dr. Potts was named among the “best Urologists” in North East Ohio, by Cleveland Magazine.

She is the editor of two urological textbooks published by Humana Press: Essential Urology and Genitourinary Pain and Inflammation. She is the author of a third book, “Tango: Lesson for Life,” published by Cleveland Clinic Press (www.doctortango.net). She has also published numerous articles in urology and family medicine, and has given over 100 lectures on UCPPS and related topics as an invited speaker at medical and urological conferences world-wide.

She has been a passionate collaborator with the NIH and the IPCN to advance research and care of patients suffering from UCPPS. Her most recent collaboration, which involved 5 other investigators from across the country, led to the first favorable outcome of a NIH clinical trial addressing UCPPS. This trial showed that physical therapy brought significant relief to UCPPS patients.

Dr. Potts is Assistant Clinical Instructor on the faculty of Case Western Reserve University School of Medicine and University Hospitals of Cleveland. Dr. Potts was the director of education for Cofederacion Americana de Urologia from 2000-08. She is currently managing the Latin American Perpetual Education Fund and was appointed to the board of directors of International Volunteers in Urology (www.IVUmed.org). With her fiancé, she also participates in Mercy Ship surgical missions. (www.mercyships.org)
Elaine S. Rosenblum
Elaine Rosenblum is an entrepreneur and visionary at heart. Foreseeing the impact of technology on communication skills, in 2001 she founded Courageous Conversation. As part of a second entrepreneurial adventure five years later, she co-founded Access Test Prep & Tutoring. Given her roles in both organizations, Elaine launched an umbrella brand, ProForm U®, to teach collaborative communication and negotiation skills not only to professionals at all levels, but also to students preparing for college and job interviews, and those in need of job search strategies and salary negotiation guidance.

Across careers as an entrepreneur, attorney, teacher and marketer, Elaine has acquired deep experience working at and consulting for corporate organizations from start-ups to Wall Street. At the intersection of advancing technology and diminishing human contact, Elaine combines her corporate and legal expertise, realizing her vision of collaborative communication is among the most valuable professional skills in that expectations for productivity and profit margins demand it.

Elaine is a graduate of the University of Texas at Austin, where she earned a BS in Advertising, and the Cardozo School of Law in New York City; she also completed Harvard Law School’s Advanced Negotiation Program for Lawyers. Elaine is a member of the New York State bar. Elaine is a trustee for The Jewish Women’s Fund of Atlanta and is on the board of Most Valuable Kids Atlanta.

Michelle J. Semins, MD
Dr. Michelle J. Semins is an Assistant Professor and Urologic Surgeon in the Department of Urology, and Director of the Kidney Stone Clinic at Mercy Hospital. She received her undergraduate degree from The University of Michigan, and her medical degree from the University of Pittsburgh School of Medicine. She then completed her internship in surgery and residency urology training at Johns Hopkins Hospital with additional specialty training in the field of endourology. Dr. Semins is a current board member of the Northeastern Section of the AUA, and is a member of the American Urological Association, Society of Endourology, the Pittsburgh Urological Society, Research on Calculus Kinetics Society, and the Society of Women in Urology. She has a clinical research focus in kidney stones and is a past awardee of a Young Investigator Research Grant by the Northeastern Section of the AUA. She was also named the Young Urologist of the Year by the AUA in 2016. Dr. Semins is a reviewer for the Journal of Urology and many other peer-review journals. She is a published author of over 40 articles, over 50 abstracts and 9 book chapters.

Anne M. Suskind, MD, MS
Dr. Anne M. Suskind, MD, MS is an Assistant Professor of Urology at the University of California, San Francisco (UCSF) who specializes in neurourolgy and in female pelvic medicine and reconstructive surgery (FPMRS). She has a deep interest, both clinically and academically, in providing care to frail older individuals. She has funding from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the National Institute on Aging (NIA), and the Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU) to explore the effects of frailty and aging on outcomes of urologic surgery and other treatments for benign urologic conditions.
Kristina D. Suson, MD
Dr. Kristina Suson, MD, is a pediatric urologist at the Children’s Hospital of Michigan. After completing medical school at the University of Maryland School of Medicine, she remained at University of Maryland to complete her urology residency. Dr. Suson finalized her training with a pediatric urology fellowship at the Johns Hopkins University School of Medicine. She then joined the staff at the Children’s Hospital of Michigan where she works with residents from both the MSU-DMC urology and Henry Ford Urology residency programs, and with Wayne State and visiting medical students. Dr. Suson’s clinical interests include vesicoureteral reflux, urinary obstruction, and penile and bladder reconstruction. She also has an avid interest in caring for children with neurogenic bladder, and enjoys her work in the Children’s Hospital of Michigan Myelomeningocele Care Center. Research interests include the extrophy-epispadias spectrum, vesicoureteral reflux, pediatric malignancies and pediatric urologic outcomes. She has most recently been published in the Journal of Urology, Journal of Pediatric Urology, Journal of Pediatric and Adolescent Gynecology, and BJU International. Dr. Suson serves nationally as a member of the executive committee of the Society of Pediatric Urology, Pediatric Urologic Oncology Working Group.

When not at work, Dr. Suson has been striving to spend more time with her two awesome children – her son, Sage, and her daughter, Verity. She knew she had a problem when her son claimed to know the principal at his elementary school better than his mom. They have reached a reluctant truce where she agrees to focus on them more each day, if they will turn off the electronics for five minutes; and if they are not at play-practice, soccer, gymnastics, voice lessons, et cetera.

Suzette E. Sutherland, MD, MS, FPMRS
Suzette E. Sutherland, MD, MS, FPMRS serves as Director of Female Urology and a member of the UW Medicine Pelvic Health Center at the University of Washington Medical Center, and Associate Professor at the University of Washington School of Medicine in Seattle, WA. As a leader in this field, she is part of the first group of female urologists/urogynecologists to be board certified in the subspecialty of female pelvic medicine and reconstructive surgery through the American Board of Urology/American Board of Obstetrics and Gynecology. She completed her medical degree and urologic training at Case Western Reserve University School of Medicine/University Hospital of Cleveland in Cleveland, Ohio. Dr. Sutherland has gained further specialty training in female urology to include urinary incontinence and voiding dysfunction, urodynamics, neuromodulation, pelvic prolapse and reconstructive surgery, pelvic floor disorders and female sexual dysfunction from the Center for Continence Care and Female Urology in Minneapolis/St. Paul, MN, and from the Institute for Sexual Medicine in Boston. After 10 years with Metro Urology – a large multi-specialty urology practice in Minneapolis/St Paul – she became a member of the academic community in the Urology Department, University of Washington, Seattle.

She has made numerous contributions to the medical literature in the form of presentations, papers and book chapters on urinary incontinence, pelvic prolapse and sexual health, and takes an active role in training future female urologists both at the resident and fellowship level. Serving as a consultant for pharmaceutical and medical device companies, she provides her expertise and innovative ideas for the future development of female urology. Dr. Sutherland remains active in associated clinical research, staying abreast of the newest developments in her field, with the goal of being able to provide the most up-to-date treatment options for her patients.
Dr. Sutherland is an active member of the American Urologic Association (AUA), the Western Section of the AUA (WS/AUA), the Northwestern Urologic Society (NWUS), the Minnesota Urologic Society (President 2012-2013), the Society for Women in Urology (SWIU: Current President), the Society for Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction (SUFU: Practice Standards Committee 2012-present; Awards Committee 2012-present; Education Committee 2014-present), the American Urogynecology Society (AUGS – Surgical Mesh Special Interest Group), the International Continence Society (ICS), the International Urogynecology Association (IUGA), the International Society for Pelvic Neuromodulation (ISPiN), and the International Society for the Study of Women’s Sexual Health (ISSWSH).

Elizabeth A. Williams, MD
Dr. Williams received her BS in biology from Saint Louis University and her MD from Saint Louis University School of Medicine, both with Summa Cum Laude honors. Her residency in urologic surgery was completed at Washington University School of Medicine, and her fellowship in female urology and voiding dysfunction at Metropolitan Urologic Specialists. She is currently a urologist at Urology Consultants, Ltd, in Saint Louis, Missouri.

Claire C. Yang, MD
Claire Yang, MD is a Professor of Urology at the University of Washington, Chief of Urology at Harborview Medical Center, Seattle, and staff urologist at the VA Puget Sound Health Care System. She has specialty training in neuourology, and her clinical and research interests in voiding dysfunction and sexual dysfunction. She is currently co-chair of the NIDDK-sponsored Symptoms of Lower Urinary Tract Dysfunction (LURN) Research Network.
SAVE THE DATES

2018 SWIU at the AUA
May 18 – 22, 2018
San Francisco, California

Saturday, May 19, 2018
SWIU NETWORKING RECEPTION

Sunday, May 20, 2018
SWIU ANNUAL BREAKFAST MEETING