Society of Women in Urology
8th Annual Clinical Mentoring Conference
January 18 – 20, 2019
Embassy Suites by Hilton Scottsdale Resort
Scottsdale, Arizona

PROGRAM BOOK

Jointly Provided By:
Creighton University Health Sciences Continuing Education and the Society of Women in Urology
# TABLE OF CONTENTS

8th Annual Clinical Mentoring Conference
Scottsdale, Arizona

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome from the President and Program Chair</td>
<td>2</td>
</tr>
<tr>
<td>2018 – 2019 Board of Directors</td>
<td>3</td>
</tr>
<tr>
<td>2019 Faculty Listing</td>
<td>4</td>
</tr>
<tr>
<td>Past Presidents</td>
<td>5</td>
</tr>
<tr>
<td>Mission Statement</td>
<td>5</td>
</tr>
<tr>
<td>General Meeting Information</td>
<td>6</td>
</tr>
<tr>
<td>Special Events</td>
<td>7</td>
</tr>
<tr>
<td>Educational Needs &amp; Objectives</td>
<td>8</td>
</tr>
<tr>
<td>Accreditation Statement</td>
<td>10</td>
</tr>
<tr>
<td>2019 Resident Travel Award Winners &amp; Contributors</td>
<td>11</td>
</tr>
<tr>
<td>Industry Support</td>
<td>12</td>
</tr>
<tr>
<td>Program Schedule</td>
<td>13</td>
</tr>
<tr>
<td>Faculty Disclosure Report</td>
<td>20</td>
</tr>
<tr>
<td>Resident Podium Session</td>
<td>25</td>
</tr>
<tr>
<td>Resident Poster Session</td>
<td>34</td>
</tr>
<tr>
<td>Speaker Biosketches</td>
<td>46</td>
</tr>
</tbody>
</table>
Dear Colleagues,

It is with great pleasure that we welcome you to the Society of Women in Urology’s 8th Annual Clinical Mentoring Conference at the Embassy Suites by Hilton Scottsdale Resort. The theme of this year’s meeting is “Advocacy: For Yourself, Your Patients, and Your Profession.” This year’s two and a half day conference will touch on all aspects of adult and pediatric urology with an emphasis on work-life balance and advocacy.

We will address leadership training/professional development with presentations on Saturday afternoon and before the President’s Banquet on Saturday evening. Our keynote speaker is Natalie Bell, the founder of Mindful Wellness, a certified mindfulness teacher, and a faculty member of UCLA’s Mindful Aware Research Center. Natalie is experienced in helping healthcare professionals of all types utilize mindfulness tactics to increase compassion and joy, and feel more fulfilled in all aspects of life.

As a mentoring meeting, we focus on the experiences and accomplishments of our trainees at all levels. This year’s meeting features podium and poster sessions showcasing the research efforts of residents, fellows and medical students. Trainees will have the opportunity to present their work, refine their presentation skills, and receive meaningful, constructive feedback from more seasoned urologists. On Sunday morning, there will be a “Mock Oral Boards” session for urologists of all levels, again led by Dr. Melissa Kaufman, as well as a “Mock Grant Writing Session” directed by Dr. Margarett Shnorhavorian, a R01-funded investigator. Many trainees are sponsored through travel awards, thanks to the generous support of our members and sponsors.

Last year’s inaugural “Speed Mentoring” program met with rave reviews and will be repeated this year, allowing mentees and mentors to meet one another for short periods similar to “speed dating.”

As always, the most important aspect of our standalone winter meeting is the collegial environment that fosters networking among women from various geographic and clinical backgrounds. These personal interactions are important not only for our members in training, but for women throughout their careers. The mission of SWIU is to support women in urology! Your attendance represents a vital component of the experience. We look forward to your participation and contributions to this year’s meeting!

Teresa D. Beam, MD, FACS
SWIU President

Kathleen Kieran, MD, MS, MME
Winter Meeting Program Chair
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Vanderbilt University Medical Center
Nashville, TN

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Chesapeake Urology Associates, PA
Silver Spring, MD

Margarett Shnorhavorian, MD, MPH, FAAP, FACS
Seattle Children’s Hospital
Seattle, WA

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

Simone Thavaseelan, MD
Brown University/Rhode Island Hospital
Providence, RI

Jannah Thompson, MD, FPMRS,
Urologic Consultants, P.C.,
Wyoming, MI

Claire C. Yang, MD
University of Washington
Seattle, WA

Anna M. Zampini, MD, MBA
Cleveland Clinic Foundation
Cleveland, OH
### Past Presidents

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<tr>
<th>Year</th>
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<tr>
<td>2018</td>
<td>Suzette E. Sutherland, MD, MS, FPMRS</td>
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<tr>
<td>2017</td>
<td>Dolores J. Lamb, PhD, HCLD</td>
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<td>2016</td>
<td>Elizabeth A. Williams, MD</td>
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<td>2015</td>
<td>Leslie M. Rickey, MD, MPH</td>
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<td>Jennifer L. Dodson, MD, PhD</td>
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<td>Melissa R. Kaufman, MD, PhD</td>
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<td>Nancy A. Huff, MD</td>
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<td>Tracy Cannon-Smith, MD</td>
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<td>Elizabeth R. Mueller, MD</td>
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<td>Harriette M. Scarpero, MD</td>
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<td>Elizabeth W. Bozeman, MD</td>
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<td>Cathy K. Naughton, MD</td>
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<td>Brenda S. Kinard, MD</td>
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<td>Martha K. Terris, MD</td>
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<td>Janice L. Arnold, MD</td>
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<td>Deborah J. Lightner, MD</td>
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<td>M’Liss A. Hudson, MD</td>
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<td>Susan J. Kalota, MD</td>
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<td>Lindsey A. Kerr, MD</td>
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<td>Gloria S. Massey, MD</td>
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<td>Nina S. Davis, MD</td>
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<td>Tamara G. Bavendam, MD</td>
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<td>Kristene E. Whitmore, MD</td>
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<td>Carole L. Gordon, MD</td>
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<td>Dana J. Weaver Osterholtz, MD</td>
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### Mission Statement

To support the professional development and career advancement of women urologists and urologic researchers through education, advocacy, and mentorship.
Registration/Information Desk Hours
Location: Silverman Foyer
Friday, January 18, 2019  6:30 a.m. – 6:30 p.m.
Saturday, January 19, 2019  6:30 a.m. – 5:30 p.m.
Sunday, January 20, 2019  7:00 a.m. – 11:00 a.m.

Exhibit Hall Hours
Location: Paloma I-III
Friday, January 18, 2019  10:00 a.m. – 6:30 p.m.
Saturday, January 19, 2019  7:00 a.m. – 1:00 p.m.

Registration Fee Includes:
- Entrance to scientific sessions
- Program materials
- Breakfasts, breaks, and lunches
- Entrance to the Welcome Reception and the President's Reception and Banquet

Welcome Reception with Exhibitors and Resident Poster Session
Date:  Friday, January 18, 2019
Time:  5:00 p.m. – 6:30 p.m.
Location:  Paloma I-III and Paloma Foyer
Cost:  Included in registration fee
Description:  The Society of Women in Urology welcomes its members to the 8th 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. The Resident/Fellow Poster Session will take place during the reception. Make sure to take time to interact with our poster presenters.

President’s Reception & Banquet
Date:  Saturday, January 19, 2019
Time:  6:15 p.m. – 9:00 p.m.
Location:  Kiva I-III
Cost:  Included in registration fee
Description:  Join fellow SWIU members for the annual President’s Banquet starting with a poolside reception. This year the banquet will include announcing the first Outstanding Resident Award, as well as the awards for best podium and poster presentations.
YOGA: Dr. Vinyasa - The Resilience of an Open Heart
Date:       Saturday, January 19, 2019
Time:       7:00 a.m. – 7:45 a.m.
Location:   Mohave I-II
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 19, 2019
Time:       3:00 p.m. – 4:30 p.m.
Location:   Mohave I-III
Description: SWIU’s 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.

Keynote Address: Being Your Own Advocate for Well Being - Using Mindful Self-Compassion for Inner Resilience
Date:       Saturday, January 19, 2019
Time:       10:30 – 12:30 p.m. | 5:30 p.m. – 6:15 p.m.
Location:   Mohave I-III
Description: Ms. Bell is the Director of Corporate Programs at Unplug Meditation where she teaches professionals to actively connect the mind and body to improve focus, decrease negative thoughts, increase happiness and relate better to others. In her extensive experience of teaching mindfulness and self-reflection to healthcare providers, Ms. Bell has helped numerous providers become more mindful, compassionate, and focused, which has directly translated into better self-care and improved relationships with their patients. In this workshop, she will lead the group through guided reflections and meditations tailored to specific stressors within urology.

Networking Breakfast
Date:       Sunday, January 20, 2019
Time:       7:00 a.m. – 11:00 a.m.
Location:   Silverman Foyer
Cost:       Included in registration fee
Description: SWIU is happy to offer another networking opportunity at the 8th Annual Clinical Mentoring Conference. Chat with attendees and SWIU board members over a complimentary breakfast before heading home.

Mock Oral Boards
Date:       Sunday, January 20, 2019
Time:       7:30 a.m. – 9:30 a.m.
Location:   Paloma I-III
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.

Mock Grant Writing Session
Date:       Sunday, January 20, 2019
Time:       7:30 a.m. – 9:30 a.m.
Location:   Hacienda I-III
Description: As available funding for research decreases at the regional and national levels, grantsmanship is more important than ever. Articulately defining a research question, designing a well-constructed research plan, and identifying outcomes of interest are key steps in study design. Dr. Shnorhavorian is one of only a few NIH R01-funded female surgeons in the country, and will offer participants the opportunity for grant writing knowledge as well as for personal feedback on draft grants.
Educational Needs:

The United States is facing an opioid crisis, with about 4% of adults regularly taking opiate medication and opiate prescriptions continue to increase. Data suggest that not only does perioperative opiate use mediate physiological changes that alter perioperative risk, but that a substantial proportion of patients with opiate dependence are first exposed to opiates through appropriately written peri- or postoperative prescriptions. These findings underscore the role of surgeons as stewards for the thoughtful prescription of opioids, and the need to partner with patients to explore non-opioid alternatives for pain management.

Increasing attention has been given to patient perspectives in health care, with measures of quality now routinely including patient-centered outcomes. Although the practice of medicine has, at its core, always been about the patient, many providers were not trained in an explicitly patient-centered model. Understanding the crucial elements of a patient-centered practice, including how to have difficult conversations with patients, can improve the provider-patient relationship, improve quality of care, and increase patient and provider satisfaction. Increased awareness of patient experience has also disclosed bioethical dilemmas in medicine in general and urology in particular; acknowledging these challenges with patients and families and partnering together to find the “right” answer for each individual patient is more important than ever.

On a population level, social, economic, and healthcare disparities continue despite our best efforts. Identifying and addressing barriers to better health care often seems overwhelming; yet, targeted advocacy at the personal, local, regional, national, and even international level is doable and impactful. Knowing where, how, and with whom to take action can help to bring about real change; conversely, not knowing how to do so may allow other, undesirable, changes to passively occur. Know how to stand up for what matters most to you!

The number of open urology positions continues to far outpace the number of urology residency graduates. Being thoughtful and strategic about what type of practice to select is valuable, and yet few urologists report receiving specific guidance in this area. Choosing the “right” job is not simply a matter of location and compensation, but also of balancing clinical and nonclinical demands, optimizing work-life balance, picking the right partners, and identifying opportunities for sponsorship and mentorship. Explicitly identifying your own values and how these align with the reality of a job in any practice sector may help pick the perfect job on the first try; if the job isn’t perfect, then negotiation and conflict management skills can help to bring expectations and reality much closer, build and reinforce valuable relationships, and accomplish common goals.

Social media, in any of its forms, fosters rapid dissemination of information to an enormous audience. As such, it provides an incredible platform to bring information to others, while simultaneously underscoring the need to control what information is shared. Controlling your “brand” (what others think of when they think of you) and harnessing social media for positive purposes can augment personal and professional growth; conversely, if you do not develop and control your brand, others will do so for you, and perhaps not to your liking. As social media continues to grow in the number of platforms and immediacy of activity, understanding its uses and limitations is more important than ever.

The hectic pace of medical practice and the myriad competing demands for our time and attention (just look at the paragraphs above!) is not sustainable unless providers prioritize self-care: identifying priorities, achieving goals, and promoting a well-rounded lifestyle. ‘Well-rounded’ means different things to different people; understanding what aligning your time with your priorities would look like to you (even with external challenges) requires thoughtful, insightful, honest reflection. Striking a balance between your own goals and the needs of others is the hallmark of true leadership.
Educational Objectives:

At the conclusion of the SWIU 8th Annual Clinical Mentoring Conference, attendees will be able to:

1. Describe current issues in opioid prescribing and overprescribing, and identify strategies to manage pain.
2. Describe how social media may be utilized by current and prospective patients, other physicians, and institutions to share medical knowledge and promote specific providers and clinical offerings.
3. Explain recent updates to the AUA Guidelines, and identify clinical situations and patient populations to whom these updates may apply.
4. Identify and implement the skills needed to conduct challenging conversations with patients and family members.
5. Identify specific challenges to the medical care of transgender patients, and describe strategies to address these challenges.
6. Describe current health policy issues and identify ways to advocate for change at the local, regional, and national levels.
7. Describe the different practice models available and the challenges and benefits inherent to each.
8. Identify ways to optimize clinic and practice flow in a patient- and provider-centered manner.
9. Explain and implement the skills needed to identify, manage, and resolve conflict.
10. Describe ways to promote one’s interests (e.g. clinical and research) locally, regionally, nationally, and virtually.
11. Identify and implement the skills needed to develop a patient-centered practice.
12. Describe ethical concerns in pediatric and adult urologic care.
13. Describe the key elements of a successful grant application.
Category 1

Creighton University Health Sciences Continuing Education designates this live activity for a maximum of 16.50 AMA PRA Category 1 Credit(s)™. Physicians should claim only credit commensurate with the extent of their participation in this 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 the Society of Women in Urology. 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.

Non-physician 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

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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. Please speak to a staff person at the registration/information desk if you require special assistance to fully participate in the meeting.
2019 Resident Travel Award Winners

Maria Becerra, MD
Alexandra Berger, MD
Molly DeWitt-Foy, MD
Paula Domino, MD  Southeastern Section
Laura Donnelly, MD  Northeastern Section (US)
Jennifer Fantasia, MD
Zeynep Gul, MD
Amanda Hird, MD  Northeastern Section (Canada)
Sarah Holzman, MD  Mid-Atlantic Section
Shreelaya Popat, MD  South Central Section
Shannon Smith, MD  New York Section
Ericka Sohlberg, MD
Alexandra Tabakin, MD

2019 Resident Travel Award Contributors

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Elizabeth W. Bozeman, MD*
Kirsten Carlson
Sheila K. Gemar, MD
Suzanne E. Generao, MD
Natasha Ginzburg, MD
Melissa R. Kaufman, MD, PhD*
Jerilyn M. Latini, MD
Sara M. Lenherr, MD, MS, FPMRS
Tamra E. Lewis, MD, FACS
Melissa M. Montgomery, MD
Elizabeth R. Mueller, MD, MSME*
Michelle Pacheco, MD
Leslie M. Rickey, MD, MPH
Julie M. Riley, MD
Courtney Rowe, MD
Chen Shenhar
Kristina D. Suson, MD
Simone Thavaseelan, MD
Jannah Thompson, MD, FPMRS
Rosalia Viterbo, MD
Ouida L. Westney, MD
Hadley M. Wood, MD

*Support completely funded one or more resident travel awards
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Industry listing as of 1/4/2019
All sessions will be located in the Hacienda I-III unless otherwise noted. Speakers and times are subject to change.

FRIDAY, JANUARY 18, 2019

OVERVIEW

6:30 a.m. - 6:30 p.m.  Registration/Information Desk Open
  Location: Silverman Foyer

10:00 a.m. - 6:30 p.m.  Exhibit Hall Open
  Location: Paloma I-III

GENERAL SESSION

8:00 a.m. - 8:05 a.m.  Welcome and Opening Remarks
  President:  Teresa D. Beam, MD, FACS
  Program Chair: Kathleen Kieran, MD, MSc, MME

8:05 a.m. - 8:35 a.m.  Opioid Stewardship in Urology
  Speaker:          Anna M. Zampini, MD, MBA

8:35 a.m. - 9:05 a.m.  Panel Discussion: Social Media, the Internet and the Patient
  Moderator:       Kathleen Kieran, MD, MSc, MME
  Panelists:         Jamie Z. Belsito
                    Jennifer L. Dodson, MD, PhD
                    Courtney Rowe, MD

9:05 a.m. - 9:35 a.m.  Caring for the Transgender Patient
  Speaker:          Geolani W. Dy, MD

9:35 a.m. - 10:05 a.m.  Time Management and Organizational Skills
  Moderator:        Claire C. Yang, MD
  Panelists:         Joanna K. Chon, MD
                    Dana W. Giel, MD

10:05 a.m. - 10:30 a.m.  Break with Exhibitors
  Location: Paloma I-III

10:30 a.m. - 11:00 a.m.  Relationship-Centered Practice
  Speaker:          Muneera Kapadia, MD, MME

11:00 a.m. - 11:30 a.m.  Building Your Practice: Improving Access for Your Patients
  Speaker:          Diana C. Londoño, MD
11:30 a.m. - 12:00 p.m. Difficult Discussions with Patients
   Speaker: Muneera Kapadia, MD, MME

12:00 p.m. - 1:00 p.m. Lunch in Exhibit Hall
   Location: Paloma I-III

1:00 p.m. - 1:30 p.m. AUA Guideline Updates: From Prostate Cancer to Peyronie's Disease
   Speaker: Gina Lockwood, MD, MS

1:30 p.m. - 2:00 p.m. Challenging Cases: Ask the Experts
   Moderator: Suzette E. Sutherland, MD, MS, FPMRS
   Panelists: Angela M. Arlen, MD
              Jerilyn M. Latini, MD
              Kristen R. Scarpato, MD, MPH

2:00 p.m. - 2:30 p.m. Well Prepared Women
   Speaker: Milka L. Micic

2:30 p.m. - 3:00 p.m. Break with Exhibitors
   Location: Paloma I-III

3:00 p.m. - 4:30 p.m. How to Negotiate for What You Want and Need
   Speaker: Sally Fortner, MD, MS

5:00 p.m. - 6:30 p.m. Welcome Reception with Exhibitors and Resident Poster Session*
   Location: Paloma I-III and Paloma Foyer
   * Not CME Accredited

Poster #1
   TRENDS IN REPRESENTATION OF WOMEN IN LAPAROSCOPIC AND ROBOTIC SURGERY: HOW DOES UROLOGY COMPARE WITH OTHER SURGICAL FIELDS?
   Presented By: Nina Mikkilineni, MD

Poster #2
   PERIOPERATIVE FACTORS CONTRIBUTING THE DELAYED RETURN TO CONTINENCE AFTER RADICAL PROSTATECTOMY
   Presented By: Divya Ajay, MD, MPH

Poster #3
   EJACULATION PRESERVING MIDDLE LOBE ONLY TRANURETHRAL RESECTION OF THE PROSTATE: 12 YEAR EXPERIENCE.
   Presented By: Zeynep Gul, MD
| Poster #4 | PERSPECTIVES ON PARENTAL LEAVE AS A PRACTICING PHYSICIAN IN A SURGICAL SPECIALTY  
Presented By: Tyler M. Gaines, BS |
| Poster #5 | VARIABILITY IN PRICES FOR ERECTILE DYSFUNCTION MEDICATIONS - ARE ALL PHARMACIES THE SAME?  
Presented By: Laura Bukavina, MD, MPH |
| Poster #6 | STAPHYLOCOCCAL AND STREPTOCOCCAL URINARY TRACT INFECTIONS ARE ASSOCIATED WITH HIGH INCIDENCE OF ABNORMAL IMAGING FINDINGS IN PEDIATRIC MALES  
Presented By: Sarah Holzman, MD |
| Poster #7 | HIGH INTENSITY FOCUSED ULTRASOUND (HIFU) FOR FOCAL PROSTATE CANCER IN ALL GRADE GROUPS  
Presented By: Maria F. Becerra, MD |
| Poster #8 | ANALYSIS OF NARRATIVE REVIEWS FOR FPMRS SPECIALISTS ON HEALTHGRADES.COM  
Presented By: Khushabu Kasabwala, MD |
| Poster #9 | OVERUSE OF SPECIALTY CARE FOR WOMEN WITH URINARY INCONTINENCE  
Presented By: Claire S. Burton, MD |
| Poster #10 | CAN COEXISTING LESIONS IN PROSTATE MRI PREDICT CANCER IN PI-RADS 3 LESIONS?  
Presented By: Grace Yaguchi |
| Poster #11 | THE IMPACT OF THE FDA TESTOSTERONE SUPPLEMENTATION THERAPY SAFETY ADVISORY ON PRESCRIBING PATTERNS  
Presented By: Gricelda Gomez, MD, MPH |
| Poster #12 | EXPLORING THE PATTERNS OF PRACTICE AND SATISFACTION AMONG FEMALE UROLOGISTS IN CANADA  
Presented By: Amanda E. Hird, MD |
SATURDAY, JANUARY 19, 2019

OVERVIEW

6:30 a.m. - 5:30 p.m.  Registration/Information Desk Open
                      Location: Silverman Foyer

7:00 a.m. - 1:00 p.m.  Exhibit Hall Open
                      Location: Paloma I-III

7:00 a.m. - 8:00 a.m.  Breakfast in the Exhibit Hall
                      Location: Paloma I-III

GENERAL SESSION

7:00 a.m. - 7:45 a.m.  YOGA: Dr. Vinyasa - The Resilience of an Open Heart*
                        Location: Mohave I-II
                        Instructor: Lindsey A. Kerr, MD
                        * Not CME Accredited

8:00 a.m. - 8:10 a.m.  Welcome and Opening Remarks
                        Program Chair: Kathleen Kieran, MD, MSc, MME

8:10 a.m. - 8:40 a.m.  Panel Discussion: Running a Practice Efficiently in Academics and Private Practice
                        Moderator: Simone Thavaseelan, MD
                        Panelists: Teresa D. Beam, MD, FACS
                                   Alison M. Christie, MD
                                   Cara B. Cimmino, MD
                                   Jerilyn M. Latini, MD

8:40 a.m. - 9:10 a.m.  Defining and Refining Your Brand
                        Speaker: Stephanie J. Kielb, MD

9:10 a.m. - 9:40 a.m.  Bioethics
                        Speaker: Margarett Shnorhavorian, MD, MPH, FAAP, FACS

9:40 a.m. - 10:15 a.m. Advocacy Panel
                        Moderator: Kathleen Kieran, MD, MSc, MME
                        Panelists: Jamie Z. Belsito
                                   Lindsey A. Kerr, MD
                                   Una J. Lee, MD, FPMRS
                                   Audrey C. Rhee, MD

10:15 a.m. - 10:30 a.m. Break with Exhibitors
                        Location: Paloma I-III
10:30 a.m. - 12:00 p.m.  Keynote Address: Being your own Advocate for Well Being - using Mindful Self-compassion for Inner Resilience  
Location: Mohave I-III  
Speaker: Natalie Bell

12:00 p.m. - 1:00 p.m.  Lunch in Exhibit Hall  
Location: Paloma I-III

1:00 p.m. - 1:20 p.m.  Mind the Gap: Transition from Training to Practice Panel  
Speakers: Jennifer E. Fantasia, MD  
Katherine L. Rotker, MD  
Cheryl S. Shih, MD

1:20 p.m. - 2:50 p.m.  Resident Podium Session  
Moderators: Anne P. Cameron, MD, FPMRS  
Priyanka Gupta, MD  
Aruna V. Sarma, PhD, MHA

1:20 p.m.  #1  RACIAL DISPARITIES IN ANALGESIC USE AMONGST PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT FOR ACUTE RENAL COLIC IN THE UNITED STATES: A POPULATION-BASED ANALYSIS  
Presented By: Alexandra Berger, MD

1:29 p.m.  #2  OVERALL SURVIVAL AND RISK OF RECURRENCE AFTER RADICAL CYSTECTOMY WITH CLOSE NEGATIVE MARGINS  
Presented By: Taylor A. Goodstein, BA

1:38 p.m.  #3  ADJUVANT CHEMOTHERAPY IN THE TREATMENT OF LYMPH NODE POSITIVE SQUAMOUS CELL CARCINOMA OF THE PENIS: ANALYSIS OF THE NATIONAL CANCER DATA BASE  
Presented By: Valary Raup, MD

1:47 p.m.  #4  A NEW PARADIGM FOR OUTPATIENT DIAGNOSIS AND TREATMENT OF LOWER URINARY TRACT SYMPTOMS UTILIZING A MOBILE APP/SOFTWARE PLATFORM AND REMOTE PATIENT VISITS: FEASIBILITY STUDY  
Presented By: Roni Manyevitch, BS
<table>
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<tr>
<th>Time</th>
<th>Session #</th>
<th>Title</th>
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<tr>
<td>1:56 p.m.</td>
<td>#5</td>
<td>SURVIVAL RATES AFTER RETROPERITONEAL LYMPH NODE DISSECTION (RPLND) FOR EARLY AND ADVANCED STAGE TESTICULAR NONSEMINOMATOUS GERM CELL TUMORS (NSGCT)</td>
<td>Alexandra Tabakin, MD</td>
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<td>2:05 p.m.</td>
<td>#6</td>
<td>FACTORS THAT PREDICT ACHIEVING 2.5L URINE VOLUME AFTER INITIAL METABOLIC ASSESSMENT AT A URINARY STONE CLINIC</td>
<td>Kimberly S. Tay</td>
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<td>2:14 p.m.</td>
<td>#7</td>
<td>MICRORNA SIGNATURE PROVIDES NOVEL BIOMARKER FOR OVERALL SURVIVAL IN PAPILLARY RENAL CELL CARCINOMA</td>
<td>Amanda Raines, MD</td>
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<td>2:23 p.m.</td>
<td>#8</td>
<td>TRENDS AND SAFETY OF CONCURRENT SACROCOLOPEXY AND RECTOPEXY</td>
<td>Claire S. Burton, MD</td>
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<td>2:32 p.m.</td>
<td>#9</td>
<td>NATURAL HISTORY OF UPPER TRACT CALCULI IN SPINAL CORD INJURY PATIENTS</td>
<td>Giulia I. Lane, MD</td>
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<td>2:50 p.m.</td>
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<td>Transition Break</td>
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<td>3:00 p.m.</td>
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<td>Mentoring Session*</td>
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<td>Moderators: Kathleen Kieran, MD, MSc, MME</td>
<td>Jannah Thompson, MD, FPMRS</td>
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<td>Anna M. Zampini, MD, MBA</td>
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<td>* Separate registration required</td>
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<tr>
<td>5:30 p.m.</td>
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<td>Keynote Address: Being your own Advocate for Well Being - using Mindful Self-compassion for Inner Resilience Part 2</td>
<td>Natalie Bell</td>
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<td>6:00 p.m.</td>
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<td>Past Presidents' Reception*</td>
<td>Presidential Suite</td>
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<td>* Invitation Only</td>
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<td>6:15 p.m.</td>
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<td>Banquet Reception</td>
<td>Silverman Terrace</td>
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<td>7:00 p.m.</td>
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<td>President’s Banquet</td>
<td>Kiva I-III</td>
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SUNDAY, JANUARY 20, 2019

OVERVIEW

7:00 a.m. - 11:00 a.m.  Registration/Information Desk Open
Location: Silverman Foyer

GENERAL SESSION

7:00 a.m. - 11:00 a.m.  Networking Breakfast
Location: Silverman Foyer

Concurrent Sessions Begins

Concurrent Session 1 of 2

7:30 a.m. - 9:30 a.m.  Mock Oral Boards*
Location: Paloma I-III
Moderator: Melissa R. Kaufman, MD, PhD, FACS
* Separate registration required

Concurrent Session 2 of 2

7:30 a.m. - 9:30 a.m.  Mock Grant Writing Session*
Location: Hacienda I-III
Instructor: Margarett Shnorhavorian, MD, MPH, FAAP, FACS
* Separate registration required

Concurrent Sessions Ends

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<table>
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<td>BEAM, MD, FACS, Teresa President, CME Organizer, Panelist</td>
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<td>KIERAN, MD, MSc, MME, Kathleen CME Organizer, Moderator</td>
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<td>Boston Scientific</td>
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<td>Grants/Research Support</td>
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<td>ARLEN, MD, Angela Panelist</td>
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<td>FANTASIA, MD, Jennifer Speaker, Moderator</td>
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<td>FORTNER, MD, MS, Sally Speaker</td>
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<td>GIEL, MD, Dana Panelist</td>
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<td>Company: Medtronic, Role with Commercial Interest: Consultant, Nature of Relationship: Faculty/Surgical Preceptor</td>
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<td>LOCKWOOD, MD, Gina Speaker</td>
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<td>ROTKER, MD, Katherine Speaker</td>
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<td>SCARPATO, MD, MPH, Kristen Panelist</td>
<td>Oakstone Urology Review, Honorarium, Teaching</td>
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<td>SHIH, MD, Cheryl Speaker</td>
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<td>SHNORHAVORIAN, MD, MPH, FAAP, FACS, Margaret Instructor, Speaker</td>
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<td>TAY, Kimberly Abstract Presenter</td>
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<td>THAVASEELAN, MD, Simone Moderator</td>
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<td>THOMPSON, MD, FPMRS, Jannah Moderator</td>
<td>Olympus Consultant Provide video and expertise</td>
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<td>ZAMPINI, MD, MBA, Anna Speaker, Moderator</td>
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Podium #1
RACIAL DISPARITIES IN ANALGESIC USE AMONGST PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT FOR ACUTE RENAL COLIC IN THE UNITED STATES: A POPULATION-BASED ANALYSIS
*Alexandra Berger1; Ye Wang1; Steven Chang1; Benjamin Chung2 and George Haleblian1
1Brigham and Women's Hospital/Harvard University; 2Stanford University
Presented By: Alexandra Berger

Introduction: The Patient Protection and Affordable Care Act was passed in 2010 to address disparities in health care delivery in the United States. Growing literature documents these disparities extend to treatment of acute, chronic and cancer-related pain. The aim of this study is to quantify racial disparities in use of analgesia amongst patients seen in the Emergency Department for uncomplicated renal colic.

Methods: We identified all individuals presenting to the Emergency Department with a primary diagnosis of urolithiasis (ICD9 592.0, 592.1, 592.9, 274.11) from 2003-2015 in the Premier Hospital Database, a nationally representative discharge database. To focus on non-toxic patients, we limited our cohort to patients with the following criteria: discharge in one day or less, no intravenous antibiotics, no admission to the ICU, no procedures, and no inpatient mortality; we also excluded patients with a history of chronic pain syndrome and renal insufficiency. We then assessed for the relationship between race/ethnicity (White, Black, Hispanic) and the receipt of narcotic pain medication, based on morphine equivalents, and ketorolac, through multivariable regression models adjusting for patient and hospital characteristics.

Results: The cohort was 266,210 patients, comprised of White (84%), Black (6%) and Hispanic (10%) patients. The overall median narcotic use per patient encounter was 20 mg and 55.5% of the cohort received ketorolac. Our adjusted model (Figure 1) showed Whites had the highest median amount of narcotic pain medications (20 mg) with less associated with Blacks (-3.2mg [95% CI: -4.4mg to -2mg]) and Hispanics (-5.9mg [95% CI: -6.9mg to -4.8mg]); a similar racial disparity for narcotics was present at the 25% and 75% percentiles. Our analysis revealed that Blacks were significantly less likely to receive ketorolac (OR: 0.72, 95% CI: 0.62 to 0.84); there was no difference between Whites and Hispanics. Additionally, patients receiving ketorolac were also associated with receiving more narcotics (+3.7mg [95% CI: +3.0mg to +4.4mg]).

Conclusion: Black and Hispanic patients seen in the Emergency Department in the United States with acute renal colic receive significantly less narcotic pain medication than White patients; Black patients are also less likely to receive ketorolac. Additional research is warranted to determine the cause of this racial disparity in analgesic use.
Podium #2
OVERALL SURVIVAL AND RISK OF RECURRENCE AFTER RADICAL CYSTECTOMY
WITH CLOSE NEGATIVE MARGINS
Madison Lyon, BS1; *Taylor A. Goodstein, BA1; Sharon White, BBA1; Colin O'donnell, PhD1;
Janine Oliver, MD1 and Shandra Wilson, MD1
1Division of Urology, Department of Surgery, University of Colorado Hospital
Presented By: Taylor A. Goodstein BA

Introduction: Radical cystectomy (RC) is the mainstay of treatment for patients with both
muscle invasive bladder cancer (MIBC) and non-muscle invasive bladder cancer (NMIBC)
with high risk features. When compared to patients with negative soft tissue surgical
margins (STSM), patients with positive STSM at the time of RC have an increased risk of
recurrence and reduced survival, and are thus managed differently, with adjuvant therapies
after RC. What isn’t known, however, is if patients with narrowly negative surgical margins
at RC have differences in survival or recurrence. In our study, we sought to determine if the
distance of negative margins on histopathologic evaluation impacted either OS or likelihood
of recurrence after RC.

Methods: Electronic medical records of patients who underwent RC for urothelial
carcinoma at the University of Colorado Hospital between 2004-2016 were retrospectively
reviewed. Margin status was obtained from pathology reports. The primary predictors were
surgical margin status and distance of histopathologic surgical margins. Four classes of
margins were analyzed: no residual tumor present at RC, >5 mm of negative STSM, <5
mm of negative STSM, and positive STSM. The primary outcome measure was overall
survival (OS) and likelihood of recurrence.

Results: A total of 417 records were analyzed, including 101 patients (24.2%) with
negative margins <5 mm, 216 patients (51.8%) with negative margins >5 mm, 28 patients
(6.7%) with no tumor present at time of RC, and 72 patients (17.3%) with positive margins
at RC. When assessing overall survival, on multivariable analysis there was a significant
difference found on log-rank test for survival between the four categories of margins: no
residual tumor present, negative STSM >5 mm, negative STSM <5 mm, and positive STSM
(p<0.001). There was a significantly higher likelihood of recurrence when comparing <5 mm
negative STSM versus >5 mm STSM (p = 0.0192).

Conclusion: Our findings are consistent with current research indicating a significantly
worse OS and increased likelihood of tumor recurrence for patients with positive STSM.
However, our findings also indicate that obtaining negative STSM of > 5 mm during RC
constitutes a significantly reduced likelihood of recurrence when compared to those
patients with negative STSM of less than 5 mm. The increased recurrence observed in
patients with closer negative STSM may suggest that patients found to have close negative
STSM on histopathologic evaluation should be treated with adjunct therapies, more
similarly to patients with positive STSM.
Podium #3
ADJUVANT CHEMOTHERAPY IN THE TREATMENT OF LYMPH NODE POSITIVE SQUAMOUS CELL CARCINOMA OF THE PENIS: ANALYSIS OF THE NATIONAL CANCER DATA BASE
*Valary Raup, MD1,2; Julie Szymaniak, MD1,2; Alexandra Berger, MD1,2; Gricelda Gomez, MD1,2; Nawar Hanna, MD1,2 and Jairam Eswara, MD1,2
1Harvard Program in Urology; 2Brigham and Women’s Hospital
Presented By: Valary Raup, MD1

Introduction: While the use of neoadjuvant TIP (paclitaxel, ifosfamide, and cisplatin) has been well described, the use of adjuvant chemotherapy (ACT) in the treatment of node positive squamous cell carcinoma (SCC) of the penis is controversial and there has been few large studies looking at utilization and outcomes. We sought to describe the use of adjuvant chemotherapy in patients with lymph node positive disease (N+) penile cancer using a large nationwide U.S. cancer database.

Methods: The National Cancer Data Base (NCDB) (2004-2014) was used to extract all patient with non-metastatic SCC of the penis who underwent partial or total/radical penectomy with inguinal lymph node dissection. Only patients found to have N+ were included in our cohort. Patients were categorized according to receipt of ACT. Descriptive statistics were used to compare patients according to receipt of ACT. Multivariable logistic regressions were performed to determine patient, tumor or facility characteristics associated with use of ACT. Finally, multivariable Cox regression analysis was used to determine the impact of ACT on overall survival (OS).

Results: A total of 661 patients with N+M0 penile SCC were identified. Of these, 253 (38.3%) patients underwent ACT. Median age at diagnosis was 59 in those who received ACT and 65 in those who did not (p<0.001). After adjusting for all variables, ACT was more likely to be administered to patients with a lower Charlson-Deyo Score (p=0.04), lower education level (p=0.02), patients treated at a community cancer center (p=0.03) or in the New England/Mid-Atlantic regions (p<0.001), and patients with higher clinical or pathologic N stage (p<0.001; p<0.001). Median survival was 23.5 months for patients who received ACT and 24.3 months for those who did not, which approached significance statistically (p=0.05). After adjusting for all available covariates, there was no statistically significant difference in median survival (p=0.224, HR 1.16, 95% CI 0.91).

Conclusion: More the a third of patients with N+ SCC of the penis receive ACT. Other than more advanced disease, many patient and facility characteristics are associated with receipt of ACT. We did not find significant differences in overall survival according to receipt of ACT. Further studies are needed to better define the role of ACT in advanced SCC of the penis.
Podium #4

A NEW PARADIGM FOR OUTPATIENT DIAGNOSIS AND TREATMENT OF LOWER URINARY TRACT SYMPTOMS UTILIZING A MOBILE APP/SOFTWARE PLATFORM AND REMOTE PATIENT VISITS: FEASIBILITY STUDY

*Roni Manyevitch, BS1; Devon N. Thomas, BS1; Eric S. W. Li, BA1; Michael Poon, MD2; Christine W. Liaw, MD3 and Jerry G. Blaivas, MD3

1Institute for Prostate and Bladder Research, New York, NY; 2Kaiser Permanente, Anaheim, CA; 3Icahn School of Medicine at Mount Sinai, New York, NY

Presented By: Roni Manyevitch, BS

Introduction: The goal of this research is to develop novel diagnostic and treatment paradigms for patients with lower urinary tract symptoms (LUTS) utilizing a software program comprised of a mobile app, validated patient reported outcome (PRO) questionnaires, bladder diaries, and remote patient monitoring. The goals are to triage patients, optimize quality, accuracy, and efficiency of in-office visits, substitute remote visits for in-office visits, enhance the quality of care, reduce costs and foster patient education, engagement, and self-help.

Methods: New patients referred to a urologist were screened for inclusion based on: age > 18, diagnosis of LUTS, benign prostatic hyperplasia, nocturia, or overactive bladder, and existing registration on the practice website. Patients without e-mail access were excluded. Participants were offered remote, instead of in-office visits, when appropriate. Those who agreed were invited to download a mobile app* containing the lower urinary tract symptom score (LUTSS) and a 24-hour bladder diary. Participants with low (<14) or intermediate (14 - 42) LUTSS were offered remote visits; those with high scores (43 – 56), reflecting severe symptoms, were offered in-office visits. Data obtained included: age, sex, number screened, excluded, included, lost to follow-up, remote visits, in-office visits, app downloads, time lapse between initial referral, invite and remote or in-office visit.

Results: Results are displayed in Figure 1. Overall, remote visits were achieved in 17% of the entire cohort and 68% of those who completed the app. 34/57 (60%) completed the satisfaction questionnaire. Among patients surveyed, 80% found the app to be an effective way of sharing information with their physician, and 74% found it to be easy and effective to use.

Conclusion: A new paradigm for outpatient diagnosis and treatment of LUTS was developed using a software program comprised of a mobile app, validated PRO questionnaires, bladder diaries, and remote patient monitoring. Patients were triaged according to symptom severity, and 68% of those who completed the app elected to have their initial evaluation performed remotely (17% of all new urology consults). Patient and physician satisfaction were high. Further studies extending and applying the paradigm to a larger and more diverse group of patients are necessary to determine the extent of its healthcare quality and economic benefit. *weShare URO
Podium #5
SURVIVAL RATES AFTER RETROPERITONEAL LYMPH NODE DISSECTION (RPLND) FOR EARLY AND ADVANCED STAGE TESTICULAR NONSEMINOMATOUS GERM CELL TUMORS (NSGCT)

*Alexandra Tabakin, MD; Sinae Kim, PhD; Charles Polotti, MD; Zorimar Rivera-Núñez, PhD; Joshua Sterling, MD, MA; Kushan Radadia, MD; Nicholas Farber, MD; Brian Shinder, MD, MS; Sammy Elsamra, MD; Isaac Kim, MD, PhD; Eric Singer, MD, MA and Thomas Jang, MD, MPH

1Rutgers Robert Wood Johnson Medical School, Division of Urology, New Brunswick, NJ; 2Rutgers Cancer Institute of New Jersey, Department of Radiation Oncology, New Brunswick, NJ; 3Section of Urologic Oncology, Rutgers Cancer Institute of New Jersey, New Brunswick, NJ

Presented By: Alexandra Tabakin, MD

Introduction: RPLND is well-established therapy to treat men with early stage NSGCT and those with advanced disease (i.e. residual mass after chemotherapy). With contemporary treatments, cure rates for these men exceed 90%. Little data exists on factors associated with decreased survival in these patients. We describe factors that impact survival in men with NSGCT who undergo RPLND.

Methods: Using 2004-2014 data from the National Cancer Database, we identified 62,727 men with 1° testicular cancer. After excluding men with benign and non-germ cell histology, seminoma histology, those who did not undergo RPLND, and those whose clinical stage (CS) and survival data were unavailable, 1,701 men comprised our final cohort. Men were further stratified according to whether they had 1° RPLND vs post-chemotherapy (PC) RPLND, with 1° RPLND defined as RPLND performed for CS IA-IIB w/o prior chemotherapy and PC-RPLND classified as RPLND performed for CS IIA-IIIC after chemotherapy. Median f/u time was 4.6 years. Descriptive statistics for all factors according to whether patients underwent 1° vs PC- RPLND were calculated. Kaplan-Meier method was used to assess overall survival and multivariate Cox proportional hazard regression models were applied to identify factors associated with decreased survival.

Results: Among 1,701 men undergoing RPLND, 89.5% and 10.5% underwent 1° RPLND and PC-RPLND, respectively. When comparing clinical and demographic characteristics between these men, there were no significant differences in age, comorbidity, income or education. Men who underwent PC-RPLND vs. 1° RPLND were more likely to have embryonal histology in their primary tumor (88% vs 81%, p=0.014). Overall survival at 5-years was 97.4% and 84.3% in the 1° RPLND and PC-RPLND groups, respectively (Figure 1a and 1b). On multivariate analyses, CS, co-morbidity, surgery type (1° vs PC) and insurance type were associated with decreased overall survival. For example, men with Medicaid/Medicare [HR, 2.84, (1.57-5.14)] or those uninsured [HR, 2.31, (1.05-5.12)] were at >2-fold risk of death vs those with private insurance (referrent).

Conclusion: Overall survival in men who undergo RPLND for NSGCT in the primary or PC setting remains excellent. Even when treatment and disease extent is taken into account, other factors including co-morbidities and insurance type significantly decreased survival in this young population.
Podium #6

FACTORS THAT PREDICT ACHIEVING 2.5L URINE VOLUME AFTER INITIAL METABOLIC ASSESSMENT AT A URINARY STONE CLINIC

*Kimberly Tay1,2; Anojan Navaratnam2; Michael Patton2; Mira Keddis2 and Mitchell Humphreys2

1University of Arizona College of Medicine Phoenix, Phoenix, AZ; 2Mayo Clinic, Department of Urology, Phoenix, AZ

Presented By: Kimberly Sarah Tay

Introduction: The American Urological Association recommends that recurrent stone formers achieve urine volume exceeding 2.5 liters (L) per day to reduce risk of recurrent urolithiasis. We have previously described factors that predict achieving 2.5L urine volume on initial metabolic urine analysis. The objective of this study is to examine a cohort of stone formers with subsequent 24-hour metabolic urine analysis, and determine predictors of achieving ≥2.5L after stone clinic evaluation.

Methods: Initial and subsequent 24-hour urine collections for stone formers presenting to Mayo Clinic Arizona between January 2007 and May 2017 were analyzed (n=1089). Subsequent collections between 6 weeks and 1.5 years of first collection depending on the clinical scenario were analyzed. We identified the patients that were unable to achieve 2.5L urine volume on initial collection (n=273) and then further divided the group into two cohorts: those that were able to or not able to achieve 2.5L urine volume on subsequent collection. We analyzed age, comorbidities, diuretic use, body mass index (BMI), insurance status, collection day, and metabolic parameters. Statistical analysis included the Chi-Square test and the non-parametric Kruskal-Wallis test to compare groups. Data was then reported as means and standard deviation.

Results: On subsequent collection, 165 patients did not achieve 2.5L/day urine output. Both cohorts completed urine collections during weekdays compared to weekends. Compared to patients who were unable to achieve subsequent 2.5L urine volume, patients who achieved subsequent 2.5L urine volume had a greater mean initial urine volume (1.5 vs 1.9L, p<0.05). Patients who achieved 2.5L urine volume on subsequent collection had decreased supersaturation of calcium oxalate (7.0 vs 3.1, p<0.05), but increased mean urine urea nitrogen (11.9±4.1 g/d, p<0.05) and protein catabolic rate (1.1±0.2 g/kg/d, p<0.05) compared to initial urine collection. Patients with a diagnosis of hyponatremia were less likely to achieve goal urine volume on subsequent collection (p<0.05). Gender, age, BMI, diuretic use and socioeconomic factors did not affect ability of patients to achieve goal urine volume.

Conclusion: This study demonstrates that 60% of patients with suboptimal urine volume after initial assessment in stone clinic are unable to achieve a goal urine volume of 2.5L on subsequent analysis. Our findings also suggest that urinary volume is linked to other modifiable dietary factors such as protein and salt intake. Hyponatremia may be a limiting clinical risk factor for achieving adequate urine volume among stone formers.
Podium #7

MICRONA SIGNATURE PROVIDES NOVEL BIOMARKER FOR OVERALL SURVIVAL IN PAPILLARY RENAL CELL CARCINOMA

*Amanda Raines, MD1; Spencer Krane1; Jacob Greenberg1 and Jonathan Silberstein1

1Tulane University Medical Center

Presented By: Amanda Raines, MD

Introduction: Renal Cell Carcinoma is newly diagnosed in 58,000 individuals in the United States annually. Papillary Renal Cell Carcinoma (pRCC) is the second most common variant of renal cell carcinoma accounting for approximately 20% of these cases. Currently, there are no widely adopted biomarkers that predict patient outcomes with pRCC. The aim of this study is to create a diagnostic score based on identified miRNA signatures that could be used predict patient survival.

Methods: Patient’s clinical data and level 3 miRNA expression profiles were obtained from the Cancer Genome Atlas (TCGA) repository, an NIH funded open genomic database (https://portal.gdc.cancer.gov). Clinical data was correlated with miRNA expression data, and regression analysis Kaplan-Meier curves and Heatmap clustering were performed using R packages ComplexHeatmap and Survival regression. Statistical analysis was also performed using R Studio v3.4.4. Significant miRNAs were isolated and a diagnostic high and low score was created correlating to a miRNA expression levels.

Results: A total of 276 patients were identified who met inclusion criteria and included in this study. Two miRNAs, hsa-mir-335 and hsa-mir-5010, were identified using regression analysis to be most associated with overall survival. Clustering analysis produced 213 patients with a high score and 63 patients with a low score. Patients with a low score showed a significant decrease in survivability (P<0.0001) (Figure 1). This was validated in multivariate analysis with known risk factors.

Conclusion: We have created a novel miRNA signature to predict survival in pRCC using previously unreported miRNA biomarkers. hsa-mir-335 has been identified in gastric cancer as biomarker and is upstream chromosome 7q from MET, a well-known amplified gene in pRCC. hsa-mir-5010 has been used a biomarker in colon cancer but has no validated targets currently. Prospective validation of these markers is ongoing along with further determination of mir-5010 role in disease progression in underway.
ANALYSIS OF NARRATIVE REVIEWS FOR FPMRS SPECIALISTS ON HEALTHGRADES.COM

*Khushabu Kasabwala, MD1; Sarah Huber, MD1; Bogdan Gadidov, MS2; Julia Vaillancourt, MS2; Jennifer Priestly, PhD2 and Patrick Culligan, MD1

1Department of Urology, New York Presbyterian Hospital, Weill Cornell Medical College, New York, NY, USA; 2Center For Statistics and Analytical Services, Kennesaw State University, Kennesaw, GA, 30144

Presented By: Khushabu Kasabwala, MD

Introduction: Physician rating websites are increasing in number and use. Given this growth, understanding online ratings and identifying factors associated with positive and negative ratings are important for both patients and surgeons. Despite their popularity, the true impact of these reviews, specifically their relevance in clinical care and practice management, remains unknown. In our study, we qualitatively analyzed the content of the written reviews to identify aspects of the patient experience that impact their perception of care and assess the specific factors associated with ratings of Female Pelvic Medicine and Reconstructive Surgery (FPMRS) specialists on a leading rating website, Healthgrades.com.

Methods: We performed a retrospective review of 689 FPMRS specialists on www.healthgrades.com. Physician demographics and the content of narrative (descriptive) reviews of all physicians with an “FPMRS” designation under fellowship was collected. Reviews were grouped into four broad themes used in other qualitative analysis studies. Four individuals working independently classified each free text narrative reviews into those broad themes: (1) physician (2) clinical outcomes (3) staff (4) non-specific or general. If a review contained remarks about more than one theme, it was assigned to each relevant theme group. Statistical analysis including inter-rater reliability was performed with SAS software.

Results: A total of 3300 narrative reviews independently categorized. The inter-rater reliability using these themes to categorize the reviews was high with Fleiss kappa scores of physician, outcomes, and staff of 0.66, 0.79, and 0.81, respectively. The intra-rater reliability was also high showing consistency in thematic assignment over time. Figure 1 depicts the distribution of the thematic categories for each corresponding rating. As expected, the patient’s perception of the physician had the greatest influence on very positive (5) or very negative (1) ratings. Although less so for the “clinical outcomes” theme, outcomes-related commentary did appear consistently in the text of very positive or very negative reviews. Ratings in the middle range (2, 3, and 4) were more greatly influenced by staff and practice qualities, with more reference to these factors than the physician or outcomes in the narrative text.

Conclusion: Content of physician reviews provides an important snapshot into the patient experience. We demonstrate that the physician is the most likely to lead to the extremes of reviews while the staff trigger a less powerful assessment. Recognition of themes in positive and negative reviews may provide an avenue to optimize the patient experience.
Podium #9
NATURAL HISTORY OF UPPER TRACT CALCULI IN SPINAL CORD INJURY PATIENTS
*Giulia I. Lane1; Rachel Mann2; John Stoffel1; William Roberts1; J Quentin Clemens1; Diana O'Dell1 and Anne Cameron1
1University of Michigan; 2University of Minnesota
Presented By: Giulia I. Lane, MD

Introduction: Patients with spinal cord injury (SCI) are at increased risk of developing renal and ureteral (upper tract) calculi. Guidelines for management of neurogenic bladder recommend regular renal ultrasound, however there is a paucity of evidence to direct management of incidentally discovered stones. This study describes the management of upper tract calculi among patients with SCI with attention to factors influencing surgical management versus observation.

Methods: In this descriptive, retrospective, cohort study patients with SCI and upper tract calculi were identified from an institutional neurogenic bladder database. Details pertinent to stone episodes (defined as clinical encounter for finding of new calculi) were gathered and evaluated from the medical record

Results: There were 37 patients with SCI with upper tract stones who were a median of 26 years (IQR 17,44) at time of their SCI. Most managed their bladders with intermittent catheterization (n=19). Among these 37 patients there were 53 stone episodes with 127 individual stones identified. Ultimately 16 (43%) patients required at least one surgical intervention. Median follow-up time was 48 months (IQR 22, 75). Of the 53 individual stone episodes, 36 were initially managed with observation whereas the remaining 17 proceeded to early/immediate surgical intervention. Of the 36 observed stone episodes, 7 (19%) ultimately underwent surgical intervention after a period of observation while 13 (36%) passed spontaneously and 16 (45%) remained on observation. Stone passage was not correlated to stone size (p=0.42), laterality (p=0.15) or location (p=0.45). Of the 26 episodes (49%) that required surgical intervention, pain was the most common primary indication for surgery (n=11/53, 46%). The median time from diagnosis to intervention was 3.5 months (IQR 1,19) and the most commonly performed surgery was ureteroscopy (n=16). Staged procedures were necessary in 25% (n=6). There was a correlation between increased number of stone episodes and requiring a surgical intervention (p=0.01).

Conclusions: In this SCI cohort with nephrolithiasis the majority of patients were asymptomatic and initially managed with observation, with only a small percentage of those deemed safe for conservative management eventually requiring surgery. Of all patients, less than half required surgery for nephrolithiasis and the only predictor of surgical intervention was the number of stone episodes’ patients experienced.
Introduction: Women have increasingly been joining the surgical workforce, however their participation in laparoscopic and robotic surgery is not well known. We evaluated trends in female attending participation in urological robotics and compared with common laparoscopic/robotic procedures in other surgical specialties.

Methods: We queried a Center for Medicare and Medicaid Services (CMS) database of surgeries performed on Medicare beneficiaries between 2012-2015 for common robotic or laparoscopic surgeries among different surgical fields, including robotic-assisted laparoscopic prostatectomy (RALP, CPT 55866), laparoscopic partial colectomy (CPT 44204, 44205, 42207), video-assisted thoracic surgery (CPT 32663), and laparoscopic hysterectomy (CPT 58548, 58571). We compared the proportion of female surgeons across procedures and evaluated for significant trends using Chi square and logistic regression, respectively.

Results: In 2012, females accounted for 2.7% of urologists performing RALPs. This percentage remained low at 1.7%, 1.2%, and 1.6% for years 2013, 2014, and 2015, respectively (OR 0.82 [CI 0.60-1.12], p=0.21). For colorectal surgeries, females accounted for 7.0% of surgeons in 2012 and increased to 10.8% by 2015 (OR 1.20 [1.01-1.43], p=0.04). For thoracic surgery, 7.4% of surgeons were female in 2012 and this remained stable at 8.2%, 6.6%, and 8.8% in 2013, 2014, and 2015, respectively (OR 1.04 [0.82-1.31], p=0.74). In gynecology, the proportion of females performing minimally invasive hysterectomies in 2012 was 26.4% and increased to 33.2% by 2015 (OR 1.12 [1.01-1.23], p=0.03). There were significantly fewer women performing RALP compared to colorectal, thoracic, and gynecology procedures (all p<0.0001).

Conclusion: There is a very small female surgical presence in RALP, unchanged over the study period. While this likely reflects a historically dominant male role in prostate cancer surgery, lack of uptrending despite diversification of the workforce deserves scrutiny. There has been a significant increase in female representation in laparoscopic colorectal surgery, though percentages remained low, perhaps reflective of a different culture within this field. Interestingly, even in gynecology, which is dominantly female, only a minority of laparoscopic surgeries were performed by women. It is not clear whether women may be discouraged from pursuing careers in minimally invasive surgery, or may generally have other interests. Scrutiny of training and mentorship are needed to ensure women have adequate opportunity to pursue careers in laparoscopic and robotic surgery if they desire.
Poster #2
PERIOPERATIVE FACTORS CONTRIBUTING THE DELAYED RETURN TO CONTINENCE AFTER RADICAL PROSTATECTOMY
*Divya Ajay, MD, MPH 1; Hanhan Li 1; Jenny Nguyen 2; Britanni Harlow 2; Xuemei Wang 3; Brian Chapin 1; John Davis 1 and O. Lenaine Westney 1
1Department of Urology, The University of Texas, MD Anderson Cancer Center, Houston, TX; 2University of Texas Health Science Center at Houston, McGovern Medical School, Houston, TX; 3Department of Biostatistics, The University of Texas, MD Anderson Cancer Center, Houston, TX
Presented By: Divya Ajay, MD, MPH

Introduction: Post-prostatectomy urinary incontinence (PPUI) is damaging to the quality of life of prostate cancer survivors. The etiology and risk factors of PPUI are poorly understood. The goal of this study was to characterize pre and intraoperative factors that contribute to a delay in regaining continence after robot-assisted radical prostatectomy (RP) at a single tertiary cancer center.

Methods: Time to dry (i.e., free from incontinence) is defined as the time interval between the date of prostatectomy and the first evaluation time with zero pad use. Patients were evaluated for pad usage at four time-points. Patients with missing data for pad use at all four evaluation time points were excluded. The probabilities of incontinence (i.e., with >0 pad use) were estimated using the Kaplan and Meier method. Cox proportional hazards regression models were used to assess the association between time to dry and patient characteristics. All statistical analyses were conducted in SAS and Splus.

Results: A total of 1275 patient were included. 851 (66.7%) ended up with zero pad use. The median time to dry was six months. The univariate analysis showed that age at RP, ethnicity (African American vs. Caucasian), clinical stage, pathologic staging, diabetes mellitus, nerve-sparing status and number of complications are significant predictors for the time to dry. On multivariate analysis, the variables that remained significant after backward model selections include age at RP, nerve-sparing status and number of comorbidities contributing to incontinence. Older age (p=0.0002) and more comorbidities (p=0.04) were associated with a prolonged time to regain continence, while having either unilateral (p=0.004) or bilateral (p=0.001) nerve-sparing RP was associated with a shorter time when compared to the non-nerve sparing group. Notably, neoadjuvant androgen deprivation therapy and preoperative hypogonadism were not correlated with worse outcomes.

Conclusion: Examining preoperative and technique factors that contribute to a delay in regaining continence after prostatectomy can help our understanding of post-prostatectomy urinary incontinence. Additionally, it can guide patient counseling.

Table 1. Multivariate Cox proportional hazards regression model for time to dry (N=1275).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Benefit Ratio</th>
<th>95% CI</th>
<th>p-value</th>
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<td>0.97</td>
<td>0.99</td>
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<td>Nerve sparing prostatectomy (unilateral versus none)</td>
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<td>1.16</td>
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<td>Nerve sparing prostatectomy (bilateral versus none)</td>
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<td>1.21</td>
<td>2.17</td>
</tr>
<tr>
<td>Number of comorbidities</td>
<td>0.87</td>
<td>0.76</td>
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EJACULATION PRESERVING MIDDLE LOBE ONLY TRANSURETHRAL RESECTION OF THE PROSTATE: 12 YEAR EXPERIENCE

*Zeynep Gul, MD1; Bilal Chughtai, MD2; Alexis E. Te, MD2 and Steven A. Kaplan, MD1
1Department of Urology, Icahn School of medicine at Mount Sinai, New York, NY; 2Department of Urology, Weill Cornell Medicine, New York, NY
Presented By: Zeynep Gul, MD

Introduction: Transurethral resection of the prostate (TURP) has been shown to be effective in the management of bladder outlet obstruction (BOO) secondary to benign prostatic hyperplasia (BPH). However, adverse sexual events after TURP, primarily ejaculatory dysfunction (EjD) occur in 50 to 75% of patients and are associated with significant bother. We hypothesized that for men with BOO secondary to intravesical-prostatic protrusion (IPP) a middle lobe only TURP (MLO – TURP) would not only provide improvement in symptoms but also preserve ejaculation. We report the long-term safety and efficacy data on MLO – TURP.

Methods: The study consisted of 312 men (mean age 61.3 +/- 8.6) who presented with significant LUTS (n = 147) or urinary retention (n = 175), had an intravesical-prostatic protrusion (IPP) of ≥ 10 mm, and were treated with MLO – TURP from 2005 to 2017. We evaluated: 1) efficacy: International Prostate Symptom Score (IPSS), Quality of Life (QoL), peak flow rate (Qmax), post-void residual urine (PVR), International Index of Erectile Function (IIEF) and ejaculatory dysfunction (EjD), which was assessed by the Male Sexual Health Questionnaire (MSHQ) and 2) Adverse events: blood transfusions, post-operative incontinence, and the need for subsequent therapy. Men were evaluated at 1 month, 6 months, and yearly thereafter.

Results: Mean baseline prostate volume was 79.8 grams (30-178 grams); mean baseline IPP was 13.6. Improvements in IPSS, QoL, Qmax and PVR were durable throughout the study period. Postoperatively, the incidence of EjD was 2.6% (N = 8) and there was 1 case of new onset ED (0.3%). There was no significant deterioration of MSHQ – EjD at 5 years (baseline: 8.8 and at 5 years: 10.4). Seven (2.2%) patients required a second TURP and 1 patient required a blood transfusion. At 5 years, 14 (5.5%) men were on an alpha blocker and 6 (2.3%) were on an antimuscarinic medication.

Conclusion: In select men with prominent middle lobes, MLO–TURP should be considered a therapeutic, ejaculation-sparing option.
Introduction: The access to and components of parental leave policies in surgical practices are largely unknown, as well as the perceptions and attitudes of surgeons regarding parental leave. Concern for discrimination and increased practice burden stand as continued barriers between surgeons and parental leave. The aim of this study is to increase knowledge of perceptions and utilization of parental leave policies in surgical practices.

Methods: Practicing surgeons were recruited to complete a survey by outreach to surgical societies using social media outlets and e-mail. Participants were asked a series of multiple choice and Likert scale questions regarding existing parental leave policies of their practices as well as their perspectives and attitudes toward parental leave in surgical practice.

Results: The survey was completed by 204 surgeons, of which 89% were female. The majority of respondents were white (69%), age 31-40 (73%), and within the first 5 years of practice (56%). Most participants accessed the survey through Facebook (62%), and were in general surgery (25%), urology (30%) or obstetrics and gynecology (10%). The presence of a parental leave policy was noted by 122(60%) of the participants. More than half of participating female surgeons received 12 weeks or less of maternity leave, of which 55 (35%) surgeons were permitted 6 weeks or less. In contrast, 105(51%) responders believed that female partners should be allotted more than 12 weeks for maternity leave. Additionally, male surgeons were granted less than 4 weeks of paternity leave at the surgical practices of 83(57%) participating surgeons. The amount of parental leave offered has a bearing on choosing an employer for 153(76%) surveyed surgeons. Only 61(40%) participants who took parental leave were fully or partially paid by the employer, and 21(14%) went unpaid. Discrimination was reportedly experienced by 88(54%) surgeons as a result of taking parental leave. The majority support the notion that parental leave should not affect time to promotion (86%) or partnership (82%).

Conclusion: This sample of surgeons illustrates the great deal of variance that currently exists in parental leave policies and coverage. There appears to be an absence of formalized policies in a considerable proportion of surgical practices. Overall, the results of this study appear to suggest most surgeons support parental leave and are in favor of policies that support new parents during and after pregnancy.
Poster #5

VARIABILITY IN PRICES FOR ERECTILE DYSFUNCTION MEDICATIONS - ARE ALL PHARMACIES THE SAME?

Kirtishri Mishra, MD¹; Laura Bukavina, MD, MPH¹; Amr Mahran, MD, MS²; Aidan Bobrow, BS²; Christina Buzzy, PhD¹; Ehud Gnessin, MD¹; Aram Loeb, MD¹ and Lee Ponsky, MD¹

¹University Hospitals Cleveland Medical Center, Urology Institute, Cleveland, Ohio; ²Case Western Reserve University School of Medicine, Cleveland, Ohio

Presented By: Laura Bukavina, MD, MPH

Introduction: To evaluate the variability in cash prices for phosphodiesterase-5 inhibitors (PDEIs) for erectile dysfunction (ED). We also evaluated whether certain types of pharmacies consistently offer better pricing than others, and whether there were any correlation with demographic factors.

Methods 331 pharmacies were contacted within a 25-mile radius of our institution to obtain the cash price for four commonly used ED medications. Pre-specified doses were identified to maintain consistency. After exclusion, 323 pharmacies were categorized as chain, independent, wholesale, or hospital-associated. Cash prices for the specified medications were evaluated. In addition, we identified population and income factors to determine if these had an impact on median drug pricing within each zip code.

Results: Independent pharmacies provided the lowest cost for three out of four of the PDEIs. We found the largest price difference for ten tablets of 100 mg Sildenafil between all pharmacies was 38,000%. The median cost difference between independent pharmacies and chain pharmacies for Sildenafil was >900%, and >1100% for independent pharmacies versus hospital associated pharmacies. Demographic factors had no impact on the cost.

Conclusion: The drastic differences in cash prices for the PDEIs give us an insight into the variability and cost-inflation for medications in the US. These patterns hold true for other essential medications as well. Improved transparency will allow patients to make informed decisions when choosing where to purchase their medications. It may also encourage certain pharmacies to provide medications at more affordable prices.

Figure 1: Cost of Generic Sildenafil (100 mg x 10 tablets) among Pharmacies in Northeast Ohio (by zip code). See Supplementary Figure 2 for the other PDEIs.
Poster #6
STAPHYLOCOCCAL AND STREPTOCOCCAL URINARY TRACT INFECTIONS ARE ASSOCIATED WITH HIGH INCIDENCE OF ABNORMAL IMAGING FINDINGS IN PEDIATRIC MALES
*Sarah Holzman, MD1; Campbell Grant, MD2; Rebecca Zee, MD3; Emily Blum, MD4; Sohel Rana, MD5; Bruce Sprague, BA3 and H. Gil Rushton, MD3
1Medstar Georgetown; 2George Washington University; 3Children’s National Medical Center; 4Children’s Hospital of Atlanta
Presented By: Sarah Holzman, MD

Introduction: Current American Academy of Pediatric guidelines for Urinary Tract Infection (UTI) recommend delaying voiding cystourethrogram until the second or third febrile UTI. Currently, there is no good clinical indicator of which patients would benefit from earlier imaging. We sought to identify whether gram-positive Staphylococcal/Streptococcal urinary tract infections were associated with a greater risk for anatomic variation in boys presenting to the emergency department (ED).

Methods: A retrospective review of all urine cultures from 2011 to 2015 in our ED was performed. Males under 18 years of age with Staphylococcus, Streptococcus, Proteus or Escherichia positive urine cultures with greater than 50,000 CFU/mL were included. Poisson regression model with robust variance was used to calculate the prevalence ratios. Percentages of categorical variables were analyzed using Chi squared and Fisher’s exact tests. Statistical analysis was performed with Stata software, version 15.1 MP (Stata Corporation, College Station, Texas, USA).

Results: A total of 703 males with urine culture results were evaluated and 357 met inclusion criteria. Median age was 7.7 months (2.5- 47.0 months IQR). Forty-two Proteus, 16 Staphylococcus, 7 Streptococcus and 292 Escherichia UTIs were included. High grade VUR (defined as grades III-V) was identified in 33.3% of gram-positive Staphylococcal/Streptococcal UTIs compared to 9.68% of gram-negative UTIs (incidence rate 3.44 95% CI: 1.18 - 10.07, p=0.024). High-grade hydronephrosis (defined as Society of Fetal Urology (SFU) grades 3 and 4) was present in 23.6% of gram-positive UTIs compared to 3.56% of gram-negative UTIs (incidence rate 6.62 95% CI: 2.21-19.81, p=0.001).

Conclusion: Staphylococcal and Streptococcal UTIs are associated with a high incidence of abnormal imaging findings in pediatric males. Patients who present with first UTI with Staphylococcal or Streptococcal species should be considered for additional imaging prior to developing a second UTI.
**Introduction:** Focal High-intensity focused ultrasound (HIFU) may reduce the morbidity associated with radical therapy while maintaining cancer control in localized prostate cancer (PCa). We report outcomes of focal HIFU for primary treatment of localized PCa in the first prospective cohort of patients in the United States.

**Methods:** Single-center prospectively collected cohort of patients were treated with primary focal HIFU from January 2016 to July 2018 for PCa. All patients underwent a 12 core TRUS-guided biopsy, in addition to MRI-US fusion biopsy if a targetable lesion was identified. Any Gleason grade was considered, however patients with very low risk or high-risk and high-volume PCa were excluded. Only patients eligible for focal (<50% of prostate volume) or subtotal (>50% but less than whole-gland) HIFU ablation were included in the study. Follow up protocol included Trimestral Prostate-specific antigen (PSA) changes and patient-reported outcome measures recorded with validated questionnaires. Additionally, MRI 1 month after HIFU, and MRI-US fusion biopsy at 6 or 12 months for high risk and low-intermediate risk PCa, respectively.

**Results:** 50 men were included in the analysis of which 17(34%), 23(46%), 5(10%), 3(6%), 2(4%) were from grade groups 1 through 5, respectively. Mean age was 68 (range 50-8), mean baseline PSA of 6.51 ng/mL (range 1.63-25.9) and mean prostate size of 35.82 (range 14-84) cc on TRUS. 43 (86%) men underwent focal ablation and 7 (13.2%) subtotal ablation. IPSS scores went back to their baseline at 3-6 months in 68% of men. 88% of patients maintained the erectile function and 12% had erectile dysfunction at 12 months. The overall complications rate was 45%. Major complications were seen in only 4(6%) patients, who required TURP due to urinary retention post HIFU. Mean follow up was 16.3 months (range 3-31). At 3 months follow up, a nadir PSA below 2ng/mL was achieved in 39(78%). 18(36%) patients underwent a control biopsy. Of these, 16 (88%) patients had negative infield biopsy (12 patients with negative biopsies and 4 with had low risk contralateral lesions) and 2 had low risk infield lesions. Of these, one continues surveillance and the other had 24 month biopsy demonstrating recurrence and required salvage prostatectomy.

**Conclusion:** Focal HIFU is a safe procedure for localized PCa with acceptable complications and excellent functional outcomes. Short-term oncological outcomes are promising but longer follow-up is needed to assess oncologic control.
ANALYSIS OF NARRATIVE REVIEWS FOR FPMRS SPECIALISTS ON HEALTHGRADES.COM

*Khushabu Kasabwala, MD1; Sarah Huber, MD1; Bogdan Gadidov, MS2; Julia Vaillancourt, MS2; Jennifer Priestly, PhD2 and Patrick Culligan, MD1

1Department of Urology, New York Presbyterian Hospital, Weill Cornell Medical College, New York, NY, USA; 2Center For Statistics and Analytical Services, Kennesaw State University, Kennesaw, GA, 30144

Presented By: Khushabu Kasabwala, MD

Introduction: Physician rating websites are increasing in number and use. Given this growth, understanding online ratings and identifying factors associated with positive and negative ratings are important for both patients and surgeons. Despite their popularity, the true impact of these reviews, specifically their relevance in clinical care and practice management, remains unknown. In our study, we qualitatively analyzed the content of the written reviews to identify aspects of the patient experience that impact their perception of care and assess the specific factors associated with ratings of Female Pelvic Medicine and Reconstructive Surgery (FPMRS) specialists on a leading rating website, Healthgrades.com.

Methods: We performed a retrospective review of 689 FPRMS specialists on www.healthgrades.com. Physician demographics and the content of narrative (descriptive) reviews of all physicians with an “FPMRS” designation under fellowship was collected. Reviews were grouped into four broad themes used in other qualitative analysis studies. Four individuals working independently classified each free text narrative reviews into those broad themes: (1) physician (2) clinical outcomes (3) staff (4) non-specific or general. If a review contained remarks about more than one theme, it was assigned to each relevant theme group. Statistical analysis including inter-rater reliability was performed with SAS software.

Results: A total of 3300 narrative reviews independently categorized. The inter-rater reliability using these themes to categorize the reviews was high with Fleiss kappa scores of physician, outcomes, and staff of 0.66, 0.79, and 0.81, respectively. The intra-rater reliability was also high showing consistency in thematic assignment over time. Figure 1 depicts the distribution of the thematic categories for each corresponding rating. As expected, the patient’s perception of the physician had the greatest influence on very positive (5) or very negative (1) ratings. Although less so for the “clinical outcomes” theme, outcomes-related commentary did appear consistently in the text of very positive or very negative reviews. Ratings in the middle range (2, 3, and 4) were more greatly influenced by staff and practice qualities, with more reference to these factors than the physician or outcomes in the narrative text.

Conclusion: Content of physician reviews provides an important snapshot into the patient experience. We demonstrate that the physician is the most likely to lead to the extremes of reviews while the staff trigger a less powerful assessment. Recognition of themes in positive and negative reviews may provide an avenue to optimize the patient experience.
Poster #9
OVERUSE OF SPECIALTY CARE FOR WOMEN WITH URINARY INCONTINENCE

*Claire S. Burton, MD1; Christopher Gonzales-Alabastro1; Eunice Choi2; Pooja Parameshwar1; Gabriela Gonzalez1; Catherine Bresee2; Karyn Eilber, MD2; A. Lenore Ackerman, MD PhD2 and Jennifer T. Anger, MD2

1University of California Los Angeles; 2Cedars Sinai Medical Center
Presented By: Claire S. Burton, MD

Introduction: The burden of urinary incontinence (UI) has significant medical and financial implications on the healthcare system. Although specialists are skilled in management of UI refractory to conservative therapy, patients are often referred prior to evaluation or initiation of conservative measures. Additionally, little is known about how provider gender impacts care for UI. We sought to measure the quality of UI care provided to patients in a single health care system prior to referral to a Female Pelvic Medicine and Reconstructive Surgery (FPMRS) specialist.

Methods: A sample of 100 women consecutively referred for new or worsening bothersome UI to a single-center FPMRS group practice between March 2017 and May 2018 was identified. Using a set of set of 12 quality-of-care indicators (QIs) previously described, we measured the quality of care provided by referring providers in the 12-month period prior to the first visit with an FPMRS specialist. QIs incorporated elements from the patient history, physical examination, urinalysis, recommended behavioral interventions, and pharmacologic treatment. We also sought to compare quality of care by provider gender.

Results: Fifty-three percent of patients were diagnosed with SUI and 34% were diagnosed with urge urinary incontinence (UUI) by their primary care provider. No attempt was made at diagnosis of type of incontinence in 31%. Overall, there was a paucity of care provided at the primary care level, with less than half of the patients receiving the recommended primary level care in eight of 12 QIs (Table 1). Overall, providers performed 40.8% of the recommended primary level care, with male providers performing 33.2% and female providers performing 44.9% (p=0.01). Many patients had no work-up (detailed history, exam, or urinalysis) prior to referral. Ten percent of patients were referred based only on an e-mail request.

Conclusion: We found low rates of conservative management initiation prior to specialist referral for women with UI, with male providers performing significantly worse than female providers. While this may be due to other factors such as patient requests and the presence of in-house specialists, improvement of UI care at the primary care level could significantly reduce costs of care and preserve outcomes, while allowing specialists to provide tertiary care to complex and refractory patients.
Poster #10
CAN COEXISTING LESIONS IN PROSTATE MRI PREDICT CANCER IN PI-RADS 3 LESIONS?
*Grace Yaguchi1; Hoang Tang1; Mustafa Deebaja1; Jacob Keeley2; Milan Pantelic3; Sean Williamson3; Nilesh Gupta4; James Peabody1; Mani Menon1; Shaheen Alanee1 and Ali Dabaja1
1VUI Henry Ford Hospital; 2V-Core Henry Ford Hospital; 3Dept Radiology Henry Ford Hospital; 4Dept Pathology Henry Ford Hospital
Presented By: Grace Yaguchi

Introduction: The Prostate Imaging Reporting and Data System (PI-RADS) Version 2 Assessment Category 3 (PI-RADS 3) lesion has an equivocal risk of malignancy. The PI-RADS Version 2 does not account for multiplicity of lesions when grading PI-RADS 3 lesions. The objective of this study is to determine if multiplicity of lesions can aid in prostate cancer risk stratification.

Methods: This is a prospective study conducted at a single academic institution. There were 91 men with ≥ 1 PI-RADS 3 lesion. We compared the cancer detection rates (CDRs) of PI-RADS 3 lesions that occurred (1) as solitary lesions, (2) as 1 of multiple PI-RADS 3 only lesions, or (3) with ≥ 1 higher grade lesion.

Results: Median age was 65.0 years (interquartile range 59.5-70.0), median prostate specific antigen was 5.95 ng/ml (interquartile range 4.30-8.83), and median prostate specific antigen density was 0.161 ng/ml2 (0.071-0.194). Forty-three men had solitary PI-RADS 3 lesions, 22 had multiple PI-RADS 3 only lesions, and 26 had multiple lesions with ≥ 1 higher grade lesion. The overall CDR (Gleason score ≥ 3 + 3) in a given PI-RADS 3 lesion in each group was 23%, 45%, and 54%, respectively (p = 0.0274). The CDRs for clinically significant disease (Gleason score ≥ 3 + 4) were 16%, 32%, and 35%, respectively (p = 0.1701).

Conclusion: Coexisting lesions increase the CDR in men with PI-RADS 3 lesions. Risk stratification algorithms to guide biopsy and management decisions of these lesions may need to include multiplicity of lesions.
Poster #11
THE IMPACT OF THE FDA TESTOSTERONE SUPPLEMENTATION THERAPY SAFETY ADVISORY ON PRESCRIBING PATTERNS
Valary Raup, MD1,2; Alexandra Berger, MD1,2; *Gricelda Gomez, MD1,2; Julie Szymaniak, MD1,2 and Martin Kathrins, MD1,2
1Harvard Program in Urology; 2Brigham and Women's Hospital
Presented By: Gricelda Gomez, MD

Introduction: On March 3, 2015 the Food and Drug Administration (FDA) released a safety advisory and prescription labeling change which warned of possible cardiovascular side effects of testosterone supplementation therapy (TST). We sought to investigate the effect of the warning on TST prescribing patterns in the Boston metro-area.

Methods: We utilized the Research Patient Data Registry, which is a de-identified clinical patient data repository pertaining to eight hospitals in the Boston metro area within Partners Healthcare. We queried the database for men age 45 to 84 years old who were prescribed TST with transdermal or injectable formulations from March 2013 until August 2016. A second query was performed of such patients to quantify the monthly instances in which during which primary diagnosis of hypogonadism was recorded (based on ICD9/10 codes). We three performed separate interrupted time series (ITS) analyses for each TST modality type and monthly visits for hypogonadism, all with respect to the March 2015 safety advisory. We calculated estimates of effect and relative effects for 1, 3, 6, 9, 12, 15, 16 months post-safety advisory. All data analyses were performed with SPSS v20. IRB approval was not necessary due to the de-identified nature of the data.

Results: The monthly prescription quantities and clinical encounters are demonstrated in Figures 1.1 and 1.2, respectively. The ITS analysis revealed the difference in slope coefficients between pre- and post-safety advisory was -26.5 (p=0.000) for transdermal formulations. The difference in coefficients was -7.5 (p=0.003) for injectable formulations. However, the difference in coefficients for clinical encounters was -3.0 (p=0.260). Limitations of the study were the inability to distinguish between new and renewed prescriptions and the retrospective nature of the database.

Conclusion: While the monthly number of interactions resulting in a primary diagnosis of hypogonadism was unchanged, the amount of monthly prescriptions for both injectable and transdermal testosterone formulations decreased significantly following the FDA safety advisory.
Poster #12
EXPLORING THE PATTERNS OF PRACTICE AND SATISFACTION AMONG FEMALE UROLOGISTS IN CANADA
*Amanda E. Hird, MD1,2; Marie-Pier St-Laurent1,3; Geneviève Nadeau1,3; Lesley Carr1,2 and Monica Farcas1,2
1Department of Urology; 2University of Toronto; 3Université Laval
Presented By: Amanda E. Hird, MD

Introduction: As the numbers and percentages of women completing surgical training increase, it is important to understand the work patterns and career decisions of women in this field. Our aim was to explore the satisfaction, personal and professional challenges, and practice barriers among female leaders within our specialty in Canada.

Materials and Methods: A literature review was completed. Trends with respect to career and personal satisfaction were identified, including academic advancement, mentorship, professional challenges, workplace discrimination, personal/family satisfaction, as well as remuneration, among others. These key themes were formatted into 44 questions and distributed electronically as a survey to 67 female Urology staff across Canada.

Results: Fifty-nine (88%) women responded to our survey. Most had been in practice <5 years (43%) and 90% completed a fellowship. 96% of women were very satisfied or somewhat satisfied with their career. Seeing more time-consuming patients and financial constraints within the healthcare system were the greatest source of dissatisfaction. 60% of respondents reported that they received significant mentorship during their training and 43% felt that it was difficult to find a mentor. 57% experienced gender discrimination during their career, most commonly from a colleague (22%) or a patient (22%). Mean time for maternity leave was 15 weeks and 33% reported a pregnancy related complication triggered by their work (pre-eclampsia, miscarriage, hypertension and premature contractions). Most women (83%) were very satisfied with their family life. However, 74% felt their career has compromised their personal life and family responsibilities. Overall, 64% of women surveyed would choose Urology again.

Conclusion: It is important to advocate for the wellness of our current female Urologists and to attract and maintain the most talented physicians. To accomplish this, we need to address the professional and personal challenges revealed in this survey. These challenges include supporting women on maternity leave, incorporating maternity leave guidelines into contract negotiations, improving female mentorship, prioritizing female urology leadership initiatives, as well as financial seminars outlining negotiation strategies. We hope to establish a formal circle of support, mentorship and promotion within the Urology community in Canada to help achieve these goals.
Angela M. Arlen, MD

Angela M. Arlen is an Assistant Professor of Pediatric Urology at Yale University School of Medicine, where she also serves as the Urology Clerkship Director and Surgical Director of the Spina Bifida Clinic. She graduated from the University of Iowa Carver College of Medicine in 2006, and completed her urology residency at the University of Iowa Hospitals and Clinics in 2012 followed by a pediatric urology fellowship at Emory University/Children’s Healthcare of Atlanta in 2014. Dr. Arlen’s research interests include hypospadias and vesicoureteral reflux clinical outcomes and she has published over 70 peer-reviewed journal articles and book chapters.

Teresa D. Beam, MD, FACS

Dr. Beam was born in Noblesville, Indiana. She is a graduate of Indiana University and Purdue University School of Science. She earned her medical degree from the University of Cincinnati College of Medicine in Cincinnati, Ohio. She completed her general surgery and urology residency at University of Cincinnati Medical Center in Cincinnati, Ohio.

Dr. Beam is certified by the American Board of Urology. She is a member of the American Medical Association, the American Urological Association, and the Society of Women in Urology. Her areas of special interest include female urologic conditions, kidney stones, and interstitial cystitis.

Dr. Beam joined Urology of Indiana in July 1997 and is one of the few women practicing urology in the Midwest. She is married and has five children.

Natalie Bell

Natalie is the founder of Mindful Wellness, a training and coaching platform to help professionals reconnect with their own source of calm, clarity and resilience. She is also the creator of the Thrive Inside online program. As a leading teacher of mindfulness and self-compassion, she works with individuals, healthcare professionals, and companies teaching people to be able to reduce stress and manage challenges through self-compassion. Natalie’s approach brings the benefits of meditation into the practical realm of our daily lives teaching us to apply on the spot techniques to be able to thrive in the face of challenge.

Natalie has been practicing mindfulness and meditation since 1985 and worked for 17 years as a physical therapist, Director of Rehabilitation and a clinical specialist for medical devices in rehabilitation. She is a faculty member of UCLA’s Mindful Awareness Research Center, MARC, the Director of Corporate Programs for LA’s renowned Unplug Meditation. Natalie is one of a distinguished group of certified Mindful Self-Compassion teachers and serves on the Healthcare Advisory Board of the Center for Mindful Self-Compassion. Natalie has been featured in the Today Show, the LA Times, MSNBC Your Business, and Thrive Global and has worked with many Fortune 500 companies.
Jamie Z. Belsito

Jamie is a Commissioner on the Ellen Story Special Commission on Postpartum Depression for the Commonwealth of Massachusetts and the former Advocacy Chair for the National Coalition for Maternal Mental Health. She is also on the Board of Trustees for Salem State University.

Jamie is a subject matter expert in maternal mental health policies on both a state and federal level, and brings her expertise to the Massachusetts Statehouse and Capitol Hill to seek better maternal health outcomes for pregnant and new moms.

Jamie received her BA from Salem State College. She is the Mom to two wicked awesome daughters.

Anne P. 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).

Joanna K. Chon, MD

Dr. Joanna K. Chon is currently in private practice in Naples, Florida. She received her undergraduate degree in bioengineering at the University of Pennsylvania and obtained her medical degree from the George Washington University School of Medicine. After her residency training at the University of Maryland in Baltimore, she then pursued fellowship training in FPMRS with Dr. Gary Leach at Tower Urology at Cedars-Sinai Medical Center in Los Angeles. She started her career in academics at the Thomas Jefferson University School of Medicine and then went into private practice in the Philadelphia suburbs. She was voted “Top Doctor” by Philadelphia Magazine and Castle Connolly in 2011 and 2012. She has also received the Top Doctor recognition 2013-2018 since practicing in Naples.

Alison M. Christie, MD

Dr. Christie completed her urology residency at University of Michigan and a fellowship in urologic oncology at Vanderbilt University Medical Center. She was a navy urologist on active duty for 6 years. She was the sole urologic oncologist and the Director of Robotic Surgery at Naval Medical Center Portsmouth for the inception of the robotic surgery program there, and a staff urologist at Naval Hospital Jacksonville during her active duty time. After that, she joined a private practice in Johnson City, Tennessee for 2 years and then moved to the James H. Quillen VA Medical Center in Johnson City and is currently a staff urologist with a concentration in urologic oncology.
Cara B. Cimmino, MD

Dr. Cara Cimmino completed her undergraduate and medical school work at the University of Michigan in Ann Arbor. She then completed her urology residency training at Lahey Clinic in Burlington, Massachusetts and went on to a one-year fellowship in male infertility, sexual medicine, and andrology at the University of Virginia in Charlottesville, Virginia. She then began her urology practice in private practice in Atlanta, Georgia, before deciding to return to academics at Emory University, joining their department in 2014.

Her practice is that of general urology, with a concentration in Men's Health and prosthetic surgery. Aside from a clinical urologist, her roles at Emory include assistant program director for the urology residency program at Emory.

Jennifer L. Dodson, MD, PHD

Dr. Jennifer Dodson is an Assistant Professor of Urology at the Johns Hopkins School of Medicine, James Buchanan Brady Urological Institute. Her areas of clinical expertise include urology and pediatric urology. She is a urological consultant at the Kennedy Krieger Institute, Multidisciplinary Spina Bifida Clinic in Baltimore, Maryland. Dr. Dodson completed her BA Degree at Columbia College of Columbia University, with a major in biology and a minor in philosophy. She earned her MD from the University of Wisconsin Medical School in Madison, Wisconsin. She completed her urology residency and subsequently a fellowship in pediatric urology at the Johns Hopkins University School of Medicine. Dr. Dodson went on to pursue a PhD in Clinical Investigation in the Graduate Training Program in Clinical Investigation at the Johns Hopkins Bloomberg School of Public Health.

Dr. Dodson's research interests include incontinence, health-related quality of life and outcomes research. Her research has focused on long-term outcomes of children with congenital urological disorders examining clinical outcome measures and patient reported outcomes. This has included measuring the Health Related Quality of Life (HRQOL) of children with abnormal bladder function or incontinence and comparing to norms using different generic HRQOL instruments, providing guidance for a standardized patient-based measure of outcome for future studies of pediatric incontinence. She is a collaborator with the Chronic Kidney Disease in Children (CKiD) national cohort study, examining the effect of abnormal bladder function, bladder catheterization, and incontinence on quality of life, health care utilization, and kidney function decline in the CKiD cohort.
Geolani W. Dy, MD

Dr. Dy is a fellow in reconstructive urology and gender confirming surgery at NYU.

She graduated from Brown University’s Program in Liberal Medical Education, where she received the Stewart Prize for humanism, the Throop Prize for patient advocacy, and was inducted into the Alpha Omega Alpha Honor Society and Gold Humanism Honor Society. Dr. Dy completed her residency at the University of Washington, where she focused on health outcomes research in pediatric urology and assessing educational gaps in transgender care. During her residency, she authored the AUA Core Curriculum in Transgender Health, and was recipient of the UW Resident Research Award and Grady-Fildes Humanism Award. Dr. Dy is currently focused on creating patient reported outcome measures for genital gender confirming surgery, and on improving urologic provider education in healthcare needs of gender diverse individuals.

Jennifer E. Fantasia, MD

Jennifer Fantasia graduated magna cum laude from American University in 2009 with a Bachelor of Science in Biology and a minor in Chinese language. During her undergraduate career, she participated in the Honors Program, receiving several merit-based academic scholarships, including the Schwartz Fellowship of Chemistry and the Women’s Guild Scholarship; she remains an active member of Phi Beta Kappa. She was heavily involved in peer-mentoring and tutoring, including leading a living-learning community for freshmen. She then attended the University of Massachusetts Medical School with a focus in Global Health, including clinical international service experiences in Qingdao, China and Ho Chi Minh City, Vietnam. While also at UMass, she founded the UMass Urology Interest Group, with specific goals to match medical students with faculty mentors to help facilitate exposure to the field. She also served as a student leader of the American Medical Women’s Association, helping to organize local networking events and subspecialty panels to connect students with successful women in competitive subspecialties. In 2015, she matched at Brown University/Rhode Island Hospital for Urology and continues to be very involved in resident and medical student education and mentoring, serving as a resident representative on the Program Evaluation Committee in addition to Brown University medical student mentoring programs. She has been honored to serve as Resident Co-Chair for SWIU's Mind the Gap: Transition to Practice taskforce and is now focusing on pursuing a career in academic medicine to continue her involvement in medical education.

Sally Fortner, MD, MS

Dr. Fortner is a Professor in the Department of Anesthesiology and Critical Care Medicine at the University of New Mexico and Faculty in the American Academy of Communication in Healthcare. She serves as a member of the American Society of Anesthesiology’s Simulation Editorial Board and as the Director for Maintenance of Certification Anesthesiology (MOCA) Simulation for the University of New Mexico. In addition, she is the Director of Professional Development for the University Of New Mexico School Of Medicine. Dr. Fortner has extensive experience in high-fidelity and standardized-person simulation. She specializes in coaching simulated encounters that highlight difficult communication scenarios.
**Dana W. Giel, MD**

Dr. Giel currently serves as Professor of Urology at University of Tennessee Health Science Center in Memphis, Tennessee. She also serves as the Program Director for the Pediatric Urology Fellowship and the Director of Research for the Division of Pediatric Urology. She was born in Memphis, and returned to her hometown following undergraduate studies at Vanderbilt University, where she obtained a BS in biology and political science. She entered medical school at University of Tennessee Health Science Center and graduated in 2000, when she then entered residency in surgery and urology, followed by a fellowship in pediatric urology. She was only the third female urology resident and the first female fellow in her respective training programs. Since completing training, she has pursued a busy clinical and academic career. Providing excellent patient care is the cornerstone of her professional mission, and she has been voted as a Castle Connolly Top Pediatric Urologist for the past 3 years, as well as a Top Doctor in Memphis by Memphis Magazine. She enjoys complex reconstructive surgery, and has established a multidisciplinary clinic for the management of patients with DSD.

Research is another mainstay of her professional pursuits, and she has participated in numerous multi-institutional collaborative studies within the field of pediatric urology, as well as publishing and presenting at various national meetings. She holds multiple leadership positions in national organizations, including being a member of the Executive Council for the Societies for Pediatric Urology and the Secretary/Treasurer of the Society for Fetal Urology. She has also served as abstract reviewer and moderator for each pediatric urology national meeting for the past 4 years, as well as serving as the Scientific Program Chair for the SFU meeting in Montreal in September 2017. She is passionate about training the next generation of urologists, and she strives to mentor urologic trainees, especially the female residents and fellows in her training program, as she sees new opportunities unfolding for future female urologists and unique challenges facing them. When Dr. Giel is not busy at work, she enjoys spending time in what she considers her most important job -- being the proud mother to her 11-year old son, Maddox, and wife to husband, Tom, who is an orthopedic surgeon. The family enjoys attending sports events (especially their son's and the Memphis Grizzlies games), being involved in community outreach activities, traveling, and seeking out new adventures each year.

**Priyanka Gupta, MD**

Priyanka specializes 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. 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 low and middle income countries. In her free time she enjoys reading, cooking, doing yoga, and spending time with her family especially her two-year old son Rishi.
Muneera Kapadia, MD, MME

Dr. Kapadia is a Clinical Associate Professor of Surgery at the University of Iowa. She received her undergraduate degree in chemical engineering from the Massachusetts Institute of Technology and her medical degree from the University of Michigan. She completed her general surgery training at Northwestern University and a fellowship in colorectal surgery at the University of Minnesota. Dr. Kapadia’s main clinical interests include inflammatory bowel disease and colorectal cancer. Dr. Kapadia earned her master’s degree in medical education from the University of Iowa. She plays an active role in medical and surgical education and serves as the Associate Program Director for the general surgery residency program. Furthermore, Dr. Kapadia is interested in communication skills education and has presented work on this subject nationally and internationally. She is currently involved in training physicians at the University of Iowa regarding relationship-centered patient care.

Melissa R. Kaufman, MD, PhD, FACS

Dr. Melissa 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, neuourology, transitional care for congenital urologic conditions, urologic prosthetics, as well as reconstructive surgery for urethral stricture, fistula and trauma. With regards to her research agendas, she currently serves as the global principal investigator for a pivotal Phase III clinical trial to pioneer the first application of autologous cell therapy for urologic indications. Dr. Kaufman was honored as the 2017 recipient of the Zimskind Award from the Society for Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction for outstanding contributions within 10 years of completion of training. She is additionally a Past-President of the Society of Women in Urology.

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 D.C. Dr. Kerr received her MD 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.
Stephanie J. Kielb, MD

Dr. Kielb is an Associate Professor of Urology and the Residency Program Director in the Department of Urology at Feinberg School of Medicine. She is a recognized expert in voiding dysfunction and incontinence, having performed sacral neuromodulation and botulinum toxin injections for urinary leakage procedures since 2004. Dr. Kielb was awarded research funding to investigate the effects of sacral neuromodulation on urinary and bowel symptoms and pain. She also performs minimally invasive procedures for stress incontinence and pelvic organ prolapse, including robotic surgery as well as native-tissue and mesh slings.

Dr. Kielb is the Urologic Director of the Multi-Disciplinary Adult Spina Bifida Clinic at the Rehabilitation Institute of Chicago and has extensive experience treating both men and women with neurogenic bladder. She manages adults with many other congenital genitourinary conditions, including cloacal extrophy, sacral agenesis, urogenital sinus conditions, vaginal agenesis/atroesia, and disorders of sexual differentiation. Additionally, Dr. Kielb specializes in the treatment of urinary symptoms related to spinal cord injury, multiple sclerosis, Parkinson’s disease, and other neurologic conditions which affect urination. Dr. Kielb is a respected clinician with surgical experience in complex reconstructive procedures, including bladder augmentation, mitrofanoff/moniti procedures (catheterizable channels), ureteral reconstruction for ureteral strictures or injury including robotic ureteral reimplant, boari flap, psoas hitch, and ileal ureter construction for extensive ureteral strictures from radiation therapy. She also treats genitourinary fistulas, including vesicovaginal (between bladder and vagina), ureterovaginal (between the ureter and vagina), and enterovesical (between bowel and bladder). Dr. Kielb regularly travels to Africa on women’s health mission trips, repairing genitourinary fistulas in Rwanda.

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.

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.
Jerilyn M. Latini, MD

Jerilyn M. Latini, MD is a board certified urologist who attended Dartmouth Medical School where she was elected to Alpha Omega Alpha graduating with highest honors. Dr. Latini completed a urology residency at the Lahey Clinic (1996-2002). There she was named the 1998-1999 Bernard F. Gordon Research Fellow and was the recipient of the 2000 Pfizer Scholars in Urology Grant. Her post-graduate fellowship was at the University of Iowa in male genitourinary reconstructive surgery and neurourolgy (2002-2003). Dr. Latini joined the faculty in the Department of Urology at the University of Michigan in 2003 where she was promoted from Assistant Professor to Associate Professor of Urology. There she served as the Medical Director of the Adult Urology Ambulatory Unit at the University Hospital and on a number of hospital and university wide committees. Dr. Latini was a Clinic Educator at the University of Michigan Medical School during her tenure in addition to her commitment to teaching urology residents and fellows. In 2012, she joined the Department of Urology at the Alaska Native Medical Center in Anchorage, Alaska where she concentrated her clinical practice in general urology with specialization in male urethral stricture and fistula care, male urinary incontinence and voiding dysfunction, and reconstructive surgery. While in Alaska, she served as the Medical Director of the Department of Urology at the Alaska Native Medical Center as well as high level medical center wide committees. During this time, she stayed on as Adjunct Professor of Urology at the University of Michigan continuing her commitment to urology resident and fellow education.

Una J. Lee, MD, FPMRS

Dr. Una Lee is a urologist in the Section of Urology at Virginia Mason Medical Center in Seattle, Washington and an Assistant Clinical Professor of Urology at the University of Washington. She is subspecialty board certified in female pelvic medicine and reconstructive surgery, and serves as Associate Program Director of the FPMRS fellowship at Virginia Mason. Her undergraduate and medical school degrees are from Stanford University. She completed her urology residency at the Cleveland Clinic, and did her fellowship in pelvic medicine and reconstructive surgery at UCLA with Dr. Shlomo Raz. Dr. Lee’s clinical practice is focused on the evaluation and management of female pelvic floor disorders. She specializes in overactive bladder, incontinence, pelvic organ prolapse and vaginal reconstructive surgery, robotic-assisted laparoscopic surgery for prolapse, as well as complications from prior surgeries using mesh. She cares deeply about patient perspectives and pursues research to work toward better meeting patient's needs.

Dr. Lee is an Advisory Board Member for the Pelvic Floor Disorders Network, which conducts clinical trials funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). She is an investigator in clinical and scientific research and conducts collaborative research at the Benaroya Research Institute at Virginia Mason. She serves as the Women’s Health Chair of the Washington State Urological Society. She has mobilized women urologists in Washington State by organizing Women in Urology Leadership Events.
Gina Lockwood, MD, MS

Gina Lockwood is a Pediatric Urologist and Clinical Assistant Professor in Urology at the University of Iowa Hospitals and Clinics, in Iowa City, Iowa. Originally from southern Illinois, she completed medical school at Southern Illinois University School of Medicine in Springfield, Illinois. She completed urology residency at the Medical College of Wisconsin in Milwaukee, Wisconsin and pediatric urology fellowship at Connecticut Children’s Medical Center in Hartford, Connecticut. She also completed her master’s in clinical and translational research at the University of Connecticut.

Her clinical and research interests include pediatric bowel and bladder dysfunction, genitourinary reconstruction, hypospadias, quality improvement in pediatric urology, and shared decision-making in pediatric urology.

Diana C. Londoño, MD

Dr. Diana Londoño is a skilled surgeon who has specialized in urology treating men and women. She is passionate about her patients and understands that many of the conditions are difficult to discuss as they impact quality of life and sexual health.

Dr. Londoño is originally from Mexico City and lived in Los Angeles for the past 20 years before bringing her practice to Miami. She has recently relocated back to Los Angeles and now is Assistant Clinical Professor at City of Hope Cancer Center, in Glendora and West Covina locations.

She received all her education in the Los Angeles Area, going to Claremont McKenna College for her undergraduate studies, then attending UCLA for her medical school training, and finished a six-year residency in urology at Kaiser Permanente, Los Angeles. She is trained in open, laparoscopic and robotic assisted surgery. She is fluent in Spanish and English.

While in Miami and Los Angeles, she has appeared in Univision, Telemundo, Mundo Fox, CNN Latino, KCET and multiple billboards, marketing campaigns in local buses and magazines as a health consultant and discussing different urological topics. She has appeared in many Latin marketing campaigns for City of Hope.
Milka L. Micic
Milka Micic is an Executive Director within JPMorgan’s Private Bank advising wealthy individuals, institutions, foundations and endowments on their investments, banking, estate planning, and lending. As a client advisor, Milka works closely with her clients and their professional advisors to develop and execute wealth management strategies to meet lifestyle needs, leave a legacy to future generations, fulfill philanthropic goals, as well as purely investment related objectives.

Prior to joining J.P.Morgan in 2004, Milka headed operations at investment and credit firm Crosby & Woodard Enterprises LLC. Milka holds her BA in Political Science from Loyola University Chicago, MBA with concentration in International Business and Finance from Roosevelt University, and a Master of Education from AIU.

Milka is a board member and treasurer of the Bill of Rights Defense Committee and an active supporter of the Young Women’s Leadership Charter School, in addition to being actively involved with educational reform efforts in the city of Chicago.

She currently lives in Chicago with her husband and son and they enjoy playing sports and board games along the lakefront together.

Audrey C. Rhee, MD
Audrey Rhee, MD is a graduate of Albert Einstein College of Medicine. She trained in urology at the Medical College of Georgia in Augusta and went on to complete her pediatric urology fellowship at Riley Children's Hospital in Indianapolis.

Dr. Rhee has been practicing pediatric urology at the Cleveland Clinic for the last six-years. Her interests include complex reconstructive surgery, posterior urethral valves and their long term management and outcomes, patient and physician advocacy, and residency education for which she is an Associate Program Director.

Katherine L. Rotker, MD
Katherine Rotker, MD is an Assistant Professor in the Department of Urology at the University of Massachusetts Medical School. She completed her urologic residency training at Brown University and went on to complete fellowship training in male reproductive medicine and surgery also at Brown University. She specializes in male infertility, erectile dysfunction and hypogonadism and has published on these topics as well as issues facing women in surgery.
Courtney Rowe, MD

Courtney Rowe received an independent undergraduate degree from Brown University entitled, "The Electronic Word," and then pursued graduate training at New York University's TISCH school in interactive telecommunications. It was there that she decided to switch paths to medicine, moving on to premedical training at Mills College followed by medical school at Boston University. She pursued a robotics research fellowship at Boston Children's Hospital after graduation, and then received her urology residency training at the Brigham and Women's/Harvard Medical School program and her fellowship training in pediatric urology at the Seattle Children's Hospital/University of Washington program. She has recently started a position as Pediatric Urologist at Connecticut Children's Hospital and Assistant Professor at the University of Connecticut Medical School, where she will focus half her time on research of patient-centered outcomes and novel surgical materials for pediatric urologic reconstructive surgery.

Aruna V. Sarma, PhD, MHA

Dr. Sarma is Interim Chief and Professor of the Dow Division of Health Services Research in the Department of Urology with a joint appointment in the Department of Epidemiology at the School of Public Health at the University of Michigan. She is an epidemiologist and an independent PI of several large funded urological studies. She has published extensively on the epidemiology of urological complications using epidemiologic and clinical datasets, population-based cohort studies and clinical trials and has played a role in the development of the epidemiologic approach to urologic research in the Department of Urology and has established herself as a prominent researcher in urology nationally.

She is currently the Chair of the Epidemiology Committee for the International Consultation on Urologic Diseases and the Director of the University of Michigan UroEPI Career Development Program, a K12 career development program designed to train academic scholars in benign urology epidemiology. She has served on numerous local and national committees and is a member of the American Urologic Association, American Diabetes Association, Society of Epidemiologic Research and an inducted member of the American College of Epidemiology.

Kristen R. Scarpato, MD, MPH

Dr. Scarpato is an Assistant Professor of Urology at Vanderbilt University where she completed her fellowship in urologic oncology. She is the Program Director for the Urology Residency. In addition to urologic cancer, she has active interests in residency education, surgical simulation and global health.
Cheryl S. Shih, MD

Dr. Shih is a board-certified urologic surgeon, providing general urologic care in Silver Spring, Maryland. She is a partner in a large group, single-specialty practice. She received her undergraduate degree from Princeton University, and her medical degree from Baylor College of Medicine in Houston, Texas. She completed a urology residency at the University of Washington in Seattle, WA.

Margarett Shnorhavorian, MD, MPH, FAAP, FACS

Dr. Margarett Shnorhavorian is Associate Professor of Urology at the University of Washington and Surgical Director of the Seattle Children’s Hospital Differences in Sex Development Program. She received her Bachelor’s Degree from University of California Los Angeles, where she graduated Phi Beta Kappa. She received her MD degree from the University of California, San Francisco, during which time she also received a Master’s in public health at the University of California Berkeley. She then completed her general and urologic surgery training at Yale University School of Medicine, followed by a fellowship in pediatric urology at the University of Washington.

Dr. Shnorhavorian is Principal Investigator for an R01 grant from the National Institutes of Health examining the reproductive health of childhood cancer survivors (1R01CA175216 - 01A).

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, Washington. 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, Minnesota, 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.
Simone Thavaseelan, MD

Simone Thavaseelan is an Assistant Professor of Surgery (Urology)/Clinician Educator at the Warren Alpert School of Medicine at Brown University where she has been faculty since 2011, and a graduate of Georgetown University SOM in 2005. She completed a urology residency in 2010 followed by fellowship in Endourology/Minimally Invasive Urology in 2011, both at Brown University. She is the Section Chief of Urology at the Providence VA Medical Center as a half-time VA employee with a concurrent halftime position at Brown Urology Inc. as the Program Director of residency since 2016. She serves on the Graduate Medical Education Committee at Brown/Rhode Island Hospital, the Board of Directors of Brown Urology Inc, the Radiation Safety Committee at the VAMC, the Advisory Board of Office of Women in Medicine & Science, and the Chair of the Diversity & Inclusion Committee for the Department of Surgery, and the Board of Directors of the Society of Women in Urology. She has participated on committees in the New England American Urologic Association (NE AUA), the AUA, and the GWIMS of the AAMC.

Jannah Thompson, MD

Dr. Jannah Thompson is a general urologist and co-director of the Continence and Pelvic Health Center at Urologic Consultants, where she has been working since 2010. She is also on the faculty at Michigan State University. Dr. Thompson earned her medical degree from Michigan State University in 2004. She then went on to complete her internship and residency at the University at Buffalo, part of the State University of New York. Before she joined Urologic Consultants, she worked at Metro Urology, PA, and in the biochemistry division of Henry Ford Health Systems. She is certified by the American Board of Urology, and has specialized fellowship training focused on prolapsed, incontinence and pelvic health disorders.
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 neurourology, and 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.

Anna M. Zampini, MD, MBA

Dr. Zampini is finishing her residency at the Glickman Urological and Kidney Institute, Cleveland Clinic Foundation in Cleveland, Ohio. While attending Tufts University School of Medicine, she simultaneously earned a Master of Business Administration in Health Management from Brandeis University Heller School of Social Policy and Management. Additionally, Dr. Zampini has a Master of Science in Nutritional Biochemistry and Metabolism from the Tufts University Friedman School of Nutrition Science and Policy. Following residency she is pursuing a fellowship in endourology at the Kidney Stone Institute of Mount Sinai, and will build upon her expertise in the microbiome and nephrolithiasis. Her interest in QI began early in residency, and has continued as the Chief Urology Resident for Quality and Patient Safety. Her interest in opioid stewardship began after hearing the former Surgeon General speak on the opioid epidemic and she led a Cleveland Clinic Quality Improvement study to explore appropriate opioid prescribing after urologic surgery. She was recently awarded an AUA scholarship to the 2018 Quality Improvement Summit on Opioid Stewardship in Urology.
SAVE THE DATES

SWIU at the AUA
May 3 – 6, 2019
Chicago, Illinois

Saturday, May 4, 2019
SWIU Networking Reception

Sunday, May 5, 2019
SWIU Annual Breakfast Meeting

SWIU 9th Annual
Clinical Mentoring
Conference
January 17 – 19, 2020
Hilton New Orleans Riverside
New Orleans, Louisiana