Society of Women in Urology

9th Annual Clinical Mentoring Conference
January 17 – 19, 2020

Hilton New Orleans Riverside
New Orleans, LA
# 9th Annual Clinical Mentoring Conference

**New Orleans, Louisiana**

Welcome from the President and Program Chairs ........................................2  
2019 – 2020 Board of Directors .................................................................3  
2020 Faculty Listing ......................................................................................4  
Past Presidents .............................................................................................6  
Mission Statement .........................................................................................6  
General Meeting Information ......................................................................7  
Special Events ..............................................................................................8  
Educational Needs & Objectives ..................................................................9  
Accreditation Statement .............................................................................12  
2020 Resident Travel Award Winners & Contributors ..............................13  
Industry Support ........................................................................................14  
Program Schedule ......................................................................................15  
Resident Poster Session ............................................................................24  
Resident Podium Session ..........................................................................48  
Speaker Biosketches ..................................................................................68
Dear Friends and Colleagues,

We are delighted to welcome you to the Society for Women in Urology 9th Annual Clinical Mentoring Conference, at the Hilton New Orleans Riverside. This year’s meeting promises to provide up-to-date education for general and subspecialist urologists, and continues this meeting’s tradition of promoting interaction among attendees at all levels to promote collegiality, knowledge sharing, and mentorship.

This year’s keynote speaker is Dr. Emily Nagoski PhD. She is the award-winning author of the New York Times bestseller, Come As You Are: the surprising new science that will transform your sex life. She began her work as a sex educator at the University of Delaware, where she volunteered as a peer sex educator, while she studied psychology with minors in cognitive science and philosophy. She went on to earn a MS in Counseling and a PhD in Health Behavior, both from Indiana University, with clinical and research training at the Kinsey Institute for Research in Sex, Gender, and Reproduction. After eight years working at Smith College, Emily is now working on her second book about women’s overall wellbeing. It’s called Burnout.

The Annual Clinical Mentoring Conference has grown dramatically since its inception in 2012. The 2019 meeting included 122 women urologists, of whom 57 were residents or fellows in training. Although the meeting has grown larger in attendance, I am happy to say that it never feels “too big;” the relaxed environment and intimate settings have helped to foster an environment of openness and interaction among urologists of diverse age, geography, specialty, and experience.

Our deliberate focus on residents and fellows sets this meeting apart from others. As in years past, we will host a “Speed Mentoring” session in which junior faculty, residents, and fellows can seek advice from more established mentors. We will also continue to highlight resident and fellow research through podium and poster presentations. This year’s meeting will also offer a cadaver lab on Saturday morning, concurrent with a panel on research featuring federally-funded women urologists.

Pottery is the traditional gift for a ninth anniversary. The flexibility of pottery and the ability to individually craft durable products from a common starting point echoes the fundamental goals of this meeting.

Come, join us, and take away what you find most important for your practice and yourself.

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Urology of Indiana
Greenwood, IN 46143

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Providence, RI 02905

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New York Presbyterian Hospital
New York, NY 10032

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Georgetown University Hospital
Washington, DC 20007

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

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New York, NY

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Dakar

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Comprehensive Urology
Royal Oak, MI

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Kaiser Permanente Medical Group
Los Angeles, CA

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Sacramento, CA

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Health
San Diego, CA

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Ann Arbor, MI

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FAAP, FACS
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Chapel Hill, NC

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San Francisco, CA

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Seattle, WA

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Iowa City, IA

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Shady Grove Fertility
Towson, MD

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Augusta, GA

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Brown University/Rhode Island Hospital
Providence, RI

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

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Ochsner Medical Center
New Orleans, LA

Elizabeth R. Williams, MD
Urology Consultants, Ltd
St. Louis, MO

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

Anna M. Zampini, MD, MBA
Kidney Stone Institute of Mount Sinai
New York City, NY
# PAST PRESIDENTS

<table>
<thead>
<tr>
<th>Year</th>
<th>President</th>
<th>Meeting Location</th>
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</thead>
<tbody>
<tr>
<td>2018 - 2019</td>
<td>Teresa D. Beam, MD, FACS</td>
<td>Chicago, IL</td>
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<tr>
<td>2017 - 2018</td>
<td>Suzette E. Sutherland, MD, MS, FPMRS</td>
<td>San Francisco, CA</td>
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<td>2016 - 2017</td>
<td>Dolores J. Lamb, PhD, HCLD</td>
<td>Boston, MA</td>
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<td>2015 - 2016</td>
<td>Elizabeth R. Williams, MD</td>
<td>San Diego, CA</td>
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<td>2014 - 2015</td>
<td>Leslie M. Rickey, MD, MPH</td>
<td>New Orleans, LA</td>
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<td>2013 - 2014</td>
<td>Jennifer L. Dodson, MD, PhD</td>
<td>Orlando, FL</td>
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<td>2012 - 2013</td>
<td>Melissa R Kaufman, MD, PhD, FACS</td>
<td>San Diego, CA</td>
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<td>2011 - 2012</td>
<td>Nancy A. Huff, MD</td>
<td>Atlanta, GA</td>
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<td>2010 - 2011</td>
<td>Tracy Cannon-Smith, MD</td>
<td>Washington, DC</td>
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<td>Elizabeth R. Mueller, MD, MSME</td>
<td>San Francisco, CA</td>
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<td>2008 - 2009</td>
<td>Harriette M. Scarpero, MD, FPMRS</td>
<td>Chicago, IL</td>
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<td>2007 - 2008</td>
<td>Elizabeth W. Bozeman, MD</td>
<td>Orlando, FL</td>
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<td>2006 - 2007</td>
<td>Cathy K. Naughton, MD</td>
<td>Anaheim, CA</td>
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<td>2005 - 2006</td>
<td>Brenda S. Kinard, MD</td>
<td>Atlanta, GA</td>
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<td>2004 - 2005</td>
<td>Martha K. Terris, MD, FACS</td>
<td>San Antonio, TX</td>
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<td>2003 - 2004</td>
<td>Janice Lee Arnold, MD</td>
<td>San Francisco, CA</td>
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<td>2002 - 2003</td>
<td>Deborah J. Lightner, MD</td>
<td>Chicago, IL</td>
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<td>Catherine R. DeVries, MD, FACS, FAAP</td>
<td>Orlando, FL</td>
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<td>M'Liss A. Hudson, MD</td>
<td>Anaheim, CA</td>
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<td>Susan J. Kalota, MD</td>
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<td>Lindsey A. Kerr, MD, RYT</td>
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<td>Gloria S. Massey, MD</td>
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<td>Nina S. Davis, MD, FACS</td>
<td>New Orleans, LA</td>
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<td>Tamara G. Bavendam, MD, MS</td>
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<td>Kristene E. Whitmore, MD</td>
<td>Las Vegas, NV</td>
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<td>Carole L. Gordon, MD</td>
<td>San Francisco, CA</td>
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<td>Dana J. Weaver-Osterholtz, MD</td>
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<td>1990 - 1991</td>
<td>* Jean L. Fourcroy, MD, PhD, MPH</td>
<td>Toronto, ON, Canada</td>
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<td>Las Vegas, NV</td>
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<td>* Jean L. Fourcroy, MD, PhD, MPH</td>
<td>Kansas City, MO</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: Churchill Foyer*
- **Friday, January 17, 2020**: 6:30 a.m. – 6:30 p.m.
- **Saturday, January 18, 2020**: 6:30 a.m. – 5:30 p.m.
- **Sunday, January 19, 2020**: 7:00 a.m. – 10:00 a.m.

Exhibit Hall Hours

*Location: Churchill C*
- **Friday, January 17, 2020**: 10:00 a.m. – 6:00 p.m.
- **Saturday, January 18, 2020**: 7:00 a.m. – 3:15 p.m.

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

**Welcome Reception with Exhibitors and Resident Poster Session**

*Date: Friday, January 17, 2020*
*Time: 5:00 p.m. – 6:00 p.m.*
*Location: Churchill C*
*Cost: Included in registration fee*
*Description:* The Society of Women in Urology welcomes its members to the 9th 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.

**President’s Banquet**

*Date: Saturday, January 18, 2020*
*Time: 6:00 p.m. – 8:00 p.m.*
*Location: River Room River Building*
*Cost: Included in registration fee*
*Description:* Join fellow SWIU members for the Annual President’s Banquet. The Program Committee is arranging a fun, interactive event you won’t want to miss. Different from previous years’ this year’s banquet format with have food stations and casual eating arrangements to allow for more networking among the guests.
SPECIAL EVENTS

**Speed Mentoring Session**
**Date:** Friday, January 17, 2020  
**Time:** 3:00 p.m. – 4:00 p.m.  
**Location:** Jackson (3rd Floor)  
**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.

**YOGA**
**Date:** Saturday, January 18, 2020  
**Time:** 7:00 a.m. – 7:30 a.m.  
**Location:** Marlborough AB  
**Description:** Join us for a heart opening, limb stretching yoga class. No experience needed. A great warm up for the day ahead.

**Clinician Scientist Workshop: Grant Writing, Research Networks, and Statistics for the Urologist**
**Date:** Saturday, January 18, 2020  
**Time:** 8:00 a.m. - 9:45 a.m.  
**Location:** Churchill D  
**Description:** This session is for the seasoned researcher and those of us who want to get more involved with research either at our own institution or with larger research networks. Our panel features highly successful grant writers, leaders in network research and experts in research statistics. Bring your questions for this highly interactive and informative session.

**Cadaver Lab for Female and Male Incontinence and Reconstruction**
**Date:** Saturday, January 18, 2020  
**Time:** 8:00 a.m. - 1:00 p.m.  
**Location:** Churchill B  
**Description:** The 9th Annual Clinical Mentoring Conference will offer hands-on breakout sessions including a cadaver lab for all meeting attendees. Plan to attend these sessions to reinforce or learn new skills and techniques.

**Networking Breakfast**
**Date:** Sunday, January 19, 2020  
**Time:** 7:00 a.m. – 10:00 a.m.  
**Location:** Churchill 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.

**Keynote Address: Come As You Are**
**Date:** Saturday, January 19, 2020  
**Time:** 1:15 p.m. - 2:15 p.m.  
**Location:** Churchill D  
**Description:** Renowned sex educator, Emily Nagoski, PhD shares research behind confidence and joy, two essentials for sexual and overall well-being. Plus, learn more about closing the gap between what’s expected of women and what it’s really like to be a woman in today’s world – from the office to the bedroom.
EDUCATIONAL NEEDS

Many procedures performed to treat pelvic organ prolapse (POP) and stress urinary incontinence (SUI) have typically been performed with polypropylene mesh. Many products have been pulled from the market over the past 10 years since the FDA Safety notification. However, it wasn’t until 2019 that the FDA pulled all vaginal mesh for the use of POP. The UK and Australia and New Zealand have also banned the use of mesh for SUI. This dynamic climate is difficult to follow for many providers as the recommendations and available products continue to change.

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. However, these tools need to provide a positive influence into life and our practices and not contribute negatively to burnout.

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.

Understanding how to have difficult conversations with patients can improve the provider-patient relationship, improve quality of care, and increase patient and provider satisfaction. Acknowledging challenges with patients and families and partnering together to find the best treatment choice for each individual patient is more important than ever. This is one of the hallmarks of shared decision making and can certainly be employed in these difficult conversations we have in urology, as recommended by the current AUA Guidelines.

The hectic pace of medical practice and the myriad competing demands for our time and attention is not sustainable unless providers prioritize self-care: identifying priorities, achieving goals, and promoting a well-rounded lifestyle. Striking a balance between your own goals and the needs of others is the hallmark of true leadership. It is also important to understand the available opportunities both regionally and nationally.

Urology has seen a change in practice patterns over the past 30 years. There are now more female urologists overall: more women are hospital employed, more women are completing fellowships, and more women are entering into academic practices. Urology has lagged behind other specialties in the recruitment of women and underrepresented minorities. While the number of women in the field has increased, there are still fewer female senior authors or women in leadership positions within individual practices or among national organizations. This cannot be explained by demographics and age alone. Women have fewer professional mentors and fewer role models, and there is implicit bias in perceptions in women’s competency.

Obstetrical fistula is a significant problem in the developing world. Patients are often ostracized from their own communities leading to desocialization and further lack of access to medical care. Many physicians offering care abroad have been criticized for performing medical tourism, and the true benefit of these endeavors has been questioned.
Fertility challenges are ever present in the field of urology whether personally or professionally. Many urologists attempt to conceive later in life, leading to decreased fertility and pregnancy rates. There are significant implications of advanced maternal and paternal age on fertility potential and pregnancy outcomes. Little is commonly known about fertility preservation options available for men and women.

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.

EDUCATIONAL OBJECTIVES
At the conclusion of the SWIU 9th Annual Clinical Mentoring Conference, attendees will be able to:

1. Review the real risk of mesh vaginal products.
2. Discuss reintroduction of previously banned products.
3. Discuss strategies to address product safety with patients.
4. Identify methods to use for daily planning to manage time at work and personal time.
5. Develop a system to effectively manage, sort, and prioritize emails.
7. Review data on opioid utilization in urology.
9. Identify difficult and potentially litigious patients.
10. Discuss how to provide satisfactory care in difficult situations.
11. Explore perspectives and advice on career development and advancement to women in urology.
12. Describe three clinical situations in which SDM could be utilized.
13. Enumerate the components of SDM.
14. Define the characteristics of an engaged patient-provider interaction.
15. Discuss the current state of representation of women and URM in urology.
16. Identify factors that can influence the lack of diversity or inclusion in urology.
17. Review specific strategies to promote the recruitment and retention of URM and women.
18. Describe the societal impact of obstetric fistula (OF).
19. Identify the physical, societal and cultural limitations that contribute to OF.
20. Discuss efforts being done to end OF in West Africa today with respect to delivery of treatment and prevention strategies.
21. Recognize the importance of developing surgical centers of excellence.
22. Identify the key factors associated with a successful global health initiative.
23. Define sustainability as it pertains to global health initiatives.
24. Discuss the importance of an integrative approach to global health that includes mutual commitments between centers in resource-rich countries with those in resource-poor countries.
25. Encourage critical analysis of medical volunteerism through discussions of ethical considerations relating to patient care.
26. Recognize and respect cultural, political, socio-economic, legal and even biological differences, which can contribute to barriers to quality health care delivery.
27. Recognize the influence of societal structure and social inequalities on access to and the quality of healthcare, especially as it pertains to women in traditional patriarchal societies.

28. Recognize the importance of sustainability through transfer of education and skills, and how to make the biggest impact.

29. Discuss the importance of academic and multi-disciplinary collaboration.

30. Recognize limitations to data collection and analysis on a local and global scale.

31. Identify various types of health data that are available.

32. Determine how evaluation of health data can provide insight into the health of the population and other population-based issues such as infrastructure and cultural practices or expectation.

33. Describe the relevance of the dual control model to sexual desire and pleasure.

34. Differentiate between “responsive desire” and “spontaneous desire,” and explain their relevance to differential desire in couples.

35. Explain arousal nonconcordance – or, why a person’s genitals might respond to stimulation that is neither wanted nor liked.

36. Identify essential components of successful grant writing.

37. Review study design/statistics for the purposes of grant writing.

38. Describe the essential characteristics of successful research collaborations.

39. Identify how the most academically and professionally successful women urologists in the country achieved their academic/professional and service success.

40. Discuss successes and failures along the way that ultimately lead to a final goal of professor, chairwoman, and presidents/leaders of national organizations.

41. Discuss the AUA opportunities available to help advance a career in urologic research.

42. Identify opportunities to get involved in leadership of the greater urology and/or urologic research communities.

43. Discuss the implications of advanced paternal and maternal age on fertility potential and pregnancy outcomes.

44. Summarize the fertility preservation options presently available for men and women.

45. Discuss the use of cryopreserved gametes and reproductive tissues for future fertility.

46. Define and characterize gender bias.

47. Recognize and discuss societal effects of gender bias.

48. Identify gender bias in various settings.

49. Implement and integrate strategies to avoid gender and other implicit biases.

50. Discuss the AUA Health Policy committee roles and responsibilities.
Category 1
Creighton University Health Sciences Continuing Education designates this live activity for a maximum of **11.75 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.

Disclosure Information
In compliance with the ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation.

The disclosure report for this meeting can be found at the following link: swiu.org/disclosures

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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.
2020 Resident Travel Award Winners

Nicole Alavi-Dunn  Northeastern Section Award Recipient, US
Meghan Cooper
Alice Drain  New York Section Award Recipient
Nadia Halstead  South Central Section Award Recipient
Khushabu Kasabwala  New York Section Award Recipient
Jennifer Kuo  Southeastern Section Award Recipient
Diana Lopategui
Diana Magee  Northeastern Section Award Recipient, Canada
Preeya Mistry  New York Section Award Recipient
Sarah Mozafarpour
Tyler Overholt
Poone Shoureshi  Western Section Award Recipient
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Hong Troung  Mid-Atlantic Section Award Recipient
Kyla Velaer
Bristol Whiles
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PROGRAM SCHEDULE

All sessions will be located in the Churchill D unless otherwise noted. Speakers and times are subject to change.

FRIDAY, JANUARY 17, 2020

OVERVIEW

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

6:45 a.m. - 7:45 a.m.  Industry Meetings with Board
   Location: Prince of Wales

7:00 a.m. - 7:50 a.m.  Networking Breakfast
   Location: Churchill Foyer

10:00 a.m. - 6:00 p.m.  Exhibit Hall Open
   Location: Churchill C

GENERAL SESSION

7:50 a.m. - 8:00 a.m.  President's Welcome and Announcements
   President: Kathleen Kieran, MD, MSc, MME

8:00 a.m. - 8:30 a.m.  Navigating the Mesh Ban and Strategic Reintroduction in the United Kingdom
   Speaker: Tamsin J. Greenwell, MBChB, MD FRCS(Urol)

8:30 a.m. - 8:50 a.m.  Ain’t Wastin’ No More Time: Tips for Time Management in a Digital World
   Speaker: Angela B. Smith, MD, MS

8:50 a.m. - 9:10 a.m.  Smart Opioid Utilization in Urology
   Speaker: Una J. Lee, MD, FPMRS

9:10 a.m. - 9:30 a.m.  The Art of Managing Difficult Patients
   Speaker: Karyn S. Eilber, MD

9:30 a.m. - 10:00 a.m.  Panel: What Would I Tell My 30 Year Old Self
   Moderator: Claire C. Yang, MD
   Panelists: Teresa D. Beam, MD, FACS
              Elizabeth W. Bozeman, MD

10:00 a.m. - 10:30 a.m.  Networking Session in Exhibit Hall
   Location: Churchill C

10:30 a.m. - 10:50 a.m.  Topic TBD: Do We Really Use Shared Decision Making in Urology?
   Speaker: Kathleen Kieran, MD, MSc, MME
10:50 a.m. - 11:10 a.m.  
**Rising Tides: Diversity & Inclusion in Urology**  
Speaker: Simone Thavaseelan, MD

11:10 a.m. - 11:30 a.m.  
**VVF in Africa: Clearing the Gaps of a Global Health Problem**  
Speaker: Medina Ndoye, MD

11:30 a.m. - 12:15 p.m.  
**Panel: Medical Missions: The Role of Global Education and the Ethics of Medical Tourism**  
Moderator: Suzette E. Sutherland, MD, MS, FPMRS  
Panelists:  
- Kristin L. Chrouser, MD, MPH  
- Maahum A. Haider, MD, MPH  
- Medina Ndoye, MD

12:15 p.m. - 1:15 p.m.  
Lunch in Exhibit Hall

1:15 p.m. - 2:15 p.m.  
**Come As You Are**  
Speaker: Emily Nagoski, PhD

2:15 p.m. - 2:30 p.m.  
**Lessons Learned in Leadership**  
Speaker: Priya Padmanabhan, MD, MPH, FACS

2:30 p.m. - 3:00 p.m.  
**Networking Session in Exhibit Hall**  
*Location: Churchill C*

3:00 p.m. - 4:00 p.m.  
**Speed Mentoring**  
*Location: Jackson (3rd Floor)*  
Moderators: Kathleen Kieran, MD, MSc, MME  
Anna M. Zampini, MD, MBA  
*Separate registration required*

5:00 p.m. - 6:00 p.m.  
**Welcome Reception with Exhibitors and Resident Poster Session**  
*Location: Churchill C*  
Moderators: Divya Ajay, MD, MPH  
Jennifer L. Dodson, MD, PhD  
Rena D. Malik, MD  
*Not CME Accredited*
| Poster #1 | RISK OF UROLOGIC INJURY AFTER GROUND LEVEL FALL  
Presented By: Lauren F. Cooley, MD, PhD |
|---|---|
| Poster #2 | TIME INTERVAL BETWEEN MRI AND FUSION BIOPSY: CAN IT AFFECT THE CANCER DETECTION RATES?  
Presented By: Maria F. Becerra, MD |
| Poster #3 | TRIAMCINOLONE ACETONIDE INJECTIONS FOR THE TREATMENT OF RECALCITRANT POST RADICAL PROSTATECTOMY VESICOURETHRAL ANASTOMOTIC STENOSIS - A LARGE MODERN DAY SERIES  
Presented By: Sarah R. Ferrara, MD, BScH, FRCSC |
| Poster #4 | DELAYED PRIMARY CLOSURE OF CLASSIC BLADDER EXSTROPHY: HOW LATE IS TOO LATE?  
Presented By: Kelly Harris, MD |
| Poster #5 | MANAGEMENT AND OUTCOMES OF PRIMARY CLOSURE OF BLADDER EXSTROPHY: A CHANGING LANDSCAPE  
Presented By: Roni Manyevitch, BS |
| Poster #6 | CONCORDANCE RATES BETWEEN MRI FUSION VERSUS TRUS PROSTATE BIOPSY AND FINAL PATHOLOGY AT THE TIME OF RADICAL PROSTATECTOMY: DATA FROM THE PURC  
Presented By: Ruchika Talwar, MD |
| Poster #7 | DIFFERING PERCEPTIONS OF OPERATIVE EDUCATION AMONG FACULTY AND TRAINEES IN A UROLOGY RESIDENCY PROGRAM  
Presented By: Shreeya Popat, MD |
| Poster #8 | VALIDATION OF BEST PRACTICE POLICY ON URODYNAMIC ANTIBIOTIC PROPHYLAXIS IN THE NON-INDEX PATIENT IN THE ERA OF STEWARDSHIP  
Presented By: Cristina M. Fox, MD |
| Poster #9 | EVALUATING NEPHROLITHIASIS RISK AMONG PROSTATE CANCER PATIENTS TREATED WITH ANDROGEN DEPRIVATION THERAPY IN A POPULATION OF MEDICARE BENEFICIARIES  
Presented By: Jessica Dai, MD |
Poster #10  THE RESIDENT FACTOR: A 10-YEAR TREND OF FEMALE MEDICAL STUDENTS PURUSING SURGICAL SUBSPECIALTIES
Presented By: Bridget L. Findlay, MD

Poster #11  PELVIC ORGAN PROLAPSE ON YOUTUBE: EVALUATION OF CONSUMER INFORMATION
Presented By: Amber Herbert

Poster #12  IMPROVED EFFICIENCY IN HOLMIUM LASER ENUCLEATION OF THE PROSTATE UTILIZING A MODULATED PULSE MODE
Presented By: Bristol B. Whiles, MD

Poster #13  SOCIOECONOMIC, CLINICAL, AND HOSPITAL FACTORS IMPACTING LENGTH OF STAY AND HOSPITAL COST IN PEDIATRIC RENAL TRAUMA PATIENTS
Presented By: Alexandra Tabakin, MD

Poster #14  IS DIGITAL ETHNOGRAPHY THE FOCUS GROUP OF THE FUTURE? FOCUS GROUPS VS. SOCIAL MEDIA ANALYSIS OF WOMEN'S EXPERIENCE WITH OVERACTIVE BLADDER (OAB)
Presented By: Paige Kuhlmann, MD

Poster #15  SOURCES OF CONFUSION: MEDIA COVERAGE OF THE 2019 UNITED STATES FOOD AND DRUG ADMINISTRATION BAN ON VAGINAL MESH FOR PELVIC ORGAN PROLAPSE
Presented By: Poone Shoureshi, MD

Poster #16  VARIATIONS IN PERI-OPERATIVE ANTIBIOTIC PRESCRIBING PATTERNS AMONG ACADEMIC UROLOGISTS AFTER AMBULATORY ENDOSCOPIC UROLOGIC SURGERY: DISCORDANCE WITH THE GUIDELINES?
Presented By: Meenakshi Davuluri, MD

6:00 p.m. - 8:00 p.m.  President's Banquet*
Location: River Room, River Building
*Networking Event with Food Stations
SATURDAY, JANUARY 18, 2020

OVERVIEW

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

7:00 a.m. - 3:15 p.m.  Exhibit Hall Open
            Location: Churchill C

7:00 a.m. - 7:50 a.m.  Networking Breakfast in Exhibit Hall
            Location: Churchill C

GENERAL SESSION

7:00 a.m. - 7:30 a.m.  Yoga*
            Location: Marlborough AB
            Instructor: Lindsey A. Kerr, MD, RYT
            *Optional activity: Wear comfortable clothes and bring a towel
            *Not CME Accredited

7:50 a.m. - 8:00 a.m.  President's Welcome and Announcements
            Speaker: Kathleen Kieran, MD, MSc, MME

Concurrent Session 1 Begins

Concurrent Session 1 of 3

8:00 a.m. - 9:45 a.m.  Breakout Session A: Cadaver Lab for Female and Male Incontinence and Reconstruction*
            Location: Churchill B
            Faculties: Iryna Crescenze, MD
                      Sarah F. Faris, MD
                      Tamsin J. Greenwell, MBChB, MD FRCS(Urol)
                      Jerilyn M. Latini, MD
                      Jennifer G. Rothschild, MD, MPH
                      Joanna M. Togami, MD
                      Elizabeth R. Williams, MD
            *Stations include female TOT slings/mini slings, sacrospinous fixation, anatomy and complications, male AUS and penile prosthesis, tibial nerve dissection.
            *Not CME Accredited
Concurrent Session 2 of 3

8:00 a.m. - 9:45 a.m.  Breakout Session B: Dry Lab for Female and Male Incontinence and Reconstruction  

*Stations include Miyazaki model vaginal hysterectomy, retropubic and TOT sling time on pelvic trainer, laparoscopic suturing tips and pearls, box trainers with vagina models, sacral and tibial neuromodulation.  

*Not CME accredited.

Concurrent Session 3 of 3

8:00 a.m. - 9:45 a.m.  Breakout Session C: The Clinician Scientist Workshop: Grant Writing, Research Networks and Statistics for the Urologist*  

*This breakout is not repeated

Concurrent Session 1 Ends

9:45 a.m. - 10:15 a.m.  Networking Session in Exhibit Hall  

Concurrent Session 2 Begins

Concurrent Session 1 of 2

10:15 a.m. - 12:00 p.m.  Breakout Session A: Cadaver Lab for Female and Male Incontinence and Reconstruction  

*Stations include female TOT slings/mini slings, sacrospinous fixation, anatomy and complications, male AUS and penile prosthesis, tibial nerve dissection.  

*Not CME accredited.
Concurrent Session 2 of 2

10:15 a.m. - 12:00 p.m.  Breakout Session B: Dry Lab for Female and Male Incontinence and Reconstruction  
Location: Churchill A  
Faculties: Yahir Santiago-Lastra, MD  
Jannah Thompson, MD, FPMRS  
*Stations include Miyazaki model vaginal hysterectomy, retropubic and TOT sling time on pelvic trainer, laparoscopic suturing tips and pearls, box trainers with vagina models, sacral and tibial neuromodulation.*  
*Not CME accredited.*

Concurrent Session 2 Ends

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

1:00 p.m. - 1:50 p.m.  Panel: Strategic Advancement of Women in Leadership Positions - How I Got Here and the Mistakes I Made Along the Way  
Moderator: Anne P. Cameron, MD  
Panelists: E. Ann Gormley, MD  
Elizabeth B. Takacs, MD  
Martha K. Terris, MD

1:50 p.m. - 2:10 p.m.  Opportunities for Research and Leadership with the American Urological Association  
Speaker: Carolyn Best, PhD

2:10 p.m. - 2:45 p.m.  Panel: Fertility Preservation and Pregnancy in Older Patients  
Moderator: Akanksha Mehta, MD, MS  
Panelists: Kate Devine, MD  
Cigdem (“Cori”) Tanrikut, MD

2:45 p.m. - 3:10 p.m.  Networking Session in Exhibit Hall  
Location: Churchill C

3:10 p.m. - 3:30 p.m.  Gender Bias: We All Have It So How to Identify and Control It  
Speaker: Polina Reyblat, MD

3:30 p.m. - 3:45 p.m.  Health Policy Update  
Speaker: Lindsey A. Kerr, MD, RYT

3:45 p.m. - 5:00 p.m.  Resident Podium Session  
Moderators: Doreen E. Chung, MD, FRCSC  
Emilie K. Johnson, MD, MPH  
Aruna V. Sarma, PhD
<table>
<thead>
<tr>
<th>Time</th>
<th>#</th>
<th>Title</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>3:45 p.m.</td>
<td>1</td>
<td>DISCUSSING URINARY INCONTINENCE WITH PROVIDERS IN THE NURSES’ HEALTH STUDIES</td>
<td>Giulia I. Lane, MD</td>
</tr>
<tr>
<td>3:51 p.m.</td>
<td>2</td>
<td>DECISION AIDS IMPROVE PATIENT-REPORTED SHARED DECISION MAKING: AN ANALYSIS OF SURGICAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) DATA</td>
<td>Giulia I. Lane, MD</td>
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<tr>
<td>3:57 p.m.</td>
<td>3</td>
<td>PTEN LOSS WITH ERG-NEGATIVE STATUS IS ASSOCIATED WITH LETHAL DISEASE AFTER RADICAL PROSTATECTOMY</td>
<td>Nora Haney, MD, MBA</td>
</tr>
<tr>
<td>4:03 p.m.</td>
<td>4</td>
<td>MOLECULAR ANALYSIS OF THREE PHENotypically DISTINCT INTERSTITIAL CYSTISIS BLADDER PAIN SYNDROME PATIENT SUBGROUPS</td>
<td>Tyler L. Overholt, MD</td>
</tr>
<tr>
<td>4:09 p.m.</td>
<td>5</td>
<td>PATIENT ENGAGEMENT IN THE 2019 BLADDER CANCER PATIENT SURVEY NETWORK</td>
<td>Judy Hamad, BS</td>
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<tr>
<td>4:15 p.m.</td>
<td>6</td>
<td>THE DIFFERENT ELEMENTS OF THE URINARY TRACT DILATION (UTD) CLASSIFICATION SYSTEM AND THEIR CAPACITY TO PREDICT FINDINGS ON MERCAPOACETYLTTRIGLYCINE (MAG3) DIURETIC RENOGRAPHY</td>
<td>Hannah E. Agard, MD</td>
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<tr>
<td>4:21 p.m.</td>
<td>7</td>
<td>DOES PROPHYLACTIC URETERIC STENTING AT THE TIME OF COLORECTAL SURGERY REDUCE THE RISK OF URETERIC INJURY? A SYSTEMATIC REVIEW AND META-ANALYSIS</td>
<td>Amanda E. Hird, MD</td>
</tr>
<tr>
<td>4:27 p.m.</td>
<td>8</td>
<td>GENDER AND RACIAL DISPARITIES IN THE TREATMENT AND OUTCOMES OF MUSCLE INVASIVE BLADDER CANCER</td>
<td>Jessica Marinaro, MD</td>
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<tr>
<td>4:33 p.m.</td>
<td>9</td>
<td>IMPLEMENTING A NEW PATHWAY FOR MICROSCOPIC HEMATURIA REFERRALS TO THE UROLOGY DEPARTMENT</td>
<td>Kara Watts, MD</td>
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<td>4:39 p.m.</td>
<td>#10 URINARY TRACT INFECTION AFTER ROBOT ASSISTED LAPAROSCOPIC PYELOPLASTY: ARE URINE CULTURES AND ANTIBIOTICS HELPFUL? Presented By: Yvonne Yuh-Ru Chan, MD</td>
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<tr>
<td>4:45 p.m.</td>
<td>#11 OPIOID PRESCRIBING HABITS FOLLOWING IMPLEMENTATION OF ENHANCED RECOVERY AFTER SURGERY (ERAS) IN PATIENTS UNDERGOING MAJOR UROLOGIC RECONSTRUCTION Presented By: Nadia V. Halstead, MD</td>
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<tr>
<td>4:51 p.m.</td>
<td>#12 NEPHROLOGY REFERRAL PATTERNS FOR RENAL CANCER NEPHRECTOMY PATIENTS Presented By: Julia Wainger, BS</td>
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</table>
| 5:00 p.m. - 6:00 p.m. | Past Presidents' Reception*  
*Invitation Only |
| 7:00 p.m. - 9:00 p.m. | Optional Event: Night Out in New Orleans*  
*Attendee Paid Excursion |

**SUNDAY, JANUARY 19, 2020**

**OVERVIEW**

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<th>Time</th>
<th>Event</th>
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| 7:00 a.m. - 10:00 a.m. | Registration/Information Desk Open  
Location: Churchill Foyer |

**GENERAL SESSION**

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<tr>
<th>Time</th>
<th>Event</th>
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</table>
| 7:00 a.m. - 10:00 a.m. | Networking Breakfast  
Location: Churchill Foyer |

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Poster #1
RISK OF UROLOGIC INJURY AFTER GROUND LEVEL FALL
Lauren Folgosa Cooley, MD, PhD, Emily Yura, MD, Jason Cohen, MD, Matthias Hofer, MD, PhD
Northwestern University
Presented By: Lauren Folgosa Cooley, MD, PhD

Introduction: Mechanism of injury is an important guiding principle in the work-up of trauma patients. Ground level falls (GLF) are becoming increasingly common as our population ages, but no prior studies have analyzed associated urologic injuries. The aim of this study was to determine the incidence of and predictive factors for urologic injury in both adult and geriatric patients following GLF.

Methods: We performed a retrospective cohort study comparing 13,718 adult (18-64 years) and 30,339 geriatric (≥ 65 years) patients for incidence of urologic injury following GLF using the National Trauma Data Bank from 2014-2016. Involuntary, low velocity GLF patients were included. Urologic injury was determined by ICD-9-CM or ICD-10-CM codes for kidney, adrenal, ureter, bladder, urethra, and male external genitalia (penis, scrotum, testes) injury. Proportion of incidents compared using chi-square. Means compared using Student’s t-test. p ≤ 0.050 was considered significant.

Results: While geriatric patients were more likely to experience a GLF overall (p<0.0001), adults were significantly more likely to sustain a urologic injury following a GLF (3.8% vs. 2.2%, p < 0.0001). Regardless of age, males were significantly more likely to sustain a urologic injury following GLF (p<0.0001). In both cohorts renal injury was most prevalent, but was statistically more common in geriatric patients (1.11% vs 0.84%, p < 0.0001). Furthermore, male gender, increased BMI, and presence of rib fracture were significantly associated with renal injury (p=0.006). In contrast, male external genitalia injury was significantly higher in adults but had low incidence overall (0.11% vs 0.03%, p <0.0001). Following any urologic injury, geriatric patients were more likely to require ICU admission (22.4% vs 11.2%, p < 0.0001). Despite a higher incidence of renal injury, geriatric patients were significantly less likely to undergo immediate operative intervention (2.1% vs 5.1%, p=0.0005).

Conclusion: Historically, low-velocity GLF injury does not prompt urologic workup. However, we found that a considerable fraction of GLF patients do sustain a urologic injury ranging from external genitalia to renal injury. Renal injuries were most common and significantly associated with male gender, age ≥ 65 years, presence of rib fracture and increasing BMI, which should serve as clinical cues to trigger urologic workup in future GLF trauma patients.

Funding: N/A
Poster #2
TIME INTERVAL BETWEEN MRI AND FUSION BIOPSY: CAN IT AFFECT THE CANCER DETECTION RATES?
Maria Becerra¹, Miao Feng², Isildinha Reis², Taylor Johnson³, Sanoj Punnen¹
¹Department of Urology, Miller School of Medicine, University of Miami, Miami, FL, USA, ²Department of Public Health Sciences, Miller School of Medicine, University of Miami, Miami, FL, USA, ³Department of Urology, Miller School of Medicine, University of Miami, Miami, FL, USA.
Presented By: Maria F. Becerr

Introduction: Multiparametric MRI fusion guided biopsy (FBx) has been shown to reliably improve the prostate cancer (PCa) detection. We aim to evaluate if the detection of prostate cancer on targeted biopsy varied based on the time interval between the MRI and the FBx.

Methods: A prospectively maintained database of patient undergoing MRI followed by FBx for elevated PSA between 10/2014 and 07/2018 at our institution was reviewed. Patients with previously diagnosed PCa were excluded from the analysis. Time between MRI and FBx were evaluated as a continuous variable and as categorical variable as follows ≤5, 5-10, >10 weeks (w). Data were documented on a per lesion basis and each target in the MRI was classified for the level of suspicion of malignancy based on the Prostate Imaging-Reporting and Data System (PI-RADS). Generalized estimating equation models for correlated binary outcome data was fitted to assess the effect of time (or time intervals) between MRI and FBx on the histopathological findings in the defined MRI targets. Separated models were fitted for the detection of any cancer or Gleason 7 or higher PCa (Gleason 7 or greater) with adjustment for relevant characteristics.

Results: A total 1,181 lesions from 806 men were analyzed. Prostate cancer was detected in 34.5% (407) of lesions, with 21.4% (253), 13% (154) and 65.5% (774) of lesions detecting clinically significant cancer (CSC), indolent (Gleason 6) PCa, or benign pathology, respectively. The MRI was performed <5w apart from the FBx in 423 patients, within 5-10 w in 261 and >10w in 122 patients. Adjusting for level of suspicion, previous biopsy result, age at MRI, race/ethnicity and marital status, the detection rates of any or CSC were not statistically different in any of the time intervals between the MRI/FBx (p=0.931 and p=0.538, respectively). Furthermore, when analyzing time as a continuous variable (per week increase) there was no association between time from MRI to FBx and PCa detection (p=0.849 and p=0.666, respectively).

Conclusion: Our data suggests that the time from MRI to fusion biopsy was not a predictor of prostate cancer detection on targeted biopsy. While these findings require further validation in cohorts with longer time intervals between MRI and fusion biopsy, it provides important information for patients and providers about the timing of biopsy after MRI.

Funding: N/A
Poster #3
TRIAMCINOLONE ACETONIDE INJECTIONS FOR THE TREATMENT OF RECALCITRANT POST-RADICAL PROSTATECTOMY VESICOURETHRAL ANASTOMOTIC STENOSIS - A LARGE MODERN-DAY SERIES
Sarah Ferrara, MD, BScH, FRCSC, Humberto Vigil, MD, MSc, BSc, FRCSC, Jenn Locke, MD, PhD, FRCSC, Sender Herschorn, MDCM, FRCSC
University of Toronto, Sunnybrook Health Sciences Centre, Urology Dept. Toronto, ON, Canada
Presented By: Sarah R. Ferrara, MD, BScH, FRCSC

Introduction: Vesicourethral anastomotic stenosis (VUAS) is a recognized complication of radical prostatectomy (RP). Recalcitrant VUAS can be difficult to manage, often requiring multiple treatments. We sought to evaluate the success of bladder neck injections of triamcinolone at the time of transurethral bladder neck incision (BNI) for prevention of recurrent or recalcitrant post-RP VUAS.

Methods: Patients with recurrent or recalcitrant VUAS post RP +/- radiation were offered triamcinolone injections at the time of BNI. VUAS was diagnosed after RP by symptoms followed by cystoscopy or urethrography. The outpatient procedures were done under general anesthesia. Cold knife incisions were made at the 3 and 9 o'clock bladder neck (BN) positions, followed by triamcinolone injections (4mg/mL) into the incision sites. Post-operative catheterization was 5-7 days. Treatment outcomes were determined by clinical follow-up and cystoscopy.

Results: A total of 18 men underwent 25 procedures over a 4-year period. Mean age at diagnosis of VUAS was 64, and mean time to VUAS was 13.8 months after RP. Fourteen patients (77.8%) had undergone some form of radiation treatment. The men had undergone 128 prior unsuccessful VUAS treatments, with a mean of 7.1 failed treatments per patient. Failed treatments included dilation, BNI, BN injection of Mitomycin C, or ALLIUM stent placement. The overall success rate after a mean of 16.2 months from the time of triamcinolone injection was 83.3%. Six patients went on to have successful incontinence surgery. Five patients (27.8%) had treatment complications (bleeding, urinary tract infection, pain, and urinary extravasation). The three patients who did not respond to treatment are stable and awaiting re-treatment with triamcinolone injection.

Conclusion: Triamcinolone bladder neck injection for post-RP VUAS is a useful and safe treatment for recurrent or recalcitrant stenosis. Associated incontinence can subsequently be treated.

Funding: N/A
Poster #4
DELAYED PRIMARY CLOSURE OF CLASSIC BLADDER EXSTROPHY: HOW LATE IS TOO LATE?
Kelly Harris, MD, Wayland Wu, MD, Mahir Maruf, MD, Rachel Davis, MD, Roni Manyevitch, Hiten Patel, MD, John Gearhart, MD
Robert D. Jeffs Division of Pediatric Urology, Brady Urological Institute, The Johns Hopkins Medical Institutions, Baltimore, Maryland
Presented By: Kelly Harris, MD

Introduction: Classic bladder exstrophy is a rare congenital defect of the lower urinary tract and pelvis. Successful outcomes are predicated on successful initial closure. Current literature suggests that delayed closure may not negatively impact operative success, however its effect is unknown on future bladder capacity. We hypothesized that timing of delay may impact bladder growth rate and thus we examined whether it depreciated significantly beyond a certain time period.

Methods: We retrospectively reviewed our institutional database of classic bladder exstrophy patients for the following inclusion criteria: successful primary closure in the neonatal period (28 days or less) or delayed fashion (beyond 28 days) with at least three consecutive bladder capacities assessed sequentially. Only capacities measured prior to continence surgery and before 14 years of age were considered for analysis. The delayed group was then divided into quartiles based on time between successful closure and date of birth. A linear mixed model was created to evaluate the effect of age and time delay until closure on bladder capacity.

Results: A total of 118 patients in the neonatal group and 28 patients in the delayed group met criteria for analysis. Median age at closure for the delayed group was 196 days [IQR 129 – 280]. For the first 3 capacity measurements, the delayed group had significantly lower capacities despite having similar age when the measurements were taken. Using linear mixed effects modeling with interaction, bladder growth rates for each quartile derived were as follows: neonate 14 cc/year, 1st quartile 13.1 cc/year, 2nd quartile 11.7 cc/year, 3rd quartile 14.5 cc/year, and 4th quartile 6.26 cc/year. When compared to neonates, 4th quartile delayed closure patients had a significantly slower bladder growth compared to neonatal closure (p = 0.003). The remaining groups did not statistically differ from neonatal closure. When examining the delayed group alone, small bladder template was not a significant predictor influencing final bladder capacity.

Conclusion: Our model suggests there is a significant decline in growth rate for patients closed beyond eight months. Additionally, among the delayed group, small bladder template did not significantly final influence bladder capacity. This suggests that if neonatal closure is not available, it is optimal to perform closure prior to 280 days of life to maximize overall growth potential. Given the rarity of this condition, this provides some insight as to when surgeons with expertise in exstrophy should close an extrophic bladder in delayed fashion before bladder growth is severely impacted.

Funding: n/a
Figure 1. Blue line represents the neonatal closure group and the red line represents the group for the 4th quartile. The remaining lines represent the remaining quartiles.
Poster #5
MANAGEMENT AND OUTCOMES OF PRIMARY CLOSURE OF BLADDER EXSTROPHY: A CHANGING LANDSCAPE
Roni Manyevitch1, Wayland J. Wu1, Mahir N. Maruf2, Heather N. Di Carlo1, John P. Gearhart1
1Robert D. Jeffs Division of Pediatric Urology, Brady Urological Institute, The Johns Hopkins Medical Institutions, Baltimore, MD, USA, 2University of Michigan, Department of Urology, Ann Arbor, MI, USA
Presented By: Roni Manyevitch, BS

Introduction: To investigate trends taking place in classic bladder exstrophy (CBE) management with regards to age at primary closure, osteotomy use, and outcome of closure. The authors hypothesize that over that past 20 years, age at closure has increased and that this correlates with increased utilization of osteotomies, and resultant improved success rates of primary closure of CBE.

Methods: An institutional database of 1355 exstrophy-epispadias complex patients was retrospectively reviewed for CBE patients who underwent primary closure between 1999 and 2018. Patients with isolated epispadias and cloacal exstrophy were excluded, as were patients for whom date of closure, osteotomy status, or outcome of procedure was unknown. Closures done at both our hospital (OH) and outside hospitals (OSH) were included.

Results: There were 286 total primary closures over 20 years, with 106 occurring at OH and 180 at OSH. Closure with an osteotomy was performed in 52.8% (56/106) of cases at OH and 50.6% (91/180) of cases at OSH, and osteotomy use generally increased over 20 years (p = 0.014). The total success rate at OH was 96.2% (102/106) and 61.1% (110/180) at OSH (p < 0.001). Over this 20 year period the median age at primary closure at OH increased from 3 days (1999-2003), to 13 days (2004-2008), 14 days (2009-2013), and 23 days (2014-2018) (p = 0.042), while the failure rate stayed below 4.2% and generally decreased over the years. Meanwhile, the median age at primary closure at OSH remained at 2 days from 1999 to 2013, then increased slightly to 4 days between 2014 and 2018 (p = 0.047), while the failure rate reached 55.3% and did not trend downward over time. Multivariate analysis suggests the institution where bladder reconstruction occurred was significantly associated with successful closure (OH vs. OSH, OR =16.3, 95% CI 6.3 - 56.3). Neither age at primary closure nor use of osteotomy significantly related to success.

Conclusion: Closure of CBE may be delayed for several reasons including insurance difficulties, transfer from another hospital, desire for second opinions, or surgeon preference. Delaying primary closure of bladder exstrophy does not increase failure rate and gives families and surgeons time to make adjustments to lifestyle, arrange travel, and alter insurance coverage, thereby making the planning for and transition after a major operation in a young child more acceptable.

Funding: N/A
**Figure 1.** Change in median age at primary closure of bladder extrophy over the past twenty years.
Introduction: Recent studies suggest that MRI-fusion guided biopsies are superior to the standard transrectal ultrasound technique. However, institutional and regional validation is important during the implementation of these newer methods. Herein, we present the Pennsylvania Urologic Regional Collaborative (PURC) experience with MRI fusion biopsy. Our objective was to calculate concordance rates between standard template transrectal ultrasound guided prostate needle biopsy versus MRI fusion biopsy and final pathology at the time of radical prostatectomy within our regional cohort.

Methods: Within PURC, a prospective quality improvement collaborative of various urology practices in Pennsylvania and New Jersey, we identified all men who underwent either a transrectal ultrasound guided (TRUS) prostate needle biopsy, or an MRI fusion transrectal guided prostate needle biopsy, followed by radical prostatectomy for definitive treatment of prostate cancer from 2015 to 2018. We analyzed pathology results and calculated the concordance and upstaging rates at the time of biopsy versus final pathology at radical prostatectomy. To assess for differences between our rates, we performed a test of equal proportions and a Pearson's chi-squared test. We defined significance as p<0.05.

Results: We identified 1,437 patients who underwent traditional TRUS (n=1247) or MRI Fusion (n=196) biopsies, followed by radical prostatectomy in the PURC database. Within this cohort, 54.6% patients (n=784) identified as Caucasian, 20.2% (n=290) identified as African American, 5.4% (n=78) identified as other, while 20% (n=283) had no race recorded. Overall pathologic grading distribution at time of biopsy was as follows: 35.8% (n=515) Grade Group (GG) 1, 28.5% (n=409) GG 2, 13.3% (n=191) GG 3, 11.5% (165) GG 4, and 10.9% (n=157) GG 5. Median number of cores at TRUS biopsy was 12 (IQR: 12, 13), while median number of cores at MRI Fusion biopsy was 15 (IQR 13,18). Therefore, we inferred that patients who underwent MRI Fusion biopsy also underwent standard biopsies at the same time. On average, the exact concordance rate between MRI Fusion biopsy and final pathology was 9.1% higher than that of TRUS biopsy (44.4% vs 35.3%, 95% CI: 1.6% - 16.5%, p <0.01, Figure 1). Overall rate of upstaging on final pathology for MRI fusion biopsies was 5.7% lower than for TRUS biopsies; however, this was not statistically significant (35.2% vs. 40.9%, 95% CI -1.5 – 13.0%, p = 0.06).

Conclusion: Within the PURC collaborative, MRI Fusion biopsies demonstrated higher concordance rates with final pathology at the time of radical prostatectomy than TRUS prostate biopsies.

Funding: Data was provided with permission from the Pennsylvania Urology Regional Collaborative (PURC), funded by participating urology practices and the Partnership for Patient Care, a quality improvement initiative supported by the Health Care Improvement Foundation, Independence Blue Cross, and southeastern PA hospitals and health systems.
**Poster #7**  
**DIFFERING PERCEPTIONS OF OPERATIVE EDUCATION AMONG FACULTY AND TRAINEES IN A UROLOGY RESIDENCY PROGRAM**  
Shreeya Popat, MD, Wesley Mayer, MD, Jennifer Taylor, MD  
*Scott Department of Urology, Baylor College of Medicine*  
Presented By: Shreeya Popat, MD

**Introduction:** Graduate medical education is increasingly constrained by duty hour restrictions, demands for efficiency, and a growing volume of content to cover, among other pressures. The operating room, which remains central to surgical training, represents a high-stakes environment where these constraints are magnified. This results in difficulty standardizing surgical education. We sought to understand perceptions of operative education among attending and resident physicians in our department.

**Methods:** A survey was distributed electronically to attending and resident physicians, with responses de-identified. The survey collected respondents’ opinions, using a 5-point Likert scale (1=lowest, 5=highest) and open-ended questions, regarding the frequency and value of educational discussions before and after surgical cases. Responses between faculty and trainee cohorts were compared.

**Results:** The survey was completed by 23 attending (92%) and 14 resident (88%) physicians. Collaborative establishment of educational goals prior to cases was rated relatively more important by residents than attending physicians (4.4 vs. 3.7, p=0.01). Both attendings and residents found it similarly challenging to discuss specific technical learning goals before cases. When asked why, residents described concerns about appearing “pushy” or “offending/upsetting” their superiors. Attending physicians described lack of continuity in teacher-student relationships, resulting in uncertainty about each trainee’s progress. The frequency at which educational goals were discussed prior to surgical cases was reported significantly lower by residents than attending physicians (1.9 vs. 2.8, p = 0.007).

Both resident and attending physicians described post-operative feedback as very important for education. However, attending physicians reported giving both immediate post-operative feedback and periodic summative feedback significantly more often than residents reported receiving it (p=0.00007 and p=0.0002, respectively). They also described a significantly longer amount of time per case devoted to feedback than residents perceived (mean 4.5 minutes vs. 1.8 minutes, p=0.0009). Attending physicians reported providing feedback that was more specific than residents reported receiving (p=0.00002). Finally, resident physicians described soliciting feedback as significantly more challenging than attending physicians rated giving feedback (p=0.000005).

**Conclusion:** Both resident and attending physicians find it challenging to establish collaborative technical educational goals. Additionally, there are significant differences between attending and resident perceptions of the frequency and specificity of post-operative feedback.

The above disparities can lead to learner and educator frustration and limit the progress of surgical trainer. Future work will address these critical areas for improvement. We have developed and plan to study the value and feasibility of a novel framework for peri-operative conversations between attending and resident physicians.

**Funding:** N/A
Poster #8
VALIDATION OF BEST PRACTICE POLICY ON URODYNAMIC ANTIBIOTIC PROPHYLAXIS IN THE NON-INDEX PATIENT IN THE ERA OF STEWARDSHIP
Cristina Fox, MD, Brian Kim, MSIV, Ali Omar, MSIV, Michelle Kim, MD, Debra Fromer, MD
Hackensack University Medical Center, Hackensack, NJ
Presented By: Cristina M. Fox, MD

Introduction: The Society of Urodynamics, Female Pelvic Medicine, and Urogynecology (SUFU) and American Urological Association (AUA) support a 2017 Best Practice Policy Statement for Urodynamic (UDS) Antimicrobial Prophylaxis. This statement advises prophylaxis at the time of UDS for non-index high-risk patients [neurogenic voiding dysfunction, elevated post void residual (PVR), age >70, chronic catheter, and orthopedic implants]. These recommendations are based on a paucity of high-level evidence. This study aims to validate these guidelines, particularly with respect to high-risk groups.

Methods: This retrospective IRB-approved single institution study reviewed 1100 patients who underwent UDS between May 2015 and July 2018. Exclusion criteria included: antimicrobial administration (including suppression) within seven days of UDS, peri-procedure prophylaxis, or lack of follow-up at 90 days. 489 patients met criteria for inclusion. UDS was performed with an 8 French cystometrogram catheter, rectal balloon, and patch electrodes. Urinalysis was performed prior, if positive, a urine culture was sent. Pathogenic culture positive specimens were treated. Chi-square, Fisher's Exact test, and t-test were used for univariate and multivariate regression analyses to assess associations between high-risk patients and urinary tract infection (UTI).

Results: Twenty-two (4.5%) patients developed symptomatic UTI within 30 days of UDS. No patient required hospitalization for sepsis or pyelonephritis. No orthopedic implants became infected. Non-index high risk groups were stratified. Univariate results are detailed in Table 1. Multivariate analysis further supported the association between UTI and a PVR > 100 and neurogenic voiding dysfunction, though other high risk groups failed to show a statistically significant correlation to UTI.

Conclusion: In the absence of prophylaxis, both index and non-index patients demonstrated low rates of infection. Even in the two statistically significant risk groups for UTI; no case of sepsis or significant morbidity was documented. This study calls into question the use of antimicrobial prophylaxis for UDS in high-risk groups.

Funding: n/a
**Table 1- Univariate Analysis**

<table>
<thead>
<tr>
<th>High Risk Variable</th>
<th>Patients (N)</th>
<th>UTI (N)</th>
<th>Rate (%)</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt;70</td>
<td>141</td>
<td>10</td>
<td>7.1</td>
<td>0.129</td>
</tr>
<tr>
<td>Age &lt;70</td>
<td>348</td>
<td>12</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>PVR &gt;100</td>
<td>88</td>
<td>10</td>
<td>11.4</td>
<td>0.002</td>
</tr>
<tr>
<td>PVR &lt;100</td>
<td>401</td>
<td>12</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>Immunosuppressed</td>
<td>44</td>
<td>4</td>
<td>9.1</td>
<td>0.126</td>
</tr>
<tr>
<td>Normal Immunity</td>
<td>445</td>
<td>18</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>NVD</td>
<td>50</td>
<td>7</td>
<td>14.0</td>
<td>0.004</td>
</tr>
<tr>
<td>Non Neurogenic</td>
<td>439</td>
<td>5</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Catheterized</td>
<td>26</td>
<td>1</td>
<td>2.8</td>
<td>1.000</td>
</tr>
<tr>
<td>Not catheterized</td>
<td>463</td>
<td>21</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Implants</td>
<td>31</td>
<td>3</td>
<td>9.7</td>
<td>0.156</td>
</tr>
<tr>
<td>No Orthopedic Implants</td>
<td>458</td>
<td>19</td>
<td>4.1</td>
<td></td>
</tr>
</tbody>
</table>

NVD = Neurogenic voiding dysfunction  
Statistical Significance: p<0.005
EVALUATING NEPHROLITHIASIS RISK AMONG PROSTATE CANCER PATIENTS TREATED WITH ANDROGEN-DEPRIVATION THERAPY IN A POPULATION OF MEDICARE BENEFICIARIES

Jessica Dai, MD, Sarah Holt, MPH, PhD, John Gore, MD, MS, Jonathan Wright, MD, MS, FACS, Mathew Sorensen, MD, MS, Jonathan Harper, MD
University of Washington
Presented By: Jessica Dai, MD

Introduction: Side effects of androgen deprivation therapy (ADT) include increased osteoporosis, weight gain, insulin resistance, and alteration of lipid profiles. These parallel the known risk factors for stone disease, including bone demineralization, obesity, and diabetes mellitus. However, the relationship between ADT and stone risk has not been examined. Our objective was to evaluate symptomatic stone episodes among Medicare beneficiaries with prostate cancer treated with ADT.

Methods: Patients ≥ 65 with new diagnoses of prostate cancer in the linked Surveillance, Epidemiology, and End Results (SEER) and Medicare databases from 2004 -2015 were included. A retrospective cohort study design was used to compare men receiving ADT within 1 year of diagnosis to individuals not receiving ADT. Primary outcome was time to first stone event after study entry (defined as an acute care visit for stone episode or stone surgery). Groups were compared using χ² test and multivariable logistic regression models were used to identify co-variates associated with stone risk in each cohort. Kaplan Meier curves were used to assess stone events over time in both groups.

Results: 144,826 patients with prostate cancer diagnoses were identified. Of these, 44,616 (30.8%) received ADT within the 1st year of diagnosis. Patients receiving ADT tended to be older with higher Charlson comorbidity score and cancer stage (p<0.001) as well as slightly more likely to have stone-specific comorbidities (nephrolithiasis diagnosis in year prior to ADT, diabetes, hypertension, obesity, osteoporosis) (p<0.001). Within the ADT group, therapy was administered for 1-12 months in 13.4%, 13-24 months in 7.4%, and ≥25 months in 10.1%. There was a significantly higher incidence of stone events at 1 year with ADT use in a dose-dependent fashion up to 24 months, which did not persist with longer ADT use (Table 1, p=0.03). There was a higher rate of stone events among ADT vs. non-ADT groups (HR 1.17, 95% CI 1.10-1.25, p<0.001) at 5 years of follow-up. Stone events were significantly associated only with age and prior stone history (p<0.001) on multivariable analysis.

Conclusion: Among Medicare beneficiaries with prostate cancer, there is an increased risk for stone events within 5 years of receiving ADT, compared with non-ADT controls. Additionally, there appears to be a dose-dependent relationship between the duration of ADT and early stone events after initiating treatment, up to 24 months. Additional research is required to elucidate potential mechanisms for this phenomenon.

Funding: N/A
Table 1. Rate of stone events at 1 year among prostate cancer patients receiving ADT within 1 year of diagnosis, compared to those receiving no ADT.

<table>
<thead>
<tr>
<th>Months of ADT</th>
<th>Total # of patients</th>
<th>Number of patients with stone events (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>94,683</td>
<td>751 (0.79)</td>
</tr>
<tr>
<td>1-6</td>
<td>9,585</td>
<td>68 (0.71)</td>
</tr>
<tr>
<td>7-12</td>
<td>7,044</td>
<td>58 (0.82)</td>
</tr>
<tr>
<td>13-18</td>
<td>5,741</td>
<td>47 (0.82)</td>
</tr>
<tr>
<td>19-24</td>
<td>4,913</td>
<td>47 (0.96)</td>
</tr>
<tr>
<td>≥25</td>
<td>14,624</td>
<td>81 (0.55)</td>
</tr>
</tbody>
</table>
Poster #10
THE RESIDENT FACTOR: A 10-YEAR TREND OF FEMALE MEDICAL STUDENTS PURUSING SURGICAL SUBSPECIALTIES
Bridget Findlay¹, Lexiaochuan Wen¹, Candace Granberg¹, Nell Maloney Patel²
¹Department of Urology, Mayo Clinic, Rochester, MN, ²Department of Surgery, Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ
Presented By: Bridget Lang Findlay, MD

Introduction: Less than 25% of General Surgery (GS) and surgical subspecialty (SS) physicians are female, with Urology having one of the lowest representations at 9%. This landscape will continue to change as >30% of senior medical students who applied for surgical residencies over the past 5 years were female. The literature suggests that access to same-sex faculty mentors has positively influenced female medical students pursuing general surgery residency, however no studies have addressed the influence of female surgical residents. We aim to study a 10-year trend of female senior medical students pursuing GS and SS in relation to presence of female surgical faculty and resident physicians at the same institution.

Methods: Residency Match data were collected from 2010-2019 at a single medical school. Graduating female seniors applying to GS or SS were identified. SS included urology, otolaryngology, ophthalmology, orthopedic, neurological, vascular, and plastic surgery. Surgical faculty at an academic medical center and resident information were collected from department websites and the General Surgery Residency Program Director.

Results: From 2010-2019, 53% (n=1251) of graduating seniors were female. Those pursuing surgical fields ranged from 11%-24% each year. Females matching to GS ranged from 8%-27% while females matching to SS ranged from 14%-36%. Percentage of female faculty was constant until 2016 when there was an increase in GS female faculty. There were significantly more female GS faculty compared to SS (39% vs. 5%; p < 0.0001). Urology, plastic surgery, and otolaryngology did not have any female faculty. The percentage of female GS residents increased from 50% to a peak of 57.4% from 2010-2014, but slowly declined to 35.6% by 2019. There was no significant correlation between trends in all female medical students matching into surgery and all female surgical residents (r = -0.251; p = 0.48). When stratifying for SS, there was a positive correlation between trends in female medical students compared to female residents (r = 0.77; p <0.01; Figure 1).

Conclusion: There is a trend towards more female medical students pursuing SS compared to GS, despite having a significantly greater proportion of female GS faculty and limited female SS faculty. Interaction with resident physicians, especially in SS, may have a positive influence on female medical students pursuing SS. Additional studies are needed, especially in fields with lower representation of women, such as urology, in order to better assess the impact of female residents as role models on female medical students.

Funding: N/A
Figure 1: 10 Year Trends of Females in Surgical Subspecialties

- $r = 0.77$
- $r^2 = 0.59$
- $p < 0.01$


Med Student | Resident
Introduction: The social media platform YouTube is a significant source of healthcare information for users with over 4,000 videos on pelvic organ prolapse (POP). Comprising 1.5 billion users, YouTube is currently being used in medicine to promote content dissemination and patient/physician education. The aim of this study was to evaluate the quality, understandability, and actionability or the ability for consumers to act after viewing, of POP videos on YouTube.

Methods: Videos were evaluated on YouTube using the search term, “Pelvic Organ Prolapse.” The first 135 YouTube videos were analyzed by five trained reviewers. Videos were excluded if they lacked narration in English, exceeded 10.00 minutes in length, demonstrated a surgical operation, or contained both no text and no audio. Videos were assessed using two validated grading system: DISCERN quality criteria and the Patient Education Materials Assessment Tool (PEMAT).

Results: In total, 100 videos met the inclusion criteria with a total of 6,307,202 views. Surgical repair was the most common treatment option discussed (57%); however few videos that covered surgical repair also reported surgical complications (Table 1). More than 50% of the videos were given low PEMAT scores (a score below 75%) for understandability and actionability (Table 2). Thirty-one percent of videos have the potential to spread misinformative or biased information to unknowing users (Table 2).

Conclusion: With millions of views on YouTube, many POP videos lack high quality information which is essential for decision-making. Thirty-one percent of POP YouTube videos can possibly spread biased or misinformative content to users. There is little oversight of the quality of information that is uploaded on YouTube, which can hinder users who are increasingly dependent upon websites like, YouTube, to make appropriate medical judgements. In addition, the validated PEMAT criteria found more than half of POP videos were given a PEMAT score of less than 75% for both understandability and actionability. YouTube videos can leave many patients unable to understand the topic, thus affecting their ability to seek proper medical care. Ultimately, this can affect the patient’s long-term quality of life. Although there is abundant publicly-available content on the internet and social media platforms, not all the information contains quality guidance. Efforts should be made to ensure the dissemination of both comprehensive and accurate healthcare options to the millions of users on YouTube and other social media websites.

Funding: Stacy Loeb, M.D., MSc is supported by the Edward Blank and Sharon Cosloy-Blank Family Foundation.
Table 1. Surgical options mentioned in YouTube videos on pelvic organ prolapse.

<table>
<thead>
<tr>
<th>Surgical Approach Videos</th>
<th>Number of videos (%), N=100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>57 (57)</td>
</tr>
<tr>
<td>Approaches to Surgery</td>
<td></td>
</tr>
<tr>
<td>Abdominal Approach</td>
<td>7 (12)</td>
</tr>
<tr>
<td>Vaginal Approach</td>
<td>9 (16)</td>
</tr>
<tr>
<td>Both</td>
<td>13 (23)</td>
</tr>
<tr>
<td>Neither</td>
<td>28 (49)</td>
</tr>
<tr>
<td>Surgical Complications</td>
<td>Number of videos (%), N=57</td>
</tr>
<tr>
<td>Urinary Incontinence after surgery</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Need for Repeat Surgery</td>
<td>5 (9)</td>
</tr>
<tr>
<td>Mesh Complications</td>
<td>Number of videos (%), N=15</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (40)</td>
</tr>
</tbody>
</table>

Table 2. Pelvic organ prolapse videos with content that includes misinformation, biased data, or insufficient scientific validation.

<table>
<thead>
<tr>
<th>Poor quality (DISCERN score &lt;3)</th>
<th>Percent of Videos</th>
<th>Mean number of views</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Misinformation* (score &gt;=3)</td>
<td>18%</td>
<td>3,506</td>
</tr>
<tr>
<td>Commercial Bias</td>
<td>21%</td>
<td>18,740</td>
</tr>
<tr>
<td>Low PEMAT Understandability</td>
<td>54%</td>
<td>88,818</td>
</tr>
<tr>
<td>Low PEMAT Actionability</td>
<td>64%</td>
<td>75,231</td>
</tr>
<tr>
<td>Total Unique Views and Videos</td>
<td>94%</td>
<td>67,502</td>
</tr>
</tbody>
</table>

*Score of some misinformation to high misinformation on a likert scale.
IMPROVED EFFICIENCY IN HOLMIUM LASER ENUCLEATION OF THE PROSTATE UTILIZING A MODULATED PULSE MODE

Bristol B. Whiles, MD1, Austin Martin, BS2, Drew Brevik, BS3, Kerri L. Thurmon, MD1
1University of Kansas, Dept. of Urology, Kansas City, KS, 2University of Kansas School of Medicine, Kansas City, KS, 3Kansas City University of Medicine and Biosciences, Kansas City, MO

Presented By: Bristol B. Whiles, MD

Introduction: Holmium laser enucleation of the prostate (HoLEP) is a well-established treatment option for men with lower urinary tract symptoms attributed to benign prostatic hyperplasia. With multiple advancements in technology various holmium laser platforms have emerged. Moses, which utilizes a modulated pulse, is one laser platform which has shown promise for use in laser lithotripsy. This same technology can be used in HoLEP; however, to our knowledge, no studies to date have formally investigated the use of Moses technology in this specific patient population.

Methods: This is a retrospective cohort study of patients who underwent HoLEP (CPT 52649) at an academic medical center between 04/2018 – 10/2018 by a single urologic surgeon. Intraoperative variables were compared between patients who underwent enucleation of the prostate with Pulse 120H laser fitted with a 550µm fiber with and without use of Moses Technology (Moses fiber and laser settings). Prostate size was determined by preoperative imaging, and enucleated tissue weight was determined by pathology. Intraoperative parameters such as enucleation time and laser energy usage were obtained from operating room documentation. Data analysis was completed in SAS Studio via Student’s t-test since all were parametrically distributed.

Results: A total of 49 patients underwent HoLEP were included in our cohort, 31 patients without and 18 patients with the use of Moses. Prostate size was larger in patients who underwent HoLEP after implementation of Moses (152g vs 119g; p=0.03). Enucleation time was similar (79.1 minutes vs 76.3 minutes; p=0.68); however, enucleated volume (100.7g vs 68.3g; p<0.01) and enucleation rate (1.32g/min vs 0.92 g/min; p=0.01) were larger and faster with use of the Moses laser technology. Percentage of tissue enucleated was 73.9g vs 58.2g in those with and without use of Moses, although this was not statistically significant (p=0.17). There were no differences in mean laser energy usage or energy usage rate between these two groups. Energy efficiency, defined by enucleated tissue per KJ of energy used, was 0.64g/KJ vs 0.47g/KJ with and without the use of Moses which approached by was not statistically significant (p=0.09).

Conclusion: Use of the Moses laser and laser fiber are associated with increased enucleation efficiency in patients undergoing HoLEP. Further studies are needed to further determine if intraoperative as well as postoperative outcomes differ when this technology is utilized.

Funding: N/A
Introduction: Trauma is the most common cause of death in pediatric patients. Although 10 to 20% of all pediatric blunt abdominal traumas involve the kidneys, very little has been reported on the characteristics and costs associated with hospitalization of these patients. Our aim is to describe patient and hospital variables affecting total hospitalization cost (HC) and length of stay (LOS) in pediatric renal trauma patients.

Methods: Using the 2016 Kids’ Inpatient Database (KID) and International Classification of Diseases, Tenth Revision (ICD-10) coding, we identified patients with renal trauma. Patient demographics, clinical characteristics, and hospital characteristics were described. Multivariate logistic regression was used to determine factors associated with increased HC and LOS.

Results: 332 children aged 20 or younger with renal trauma were identified. Mean age at admission was 14.95 years. White patients comprised 53.40% of the cohort, and 84.59% lived in metropolitan areas. 61.03% were male, and 33% of all patients came from the lowest national income quartile. 49.55% had private insurance followed by 40.18% with non-private insurance (Medicare or Medicaid) and 10.27% with no insurance. Total HC was under $50,000 in 35.28%, between $50,001 and $200,000 in 40.36%, and greater than $200,000 in 23.62% of patients, with an approximate mean cost of $161,141. LOS was 3 days or less in 34.94%, between 4 to 10 days in 40.06%, and greater than 10 days in 25% of patients. On multivariate adjusted logistic regression, higher total HC was significantly associated with a higher number of ICD-10 coded diagnoses (OR = 2.91, 95% CI: 1.41-6.14), greater number of inpatient procedures performed (OR = 9.92, 95% CI: 4.89-20.05), longer LOS (OR = 8.64, 95% CI: 4.19, 17.84) and private, invest-own hospital ownership (OR = 4.56, 95% CI: 1.22-17.08). Longer LOS was related to greater severity of illness (OR = 2.85, 95% CI: 1.49, 5.43), transfer to another hospital (OR = 4.28, 95% CI: 2.05, 8.93), and higher total cost (OR = 6.55, 95% CI: 3.68, 11.67, Table 5). There was no correlation between total HC or LOS with patient race, gender, residence, income or insurance status.

Conclusion: Pediatric renal trauma accounts for a large volume of health care expenditures. These costs dramatically increase for patients who have more medical issues, longer LOS, and inpatient procedures performed. Importantly, socioeconomic factors did not impact LOS or total HCs. More studies are needed to uncover disparities in the care of pediatric renal trauma patients.

Funding: N/A
### Table 1: Multivariate logistic regression analyses of the characteristics associated with total cost and length of stay among children with renal trauma, 2016 KID database.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>OR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Cost</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>1.00 (Referent)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>≥5</td>
<td>8.64 (4.19, 17.84)</td>
<td></td>
</tr>
<tr>
<td>Number of diagnosis, ICD-10</td>
<td></td>
<td>0.0041</td>
</tr>
<tr>
<td>&lt;13</td>
<td>1.00 (Referent)</td>
<td></td>
</tr>
<tr>
<td>≥13</td>
<td>2.91 (1.41, 6.14)</td>
<td></td>
</tr>
<tr>
<td>Number of procedures performed</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>≤2</td>
<td>1.00 (Referent)</td>
<td></td>
</tr>
<tr>
<td>&gt;2</td>
<td>9.92 (4.89, 20.05)</td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td></td>
<td>0.0006</td>
</tr>
<tr>
<td>Government, non-federal</td>
<td>1.00 (Referent)</td>
<td></td>
</tr>
<tr>
<td>Private, non-profit</td>
<td>0.51 (0.20, 1.28)</td>
<td></td>
</tr>
<tr>
<td>Private, invest-own</td>
<td>4.56 (1.22, 17.08)</td>
<td></td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity of illness, patient refined diagnostic related group (DRG)</td>
<td></td>
<td>0.0015</td>
</tr>
<tr>
<td>Minor &amp; moderate</td>
<td>1.00 (Referent)</td>
<td></td>
</tr>
<tr>
<td>Major &amp; extreme</td>
<td>2.85 (1.49, 5.43)</td>
<td></td>
</tr>
<tr>
<td>Transferred out</td>
<td></td>
<td>0.0001</td>
</tr>
<tr>
<td>No</td>
<td>1.00 (Referent)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.28 (2.05, 8.93)</td>
<td></td>
</tr>
<tr>
<td>Total cost&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>&lt;$83,700</td>
<td>1.00 (Referent)</td>
<td></td>
</tr>
<tr>
<td>≥$83,700</td>
<td>6.55 (3.68, 11.67)</td>
<td></td>
</tr>
</tbody>
</table>

---

<sup>a</sup> The median total hospital charge among pediatric patients with renal trauma in the 2016 KID database was $83,700. Thus, $83,700 was used as the cut-off point to dichotomize the variable.

<sup>b</sup> The median length of stay among pediatric patients with renal trauma in the 2016 KID database was 5. Thus, 5 was used as the cut-off point to dichotomize the variable.

<sup>c</sup> The median number of diagnosis based on ICD-10 among pediatric patients with renal trauma in the 2016 KID database was 13. Thus, 13 was used as the cut-off point to dichotomize the variable.

<sup>d</sup> The median number of procedures performed among pediatric patients with renal trauma in the 2016 KID database was 2. Thus, 2 was used as the cut-off point to dichotomize the variable.
Poster #14
IS DIGITAL ETHNOGRAPHY THE FOCUS GROUP OF THE FUTURE? FOCUS GROUPS VS. SOCIAL MEDIA ANALYSIS OF WOMEN'S EXPERIENCE WITH OVERACTIVE BLADDER (OAB)
Paige Kuhlmann, MD, Gabriela Gonzalez, Yuliya Zektser, Corey Arnold, PhD, Christopher Almario, MD, MSHPM, Brennan Spiegel, MD, MSHS, Jennifer Anger, MD, MPH
1Cedars Sinai Medical Center, 2David Geffen School of Medicine at UCLA, 3University of California, Los Angeles
Presented By: Paige Kuhlmann, MD

Introduction: Qualitative methods assessing women’s perspectives on living with OAB have traditionally been obtained via focus groups and in-person interviews. Now, a plethora of cyber forums have emerged, allowing women to discuss their OAB experiences anonymously. The aim of this study was to compare patient perceptions of OAB generated through focus groups to those gleaned from online social media. Comparing the results from these methods will validate and enhance providers’ understanding of women’s experiences with OAB, leading to more enlightened patient care.

Methods: For the digital ethnography analysis, 2,618 posts pertaining to OAB from 203 social media sites were identified by using keywords as search terms in a Java-based natural language processing platform and a social media data mining service. Of these, 200 posts were randomly selected for inclusion. The focus groups included were conducted previously (Anger et al, 2011). Women seen in urology clinic were identified by ICD-9 codes for OAB symptoms and recruited to participate in one of five focus groups, totaling 33 patients. Non-clinician moderators conducted the focus group sessions. Data from both methods were analyzed using grounded theory methodology. The data sets were coded independently and then compared.

Results: Each of the major themes that emerged during analysis of focus group data was echoed in the themes uncovered in the analysis of social media posts. While major themes were generally similar, several unique subthemes were identified in each of the groups (Table 1). The subthemes unique to the focus groups were centered on symptoms and their management. The subthemes unique to the social media group were much more personal, reflecting a sense of comfortability with sharing private insights under the cover of anonymity. Finally, a new major theme was identified in the digital ethnography analysis: Online Community Engagement. The subthemes listed under this major theme highlighted that women are pursuing self-education via online resources instead of relying on information from providers.

Conclusion: In addition to confirming our understanding of women’s experiences with OAB, this study highlights the reliability of qualitative data collected through social media compared to focus groups, as well as social media’s ability to procure personal, unbiased information. Digital ethnography provides immediate access to data on a large, diverse population, obviating the logistics required for focus groups. It presents an opportunity for providers to gain awareness of their patients’ perceptions, as well as what information their patients seek, facilitating a more effective patient-provider relationship.

Funding: N/A
# RESIDENT POSTER SESSION

## Themes & Subthemes

<table>
<thead>
<tr>
<th>Social Media</th>
<th>Both</th>
<th>Focus Groups</th>
</tr>
</thead>
</table>
| - Emotional challenges  
  - suicidality, depression, embarrassment  
  - Dating, sex | - Lack of understanding of etiology of OAB  
  - Confusion with other pelvic disorders  
  - Defecatory symptoms  
  - Misconceptions of definitions of incontinence  
  - Small Vadder, weak bladder | - Nocturia  
  - Insomnia  
  - Fatigue during the day  
  - May trigger for incontinence |
| - Anxiety, dyspareunia  
  - Birth trauma | | |
| | | |

## Patient-Physician Interactions

- Non patient-centered care  
  - Distress in physicians / alleged mismanagement  
  - Delays in specialty referred  
  - Lack of symptom validation  

## Medications & Side Effects

- Miscommunication by patients & providers over Kegel exercises & medications  
  - Lack of understanding of diagnostic tests that physicians order  

## Alternative Therapies for Controlling Symptoms

- Strengthening abdominal muscles  
  - Homeopathy  
  - Bladder training  
  - Moxa Lina  
  - Physical therapy  

## Table 1. Comparison of themes identified through digital ethnography evaluation of women’s perspectives of OAB to themes identified through focus group discussions including women with OAB
Introduction: To assess online user behavior on pelvic-mesh related articles after the April 2019 United States Food and Drug Administration (FDA) ban on transvaginal mesh for pelvic organ prolapse (POP).

Methods: We used Google Trends® to identify the terms related to pelvic mesh that experienced increased activity after the FDA ban. The terms identified were “pelvic mesh”, “FDA mesh”, “transvaginal mesh”, “vaginal mesh”, and “surgical mesh”. The latter was excluded as the related articles were not solely focused on POP. The four terms were analyzed for worldwide social media engagement (Facebook, Twitter, Pinterest, and Reddit) between April 16th and April 19th. We analyzed the top ten lay press articles shared for each term, and then examined the top ten Google search results for each term on June 6th, 2019 in the United States, to evaluate what information was available after peak interest subsided.

Results: Thirty unique articles with peak activity after the FDA ban were identified. Twenty-six articles were from news/journalist organizations and four from healthcare related entities. Two (6.7%) did not mention the April 2019 FDA announcement. Seven (23%) discussed mesh for stress urinary incontinence (SUI) without clarifying the difference between SUI and POP mesh. Eighteen (69%) mentioned lawsuits or negative individual experiences without clarifying the type of pelvic mesh used. Google identified 26 unique articles for the four terms when searched on June 6th: twelve from news/journalist organizations, eight healthcare related, 5 governmental, and 1 law firm. Seven (27%) did not mention the FDA announcement, 3 (12%) mentioned mesh for SUI, and 11 (42%) discussed lawsuits or negative individual experiences.

Conclusion: Internet search patterns and social media behavior following the April 2019 FDA ban on transvaginal POP mesh reveal that some of the most disseminated information did not accurately or thoroughly distinguish the type of mesh discussed. Surgeons performing surgery for stress urinary incontinence and pelvic organ prolapse must provide adequate time during preoperative counseling to clarify differences between types of mesh impacted by the ban and those not affected. Moreover, focused educational materials for patients who may be or think they are affected by the recent FDA ban would be a timely and beneficial resource to the public during this time.

Funding: N/A
Poster #16
VARIATIONS IN PERI-OPERATIVE ANTIBIOTIC PRESCRIBING PATTERNS AMONG ACADEMIC UROLOGISTS AFTER AMBULATORY ENDOSCOPIC UROLOGIC SURGERY: DISCORDANCE WITH THE GUIDELINES?
Meenakshi Davuluri, MD, MPH1, Ari Bernstein2, Ethan Fram, MD1, Kara Watts, MD1
1Department of Urology, Montefiore Medical Center, 2Albert Einstein College of Medicine
Presented By: Meenakshi Davuluri, MD

Introduction: Adherence to the American Urologic Association (AUA) best practice statement regarding optimal antibiotic duration in the peri-operative setting (up to 24 hours post-operatively) for endoscopic urologic surgery is unclear. We sought to evaluate peri-operative antibiotic prescription practices after ambulatory endoscopic urologic surgeries among adult urologists at an academic institution and their correlations with the AUA antimicrobial prophylaxis best practice statement.

Methods: We performed a retrospective chart review of all adult endoscopic ambulatory urologic surgeries performed over an 18-month period by our adult urologists at our academic institution. Patient demographics, clinical variables, pre-and post-operative (up to 30 days) urine cultures, operative details, use of an implant (stent or foley), and antibiotic prescriptions were collected. Chi-squared and linear regression analyses were done.

Results: 355 patients underwent ambulatory endoscopic urologic surgery and were included for analysis. 62% of patients were prescribed an oral antibiotic to take post-operatively, and average duration of antibiotic prescription was 4 days (range 1-10). Patients who underwent upper tract procedures (ie: ureteroscopy) were more likely to receive post-operative antibiotics than those who underwent bladder procedures (ie: cystoscopic procedures) (70% vs 49%, p = 0.002). Bactrim and fluroquinolones were the most often prescribed (43% and 39%, respectively). The following factors significantly predicted antibiotic prescriptions on multivariate analysis: diabetes, a positive urine culture within 12 months prior to surgery, and intra-operative placement of a ureteral stent. Presence of a foley catheter prior to or at conclusion of surgery did not influence antibiotics prescriptions. Of the patients in our cohort, 2.8% had positive post-operative urine cultures. Within this sub-group, there was no significant difference in positive post-operative urine cultures between patients who did not receive a post-operative antibiotic prescription and those who did.

Conclusion: At our academic institution, post-operative antibiotic prescriptions after ambulatory endoscopic urologic surgery were prescribed for a much longer duration than AUA best practice guidelines. Despite this, our data suggest that antibiotic prescriptions did not impact rates of post-operative urine cultures. Reasons for these deviations are currently being evaluated to determine strategies to reduce over-prescription of antibiotics.

Funding: N/A
Introduction: Urinary incontinence (UI) occurs in up to 60% of women, increases with age and its effects on quality of life can be profound. However, few women discuss UI with medical providers. We aimed to evaluate the prevalence of reported discussions of UI with healthcare providers among two cohorts in the Nurses’ Health Study that span a wide age range, to evaluate potential generational differences between the cohorts.

Methods: Data from the Nurses’ Health Study (NHS I) in 2012, which enrolled women aged 30 to 55 in 1976, and NHS II in 2013, which enrolled women between 25 and 42 years old in 1989 was used to evaluate the role of age and other factors in participant discussions of UI with their healthcare providers. We used multivariable-adjusted logistic regression to estimate odds ratios (OR) of reported provider discussions across relevant characteristics.

Results: Among 94,692 women with UI whose age ranged from 48 to 93, 34% reported discussing UI with their provider. Age was not associated with talking to one’s doctor until age was greater than 80 years (OR 0.81 95% CI (0.73, 0.89). Provider discussions were directly associated with UI frequency and severity. The odds of women with daily UI to discuss UI with their providers were 4.4 times greater than women who had UI less than once per month (OR =4.36, 95% CI 4.06-4.69). Similarly, women with severe UI (combinina high frequency with high volume of urine loss) were twice as likely to discuss UI with their providers compared to women with mild UI (OR=2.01, 95% CI 1.88, 2.16). Greater baseline healthcare utilization was also associated with increased odds of discussing UI with a provider. Factors that decreased odds of discussion included obesity (NHS II: OR=0.88, 95% CI 0.84-0.92), smoking (NHS II OR=0.68, 95% CI 0.61-0.76 and NHS I OR=0.63, 95% CI 0.56-0.71) and age >80 years.

Conclusion: This study finds that only about ⅓ of women with UI discuss this with their health provider across most age groups. Women with more frequent and severe UI were at increased odds of discussing UI with providers. Whereas, women who were elderly, smokers, or obese had decreased odds of discussing UI.

Funding: NIDDK, NCI
Table 1: Odds ratios* and 95% confidence intervals for report of talking with a provider about their UI among women in the Nurses' Health Studies with urinary incontinence (UI) in 2012/2013 according to demographics, health behaviors, health status and UI symptoms

<table>
<thead>
<tr>
<th>Demographic Factors</th>
<th>Nurses’ Health Study II</th>
<th>Nurses’ Health Study I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women 48-68 years of age</td>
<td>Women 66-93 years of age</td>
</tr>
<tr>
<td></td>
<td>Talked with Provider (n=14,536)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>White race, %</td>
<td>14,497</td>
<td>1.09 (0.96, 1.23)</td>
</tr>
<tr>
<td>Employment status, %</td>
<td>9369</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>Not employed outside the home or retired</td>
<td>7038</td>
<td>0.82 (0.76, 0.88)</td>
</tr>
<tr>
<td>Employed outside the home, nursing</td>
<td>754</td>
<td>0.82 (0.74, 0.90)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Behaviors</th>
<th>Nurses’ Health Study II</th>
<th>Nurses’ Health Study I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women 48-68 years of age</td>
<td>Women 66-93 years of age</td>
</tr>
<tr>
<td></td>
<td>Talked with Provider (n=14,536)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>9763</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>Past</td>
<td>4556</td>
<td>0.95 (0.91, 1.00)</td>
</tr>
<tr>
<td>Current</td>
<td>579</td>
<td>0.68 (0.61, 0.76)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Nurses’ Health Study II</th>
<th>Nurses’ Health Study I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women 48-68 years of age</td>
<td>Women 66-93 years of age</td>
</tr>
<tr>
<td></td>
<td>Talked with Provider (n=14,536)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Obesity (&lt;39 kg/m2)</td>
<td>9456</td>
<td>0.88 (0.84, 0.92)</td>
</tr>
<tr>
<td>Co-morbidities**</td>
<td>3744</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>0</td>
<td>5563</td>
<td>1.10 (1.05, 1.16)</td>
</tr>
<tr>
<td>&gt;1</td>
<td>5,642</td>
<td>1.04 (1.04, 1.17)</td>
</tr>
<tr>
<td>Low SF-36 Physical Function Score</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Low Mental Health Score***</td>
<td>3,422</td>
<td>0.98 (0.93, 1.04)</td>
</tr>
<tr>
<td>Reported preventative health screening in the last 2 years****</td>
<td>14,745</td>
<td>2.19 (1.85, 2.69)</td>
</tr>
<tr>
<td>Current post-menopausal hormone use</td>
<td>5,664</td>
<td>1.63 (1.50, 1.79)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UI Symptoms</th>
<th>Nurses’ Health Study II</th>
<th>Nurses’ Health Study I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women 48-68 years of age</td>
<td>Women 66-93 years of age</td>
</tr>
<tr>
<td></td>
<td>Talked with Provider (n=14,536)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>UI frequency, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1/month</td>
<td>3,406</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>1/month</td>
<td>3,585</td>
<td>1.48 (1.36, 1.60)</td>
</tr>
<tr>
<td>2-3/month</td>
<td>2,724</td>
<td>1.84 (1.81, 2.09)</td>
</tr>
<tr>
<td>1/week</td>
<td>2,976</td>
<td>2.04 (1.83, 2.26)</td>
</tr>
<tr>
<td>1/day</td>
<td>4,471</td>
<td>3.94 (3.59, 4.39)</td>
</tr>
<tr>
<td>UI severity, %</td>
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<td></td>
</tr>
<tr>
<td>Mild</td>
<td>4,666</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>Moderate</td>
<td>4,456</td>
<td>1.55 (1.35, 1.75)</td>
</tr>
<tr>
<td>Severe</td>
<td>5,344</td>
<td>2.03 (1.83, 2.25)</td>
</tr>
<tr>
<td>UI type, %</td>
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<td></td>
</tr>
<tr>
<td>Stress</td>
<td>5,382</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>Urges</td>
<td>3,526</td>
<td>1.31 (1.24, 1.38)</td>
</tr>
<tr>
<td>Mixed</td>
<td>4,069</td>
<td>1.29 (1.23, 1.37)</td>
</tr>
<tr>
<td>Other</td>
<td>9,20</td>
<td>1.04 (0.95, 1.13)</td>
</tr>
<tr>
<td>Duration of UI, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10 years</td>
<td>1,804</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>10+ years</td>
<td>13,134</td>
<td>1.41 (1.35, 1.50)</td>
</tr>
</tbody>
</table>

*Adjusted for all variables included in the table and age
**Co-morbidities include high cholesterol, hypertension, type 2 diabetes, myocardial infarction, and stroke.
***NHSSE Center for Epidemiologic Studies Depression Scale; score of 10 or more is cut point for depression, range: 0-30. (NHSE: Geriatric Depression Scale- score of 6 or more is cut point for depression, range: 0-15.
****Preventative health screenings include physical exam, eye exam, mammogram or colonoscopy.
Podium #2

DECISION AIDS IMPROVE PATIENT-REPORTED SHARED DECISION MAKING: AN ANALYSIS OF SURGICAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) DATA

Giulia I. Lane, MD
Nicholas L. Berlin, MD
Chad Ellimoottil, MD
Sara M. Lenherr, MD
J. Quentin Clemens, MD

1University of Michigan, 2University of Utah

Presented By: Giulia Ippolito Lane, MD

Introduction: Shared Decision Making (SDM) is a process of making medical decisions that balances the best available evidence with patients’ preferences and values. While SDM can include the use of decision aids (DA), it is unclear whether use of DA correlates with SDM. The purpose of this study was to examine whether the use of DA was associated with improved patient-reported SDM or increased satisfaction with their surgeon.

Methods: We performed a secondary analysis of prospectively collected Surgical Consumer Assessment of Healthcare Providers and Systems (S-CAHPS) surveys from adults undergoing elective, pelvic reconstructive surgeries between 2011-14 by 7 urologists. S-CAHPS is a standardized 45-question tool used to assess patient satisfaction around one episode of surgical care. For this study we created a novel SDM composite score from 3 items related to SDM. DA use and patients’ satisfaction with surgeons were based on patients’ response to one question items. (Figure) Ordinal logistic regression was performed to assess factors influencing patients’ evaluation of shared decision making and overall satisfaction with their surgeon.

Results: A total of 430 surveys (34%) were returned. Respondents were mostly Caucasian (94%) females (54%) with a mean age of 60 years. Among respondents, 59% reported DA use during preoperative visits and the majority (71%) achieved a maximum score (3) on the SDM composite. We found that utilizing a DA increased the odds of SDM (OR 1.77, 95% CI 1.07, 2.93) when controlling for patient age, time to survey response, surgeon, patient education rating, ethnicity, race, gender, and overall patient satisfaction with surgeon. However, there was no association between DA use nor SDM composite scores with patient reported satisfaction with their surgeon.

Conclusion: Our findings suggest that that decision aids increase the odds of patients reporting higher levels of shared decision making during pre-surgical counseling. However, neither DA use nor SDM composite scores were associated with patient reported satisfaction with their surgeon.

Funding: N/A
Figure 1: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey Shared Decision Making 3-question composite items and Decision Aid items.

**Shared Decision Making Composite Items:**

5. During your office visits before your surgery, did this surgeon tell you there was more than one way to treat your condition?
   - [ ] Yes
   - [ ] No

6. During your office visits before your surgery, did this surgeon ask which way to treat your condition you thought was best for you?
   - [ ] Yes
   - [ ] No

7. During your office visits before your surgery, did this surgeon talk with you about the risks and benefits of your treatment choices?
   - [ ] Yes
   - [ ] No

**Decision Aid Items:**

12. During your office visits before your surgery, did this surgeon or a health provider from this surgeon’s office use pictures, drawings, models, or videos to help explain things to you?
   - [ ] Yes
   - [X] No → If No, go to #14

**Surgeon Ranking Item:**

36. Using any number from 0 to 10, where 0 is the worst surgeon possible and 10 is the best surgeon possible, what number would you use to rate this surgeon?
   - [ ] 0 Worst surgeon possible
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] 5
   - [ ] 6
   - [ ] 7
   - [ ] 8
   - [ ] 9
   - [ ] 10 Best surgeon possible
**Podium #3**

**MOLECULAR ANALYSIS OF THREE PHENotypically DISTINCT INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME PATIENT SUBGROUPS**

Tyler Lynne Overholt, MD¹, Robert Evans, MD¹, Catherine Matthews, MD¹, Gopal Badlani, MD¹, Trang Simon, BS², Olivia Cain, Stephen Walker, PhD²

¹Wake Forest Baptist Medical Center Department of Urology, ²Wake Forest Institute for Regenerative Medicine

Presented By: Tyler Lynne Overholt, MD

**Introduction:** Interstitial cystitis/bladder pain syndrome (IC/BPS) is a chronic, heterogeneous pain condition of unknown etiology. The identification of relevant IC/BPS patient subgroups would be clinically useful for addressing challenges in both diagnosis and management. To this end, using anesthetic bladder capacity (BC) as the clinical delineator, we previously investigated gene expression differences in bladder biopsy tissue from IC/BPS patients. We found that samples from low BC (<400cc) patients had a significantly different expression profile compared to non-low BC (>400cc) and control samples. In the current study we extend these findings to include microRNA (miRNA) expression profiles in samples from phenotypically unique IC/BPS subgroups.

**Methods:** Bladder tissue samples from 18-80 y/o IC/BPS patients representing three clinical subgroups were selected from our large repository as follows: **Group 1:** low BC (<400cc); **Group 2:** low BC, with Hunners lesion (HL+); and **Group 3:** non-low BC (>400cc). Tissues were obtained during hydrodistention via cystoscopically-guided biopsy. Total RNA (mRNA + miRNA) was isolated via standard protocols and assayed on whole genome microarrays (mRNA expression) and miRNA expression arrays. Comparisons of differential mRNA and miRNA expression were made between Group 1 & 3 (low vs non-low BC) and Groups 1 & 2 (HL+ vs HL-). Ingenuity Pathway Analysis (IPA) software was used to map miRNAs to specific genes.

**Results:** The comparison of low vs non-low BC identified 744 differentially expressed transcripts (DETs; p<0.01) and 54 differentially expressed miRNAs (p<0.05). Using IPA, 11 miRNAs mapped to 40 genes with experimentally demonstrated function (EDF). The comparison of HL+ vs HL- samples identified 917 DETs (p<0.01) and 54 miRNAs (p<0.05); 4 miRNAs mapped to 13 genes with EDF. Upregulated genes in the low BC group compared to the non-low BC group were significantly over-represented in cell cycle progression, apoptosis, and inflammatory cell signaling pathways (Table 1A). This suggests that inflammation and abnormal cell proliferation may be important underlying factors for the low BC phenotype. When comparing the HL+ vs HL- groups, in addition to abnormal cell proliferation and inflammatory pathways being over-represented in the HL+ group, there was also a large number of upregulated genes involved in bioenergetics (oxidation-reduction; redox) reactions. This suggests that, in addition to inflammation and abnormal cell proliferation (Table 1B), oxidative stress and damage may underlie the HL+ phenotype.

**Conclusion:** The present study has identified significant molecular differences in IC/BPS associated with the low vs non-low BC IC/BPS phenotype, and additional molecular findings that further define the Hunners lesion phenotype.

**Funding:** NIH R21 DK106554-01 (SJW)
Table 1. Differentially expressed miRNAs mapped to differentially expressed transcripts. Part A indicates the comparison between low bladder capacity vs non-low bladder capacity IC/BPS bladder biopsy tissue. Arrows indicate the direction of change (either up- or down-regulated) in the low bladder capacity group. Part B indicates the comparison of Hunners lesion positive to Hunners lesion negative IC/BPS patient bladder biopsy tissue. Arrows indicate the direction of change (either up- or down-regulated) in the HL+ group.

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<th>mRNA</th>
<th>Pathways genes are involved in</th>
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<td><strong>Part A: Low vs non-low BC IC/BPS comparison</strong></td>
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<tr>
<td>hsa-miR-15a-5p (↓)</td>
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<td>CREBL2 (↑)</td>
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<td>hsa-miR-29c-3p (↑)</td>
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Podium #4
PATIENT ENGAGEMENT IN THE 2019 BLADDER CANCER PATIENT SURVEY NETWORK

Judy Hamad1, John Gore2, Stephanie Chisolm3, Robert Lipman3, Angela Smith4
1University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC,
2Department of Urology, University of Washington, Seattle, WA, 3Bladder Cancer Advocacy Network, Bethesda, MD, 4Department of Urology, University of North Carolina at Chapel Hill, Chapel Hill, NC
Presented By: Judy Hamad, BS

Introduction: Incorporating patients in the research process and including patient-centered outcomes has become an important standard in research, as it leads to meaningful results that help patients make better healthcare decisions. The Bladder Cancer Advocacy Network’s (BCAN) Patient Survey Network (PSN) established a diverse and engaged bladder cancer patient population who contribute to the prioritization of bladder cancer research topics through annual surveys and summits.

Methods: Through the PSN, patient participants were asked to report age, gender, race, highest level of education, household income, histology, disease stage, treatments received, and date of last treatment. Caregiver participants were asked to report on these measures on behalf of their loved ones. Respondents were also asked to prioritize a series of stakeholder-identified research questions within their own disease stage category with the option to include their own prioritized question via free-text.

Results: By year three of the PSN, the network enrolled over 1300 patients and caregivers. 405 patients and caregivers responded to the 2019 research prioritization survey. The average age of respondents was 67 years. The majority of respondents were male (62.5%) with non-muscle invasive bladder cancer (62.6%) diagnosed in the past five to ten years. 80.5% of respondents reported receiving greater than one form of treatment, with transurethral resection of bladder tumor (TURBT) and intravesical therapy being the most commonly received treatments. Prioritization rankings of research questions were stratified by disease stage: A) non-muscle invasive bladder cancer (NMIBC), B) muscle-invasive bladder cancer (MIBC), C) metastatic bladder cancer, and D) upper tract urothelial cancer (Figure 1). For NMIBC, the highest-ranked question involved the study of biomarkers to predict cancer recurrence (average rank of 1.82 on a scale of 1-5). Respondents with MIBC, metastatic bladder cancer, and upper tract urothelial cancer prioritized a similar research question regarding strategies to help patients understand their cancer prognosis (mean ranking 1.95 on a scale of 1-5 for MIBC; mean ranking 1.85 and 1.94 on a scale of 1-4, respectively, for metastatic and upper tract urothelial cancer). Free-text questions submitted by respondents were similar to those included in previous PSN iterations.

Conclusion: The 2019 PSN highlights patient-prioritized research questions for a large group of bladder cancer patients and caregivers. These high-priority research questions, as well as a consolidated list of respondent-submitted research questions, will be distributed to funding agencies and will serve to guide future studies incorporating patient-centered outcomes.

Funding: N/A
Figure 1. Rank order prioritization of research questions for A) non-muscle invasive bladder cancer, B) muscle-invasive bladder cancer, C) metastatic bladder cancer, and D) upper tract urothelial cancer.
Podium #5
THE DIFFERENT ELEMENTS OF THE URINARY TRACT DILATION (UTD) CLASSIFICATION SYSTEM AND THEIR CAPACITY TO PREDICT FINDINGS ON MERCAPOACETYLTRIGLYCINE (MAG3) DIURETIC RENOGRAPHY

Carlos Villanueva Del Rio, Eric Massanyi, Hannah Agard, Megan Albertson, Matthew Anderson, Morshed Alam, Elizabeth Lyden

1Phoenix Children’s Urology/Phoenix Children’s Hospital, Phoenix, AZ, 2Pediatric Adolescent Urology, Inc./Akron Children’s Hospital, Akron, OH, 3Cleveland Clinic Akron General Urology Residency Program, Akron, OH, 4University of Nebraska Medical Center, Omaha, NE

Presented By: Hannah Elizabeth Agard, MD

Introduction: In 2014, a new ultrasound classification system for hydronephrosis was proposed which combined elements used by perinatologists (i.e., anteroposterior diameter) with components of the Society for Fetal Urology classification. The UTD Classification system risk stratifies postnatal dilation into three groups: low risk (UTD P1), intermediate risk (UTD P2), and high risk (UTD P3). In this study, we investigate how the different elements of the UTD classification system predict differential renal function (DRF) as well as diuretic half-life (T1/2) on a MAG3 scan in infants being initially evaluated for prenatally detected UTD.

Methods: This is a multicenter retrospective chart review of infants 6 months of age or younger evaluated for prenatal UTD, correlating their first MAG3 and first postnatal renal ultrasound (RUS). Patients with bilateral UTD P2 or P3 were excluded. In patients with bilateral UTD, only the kidney with the higher UTD grade or the kidney with the greater anteroposterior diameter (APD) (when both kidneys were UTD P0 or P1) from each patient was analyzed. Logistic regression models were used to find UTD elements predictive of either DRF of <40% or T1/2 > 20 minutes. SAS University edition was used for the analysis.

Results: 517 patients were included. Median age at time of RUS and MAG3 renal scan was 48 days (IQR 31-81) and 63 days (IQR 45-98), respectively. 6% of kidneys with UTD P2 and 35% of kidneys with UTD P3 had a DRF <40%. 31% of kidneys with UTD P2 and 79% of kidneys with UTD P3 had a T1/2 >20 minutes. An abnormal ureter (OR 2.8, 95% CI 1.3 -6.2) and parenchymal thinning (OR 16, 95% CI 7.9 -32.1) were significant at predicting DRF < 40%. Each cm increase in APD had an OR of 5.7 (95% CI 3.8-8.8), and parenchymal thinning conferred an OR of 3.1 (95% CI 1.5 -6.2) for predicting T1/2 > 20 minutes.

Conclusion: Of the different elements of the UTD classification system, parenchymal thinning is the most predictive of decreased DRF, and APD is the most predictive of delayed diuretic washout. Given the high incidence of poor function and poor drainage in the UTD P3 group, Mag 3 should be indicated in the evaluation of these patients. Conversely, given the low chance of poor function in the UTD P2 group, and the fact that poor drainage improves in most infants, Mag 3 should be left at the discretion of the physician for UTD P2.

Funding: N/A
Introduction: Ureteric injury is an uncommon, but serious complication that can occur during pelvic surgery. Cystoscopic placement of ureteric stents may aid in the intraoperative identification of the ureters and prevent injury. However, this can be associated with prolonged operative time, increased cost, and adverse events. No formal recommendations are in place regarding the use of ureteric stents prior to colorectal surgery (CRS). A systematic review and meta-analysis was conducted to determine the effect of prophylactic ureteric stent insertion on the risk of intraoperative ureteric injury among adult patients undergoing CRS.

Methods: A systematic search was conducted using the Ovid platform of EMBASE, MEDLINE, Cochrane systematic reviews and Cochrane clinical trials, and Web of Science from database inception until January 31, 2019. The study protocol was developed in accordance with the PRISMA-P guidelines and registered with PROSPERO. The primary outcome was risk of iatrogenic ureteric injury based on whether preoperative ureteric stenting was or was not performed. A ureteric injury was defined as any intervention requiring surgical intervention (operative repair, drain placement, or post-operative nephrostomy tube/stent placement). Secondary outcomes included the risk of acute kidney injury (AKI), urinary tract infection (UTI), sepsis, length of stay (LOS), operative time, and mortality. Statistical heterogeneity was estimated using the inverse-variance method and quantified using the I² statistic. The Paule-Mandel pooling and a random effects model was used to produce odds ratios (OR) with 95% confidence intervals (CI) for binary outcomes. Standardized mean differences (MD) were reported for continuous variables. Analyses were completed using R3.5.

Results: Nine retrospective cohort studies evaluating 98,507 patients were included. The incidence of ureteric injury was 0.6%. Overall, 5.1% of patients underwent ureteric stenting. There was no change in the odds of ureteric injury among stented patients compared to controls (OR 1.30,95%CI 0.39-4.29, I²=25%). Operative time was significantly longer (MD 49.3 minutes, 95%CI 35.3-63.4, I²=96%) in the intervention group. There was no difference in rates of AKI, UTI, sepsis, LOS, or mortality between groups.

Conclusion: Prophylactic ureteric stent insertion was not associated with a decreased odds of ureteric injury. However, given the retrospective nature of the identified studies, and thus the non-random allocation of the intervention, the benefit of prophylactic ureteric stenting remains uncertain. Although prophylactic ureteric stenting was not associated with increased patient morbidity, operative time was significantly increased, which may have potential significant cost implications.

Funding: N/A
Podium #7
PTEN LOSS WITH ERG-NEGATIVE STATUS IS ASSOCIATED WITH LETHAL DISEASE AFTER RADICAL PROSTATECTOMY
Nora Haney, MD\textsuperscript{1}, Farzana Faisal, MD\textsuperscript{1}, Jiayun Lu\textsuperscript{2}, Liana Guedes, MD\textsuperscript{3}, Corinne Joshu, PhD\textsuperscript{3}, Luigi Marchionni, MD\textsuperscript{4}, Victor Reuter, MD\textsuperscript{5}, Howard Scher, MD\textsuperscript{6}, James Eastham, MD\textsuperscript{7}, Anuradha Gopalan, PhD\textsuperscript{5}, Tamara Lotan, MD\textsuperscript{3}
\textsuperscript{1}Johns Hopkins Urology, \textsuperscript{2}Johns Hopkins Epidemiology, \textsuperscript{3}Johns Hopkins Pathology, \textsuperscript{4}Johns Hopkins Oncology, \textsuperscript{5}Memorial Sloan Kettering Pathology, \textsuperscript{6}Memorial Sloan Kettering Oncology, \textsuperscript{7}Memorial Sloan Kettering Urology
Presented By: Nora Haney, MD, MBA

Introduction: The loss of PTEN tumor suppressor gene often occurs with ERG rearrangement and is associated with increased risk of biochemical recurrence after radical prostatectomy (RP). However, few studies have investigated the combined effects of PTEN and ERG status on more clinically meaningful outcomes for prostate cancer (PCa) in surgically treated patients. The purpose of the current study was to examine the association of PTEN/ERG status with lethal PCa in patients treated with RP.

Methods: We included 791 patients with clinically localized PCa treated with RP at a single institution. Genetically validated immunohistochemistry (IHC) assays for PTEN and ERG were performed on tissue microarrays. Cox proportional hazard models assessed the association of PTEN/ERG status with lethal PCa (defined as metastasis or PCa-specific death). Multivariate models were adjusted for age at RP, race, pathologic grade and stage, and surgical margin status.

Results: Median follow up for the cohort was 12.8 years. Twenty-five percent of cases (203/791) demonstrated PTEN loss, and 43% (330/776) had ERG-positive rearrangements. On multivariate analysis, PTEN loss (HR 1.9, 95% CI 1.2-3.0, p=0.012) but not ERG expression (HR 0.6, 95% CI 0.4-1.1, p=0.11) was associated with increased risk of lethal PCa. When analyzing both PTEN and ERG status together, the association of PTEN loss with lethal disease only remained among men with ERG-negative tumors (HR 2.3, 95% CI 1.3-4.1, p=0.005) and not ERG-positive tumors (HR 1.1, 95% CI 0.6-2.1, p=0.81).

Conclusion: PTEN loss is associated with an increased risk of lethal PCa in surgically treated patients, and this risk is most pronounced in the subgroup of patients with ERG-negative tumors. This work corroborates the use of both PTEN and ERG IHC assays as prognostic tools for risk stratification and treatment management post-RP.

Funding: W81XWH-16-1-0737 (CDMRP Prostate Cancer Research Program Award to TL, LM, AG.)
### Univariable and multivariable Cox proportional hazard models for lethal prostate cancer

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<th>Multivariable analysis*</th>
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<tr>
<td>PTEN loss/ERG positive</td>
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*Adjusted for age at radical prostatectomy, race, grade group, stage and surgical margin status.
Podium #8
GENDER AND RACIAL DISPARITIES IN THE TREATMENT AND OUTCOMES OF MUSCLE INVASIVE BLADDER CANCER
Jessica Marinaro, MD¹, Alexander Zeymo, MS², Filipe Carvalho, MD, PhD¹, Ross Krasnow, MD³, Lambros Stamatakis, MD³, John Lynch, MD¹, Jonathan Hwang, MD³, Stephen Williams, MD⁴, Keith Kowalczyk, MD¹
¹MedStar Georgetown University Hospital, Dept of Urology, Washington, DC, ²MedStar Health Research Institute, Washington, DC, ³MedStar Washington Hospital Center, Dept of Urology, Washington, DC, ⁴The University of Texas Medical Branch at Galveston, Dept of Urology, Galveston TX
Presented By: Jessica Marinaro, MD

Introduction: While men are more likely to be diagnosed with bladder cancer, studies have shown that women are more likely to have more aggressive bladder cancer, increased recurrence of disease, as well as increased cancer-specific mortality. In addition, black patients have also been noted to have worse outcomes. The causes of these disparities remain unknown. Utilizing a large population-based database, we sought to identify disparities in the treatment of muscle-invasive bladder cancer by gender and race.

Methods: Data from the National Cancer Database was used to identify patients diagnosed with bladder cancer from 2004-2014. Patients were excluded if they had non-muscle invasive disease or had missing gender. Treatments analyzed included no treatment, cystectomy alone, neoadjuvant chemotherapy followed by cystectomy, or radiation therapy with chemotherapy. Thirty and 90-day mortality was analyzed using logistic regression. Logistic models were also used to determine if there were sexual disparities in receiving optimal treatment defined as neoadjuvant chemotherapy followed by cystectomy.

Results: 47229 patients were identified and included in our cohort. Most of the cohort was male (73.4%) and had cystectomy alone as their first course of treatment (69.2%). Logistic regression estimated no difference in the odds of receiving optimal treatment between male and female patients (OR 0.988, 95% CI 0.93-1.05), but detected that black patients had a lower odds of optimal treatment compared to white patients (OR 0.844, 95% CI 0.79-0.98). Further, female patients were estimated to have a higher odds of 30-day and 90-day mortality (ORs 1.134 and 1.224 respectively) while black patients had a higher odds of 90-day mortality only (OR 1.161, 95% CI 1.01-1.34).

Conclusions: Our study shows that male and female patients are just as likely to receive optimal treatment for muscle-invasive bladder cancer, and thus treatment disparities cannot explain differences in outcomes between genders. However, we did find that black patients were less likely to receive optimal treatments. Further, both female and black patients had increased risk of mortality following treatment. Further study is needed to determine variables leading to worse outcomes in female patients as well as to identify impediments to black patients receiving optimal treatment.

Funding: n/a
Introduction: Microscopic hematuria (AMH) is a common condition evaluated in the outpatient setting by urologists. Prior studies, in addition to review of our institutional baseline data, demonstrated inefficiency with evaluation of patients referred for this condition and delays in care. As such, we developed and implemented an expedited pathway for evaluating new patients referred for AMH with the goal of decreasing time from referral to completion of workup to improve care delivery to our patients.

Methods: During a 9-month period, we prospectively identified new patients referred for AMH via our call center who were scheduled for evaluation through either our traditional pathway (new patient appointment à +/- imaging à cystoscopy appointment) or our expedited pathway. Our expedited pathway comprised a nurse (RN)-delivered phone screen within 48 hours of referral to briefly review patient’s urologic history and lab results. For patients meeting American Urologic Association (AUA) criteria for AMH evaluation, they were scheduled directly for cystoscopy with imaging studies ordered prior. For those not meeting AUA criteria, they were scheduled for a new patient appointment. Patient demographics, comorbidities, tobacco use, guideline-concordance of referral, and timelines of care (time from referral to cystoscopy and to completion of workup) were retrospectively collected and analyzed using chi squared and t-test statistics for both cohorts.

Results: 505 patients were referred to urology and evaluated for AMH and their records reviewed during our study period. 379 (75.0%) patients were evaluated under the standard pathway and 126 patients (25.0%) under the expedited pathway. Both groups were comparable for baseline demographics, comorbidities, and smoking history. The percentage of guideline-concordant referrals was 41.4% and 52.1% (p = 0.06) in the traditional versus expedited pathways. The mean time from referral to cystoscopy and to completion of workup in the traditional versus expedited pathway was 89.0 vs 37.9 days (p < 0.0001) and 89.9 vs 41.0 days (p < 0.0001), respectively (Figure 1).

Conclusion: Implementation of an expedited pathway for new patients referred for AMH evaluation demonstrated feasibility of a one-visit approach and significantly reduced time from referral to cystoscopy and to completion of workup. This is currently being expanded to include all hematuria referrals to our department. Depending on practice resources, this pathway may be useful for other practices to adopt in order to eliminate unnecessary office visits, streamline care for patients, and avoid delays in diagnosis and intervention.

Funding: N/A
Average Time to Completion of Workup

Days to Completion of Workup

Referrals Grouped by Months

- Old Protocol
- New Protocol

1 2 3 4 5 6 7 8 9 10 11
Podium #10
URINARY TRACT INFECTION AFTER ROBOT-ASSISTED LAPAROSCOPIC PYELOPLASTY: ARE URINE CULTURES AND ANTIBIOTICS HELPFUL?
Yvonne Chan, MD, Ilina Rosoklija, Rachel Shannon, Ashima Singal, MD, Anthony D'Oro, Patrick Meade, Edward Gong, MD, Bruce Lindgren, MD, Emilie Johnson, MD, MPH
Ann and Robert H. Lurie Children's Hospital of Chicago
Presented By: Yvonne Yuh-Ru Chan, MD

Introduction: Utilization of pre- and intra-operative urine cultures (UCx) and urinalysis (UA) and post-operative prophylactic antibiotics after robot-assisted laparoscopic pyeloplasty (RALP) differ by surgeon. It is unclear whether these differences in practice patterns influence post-RALP urinary tract infection (UTI) rates. This study aims to evaluate the relationship between pre- and intra-operative UCx utilization and post-operative antibiotic prophylaxis and post-RALP UTI.

Methods: A retrospective review of patients who underwent RALP at a single institution from January 2014-October 2018 was performed. Patients with a history of vesicoureteral reflux, neurogenic bladder, intermittent catheterization, <2 months followup after stent removal, or age >=18 years were excluded. The primary outcome was symptomatic UTI after RALP, tracked until 60 days after ureteral stent removal. UTI was defined as fever or urinary symptoms, a positive UCx with >=10,000 colony forming units of a single uropathogen, and a positive UA.

Results: 152 patients were included (72% male [73% circumcised], 61% white, 23% Hispanic). One patient had a reoperation for recurrent UPJ obstruction, yielding 153 surgical encounters. 22% of patients had a reported history of UTI prior to RALP, and 15% were on prophylactic antibiotics. UCx/UA were ordered prior to pyeloplasty in 65% and were positive in 22% of the cases. Intraoperative UCx was obtained at pyeloplasty and stent removal in 94% and 91% of cases, respectively; UCx was positive in 3% of both cases. 55% received post-RALP prophylactic antibiotics. Eight patients (5.2%; 95% confidence interval 1.7-8.7%) developed post-RALP UTI (Table 1- Factors associated with post-RALP UTI). Uncircumcised status and use of preoperative prophylactic antibiotics were associated with post-RALP UTI (p=0.02 and p<0.01, respectively). Use of post-RALP antibiotic prophylaxis was not associated with post-RALP UTI (p=1.0). Positive pre-RALP UCx/UA was associated with post-RALP UTI (p=0.03), whereas intraoperative UCx results during pyeloplasty had no association. UCx/UA prior to stent removal had no association with post-RALP UTI, but those with negative intraoperative UCx during stent removal had lower rates of UTI (p<0.01).

Conclusion: In this cohort of >150 children undergoing RALP, the rate of post-RALP UTI was 5.2%. Variability was noted in utilization of preoperative and intraoperative UA/UCx and post-RALP antibiotic prophylaxis. As post-RALP antibiotic prophylaxis was not associated with lower UTI rates, consideration may be to reserve them for patients with risk factors. Development of a care pathway could help safely decrease unnecessary utilization of UA/UCx and antibiotics without affecting post-RALP UTI rates.

Funding: N/A
### Table 1. Demographic and Clinical Factors Associated with Post-RALP UTI – Univariate Analysis

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<tr>
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<td>Unavailable/Not ordered</td>
<td>43 (29%)</td>
<td>3 (37%)</td>
<td></td>
</tr>
<tr>
<td><strong>Pyeloplasty intra-operative culture results</strong></td>
<td></td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>Negative</td>
<td>132 (91%)</td>
<td>8 (100%)</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>4 (3%)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Not obtained</td>
<td>9 (6%)</td>
<td>0</td>
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<tr>
<td><strong>Post-pyeloplasty antibiotics prescribed on discharge</strong></td>
<td></td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>No</td>
<td>65 (45%)</td>
<td>4 (50%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>89 (55%)</td>
<td>4 (50%)</td>
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<tr>
<td><strong>Stent removal pre-operative culture/UA results</strong></td>
<td></td>
<td></td>
<td>0.43</td>
</tr>
<tr>
<td>Negative</td>
<td>58 (40%)</td>
<td>3 (37%)</td>
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<tr>
<td>Positive</td>
<td>36 (25%)</td>
<td>4 (50%)</td>
<td></td>
</tr>
<tr>
<td>Unavailable/Not ordered</td>
<td>51 (34%)</td>
<td>1 (13%)</td>
<td></td>
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<tr>
<td><strong>Stent removal intra-operative culture results</strong></td>
<td></td>
<td></td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Negative</td>
<td>127 (87%)</td>
<td>4 (50%)</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>1 (1%)</td>
<td>4 (50%)</td>
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</tr>
<tr>
<td>Not obtained</td>
<td>14 (10%)</td>
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</tr>
<tr>
<td>Unknown</td>
<td>3 (2%)</td>
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*Univariate analysis by Fisher’s exact test.*
Podium #11
OPIOID PRESCRIBING HABITS FOLLOWING IMPLEMENTATION OF ENHANCED RECOVERY AFTER SURGERY (ERAS) IN PATIENTS UNDERGOING MAJOR UROLOGIC RECONSTRUCTION
Nadia Halstead, MD, MPH¹, Sarah Hecht, MD¹, Peter Boxley, BS², Megan Brockel, MD³, Kyle Rove, MD¹
¹Department of Surgery, Division of Urology, University of Colorado School of Medicine, Children’s Hospital of Colorado, Aurora, CO, ²University of Colorado School of Medicine, ³Department of Anesthesiology, Children’s Hospital Colorado
Presented By: Nadia V. Halstead, MD

Introduction: With increasing awareness of the opioid epidemic, there is a push for providers to minimize opioid prescriptions after surgery. Enhanced recovery after surgery (ERAS) pathways include minimization of opioid analgesia in favor of non-opioid alternatives and regional anesthesia for postoperative pain control. In 2014, our center implemented an ERAS pathway for children undergoing urologic reconstructive surgery. This led to significantly lower intra- and postoperative use of opioids, among other benefits. It is unclear whether the decreased in-hospital opioid requirements affected opioid prescribing practices or patient needs upon discharge. We hypothesized that ERAS would result in fewer opioid prescriptions.

Methods: A retrospective review was performed of all patients who underwent bladder augmentation, creation of a continent catheterizable channel, bladder neck reconstruction or closure, or revision of prior reconstructive procedures at our facility from October 2011 to August 2017. Patients were divided into historical and ERAS cohorts based on whether surgery occurred before or after ERAS implementation. The Colorado Physician Drug Monitoring Program (PDMP) was used to track filling of post-operative opioid prescriptions. Median values, interquartile ranges, and non-parametric statistical tests were calculated with a significance level of 0.05. Multivariate logistic and linear regression analyses were performed to identify predictors of outcome variables of interest.

Results: A total of 190 urologic reconstructive surgeries were included in our analysis, 92 historical and 98 after ERAS implementation. The patient cohorts were demographically similar. The percentage of patients who received an opioid prescription and those who subsequently filled them as confirmed by querying the PDMP was significantly higher in the ERAS cohort (93.9% vs 82.6%, p=0.015; 76.1% vs 57.9%, p=0.012). There were no differences, however, in prescription total morphine milligram equivalents (MME) by body weight (p=0.164) or opioid days supplied (p=0.567) between the two groups. The number of patients who requested and received additional opioid prescriptions (within 90 days) also did not vary between the two groups (19.4% ERAS vs 17.4% historical, p=0.723). Urology residents prescribed higher total MME by weight compared to pediatric urology fellows (2.9 mg/kg vs 1.5 mg/kg, p=0.001).

Conclusion: There was an unexpected increase in post-operative opioid prescriptions written and filled at discharge following implementation of an ERAS protocol for major urologic reconstructive surgery. Decreased length of stay may have increased provider concern about pain control at home. Understanding factors affecting opioid prescribing practices and patient needs are important prior to designing interventions to minimize opioids after surgery.

Funding: N/A
Podium #12
NEPHROLOGY REFERRAL PATTERNS FOR RENAL CANCER NEPHRECTOMY PATIENTS
Julia Wainger1,2, Joseph Cheaib1, Hiten Patel1, Mitchell Huang1, Meredith Metcalf1, Joseph Canner2, Phillip Pierorazio1
1Brady Urological Institute, Johns Hopkins Hospital, Baltimore, MD, USA, 2Johns Hopkins Surgery Center for Outcomes Research, Johns Hopkins University School of Medicine, Baltimore, MD, USA
Presented By: Julia Wainger, BS

Introduction: Chronic kidney disease (CKD) is a known sequela of renal surgery. Currently, data are limited describing the extent to which at-risk patients are being referred to nephrology per 2017 American Urologic Association guidelines. Our objective was to assess nephrology referral rates amongst patients undergoing nephrectomy for renal cancer to identify referral predictors and to assess the association of nephrology referral with survival.

Methods: We obtained data from the SEER-Medicare database for first-time cancer patients ≥66 years of age who received nephrectomies for malignancy from 1999-2014 (N=25,641). Referral data were derived from nephrology claims. We identified if and when patients were referred to nephrology by CKD disease status and surgery type, used logistic regression to identify patient factors associated with nephrology referral and used a Cox proportional hazard regression model to assess associations between referral and survival. Logistic regression and survival analyses were conducted for patients who had surgery from 2004-2014 with available comorbidity data (N=16,612).

Results: Of 24,641 patients treated from 1999-2014, 16.3% had CKD pre-operatively. An additional 43.4% of patients developed CKD post-operatively. Of post-operatively diagnosed patients, 4.8% were referred pre-operatively and 50.2% were referred post-operatively. See Figure 1 for referrals by CKD status and surgery type. Stage III disease (OR: 1.27, CI: 1.10-1.48, p=0.002), higher Charlson Comorbidity Index (CCI) scores (OR: 1.70, 95% CI: 1.40-2.05, p<0.001), and all stages of pre-operative CKD diagnosis, peaking with Stage 4 disease, (OR: 17.4, 95% CI: 8.72-34.74, p<0.001) were associated with pre-operative referral. For those who developed CKD post-operatively, post-operative referrals by twelve months were associated with diabetes (OR: 1.35, 95% CI: 1.17-1.56, p<0.001), radical nephrectomy (OR: 1.80, 95% CI: 1.43-2.26, p<0.001), and CKD stage at 12 months, with peak odds of nephrology referral associated with stage 4 CKD (OR: 21.84, 95% CI: 12.1-39.5, p<0.001). In an adjusted model, there was no significant survival difference (HR= 0.97, 95% CI: 0.88-1.08, p=0.609) for patients with pre-operative referral or post-operative referral by twelve months (HR 1.04, 95% CI: 0.96-1.13, p=0.372).

Conclusion: Few renal cancer patients at risk for CKD progression or development present with an established nephrologist or receive pre-operative referral, suggesting missed opportunities to refer high risk patients. Pre-operative referral does not appear to improve survival; however, referred patients may represent a higher risk subset, and other patients who may benefit appear under-referred.

Funding: This abstract was made possible by the Johns Hopkins Institute for Clinical and Translational Research (ICTR) which is funded in part by Grant Number TL1 TR003100 from the National Center for Advancing Translational Sciences (NCATS) a component of the National Institutes of Health (NIH), and NIH Roadmap for Medical Research. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the Johns Hopkins ICTR, NCATS or NIH.
Figure 1. Patients with Nephrology Referral by Surgery Type and CKD Status

A

N = 20,631 patients receiving a radical nephrectomy

n = 3,168 (15.5%) Patients with pre-existing CKD

- n = 1,005 (31.5%) with an established nephrologist
- n = 935 (29.9%) with a referral by 3 mo. post-op
- n = 2,102 (65.9%) with no nephrology pre-op
- n = 81 (2.5%) with a pre-op referral

n = 17,443 (84.6%) Patients without pre-existing CKD

- n = 403 (2.3%) with an established nephrologist
- n = 16,001 (95.9%) with no nephrology pre-op
- n = 138 (0.8%) with a pre-op referral

B

N = 5,010 patients receiving a partial nephrectomy

n = 994 (19.8%) Patients with pre-existing CKD

- n = 313 (31.5%) with an established nephrologist
- n = 657 (64.1%) with no nephrology pre-op
- n = 44 (4.4%) with a pre-op referral

n = 4,016 (80.2%) Patients without pre-existing CKD

- n = 131 (3.3%) with an established nephrologist
- n = 3,823 (95.3%) with no nephrology pre-op
- n = 59 (1.5%) with a pre-op referral
Divya Ajay, MD, MPH
Dr. Divya Ajay is the Urinary Tract and Pelvic Reconstruction fellow at MD Anderson Cancer Center, University of Texas, Houston, TX. Her interests are male and female urinary incontinence, cancer survivorship, upper tract reconstruction and outcomes-based research.

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, Cincinnati, OH. She completed her general surgery and urology residency at University of Cincinnati Medical Center in Cincinnati, OH.

Dr. Beam is certified by the American Board of Urology. She is a member of the American Medical Association, the American Urological Association, and 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.

Carolyn J. M. Best, PhD
Dr. Best is Director of Research for the American Urological Association (AUA). The AUA promotes the highest standards of urological clinical care through education, research, and the formulation of health care policy. Dr. Best is responsible for all programs, events, and resources of the AUA's Office of Research, which supports urologic research through funding, education, and advocacy. This support includes a large diversity of programs that facilitate research for the spectrum of urologic cancers and benign diseases and conditions. This also includes collaborative relationships with federal and non-federal funding agencies, patient advocacy groups, AUA sections and subspecialty societies, and other urologic research stakeholders.

Dr. Best obtained her PhD in experimental pathology from the University of Maryland, Baltimore, and subsequently trained at the National Cancer Institute (NCI) in the Laboratory of Pathology, Laboratory of Biosystems and Cancer, and the Molecular Therapeutics Program. During her training at the NCI, Dr. Best was the inaugural recipient of the Sallie Rosen Kaplan Fellowship for Women Scientists in Cancer Research, among other awards.

Elizabeth W. Bozeman, MD
Elizabeth Wagner Bozeman received her undergraduate degree in Psychobiology from Emory University. She then attended the Medical University of South Carolina earning her medical degree in 1989. She went on to do her Urology residency at the same institution finishing in 1994. After 2 years of private practice in Charleston, SC, she married Dr. Gary Bozeman, a fellow urologist, and they moved to Spartanburg, SC. While there she was actively involved with the Southeastern Section, served as President of the SC Urologic, and served on the Board of the SEAU. She is quite proud to have served SWIU as a Past President in 2007. She had a very successful practice in Spartanburg for over 18 years but left in 2013 for a new adventure. She and her husband joined Associated Medical Professionals based in Syracuse, NY. She is currently enjoying private practice in the small town of Fulton, NY. She thoroughly enjoys exploring a different area of the country, working in a rural and underserved area, and loves having four distinct seasons.
Anne P. Cameron, MD
Anne P. Cameron, MD, FRCSC, FPMRS is a Professor of Urology at the University of Michigan and Director of the Clinical Urology Research Endeavor (CURE). 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 an active clinician, but also participates in several research trials including the NIDDK Funded LURN. Her clinical interests include complex incontinence, female urethral disease and the care of neurogenic bladder. She also has a strong interest in medical education and is Associate Fellowship Director and Clerkship Director for the Urology Residency.

Kristin L. Chrouser, MD
Dr. Chrouser is an Associate Professor of Urology at the University of Michigan and the VA Ann Arbor Chief of the Division of Urology. Her clinical focus is reconstruction of the urethra after damage by stricture disease or vesicovaginal fistulae (VVF). Her research interests include maximizing intraoperative surgical quality and patient safety and optimization of surgeon performance. Her educational work is diverse, ranging from intraoperative ergonomic courses to instruction on VVF repair techniques for the management of obstetric fistulae. She is passionate about providing surgeons in low and middle income countries with high quality education in both technical and non-technical skills. She is a graduate of Princeton University (Biology), Mayo Medical School (MD) and the Johns Hopkins Bloomberg School of Public Health (MPH). She did her urology residency at the Mayo Clinic and completed a fellowship in reconstruction and international urology with IVUmed.

Doreen E. Chung, MD, FRCSC
Doreen E. Chung, M.D. specializes in male and female urinary incontinence, pelvic organ prolapse, female urology, genitourinary reconstruction, neurourology, and benign prostatic hyperplasia (BPH). She also has an interest in vaginal and minimally-invasive surgery for urinary incontinence and pelvic organ prolapse, artificial urinary sphincters for post-prostatectomy male incontinence, and laser procedures for the treatment of BPH (including vaporization and enucleation techniques).

Her current investigations focus on topics such as clinical outcomes, the effect of diabetes on voiding function and surgical outcomes, predictors of complications of various female urology procedures, and the impact of teaching on surgical complications.

Dr. Chung completed her medical degree and residency at the University of Toronto. Following her residency, she completed fellowships in voiding dysfunction, incontinence, and female urology at Weill Cornell Medical College and Memorial Sloan-Kettering Cancer Center. Before joining Columbia, Dr. Chung was a Clinical Assistant Professor of Surgery at The University of Chicago Medicine. Dr. Chung is board certified in Urology as well as in the subspecialty of Female Pelvic Medicine and Reconstructive Surgery. She is a member of the American Urological Association, the American Urogynecologic Society, the International Continence Society and the Society of Urodynamics, Female Pelvic Medicine, and Urogenital Reconstruction.
Iryna Crescenze, MD
Dr. Crescenze specializes in female pelvic medicine and reconstructive surgery as well as neuro-urology. With each patient, she hopes to provide the best outcome possible and improve their quality of life. She sees patients due to urinary incontinence, urinary retention, pelvic organ prolapse, neurogenic bladder, urethral strictures and diverticulum, or ureteral obstruction.

Kate Devine, MD
Dr. Devine is a reproductive endocrinologist practicing at Shady Grove Fertility in Washington, DC. She also serves as a Research Director, which is the largest volume of IVF practices in the U.S. In addition, she serves as an Assistant Professor of Obstetrics and Gynecology at Georgetown University School of Medicine in Washington, DC. Dr. Devine serves as Research Collaborator and core faculty for the Reproductive Endocrinology and Infertility Fellowship of the National Institute of Child Health and Human Development (NICHD), within the National Institutes of Health (NIH), where she also completed her Fellowship in Reproductive Endocrinology and Infertility.

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.

Karyn S. Eilber, MD
Karyn S. Eilber, MD is Associate Professor of Urology and Obstetrics & Gynecology, Associate Director of the FPMRS fellowship, and Associate Program Director for the Urology Residency Training at Cedars-Sinai Medical Center in Los Angeles. Prior to joining Cedars-Sinai, Dr. Eilber served at the Memorial Sloan-Kettering Cancer Center's Urology Department, where she gained extensive experience in pelvic reconstruction following cancer treatment and male incontinence after prostatectomy. Also at that time she was an Assistant Professor at Weill Medical College at Cornell University.

Dr. Eilber earned her bachelor's in biomedical sciences from the University of California, Riverside and her medical degree from the University of California, Los Angeles School of Medicine (UCLA). She completed an internship, residency and urology fellowship at UCLA with special training in incontinence, voiding dysfunction and female pelvic reconstruction.

Sarah F. Faris, MD
Dr. Faris is an urologist in Chicago, IL and is affiliated with University of Chicago Medical Center. She received her MD from University of Michigan Medical School.
E. Ann Gormley, MD
E. Ann Gormley, MD is a Professor of Surgery (Urology) at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire. She received a BA in English and her medical degree at the University of Saskatchewan. While completing her residency in Urology at the University of Alberta, she earned an MSc in Experimental Surgery. She then completed a fellowship in Female Urology and Voiding Dysfunction. Dr. Gormley is a member of the Royal College of Physicians and Surgeons of Canada and is Board Certified by the American Board of Urology with sub-certification in Female Pelvic Medicine and Reconstructive Surgery.

Dr. Gormley's interests are in female urology, voiding dysfunction and resident education. She was the Program Director for the Urology Program at Dartmouth-Hitchcock from 2001-2019 and now serves as the Associate Program Director. Dr. Gormley was elected to the Geisel Academy of Master Educators in 2016. She is a member of the Appointments, Promotions and Titles Committee for the Geisel School of Medicine at Dartmouth.

Tamsin J. Greenwell, MBChB, MD, FRCS(Urol)
Tamsin Greenwell has been a Consultant Urological Surgeon with a Special Interest in Female, Functional and Restorative Urology at University College London Hospitals, London UK since 2002. Her particular interests are vesico-vaginal fistula, urethral diverticulum, male and female urethral and ureteric stricture, male and female recurrent urinary incontinence. She has an extensive interest in surgical education.

Maahum A. Haider, MD, MPH
Maahum Haider, MD, MPH is a physician at the University of Washington in Seattle and the Puget Sound Veterans Administration Hospital. She is a UW assistant professor of Urology.

Dr. Haider earned her MD at UCLA and her MPH in global health at the University of Washington. She is a member of the American Urologic Association and Society for Women in Urology. She is also a board member for IVUmed, an international urologic NGO dedicated to teaching urologic skills abroad. Dr. Haider's clinical interests include the treatment of kidney stones, bothersome urinary symptoms, obstruction and incontinence. Her research interests include minimally invasive technologies for the treatment of BPH and global health equity and training.

Emilie K. Johnson, MD, MPH
Emilie K. Johnson, MD, MPH is a pediatric urologist and health services and outcomes researcher in Chicago, IL. She completed medical school and residency at the University of Michigan. She then pursued pediatric urology and health services research fellowships at Boston Children's Hospital. During fellowship, she also completed an MPH at Harvard School of Public Health. Dr. Johnson's clinical practice is now based at Ann & Robert H. Lurie Children's Hospital of Chicago, and she is an assistant professor of Urology at Northwestern University Feinberg School of Medicine. Along with caring for pediatric urology patients with a wide range of conditions, Dr. Johnson's research focuses on individuals with disorders of sex development/intersex, and optimizing access to desired neonatal circumcision.
Lindsey A. Kerr, MD, RYT
Dr. Lindsey Kerr is the Founder and Director of the Center for Pelvic Care and Continence at York Hospital. In her previous position, Dr. Kerr was an Associate Professor of Urology and Director of the Pelvic Floor Center at the University of Utah. She has served on the Board of Directors of the National Association for Continence and was their National Spokesperson. She has chaired the Not-for-profit Society for Women's Health Research in Washington DC. Dr. Kerr received her Medical Degree from Duke University. She completed her urology training at the Mayo Clinic and Foundation. Dr. Kerr also completed her Master's Degree in Immunology followed by a fellowship in Female Urology and Pelvic Reconstructive Surgery at Harvard University.

Kathleen Kieran, MD, MSc, 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 MD 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.

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 Urology residency at the Lahey Clinic (1996-2002).

She is currently Associate Professor of Urology at the Boston University School of Medicine. She continues to be a very strong advocate for resident education where she works full-time with the Urology residents from Boston University Medical Center and Brigham & Women’s Hospital (Harvard Program in Urology) during their concurrent full-time VA Boston rotations as part of each programs’ core curriculum. Dr. Latini concentrates her clinical research in adult male urethral stricture and fistula disease, male urinary incontinence and voiding dysfunction, and reconstructive surgical techniques in Urology.

Una J. Lee, MD, FPMRS
Dr. Una Lee is an 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.
Rena D. Malik, MD
Dr. Malik is an urologist who specializes in Female Pelvic Medicine and Reconstructive Surgery. She joined the University Of Maryland School of Medicine in 2018 as Assistant Professor of Surgery in the Division of Urology. Dr. Malik received her Medical Diploma from the New York University School of Medicine and completed a Urology Residency at the University of Chicago. Dr. Malik completed a Fellowship Program in Female Pelvic Medicine and Reconstructive Surgery at the UT Southwestern Medical Center in Dallas, TX.

Dr. Malik specializes in reconstructive urology including the management of female and male voiding dysfunction (or problems urinating), urinary incontinence (leakage of urine), vaginal and robotic surgery for pelvic organ prolapse including cystocele (bladder), vaginal vault/enterocele (uterus or bowel), and rectocele (rectum), overactive bladder, neurogenic bladder, urodynamic evaluation (test to evaluate bladder function), male and female urethral stricture, vesicovaginal fistula, urethral diverticulum, and mesh-related complications.

Akanksha Mehta, MD, MS
Dr. Akanksha Mehta is an Assistant Professor, and Residency Program Director for the Department of Urology at Emory University School of Medicine. Dr. Mehta graduated magna cum laude from Brown University in Providence, Rhode Island, with double Bachelor degrees; Science (Biology) and International Relations. Dr. Mehta attended Alpert Medical School at Brown University/Rhode Island Hospital, Providence, RI, where she also did her General Surgery internship and Urology residency. She then completed a fellowship in Male Infertility and Microsurgery at Weill Cornell Medical Center in New York, NY.

Dr. Mehta’s clinical interests lie in the area of male reproductive and sexual medicine, and microsurgery. Her research is focused on access to care for male factor infertility, as well as the recovery of sexual function among prostate cancer survivors.

Elizabeth R. Mueller, MD, MSME
Dr. Elizabeth R. Mueller MD, MSME, is a Professor of Urology and Obstetrics/Gynecology at Loyola University Chicago Stritch School of Medicine. She is also Division and Fellowship Director of Female Pelvic Medicine and Reconstructive Surgery Program. She completed a BS in Mechanical Engineering at the University of Missouri-Rolla and a MS in Mechanical Engineering at Washington University in St. Louis. She practiced as an engineer and business manager with Procter and Gamble for six years before attending St. Louis University’s School of Medicine. She completed her urology residency and FPMRS fellowship at Loyola University. She is board-certified in both.

Emily Nagoski, PhD
Emily Nagoski is the award-winning author of the New York Times bestseller, Come As You Are: the surprising new science that will transform your sex life and The Come As You Are Workbook, and co-author, with her sister Amelia, of Burnout: the secret to unlocking the stress cycle. She began her work as a sex educator at the University of Delaware, where she volunteered as a peer sex educator while studying psychology with minors in cognitive science and philosophy. She went on to earn a MS in Counseling and a PhD in Health Behavior, both from Indiana University, with clinical and research training at the Kinsey Institute. Now she combines sex education and stress education to teach women to live with confidence and joy inside their bodies.
Madina Ndoye, MD
Dr. Ndoye completed her medical studies at University Cheikh Anta Diop of Dakar in 2006. First rank at the residency admission exam, she spent five years training in urology surgery, from 2004 to 2009 under the lead of Professor Serigne Gueye, head of the Department at General Hospital of Grand Yoff. At Senegal, she was the Chief of the Urology Department at Ziguinchor Regional Hospital before joining Professor Serigne Gueye’s team as consultant urologist at General Hospital of Grand Yoff. She had done international training as a fellow at France on endourology and incontinence surgery. In 2010 she was awarded by the NIH/NCI for a training on cancer epidemiology and prevention at Maryland USA. In addition to general urology, her main, clinical activities are oriented on reconstructive urology for kids and adults. Her growing interest on reconstructive urology surgery, motivated several training at Children’s hospitals in Pittsburgh, Alabama and San Francisco General Hospital where she stayed one year for the SIU research fellowship. As a university assistant, she participates at the academic activities of the department and is author of many publications.

Priya Padmanabhan, MD, MPH, FACS
Priya Padmanabhan, MD, MPH, FACS is a Professor of Urology at the William Beaumont Medical Center. After growing up in Ann Arbor, Michigan, Dr. Padmanabhan earned her undergraduate degree from Bryn Mawr College in 1994. She returned home to complete a Masters of Public Health at The University of Michigan School of Public Health. She obtained her Medical Degree and completed urology residency at New York University Medical Center. She subsequently completed an accredited ABOG/ABU fellowship in female urology and pelvic reconstruction surgery at Vanderbilt University Medical Center.

Dr. Padmanabhan’s clinical and scholarly interests include genitourinary reconstruction, lower urinary tract dysfunction, neurogenic bladder, and robotic surgery, with particular focus on quality of life issues.

Polina Reyblat, MD
Dr. Polina Reyblat is a Chief of Urology at Kaiser Permanente Los Angeles Medical Center.

She was born in Latvia, a small country on the Baltic Sea. After high school, she came to the United States seeking refuge and the opportunity to get an education. She did her undergraduate studies at UCLA and medical school at University of Southern California. She did her Urology training at USC under tutelage of Dr. Donald G Skinner. She completed fellowship in pelvic floor reconstruction, neuourology and prosthetics with Dr. David Ginsberg and Dr. Stuart Boyd. She started her practice at Kaiser Permanente Los Angeles Medical Center, where she currently serves as a chief of the department.

Dr. Reyblat’s interests are neurogenic bladder, lower urinary tract reconstruction, prosthetics, male and female voiding dysfuncntion. Dr. Reyblat dedicates a large portion of her practice to transgender care and is a co-lead of the Gender Affirmation Surgery Program at Southern California Permanente Medical Group.
Jennifer G. Rothschild, MD, MPH
Dr. Rothschild attended Boston University School of Public Health with a focus on Health Law where she earned her MA/MPH. She then completed medical school at the Boston University School of Medicine. She fulfilled her Urology residency in upstate New York at the University of Rochester. Dr. Rothschild completed her Fellowship in Female Pelvic Medicine and Reconstructive Surgery at Vanderbilt University and is Board Certified in FPMRS. She currently is an Assistant Professor faculty with the Department of Urology at UC Davis Medical System, in Sacramento, California. Dr. Rothschild specializes in the diagnosis and treatment of male and female urinary incontinence and reconstructive urology. Her expertise includes neuro-urology, lower urinary tract reconstruction, and prosthetic surgery. Currently her research includes resident education, urinary incontinence, and transitional urology. She is the director of the UC Davis Transitional Care Urology Program for adult patients with congenital urologic conditions that require long-term urologic care.

Yahir Santiago-Lastra, MD
Yahir Santiago-Lastra, MD, is an urologist who specializes in diagnosing and treating a wide range of urogenital conditions in both men and women, including those caused by neurologic disorders. These include pelvic organ prolapse, urinary incontinence, voiding dysfunction, overactive bladder, neurogenic bladder, ureteral stricture, and post-prostatectomy incontinence, among other pelvic floor disorders. Her other areas of expertise include procedures such as neuromodulation for overactive bladder, bladder augmentation and urinary diversion. She also works with patients with congenital urologic malformations who are transitioning from pediatric to adult care.

As an assistant professor in the Department of Urology, Dr. Santiago-Lastra instructs medical students, residents and fellows at UC San Diego School of Medicine. Her research interests include transitional care in patients with neurogenic bladder, sacral and peripheral neuromodulation, urinary diversion and urinary incontinence.

Dr. Santiago-Lastra completed a fellowship in female pelvic medicine and reconstructive surgery at University of Michigan Medical School and a residency in urology at Harvard Medical School, Massachusetts General Hospital, where she was selected for her clinical and leadership skills to serve as chief resident. Following her residency, Dr. Santiago-Lastra served as a clinical instructor in surgery in the Department of Urology at Harvard Medical School.

Aruna V. Sarma, PhD
Dr. Sarma is 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. 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.
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.

Angela B. Smith, MD, MS
Angela Smith is an Associate Professor at the University of North Carolina (UNC) Department of Urology in Chapel Hill, North Carolina. She received her MD and Masters of Science in Clinical Research from the University of North Carolina, where she completed her urology residency. She is the Director of Urologic Oncology at the UNC Lineberger Comprehensive Cancer Center where she treats GU malignancies, including bladder, prostate and kidney cancer. She has a background in health services research and biostatistics with particular interests in patient-centered outcomes research, risk stratification, and quality of care for invasive bladder cancer. She is the co-PI for a PCORI large pragmatic trial in BCG refractory bladder cancer, PI for a PCORI Engagement Award with the Bladder Cancer Advocacy Network to engage patients in the research process, and has been funded by an AHRQ K08 grant that integrates patient-reported outcomes into post-cystectomy care through mobile health technology. She has previously served on the PCORI Advisory Panel for the Assessment of Prevention, Diagnosis and Treatment Options, representing clinicians. Dr. Smith also serves as the Assistant Secretary of the American Urological Association and is also on the AUA Quality Improvement and Patient Safety Committee, Scientific Advisory Board for the Bladder Cancer Advocacy Network, Journal of Urology Editorial Board, and chair of the Urology Care Foundation Bladder Health Committee.

Anne M. Suskind, MD, MS
Dr. Anne M. Suskind, MD, MS is an Assistant Professor of Urology at the University of California, San Francisco (UCSF) who specializes in Neurourology and in Female Pelvic Medicine and Reconstructive Surgery (FPMRS). She has a deep interest, both clinically and academically, in providing care to frail older individuals. She has funding from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the National institute on Aging (NIA), and the Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU) to explore the effects of frailty and aging on outcomes of urologic surgery and other treatments for benign urologic conditions.

Suzette E. Sutherland, MD, MS, FPMRS
Suzette E. Sutherland, MD, MS, FPMRS serves as Director of Female Urology and a member of the UW Medicine Pelvic Health Center at the University of Washington Medical Center, and Associate Professor at the University of Washington School of Medicine in Seattle, WA. As a leader in this field, she is part of the first group of female urologists/urogynecologists to be board certified in the subspecialty of Female Pelvic Medicine and Reconstructive Surgery through the American Board of Urology/American Board of Obstetrics and Gynecology. She completed her medical degree and urologic training at Case Western Reserve University School of Medicine / University Hospital of Cleveland in Cleveland, Ohio. Dr. Sutherland has gained further specialty training in female urology to include urinary incontinence and voiding dysfunction, urodynamics, neuromodulation, pelvic prolapse and reconstructive surgery, pelvic floor disorders and female sexual dysfunction from the Center for Continence Care and Female Urology in Minneapolis/St. Paul, MN, and from the Institute for Sexual Medicine in Boston.
Elizabeth B. Takacs, MD
Dr. Takacs currently serves as Clinical Associate Professor of Urology with a secondary appointment in the Department of Obstetrics and Gynecology at the University of Iowa. She received FMPRS subspecialty certification from the American Board of Urology in 2013. The focus of her practice is urologic conditions that affect women, specifically incontinence, pelvic organ prolapse, and recurrent UTIs.

Dr. Takacs received her medical degree from the University of Iowa Carver College of Medicine, where she also completed a postdoctoral research fellowship. She then completed her residency at the State University of New York at Buffalo, followed by a fellowship in female urology, incontinence and urodynamics at the University of Texas Southwestern at Dallas.

Medical education is Dr. Takacs’ primary interest outside of clinical medicine. She served as the Urology Medical Student Clerkship Director for six years, continues to participate in small group teaching for first- and second-year medical students, and serves as Director of Urologic Experience for the Department of Obstetrics and Gynecology FPMRS fellowship, and mentors the Department of Urology GURS fellows. She has focused on improving feedback and evaluation processes for the residents over the past year and is recipient of the an SAU grant on development of an automated evaluation process.

Cigdem Tanrikut, MD
Cigdem (“Cori”) Tanrikut, MD, FACS, graduated *summa cum laude* from the University of Pennsylvania and earned her Medical Degree from the Georgetown University School of Medicine. She completed her urologic surgery residency training at Massachusetts General Hospital (MGH)/Harvard Medical School, and then continued on to Weill Cornell Medical College in New York to pursue a fellowship in male infertility and microsurgery. Upon completing her fellowship training, she became the Director of Male Reproductive Medicine at the MGH Fertility Center. While at Harvard, she was an Associate Professor in Surgery at Harvard Medical School. In 2015, she was named the Quality Chair for the MGH Department of Urology, and in 2017, she became the President of the Society for Male Reproduction and Urology.

Dr. Tanrikut's research endeavors include assessing how lifestyle and medications may impact male reproductive health, sperm banking trends, and sperm-related factors to optimize fertility treatment outcomes.

Martha K. Terris, MD, FACS
Martha K. Terris, MD is Professor and Chief of the Section of Urology, holding the Witherington Distinguished Chair in Urology at the Medical College of Georgia/Augusta University. Dr. Terris strives to maintain resident and student teaching as a priority in tertiary urologic care and takes great pride in the quality of the urologic training program at the Medical College of Georgia. She received her general surgery training at Duke University and urology residency and fellowship at Stanford University. She served as Assistant Professor of Urology at Stanford University until joining the Medical College of Georgia in 2002 as Professor and Program Director as well as Chief of the Augusta VA Urology Service. Dr. Terris assumed the role of Section Chief at the Medical College of Georgia in 2012 where she provides the full spectrum of urologic oncology patient care. She has published over 300 scientific articles including some of the seminal articles on urologic cancer diagnosis and risk factors for poor cancer outcomes. She is past president of both the Society of University Urologists and Society of Urology Chairs and Program Directors, has served on the urology Residency Review Committee, and is currently Trustee of the American Board of Urology.
Simone Thavaseelan, MD
Simone Thavaseelan is an Associate Professor of Surgery (Urology)/Clinician Educator at the Warren Alpert School of Medicine at Brown University where she has been faculty since 2011. She is a graduate of Georgetown University SOM in 2005, 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 the residency program since 2016 and subspecializes in Endourology. 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, FPMRS
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.

Joanna M. Togami, MD
Joanna Togami earned her M.D. from University of New Mexico Health Science Center. She trained in Urology at University of Illinois at Chicago and did her fellowship in Female Pelvic Medicine at the Cleveland Clinic in Florida with Gamal Ghoniem.

She started practicing in 2004 on the Northshore with Ochsner Health Center and transitioned full time to Ochsner Medical Center, in order to teach in 2011. She specializes in treating patients with pelvic organ prolapse, urinary incontinence and voiding dysfunction, pelvic floor disorders and reconstructive surgery. She sees both men and women. She is published in the areas of pelvic organ prolapse, urinary incontinence and urinary issues particular to multiple sclerosis. She is particularly interested in the microbiome as it applies to urologic diseases. She is board certified in Female Pelvic Medicine and Reconstructive Surgery.

Being from the Southwest, she enjoys the outdoors, never imagined she’d be a Southerner, but loves being one. She also loves Louisiana, its people and culture.
Elizabeth R. Williams, MD
Dr. Williams received her MD from St. Louis University School of medicine. Her clinical focus resides in Female urology, urinary incontinence, vaginal and robotic surgery for prolapse of the pelvic organs (cystocele, rectocele, vault prolapse), urodynamics, urogynecology, neuromodulation, voiding dysfunction in men and women, and general urology.

Claire C. Yang, MD
Claire Yang, MD is 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. Dr. Yang has specialty training in Neuourology, and clinical and research interests in voiding dysfunction and sexual dysfunction. She has been a member of SWIU since 1988.

Anna M. Zampini, MD, MBA
Dr. Zampini completed her residency at the Glickman Urological and Kidney Institute, Cleveland Clinic Foundation in Cleveland, OH and is currently an Endourology Fellow at the Kidney Stone Institute of Mount Sinai in New York City. 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 that she is excited to be utilizing as a budding Endourologist and hopes to 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.
SWIU at the AUA
May 15 – 18, 2020

Saturday, May 16, 2020
SWIU Networking Reception

Sunday, May 17, 2020
SWIU at the AUA
Annual Meeting

SAVE THE DATES

SWIU 10th Annual Clinical Mentoring Conference
January 20 – 24, 2021
Embassy Suites by Hilton Scottsdale Resort
Scottsdale, Arizona