香港泌尿外科學會
HONG KONG
UROLOGICAL ASSOCIATION

香港泌尿外科學會
Hong Kong Urological Association

The 25th Annual Scientific Meeting 2020

25th October 2020

SCIENTIFIC PROGRAMME

GRAND BALLROOM 1/F (WEBINAR ROOM 1)

Registration:
Please register for the webinar through the link above.

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UROLOGY NURSING SYMPOSIUM

GRAND SALON 1/F (WEBINAR ROOM 2)

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(hotline service available on Oct 21-25)

THE 25th ANNUAL SCIENTIFIC MEETING 2020

香港泌尿外科學會

Hong Kong Urological Association

Date : 25th October 2020 (Sunday)

Time : 0845-1700

Venue : Harbour Grand Kowloon, 20 Tak Fung Street,
Whampoa Garden, Hunghom,
Kowloon, Hong Kong
(MTR Whampoa Station, Exit D2)

Hong Kong Urological Association

INTRODUCTION

Hong Kong Urological Association was incorporated on 11th September 1987.

The Main Objectives Of The Association Are:

- To promote the interest in and a better understanding of Urological problems in Hong Kong;
- To provide a venue for discussion of problems related to Urology;
- To improve and set the standard of urological care in Hong Kong;
- To provide a means of liaison with workers in Urology in other parts of the world;
- To advise and provide information on postgraduate urological training;
- To collect and disseminate information regarding members of the Association and information of any event or happening.

To achieve the objectives, monthly council meeting is held to plan, organize, implement and review the actvities of the Association. Regular academic meeting, which include case presentations, topic discussions and talks by invited speakers, are held monthly. Renowned overseas speakers have been invited to deliver lectures on subjects of special interest. Seminars, workshops, education programmes and talks to the public, general practitioners and other associations have been organized to enhance coummunication with the community and other medical specialties.

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WELCOME MESSAGE FROM PRESIDENT

On behalf of the organizing committee and council of HKUA, I am delighted to welcome all of you to participate in the 25th Annual Scientific Meeting of Hong Kong Urological Association.

Year 2019/20 is a very special and challenging time for all of us. We have necessitated a tremendous change, but our dedication to the pursuit of excellence in knowledge exchange and professional education remains unchanged. This year, our organizing committee members are versatile to turn the physical meeting into hybrid under social distancing situation.

This year, we are pleased to have features leaders from international partners, Urological Association of Asia Congress (UAA), BJU International (BJUI) and Société Internationale d'Urologie (SIU), as well as local partner, The Hong Kong Geriatrics Society (HKGS) to present four keynote lectures on the latest updates on various common diseases. The nursing chapter symposium would serve as an excellent platform for sharing among our allied health members.

The unfailing support from our members, colleagues and industrial partners provide us impetus to advance cutting-edge urology development and nurture young urologists in these extraordinary times. We are glad to have the senior urologists, who are always been supportive to HKUA to participate as adjudicators and abstracts reviewers.

Last but not the least, I would like to express my sincerely appreciation to the organizing committee for your hard work to make this meeting a successful and memorable one.



Dr James C.M. LI
President
Hong Kong Urological Association

HKUA COUNCIL (2020-2022)



Dr. James Cheuk-man LI
President



Prof. Peter Ka-fung CHIU
Honorary Secretary



Dr. Raymond Wai-man KAN
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Dr. Chun-ki CHAN
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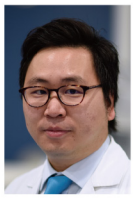
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Dr Marco Tsz-yeung CHAN



Dr Wilson Hoi-chak CHAN



Dr Franklin Kwok-leung HO



Dr Wai-kit MA



Dr Samuel Chi-hang YEE

SUBCOMMITTEE MEMBERS (2020-2022)

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Dr. Phoebe Man-hung CHEUNG

Dr. Franklin Kwok-leung HO

Dr. Raymond Wai-man KAN

Dr. Clarence Lok-hei LEUNG

External Affairs

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Dr. Bryan Kwun-chung CHENG

Dr. Phoebe Man-hung CHEUNG

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Dr. Terence Chun-ting LAI

Dr. Ting-kit LO

Dr. Donald Chi-ho IP

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Dr. Wilson Hoi-chak CHAN

Dr. Phoebe Man-hung CHEUNG

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Dr. Chun-ki CHAN

Dr. Wilson Hoi-chak CHAN

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Dr. Trevor Churk-fai LI

Dr. Chang-chung NGO

Dr. Samuel Chi-hang YEE

Social Media

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Young Urologist Section

Dr. Chun-ki CHAN

Dr. Wilson Hoi-chak CHAN

Dr. Samuel Chi-hang YEE

UROLOGY NURSING CHAPTER COUNCIL MEMBERS (2020-2022)

Chairperson	:	Mr Kevin Chi-chiu TANG
Honorary Secretary	:	Ms Irene Pui-hing WU
Honorary Treasurer	:	Mr Gilbert Ka-lok LUI
Ex-Officio	:	Mr Benny Kwok-kin LEUNG

Sub-committee members

Educational	:	Ms Mondy Man-yee LIU
		Ms Amy Yi-ying LO
		Ms Helen Kit-ling YAU
IT	:	Mr Alan IP
Welfare	:	Mr Jan Lok-sang CHING
		Ms Hilda Sze-wan KWOK
		Ms Crystal Suk-yin LI

PAST PRESIDENTS

2018 - 2020	Dr. Eddie Shu-yin CHAN
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2012 - 2014	Dr. Steve Wai-hee CHAN
2010 - 2012	Dr. Peggy Sau-kwan CHU
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2006 - 2008	Dr. Wai-sang WONG
2004 - 2006	Dr. Chi-wai MAN
2002 - 2004	Dr. Rudolph Loi-cheong NGAI
2000 - 2002	Dr. Bill Tak-hing WONG
1998 - 2000	Dr. Tim-fuk YIU
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References: 1. Xtandi® Hong Kong Prescribing Information. Astellas. **2.** Hussain M et al. N Engl J Med. 2018;378:2465-2474. **3.** Tombal B et al. Lancet Oncol. 2019;20:557-569.

Abbreviated prescribing information of Xtandi® soft capsules Version 006 Effective May 2018

Composition: Each capsule contains 40 mg enzalutamide. **Indications:** Treatment of castration-resistant prostate cancer: treatment of castration-resistant prostate cancer in adult men with metastatic castration-sensitive prostate cancer who are progression prior or while androgen deprivation therapy is given; chemotherapy is not yet clinically indicated. Treatment of adult men with non-metastatic castration-resistant prostate cancer whose disease has progressed on or after decreased therapy. **Dosage:** 160 mg (four 40 mg caps) as a single oral daily dose. **Administration:** Swallow whole with water, can be taken with or without food. **Contraindications:** Hypersensitivity to the active substance or to any of the excipient. Women who are or may become pregnant. **Special warnings and precautions for use:** Risk of seizure: Use of enzalutamide has been associated with seizure (see section 'Undesirable effects'). The decision to continue treatment in patients who experience seizure should be taken case by case. Specific metabolic or blood related reactions: Rare hemolytic anaemia (hemolytic anaemia) has been reported in patients receiving Xtandi. PRES: In patients receiving Xtandi, PRES is a rare, reversible, neurological disorder which can present with rapidly evolving symptoms including seizure, headache, confusion, blindness, and other visual and neurological disturbances, with or without associated hypertension. A diagnosis of PRES requires confirmation by brain imaging, preferably magnetic resonance imaging (MRI). Discontinuation of Xtandi in patients who develop PRES is recommended. Concomitant use with other medicinal products: Enzalutamide is a potent enzyme inducer and may lead to loss of efficacy of many commonly used medicinal products. A review of concomitant medicinal products should therefore be completed when initiating enzalutamide treatment. Concomitant use of enzalutamide with medicinal products that are sensitive substrates of many metabolising enzymes or transporters should generally be avoided if their therapeutic effects of large importance is to be monitored, and if dose adjustments cannot easily be performed based on monitoring of efficacy or plasma concentrations. Co-administration with warfarin and other coumarin-like anticoagulants should be avoided. If this is not possible, levels of INR are to be closely monitored. Use in patients who have undergone bilateral orchiectomy or are receiving concomitant GnRH analogue therapy: Overall survival data are not available for patients who have undergone bilateral orchiectomy. Concomitant use of enzalutamide with GnRH analogues has not been evaluated in the pivotal study [see Pharmacodynamics]. As concomitant bilateral orchiectomy can be considered a surrogate for castration, the clinical benefit of enzalutamide in patients with severe hepatic impairment (possibly related to increased brain enzalutamide exposure) is unknown. A pharmacokinetic study in patients with severe hepatic impairment (Child-Pugh Class C) showed that the exposure to enzalutamide was 2-fold higher than in patients with normal hepatic function. No dose adjustment is recommended for patients with mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment. Patients with severe hepatic impairment should be treated with caution. Renal impairment: No dose adjustment is recommended for patients with mild (creatinine clearance 60 to 89 ml/min), moderate (creatinine clearance 30 to 59 ml/min) or severe (creatinine clearance 15 to 29 ml/min) renal impairment or patients undergoing dialysis. Xtandi has not been studied in patients with end-stage renal disease (creatinine clearance less than 15 ml/min). Pregnancy and lactation: Xtandi is not indicated for use in women. Xtandi should not be used by women who are pregnant or may become pregnant while receiving Xtandi. Xtandi may cause embryo-foetal harm when administered to a pregnant woman. It is not known whether enzalutamide is excreted in human breast milk. Xtandi should not be used during breast-feeding. Fertility: Enzalutamide may impair male fertility. **Undesirable effects:** Summary of the safety profile: The most common adverse reactions are asthenia/fatigue, hot flush, fractures, and hypertension. Other important adverse reactions include seizure, cognitive disorder, and decreased sperm counts. Tabulation of undesirable effects: Undesirable effects reported in clinical trials are listed below by frequency category. Frequency categories are defined as follows: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000), not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Adverse reactions identified in post-marketing clinical experience are in italics. Blood and lymphatic system disorders: Uncommon: leukopenia, neutropenia. Not known: thrombocytopenia. Immune system disorders: Not known: hypersensitivity reactions. Nervous system disorders: Common: seizure, dizziness, headache, memory impairment, disturbance in attention, cognitive disorder, amnesia. Uncommon: hypoesthesia, paresthesia, dysgeusia, somnolence, tremor, balance disorder. Not known: convulsive seizure. Vascular disorders: Very common: hot flush. Common: hypertension. Uncommon: hypertensive crisis. Respiratory, thoracic and mediastinal disorders: Common: dyspnoea. Gastrointestinal disorders: Common: diarrhoea, nausea, vomiting. Skin and subcutaneous tissue disorders: Common: dry skin, pruritus. Uncommon: rash. Musculoskeletal and connective tissue disorders: Very common: asthenia, fatigue, arthralgia. Common: fracture, myalgia, back pain. Uncommon: muscular weakness. Reproductive system and breast disorders: Common: decreased libido, gynaecomastia. Uncommon: erectile dysfunction. Investigations: Common: weight decreased. Not known: weight increased. Injury, poisoning and procedural complications: Common: fall. Uncommon: contusion, cerebral ischemic attack, cerebrovascular accident, cerebral infarction, cerebral hemorrhage, subdural hematoma, loss of consciousness, syncope, head injury, concussion. Not known: fracture. This includes rare cases of seizure with complications leading to death. As evaluated by narrow SMQs of Myocardial Infarction and Other Ischemic Heart Disease, including the following preferred terms observed in at least two patients in randomised placebo-controlled phase 3 studies: angina pectoris, coronary artery disease, myocardial infarction, acute coronary syndrome, angina unstable, myocardial ischaemia, and arteriosclerosis coronary artery. † Includes all preferred terms with the word fracture' in bone. Description of selected adverse reactions: Seizure: In controlled phase studies, 13 patients (0.4%) developed a seizure; all of 2,791 patients treated with a daily dose of 160 mg once daily vs. none of 1,671 patients receiving a placebo dose once daily or 320 mg/day bicalutamide, developed a seizure. Dose aggression to be an important predictor of the risk of seizure, as evidenced by a two-fold increase in seizure rate at 240 mg/day compared to 160 mg/day. In the controlled clinical studies, patients with prior seizure risk factors for seizure were excluded. In the AFFIRM-2 (STUDY 3) PLACEBO-controlled study, seizures occurred in 0.8% (6/1,199) of patients treated with enzalutamide and in 0.2% (1/800) of patients treated with placebo. Seizures occurred in patients with predisposing factors for seizure, followed 1,068 had a history of seizures, 8 of 806 (1.0%) patients treated with enzalutamide experienced a seizure. The median duration of treatment was 9.3 months. The mechanism by which enzalutamide may cause the seizure is not known, but may be related to concentrations also studies showing that enzalutamide and its active metabolite bind to and stabilise the activity of the GABA-gated chloride channel. Ischemic Heart Disease: In randomized placebo-controlled clinical studies, ischemic heart disease occurred in 2.5% of patients treated with enzalutamide plus ADT compared to 1.3% of patients treated with placebo plus ADT.

Full prescribing information is available upon request.

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XTD-MED-191119-0001



OAB: overactive bladder

Abbreviated prescribing information of Betmiga® prolonged-release tablets

Version: 003 PI version: Apr 2016. **Composition:** Mirabegron **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Dosage:** Adult including elderly 50 mg once daily with or without food. **Administration:** Swallow whole with liquids. Do not chew/divide/crush. **Contraindications:** Mirabegron is contraindicated in patients with - Hypersensitivity to the active substance or to any of the excipients. - Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Special warnings and precautions for use:** Renal impairment: Betmiga has not been studied in patients with end stage renal disease (GFR < 15 mL/min/1.73 m2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m2); based on a pharmacokinetic study a dose reduction to 25 mg is recommended in this population. Betmiga is not recommended for use in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m2) concomitantly receiving strong CYP3A inhibitors. Hepatic impairment: Betmiga has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. Betmiga is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors. Hypertension: Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with Betmiga, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation: Betmiga, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies. However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinics medications for OAB: Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medications for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with Betmiga; however, Betmiga should be administered with caution to patients with clinically significant BOO. Betmiga should also be administered with caution to patients taking antimuscarinic medications for the treatment of OAB. **Undesirable effects:** Summary of the safety profile: The safety of Betmiga was evaluated in 8,433 patients with OAB, of which 5,648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received Betmiga for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with Betmiga, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for patients treated with Betmiga 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving Betmiga 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving Betmiga 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving Betmiga 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving Betmiga 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. List of adverse reactions: The table below reflects the adverse reactions observed with mirabegron in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Infections and infestations: Common: Urinary tract infection. Uncommon: Vaginal infection, Cystitis. Psychiatric disorders: Not known (cannot be estimated from the available data): Insomnia*. Eye disorders: Rare: Eyelid oedema. Cardiac disorders: Common: Tachycardia. Uncommon: Palpitation, Atrial fibrillation. Vascular disorders: Very rare: Hypertensive crisis*. Gastrointestinal disorders: Common: Nausea*, Constipation*, Diarrhoea*. Uncommon: Dyspepsia, Gastritis. Rare: Lip oedema. Skin and subcutaneous tissue disorders: Uncommon: Urticaria, Rash, Rash macular, Rash popular, Pruritus. Rare: Leukocytoclastic vasculitis, Purpura, Angioedema*. Musculoskeletal and connective tissue disorders: Uncommon: Joint swelling. Reproductive system and breast disorders: Uncommon: Vulvovaginal pruritus. Investigations: Uncommon: Blood pressure increased, GGT increased, AST increased, ALT increased. Renal and urinary disorders: Rare: Urinary retention*. Nervous system disorders: Common: Headache*, Dizziness*. *observed during post-marketing experience. **Full prescribing information is available upon request.**

Reference: **1.** Chapple C.R. et al. Neurourol Urodynam 2014 Jan;33 (1):17-30 **2.** Hong Kong package insert of Betmiga® Apr 2016

Betmiga® mirabegron

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MEMBER'S PUBLICATIONS FROM OCT 2019 – PRESENT

Publications

1. Cheng KC, Lam WC, Chan HC, Ngo CC, Cheung MH, So HS et al. Emergency Attendances and Hospitalizations for Complications after Transrectal Ultrasound-guided Prostate Biopsies - A Five-year Multicentre Study. Hong Kong Medical Journal. 2019 Oct;25(5):349-55.

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Book Chapter

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AGENDA

Date : 25th October 2020 (Sunday)
Time : 0845-1700
Venue : Harbour Grand Kowloon, 20 Tak Fung Street, Whampoa Garden, Hunghom, Kowloon, Hong Kong (MTR Whampoa Station, Exit D2)

SCIENTIFIC PROGRAMME

GRAND BALLROOM 1/F (WEBINAR ROOM 1)

START	END	DURATION	
0845	0900	15 Mins	Welcoming Speech
0900	0930	30 Mins	UAA Lecture: Minimally Invasive Surgical Therapy For Benign Prostatic Hyperplasia Speaker : Prof. Henry Woo Moderators : Dr. Eddie SY Chan, Dr. Eric SK Li
0930	1000	30 Mins	HKGS Lecture: Challenges Of Managing LUTS In Elderly Speaker : Dr. William Kk Wong Moderators : Dr. Clarence LH Leung, Dr. Phoebe MH Cheung
1000	1100	60 Mins	Oral Presentation Session 1 Chairmen / Adjudicators : Dr. Po Chor Tam, Dr. Chi Wai Fan
1100	1130	30 Mins	Coffee Break
1130	1200	30 Mins	Sponsored Lecture: Management Of Advanced Prostate Cancer- What Is New In 2020? Speaker : Prof. Christopher Evans Moderators : Prof. Peter KF Chiu, Dr. Marco TY Chan
1200	1300	60 Mins	Lunch
1300	1500	120 Mins	Oral Presentation Session 2 Chairmen / Adjudicators : Dr. Po Chor Tam, Dr Chi Wai Fan
1500	1530	30 Mins	Coffee Break
1530	1600	30 Mins	SIU Lecture: Treating Stones With RIRS- The Latest Indications And Gadgets In 2020 Speaker : Dr. Ranan Dasgupta Moderators : Dr. Chun Ki Chan, Dr. Franklin KL Ho
1600	1630	30 Mins	BJUI Lecture: Optimising Assessment Of Male Lower Urinary Tract Symptoms (Luts); Insights From The "Urodynamics For Prostate Surgery: Randomised Evaluation Of Assessment Methods" (Upstream) Trial Speaker : Prof. Marcus Drake Moderators : Dr. Raymond WM Kan, Dr. Wilson HC Chan
1630	1700	30 Mins	Closing Remarks and Award Presentation

UROLOGY NURSING SYMPOSIUM

GRAND SALON 1/F (WEBINAR ROOM 2)

START	END	DURATION	
1300	1310	10 Mins	Opening Speech
Session 1 : Lecture			
1310	1340	30 Mins	"Prostate Cancer Screening and Treatment Update" - Dr. Terence CT Lai
1340	1355	15 Mins	"Nursing Management on Erectile Dysfunction after Radical Prostectomy" - Mr. Gilbert KL Lui
1355	1410	15 Mins	"Nursing Management on Urinary Incontinence after Radical Prostectomy" - Ms. Veronica YC Kam
Session 2 : Oral Free Paper			
1410	1455	45 Mins	Oral Presentations
1455	1500	5 Mins	Closing Remarks

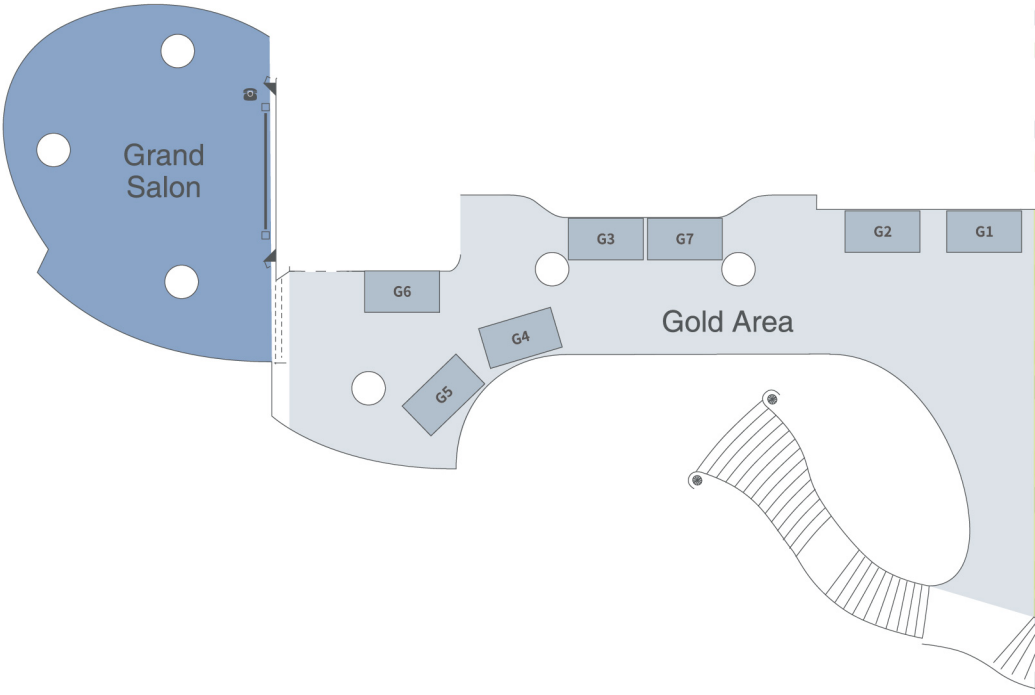
POSTER PRESENTATION (AUDIO POSTERS)

START	END	DURATION	
1530	1630	60 Mins	Poster Presentation Adjudicators : Dr Ho Lap Yin, Dr Ho Kwan Lun

VENUE FLOOR PLAN

Grand Salon (1/F)

- Nursing Session
- Exhibition Venue 1



VENUE FLOOR PLAN

Grand Ballroom (1/F)

- UAA Lecture
- HKGS Lecture
- SIU Lecture
- BJUI Lecture
- Oral Presentation
- Sponsored Lecture
- Award Presentation
- Registration Counter
- CME / CNE Counter
- Photobooth
- Exhibition Venue 2



EXHIBITORS

DIAMOND

D1	Olympus Hong Kong and China Ltd
D2	Astellas Pharma Hong Kong Co., Ltd.

PREMIUM PLATINUM

PP1	KARL STORZ Endoscopy China Ltd.
PP2	Da Hon / Becton Dickinson

PLATINUM

P1	Beaufour Ipsen International (Hong Kong) Limited
P2	Intuitive Surgical-Fosun (Hongkong) Co., Ltd
P3	Janssen, a division of Johnson & Johnson (HK) Ltd.
P4	Merck Sharp & Dohme (Asia) Ltd

GOLD

G1	Ferring Pharmaceuticals Limited
G2	Tronda Electronics Ltd.
G3	Boston Scientific Hong Kong Ltd
G4	Chindex Hong Kong limited
G5	A. Menarini Hong Kong Limited
G6	Sanofi Aventis Hong Kong
G7	GlaxoSmithKline Limited

SILVER

S2	Chavon Medical Systems Ltd.
S3	Lumenis (HK) Ltd
S4	Baxter Healthcare Ltd
S5	Zenfields (HK) Limited
S6	Bayer HealthCare Limited
S8	Medical Distributor Alliance
S9	B. Braun Medical (H.K.) Ltd.
S10	Medtronic Hong Kong Medical Limited
S12	Main Life Corporation Limited
S13	Takeda Pharmaceuticals (Hong Kong) Limited
S14	Mylan Pharmaceutical HK Ltd
S15	Synmosa Biopharma (HK) Co.,LTD.
S16	Pfizer Upjohn Hong Kong Limited
S17	Beckman Coulter HK Limited

UAA LECTURE BY PROF. HENRY WOO

"Minimally invasive surgical therapy for benign prostatic hyperplasia."



Prof. Henry Woo

- Board Director, Australian and New Zealand Urogenital and Prostate Cancer (ANZUP)
- Board Director, Australian Urological Foundation
- Inaugural Editor-in-Chief, BJUI Knowledge, 2012- 2015
- Associate Editor, Prostate Cancer and Prostatic Disease
- Editorial Board of journals: Prostate Cancer Prostatic Diseases, European Urology, BJUI, Prostate International, World Journal of Men's Health, World Journal of Clinical Urology
- Executive Committee, Asian Pacific Prostate Society
- Social Media WorkGroup, American Urological Association
- Member: Urological Society of Australia and New Zealand (USANZ), American Urological Association (AUA), European Association of Urology (EAU), Societe Internationale d'Urologie (SIU), International Endourology Association, Australian Medical Association (AMA).

Prof. Henry Woo is a urological surgeon with a subspecialised clinical practice in prostate surgery. He has published widely on the subject matter of benign prostatic hyperplasia and prostate cancer and has an international reputation for his work in the field.

He is the foundation Professor of Surgery at the Sydney Adventist Hospital Clinical School of the University of Sydney. Up until 2012 he had been a visiting surgeon at Westmead Hospital and associated with the Western Clinical School. Since 2016, he has also been the Director of Uro-Oncology and Professor of Robotic Cancer Surgery at the Chris O'Brien Lifehouse.

He is currently an Associate Editor of the nature owned journal, Prostate Cancer and Prostatic Diseases (IF 4.600) and is on the Editorial Boards of several journals including European Urology (IF 14.976), BJU International (IF 4.387), Prostate Cancer and Prostatic Diseases (IF 3.803), Asian Journal of Urology, Prostate International, World Journal of Men's Health and World Journal of Clinical Urology.

He is the coordinator of the highly successful International Urology Journal Club on Twitter, a model which has since been followed by multiple other specialties. He is an active influencer on social media, particularly with regard to leadership and medical education.

HKGS LECTURE BY DR. WILLIAM KK WONG

"HKGS Lecture: Challenges of Managing LUTS in Elderly."



Dr. William KK Wong MBBS(HKU), MRCP(UK), FHKAM (Geriatric Medicine)

- Associate Consultant, Department of Medicine and Geriatrics, Kwong Wah Hospital
- Programme Director of Basic Physician Training, Basic Physician Board, Hong Kong College of Physicians
- Trainer for Basic and Higher Physician Trainee in Advanced Internal Medicine and Geriatric Medicine
- Hospital Training Coordinator of Specialty Board in Geriatric Medicine
- Board Member (Observer) of Special Board in Geriatric Medicine, Hong Kong College of Physicians
- Author of Chapter on Continence Care in Elderly, Handbook of Internal Medicine, COC (Medicine) Hospital Authority, 7th Edition 2015
- Convener (2018) of Clinical Guidelines on Geriatric Urinary Incontinence. Guidelines Development Group on Continence Care. Geriatric Subcommittee. COC Internal Medicine. Hospital Authority
- Council member of Hong Kong Geriatrics Society
- Convenor of Special Interest Group in Continence Care, Hong Kong Geriatrics Society
- Honorary Clinical Assistant Professor, Department of Medicine, Faculty of Medicine, The University of Hong Kong
- Honorary Clinical Assistant Professor, Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong

Dr. William Wong completed his basic medical training at The University of Hong and obtained fellowship in Geriatric Medicine in 2006. Dr. William Wong is currently the convenor of Special Interest Group (SIG) in Continence Care, Hong Kong Geriatrics Society and the physician in charge of Continence Clinic of Medical and Geriatrics Department of Kwong Wah Hospital.

Dr. William Wong's special interest is in continence care and he was attached to the Research Department of Clinical Physiology, Division of Medicine, Whittington Campus, University College London Medical School in 2013 which was a tertiary medical centre for management of LUTS (LUTS Service) in London, United Kingdom. He was actively involved in various research activities eg. Role of chronic urinary infections in overactive bladder during his attachment. Dr. William Wong also participate actively in various educational activities on basic and advanced medical training in Geriatric Medicine. He was the author of Chapter on Continence Care, Handbook of Internal Medicine, COC (Medicine) Hospital Authority, 7th Edition 2015 and Convenor of Clinical Guidelines on Geriatric Urinary Incontinence. Guidelines Development Group on Continence Care. Geriatric Subcommittee. COC Internal Medicine. Hospital Authority in 2018. He is currently the Programme Director of Basic Physician Training, Basic Physician Board and Board Member (Observer) of Special Board in Geriatric Medicine of Hong Kong College of Physicians.

SPONSORED LECTURE BY PROF. CHRISTOPHER EVANS

"Management of advanced prostate cancer- what is new in 2020?"



Prof. Christopher P. Evans, M.D., F.A.C.S.

- Professor and Chair, Department of Urologic Surgery
- University of California, Davis, School of Medicine
- Immediate Past President, Society of Urologic Oncology

Prof. Christopher Evans is professor and chair of the Department of Urologic Surgery at University of California, Davis School of Medicine and a member of the UC Davis Cancer Center. Prof. Evans attended Dartmouth Medical School on a Health Professional Services Program scholarship and he served on active duty in the United States Army, including two years as Chief of Experimental Surgery at the Walter Reed Army Institute of Research. He completed surgery and urology training at the University of California, San Francisco where he was also a National Kidney Foundation Scholar. Prof. Evans completed fellowship training in urologic oncology at the University of Texas, M.D. Anderson Cancer Center. He came to UC Davis in 1997 at which time he was also Director of Urology Research. In 2006, Prof. Evans became Department Chair, and in 2010 he became Chair of the UC Davis Medical Group Practice Management Board. Prof. Evans' practice is dedicated to the management of patients with urologic malignancies. He works with medical oncologists and radiation oncologists to provide multimodal approaches to cancer therapy.

Prof. Evans' research laboratory focuses on prostate cancer; specifically, mechanisms signaling the androgen receptor to activate prostate cancer growth and progression following castration and mechanisms of drug resistance. His laboratory has developed models to study this and has identified novel mechanisms that activate the androgen receptor. His laboratory work has tested new agents and brought them from bench studies to animal models to clinical trials.

Prof. Evans is Past President of the Society of Urologic Oncology and Past Chair of the ASCO-GU Steering Committee. He is also an elected member of the American Association of Genitourinary Surgeons. His research laboratory has received funding from the National Institutes of Health, Department of Defense, New York Academy of Medicine, Prostate Cancer Foundation, Stand-Up To Cancer and the American Cancer Society. He has published over 200 peer-reviewed articles.

SIU LECTURE BY DR. RANAN DASGUPTA

"Treating Stones with RIRS- the latest indications and gadgets in 2020."



Dr. Ranan Dasgupta

- Chair of Research Audit Committee (uCARE, SIU)
- Clinical Lead Endourology (Imperial College London)
- Visiting Professor (Cleveland Clinic, USA)
- Faculty of JCIE – Intercollegiate Specialty Fellowship Examination, FRCS (Urol)

Dr. Ranan Dasgupta qualified from Cambridge University (MBBChir), before proceeding to higher surgical training in London (MRCS, FRCS(Urol)), including a higher degree (MD) at UCL, London. He has lectured widely, and undertaken live surgery in several conferences, in the fields of endourology and neuro-urology. He has been Principal Investigator in a number of clinical trials (TISU, UK-ROPE, PURE), published over 50 peer-reviewed journals, over 10 book chapters, and co-edited 2 books; he reviews for several leading journals. As an examiner for MBBS (Imperial College) and FRCS(Urol) (JCIE), and as Urology lead for Undergraduate Urology (Imperial College) and Educational Supervisor for Specialist Training (London Deanery) he remains committed to education. Within his role in uCARE (SIU) he remains committed to maintenance of quality outcomes in research.

BJUI LECTURE BY PROF. MARCUS DRAKE

"Optimising assessment of male lower urinary tract symptoms (LUTS); insights from the "Urodynamics for Prostate Surgery: Randomised Evaluation of Assessment Methods." (UPSTREAM) trial"



Prof. Marcus Drake

- Professor of Physiological Urology, University of Bristol
- Member of the Board of Trustees, International Continence Society
- Board member of the European Society of Female and Functional Urology

Prof. Marcus Drake is Professor of Physiological Urology at the University of Bristol, and Honorary Consultant Surgeon at the Bristol Urological Institute at Southmead Hospital, Bristol, UK. He undertook his medical training at the Universities of Cambridge and Oxford and was awarded his research Doctorate Thesis by the University of Oxford. His clinical interests in Urology are Urodynamics, Neuro-urology, LUTS and Nocturia.

He is Chief Investigator of UK National Institute of Health Research grants in Male LUTS (HTAs UPSTREAM & TRIUMPH), Nocturia (RfPB PLANET), catheter design (RfPB Flume), recurrent stress incontinence (HTA PURSUIT), and UTI diagnostics (i4i QUICK). He is co-CI of an NIH RO1 grant in Physiology (sildenafil effects on voiding). He was CI of the MeNiMS study of nocturia in MS. He was CI of the pharmaceutical trials BESIDE and NEPTUNE2. He is co-investigator for NIHR studies in male stress incontinence (HTA MASTER), urodynamics (HTAs FUTURE & PRIMUS), and preparation for surgery (HTA INSPIRE) and the UK Research Council emPOWER study. His total cumulative career grant awards are £24M, of which £10M are as CI.

He is a Trustee of the International Continence Society. He is a board member of the European Society of Female and Functional Urology. He was Chairman of the International Continence Society's Standardisation Steering Committee for 6 years, and board member of the European School of Urology for 8 years. He was a member of the European Association of Urology Guidelines committee for male urinary symptoms (LUTS). He has recently completed writing the 4th Edition of "Abrams Urodynamics"

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ORAL PRESENTATION SESSION 1

(10:00-11:00)

10:00- 10:10
[OP.1-1]
Oral Presentation Group: Benign Urological diseases
Health seeking behaviour of men with acquired penile curvature: A population-based study
A Wong[1], CF Tsang[1], BSHo[1], ATL Ng[1], HL Tsu[1], W Lam[2]
[1] Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong
[2] Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong

10:10- 10:20
[OP.1-2]
Oral Presentation Group: Benign Urological diseases
Feasibility of Mobile Phone-Based Acoustic Uroflowmetry
FH Cheung, CM Ng, HC To, HY Ngai, WH Au
Division of Urology, Queen Elizabeth Hospital, Kowloon, Hong Kong

10:20 – 10:30
[OP.1-3]
Oral Presentation Group: Benign Urological diseases
Optimization of Care in Posterior Urethral Valve (PUV): A Pilot Study
JLY Wong, JKF Chan, SMS Wong, JHK Ngan
Dr John Ngan Adult and Paediatric Urology

10:30- 10:40
[OP.1-4]
Oral Presentation Group: Benign Urological diseases
Stentless Open Pyeloplasty Remains a Feasible Option for Very Young Children
J Kwok, SMS Wong, JHK Ngan
Dr John Ngan Adult and Paediatric Urology

10:40- 10:50

[OP.1-5]

Oral Presentation Group: Benign Urological diseases

The Efficacy of a Transurethral Prostatic Implantable Device (Urolift®) on Lower Urinary Tract Symptoms (LUTS) and Trial Without a Catheter (TWOC) for Acute Urinary Retention in Men Secondary to Benign Prostatic Obstruction (BPO); a Prospective Single-Arm Pilot Study

VYK Poon, C H Ip, CK Chan, Y Chiu, YC Lam, TY Chu, WK Ma

Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

10:50-11:00

[OP.1-6]

Oral Presentation Group: Benign Urological diseases

Local Experience of Magnetic Ureteral Double J Stenting

YH Fan, WPL Hung, F Wong, MH Yu, KF Chau, KW Wong, SK Li, CM Li

Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

ORAL PRESENTATION SESSION 2

(13:00-15:00)

13:00- 13:10

[OP.2-1]

Oral Presentation Group: Benign Urological diseases

Thulium-YAG Laser Vaporesection (Thuvrp) for Large Prostate Greater Than 80cc: A Journey from Zero Experience

CH Ip, CH Chan, Y Chiu, TY Chu, CK Chan, YK Poon, YC Lam, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

13:10-13:20

[OP.2-2]

Oral Presentation Group: Cancer diagnosis

Detecting Bladder Tumour with a newly developed Computer-aided Endoscopic Diagnostic System

EOT Chan[1], A Cheuk[1], RCK Chan[2], J Qin[3], CF Ng[1], JYC Teoh[1]
[1] S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong, China
[2] Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong, China
[3] Center for Smart Health, School of Nursing, The Hong Kong Polytechnic University, Hong Kong, China

13:20 – 13:30

[OP.2-3]

Oral Presentation Group: Cancer diagnosis

Prostate Health Index (*phi*) is an Effective Risk Stratification Tool: An Analysis of Biopsy and Cancer Diagnoses at a Median Follow-Up of 3 Years

A Cheung[1], PK Chiu[1], BS Lau[2], CC Ho[3], SY Li[1], SW Kwok[1], JY Teoh[2], CH Yee[1], CK Chan[1], SM Hou[1], WL Tang[3], WT Poon[3], CF Ng[2]
[1] Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong
[2] SH Ho Urology Centre, The Chinese University of Hong Kong
[3] Department of Pathology, Pamela Youde Nethersole Eastern Hospital, Hong Kong

13:30- 13:40

[OP.2-4]

Oral Presentation Group: Cancer diagnosis

The Combination Of PSA-Density (PSA-D) And PIRADS For More Accurate Detection of Clinically Significant Prostate Cancer In MRI-Fusion Biopsies

TWK Wong[1], HC Chan[1], CC Ngo[2], WC Lam[2], LF Lee[1], KC Cheng[1], MH Cheng[2], NH Chan[2], HS So[1]
[1] Divison of Urology, Department of Surgery, United Christian Hospital
[2] Division of Urology, Department of Surgery, Tseung Kwan O Hospital

13:40 – 13:50

[OP.2-5]

Oral Presentation Group: Cancer diagnosis

How Good Is Ginsburg Protocol in Cancer Diagnosis in Transperineal Prostate Biopsy?

CW Wu, TCF Li, CF Kan, WH Au

Division of Urology, Department of Surgery Queen Elizabeth Hospital, Hong Kong13:50-14:00

13:50 – 14:00

[OP.2-6]

Oral Presentation Group: Oncology

Complications of Prostate Cancer Treatment – Any Difference in Terms of Unplanned Hospital Admission?

H Chow[1], SCH Leung[1], SYS Chan[1], H Chau[2], SK Chu[2], ML Li[2], JYC Teoh[1], PKF Chiu[1], SCH Yee[1], CF Ng[1]

[1] SH Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong

[2] Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

14:00-14:10

[OP.2-7]

Oral Presentation Group: Oncology

The Life Journey of My Patients — an Observational Study of Patients Diagnosed with Metastatic Prostate Cancer in Hong Kong

CWH Mak[1], SCH Leung[1], SYS Chan[1], H Chau[2], SK Chu[2], ML Li[2], JYC Teoh[1], PKF Chiu[1], CF Ng[1]

[1] SH Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong

[2] Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

14:10-14:20
[OP.2-8]
Oral Presentation Group: Oncology
Peri-operative Outcomes of Intracorporeal Versus Extracorporeal Urinary Diversion Following Robotic-Assisted Radical Cystectomy: Results from the Asian RARC Consortium
EOT Chan [1], SH Kang [2], M Patel [3], S Horie [4], S Muto [4], C Ohyama [5], S Hatakeyama [5], T Chow [1], A Mok [1], H Chen [6], R Zhang [6], K Kijvikai [7], LS Lee [8,9], JYC Teoh [1], ESY Chan [1].

[1] S.H. Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong.
[2] Department of Urology, Korea University College of Medicine, Korea University Hospital.
[3] Department of Urology, Westmead Hospital and Discipline of Surgery, University of Sydney.
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[5] Department of Urology, Hirosaki University Graduate School of Medicine.
[6] Department of Urology, Renji Hospital, Shanghai Jiaotong University School of Medicine, Shanghai, China.
[7] Department of Urology, Ramathibodi Hospital, Mahidol University, Thailand.
[8] Urology Service, Department of Surgery, Sengkang General Hospital, Sengkang, Singapore
[9] Department of Urology, Singapore General Hospital, Singapore.

14:20-14:30
[OP.2-9]
Oral Presentation Group: Oncology
Urinary Leakage Post Partial Nephrectomy: A 5-Year Review in Tuen Mun Hospital
CKY Chan, CH Cheng, CYK Lee, MTY Chan, LH Chau, CW Man, PSK Chu.
Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

14:30-14:40
[OP.2-10]
Oral Presentation Group: Oncology
Enhanced Recovery After Surgery (ERAS) For Robotic-Assisted Laparoscopic Radical Cystectomy: The Way Forward
CH Tam, Y Chiu, FH Cheung, H Chow, KC Wong, CY Ng, YK Poon, CH Ip, CK Chan, YC Lam, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

14:40-14:50

[OP.2-11]

Oral Presentation Group: Oncology

Outcome of Adjuvant and Salvage Radiotherapy in Patients with Pathological T3 Disease or Positive Surgical Margin after Radical Prostatectomy

HHY Lie[1], CF Tsang[1], W Lam[2], BSH Ho[1], ATL Ng[1], JHL Tsu[1]

[1] Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong

[2] Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong

14:50-15:00

[OP.2-12]

Oral Presentation Group: Oncology

Approach to Implant Fiducial Gold Marker For Prostate Cancer: Transperineal V.S Transrectal

MWC Yu[2], KL Lo[2], DKW Leung[2], KK Yuen[1], KM Li[1], SK Mak[2], JHM Wong[2], CF Ng[1]

[1] SH Ho Urology Centre, Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong

[2] North District Hospital, Hong Kong

[OP.2-13]

Oral Presentation Group: Oncology

How to Manage Patients with Suspected Upper Tract Urothelial Carcinoma in the Pandemic of COVID-19?

DKW Leung[5], HY Lee[1,2,3,4], E Chan[5], CC Li[3,4], WM Li[3,4,6] , HC Yeh[1,3,4], PKF Chiu5, HL Ke[3,4], CH Yee[5], JHM Wong[5], CF Ng[5], *JYC Teoh[5], *WJ Wu[3,4]

[1] Urology Department, Kaohsiung Municipal Ta-Tung Hospital, Kaohsiung, Taiwan.

[2] Graduate Institute of Clinical Medicine, College of Medicine, Kaohsiung Medical University, Kaohsiung, Taiwan

[3] Department of Urology, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan

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[5] S.H. Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong, Hong Kong, China

[6] Department of Urology, Ministry of Health and Welfare Pingtung Hospital, Pingtung, Taiwan

MODERATED POSTERS

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[MP.1]
Efficacy and Safety of Desmopressin in the Chinese Population with Nocturia: A Double-Blind Randomized Placebo-Controlled Study
KC Wong, YC Lam, YC Ma, HK Lau, CH Chan, CH Tam, CY Ng, YK Poon, CH Ip, CK Chan, Y Chiu, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital

[MP.2]
Oncologic Outcomes of Localised Upper Urinary Tract Urothelial Carcinoma Treated with Nephroureterectomy
CHT Yu[1], CF Tsang[1], W Lam[2], B Ho[1], ATL Ng[1], HL Tsu[1]
[1] Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong
[2] Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong

[MP.3]
10-Year Retrospective Review on Surgical Management of Extramammary Paget's Disease in a Local Hospital in Hong Kong
SK Tam, HC Chan, LF Lee, KC Cheng, HS So
Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

[MP.4]
Urologist in Spina Bifida Clinic – An Initial Experience in China
CLH Leung, HL Xia, RWM Kan, SMS Wong, JHK Ngan
MedArt

[MP.5]
Intravesical BCG Therapy for Patients with Non-Muscle Invasive Bladder Cancer
WL Chan, RWM Kan, CF Kan, TCF Li, CM Ng, HY Ngai, WH Au
Department of Surgery, Department of Surgery, Queen Elizabeth Hospital

[MP.6]

The Role of Nurse-Led Hematuria Clinic in Urothelial Cancer Detection Amid COVID-19 Pandemic

TCK Ng, CH Ip, MS Yim*, KW Wong*, PF Chak* CM Cheng, FH Cheng, CY Ng, YK Poon, CK Chan, Y Chiu, YC Lam, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong
*Urology nurse

[MP.7]

Metallic Ureteral Stents in Malignant Ureteral Obstruction: Treatment Outcomes and Factors Predicting Stent Failure

YK Ng, RWM Kan, TCF Li, CM Ng, CF Kan, HY Ngai, WH Au
Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong

[MP.8]

A Single-Center Experience Of MRI-USG Fusion Targeted Biopsy of Prostate

TK Lo, TY Chan, YK Lee, CH Cheng, H Chau, CW Man, SK Chu
Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

[MP.9]

Implementation of a Nurse-Led Triage Clinic for Men with Elevated Serum Prostate Specific Antigen (PSA) in a Tertiary Center: Initial experience

FH Cheung, YK Poon, *MS Yim, *KW Wong, *PF Chak, CH Ip, CK Chan, Y Chiu, YC Lam, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong
* Urology nurse

[MP.10]

Use of Infrared Illumination System (IRIS) for Ureteral Catherization to Reduce Ureteric Injury

AMH Yeung, CH Cheng, LH Chau, SK Chu, CW Man
Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

[MP.11]

A Single-Centre Retrospective Review on Laparoscopic Partial Nephrectomy

AMH Yeung, TTC Chan, WKW Chan
Division of Urology, Department of Surgery, Kwong Wah Hospital

[MP.12]

Ureteric Stent Removal by String to Reduce Flexible Cystoscopy Case Load During COVID-19 Pandemic

A Cheung[1], KL Lo[1], CWH Mak[1], SKK Yuen[1], SYS Chan[1], JKM Li[1], SK Mak[1], JHM Wong[1], CK Chan[1], CF Ng[2]
[1] NTEC Urology, Department of Surgery, North District Hospital
[2] SH Ho Urology Centre, Department of Surgery, the Chinese University of Hong Kong

[MP.13]

A Successful Salvage of an Infected Inflatable Penile Prosthesis (IPP) Without Explantation: A Case Report

WPL Hung, YH Fan, Francis Wong, Jeffry MH Yu, KF Chau, KW Wong, SK Li, SK Li, CM Li
Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

[MP.14]

Laparoscopic Repair of Paediatric Inguinal Hernia – The Kwong Wah Hospital Experience

IC Law, KW Chan, TH Leung
Division of Urology, Department of Surgery, Kwong Wah Hospital, Hong Kong

[MP.15]

Robot-Assisted Ureteroplasty with Buccal Mucosal Graft – Illustration of Technique and our Initial Experience

TF Wong, B Ho, ATL Ng, CF Tsang, JHL Tsu, W Lam
Division of Urology, Department of Surgery, Queen Mary Hospital, University of Hong Kong

[MP.16]

Retroperitoneal Laparoscopic and Robotic Partial Nephrectomy: A Comparison with the Transperitoneal Approach

DKW Leung[2], SKK Yuen[2], KM Li[2], HM Tam[1], KL Lo[2], JYC Teoh[3], SK Mak[2], KF Chiu[1], CH Yee[1], CK Chan[1], SM Hou[1], CF Ng[3] , JHM Wong[2]
SH Ho Urology Centre, Division of Urology, Department of Surgery,
[1] Prince of Wales Hospital
[2] North District Hospital
[3] The Chinese University of Hong Kong

[MP.17]

Transcending from Transrectal to Transperineal Prostate Biopsy Service: Setup, Technique, Training and Results

TCF Li, HY Ngai, WH Au
Division of Urology, Department of Surgery Queen Elizabeth Hospital, Hong Kong

[MP.18]

Retropubic and Transobturator Mid-Urethral Sling for Female Stress Urinary Incontinence: Local Experience

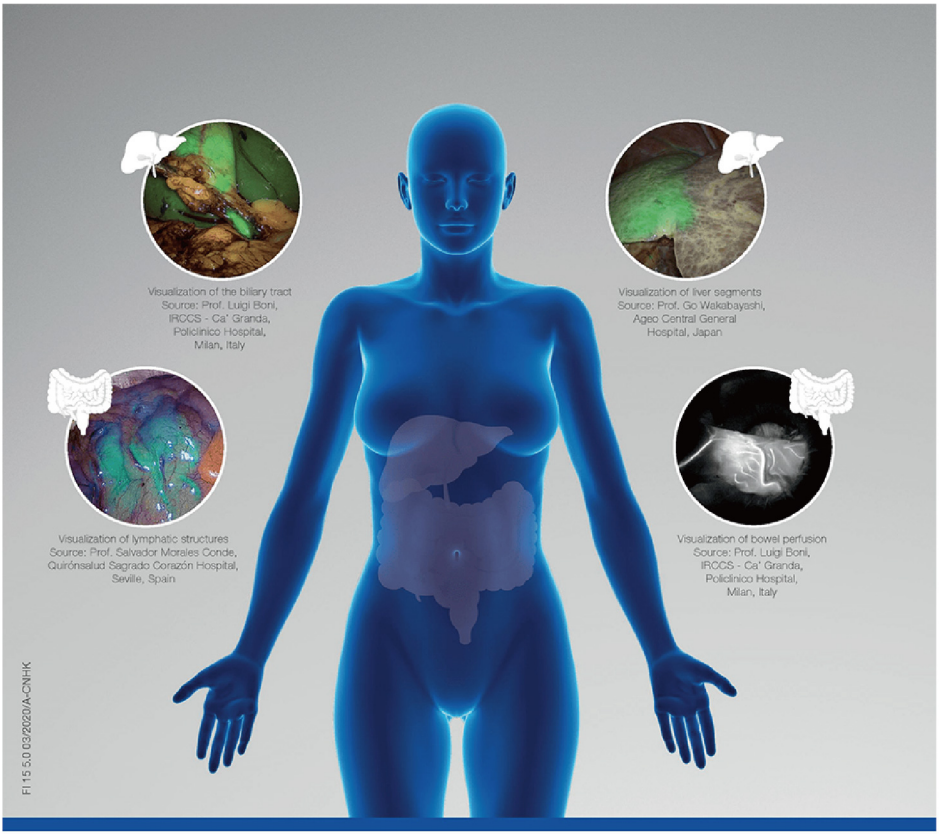
DKW Leung, KW Chan, E Tung, M Tam, CLH Leung, TCT Lai, IC Law
Division of Urology, Department of Surgery, Kwong Wah Hospital, Hong Kong

14:11-14:22
[UNS.1]
A Comparison of the Effectiveness of Using Tristel Fuse (Chlorine Dioxide) with Cidex OPA (Ortho-Phthaldehyde) as High Level Disinfection for Flexible Cystoscopes
WC Kung, KL Lui, KY Lau, YW Sy, SK Li, KW Wong, NH Chan, CM Li, CN Tang
Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

14:22-14:33
[UNS.2]
Retrospective Review of Nurse Initiated Screening Service for Patients Undergoing Transurethral Resection of Prostate (TURP)
YW Sy, KY Lau, KL Lui, WC Kung, MH Yu, CH Wong, KF Chau, SK Li, KW Wong, NH Chan, CM Li, CN Tang
Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

14:33-14:44
[UNS.3]
Enhanced Nurse Clinic Model: a Review of Prostate Specific Antigen (PSA) Triage Clinic Model in Facilitating Early Detection of Patients with Carcinoma of Prostate
MS Yim, KW Wong, PF Chak, YS Wong, YK Poon, FH Cheung, T Y Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

14:44-14:55
[UNS.4]
Telephone Reminder Service Help to Reduce Non-Attendance Rates for Flexible Cystoscopy Service in Prince of Wales Hospital (PWH) Urology Centre during COVID-19 Pandemic
KS Lo, SW Kwok, TK Ngan, WY Tang, WS Kam, WK Au, KL Yuen, CSY Li
Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong



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[OP.1-1]

Oral Presentation Group: Benign Urological diseases

Health Seeking Behaviour Of Men with Acquired Penile Curvature: A Population-Based Study

A Wong[1], CF Tsang[1], BSHo[1], ATL Ng[1], HL Tsu[1], W Lam[2]

[1] Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong

[2] Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong

Objective:

A contemporary study reported a higher prevalence of Peyronie's disease than historically considered, but not reflected in practice. This study evaluates health-seeking behaviour of men reporting an acquired penile curvature.

Patients & Methods:

A population-based survey was conducted at an ambulatory care center and university campus. Men reporting acquired penile curvature after age 16 were assessed for demographics, symptoms and health-seeking behaviour.

Results:

444/5411 men reported an acquired penile curvature. Median age was 58 years. 41% had curvature over 30o. 93% of men did not seek medical attention. Regardless of deformity severity (>45º), common reasons not to seek help were: believed it was 'normal' (65%), no treatment available (13%) and embarrassment (13%) particularly in younger men ($p = 0.03$). Health seeking was more if had reported penile injury, sexual dysfunction, and ventral curvature, independent of relationship status or if sexually active ($p = 1.00$). Men with regular clinic attendance for chronic ($p = 0.08$) or urological diseases ($p = 0.05$) were not more likely to seek help despite the opportunity. 1% of men were declined by GP for referral.

Conclusion:

Men with acquired penile curvature did not seek medical attention due to a lack of disease awareness and embarrassment, especially if young. Public education and centralized care may help.

[OP.1-2]

Oral Presentation Group: Benign Urological diseases

Feasibility of Mobile Phone-Based Acoustic Uroflowmetry

FH Cheung, CM Ng, HC To, HY Ngai, WH Au

Division of Urology, Queen Elizabeth Hospital, Kowloon, Hong Kong

Objective:

To evaluate the usefulness of a mobile phone-based acoustic uroflowmetry

Patients & Methods:

Healthy male volunteers from the urology team were recruited. U Flow Bladder Diary, a free mobile phone-based application, was used to record the intensity of the sound of urine hitting the collecting apparatus of a conventional load-cell uroflowmetry machine, which collected the urine simultaneously and acted as a reference. Flow pattern, flow time, and estimated maximal flow rate were evaluated and compared. The area under curve was standardized according to the voided volume in estimation of maximal flow rate.

Results:

A total of 15 pairs of tracings from 6 participants were included. 2 were excluded due to suboptimal tracing quality. The mean age (±SD) was 32 (±13). The estimated maximal flow rate (mean = 35.6 mL/s vs 34.1 mL/s in the reference, $p = 0.620$) and the acoustic duration (mean = 27.7s vs 25.6s, $p = 0.467$) were comparable to the reference. All tracings were bell-shaped and the flow patterns were comparable also.

Conclusion:

Mobile phone-based acoustic uroflowmetry may have a role in the assessment of the lower urinary tract of men, especially when conventional uroflowmetry is not available.

[OP.1-3]

Oral Presentation Group: Benign Urological diseases

Optimization of Care in Posterior Urethral Valve (PUV): A Pilot Study

JLY Wong, JKF Chan, SMS Wong, JHK Ngan

Dr John Ngan Adult and Paediatric Urology

Objective:

To define a better clinical algorithm for PUV patients, we performed a pilot review.

Patients & Methods:

13 Type 1 PUV confirmed on cystoscopy in 2018 were reviewed. Patients were either < 1 (group1; n = 5) or 6 - 12 (group2; n = 8) years old. All patients received cold-knife endoscopic valve ablation by a single surgeon. Follow-up was 33.8 ± 22.9 months.

Results:

Daytime enuresis (8) and urinary tract infection (6) were the main presenting symptoms. Group 1 presented uniformly with UTI, whereas group 2 with daytime enuresis. In group 2, 3 demonstrated urinary frequency and 4 showed reduced capacity by bladder diary. None had diminished maximum flow rate. Concomitant vesicoureteral reflux (4) were found only in group 1. 8 PUV were identified by VCU performed by our team. The other 5, whose VCU were mostly performed outside and deemed normal, were only identified on cystoscopy. Symptoms resolved in all patients after cold-knife ablation. None required repeat reassessment by radiology or cystoscopy.

Conclusion:

PUV presented with UTI in infancy and daytime enuresis in school-aged years. Bladder diary may be helpful to guide investigation. Uroflowmetry was non-contributory. VCU can miss significant PUV when not performed carefully. Cold knife valve ablation is safe and effective.

[OP.1-4]

Oral Presentation Group: Benign Urological diseases

Stentless Open Pyeloplasty Remains a Feasible Option for Very Young Children

J Kwok, SMS Wong, JHK Ngan

Dr John Ngan Adult and Paediatric Urology

Objective:

Unrecoverable renal function loss can occur if significant ureteropelvic junction obstruction (UPJO) is not diagnosed and treated promptly. Laparoscopic treatment, though popular, has a high reoperation rate in very young children. The usual consequence is postponement of necessary surgery, use of drain/stent, and multiple general anesthesia. We hypothesize that open pyeloplasty remains a feasible option for very young children.

Patients & Methods:

18 consecutive infants (19 kidneys) who received stentless open pyeloplasty for UPJO by a single surgeon were reviewed (M: F = 12:6). Median age and weight at pyeloplasty were 8months and 8.6kg respectively.

Results:

15/18 infants had hydronephrosis diagnosed prenatally. Median operative time was 5hours. There was no intraoperative complication. Postoperatively, feeding was resumed in 3hours. None required parenteral analgesics. Oral codeine was given in only 7 patients in hospital. Median postoperative hospital stay was 2.9days (range 1-8days). Surgical success was achieved in all 19 kidneys with 21 anaesthesia. 1/19 (5%) had urine leak and was successfully treated by ureteral stent. There was 1 age-related morbidity (pseudohypoaldosteronism), highlighting the complexity of paediatric surgical care.

Conclusion:

Open pyeloplasty in the modern era has excellent results in safety and effectiveness in very young children. Morbidity is comparable, if not better, than laparoscopic pyeloplasty.

[OP.1-5]

Oral Presentation Group: Benign Urological diseases

The Efficacy of a Transurethral Prostatic Implantable Device (Urolift®) on Lower Urinary Tract Symptoms (LUTS) and Trial Without a Catheter (TWOC) for Acute Urinary Retention in Men Secondary to Benign Prostatic Obstruction (BPO); a Prospective Single-Arm Pilot Study

VYK Poon, C H Ip, CK Chan, Y Chiu, YC Lam, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

Objectives:

The permanent transurethral implantable device (Urolift®) provides an alternative to medical therapy and conventional surgery for patients with BPO. We aim to assess the efficacy of Urolift® on men with LUTS and acute urinary retention (AUR).

Patients & Methods:

This is a prospective study recruiting men who opted for Urolift® device for suboptimal LUTS control or AUR, with prostate gland size ≤ 80 cc. The devices were placed under local anaesthesia except for the initial 3 patients. International Prostatic Symptom Score (IPSS), uroflowmetery were compared at baseline, 1 and 3 months for LUTS patients. Patients who received Urolift® for LUTS and AUR had TWOC on post-op day 1 and 7 respectively.

Results:

A total of 20 patients received Urolift® (8 for LUTS, 12 for AUR). LUTS group had a mean baseline IPSS 22, QOL 4, Qmax 8.6 mL/s, PVRU 108 mL. At 1 and 3 months, mean change in IPSS-6.1, -8.2; QOL-1.25, -1.3; Qmax+2.7, +0.44 mL/s; PVRU-12, -26 mL respectively. The TWOC success rate on post-op day 7 for the AUR group was 75%; and catheter free rates on day 14 and 28 were 67% and 83% respectively.

Conclusion:

Urolift® offers a safe and efficacious alternative to conventional treatments. There is foreseeable potential in the ambulatory surgery role.

[OP.1-6]

Oral Presentation Group: Benign Urological diseases

Local Experience of Magnetic Ureteral Double J Stenting

YH Fan, WPL Hung, F Wong, MH Yu, KF Chau, KW Wong, SK Li, CM Li

Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

Objective:

Magnetic double J stent allows removal in an office setting without the use of cystoscopy. It potentially reduces cost and stenting time due to long endoscopies waiting list. This study aims to evaluate the efficacy of magnetic double J stents and the applicability of ultrasound-guided removal of the stent in selected cases.

Patients & Methods:

This is a retrospective review of patients with Black-Star® magnetic double J stent inserted between December 2018 to August 2020. Patient demographics, tolerability, time to stent removal, positions of magnetic end and method of removal were analysed. Technique of ultrasound-guided removal of stent was introduced for cases with magnetic end located lateral to ureteric orifice from 2020 onwards.

Results:

Seventy-five patients with median age of 59 were recruited. The median time to stent removal was 8 ± 5 days. The median visual analogue score (VAS) for pain during stent removal was 3.0 ± 2.4. Four patients (5.3%) had magnetic end positioned laterally, in which one of them experienced failure of stent removal and required the use of flexible cystoscopy before introduction of our new technique. All other patients had stents retrieved successfully and none required readmission.

Conclusion:

The magnetic double J stent is both cost and time efficient and has an excellent bedside retrieval rate.

[OP.2-1]

Oral Presentation Group: Benign Urological diseases

Thulium-YAG Laser Vaporesection (Thuvrp) for Large Prostate Greater Than 80cc: A Journey from Zero Experience

CH Ip, CH Chan, Y Chiu, TY Chu, CK Chan, YK Poon, YC Lam, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

Objective:

To evaluate the initial ThuVRP results and its learning curve for men with LUTS and acute urinary retention.

Patients & Methods:

Patients with prostate size ≥ 80 cc undergoing ThuVRP at our center from June 2018 to December 2019 were studied (n = 30). The operative parameters and postoperative outcomes were evaluated regarding increase in surgeons 'experience.

Results:

Patients with mean age of 77 (range: 64 - 89) and mean prostate volume of 118.6cc (range: 80 - 250 cc) received ThuVRP, with 53.3% being catheter-dependent pre-operatively. The mean laser energy and time spent were 508.5 kJ and 64.6 minutes, respectively. The catheter-free rate was 100% post-operatively. For LUTS patients, the mean changes in functional outcome parameters at 3 and 12 months were as follow: IPSS of -10, -9; Qmax of + 12.2 mL/s, + 12.0 mL/s; PVRU of - 78.5 mL, - 109.3 mL. The mean drops in serum hemoglobin and sodium level were 0.9 g/dL and 0.8 mmol/L respectively. Early postoperative urinary incontinence rate was 13.3% at both 3 months and 6 months. The operative efficiency, in terms of mean laser time spent with respect to prostate volume, decreased with accumulating experience (0.64 min/cc in initial 10 cases vs 0.44 min/cc after 20 cases, p = 0.037), while the functional outcome improvement remained similar.

Conclusion:

Thu VRP for large prostate can provide significant functional outcome improvement and requires a relatively short learning curve.

[OP.2-2]

Oral Presentation Group: Cancer diagnosis

Detecting Bladder Tumour with a newly developed Computer-aided Endoscopic Diagnostic System

EOT Chan[1], Alan Cheuk[1], Ronald CK Chan[2], J Qin[3], CF Ng[1], JYC Teoh[1]

[1] S.H. Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong, China

[2] Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong, China

[3] Center for Smart Health, School of Nursing, The Hong Kong Polytechnic University, Hong Kong, China

Objective:

To develop a computer-aided endoscopic diagnostic system to facilitate diagnosis of bladder cancer and post-TURBT surveillance by detecting subtle bladder changes.

Patients & Methods:

Cystoscopic videos from TURBT and FC were retrieved to extract bladder images (one in every 50 frames). The extracted images were reviewed to exclude the poor quality. After exclusion, contour of bladder tumours in the images were manually annotated with a digital software. ~80% of images were used to train a deep-learning algorithm for developing the diagnostic system. The remained images were to validate the algorithm performance.

Results:

Cystoscopic videos from 210 patients who had TURBT or FC in Prince of Wales Hospital were retrieved, obtaining 8320 good quality images, including both normal and tumour images. The images were pre-processed by a segmentor to segment the tumour at pixel level and by a classifier to distinguish malignant and benign lesions at image level (Figure 1). The training dataset contained 6658 images. The validation dataset contained 1662 images. The algorithm denoted “ground truth” by green box and “prediction” by blue box (Figure 2). The AUC, accuracy and precision of the algorithm were 0.960, 0.910 and 0.870 respectively.

Conclusion:

A high-performance computer-aided endoscopic diagnostic system was developed to identify suspicious bladder changes.

[OP.2-3]

Oral Presentation Group: Cancer diagnosis

Prostate Health Index (*phi*) is an Effective Risk Stratification Tool: An Analysis of Biopsy and Cancer Diagnoses at a Median Follow-Up of 3 Years

A Cheung[1], PK Chiu[1], BS Lau[2], CC Ho[3], SY Li[1], SW Kwok[1], JY Teoh[2], CH Yee[1], CK Chan[1], SM Hou[1], WL Tang[3], WT Poon[3], CF Ng[2]

[1] Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong

[2] SH Ho Urology Centre, The Chinese University of Hong Kong

[3] Department of Pathology, Pamela Youde Nethersole Eastern Hospital, Hong Kong

Objective:

To evaluate prostate biopsy decisions and diagnosis of prostate cancer (PCa) in different *C* risk groups upon longer-term follow-up

Patients & Methods:

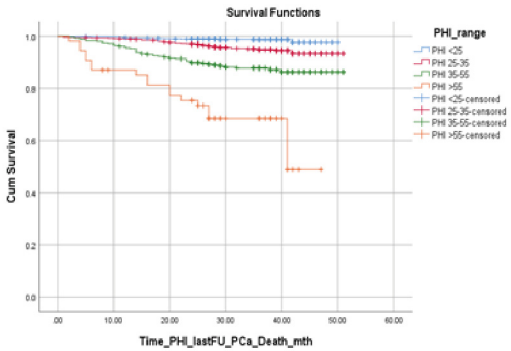
3189 men with PSA 2 - 20 ng/mL and normal DRE received a blood *phi* test from May 2016 to August 2017. 169 men were diagnosed with PCa on biopsy early after the *phi* test and were excluded from the current analysis. The remaining men with at least one repeat PSA test were included in this analysis. Kaplan Meier analysis was used to compare men who were diagnosed with PCa in different *phi* risk groups (Group1: *phi* < 25, Group 2: *phi* 25 - 34.9, Group 3: *phi* 35 - 54.9, Group 4: *phi* ≥ 55).

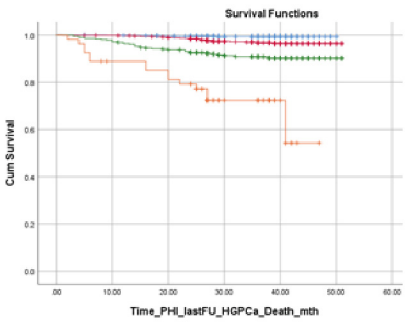
Results:

2672 consecutive men were included, with median follow-up of 36 months (IQR 26 - 39). In men with pre-biopsy MRI prostate performed, 19.3%, 26.0%, 28.8% and 66.7% in Groups 1 - 4 had PI-RADS score 4 - 5, respectively (chi-square, $p < 0.001$). Prostate biopsies were eventually performed in 11.7%, 21.8%, 35.4% and 50.0% in Groups 1 - 4 respectively within 3 years (chi-square, $p < 0.001$). A higher phi range was significantly associated with diagnosis of PCa and ISUP grade group ≥ 2 PCa. (Log-rank tests, $p < 0.001$) (Figures 1 & 2).

Conclusion:

phi is an effective risk stratification tool and predicts MRI findings, biopsy decisions, and PCa diagnosis at 3 years.





[OP.2-4]

Oral Presentation Group: Cancer diagnosis

The Combination Of PSA-Density (PSA-D) And PIRADS For More Accurate Detection of Clinically Significant Prostate Cancer In MRI-Fusion Biopsies

TWK Wong[1], HC Chan[1], CC Ngo[2], WC Lam[2], LF Lee[1], KC Cheng[1], MH Cheng[2], NH Chan[2], HS So[1]

[1] Divison of Urology, Department of Surgery, United Christian Hospital

[2] Division of Urology, Department of Surgery, Tseung Kwan O Hospital

Objective:

MRI-fusion prostate biopsies have shown to increase detection of clinically significant prostate cancers (csPC) and reduction of unnecessary biopsies compared to conventional systemic random biopsies. In our cohort, we found the detection rate of csPC was lower than international results in PI-RADS 3-5. This study shows PSA-density (PSA-D) can help increase accuracy of the P-IRADS in predicting csPC.

Patients & Methods:

From January 2017 to July 2020, 159 patients with mpMRI PIRADS ≥3 underwent MRI-fusion biopsies in UCH / TKOH, a total of 225 cores were obtained. Demographic data, PI-RADS and PSA-D levels and pathological results were recorded prospectively. Statistical analysis was performed by SPSS version 24.

Results:

The total cancer detection rates and csPC detection rates were 12.6% and 8.7% in PI-RADS3 lesions, 22.4% and 18.7% in PI-RADS4 lesions, and 85.7% and 71.4% in PI-RADS5 lesions. Logistic regressions and ROC curves were used to compare PSA density (PSA-D) and PI-RADS vs PI-RADS alone as a predictor of csCP, we found that the prior has a higher AUC curve (0.763 vs 0.643, $p < 0.05$, CI 68.7 - 83.9%).

Conclusion:

PSA-density (PSA-D) is a valuable clinical tool in addition to PI-RADS in predicting csPC in MRI-fusion biopsies. A standardized clinical pathway should be proposed in our locality.

[OP.2-5]

Oral Presentation Group: Cancer diagnosis

How Good Is Ginsburg Protocol in Cancer Diagnosis in Transperineal Prostate Biopsy?

CW Wu, TCF Li, CF Kan, WH Au

Division of Urology, Department of Surgery Queen Elizabeth Hospital, Hong Kong

Objective:

To compare the cancer detection rate (CDR) of systematic transperineal prostate biopsy under Ginsburg protocol (sTPPB) with systematic 12 core transrectal prostate biopsy (sTRPB).

Patients & Methods:

Patients with sTPPB performed in 10/2018 to 6/2020 were reviewed retrospectively, comparing to a historical cohort of sTRPB performed in 1-12/2016. 96.6% of sTPPB were done under local anaesthesia with freehand trocar technique. Patients with pre-biopsy PSA > 20 or those on active surveillance were excluded. Ginsburg protocol was adopted as the systematic biopsy regimen.

Results:

CDR for sTPPB (32.5%, 39/120 patients) was higher than sTRPB (22.7%, 81/357 patients, p = 0.032). 62.5% of positive cancer in sTPPB were Gleason grade group 1 cancer compare to 60.8% for sTRPB group.

Mean 24.4 cores (6 - 28) were taken in sTPPB group. Age and PSA density were not significantly different between the 2 group. Subgroup analysis showed significant difference in patients with repeated biopsy setting (32.3% sTPPB vs 12.5% sTRPB, p = 0.001) but not in biopsy naive patients (33.3% sTPPB vs 26.4% sTRPB, p = 0.49).

Conclusions:

CDR for sTPPB under Ginsburg protocol was higher than sTRPB at least in the repeated biopsy setting. A larger sample size was required to confirm its superiority in biopsy naive patients.

[OP.2-6]

Oral Presentation Group: Oncology

Complications of Prostate Cancer Treatment – Any Difference in Terms of Unplanned Hospital Admission?

H Chow[1], SCH Leung[1], SYS Chan[1], H Chau[2], SK Chu[2], ML Li[2], JYC Teoh[1], PKF Chiu[1], SCH Yee[1], CF Ng[1]

[1] SH Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong

[2] Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

Objective:

To review any difference in unplanned hospital admission rate due to treatment complications between radical prostatectomy and radical radiotherapy.

Patients & Methods:

Patients with prostate cancer receiving radical prostatectomy (RP) or radical radiotherapy (RT) from 2016 to 2017 were prospectively recruited in HK-Cap database. Their baseline demographics, disease staging, unplanned admission rate due to treatment complications were retrieved for review.

Results:

222 patients (113 in RP and 109 in RT) from New Territories East and West Cluster were selected with similar baseline comorbidities. RT group had significantly higher T staging disease ($p = 0.001$). 14 RT patients and 7 RP patients required emergency admissions due to treatment-related complications ($p = 0.09$) with more admission episode in RT group (mean episode 1.95 vs 1.00, $p = 0.04$) and longer hospital stay (mean 11.3 vs 1.6 days, $p = 0.19$). Per rectal bleeding ($n = 6$) and haematuria ($n = 4$) were common causes of admission in RT group, usually developed one year after treatment and required further endoscopy workup. Conversely, haematuria ($n = 3$), Foley related complications ($n = 2$) and wound complications ($n = 2$) were noted in RP group within one month after operation and self-limiting.

Conclusions:

Complications from RT were associated with more emergency admission, longer hospital stay and follow-up investigation.

[OP.2-7]

Oral Presentation Group: Oncology

The Life Journey of My Patients — an Observational Study of Patients Diagnosed with Metastatic Prostate Cancer in Hong Kong

CWH Mak[1], SCH Leung[1], SYS Chan[1], H Chau[2], SK Chu[2], ML Li[2], JYC Teoh[1], PKF Chiu[1], CF Ng[1]

[1] SH Ho Urology Centre, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong

[2] Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

Objective:

The benefit of early prostate cancer detection is controversial. However, patient's suffering from cancer-related complications may be reduced by early cancer detection. Therefore, we aim to study the disease course and complications in patients presented with metastatic prostate cancer.

Patients & Methods:

There were 100 consecutive patients (1/2016 - 8/2017) with metastatic prostate cancer on first presentation prospectively recorded in HK-Cap database. Clinical information was collected retrospectively to study the incidence of prostate cancer-related complications and the number of unplanned hospitalizations.

Results:

The mean follow-up period was 32.9 months. Prostate cancer-related mortality was 33%. Bone pain was the most common symptom (41%). Nineteen patients suffered from bone fracture and 8 patients had spinal cord compression. Twenty-eight patients suffered from retention of urine and 11 patients required long term urethral catheter. Incidence of ureteric obstruction was 15% and 8% requiring drainage. Symptomatic anaemia, haematuria and psychiatric illness were also observed.

There were 23 patients who had frequent unplanned hospital admissions (> 5). Major causes were bone pain, anaemia and haematuria.

Conclusion:

This study sheds light on the life journey of mHSPC patients. Hopefully, early cancer detection will help reduce metastatic cases on first presentation and minimize their suffering.

[OP.2-8]

Oral Presentation Group: Oncology

Peri-operative Outcomes of Intracorporeal Versus Extracorporeal Urinary Diversion Following Robotic-Assisted Radical Cystectomy: Results from the Asian RARC Consortium

EOT Chan [1], SH Kang [2], M Patel [3], S Horie [4], S Muto [4], C Ohyama [5], S Hatakeyama [5], T Chow [1], A Mok [1], H Chen [6], R Zhang [6], K Kijvikai [7], LS Lee [8,9], JYC Teoh [1], ESY Chan [1].

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[3] Department of Urology, Westmead Hospital and Discipline of Surgery, University of Sydney.
[4] Department of Urology, Juntendo University Graduate School of Medicine.
[5] Department of Urology, Hirosaki University Graduate School of Medicine.
[6] Department of Urology, Renji Hospital, Shanghai Jiaotong University School of Medicine, Shanghai, China.
[7] Department of Urology, Ramathibodi Hospital, Mahidol University, Thailand.
[8] Urology Service, Department of Surgery, Sengkang General Hospital, Sengkang, Singapore
[9] Department of Urology, Singapore General Hospital, Singapore.

Objective:

To compare peri-operative outcomes of intracorporeal urinary diversion (ICUD) versus extracorporeal urinary diversion (ECUD) following robotic-assisted radical cystectomy (RARC) in patients with bladder cancer.

Patients & Methods:

This is a retrospective, multi-centre study on patients who underwent RARC in Asia. Patient and disease characteristics, surgical approach and peri-operative outcomes were reviewed and compared between ICUD and ECUD groups. Multivariate regression analyses were performed to adjust for potential confounding factors.

Results:

501 patients from eight Asian centres underwent RARC. The mean age was 66.4 ± 9.8 years. 57.7% had ileal conduit for urinary diversion. 58.9% had ICUD. 53.1% had T2 or above disease, with 69.1% high-grade tumours and 17.6% positive pathological nodal status. The ICUD group had less blood loss (423.6 ± 367.0 vs 598.8 ± 467.8 mL, $p < 0.001$) and a shorter hospital stay (15.3 ± 11.9 vs 17.8 ± 10.5 days, $p = 0.019$) than ECUD group. Mean operative time, 30-day readmission and overall complication rates were similar between both groups. Upon multivariate regression analysis, neobladder reconstruction was associated with a longer hospitalization (Regression coefficient 5.55, $p < 0.001$). Older age (OR 1.05, $p = 0.004$) and neobladder reconstruction (OR 2.86, $p < 0.001$) were associated with a higher complication rate.

Conclusion:

RARC with ICUD was safe and technically feasible with similar operative time as ECUD, with potential benefits of reduced blood loss and shorter hospitalization.

[OP.2-9]

Oral Presentation Group: Oncology

Urinary Leakage Post Partial Nephrectomy: A 5-Year Review in Tuen Mun Hospital

CKY Chan, CH Cheng, CYK Lee, MTY Chan, LH Chau, CW Man, PSK Chu.
Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

Objective:

To evaluate the associated factors of urinary leakage for patients underwent partial nephrectomy in a local hospital.

Patients & Methods:

91 patients underwent open partial nephrectomy and 1 by laparoscopic approach in Tuen Mun Hospital from 2015 to 2019 was retrospectively studied. Patient demographics, tumour characteristics and operative procedures between patients with and without leakage were analysed with Student's T-test or Fisher's exact/Chi-square test with subsequent subgroup analysis.

Results:

8 out of 92 patients (8.7%) with mean tumour size of 4.79 cm had urine leakage while tumour size of control group was 3.89cm. Subgroup analysis of RENAL nephrometry score revealed that "R2", "L3" and hilar location status had statistically significant higher risk of urinary leakage. No significant difference was found in terms of patient characteristics (age, CCI, status of DM, hypertension and chronic kidney disease), overall RENAL score and intra-operative factors (clamping techniques, ischemia time, blood loss, ureteric stenting and renorrhaphy methods).

Conclusion:

Renal mass of size 4-7 cm or significant involvement of mid-pole or hilar tumours may have higher risk of urine leakage after partial nephrectomy. Understanding these risk factors may help us to prevent the complication timely and allow early post-operative detection and intervention of urine leakage.

[OP.2-10]

Oral Presentation Group: Oncology

Enhanced Recovery After Surgery (ERAS) For Robotic-Assisted Laparoscopic Radical Cystectomy: The Way Forward

CH Tam, Y Chiu, FH Cheung, H Chow, KC Wong, CY Ng, YK Poon, CH Ip, CK Chan, YC Lam, TY Chu, WK Ma

Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

Objective:

Enhanced Recovery After Surgery (ERAS) is a multimodal perioperative protocol to improve outcome after major surgery. The aim of this study is to evaluate the efficacy of ERAS in robotic-assisted laparoscopic radical cystectomy (RARC) since its implementation in our center in December 2017.

Patients & Methods:

Patients with RARC performed under ERAS at PMH from 1st December 2017 to 20th August 2020 were recruited. Results were compared with a historic cohort of RARC from the non-ERAS era (2015 to 2017). Patients' demographics, intra-operative and post-operative outcomes were reviewed.

Results:

Baseline characteristics were comparable in both ERAS (n = 33) and non-ERAS group (n = 12). RARC under ERAS had significantly less blood loss (500 mL vs 900 mL, p = 0.000) and required less transfusion peri-operatively (21% vs 66%, p = 0.016). Time to regain first flatus post-operatively (3.0 days vs 4.5 days, p = 0.002) and to resume normal diet were also earlier in ERAS group (8.0 days vs 9.0 days, p = 0.034). Median hospital stay was significantly shorter in ERAS patients (14.0 days vs 16.5 days, p = 0.012).

Conclusion:

ERAS programme was shown to improve both peri-operative outcomes and post-operative recovery. It is a paradigm shift in perioperative care and should be considered in all patients planning for RARC.

[OP.2-11]

Oral Presentation Group: Oncology

Outcome of Adjuvant and Salvage Radiotherapy in Patients with Pathological T3 Disease or Positive Surgical Margin after Radical Prostatectomy

HHY Lie[1], CF Tsang[1], W Lam[2], BSH Ho[1], ATL Ng[1], JHL Tsu[1]

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[2] Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong

Objective:

To review the oncological outcome of the approaches of adjuvant radiotherapy and observation in patients with adverse pathologic findings (either pT3 or positive surgical margins) after radical prostatectomy (RP)

Patients & Methods:

Patients who received RP from January 2001 to July 2017 in our centre were retrospectively reviewed. Those with adverse pathologic findings, defined as either pT3 or positive surgical margins (PSM), were further analysed. Their oncological outcomes were evaluated.

Results:

574 patients were included. 57 patients had pT3 disease and 118 had PSM. Seventeen (12.5%) received adjuvant radiotherapy (ART) whilst the rest opted for observation treatment. Of the observation group, 39 patients (32.77%) developed biochemical recurrence (BCR) and received salvage radiotherapy (SRT). In the ART group, the 5-year BCR-free survival was 82.4% and metastasis-free survival was 100%. For those who required SRT for BCR, the 5-year BCR-free survival was 61.54% and metastasis-free survival was 87.18%.

Conclusion:

Although ART may be overtreatment for some patients with adverse pathologic results after radical prostatectomy, up to 41% of those in our cohort who opted for observation eventually required SRT for BCR.

[OP.2-12]

Oral Presentation Group: Oncology

Approach to Implant Fiducial Gold Marker For Prostate Cancer: Transperineal V.S Transrectal

MWC Yu[2], KL Lo[2], DKW Leung[2], KK Yuen[1], KM Li[1], SK Mak[2], JHM Wong[2], CF Ng[1]

[1] SH Ho Urology Centre, Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong

[2] North District Hospital, Hong Kong

Objective:

Transrectal fiducial gold marker implantation enables image-guided radiotherapy for prostate cancer. We aim to investigate the outcomes of transperineal implantation against transrectal approach.

Patients & Methods:

This was a retrospective comparison between 50 transperineal cases and 25 transrectal cases in NTEC. All patients' clinical parameters (including age, PSA and prostate size), 30-day complications and readmission rates were retrieved, collected and analyzed.

Results:

Transperineal and transrectal cases were performed from 01/2019 to 12/2019 and from June 2018 to December 2018, respectively. Two groups had no statistical difference for mean age (70. 9 vs 70. 0, $p = 0.685$), mean prostate size (41.2 mL vs 39.0 mL, $p = 0.676$), median PSAlevel (8. 90 ng/dL vs 9. 30 ng/dL, $p = 0.991$), median Gleason score (7 vs 6, $p = 0.058$) and staging. For complications, no infection was observed in the transperineal group, while 4 (16%) in transrectal group developed sepsis after the procedure, requiring admission and antibiotic treatment ($p = 0.01$). No patient developed hematuria, per rectal bleeding, haematospermia or acute urinary retention requiring admission. There was no migration of fiducial gold markers in all cases.

Conclusion:

Transperineal implantation of fiducial markers prevented sepsis arised from conventional transrectal route, which will revolutionize the practice of image-guided radiotherapy for prostate cancer.

[OP.2-13]

Oral Presentation Group: Oncology

How to Manage Patients with Suspected Upper Tract Urothelial Carcinoma in the Pandemic of COVID-19?

DKW Leung[5], HY Lee[1,2,3,4], E Chan[5], CC Li[3,4], WM Li[3,4,6], HC Yeh[1,3,4], PKF Chiu5, HL Ke[3,4], CH Yee[5], JHM Wong[5], CF Ng[5], *JYC Teoh[5], *WJ Wu[3,4]

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[5] S.H. Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong, Hong Kong, China

[6] Department of Urology, Ministry of Health and Welfare Pingtung Hospital, Pingtung, Taiwan

Objective:

To evaluate the optimal treatment of upper tract urothelial cancer(UTUC) during the COVID-19 pandemic.

Patients and Methods:

In this multi-centre retrospective cohort involving PWH,NDH and two Taiwanese hospitals, patients with suspected UTUC undergoing nephroureterectomy(NU) in2000-2019 were included. Demographics,tumor factors,investigations including ureteroscopy(URS) and CT were recorded. Overall survival of early-NU(<3months from diagnosis) versus delayed-NU(≥3months) and diagnostic performance of the investigations were analysed.

Results:

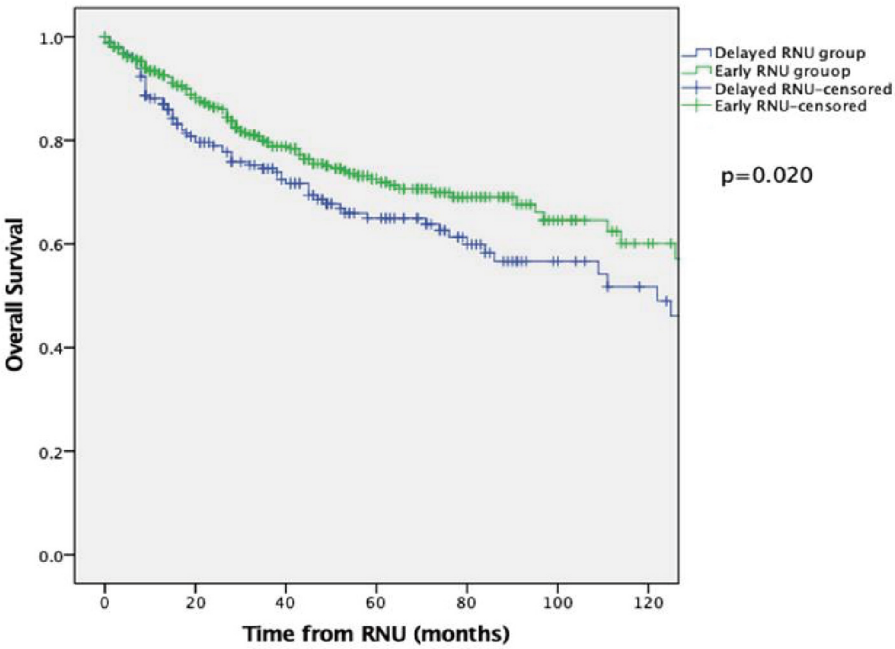
Among the 665patients, the diagnostic performance of gross hematuria, abnormal cytology-(suspicious/malignant), CT enhancing mass and URS was investigated.

The presence of all four factors including URS achieved the best diagnostic performance to predict UTUC pathology with AUC=0.851. The presence of all factors except URS achieved AUC=0.809. The presence of any two out of the three pre-URS factors achieved an AUC of over 0.7 consistently. Regardless of which model(with-or-without URS), all of the combinations (≥2 factors) achieved nearly 100%PPV and very low NPV(0.6-3.1%).

Comparing 433 early-NU and 216 delayed-NU cases, their demographics were comparable for age,gender,tumour size,multi-focality,stage,carcinoma-in-situ(CIS) and lymphovascular invasion. Early-NU had higher ASA(p=0.001) and higher tumour grading(p=0.008) than delayed-NU. Early-NU gave better overall survival than delayed-NU upon Kaplan-Meier (p=0.020) and multivariate-Cox-regression analyses.(Figure1)

Conclusion:

Omitting URS can safely expedite UTUC treatment during the COVID-19 pandemic, and early nephroureterectomy<3months resulted in better overall survival.

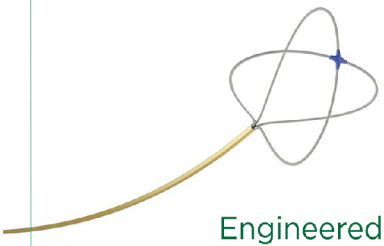


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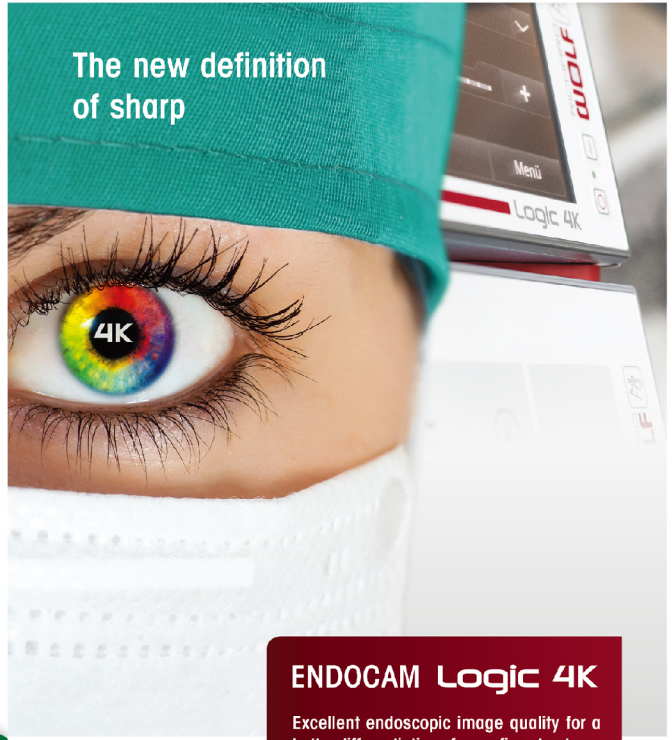
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[MP.1]

Efficacy and Safety of Desmopressin in the Chinese Population with Nocturia: A Double-Blind Randomized Placebo-Controlled Study

KC Wong, YC Lam, YC Ma, HK Lau, CH Chan, CH Tam, CY Ng, YK Poon, CH Ip, CK Chan, Y Chiu, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital

Objective:

To investigate the safety and efficacy of desmopressin in men and women with nocturia in the Chinese population.

Patients & Methods:

Men and women with nocturia (≥ 2 voids per night) were recruited. A dose-titration phase established the optimum dosage of desmopressin. Side effects were recorded for all patients who received desmopressin. Patients who agreed to join the trial were subsequently randomized to receive desmopressin or placebo. Effects were recorded after 3 weeks of treatment.

Results:

A total of 112 patients joined desmopressin titration phase. 29.5% (n = 33) of all patients who received desmopressin experienced side effects. The most common complication was dizziness (12.5%, n = 14), followed by hyponatremia (9.8%, n = 11).

Eventually, 37 patients agreed to join the RCT (20 received desmopressin, 17 received placebo). Mean number of nocturnal void reduced by 2.1 in treatment group versus 1.1 in placebo group ($p = 0.043$). Mean nocturnal urine volume decreased by 449 mL in treatment group versus 207 mL in placebo group ($p = 0.62$). Sleep and bother domains of nocturia Quality-of-Life reduced by -1.9 in treatment group versus +1.1 in placebo group ($p = 0.039$).

Conclusion:

Desmopressin is a safe and effective drug for men and women with nocturia in the Chinese population.

[MP.2]
Oncologic Outcomes of Localised Upper Urinary Tract Urothelial Carcinoma Treated with Nephroureterectomy

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[1] Division of Urology, Department of Surgery, Queen Mary Hospital, Hong Kong
[2] Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong

Objective:
To review the oncologic outcome of patients with localized upper urinary tract urothelial carcinoma (UTUC) treated with nephroureterectomy (NU).

Patients & Methods:
All patients with UTUC treated with NU between 2008 and 2019 were studied. Patient demographics, tumor details, operative data and oncologic outcomes were reviewed. Cox regression analysis was performed for factors affecting oncologic outcomes.

Results:
52 patients were included with mean age at 69 ± 10.4 and median follow-up at 39 (2-149) months. Preoperative ureteroscopy was performed in 73.1% of patients. Distal ureter was dealt with openly in 78.8%. Local recurrence, bladder recurrence, and distant metastases occurred in 9.6%, 28.8% and 36.5% respectively. Overall survival was 63.5%. Tumor stage significantly affected metastasis-free survival ($p = 0.001$), disease-specific survival ($p = 0.001$), progression-free survival ($p = 0.002$) and overall survival ($p = 0.001$) whilst smoker status worsened disease-specific survival ($p = 0.044$) and overall survival ($p = 0.041$). High grade tumor pathology and larger tumour size showed a trend towards worse disease-specific survival ($p = 0.085$ and 0.079 respectively).

Conclusion:
Tumor stage and smoker status were significant predictive factors for survival in UTUC patients undergoing NU in our cohort.

[MP.3]

10-Year Retrospective Review on Surgical Management of Extramammary Paget's Disease in a Local Hospital in Hong Kong

SK Tam, HC Chan, LF Lee, KC Cheng, HS So
Division of Urology, Department of Surgery, United Christian Hospital, Hong Kong

Objective:
To review outcomes of patients who underwent Wide Local Excision for Extramammary Paget's disease from 1/2010 to 8/2020 in United Christian Hospital.

Patients & Methods:
Nineteen patients were identified using Clinical Data Analysis Reporting System (CDARS) with Extramammary Paget's. Co-existing malignancies were excluded. Fourteen patients underwent wide local excision. Demographic data, risk factors, pathology, extent of excision margin, positive margin involvement, disease recurrence, pre-operative imaging and investigations were pooled and analyzed by SPSS version 23.

Results:
The area involved was commonly at penis, scrotum and vulva, with one case with perineal involvement. Overall survival (OS) and disease-free survival (DFS) was 100% and 92.9% with mean follow-up of 22 months. 50% of cases had skin flap or skin graft performed. No statistically significant difference in disease recurrence with excision margin $\leq$ 1 cm and > 1 cm ($p = 0.839$, Mann-Whitney U test) and with or without the positive margin involvement ($p = 6.06$ Mann-Whitney U test).

Conclusion:
Extramammary Paget's disease is a rare and indolent disease with excellent overall survival after wide local excision. Only one case had recurrence and required second wide local excision. Extent of excision margins and margin involvement had no correlation with disease recurrence in our cohort. 1cm margin should be adequate to avoid recurrence.

[MP.4]
Urologist in Spina Bifida Clinic – An Initial Experience in China

CLH Leung, HL Xia, RWM Kan, SMS Wong, JHK Ngan
MedArt

Objective:

MedArt medical team is formed by a group of doctors and other medical professionals who aim to seek and address the needs of orphaned babies in China suffering from different illnesses. Spina Bifida Clinic is one of the programs that we have started since 2013. Multidisciplinary management is required since multiple systems are involved. Urologic protocols have been established by our team to prevent urologic complications.

Patients & Methods:

We retrospectively reviewed 33 cases with spina bifida over 7 years. The median age of first presentation is 12 months (range: 6 - 56 months) and mean follow up period is 28.2 months (range: 12 - 86 months). Upon presentation, 12 of them were of high-risk bladder, 5 were of intermediate-risk and 16 were of low-risk.

Results:

3 out of 12 high-risk cases were noted to have improved after neurosurgical surgical intervention. Urodynamic studies have been useful in making the diagnosis of persistent neurosurgical problems in these children. This guided the further neurosurgical interventions which resulted in an improvement of bladder function in all 3 cases.

Conclusion:

Urology input is an essential part for assessment of children with spinal dysraphism. Close monitoring with urodynamic study is vital to prevent the complication and mortality both urologically and neurologically.

[MP.5]

Intravesical BCG Therapy for Patients with Non-Muscle Invasive Bladder Cancer

WL Chan, RWM Kan, CF Kan, TCF Li, CM Ng, HY Ngai, WH Au
Department of Surgery, Department of Surgery, Queen Elizabeth Hospital

Objectives:

To evaluate the completion rate of our 3-year course of intravesical bacillus Calmette-Guerin therapy (IVBCG), report the recurrence and progression rates of patients with non-muscle-invasive bladder cancer who underwent IVBCG, and review the outcome of patients with carcinoma-in-situ (CIS).

Patients & Methods:

Clinical data of 108 patients who underwent IVBCG from 2016 to 2019 were retrospectively reviewed.

Results:

45% of our patients were able to complete 3-year IVBCG. Overall recurrence rates at 1 year and 3 years were 14% & 18% respectively, while the overall progression rates at 1 year and 3 years were 4% and 10% respectively. The recurrence and progression rates after stratification according to risk groups were detailed in Table 1. In a sub-group analysis of patients with CIS, the progression rate at 1 year was 4%, which increased to 17% at 3 years. On the contrary, for patients with high-risk disease without carcinoma in-situ, the progression rate at 1 year was 5%, which remained steady at 7% at 3 years.

Conclusion:

The substantial risks of recurrence and progression justify a stringent and structured protocol of follow-up cystoscopy and side effect management.

TABLE 1

	Recurrence rate		Progression rate	
	1 year	3 year	1 year	3 year
Intermediate-risk disease	10%	18%	0%	8%
High-risk disease	15%	19%	5%	11%

[MP.6]

The Role of Nurse-Led Hematuria Clinic in Urothelial Cancer Detection Amid COVID-19 Pandemic

TCK Ng, CH Ip, MS Yim*, KW Wong*, PF Chak* CM Cheng, FH Cheng, CY Ng, YK Poon, CK Chan, Y Chiu, YC Lam, TY Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong
*Urology nurse

Objective:

To assess the detection rate of urothelial cancer in nurse-led hematuria clinic amid COVID-19 pandemic.

Patients & Methods:

The retrospective data of patients with microscopic or macroscopic hematuria, who were triaged to nurse-led clinic after the outbreak of COVID, between February and May 2020 (n = 200), were compared with a cohort attending the nurse-led clinic in 4 months before the pandemic (n = 237). All cases were offered full hematuria workup, including laboratory tests, imaging and cystoscopy after assessment by a specialty nurse.

Results:

The number of nurse clinics and cystoscopy sessions were reduced at the initial phase of COVID-19 pandemic. During COVID-19 outbreak, the default rate of nurse clinic was higher (24% vs 15%), more patients had private CTU (76% vs 59%), fewer patients opted for and underwent cystoscopic examination (47% vs 62% and 16% vs 46%, retrospectively). Fewer patients agreed for both CT and cystoscopy during the pandemic (38% vs 55%). Despite that, the overall cancer detection rate was similar before and during the COVID-19 pandemic (4.61% vs 4.95%, p = 0.886).

Conclusion:

The similar detection rate of urothelial cancer reflected the important role of hematuria nurse-led clinic amid COVID-19 pandemic despite the limitation of healthcare resources.

[MP.7]

Metallic Ureteral Stents in Malignant Ureteral Obstruction: Treatment Outcomes and Factors Predicting Stent Failure

YK Ng, RWM Kan, TCF Li, CM Ng, CF Kan, HY Ngai, WH Au
Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong

Objectives:

To evaluate treatment outcomes of metallic ureteral stent in patients with malignant ureteral obstruction and identify factors predicting stent failure.

Patients & Methods:

Patients with malignant ureteral obstruction treated with metallic ureteral stents between July 2013 and Jun 2020 were retrospectively evaluated. Patient overall survival, stent functional duration, failure rate and complication profile were measured and evaluated.

Results:

50 patients with malignant ureteral obstruction (65 ureteral units) were treated with metallic stents (Resonance®). Mean observation period was 10.8 months. Mean overall survival was 12.8 months (95% CI: 9.0 - 16.7). Mean functional duration of the metallic stents was 26.1 months (95% CI: 21.5 - 30.9). Stent patency rate was 89.2% at one year and 84.6% at two years. Patients with history of irradiation (HR 3.8, 95% CI: 1.1 - 13.5, $p = 0.040$) and obstruction caused by lymph node compression (HR 13.3, 95% CI: 1.2 - 149.5, $p = 0.036$) were risk factors for stent failure. Six (12%) patients reported minor complications that resolved with medical treatment.

Conclusions:

Metallic ureteral stents are safe and effective for treatment of malignant ureteral obstruction. Ureteral obstruction in patients with history of irradiation or related to lymph node compression was associated with shorter functional duration.

[MP.8]
A Single-Center Experience Of MRI-USG Fusion Targeted Biopsy of Prostate

TK Lo, TY Chan, YK Lee, CH Cheng, H Chau, CW Man, SK Chu
Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong

Objective:
To evaluate the outcome of MRI-USG fusion targeted biopsy of prostate

Patients & Methods:
All patients undergoing MRI-USG fusion targeted biopsy (TBx) of prostate in our center were prospectively reviewed. All of them had at least PIRADS 3 lesions on MRI. Systematic biopsy (SBx) was routinely performed after TBx. The pathology of TBx and SBx were compared.

Results:
Total of 47 patients and 89 target lesions were evaluated. Mean PSA was 15.1 ng/mL. Mean prostate volume was 63.1 mL. Mean number of cores taken per target was 4. Cancer was detected in 21 patients (44.7%). Cancer detection rates were 38.3% in TBx and 44.7% in SBx. The 3 additional cancer detected on SBx were either low or very low risk cancer. Combined biopsy led to upgrade of grade group in 14 patients (66.7%). Of the 89 target lesions, the cancer detection rates were 23.3%, 32.0% and 60% in PIRADS 3, 4 and 5 lesions respectively.

Conclusion:
In this cohort with relatively high PSA, TBx detects equal number of significant cancer with fewer cores required when compared to SBx. Despite only low or very low risk cancer are additionally detected on SBx, both techniques are complementary to each other as combined biopsy provides more accurate grading compared to both techniques alone.

[MP.9]

Implementation of a Nurse-Led Triage Clinic for Men with Elevated Serum Prostate Specific Antigen (PSA) in a Tertiary Center: Initial experience

FH Cheung, YK Poon, MS Yim*, KW Wong*,PF Chak*, CH Ip, CK Chan, Y Chiu, YC Lam, TY Chu, WK Ma

Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

* Urology nurse

Objective:

To evaluate the impact of a nurse-led triage clinic for men with elevated serum PSA on the diagnosis of prostate cancer and resource utilization.

Patients & Methods:

All patients with LUTS and elevated PSA of 4 – 10 ng/mL triaged to the clinic since November 2019 (n = 64) were prospectively studied. Serum Prostate Health Index (PHI), transrectal ultrasound (TRUS) sizing and counselling for multiparametric MRI (mpMRI) were performed, before attending urologist clinic. Data were compared to a matched historical cohort of patients receiving TRUS-guided prostate biopsies in 2019 (n = 69).

Results:

All patients in the PSA clinic had PHI testing (64 vs 0) with PHI > 35 detected in 39.1%. More patients had mpMRI performed (48.4% vs 1.45%) and biopsy rate was 14.1% (9/64), of which mpMRI was done in 77.8% (7/9; 4/7 were fusion biopsies). The overall cancer detection rate and proportion of clinically significant cancers were 77.8% (7/9) and 66.7% (6/9) respectively, which were much higher than that of historical cohort (27.5% or 19/69, and 5.8% or 4/69). Moreover, patients were more likely to arrange either mpMRI or biopsy earlier (mean time = 35.4 days vs. 91.6 days).

Conclusion:

Nurse-led PSA-triage clinic streamlines prostate cancer diagnosis and improves detection of clinically significant prostate cancers.

[MP.10]
Use of Infrared Illumination System (IRIS) for Ureteral Catherization to Reduce Ureteric Injury

AMH Yeung, CH Cheng, LH Chau, SK Chu, CW Man
Division of Urology, Department of surgery, Tuen Mun Hospital, Hong Kong

Objective:
To evaluate the use of infrared illumination system (IRIS) for ureteric catherization in high-risk pelvic surgery to reduce ureteric injury.

Patients & Methods:
A case of 70-year-old lady with history of pelvic abscess secondary to perforated sigmoid cancer was chosen for pre-operative bilateral IRIS stenting for laparoscopic sigmoidectomy and hysterectomy.

Results:
Uneventful procedure with easy identification of bilateral ureters under direct vision from laparoscope. Ureteric injury was avoided by careful dissection with guidance with IRIS. No complication was reported up till latest follow up at 4-month post-operation.

Conclusion:
IRIS may be a way to potentially reduce ureteric injuries in laparoscopic pelvic surgery. However, ureteric stenting is not without risk, and it is also known that they will hinder manipulation of the ureter. Therefore, pre-operative stenting should only be considered in selected high-risk cases instead of a routine procedure. Up till now, there is still no concrete evidence that ureteric stenting can prevent ureteric injury. More prospective trials are required to evaluate the use of IRIS to reduce ureteric injury.

[MP.11]

A Single-Centre Retrospective Review on Laparoscopic Partial Nephrectomy

AMH Yeung, TTC Chan, WKW Chan
Division of Urology, Department of Surgery, Kwong Wah Hospital

Objective:

Laparoscopic partial nephrectomy is a known effective and safe treatment modality managing small renal mass. We evaluated a single centre experience and report the results on laparoscopic partial nephrectomy.

Patients & Methods:

A retrospective review of 38 patients in a single centre with laparoscopic partial nephrectomies performed during 2014-2019 for small renal masses. Both transperitoneal and retroperitoneal approach procedures were included. Outcome measures included operative time, ischemic time, deterioration in renal function, blood loss, transfusion rate, positive resection margin, morbidity, mortality.

Results:

Overall complication rates were 34.2%. All complication reported was Clavian-Dindo Classification grade 2 or below. No patients ended up in chronic renal failure requiring dialysis. No mortality was reported.

Conclusion:

Laparoscopic partial nephrectomy may be an effective option in managing small renal mass. It offers the advantages of minimally invasive surgery with shorter length of stay, rapid recovery, without compromising oncological outcomes.

[MP.12]

Ureteric Stent Removal by String to Reduce Flexible Cystoscopy Case Load During COVID-19 Pandemic

A Cheung[1], KL Lo[1], CWH Mak[1], SKK Yuen[1], SYS Chan[1], JKM Li[1], SK Mak1, JHM Wong[1], CK Chan[1], CF Ng[2]

[1] NTEC Urology, Department of Surgery, North District Hospital

[2] SH Ho Urology Centre, Department of Surgery, the Chinese University of Hong Kong

Objective:

Post-operative ureteric stent removal constitutes around 20% of the flexible cystoscopy caseload in North District Hospital. This study aims to explore the safety and feasibility of ureteric stent removal by string as a bedside procedure in our locality.

Patients & Methods:

Patients undergoing elective URSL with complete ureteric stone clearance planned for ureteric stent insertion post-operation were recruited. Patients with intra-operative ureteric injuries or those needing prolonged ureteric stent placement were excluded. Patients were followed up for any complications after bedside stent removal.

Results:

Four patients were recruited into the study. Stents were removed on day 1 to day 30 post-operation. All ureteric stents were removed by string uneventfully as a bedside procedure. None of the patients required hospital readmissions, outpatient clinic or emergency department attendance after stent removal.

Conclusion:

Ureteric stent removal by string is a safe alternative which may significantly reduce flexible cystoscopy caseload and minimize patient flow in endoscopy centre, which is of particular importance in times of COVID-19.

[MP.13]

A Successful Salvage of an Infected Inflatable Penile Prosthesis (IPP) Without Explantation:

A Case Report

WPL Hung, YH Fan, FWong, JMH Yu, KF Chau, KW Wong, SK Li, SK Li, CM Li
Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

Objective:

To report a case of complication after insertion of an inflatable penile prosthesis (IPP), review the literature and our experience on the management of penile prosthesis infection.

Patients & Methods:

This is a retrospective review of a patient who underwent IPP for erectile dysfunction and complicated with infected unhealed scrotal wound with persistent discharge.

Results:

IPP (AMS 700CX) was implanted in the patient. He developed infected scrotal wound with serous discharge six weeks postoperatively, with no clinical improvement despite antibiotics and wound dressing. Exploration of wound two weeks later showed infected site located anterior to pump with cavity formation filled with serous discharge. Cylinders and reservoir were not exposed, and no frank pus was noted intraoperatively. Unhealthy wound edge was excised, and cavity was irrigated with aqueous hibitane, hydrogen peroxide solution and antibiotics solution. The same pump was placed back to cavity with primary wound closure. The patient recovered eventually and started intercourse with satisfaction a year after operation.

Conclusion:

Explanation with or without salvage procedure remains the mainstay of management for infected IPP. Conservative management with surgical toileting and re-using of the same implant in selected cases, however, may serve as a viable alternative.

[MP.14]

Laparoscopic Repair of Paediatric Inguinal Hernia – The Kwong Wah Hospital Experience

IC Law, KW Chan, TH Leung
Division of Urology, Department of Surgery, Kwong Wah Hospital, Hong Kong

Objective:

The traditional open approach for paediatric inguinal hernia repair has been used for decades due to surgeons' familiarity and historically high success rates. With increase in the use of minimally invasive techniques; the laparoscopic approach has become a popular alternative. This presentation aims to evaluate the single-centre experience of the laparoscopic approach over an 18-month period with an emphasis on its safety and feasibility.

Patients & Methods:

A total of 28 cases of laparoscopic inguinal hernia repair were performed between January 2018 and July 2020. Data including patient age, laterality, operating time, reported complications, recurrence and associated hydroceles or cryptorchidism were acquired from patient records and analysed.

Results:

The median age of the patient group was 4 years old (25 males, 3 females). All were indirect inguinal hernias; 15 were right-sided; 8 left-sided and 5 were bilateral. 8 were associated with congenital hydrocele and 2 were associated with undescended testes. Mean operating time was 84 minutes (range 41 - 177 mins). None of the cases reported complications and 3 cases had recurrence requiring a second operation.

Conclusion:

Inguinal hernia is one of the most common pediatric urological conditions encountered and the laparoscopic approach for inguinal hernia repair is a safe and feasible alternative to the open approach.



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DIP-HK-000160 September 2020

[MP.15]
Robot-Assisted Ureteroplasty with Buccal Mucosal Graft – Illustration of Technique and our Initial Experience

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Objective:
Management of ureteric stricture can be challenging, especially for strictures involving a long segment in the proximal to mid ureter. We aimed to demonstrate our initial experience and technique of robot-assisted ureteroplasty with buccal mucosal graft.

Patients & methods:
All patients were symptomatic with diagnosis confirmed on CT urogram and retrograde ureteropyelogram. MAG-3 diuresis renogram confirmed obstruction, with a differential renal function of over 20%. A step-by-step description of our technique is demonstrated.

Results:
Patients underwent cystoscopy and insertion of a ureteric access sheath to enable intra-operative access into the ureter endoscopically during the procedure. Ureteric stricture sites were precisely identified using both indocyanine green and real-time retrograde flexible ureteroscopy. Non-transecting dorsal incision of the ureter was made at the level of strictures in this series. Onlay buccal mucosal grafts were used to cover the defect together with an omental wrap. Patients had an uneventful recovery and were discharged on post-operative day 1 or 2. Ureteric stent was removed 6 weeks post-operatively, and MAG-3 diuresis renogram at 3 months showed no evidence of obstruction. All patients remained symptom free at 1 year post-operatively.

Conclusion:
Buccal mucosal graft ureteroplasty appears to be a safe and feasible minimally invasive surgical treatment option for patients with ureteric stricture.

[MP.16]

Retroperitoneal Laparoscopic and Robotic Partial Nephrectomy: A Comparison with the Transperitoneal Approach

DKW Leung[2], SKK Yuen[2], KM Li[2], HM Tam[1], KL Lo[2], JYC Teoh[3], SK Mak[2], KF Chiu[1], CH Yee[1], CK Chan[1], SM Hou[1], CF Ng[3] , JHM Wong[2]
SH Ho Urology Centre, Division of Urology, Department of Surgery,
[1] Prince of Wales Hospital
[2] North District Hospital
[3] The Chinese University of Hong Kong[3]

Objective:

To compare retroperitoneal approach (REPN) against transperitoneal approach (TRPN) for laparoscopic or robotic partial nephrectomy.

Patients & Methods:

Consecutive cases of renal tumors treated with REPN and TRPN in NDH&PWH during 2005-2019 were included. Their baseline demographics, tumor factors and clinical outcomes were compared using Mann-Whitney U, Chi-squared and Fisher exact tests where appropriate.

Results:

Among the 186 laparoscopic and robotic PN, 50 were retroperitoneal and 136 were transperitoneal. Their baseline characteristics including age,tumor size,T-stage and RENAL score (median7) were comparable, except more ASA≥3 in TRPN (23.5%vs8%;p=0.02). REPN had significantly more posterior tumors (76%vs20%;p<0.001) and less malignant pathology than TRPN (70%vs83.1%;p=0.05).

REPN had shorter operative time(181 vs 220min;p=0.002) and shorter ischemic time(17 vs 27min;p=0.022) than TRPN. Blood loss and open conversion rates (TRPN3.5% vs REPN5.7%) were similar in both groups.

Postoperatively, REPN had a trend towards less bleeding(4%vs14%;p=0.057), similar urine leak (2%vs1.5%;p=1), and significantly less Clavien≥3 complications (2%vs12.5%;p=0.046) than TRPN. REPN group had significantly shorter hospital stay than TRPN group(4vs5 days;p=0.001). For malignant pathology, both groups attained low positive margin rates(REPN0% vs TRPN2.7%;p=1).

Conclusion:

For selected cases, particularly posterior tumors, retroperitoneal PN can achieve shorter operative time and ischemic time, superior safety profile and shorter hospital stay compared to transperitoneal PN.

[MP.17]

Transcending from Transrectal to Transperineal Prostate Biopsy Service: Setup, Technique, Training and Results

TCF Li, HY Ngai, WH Au
Division of Urology, Department of Surgery Queen Elizabeth Hospital, Hong Kong

Objective:

To share our experience in setting up transperineal prostate biopsy (TPPB) service from scratch to replace transrectal prostate biopsy (TRPB) service.

Patients & Methods:

With a transition period of more than 1 year, TPPB have completely replaced TRPB since 2/2020 in our centre to avoid surge of infective complications in TRPB. Process of equipment sourcing, nurse training, collaborations with microbiologist and pathologist, biopsy technique development, surgeon's training and auditing were undergone in this period. Ginsburg protocol was adopted for the systematic biopsy regimen. All cases were performed by freehand trocar method under local anaesthesia except for the initial 5 cases.

Results:

159 patient undergone TPPB from 10/2018 to 6/2020, 43% with targeted biopsy performed mostly by software assisted cognitive fusion technique. Overall Cancer detection rate was 38.6%. 1.3% experienced infective complications subsided with augmentin and 3% urinary retention rate recorded. Mean VAS was 2.85/10. With mentorship the procedural time dropped from ~ 60mins initially to ~ 30 mins after first 5-10 cases.

Conclusions:

Collaboration of multiple parties were required for smooth transition from transrectal to transperineal prostate biopsy service. Freehand trocar method allowed the most economic way of biopsy with good patient tolerance and acceptable learning curve.

[MP.18]

Retropubic and Transobturator Mid-Urethral Sling for Female Stress Urinary Incontinence : Local Experience

DKW Leung, KW Chan, E Tung, M Tam, CLH Leung, TCT Lai, IC Law
Division of Urology, Department of Surgery, Kwong Wah Hospital, Hong Kong

Objective:

To review and compare results of retropubic (TVT) and transobturator (TOT) mid-urethral sling (MUS) for female stress urinary incontinence (SUI) in Kwong Wah Hospital (KWH).

Patients and Methods:

Thirteen female patients with TVT and nine with TOT performed for SUI in KWH were included from 2015 to 2019. Their demographics, symptoms, subjective and objective outcomes and postoperative complications were compared.

Results:

Among the recruited cases, the mean follow-up duration was 87 weeks and mean hospital stay was 2.3 +/- 1.3 days. The mean operative time was comparable (TVT 43min vs TOT 49min; p=0.093).

Postoperatively, the objective dry rates by 1-hour pad test were 100% for both groups, whereas the subjective dry rates were 84.6% for TVT and 88.9% for TOT respectively (p=0.796). There was one case of intraoperative bladder injury managed conservatively in the TVT group. Otherwise, the two groups showed nil significant difference in complication rates for de novo urgency, infection, dyspareunia, pain or numbness. There was no incidence of mesh erosion for all the patients during follow-up.

Conclusion:

For selected patients with SUI, both retropubic and transobturator approaches could successfully implant MUS with satisfactory clinical outcomes. The treatment of choice depends on patient's preference and surgical experience.

[UNS.1]

A Comparison of the Effectiveness of Using Tristel Fuse (Chlorine Dioxide) with Cidex OPA (Ortho-Phthaldehyde) as High Level Disinfection for Flexible Cystoscopes

WC Kung, KL Lui, KY Lau, YW Sy, SK Li, KW Wong, NH Chan, CM Li, CN Tang
Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

Objective:

To compare the effectiveness of Tristel Fuse with Cidex OPA for clinical efficacy, safety, cost-effectiveness and ease-of-use for high-level disinfection after flexible cystoscopy.

Patients & Methods:

Participants were recruited if they were arranged flexible cystoscope for diagnostic purposes. All patients provided written informed consent, and had negative MSU, no symptoms of UTI, no specific indication for parenteral antibiotic prophylaxis, no current indwelling urinary catheter and no recent urogenital tract surgery. If the patient required cystoscopic biopsy were excluded. The clinical endpoints used included the rate of UTIs 3 days after cystoscopy, microbiological- & cost-effectiveness.

Results:

280 participants were recruited from October 2019 to December 2019 and the mean age was 72.4 years, 34% were females. The urine analysis was positive with symptomatic UTI in 5% of patients in (Tristel) group and 5.4% of patients in (Cidex) group ($p = 0.05$). The turnover (minutes per cycle) was 44.1 (Tristel) vs 9.8 (Cidex). The pre-procedure costs were $90.4 (Tristel) and $169.1 (Cidex).

Conclusion:

Given that the agent is microbiologically equivalent to Cidex OPA, Tristel Fuse appears to be more cost-effective and user-friendly than Cidex OPA, and that the patient throughput is more rapid, Tristel Fuse may become an agent of choice for high-level disinfection of flexible cystoscopes.

[UNS.2]

Retrospective Review of Nurse Initiated Screening Service for Patients Undergoing Transurethral Resection of Prostate (TURP)

YW Sy, KY Lau, KL Lui, WC Kung, MH Yu, CH Wong, KF Chau, SK Li, KW Wong, NH Chan, CM Li, CN Tang
Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

Objective:

The objective is to evaluate the impact of new service in management of patients with BPH required surgical treatment.

Patients & Methods:

A new operating protocol for BPH patients has been commenced in January 2019. Patients eligible for TURP are chosen by urologist & the screening is performed by urology nurses. Video of TURP surgery was showed to patient with briefly explanation. Prostate size was also measured with pre-op education given. Screening on patient's medical history was conducted to determine the necessary of seeking medical assessment in order to optimize the medical condition before surgery.

Results:

220 patients were undergoing nurse-initiated screening service since January 2019. Compared with patients before the service, the cancellation rate of TURP reduced from 2.2% to 1.1%, and the utilization rate of operation theatre for TURP surgery was increased from 88.6% to 97.6%. In addition, the waiting time for TURP patients can be shortened from 6 weeks to 3 weeks. Moreover, the mean length of stay for TURP patients was reduced from 2.58 days to 2.3 days, and the unplanned admission rate decreased from 9.7% to 4.7%.

Conclusion:

Conducting the nurse-initiated screening service for patients undergoing TURP allows better patients preparation and minimizes last-minute cancellation of operation.

[UNS.3]

Enhanced Nurse Clinic Model: a Review of Prostate Specific Antigen (PSA) Triage Clinic Model in Facilitating Early Detection of Patients with Carcinoma of Prostate

MS Yim, KW Wong, PF Chak, YS Wong, YK Poon, FH Cheung, T Y Chu, WK Ma
Division of Urology, Department of Surgery, Princess Margaret Hospital, Hong Kong

Objectives:

Review of effectiveness of PSA triage clinic model in facilitating early detection of patient with Ca Prostate. Fast tract of patient with elevated PSA of 4 - 10 ng/ml referral from Urologist according to established nurse clinic model.

Patient and Methods:

A PSA triage clinic model was established by Chief Urology Consultant and urology clinic nurses and implementation since November 2019. According to the model, patients need to be assessed within 3 weeks and need to attend two clinic sessions. Nurses performed initial assessment and arrange primary workup for patients. Nurses will refer patient to urologist according to PSA triage model. Low risk cases will be referred back to nurse clinic for monitoring of PSA level.

Results:

Total 250 patients had attended PSA clinic (till 30th July 2020). All patients with PHI taken. 30% of patient had taken MRI prostate after counselling and 55% of patients have PIRADS 3 or above lesions. As compared to prostate biopsy data in 2019, PSA clinic has brought about much higher rate of pre-biopsy MRI examination, and many unnecessary biopsies are saved.

Conclusion:

PSA triage clinic model has effectively facilitating early detection of patient with Ca Prostate and prevention of unnecessary prostate biopsies.

[UNS.4]

Telephone Reminder Service Help to Reduce Non-Attendance Rates for Flexible Cystoscopy Service in Prince of Wales Hospital (PWH) Urology Centre during COVID-19 Pandemic

KS Lo, SW Kwok, TK Ngan, WY Tang, WS Kam, WK Au, KL Yuen, CSY Li
Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong

Objectives:

Flexible cystoscopy (FC) is a common diagnostic procedure in urology. In Prince of Wales Hospital, more than 2000 cystoscopies performed each year. This resulted in a long waiting time and non-attendance (defaulted). During COVID-19 pandemic, patient called to our centre for reschedule/cancellation of FC appointment. We provide a telephone reminder service to patients for reduce non-attendance rate during COVID-19 pandemic.

Patient and Methods:

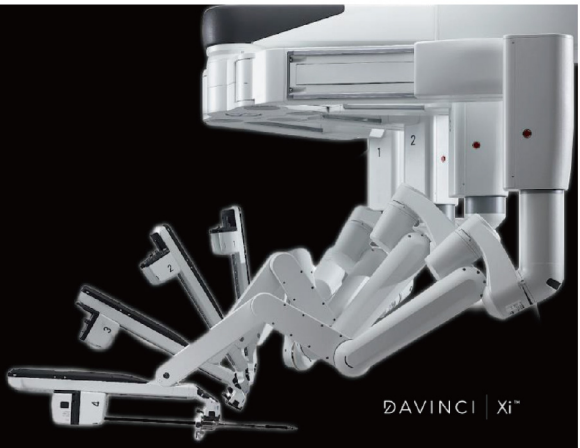
A retrospective review on patient with FC booked from Aug 2018 to Feb 2020 (N = 3,037). Patients with FC from Mar 2020 to Aug 2020 (N = 1,338) was phone contacted within 1 week before their appointment. Patients not shown up on appointment date was regarded as defaulted.

Results:

After telephone reminder service launched, the non-attendance rate was 6% compared to 11% for non-telephoned patient ($p < 0.0001$). During telephone patient, 19% patients requested to reschedule/cancel their appointments.

Conclusion:

The non-attendance maybe due to COVID-19 pandemic or case sensitive, but this was not investigated in this study. Telephone reminder service can significantly reduce non-attendance rate. Calling patients and reschedule appointment may increase workload, but the slot can be effectively utilised by other patients. This gives a substantial net benefit to the centre.



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References: 1. ERLEADA™ Hong Kong prescribing information. 2. Chi KN, et al. N Engl J Med. 2019;381(1):13-24. 3. Chi KN, et al. N Engl J Med. 2019;381(1):13-24. Supplementary information.

Erleada™ Tablets 60mg ABBREVIATED PRESCRIBING INFORMATION

ACTIVE INGREDIENT(S): Apalutamide **INDICATION(S):** ERLEADA is indicated for the treatment of patients with metastatic castration-sensitive prostate cancer (mCSPC) or non-metastatic, castration-resistant prostate cancer (nM-CRPC) **DOSAGE & ADMINISTRATION:** Recommended dose is 240 mg (four 60 mg tablets) administered orally once daily. Swallow the tablets whole. Taken with or without food. **CONTRAINDICATIONS:** None. **SPECIAL WARNINGS & PRECAUTIONS:** Ischemic Cerebrovascular Events: Subjects with cerebrovascular events, including events leading to fatal outcomes, in patients treated with ERLEADA. Monitor for signs and symptoms of ischemic heart disease. Optimize management of cardiovascular risk factors, such as hypertension, diabetes, or dyslipidemia. Consider discontinuation for Grade 3 and 4 events. Fractures: Evaluate patients for fracture risk. Monitor and manage patients at risk for fractures according to established treatment guidelines and consider use of bone-targeted agents. Falls: Evaluate patients for fall risk. Seizure: Permanently discontinue ERLEADA in patients who develop a seizure during treatment. Embryo-Fetal Toxicity: Advise males with female partners of reproductive potential to use effective contraception during treatment and for 3 months after the last dose of ERLEADA **SIDE EFFECTS:** Ischemic Cardiovascular Events, Fractures, Falls, Seizure, Fatigue, Asthenia, Rash, Hypothyroidism, Decreased appetite, Weight decreased, Hypertension, Hot flush, Diarrhea. Refer to the full prescribing information for other side effects. **PREGNANCY & LACTATION:** ERLEADA can cause fetal harm and loss of pregnancy. If it is not indicated for use in females. **INTERACTIONS:** Weak and Moderate CYP2C8 Inducers: Avoid concomitant use of ERLEADA with weak or moderate CYP2C8 inducers. Dose adjustment of ERLEADA may be needed based on tolerability. Strong CYP2C8 Inducers: Avoid concomitant use of ERLEADA with strong CYP2C8 inducers. Substitution for CYP3A4, CYP2C9, CYP2C19 is not warranted. Use caution if substrates of UGT enzymes are co-administered with ERLEADA. **PLEASE REFER TO FULL PRESCRIBING INFORMATION BEFORE PRESCRIBING.** Erleada AP ver2.0

CP19APR 30.12.2020 ALL SIB

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KEYTRUDA®
(pembrolizumab)

GIVE YOUR PATIENTS A KEY TO TREATING ADVANCED UROTHELIAL CARCINOMA

FIRST-LINE MONOTHERAPY

- CISPLATIN INELIGIBLE treatment in locally advanced or mUC

SECOND-LINE MONOTHERAPY

- POST–PLATINUM FAILURE or greater treatment in locally advanced or mUC
- The **ONLY** checkpoint inhibitors recommended as a Preferred regimen with **Category 1 level Evidence in NCCN Guideline**

KEYTRUDA® (pembrolizumab) is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma (mUC) who are not eligible for cisplatin-containing chemotherapy and whose tumors express PD-L1 [Combined Positive Score (CPS) ≥10] as determined by a validated test, or in patients who are not eligible for any platinum-containing chemotherapy regardless of PD-L1 status.

KEYTRUDA is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma (mUC) who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

Selected Safety Information for KEYTRUDA (pembrolizumab)

Indications: • Melanoma: **KEYTRUDA**, pembrolizumab, is indicated for the treatment of patients with unresectable or metastatic melanoma. • Non-Small Cell Lung Cancer: **KEYTRUDA**, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of patients with metastatic nonsquamous non-small cell lung cancer (NSCLC), with no EGFR or ALK genomic tumor aberrations. **KEYTRUDA**, as a single agent, is indicated for the first-line treatment of patients with metastatic NSCLC whose tumors have high PD-L1 expression (Tumor Proportion Score (TPS) ≥50%) as determined by a validated test, with no EGFR or ALK genomic tumor aberrations. **KEYTRUDA**, as a single agent, is indicated for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS≥1%) as determined by a validated test, with no EGFR or ALK genomic tumor aberrations and who have disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving **KEYTRUDA**. • Head and Neck Squamous Cell Cancer: **KEYTRUDA** is indicated for the treatment of patients with recurrent or metastatic head and neck squamous cell cancer (HNSCC) with disease progression on or after platinum-containing chemotherapy. • Classical Hodgkin Lymphoma: **KEYTRUDA** is indicated for the treatment of patients with refractory classical Hodgkin lymphoma (cHL), or who have relapsed after 3 or more prior lines of therapy. • Urothelial Carcinoma: **KEYTRUDA** is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. • Microsatellite Instability-High Cancer: **KEYTRUDA** is indicated for the treatment of adult patients with unresectable or metastatic, microsatellite instability-high (MSI-H) solid tumors as determined by an FDA-approved test, that have progressed following prior treatment and who have no satisfactory alternative treatment options. • Gastric Cancer: **KEYTRUDA** is indicated for the treatment of adult patients with recurrent locally advanced or metastatic gastric or gastroesophageal junction (GEJ) adenocarcinoma whose tumors express PD-L1 (CPS ≥1) as determined by an FDA-approved test, with disease progression on or after two or more prior lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy and if appropriate, HER2/neu-targeted therapy. • Cervical Cancer: **KEYTRUDA** is indicated for the treatment of patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy whose tumors express PD-L1 (CPS ≥1) as determined by an FDA-approved test. • Esophageal Cancer: **KEYTRUDA** is indicated for the treatment of patients with recurrent locally advanced or metastatic esophageal cancer (EC) or who are transplant ineligible and have failed for disease progression after one or more prior lines of therapy. • Primary Mediastinal Large B-cell Lymphoma: **KEYTRUDA** is indicated for the treatment of adult patients with refractory primary mediastinal large B-cell lymphoma (PMBCL), or who have relapsed after two or more prior lines of therapy.

Dosage and Administration: • Melanoma: 2 mg/kg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity. • NSCLC: In combination with pemetrexed and platinum chemotherapy or as a single agent for metastatic NSCLC patients that received prior treatment with chemotherapy, 200 mg. When administering **KEYTRUDA** in combination with chemotherapy, it should be administered prior to chemotherapy when given on the same day. As a single agent for metastatic NSCLC patients that had been previously treated with chemotherapy, 2 mg/kg. **KEYTRUDA** should be administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression. • Urothelial Carcinoma: 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression. • Classical Hodgkin Lymphoma: 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity or up to 24 months in patients without disease progression. **Contraindications:** None **Precautions:** • Immune Mediated Pneumonitis • Immune Mediated Colitis • Immune Mediated Hepatitis • Immune Mediated Endocrinopathies: Hypophysitis, hypothyroidism and hyperthyroidism, hypothyroidism and hyperthyroidism, Type 1 diabetes • Immune Mediated Nephritis and Renal Dysfunction • Immune Mediated Skin Adverse Reactions: SJS, TEN, cutaneous dermatitis or bullous pemphigoid • Other Immune Mediated Adverse Reactions • Infusion Related Reactions (including hypersensitivity and anaphylaxis) • Complications of Allogeneic HSCT in Patients with Allogeneic HSCT prior to **KEYTRUDA** treatment • Increased Mortality in Patients with Multiple Myeloma • Embryofetal Toxicity • For detailed precautions, please consult the full prescribing information. **Adverse Events:** Most common adverse reactions reported in ≥20% of patients when Keytruda was used as a single agent were fatigue, musculoskeletal pain, decreased appetite, pruritus, diarrhea, nausea, rash, pneumonia, cough, dyspnea, constipation, pain, and abdominal pain. When Keytruda was used in combination with pemetrexed and cisplatin, chemotherapy were fatigue/asthenia, nausea, constipation, diarrhea, vomiting, cough, dyspnea, and pyrexia. • Immune mediated pneumonitis • Immune mediated colitis • Immune-mediated hepatitis • Immune-mediated nephritis and renal dysfunction • Immune-Mediated Skin Adverse Reactions SJS, TEN, cutaneous dermatitis or bullous pemphigoid • Other immune-mediated adverse reactions • Infusion-related reactions • As with all therapeutic proteins, there is the potential for immunogenicity. For detailed adverse events, please consult the full prescribing information. *Before prescribing, please consult the full prescribing information.*

Before prescribing, please consult the full prescribing information.

Reference: 1. KEYTRUDA Product Circular. MSD Hong Kong. 2 Bladder Cancer (2019). NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Version 4, 2019

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