

CUA 2022 Annual Meeting Abstracts – Poster Session 11: EDI, COVID, Patient Relations

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MP-11.1

Evaluation the outcome of urological phone consultation during COVID-19 pandemic

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Introduction: We aimed to assess patient satisfaction of conversion to phone consultation in urology clinic during the COVID-19 pandemic, and to investigate potential patient complaints that could be handled as phone consultations in the future.

Methods: We conducted a retrospective review for new urological teleconsultations between April 2020 and September 2020 at our institute. A telephone interview was conducted with potential participants who were invited to answer a designed questionnaire. The questionnaire included nine questions covering patient satisfaction, quality of educational information, confidentiality, ability to share sensitive information, efficacy in absence of physical examination, overall acceptance, and preference of future teleconsultation regarding time and cost saving. Patients' responses were scaled using a five-point Likert scale (1=strongly disagree to 5=strongly agree).

Results: After screening and assessment, 770 of 864 (89.1%) patients fulfilled the inclusion criteria; 94 (10.9%) were excluded due to hearing impairment or age under 18. Forty-two (5.5%) refused to participate, 310 (40.3%) of the patients could not be reached by phone, and eventually 307 (39.9%) completed the questionnaire. The highest percentage of agreement (94.4%) was among those who felt consultation was private and confidential. The lowest agreement was found in the question relating to the ability of the physician to do the job without physical exam (72.3%). A total of 204 (66.4%) patients agreed to future teleconsultation regarding time and cost savings (Table 1). On multivariate analysis, irritative lower urinary symptoms was the only independent factor associate with high degree of satisfaction ($p=0.02$) and wish for future teleconsultation ($p=0.03$).

Conclusions: Urological teleconsultation is a feasible option during travel restrictions, as during COVID-19 pandemic. Two-thirds of patients agree to future teleconsultation. For one-third of patients, the inability to perform physical examinations is a concern.

MP-11.5

Quality improvement of surgical team communication of required percutaneous nephrolithotomy equipment

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Introduction: Percutaneous nephrolithotomy (PCNL) allows for a range of instruments within the urologist's armamentarium. Case-to-case variation creates challenges within the operating room. Appropriate communication can help ensure safe, efficient, and cost-effective patient care. The goal of our study was to first perform a quality assessment of equipment communication. Second, we identified and assessed a target intervention to improve communication and surgical case cost.

Methods: We administered 45 prospective (30 baseline, 15 post-intervention) questionnaires to multidisciplinary endourology members involved in ≥ 3 PCNL cases between August 1, 2021, and October 30, 2021. The primary objective was postoperative perception of communication regarding equipment (Likert scale: 1-poor, 10-perfect). A real-time, editable equipment whiteboard was designed and implemented with post-intervention provider surveys. The relative difference in pre- and post-intervention equipment accuracy, as well as overall case costing, was compared 30 days prior to implementation to the period after the intervention. Comparisons used Fisher's exact test ($p<0.05$).

Results: Baseline surveys ($n=30$) were completed (15 registered nurses, eight resident physicians, five surgical techs, two fellows) with an average 2.6 years (range $<1-7$ years) of PCNL experience. Pre- and postoperative assessment of communication improved after implementation of the whiteboard (preoperative: 6.7 vs. 8.9, $p<0.001$; postoperative: 7.0 vs. 9.3, $p<0.001$). On average, 3.2 items (range 2–5) out of five items were accurate on pre-intervention cases. Post-intervention accuracy improved to 4.4 (3–5)/5 items ($p=0.049$). There was a significant relative case cost improvement after implementing the whiteboard, with an average of \$292.50 USD savings per case ($p=0.045$).

Conclusions: The development of a real-time, editable PCNL equipment whiteboard improved team perception of equipment communication, case

MP-11.1. Table 1. Participants' response to questionnaire

	Extremely disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Extremely agree n (%)
Q1: Ability to express concerns	2 (0.7)	5 (1.6)	27 (8.8)	107 (34.9)	164 (53.4)
Q2: Quality of teleconsultation	2 (0.7)	10 (3.3)	22 (7.2)	106 (34.5)	166 (54.1)
Q3: Timing and efficacy	3 (1.0)	2 (0.7)	18 (5.9)	78 (25.4)	206 (67.1)
Q4: Confidentiality	0 (0.0)	1 (0.3)	14 (4.6)	60 (19.5)	230 (74.9)
Q5: Ability to share sensitive information	0 (0.0)	6 (2.0)	17 (5.5)	65 (21.2)	219 (71.3)
Q6: Quality of education	1 (0.3)	9 (2.9)	33 (10.7)	86 (28.0)	178 (58.0)
Q7: Degree of overall satisfaction	2 (0.7)	9 (2.9)	26 (8.5)	87 (28.3)	183 (59.6)
Q8: Ability to conduct teleconsultation without physical examination	6 (2.0)	19 (6.2)	58 (18.9)	104 (33.9)	118 (38.4)
Q9: Preference of future teleconsultation regarding cost and distance	16 (5.2)	27 (8.8)	58 (18.9)	79 (25.7)	125 (40.7)

item accuracy, and provided a relatively average cost saving for PCNL at our center.

MP-11.6
Improving patient understanding of post-holmium laser enucleation of the prostate recovery expectations: A quality improvement initiative

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Introduction: A quality assessment performed at our center revealed 10.9% of patients were not aware that ejaculate volume may change postoperatively, with >25% recommending a patient handout to improve communication. Therefore, a multidisciplinary team created a holmium laser enucleation of the prostate (HoLEP) expectations communication handout to improve surgeon-patient communication.

Methods: Patients presenting for preoperative consultation prior to HoLEP were assessed with post-procedure patient-reported outcomes (PRO) questionnaires before (n=50) and after (n=50) the implementation of a surgeon-patient HoLEP expectations handout. Patient perioperative course was examined in the context of their responses. Comparisons were made with a Chi-squared test (p<0.05). Our primary objective was to improve patient understanding of retrograde ejaculation and HoLEP recovery.

Results: We observed a response rate of 96% (46/50 baseline, 50/50 post-handout). Overall, 89/96 (93%) patients felt they had a reasonable understanding of HoLEP expectations, with no significant difference between cohorts (45/46 vs. 48/50, p=0.71). There was no difference in the proportion of respondents reporting an understanding of post-HoLEP dysuria (p=0.59), hematuria (p=0.12), or urinary incontinence (UI) (p=0.99). The implementation of the communication handout improved patient understanding of retrograde ejaculation (41/46 baseline vs. 50/50 post-handout, p=0.022). Fifty-five patients experienced any dysuria postoperatively, with 85% reporting less than or equal to what they expected. Close to 30%

(28/94) of respondents offering ways to improve communication suggested a HoLEP website for more information.

Conclusions: The implementation of a summative surgeon-patient communication handout during preoperative HoLEP consultation improved the understanding of postoperative retrograde ejaculation at our center. We identified additional areas for future technology-aided improvements in post-HoLEP communication.

MP-11.7
The rising burden of acute urological disease at an urban, academic hospital network

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Introduction: Urological presentations to the emergency department (ED) constitute a significant burden of disease. We aimed to evaluate trends in the incidence, management, and followup of patients presenting to an urban, academic, tertiary care hospital with renal colic (RC), acute urinary retention (AUR), and gross hematuria (GH) over a 10-year period.

Methods: A retrospective cohort study was conducted to include all patients presenting with RC, AUR, or GH to University Health Network EDs over two different time periods: 2008–09 and 2018–19. Multilevel regression models were used to evaluate differences between the two time periods for the following outcomes: patient demographics, incident ED visits based on presenting diagnosis, return visits to the ED, and time to urology clinic followup.

Results: A total of 3510 ED visits were included, of which 991 were from 2008–09 and 2519 were from 2018–19 (Table 1). Mean age decreased from 62.6 to 60.1 years in 2018–19, with more females in the 2018–19

MP-11.7. Table 1. Characteristics of 2751 unique patients presenting with renal colic, gross hematuria, or acute urinary retention to the emergency department (stratified by year of visit and summarized for combined urological presentations)

Characteristic	Full sample	2008–2009	2018–2019	Change	p
ED visits	3510	991	2519	+1528 visits	
Mean age (SD)	60.8 (19.2)	62.6 (18.5)	60.1 (19.4)	-2.5 years	<0.001**
Gender					0.0036*
Female	798 (22.7%)	193 (19.5%)	605 (24%)	+4.5%	
Male	2712 (77.3%)	798 (80.5%)	1914 (76 %)	-4.5%	
Season					0.43
Spring	1033 (29.4%)	284 (28.7%)	749 (29.7%)	+1.1%	
Summer	1229 (35%)	368 (37.1%)	861 (34.2%)	-3.0%	
Fall	642 (18.3%)	176 (17.8%)	466 (18.5%)	+0.7%	
Winter	606 (17.3%)	163 (16.4%)	443 (17.6%)	+1.1%	
Borough					0.0016*
Downtown Toronto	948 (27%)	256 (25.8%)	692 (27.5%)	+1.6%	
Central Toronto	379 (10.8%)	97 (9.8%)	282 (11.2%)	+1.4%	
East Toronto	84 (2.4%)	21 (2.1%)	63 (2.5%)	+0.4%	
West Toronto	625 (17.8%)	169 (17.1%)	456 (18.1%)	+1.0%	
North York	243 (6.9%)	80 (8.1%)	163 (6.5%)	-1.6%	
East York	70 (2%)	22 (2.2%)	48 (1.9%)	-0.3%	
York	376 (10.7%)	133 (13.4%)	243 (9.6%)	-3.8%	
Etobicoke	190 (5.4%)	69 (7%)	121 (4.8%)	-2.2%	
Scarborough	103 (2.9%)	22 (2.2%)	81 (3.2%)	+1.0%	
Other	492 (14%)	122 (12.3%)	370 (14.7%)	+2.4%	
Downtown core					0.096
Within core	1327 (37.8%)	353 (35.6%)	974 (38.7%)	+3.1%	
Outside core	2183 (62.2%)	638 (64.4%)	1545 (61.3%)	-3.1%	

*Significant at p<0.05. **Significant at p<0.001.

cohort (19.5 vs. 24%). There was an increase in RC presentations (248 vs. 1138 visits in 2018–19), AUR presentations (373 vs. 679), and GH presentations (370 vs. 702). In 2018–19, 7.9% of ED visits occurred within 30 days of surgery, 10.1% of all patients were admitted as in-patients from the ED (6.7% for RC, 6.3% for AUR, and 19.5% for GH), and 31.8% of patients returned to the ED within 30 days of initial ED presentation. Multilevel regression analyses showed that older patients (odds ratio [OR] 1.07, $p=0.02$), patients living in the downtown core (OR 1.34, $p=0.001$), and 2018–19 ED patients (OR 1.23, $p=0.039$) were more likely to return to the ED within 30 days. Time to be seen in urology clinic post-ED visit increased significantly over time for the entire cohort (mean 21.1 vs. 29.8 days, $p<0.001$) and 14.4% of all patients had multiple ED visits prior to being seen in urology clinic (9% vs. 17% in 2018–9, $p<0.001$).

Conclusions: The incidence of acute urological presentations increased significantly over a 10-year period at a tertiary care hospital. These findings demonstrate an increasing burden of acute urological disease that is outpacing population growth and currently available healthcare resources.

MP-11.8 Patient satisfaction with telehealth during the COVID-19 pandemic in a Canadian community urologic practice

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Introduction: Measuring patient satisfaction is important and useful for continual quality improvement. During the COVID-19 pandemic, telehealth has become increasingly useful for patient-physician interactions. The aim of this study is to evaluate patient satisfaction with telephone appointments replacing the standard in-person appointments in a regional urological practice.

Methods: Using the validated telehealth satisfaction scale (TeSS), minimally modified for use with urological patients,¹ this study was completed in Peterborough, Ontario, which serves a population of approximately 300 000 people. A total of 761 patients were called, with 400 surveys completed (361 patients didn't answer or declined). One patient from the 400 was later excluded from analysis due to missing data. Questions 1–7 addressed the quality and general satisfaction of the telehealth phone calls, questions 8 and 9 are characteristics hypothesized as possibly affecting patient preference, and question 10 is a global rating of preference.

Results: Refer to Tables 1–5 for survey analysis and Tables 6–8 for statistical significance testing amongst subgroups. Of the 399 patients, 248 (62.2%) would prefer in-person appointments. In patients less than 60 years old, 14.7% would prefer in-person appointments, while 73.1% of those over age 60 would prefer in-person appointments (statistically significant). Given the large geographical area served, the impact on commute was examined and was found to not be statistically significant. Consultation vs. followup was examined; 83.8% of the consult patients vs. only 46.6% of the followup patients would prefer in-person appointments (statistically significant).

Conclusions: Most of the people surveyed found telehealth to be respectful and thorough. Despite the majority preferring an in-person visit, there is a non-trivial minority that would prefer telehealth; this is particularly

true in some subgroups. Therefore, it is reasonable to consider continuing telehealth in this studied population post-pandemic.

Reference

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MP-11.9 Septic and febrile kidney stone presentation during the COVID-19 pandemic at Nova Scotia Health Central Zone hospitals: What is the effect of lack of access to care during pandemic restrictions?

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Introduction: At the Nova Scotia Health hospitals in Halifax, a subjective increase in the number of septic/febrile patients requiring emergent stone therapy has been observed. This may be due to reductions in elective surgeries and limited access to laboratory tests, such as urinalysis and culture. This study examines the volume and severity of septic stone patients requiring emergent intervention amidst the COVID-19 pandemic healthcare restrictions.

Methods: In this retrospective, single-center, observational study, we reviewed the charts of all urgent or emergent septic stone patients requiring ureteral stent insertion from August 2019 to January 2020 (pre-COVID cohort) and August 2020 to January 2021 (intra-COVID cohort). The primary outcome was the number of patients requiring stenting. The secondary outcome included the number of patients classified as emergency status as per the American Society of Anesthesiologists (ASA) classification.

Results: The number of septic stone presentations increased by approximately 17% during the COVID pandemic (24 patients pre-COVID vs. 28 patients intra-COVID). There was an increase in patients classified as emergency (ASA) of approximately 62% (13 patients pre-COVID vs. 21 patients intra-COVID). The pre-COVID timeframe showed a predominance of women ($n=18$) compared to men ($n=6$), similar to the intra-COVID cohort, demonstrating 21 females and seven men. The mean age for the pre- and intra-COVID cohorts were 60.1 and 59.9 years, respectively.

Conclusions: An increased number of patients required ureteral stent insertion for septic kidney stones during COVID-related reductions in healthcare. The number of patients classified as an emergency procedure (ASA classification) increased. The exact cause is unknown but during this timeframe, there was delayed urological followup, lack of access to primary care, deferred elective treatment, limited access to lab testing, and a reluctance by patients to seek medical care due to fear of exposure to COVID-19.

MP-11.8. Table 1. Telehealth satisfaction scale

Statement	Excellent n (%)	Good n (%)	Fair n (%)	Poor n (%)
1 Your personal comfort in using the telehealth system	192 (48.1%)	158 (39.6%)	45 (11.3%)	4 (1.0%)
2 The ease of getting a telehealth appointment	213 (53.4%)	142 (35.6%)	41 (10.3%)	3 (0.75%)
3 The length of time of the appointment	198 (49.6%)	146 (36.6%)	52 (13.0%)	3 (0.75%)
4 The explanation of your treatment by the doctor	208 (52.1%)	142 (35.6%)	47 (11.8%)	2 (0.50%)
5 The thoroughness, carefulness, and skilfulness of the doctor	211 (52.9%)	140 (35.1%)	47 (11.8%)	1 (0.25%)
6 The courtesy, respect, sensitivity, and friendless of the doctor	215 (71.7%)	140 (35.1%)	41 (10.3%)	3 (0.75%)
7 How well was your privacy respected?	216 (54.1%)	141 (35.3%)	42 (10.5%)	0 (0.0%)

MP-11.8. Table 2. Hypothesized variables affecting patient preference

Statement	Followup n (%)	Consult n (%)
*8 Was this for a first appointment with the doctor for this problem or a follow up appointment?	232 (58.1%)	167 (41.2%)

Statement	<30 min n (%)	30–60 min n (%)	>60 min n (%)
*9 How far away would your drive have been for an office appointment?	166 (41.6%)	193 (48.4%)	40 (10.0%)

MP-11.8. Table 3. Global rating of preference

	In person n (%)	Telehealth n (%)
*10 Assuming you had a similar need to see the doctor, would you prefer to see the doctor in person or by telephone?	248 (62.2%)	151 (37.8%)

MP-11.8. Table 4. Preferred appointment type by subgroups

All, n=399	Category	In person n (%)	Telehealth n (%)
Age of patient			
	<60 years, n=75	11 (14.7%)	64 (85.3%)
	>60 years, n=324	237 (73.1%)	87 (24.9%)
Length of commute			
	<30 min, n=166	95 (57.2%)	71 (42.8%)
	30–60 min, n=193	129 (66.8%)	64 (33.2%)
	>60 min, n=40	25 (62.5%)	15 (37.5%)
Appointment type			
	Consult, n=167	140 (83.8%)	27 (16.2%)
	Followup, n=232	108 (46.6%)	124 (53.4%)

MP-11.8. Table 5. Appointment preference

		In person n (%)	Telehealth n (%)
All (399)	Observed	248 (62.2%)	151
Null	Expected	199.5	199.5

Assuming a null hypothesis that patients would have no preference. Using Chi-squared test, null hypothesis rejected, $p < 0.05$, difference is statistically significant. 62.2% of the entire population preferred in person appointments. Therefore, to compare between the subgroups and determine if a difference existed, we utilized as a null hypothesis that 62.2% of each subgroup should prefer in person appointments.

MP-11.8. Table 6. Age of patient and appointment preference

	Age of patient	
	<60 years	>60 years
Observed	11	237
Expected (62.2% of patients in the subgroup)	46.7	201.5

*Using Chi-squared test, null hypothesis rejected, $p < 0.05$, difference is statistically significant.

MP-11.8. Table 7. Length of commute and appointment preference

	Length of commute		
	<30 min	30–60 min	>60 min
Observed	95	129	25
Expected (62.2% of patients in the subgroup)	103.3	120	24.9

*Using Chi-squared test, null hypothesis accepted, a difference is not statistically significant.

MP-11.8. Table 8. Appointment type and appointment preference

	Appointment type	
	Consult	Followup
Observed	140	108
Expected (62.2% of patients in the subgroup)	103.9	144.3

*Using Chi-squared test, null hypothesis rejected, $p < 0.05$, difference is statistically significant.

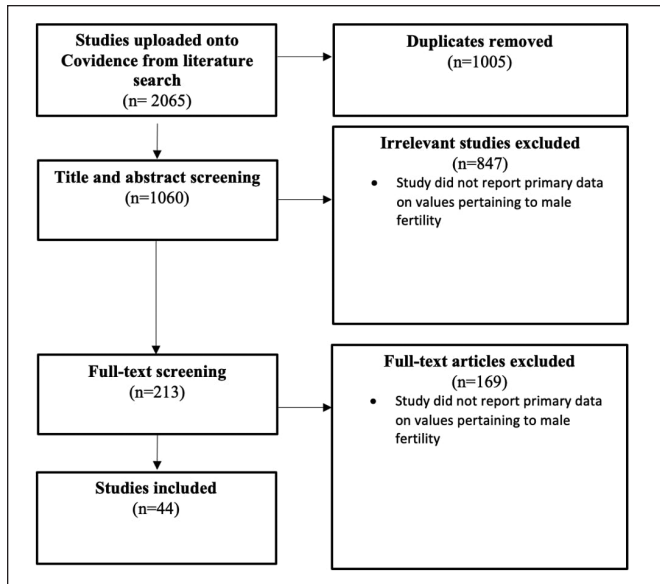
**MP-11.10
Impact of SARS-CoV-2 on male fertility: A systematic review and meta-analysis**

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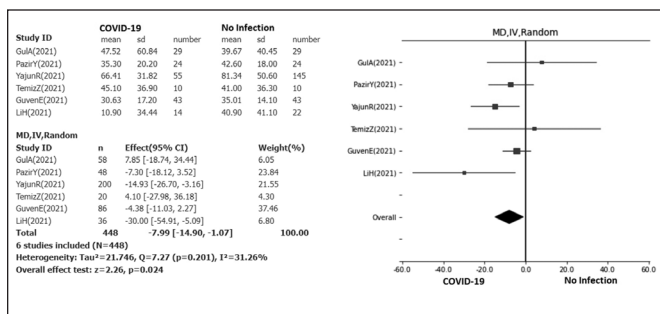
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Introduction: Current evidence shows that the novel severe acute respiratory syndrome coronavirus-2 (COVID-19) can travel across the blood testes barrier and enter the seminiferous tubules.¹ COVID-19 has the potential to induce a cytokine storm that can affect the testes.¹ The objective of this study was to identify and analyze the available information on male fertility for changes in sperm and seminal parameters and disruption of the male sex hormone profile.

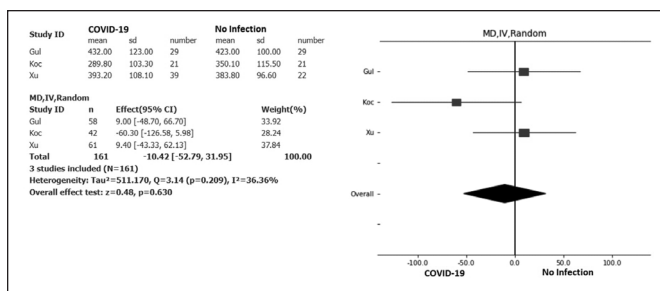
Methods: This study was registered a priori on Open Science Framework (ID: gkpn5). A comprehensive search of OVID Medline, EMBASE, Web of Science, and *Clinicaltrials.gov* was conducted from inception to October 15, 2021. Primary studies that examined COVID-19 or a COVID-19 vaccine on male fertility-related parameters, such as sperm count or morphology and sex hormone changes, were included. DerSimonian and Laird's random effects meta-analysis was conducted to evaluate the effect of COVID-19 on sperm count and testosterone levels. Heterogeneity was assessed with Cochran's Q and I².



MP-11.10. Figure 1. Study selection flow diagram.



MP-11.10. Figure 2. Random effect model of COVID-19 on sperm count.



MP-11.10. Figure 3. Random effect model of COVID-19 on testosterone levels.

Results: The search yielded 2065 results, of which 1005 (51%) were duplicates; 44 studies met the final inclusion criteria, of which six studies fit the criteria for meta-analysis on the effect of COVID-19 infection on sperm count (Figure 1). The analysis indicated a significant reduction in sperm count in men (n=448) recovered from COVID-19 infection (mean difference -7.99, 95% confidence interval [CI] 1.07, 14.9, I²=31.26%, p=0.024) (Figure 2). Three studies were included in the meta-analysis on the effect of COVID-19 infection on testosterone levels, which revealed no significant difference in men (n=161) recovered from COVID-19 infection (mean difference -10.42, 95% CI -52.79, 31.95, I²=36.36%, p=0.63) (Figure 3).

Conclusions: This study suggests that seminal parameters may be affected by COVID-19 infection. A significant decrease in sperm count was detected, however, a difference in testosterone levels was not.

Reference

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MP-11.11
Examining the one-year impact of COVID-19 on urology resident surgical experience: An analysis of national surgical case logs

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Introduction: The emergence of the COVID-19 pandemic resulted in elective surgical closures beginning in March 2020. In the immediate six months after COVID-19 began, there was a significant reduction in national resident operative experience. Our objective was to evaluate the impact of COVID-19 on urology resident surgical experience the year before and after COVID-19 using a national surgical case log registry.

Methods: Canadian national urology resident case log data (T-Res) was analyzed for the two-year time period from March 15, 2019, to March 14, 2021, with respect to the 14 most commonly performed urological procedures. The 12-month time period prior to COVID-19 was compared to the 12-month time period after COVID-19. Data was analyzed from 11 residency programs with regular active users generating case logs over this time period. Total and specific case volumes per program and per resident user of the time period were analyzed. A paired Wilcoxon signed-rank test was used for comparison of mean cases pre- and post-COVID-19.

Results: A total of 26 715 procedures were recorded over the 24-month period among 150 unique resident users. In the 12 months prior to COVID-19, 11 906 procedures were logged, while 14 809 procedures were logged in the 12 months after. Mean case volume by procedure type was unchanged, other than partial nephrectomy, which showed a small increase in the post-COVID window. Looking at total cases per program, seven programs showed an increase post-COVID. When the data was adjusted per resident, there were no differences in specific cases. When looking at case volumes per resident, three programs show a decreased case volume since COVID and three programs show an increase.

Conclusions: Based on this national case log sample, resident operative experience has rebounded one year after COVID-19. However, 27.3% of programs still report significantly reduced case volumes per resident after COVID-19, and this may warrant further examination to ensure focal deficiencies in training don't arise.

MP-11.12
Assessing quality of bladder cancer care: Wait time variability at a tertiary institution

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Introduction: Current consensus statements recommend a wait time less than four weeks for cystoscopic evaluation of hematuria.¹ Disruptions to healthcare delivery have been prevalent throughout the COVID-19 pandemic. The goal of this study was to assess cystoscopy wait times for hematuria and identify the impact of COVID-19 on access to care.

Methods: New referrals for hematuria at The Ottawa Hospital (TOH) were identified across three time periods: December 2019 to February 2020 (P1); March to May 2020 (P2); and July to September 2020 (P3). June 2020 was omitted, as clinical activity transitioned to full capacity. We excluded patients <18 years, cystoscopies outside TOH, known bladder cancer, and patients with incomplete data.

Results: Cystoscopy appointment offerings did not differ across time periods: M=5 weeks in P1, M=6 weeks in P2, and M=6 weeks in P3 (p=0.39). However, cancellations were more prevalent during the first wave of COVID-19 (P2, 34%) than during P1 (14%) and P3 (6%) (p<0.05). Of

those patients that missed scheduled cystoscopy, patients in P2 (COVID-19 wave) waited longer to be rescheduled (13 weeks) than those in P1 (seven weeks) and P3 (four weeks) but this difference did not reach statistical significance ($p=0.11$). Sixty of 597 cystoscopies identified a bladder tumor (~10%) and most tumors (56/60, 93%) were in the context of gross hematuria. High-grade pathology was associated with shorter wait times than low-grade (three weeks vs. four weeks) but this finding did not reach statistical significance ($p=0.61$).

Conclusions: The first wave of COVID-19 resulted in delayed cystoscopic evaluation of hematuria. Our data continues to support hematuria as a warning sign for bladder cancer and timely evaluation and treatment is paramount.

Reference

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MP-11.13

Early impacts of the COVID-19 pandemic on renal transplant practices at a Canadian center

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Introduction: It is well-known that the COVID-19 pandemic has had a significant impact on healthcare practices; however, the impact on renal transplant practice is unknown. This study aimed to determine the effect COVID-19 has had on the demographics and comorbidities of renal transplant recipients and its impact on surgical outcomes at a Canadian site.

Methods: Data were collected via retrospective chart review. Renal transplant patients from 2019–2020 were identified using the St. Joseph's Healthcare Hamilton renal transplant database. Pre-COVID-19 transplants occurred between January 1, 2019, and March 12, 2020, and during COVID-19 transplants occurred between March 12, 2020, and August 1, 2020. The Charlson Comorbidity Index (CCI) is a weighted scoring system of medical conditions that is validated in renal transplants to predict mortality. CCI scores were calculated for each patient.

Results: Data existed for 142 renal transplants pre-COVID-19 and 25 renal transplants during COVID-19. Most transplants done for both groups were from deceased donors (72.5% vs. 80.0%). Recipients of renal transplants pre-COVID-19 were older than those during COVID-19 (55.6 years vs. 47.7 years, $p=0.02$). There was no significant difference in the body mass index between the patient groups (27.8 pre-COVID-19 vs. 26.1 during COVID-19, $p=0.1$). CCI scores during COVID-19 were lower than pre-COVID-19, but this was not statistically significant (3.5 vs. 4.2, $p=0.1$). These scores correspond to a 10-year survival of 67.0% and 47.2%, respectively. As expected, there were no significant differences in perioperative outcomes, including estimated blood loss, warm ischemic time, length of stay, and 30-day readmission rate.

Conclusions: These results demonstrate that patients undergoing renal transplants at St. Joseph's Healthcare Hamilton during the early waves of the COVID-19 pandemic were younger, but otherwise, differences in demographics and surgical outcomes were minimal.

MP-11.14

The quality and readability of online patient education material on SARS-COV-2 vaccination and prostate cancer: Room for improvement

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Introduction: Prostate cancer patients are at increased risk for COVID-19, however, some patients remain vaccine-hesitant. Reasons for hesitancy include concerns vaccination will impair cancer treatment or exacerbate their disease. Vaccine hesitancy is associated with poor health literacy; therefore, ensuring patients have high-quality patient education resources is essential to combat this. This study assessed the readability and quality of resources on COVID-19 vaccination for prostate cancer found on the internet.

Methods: The first 20 Google search results for "prostate cancer COVID-19" were assessed. Quality was assessed using the DISCERN instrument, a 16-question tool that provides sub-scores for resource reliability and trustworthiness, and treatment options. Readability was assessed using the Fleisch-Kincaid Grade Level (FKG), providing a score equivalent to the school grade comprehension required. Inferential statistics were conducted using Mann-Whitney U tests.

Results: Eight websites were excluded based on exclusion criteria. Most sites ($n=8$) were from the United States, while three were from Australia and one from the United Kingdom. Most sites were produced by health charities ($n=7$). The mean FKG score was 10.6, with no significant difference between resources from Australia or the U.S. The mean overall DISCERN score was 51.3; DISCERN subsection 1 score was 28.3 and DISCERN subsection 2 score was 22.9. There was no significant difference between overall or subsection scores between resources from Australia or the U.S.

Conclusions: Online information about COVID-19 vaccination in prostate cancer requires a 10th-grade education level to comprehend, which is higher than the 8th-grade recommended in Canada. Quality, in terms of reliability and trustworthiness, treatment information, and overall, was average. Health professionals working with men with prostate cancer should be mindful to produce and direct patients towards high-quality resources, as those available online currently do not meet that standard.

MP-11.15

Open surgery for urinary stone management despite the era of modern endourology: A call for global representation

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Introduction: Although endoscopic management is the goal standard for treating the majority of urinary stones that meet the indication for surgical intervention, we still offer open surgery for all our patients. This study aimed to share our experience and challenges in open surgery for urinary stone management in the era of modern endourology.

Methods: This was a retrospective study. Information of patients who had surgery for urinary stones between January 2018 and January 2021 had their information retrieved and analyzed.

Results: A total of 28 patients were treated during the study period. The percentage of those that had anatomic nephrolithotomy, extended pyelolithotomy, ureterolithotomy, cystolithotomy, and urethrolithotomy were 21.4%, 10.7%, 17.9%, 39.3%, and 10.7%, respectively. The most common indication for surgery was persistent pain (61.2%) followed by obstruction. There was a good outcome, with 100% stone-free rate; however, the average hospital stay was six days, as external stent was used for most (91.3%) of the upper tract cases.

Conclusions: Although a 100% stone-free rate was reported in our study, endoscopic management is the preferred option, as there will be a shorter hospital stay and good cosmetic outcomes. With the provision of adequate equipment and training, endoscopic management for urinary stones can be a reality in our resource-poor setting.