Establishing maximal wait times for urologic surgery in Canada in 2024

Hassan Razvi[1], Troy Sitland[2], Fred Saad[3]

[1]Past Chair, CUA Advocacy Committee; [2]Chair, CUA Health Policy Committee; [3]Chair, CUA Advocacy Committee

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PREAMBLE

Waiting for specialist consultation and surgical treatment has become a defining characteristic of the Canadian healthcare system. Data collected during the past two years and encompassing the pandemic would suggest that wait times continue to increase for patients requiring treatment from many surgical disciplines.[1]

Research has repeatedly found that wait times for medically necessary treatment impact the patient experience and can have serious consequences, including increased pain, mental anguish, and impairment in quality of life. Medical outcomes may also be negatively affected due to delays in diagnosis and treatment, transforming potentially reversible conditions into chronic or permanent disabilities. Although more difficult to measure, the economic impact on the individual patient and society is also significant if patients cannot work while waiting for treatment. Moreover, should acute conditions not be promptly managed and become chronic illnesses, more significant financial impacts can continue for both the patient and the healthcare system.

Several provinces record wait times for initial consultation and wait time for urologic surgery, however, some do not. Where wait time benchmarks exist, the methodology and basis for the times recommended are not always clear. The determination of clinically acceptable benchmarks for surgical wait times is a nuanced exercise and requires careful consideration of the biology of the disease, resource availability, and individual patient factors.

As *The Voice of Urology in Canada,* the Canadian Urological Association (CUA) has a mandate to support its members and their patients in ensuring the highest quality of urologic care is provided across the country. To this end, the CUA, through its Health Policy and Advocacy Committees, established a working group to engage content experts within the organization and its subspecialty affiliates to create a consensus opinion on acceptable urologic surgery wait times.

The content experts and affiliate societies were asked to benchmark the wait time from urologist decision to treat until surgical date. The groups were specifically asked to provide the maximum, clinically acceptable wait times for a given procedure. A sample of common urologic procedures for both benign and malignant disease entities, as well as for children and adults, were chosen to reflect conditions with important impacts on patient quality of life and potential mortality if not promptly treated. The content experts were asked to provide evidence to support the wait times recommendations if such information existed, or if such data has not been published, to propose consensus opinions in the Canadian context.

The urologic procedures chosen for CUA wait time benchmarking were the following:

1. Urinary stone and benign prostatic hyperplasia (BPH) treatments
   - Transurethral resection of the prostate (TURP)/laser prostatectomy
   - Ureteroscopy
   - Percutaneous nephrolithotomy (PCNL)
2. Urinary reconstruction and female incontinence treatments
   - Urinary sling procedure
   - Urethroplasty
3. Urologic oncology treatments
   - Transurethral resection of bladder tumor (TURBT)
   - Radical cystectomy
   - Radical prostatectomy
   - Radical/partial nephrectomy
   - Radical orchidectomy
4. Pediatric urologic treatments
   - Pyeloplasty
   - Ureteral reimplantation
   - Circumcision
   - Hypospadias repair

RECOMMENDATIONS

Urinary stone and benign prostatic hyperplasia treatments

The Canadian Endourology Group (CEG) was tasked with providing recommendations on the maximal wait times for surgical treatments for urinary stones and symptomatic lower urinary tract symptoms (LUTS) attributed to BPH. High-level published data on surgical wait times for these common endourologic procedures does not exist. As such, CEG surveyed its members, and with the direction of its leadership group, proposed the maximum wait times based on expert consensus opinion (Table 1).

Urinary reconstruction and female incontinence treatments

The Functional and Reconstructive Urological Society of Canada (FRUSC) was asked to provide guidance on maximal wait times for several reconstructive procedures, including urethroplasty and surgical correction of female urinary incontinence. High-level evidence was not available to guide this work. Maximum wait times were proposed based on expert opinion (Table 2).

Urologic oncology treatments

The Surgical Wait Time (SWAT) Initiative was established in 2006 and included oncologists, surgeons, and methodologists.[2] The mandate of this group was to provide a reference document regarding maximum surgical wait times for various urologic oncology disease sites incorporating, if available, published data, as well as consensus opinion from Canadian uro-oncology experts. In addition, and specifically for bladder cancer care, the 3rd Bladder Cancer Canada-CUA-Canadian Urologic Oncology Group consensus meeting published its recommendation in 2020.[3]

Clinical stage and patient performance status are especially relevant when triaging patients with suspected or known urologic malignancies for surgical management. These important factors were also incorporated into the above-referenced consensus groups' recommendations. These benchmarks were then reviewed and updated by the CUA Board of Directors and experts in the field to ensure the recommendations remain current (Table 3).

Pediatric urologic treatments

The Pediatric Urology Committee (PUC) was asked to provide recommendations on the selected pediatric procedures. Maximal wait times have been determined through the Pediatric Access Coding Targets for Surgery (P-CATS) methodology. P-CATS was created in 2008 as part of the Canadian Pediatric Surgical Wait Times Project, funded by Health Canada and the Health Care Policy Contributions Program.[4]

The intent of P-CATS was to develop a methodology for measuring and comparing elective pediatric surgery wait times across Canada. The latest iteration (P-CATS version 2) was last updated in 2016 and includes recommended surgical wait times for all pediatric surgical disciplines, including urology. Table 4 lists the recommended

Table 1. Wait times for urinary stone and BPH treatments

Procedure	Recommended maximum wait time (weeks)
TURP/laser prostatectomy	Elective: 24 For urinary retention: 8
Ureteroscopy	Asymptomatic renal: 24 Symptomatic/obstructed: 6 Complicated: 4
PCNL	Asymptomatic: 12 Symptomatic/obstructed: 6 Complicated: 4

BPH: benign prostatic hyperplasia; PCNL: percutaneous nephrolithotomy; TURP: transurethral resection of the prostate.

Table 2. Wait times for urinary reconstruction and female incontinence treatments

Procedure	Recommended maximum wait time (weeks)
Urethroplasty	Elective: 24 For urinary retention: 8
Surgical correction of female urinary incontinence	24

Table 3. Wait times for urologic oncology treatments

Procedure	Recommended maximum wait time
TURBT	≤4 weeks from diagnostic cystoscopy
Radical cystectomy	≤6 weeks after TURBT or termination of neoadjuvant chemotherapy
Radical prostatectomy	≤12 weeks from the decision to treat ≤6 weeks for high-risk (PSA>20, Gleason 7+, stage ≥T3):
Radical nephrectomy	≤6 weeks
Partial nephrectomy	≤12 weeks
Radical orchidectomy	≤1 week

PSA: prostate-specific antigen; TURBT: transurethral resection of bladder tumor.

Table 4. Wait times for pediatric urologic treatments	
Procedure	**Recommended maximum wait time (weeks)**
Pyeloplasty	Symptomatic: 3 Asymptomatic: 12
Ureteral reimplantation for reflux	26
Circumcision (medically indicated)	52
Hypospadias repair	Child <1 year of age: 52 Child >1 year of age: 26

maximum wait times for a select group of procedures.

CONCLUSIONS

This was the CUA's first attempt to establish nationally acceptable surgical wait time benchmarks for various benign and malignant urologic conditions. It is our hope that further expertise can be gathered to expand the recommendations to additional procedures not included in this report. It is also envisioned that further research will be conducted to provide even more robust evidence to guide resource allocations and clinical decision-making as the Canadian population continues to grow.

While improving surgical wait times is a critical step in advocating for our patients with urologic conditions, it is important to remember that quality of care cannot be sacrificed in the process. Moreover, the development of maximal surgical wait times is just one step toward improving access to urologic care for patients in Canada.

In addition to the timeliness of a surgical procedure, adequate diagnostic and surgical resources must also be in place to ensure patients are receiving state-of-the-art surgical care in accordance with contemporary clinical practice guidelines. Ensuring adequate human resources in communities based on population demographics is another piece of the puzzle that must be factored in when attempting to address regional wait time disparities.

It should be emphasized that the optimal surgical wait time for an individual patient might be significantly less than the recommendations in this document; the unique patient factors and shared-decision-making discussions between the treating physician and the patient must be considered. For benign conditions, in particular, the duration of time the patient has already waited to see their urologist should be an important consideration when scheduling surgery.

Finally, establishing maximal surgical wait times must not be used in a way that imparts blame or liability on healthcare providers. This information should serve instead as a barometer to healthcare providers, policymakers, regional health authorities, and hospital administrators on where there may be gaps in surgical access as we attempt to collaboratively navigate and improve an imperfect system.

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REFERENCES

1. Moir M, Barua B. Waiting your turn: Wait times for healthcare in Canada, 2022 report. Fraser Institute. Available at: https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2022. Accessed Sept. 18, 2024
2. Aprikian A, Bagnell S, Bell D, Donnelly B, et al. Consensus document: recommendations for optimal surgical wait times for patients with urological malignancies. *CJU* 2006;13:62-4.
3. Kassouf W, Aprikian A, Saad F, et al. Continuing towards optimization of bladder cancer care in Canada: Summary of the third Bladder Cancer Canada-Canadian Urological Association-Canadian Urologic Oncology Group (BCC-CUA-CUOG) bladder cancer quality of care consensus meeting. *Can Urol Assoc J* 2020;14:E115-25. http://dx.doi.org/10.5489/cuaj.6378
4. Pediatric Canadian Access Targets for Surgery. Available at: https://www.cihi.ca/sites/default/files/document/pcats-2016-feb-2017-en-web.pdf. Accessed Sept. 18, 2024

CORRESPONDENCE: Dr. Hassan Razvi, Past Chair, CUA Advocacy Committee; hrazvi@uwo.ca