Poster Session 8: BPH (Part 2), Functional Urology (Part 2)
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MP 8.1

Incidence and predictors of the complications of catheter-dependent benign prostatic hyperplasia wait times: A retrospective study

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Introduction: Surgical wait times are a key quality indicator in healthcare. Recent literature has focused on reducing delays for oncologic surgeries, while non-oncologic surgeries have received little to no attention. Benign prostatic hyperplasia (BPH) affects nearly 80% of men by their eighties, often causing lower urinary tract symptoms (LUTS) and urinary retention, leading to reduced quality of life and financial burden. Treatment options for moderate-to-severe LUTS-BPH range from medical therapy to minimally invasive and invasive surgeries. This study aimed to examine surgical wait times for BPH and identify predictors of complications related to catheter dependence.

Methods: A retrospective review was undertaken to identify catheter-dependent BPH patients who underwent surgical treatment in the form of transurethral resection of prostate (TURP), GreenLight laser of prostate (GLLP), robotic simple prostatectomy, and holmium laser enucleation of the prostate (HoLEP) from May 1, 2022, to May 1, 2024, in Edmonton. Collected data included patient characteristics (BMI, ASA classification, preoperative anti-coagulation use, prior BPH surgery, preoperative 5-alpha reductase inhibitor use, prostate volume), catheter-dependent period until surgery, and preoperative complications.

Results: Of 255 catheter-dependent patients, 115 (45.1%) underwent TURP, 76 (29.8%) GLLP, 16 (6.3%) simple prostatectomy, and 48 (18.8%) underwent HoLEP. Excluding patients with comorbidities delaying surgery, the mean time from catheter insertion to OR was 101 days (median: 85 days). Preoperative complications occurred in 155 patients (60.8%), including ER visits for UTI (79.4%), recurrent UTIs (23.9%), hematuria (37.4%), epididymitis (3.2%), catheter-related issues (37.4%), and hospital admissions for urosepsis or hematuria (12.9%). Binary regression identified catheter duration as the only significant predictor of complications (OR 1.013, p<0.001), representing a 1.3% increase in the odds of complications per additional day with catheter. The mean time to complication was 43 days (median: 30 days).

Conclusions: To our knowledge, this study is the first to depict surgical wait times in catheter-dependent BPH patients. More than half of the patients experienced complications associated with prolonged catheterization. These findings highlight the significant impact of delayed surgical intervention, emphasizing the need for targeted strategies to reduce wait times and enhance patient care.

MP 8.2

National review of reoperation rates for endoscopic benign prostatic hyperplasia procedures using a live claims database

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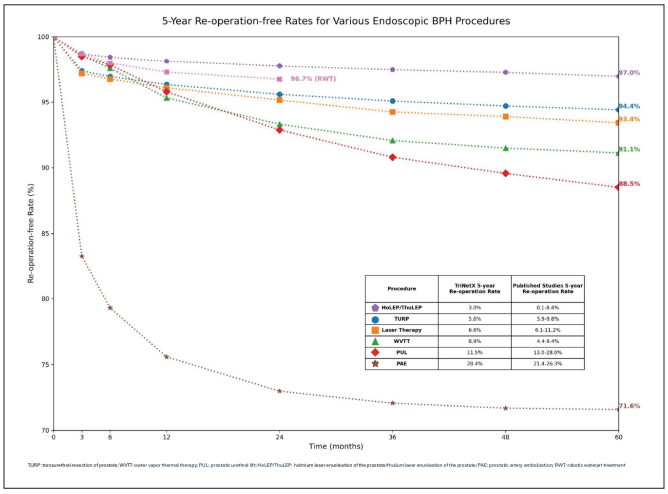
Introduction: Endoscopic management of benign prostatic hyperplasia (BPH) has advanced rapidly over the past 20 years with new surgical techniques. Procedure longevity is crucial for patients and providers considering surgical options. This study provides real-world data on reoperative rates of common BPH surgeries using a live national claims database.

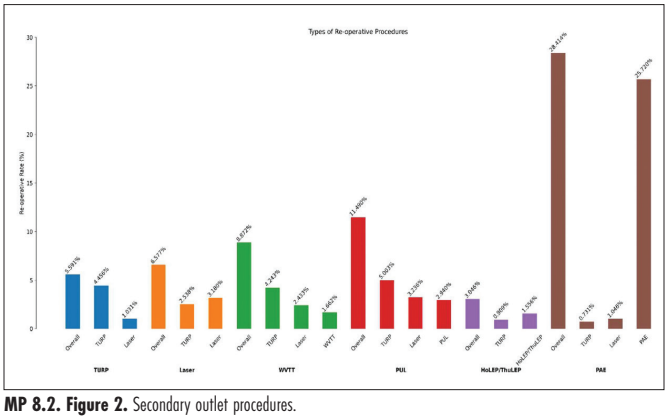
Methods: This observational study analyzed the TriNetX dataset from 2018 to October 2024, including adult males (18+) with BPH who underwent surgery. Reoperation rates and associations with primary procedures were assessed from three months to five years post-surgery at set intervals. Statistical analyses, including Z-tests, Chi-squared tests, and Cramér's V tests, were conducted.

Results: Our cohort included 127 983 patients, with 9286 undergoing reoperations within five years. Holmium laser enucleation of the prostate (HoLEP) and transurethral resection of the prostate (TURP) showed the lowest five-year reoperation rates at 3.0% and 5.6%, respectively. Robotic waterjet treatment (RWT), a newer procedure with two years of data, had a two-year reoperation rate of 3.3%. Significant differences in reoperative rates were found across groups at five years (p<0.01) (Figure 1), and Chi-squared analysis confirmed differences at all intervals (p<0.001). Cramér's V demonstrated moderate associations between reoperation rates across procedures. TURP was the most common secondary procedure, except in patients who had HoLEP and prostatic artery embolization (Figure 2).

Conclusions: This study reflects real-world patient outcomes with varied surgeon and center experience. The dataset allows for near real-time assessment of emerging therapies like RWT. TURP and HoLEP remain the endoscopic procedures with the lowest reintervention rates.



MP 8.2. Figure 1. Five-year reoperation-free rates for various endoscopic BPH procedures.



MP 8.2. Figure 2. Secondary outlet procedures.

MP 8.3

Risk factors for retrograde ejaculation after Rezum treatment: A multicenter analysis

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Introduction: Treatments for benign prostatic hyperplasia (BPH) can significantly impact ejaculatory function, potentially leading to reduced semen production or even an absence of ejaculate. Rezum thermal therapy has emerged as a promising option for preserving ejaculatory function while minimizing sexual dysfunction. Its therapeutic effects on lower urinary tract symptoms (LUTS) are typically observed within six weeks to three months after treatment.

Methods: This is a retrospective review of a prospectively collected database of two high-volume Rezum therapy practices in Canada and Italy. Institutional ethics board approval was obtained at each center. The cohort comprises patients who underwent Rezūm therapy between April 2019 and August 2024.

Results: A total of 712 patients were included in this analysis, of whom 64 (9%) experienced retrograde ejaculation (RE) following Rezum therapy. Statistically significant differences were found between the RE and non-RE groups for baseline prostate volume (p=0.036), with the RE group showing a significantly lower median prostate volume (60.0 vs. 67.0 mL). In a univariable logistic regression analyses, a history of previous TURP was strongly linked to an increased risk of RE, with an OR of 8.28 (95% CI 2.65–24.61, p<0.001). Medication use was another significant factor associated with a higher risk of RE. Specifically, stool softeners (OR 2.94, 95% CI:1.34–7.73, p=0.014), pain medications (OR 5.00, 95% CI 2.30–13.30, p<0.001), and bladder medications (OR 6.23, 95% CI 2.72–18.05, p<0.001) were all significantly associated with an increased likelihood of developing RE. Additionally, multivariable logistic regression analysis confirmed that pain medication use was strongly linked to an increased risk of RE. The adjusted OR for pain medication use was 14.84 (95% CI 2.49–88.54, p=0.003).

Conclusions: The study also highlights significant risk factors for RE, with a history of previous TURP procedures and the use of pain medications being strongly associated with an increased likelihood of developing RE.

Acknowledgements: Funded by Boston Scientific.

MP 8.4

One-year followup of a randomized, prospective clinical trial comparing holmium MOSES vs. thulium fiber laser enucleation of the prostate for the treatment of benign prostatic hyperplasia

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Introduction: We sought to compare intraoperative and one-year postoperative outcomes of patients treated for benign prostatic hyperplasia (BPH) with either holmium laser enucleation of the prostate using MOSES technology (M-HoLEP) or thulium fiber laser enucleation of the prostate (ThuFLEP).

Methods: We included 104 patients who underwent endoscopic enucleation of the prostate (EEP) using either MOSES technology or thulium fiber laser (TFL) between June 2022 and January 2024 in this randomized controlled trial (RCT). Patients' preoperative and prostate data were evaluated. Intraoperative data and perioperative outcomes, including hospital admission, perioperative complications, readmission rates, and measures such as IPSS, QoL, flow rate, PVR, PSA, and TRUS-size reduction, were collected and analyzed over a 12-month followup period.

Results: Of the 104 patients in the study, 52 underwent M-HoLEP, and 52 were managed with ThuFLEP (Table 1). There were no statistically significant differences in preoperative characteristics between the two groups. Patients in the M-HoLEP group had a shorter median enucleation time (50 vs. 57.5 minutes, p<0.001) and demonstrated significantly higher enucleation efficiency than the ThuFLEP group (1.97 vs. 1.49 g/min, p<0.001). Furthermore, significant differences were observed in favor of M-HoLEP regarding continuous bladder irrigation (CBI) time, hematuria scale, duration of postoperative hematuria, catheterization time, and

MP 8.4. Table 1. Preoperative, operative, and followup data

Parameter		M-HoLEP 52 patients	ThuFLEP 52 patients	p
Preoperative data				
Age at surgery median (range) years		72 (51–84)	72 (56–88)	0.9
Preoperative IPSS median (range)		24 (16–32)	22 (16–34)	0.25
Preoperative QoL median (range)		5 (3–6)	5 (3–6)	0.86
Preoperative Qmax median (range) mL/s		7.1 (2–14.4)	7.4 (1.3–13.8)	0.74
Preoperative PVR median (range) mL		190 (0–613)	165 (0–536)	0.6
Prostate volume median (range) cc		110 (80–235)	103 (80–189)	0.32
Preoperative PSA median (range) ng/mL		4.1 (0.84–25.6)	5 (0.33–25)	0.97
Operative data				
Enucleation time median (range) min		50 (27–95)	57.5 (30–110)	
Morcellation time median (range) min		10 (5–30)	10 (5–45)	0.85
Hemostasis time median (range) min		7 (3–16)	9 (4–15)	0.08
Resected weight median (range) g		89 (55–180)	82.5 (50–176)	0.23
Energy median (range) kJ		95.4 (48.9–158.9)	103.3 (53.8–227)	0.028
Enucleation efficiency median (range) g/min		1.97 (1.09–3.3)	1.49 (0.94–2.67)	
Hemoglobin drop median (range) g/L		10 (2–25)	13 (1–47)	0.014
CBI time hours	Median (range)	2 (2–14)	2 (2–30)	0.008
	Mean	2.6	6.1	
Postoperative hematuria time hours	Median (range)	0 (0–18)	0 (0–24)	0.003
	Mean	0.5	3.6	
Hematuria scale in the operating room	Median (range)	1 (1–5)	1 (1–5)	0.008
	Mean	1.2	1.4	
Hematuria scale in recovery	Median (range)	1 (1–5)	2 (1–5)	
	Mean	1.36	2.7	
Blood transfusion n (%)		0	3 (5.8)	0.08
Postoperative pain scale	Median (range)	1 (0–9)	0 (0–8)	0.19
	Mean	1.5	0.93	
Admissions n (%)		4 (7.7)	16 (30.8)	0.003
Same-day TOV n (%)		48 (92.3)	36 (69.2)	0.003

MP 8.4. Table 1 (cont'd). Preoperative, operative, and followup data

Parameter		M-HoLEP 52 patients	ThuFLEP 52 patients	p
Operative data (cont'd)				
Successful same-day TOV n (%)		45/48 (93.8)	29/36 (80.6)	0.06
Catheterization time hours	Median (range)	3 (3–30)	3 (3–46)	0.01
	Mean	4.1	10.5	
Hospital stay hours	Median (range)	4 (4–48)	4 (4–48)	0.016
	Mean	6.3	11.9	
Early postoperative compli-cations n (%)	No complications	42 (80.8)	26 (50)	0.006
	Clavien I	10 (19.2)	22 (42.3)	
	Clavien II	0	3 (5.8)	
	Clavien III	0	1 (1.9)	
Emergency room visit n (%)		4 (7.7)	10 (19.2)	0.08
Readmissions n (%)		2 (3.8)	5 (9.6)	0.24
6-month followup				
TRUS volume median (range) cc		22 (12.7 –49)	20.4 (12–40)	0.3
% volume reduction median (range)		79.3 (46.2–93.9)	80.5 (60.8–90.6)	0.51
12-month followup				
Number of patients		43	42	–
IPSS median (range)		3 (0–11)	3 (0–17)	0.6
QoL median (range)		1 (0–4)	1 (0–4)	0.99
Qmax median (range) mL/s		25.8 (12.5–50.4)	24 (5.8–57.6)	0.2
PVR median (range) mL		36 (0–128)	38 (0–250)	0.59

length of hospital stay. Approximately 30.8% of ThuFLEP patients were admitted with immediate postoperative hematuria compared to 7.7% in the M-HoLEP group (p=0.003). Postoperative outcomes, including IPSS, QoL, Qmax, PVR, PSA, and TRUS-size reduction, were comparable between the two cohorts up to 12 months postoperatively. Two patients (3.8%) from the ThuFLEP group had bladder neck contractures until the final followup visit.

Conclusions: Both TFL and MOSES technology achieved satisfactory intraoperative and postoperative functional outcomes in EEP; however, MOSES technology demonstrated superior results in terms of enucleation time, enucleation efficiency, catheterization time, and hospital stay. M-HoLEP facilitates same-day trial of void (TOV) and reduces the rate of postoperative hospital admissions.

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MP 8.5

Safety, efficiency, and postoperative outcomes associated with the initiation of a laser enucleation of the prostate mentorship program at an academic center

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Introduction: It has been previously determined that laser enucleation of the prostate (LEP) outperforms standard TURP and open simple prostatectomy in terms of amount of prostate tissue removed, blood loss, catheterization time, and improvements in PVR. The steep learning curve associated with LEP has been well studied; however, the system and patient impacts associated with starting an enucleation mentorship program at an academic university have yet to be explored.

Methods: This study was a retrospective analysis of patients who had undergone a LEP at the Royal Alexandra Hospital after its introduction in October 2023. All cases were performed with a 60 W thulium fiber laser and a Wolf piranha morcellator. Our LEP mentorship program has been led by a fellowship-trained endourologist at the commencement of his independent practice. We collected data on patient characteristics and perioperative outcomes, including intraoperative efficiencies. Finally, postoperative outcomes, including catheter status, complications, PVR (mL), ED visits, and final pathology were collected at the three-month followup.

Results: Overall, 83 patients underwent LEP. Of these cases, 29 were performed with a urologist trainee, 49 were performed with a resident/fellow trainee, and five were performed independently. Urologist mentorship cases were associated with worse mean enucleation efficiency 0.61 vs 1.45 g/min (p<0.0001); however, there was no difference in morcellation efficiency 6.71 vs. 7.45 g/min (p<0.583). Resident/fellow training cases were not associated with a reduction in enucleation (1.25 vs. 1.45 g/min, p<0.418) or morcellation efficiency (7.42 vs. 7.45 g/min, p<0.979). Across all 83 patients, there were two intraoperative complications (2.4%), including a capsule perforation and an equipment failure. The mean postoperative Foley duration was 1.22 days. Notably, 98.8% of patients were catheter-free at the three-week followup. The 90-day ER presentation rate was 2.4%. Additionally, 12 patients reported ongoing degrees of urinary incontinence at the three-month followup. Overall, the mean preoperative PVR was 649.4 mL, while the mean three-month postoperative PVR was significantly reduced to 114.6 mL (p<0.000001).

Conclusions: While our preliminary data reiterates a steep learning curve to perform LEP, we continue to provide excellent postoperative outcomes. As our study progresses we plan to shed further light on the system, patient, and urologist costs of the initiation of a LEP mentorship program into an academic center.

MP 8.6

Financial burden of prolonged wait times for holmium enucleation of the prostate in patients with acute urinary retention in the Quebec healthcare system

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Introduction: Acute urinary retention (AUR), often secondary to benign prostatic hyperplasia (BPH), significantly impacts patients' quality of life and often requires surgical intervention like holmium laser enucleation of the prostate (HoLEP). Since the COVID-19 pandemic, Quebec's increased surgical wait times have prolonged catheter use, leading to complications, more healthcare visits, and higher costs for the healthcare system. We aimed to assess the financial burden of prolonged AUR management in patients awaiting HoLEP in Quebec.

Methods: Our retrospective study included 91 patients with BPH-related AUR on our health center's HoLEP waitlist (2021–2024). Wait time, urologic and ER visits, interventions, and costs were collected and analyzed using IBM SPSS, with continuous variables reported as means (standard deviation [SD]) or medians (interquartile range [IQR]).

Results: Mean age of patients was 71.0 years (SD 8.0), with mean prostate size of 122.5 g (SD 53.5). Median wait time from retention to surgery was 220.0 days (IQR 148.0–300.0), with median total cost of $5329.2 (IQR $4310.40–7373.10). A total of 685 urology clinic visits and 55 ER visits were noted, of which nine (16%) resulted in hospital admissions. Complications were noted in 50 patients, including infections (62%), hematuria (48%), catheter issues (18%), and urosepsis

(16%). Admissions were due to acute kidney injury (AKI) (3), urosepsis (2), pyelonephritis (2), and hematuria (2), with pyelonephritis, urosepsis, and AKI contributing the highest costs ($4681, $4006.50, and $3441, respectively). Longer wait times significantly correlated with higher costs ($r=0.359$, $p<0.001$). Notably, patients with complications required more healthcare visits and incurred higher costs (all $p<0.05$).

Conclusions: Prolonged AUR management in patients awaiting surgery increases healthcare costs and resource use, stressing Quebec's already burdened healthcare system. Prioritizing earlier surgeries may reduce complications, lessen economic strain, and improve patient outcomes.

Acknowledgements: Special thanks to Andre Guigui and the MUHC Cost Service for providing the cost data.

MP 8.7

Slim 22 F vs. standard 26 F sheath holmium laser enucleation of the prostate in the management of benign prostatic hyperplasia: A prospective, randomized controlled trial

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Introduction: We aimed to compare the outcomes of ambulatory miniaturized holmium laser enucleation of the prostate (MiLEP) performed with a slim 22 F sheath vs. standard holmium laser enucleation of the prostate (HoLEP) with a 26 F sheath.

Methods: We included 82 patients in this ongoing randomized controlled trial (RCT) who underwent endoscopic enucleation of the prostate (EEP) with either 22 F MiLEP or standard 26 F HoLEP between April and September 2024. Patients' preoperative and prostate data were evaluated. Intraoperative data and perioperative outcomes, including hospital admission and readmission rates, as well as measures such as IPSS, QoL, Qmax, PVR, and postoperative PSA, were collected and analyzed at one- and three-month followup intervals.

Results: Of the 82 patients in the study, 41 underwent 22 F MiLEP, and 41 were managed with 26 F HoLEP. There were no statistically significant differences in preoperative characteristics between the two groups. Additionally, no significant differences were observed between the cohorts in terms of enucleation time, morcellation time, resected weight, or enucleation and morcellation efficiency; however, significant differences were observed in favor of the 26 F sheath regarding the duration of postoperative hematuria, catheterization time, and length of hospital stay. Approximately 29.3% of patients in the 22 F sheath group were admitted with immediate postoperative hematuria, compared to 9.8% in the 26 F sheath group ($p=0.026$). Patients treated with 26 F HoLEP were more likely to achieve a successful same-day trial of void (TOV), with rates of 89.2% and 62.1% in the 26 F and 22 F groups, respectively ($p=0.009$). Postoperative outcomes, including IPSS, QoL, Qmax, PVR, and postoperative PSA, were comparable between the two cohorts up to three months after surgery (Table 1).

Conclusions: Both the 22 F and 26 F sheaths achieve satisfactory intraoperative and postoperative functional outcomes in EEP; however, 26 F HoLEP facilitates same-day trial TOV and reduces postoperative hospital admission rates.

MP 8.7. Table 1. Preoperative, operative, and followup data (up to 3 months)

Parameter		22 F MiLEP 41 patients	26 F HoLEP 41 patients	p
Preoperative data				
Age, years, median (range)		72 (58–90)	73 (52–89)	0.72
BMI, kg/m², median (range)		28.1 (21.9–37.8)	28.1 (23.2–39.3)	0.64
Indication	LUTS n (%)	31 (75.6)	30 (73.2)	0.8
	Retention n (%)	10 (24.4)	11 (26.8)	
Preoperative IPSS median (range)		21 (15–32)	21.5(15–34)	0.45
Preoperative QoL median (range)		5 (3–6)	5 (3–6)	0.13
Preoperative PVR mL median (range)		112 (11–566)	156.5 (24–734)	0.07
Preoperative Qmax mL/s median (range)		9 (2–14.9)	8.85 (4–14.8)	0.93
Preoperative PSA ng/mL median (range)		3.5 (0.69–13.9)	3.1 (0.82–25)	0.95
Preoperative TRUS size g median (range)		112 (80–227)	101(80–298)	0.58
Preoperative ASA score median (range)		3 (2–4)	3 (1–4)	0.9
Operative data				
Enucleation time min median (range)		38 (17–57)	35(15–74)	0.24
Resected weight g median (range)		82 (45–199)	79 (52–263)	0.63
Energy kJ median (range)		73.1(26.5–110)	70.41 (31.47–123.48)	0.62
Morcellation time min median (range)		9 (4–39)	9 (4–27)	0.32
Hemostasis time min median (range)		7 (3–16)	6 (2–12)	0.19
Enucleation irrigation mL median (range)		18000 (9000–36000)	18000 (4800–42000)	0.53
Morcellation irrigation mL median (range)		9000 (3000–39000)	9000 (2250–24000)	0.68
Enucleation efficiency g/min median (range)		2.3 (1.3–4.2)	2.34 (1.41–6)	0.48
Morcellation efficiency g/min median (range)		8.7 (2.9–14.6)	9 (4.81–21)	0.29
Core body temperature °C median (range)		36.2 (34.7–36.8)	36.2 (35–37)	0.33
Intraoperative complications (bladder mucosal injury)		4 (9.8%)	0 (0)	0.04
CBI time hours median (range)		2 (2–23)	2 (2–20)	0.1
Postoperative hematuria duration hours median (range)		0 (0–20)	0 (0–18)	0.007
Successful same-day TOV n (%)		18/29 (62.1)	33/37 (89.2)	0.009

MP 8.7. Table 1 (cont'd). Preoperative, operative, and followup data (up to 3 months)

Parameter		22 F MiLEP 41 patients	26 F HoLEP 41 patients	p
Operative data (cont'd)				
Catheterization time hours		4 (2–40)	3 (3–46)	0.04
Hospitalization time hours	Median (range)	5 (3–48)	5 (3–48)	0.03
	Mean	11.1	7.2	
Admission n (%)		12 (29.3)	4 (9.8)	0.026
Emergency room visit n (%)		4 (9.8)	2 (4.9)	0.4
Readmission n (%)		3 (7.3)	2 (4.9)	0.64
One-month followup				
Number of patients		41	41	–
IPSS median (range)		9 (2–24)	8 (1–21)	0.39
QoL median (range)		2 (0–6)	2 (0–6)	0.86
Qmax mL/s median (range)		18.7 (4.8–40.8)	20.9 (10.7–40.4)	0.33
PVR mL median (range)		56 (0–300)	45 (0–440)	0.2
Stress incontinence n (%)		3 (7.3)	3 (7.3)	1
Three-month followup				
Number of patients		33	37	—
IPSS median (range)		6 (1–17)	4 (1–18)	0.15
QoL median (range)		2 (0–3)	1 (0–5)	0.37
Qmax mL/s median (range)		23.7 (13.8–44.7)	22.9 (8.9–38.8)	0.92
PVR mL median (range)		30 (0–245)	28 (0–220)	0.24
Stress incontinence n (%)		1 (3)	1 (2.7)	0.93
Postoperative PSA ng/mL median (range)		0.64 (0.023–1.1)	0.5 (0.23–2.4)	0.34

MP 8.8

Real-world outcomes of Aquablation for benign prostatic hyperplasia: A comparative analysis with the WATER and WATER II trials

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Introduction: The WATER and WATER II studies of Aquablation demonstrated efficacy for treatment of lower urinary tract symptoms secondary to benign prostatic hyperplasia (BPH) in men with prostate volumes (PV) 30–80 and 80–150 cm^3 in size, respectively. In this study, we compare real-world outcomes of men undergoing Aquablation with similar PVs to results from the randomized trials.

Methods: We retrospectively analyzed 1946 men from the International Collaborative Aquablation Research Urology Society (ICARUS) database with PV ≤150 mL who underwent Aquablation at one of four international centers. Baseline characteristics, complications, and functional outcomes were compared with data from the WATER and WATER II trials.

Results: From the ICARUS database, 1069 men with PV ≤80 mL were compared to 116 men from the WATER I trial, and 877 men with PV 80–150 mL were compared to 101 men from the WATER II trial (Table 1). Patients presenting in the real world had on average, slightly lower baseline Qmax flow rates, slightly higher baseline postvoid residuals (PVR), slightly lower baseline International Prostate Symptom Scores (IPSS) and Quality of Life (QoL) scores, and higher urinary retention rates. Notably, transfusion rates were lower in the real-world dataset. When comparing postoperative outcomes, IPSS and QoL scores were slightly higher at some timepoints in the real world, but anejaculation rates, Qmax flow rates, and PVRs were similar across the cohorts.

Conclusions: Real-world outcomes of Aquablation for men with BPH are broadly comparable to those observed in the pivotal WATER and WATER II trials, despite broader inclusion criteria and a more diverse patient population. These findings support the generalizability and sustained efficacy of Aquablation, reinforcing its role as a viable treatment for BPH in routine clinical practice.

MP 8.9

Autologous fascia pubovaginal sling for stress urinary incontinence: Enhanced overactive bladder outcomes with primary vs. rescue treatment in a Canadian cohort

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Introduction: Stress urinary incontinence (SUI) is a common urologic condition affecting quality of life (QoL) in women.[1] Autologous fascia pubovaginal sling (AF-PVS) has re-emerged as an option for SUI treatment due to complications of synthetic mid-urethral slings (MUS) and concerns regarding the use of vaginal mesh.[2] While AF-PVS has shown promising potential in mitigating SUI, whether surgical outcomes vary between patients who underwent PVS as the first surgical treatment for SUI (primary PVS [PVS1]) and those who had PVS as a rescue treatment for previously failed SUI surgeries (secondary PVS [PVS2]) has yet to be elucidated.[3] The objectives of this study were to assess the adverse effects of AF-PVS, as well as the functional outcomes between PVS1 and PVS2 patients at one, six, and 12 months postoperatively.

Methods: After research ethics committee approval, we conducted a single-center, two-surgeon, retrospective cohort study from January 2013 to April 2022 including 93 patients who underwent AF-PVS using a standardized technique (Figure 1) with a minimum of one year of followup. The PVS1 and PVS2 groups consisted of 37 and 56 patients, respectively. Demographics and clinical data were collected, including age, body mass index (BMI), pads per day, clinical diagnosis (SUI or mixed urinary incontinence [MUI]), as well as surgical SUI history. Postoperative complications were measured and included de novo overactive bladder (OAB), urinary retention/obstruction, wound infection, hematoma, or seroma, and urinary tract infection. Changes in pre- and postoperative Overactive Bladder Symptom Score (OABSS), International Consultation on Incontinence Questionnaire- Short Form (ICIQ-SF), and Incontinence Impact Questionnaire (IIQ-7) scores were evaluated, as well as the rate of persistent OAB and SUI. Chi-squared test and Student t test were used to evaluate dichotomous variables and continuous normally distributed data, respectively. Data were summarized using mean and standard deviation for quantitative variables and absolute and relative frequency for categorical variables. Paired analysis was conducted to compare questionnaire scores between both groups. An alpha significance level of 5% was used.

Results: The PVS2 group was found to be significantly older than the PVS1 group (60.33±11.05 vs. 52.66±12.64, presented as mean ± SD, $p<0.005$). The PVS1 group showed significant improvement in OABSS, ICIQ-SF, and IIQ-7 scores, with a lower incidence of persistent OAB at six and 12 months compared to PVS2 (14.3% vs. 47.2% and 26.7% vs. 65.5%, respectively, $p<0.005$). There was no significant difference in the rate of complications or the incidence of persistent SUI within both groups.

Conclusions: The use of AF-PVS for correction of SUI is equally safe in patients with and without history of previous surgical treatments for SUI. PVS may be more effective for OAB improvement in primary SUI cases, while multiple prior SUI surgeries may increase the risk of persistent OAB in patients with underlying OAB diagnosis. On the contrary, there was no difference in persistent SUI or complications between either group, suggesting that multiple past SUI surgeries had no important effect on the success of PVS or its adverse outcomes.

MP 8.8. Table 1. Comparison between ICARUS database and WATER study

	ICARUS <80 (n=1069)	WATER I 30–80 (n= 116)	p	ICARUS 80–150 (n=877)	WATER II 80–150 (n=101)	p
Age (mean, SD) n	64.48 (8.29) 1065	65.9 (7.3) 116	p=0.76	69.71 (7.84) 873	67.5 (6.6) 101	**p=0.01**
Prostate volume, mL (median, IQR) n	57.0 (45.0–67.0) 1069	52.3 (40.1–67.9) 116	**p<0.001**	102.0 (90.0–120.5) 877	105.0 (90.7–120.0) 101	**p<0.001**
Baseline Qmax (median, IQR) n	8.8 (6.0–13.2) 569	9.25 (6.9–12) 116	**p<0.001**	5.65 (3.4–8.5) 380	8.8 (6.7–11.0) 101	**p<0.001**
Baseline PVR (median, IQR) n	95.0 (35.0–189.7) 733	85 (29.5–159.5) 116	**p<0.001**	120.2 (50.0–300.0) 545	101 (51.0–183.0) 101	p=0.17
Baseline IPSS (mean, SD) n	20.37 (7.35) 860	22.9 (6.0) 116	**p<0.001**	20.5 (8.0) 640	23.2 (6.3) 101	p=0.001
Baseline QoL (median, IQR) n	4.0 (3.0–5.0) 251	5.0 (4.0–6.0) 116	**p<0.001**	4.0 (3.0–5.0) 253	4.0 (4.0–5.0) 101	p=0.81
Baseline PSA (median, IQR) n	2.4 (1.37–4.22) 752	2.8 (1.3–5.0) 116	**p=0.02**	4.8 (3.07–7.60) 607	5.2 (2.6–10.2) 101	**p=0.01**
Baseline urinary retention requiring catheterization n (%) n	90 (9.4%) 961	0		150 (20%) 752	0	
Baseline presence of median lobe n (%) n	595 (59.9%) 993	NA	NA	534 (64.4%) 829	84 (83.2%) 101	**p<0.001**
Blood transfusion n (%) n	2 (0.19%) 1067	1 (0.9%) 116	p=0.27	11 (1.26%) 874	6 (5.9%) 101	**p=0.01**
Anejaculation n (%) n	28 (13%) 223	8 (7%) 116	p=0.14	26 (12%) 215	15 (15%) 101	p=0.48
3-month Qmax (mean, SD) n	21.7 (10.6) 333	20.8 (13.4) 116	p=0.46	20.9 (8.9) 261	19.4 (10.7) 101	p=0.18
3-month PVR (mean, SD) n	45.0 (67.0) 786	49.3 (51.1) 116	p=0.51	50.1 (72.6) 620	55.4 (63.7) 101	p=0.49
3-month IPSS (mean, SD) n	9.9 (6.9) 631	7.0 (5.7) 116	**p<0.001**	9.0 (6.1) 535	6.7 (5.0) 101	**p<0.001**
4–8 months IPSS (mean, SD) n	8.0 (5.9) 326	5.9 (4.9) 116	**p<0.001**	6.6 (5.1) 262	6.0 (5.2) 101	p=0.32
9–12 months IPSS (mean, SD) n	6.2 (5.4) 101	7.7 (7.8) 115	p=0.11	5.8 (5.4) 63	6.2 (5.0) 101	p=0.62

Bold values indicate statistical significance.

MP 8.8. Table 1 (cont'd). Comparison between ICARUS database and WATER study

	ICARUS <80 (n=1069)	WATER I 30–80 (n= 116)	p	ICARUS 80–150 (n=877)	WATER II 80–150 (n=101)	p
13–24 months IPSS (mean, SD) n	7.9 (6.6) 161	7.7 (6.6) 115	p=0.80	6.0 (5.4) 151	5.8 (4.5) 101	p=0.76
3-month QoL (mean, SD) n	2.4 (1.8) 181	1.5 (1.5) 116	p<0.001	2.0 (1.6) 202	1.8 (1.8) 101	p=0.33
4–8 months QoL (mean, SD) n	2.2 (1.5) 114	1.3 (1.4) 116	p<0.001	1.7 (1.5) 119	1.4 (1.7) 101	p=0.17
9–12 months QoL (mean, SD) n	2.2 (2.3) 17	1.6 (1.6) 115	p=0.18	3.1 (3.6) 20	1.3 (1.5) 101	p<0.001
13–24 months QoL (mean, SD) n	2.1 (1.7) 80	1.6 (1.6) 115	p=0.04	1.6 (1.27) 78	1.1 (1.3) 101	p=0.01

Bold values indicate statistical significance.

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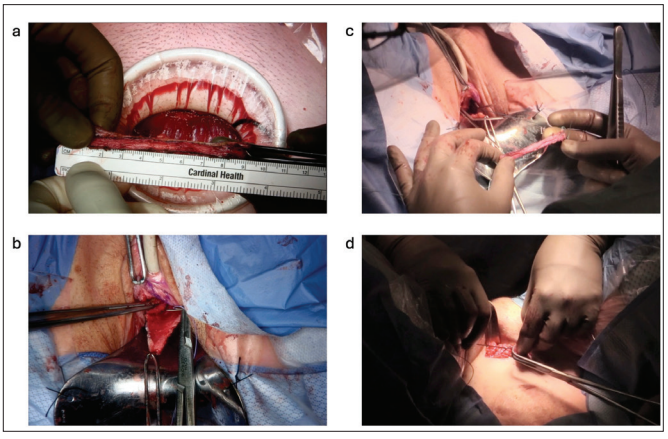

MP 8.9. Figure 1. AF-PVS surgical technique using rectus fascia.

MP 8.10

Buccal mucosal grafts perform less favorably after urethroplasty in a radiated setting

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Introduction: Buccal mucosal grafts (BMG) are the preferred tissue for substitution urethroplasty, particularly in the bulbar urethra; however, it is unclear if BMG performs equally well across all stricture etiologies, especially in the longer term. The objective of this study was to examine etiology-specific outcomes of bulbar urethroplasty using BMG.

Methods: From September 2003 to May 2023, 1870 patients undergoing anterior urethroplasty at a single center were reviewed using regional electronic records and telephone interviews. The primary outcome was urethroplasty failure, defined as a recurrent stricture (<16 Fr) confirmed on cystoscopy. Secondary outcomes included 90-day complications (Clavien-Dindo ≥2), patient-reported erectile dysfunction, chordee, and satisfaction. Multivariable Cox regression analysis was used to evaluate associations with stricture recurrence and Chi-squared to assess secondary outcomes.

Results: Of 914 patients undergoing bulbar urethroplasty with BMG, the median patient age was 48 years (IQR 24) and stricture length was 4.0 cm (IQR 2). Most (91.0%) patients failed a median of two (IQR 2) prior endoscopic treatments. With a median followup of 103 months (IQR 106), 62 recurrences were observed. For the entire cohort, the cumulative incidence of stricture recurrence was 5.1%, 6.7%, 7.8%, and 9.0% after one, two, five, and 10 years, respectively. On multivariable assessment, stricture etiology, in particular radiation (HR 6.3, 95% CI 3.0–13.0, p<0.0001), was associated with a heightened risk of stricture recurrence, as well as stricture length (HR 1.2, 95% CI 1.1–1.3, p=0.0001), diabetes (HR 2.0, 95% CI 1.1–3.7, p=0.02), and prior urethroplasty (HR 2.4, 95% CI 1.3–4.5, p=0.007). For radiation strictures, the estimated incidence of recurrence was 28.2%, 31.9%, and 39.5% at one, two, and five years, respectively, compared to 2.9%, 4.8%, and 6.1%, respectively, for idiopathic strictures (p<0.001). There was no difference between etiologies with respect to 90-day complications (p=0.77) or de novo erectile dysfunction (p=0.53) but patients with radiation strictures reported lower postoperative satisfaction when compared to other etiologies (83.9% vs. 92.2%, p=0.04).

Conclusions: While bulbar urethroplasty with buccal mucosa is an effective treatment for recurrent bulbar urethral strictures, this tissue does not perform as favorably in the radiated setting, perhaps due to a poor periurethral milieu associated with this condition.

MP 8.11

UroLOGIC: Developing a patient-friendly predictive tool for urethroplasty outcomes for management of urethral strictures

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Introduction: Urethroplasty is generally regarded as the most effective treatment of urethral stricture; however, recurrences and complications can occur even in the most skilled hands, and reliably predicting these outcomes remains elusive. The purpose of this study was to develop clinical tools to predict patient-specific surgical outcomes using machine learning.

Methods: A retrospective review was performed of men undergoing anterior urethroplasty at a single center from 2003–2024. Stricture-specific and patient-specific variables were identified. Success was defined as easy passage of a flexible cystoscope at routine followup with no change in urinary function thereafter. Complications were defined as a Clavien >1 90-day complication. Associations between clinical variables and stricture recurrence were evaluated using classical Cox regression analysis. Operator characteristic (ROC) analysis was performed on U-Score (US), LSE, and variables independently associated with outcomes (LERNS). A multitask logistic regression deep machine-learning algorithm for survival prediction was developed using surgeon and patient-reported data and associations between these factors and outcomes.

Results: A total of 2068 patients underwent urethroplasty over the study period, with a median patient age of 49 years (IQR 27) and stricture length of 4 cm (IQR 3). On classical multivariable Cox regression, stricture length (L) (HR 1.09, 95% CI 1.04–1.16, p=0.001), etiology (E) (HR 1.16, 95% CI 1.06–1.28, p=0.002), revision urethroplasty (R) (HR 1.56, 95% CI 1.07–2.28, p=0.02), stricture number (N) (HR 2.34, 95% CI 1.01–7.43, p=0.05), and location/segment (S) (HR 1.32, 95% CI 1.04–1.68, p=0.02) were independently associated with stricture recurrence after urethroplasty. On ROC analysis, US (AUC 0.71, 95% CI 0.66–0.75, p<0.001) and LSE (AUC 0.69, 95% CI 0.64–0.74, p<0.001) provided acceptable discrimination for stricture recurrence, while LERNS provided improved but not excellent discrimination (AUC 0.76, 95% CI 0.71–0.80, p<0.001). All provided poor diagnostic discrimination for complications (US AUC 0.57, LSE 0.55, LERNS 0.58). Multitask logistic regression using deep machine learning calculated a predictive combined model using a training data set and provided an AUC of 0.84.

Conclusions: Classical regression tools and staging systems fail to provide excellent diagnostic discrimination in predicting urethroplasty outcomes. Machine-learning algorithms can be used to create more accurate and patient-specific outcome predictions.

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MP 8.12

Mediation analysis of adherence to pelvic floor muscle training and weekly self-monitoring on urinary symptoms in men with localized prostate cancer: A secondary analysis of the Prostate Cancer-Patient Empowerment Program (PC-PEP) randomized controlled trial

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Introduction: Patients receiving curative treatment for localized prostate cancer often face urinary complications that affect quality of life. The Prostate Cancer Patient Empowerment Program (PC-PEP) is a six-month intervention including pelvic floor muscle training (PFMT) along with stress management, dietary guidance, physical exercise, and intimacy support. While previous research has demonstrated that early initiation of PC-PEP can improve urinary outcomes, the influence of participant adherence to PFMT and self-monitoring on these outcomes remains unclear. This study evaluates both the direct effects of adherence to PFMT and the mediating role of weekly self-monitoring on the association between timing of the PC-PEP delivery (early vs. late) and urinary outcomes.

Methods: In a randomized controlled trial, 128 patients diagnosed with localized prostate cancer were randomly assigned to receive either PC-PEP with standard care (n=66) (early group) or standard care alone (n=62) for six months; at six months, the standard care group received the intervention for six months (late group). Here, we compare the impact of the delivery timing of the intervention: early vs. late on urinary outcomes assessed with the Expanded Prostate Cancer Index Composite (EPIC) administered via online surveys. Weekly self-monitoring compliance surveys were administered during the intervention period to track adherence. Linear mixed models were employed to examine the associations between average weekly PFMT duration, self-monitoring survey completion rates, and urinary symptoms post-intervention. Mediation and moderated mediation analyses were conducted using the PROCESS macro. Covariates included baseline urinary scores, time from randomization to treatment, age, Charlson comorbidity index, and treatment modality.

Results: There were no significant differences in average weekly PFMT duration between the early and late intervention groups; however, adherence to weekly self-monitoring surveys was significantly higher in the early intervention group (p<0.001), with a mean completion rate of 98.8% compared to 64.1% in the late group. Average weekly PFMT duration was significantly associated with improved urinary continence symptoms (F=6.78, p=0.011), whereas self-monitoring survey completion rate was not significantly associated with urinary outcomes (F=1.103, p=0.366). No significant interaction effect was found between the intervention group and average weekly PFMT duration (p=0.704), indicating a consistent benefit across both groups. Mediation analysis revealed that adherence to self-monitoring surveys partially mediated the relationship between intervention timing and urinary continence symptoms (indirect effect 4.12, 95% CI 0.12–9.08). The treatment modality did not significantly modify the mediation effect.

Conclusions: This study highlights that early intervention in PC-PEP is associated with higher adherence to self-monitoring surveys. While PFMT adherence emerged as a key predictor of improved urinary symptoms, the findings underscore the importance of early engagement and consistent self-monitoring. Our results suggest that the PC-PEP's unique approach — emphasizing early initiation and participant accountability — plays a critical role in enhancing urinary rehabilitation in prostate cancer care. Incorporating these components into standard care could significantly improve patient outcomes.

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MP 8.13

The Optilume drug-coated balloon for recurrent anterior urethral strictures: ROBUST III study 4-year results

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Introduction: The ROBUST III study is a randomized controlled trial comparing the Optilume® drug-coated balloon (DCB) against direct visual internal urethrotomy (DVIU) or dilation. The Optilume® DCB is a dilation balloon with a paclitaxel coating that combines mechanical dilation for immediate symptomatic relief with local drug delivery to maintain urethral patency. Outcomes after four-year followup are presented here.

Methods: A total of 127 subjects were randomized in a 2:1 fashion at 23 sites. Seventy-nine were treated with the DCB and 48 were treated with DVIU or dilation. Followup past one year was limited to those treated with the DCB. Eligibility criteria included adult males with anterior strictures with ≥2 prior treatments and stricture length ≤3 cm. Long-term endpoints included freedom from repeat treatment, International Prostate Symptom Score (IPSS), and peak urinary flow rate (Qmax).

Results: Subjects randomized to receive the DCB had an average of 3.2 prior treatments and average stricture length of 1.6 cm (46% ≥2 cm), with 8/79 (10.1%) having penile strictures and 9/79 (11.4%) having prior pelvic radiation. IPSS significantly improved from 21.9 at baseline to 12.8 at four years. Qmax significantly improved from a baseline of 7.7 mL/sec to 10.3 mL/sec at four years. Freedom from repeat intervention for DCB subjects was estimated to be 68%. No late-onset treatment-related adverse events were observed.

Conclusions: The Optilume® DCB continues to achieve significant improvements in symptoms, flow, and reintervention rates through four years post-treatment.

MP 8.14

Shared decision-making for female stress urinary incontinence: Current practice in three Western countries

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Introduction: Different decision-making styles can be used to provide counseling for the multiple reasonable treatment options for patients with stress urinary incontinence (SUI). Shared decision-making (SDM) is currently advocated as the preferred style for preference-sensitive decisions, as SDM takes patient preferences into account. This study aimed to map the current decision-making process for SUI in three Western countries.

Methods: We included 124 patients and 18 physicians in a multicenter, prospective study in five hospitals in Canada, the U.K., and the Netherlands. We used patient and physician versions of the Control Preference Scale (CPS) questionnaires and examined audio recordings of consultations with the OPTION-5 instrument to assess the degree of SDM.

Results: Most patients (63%) perceived the decision-making as informative, some (29%) as shared, and only a few (8%) as paternalistic. Dutch patients more often perceived the decision-making as informative than U.K. or Canadian patients. Patients' preferred and perceived decision-making styles matched in 70% of consultations. Patients' and physicians' perceptions of decision-making were the same in 60% of consultations, but their perceptions of SDM use did not match. This also did not match the OPTION-5 scores reflecting the use of SDM. Almost all patients were satisfied with the decision-making they perceived.

Conclusions: Most patients and physicians prefer and perceive the current decision-making process as informative; however, patients and physicians have different perceptions of their mutual consultation. This highlights the imprecise concept of SDM for both patients and physicians.

MP 8.15 - WITHDRAWN