# Poster Session 9: Female Urology, Infertility, Best Practices
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## Abstract #113

### Optimizing vasectomy care: Initial evaluation of a clinical pathway to improve efficiency and followup

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**Introduction:** Following the 2022 overturning of Roe v. Wade and gradual ease of COVID era restrictions, the rate of men seeking vasectomy has been reported higher. At the same time, post-vasectomy followup has historically been poor due to problems with patient compliance. In response, we developed and implemented a structured clinical pathway designed to improve efficiency, reduce unplanned clinic contact, and maximize followup adherence. This study aimed to evaluate the initial effectiveness of that pathway.

**Methods:** We retrospectively reviewed patients who sought vasectomy consultation between May 2023 and December 2024. All procedures were performed by a single surgeon. Data collected included pathway completion, unplanned calls or visits (UPC), and responses to patient surveys regarding their own preparation, experience, and decision-making factors.

**Results:** Of 364 men who presented for consultation, 241 (66%) underwent vasectomy and 190 (52%) completed the full clinical pathway. The most common reason for not proceeding with vasectomy was reconsideration of family planning (46%). Only 3% of respondents cited the supreme court decision as a factor in their choice, with just one individual identifying it as the primary reason for considering vasectomy. Among those who went through with vasectomy, 190 (78.8%) completed a post-vasectomy semen analysis, and 140 (58%) attended a followup visit. Most patients reported resolution of bruising or swelling within two weeks (92%), and 72% felt fully recovered within the same timeframe. UPC occurred in 13% of cases and was consistent throughout the study period. Nursing followup phone calls did not alter this rate. The most common reasons for UPCs included swelling, pain, and incision- or suture-related concerns.

**Conclusions:** After initial review of the implemented pathway, UPC rates were consistent, and followup compliance was strong. Only 3% of NY men cited the supreme court decision was involved in their vasectomy interest. A surprising (34%) number of men did not proceed from vasectomy consultation to the procedure. Future work will address lowering UPC and increasing progression to vasectomy procedure.

## Abstract #114

### Opinions on vasectomies across the United States in the post-Dobbs era

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**Introduction:** On June 24, 2022, the U.S. Supreme Court overruled Roe v Wade in the historic case of Dobbs v Jackson Women's Health Organization; it was ruled that the Constitution does not confer a right to abortion, leaving the decision regarding the legality of reproductive healthcare to individual states. It is well-established that women's healthcare was significantly impacted by this legislation. In this project we took aim at a lesser-studied population: men. It has already been shown in a large healthcare organization that men are seeking consultations on and undergoing vasectomies at a greater rate post-Dobbs compared to pre-Dobbs. These important analyses shed light on how men's health was impacted by this change in legislation; however, these studies were conducted in singular healthcare settings and lack perspective across states with varying legislation.

**Methods:** We surveyed men across all 50 states in the U.S. to better understand the true impact on men's healthcare across state borders. Our survey was distributed using the ResearchMatch platform. Offers to participate were sent to 39 534 men aged 18–50, of which 811 agreed to be contacted and 649 completed the survey. We inquired about opinions on abortion, vasectomies, other forms of contraception, current state policy, and communication about contraception with sexual partners. Chi-squared analyses of contingency tables were used to determine statistical significance ($p<0.05$).

**Results:** A total of 71% (461) of respondents identified as pro-choice, 69% (448) reported using contraception of some form, and 17% (109) have undergone a vasectomy; 26% (170) of men report that they are more likely to get a vasectomy since the Dobbs decision and 47% (121) of respondents report having more conversations about pregnancy, contraception, and abortion since the legislative change. There was no statistical difference between men who live in abortion-accessible vs. restricted states in use of contraception, history of vasectomy, and change in interest in vasectomy post-Dobbs; however, responses to all these questions were found to be significantly different when comparing between men who identify as pro-life vs. pro- choice.

**Conclusions:** Despite recent changes in the political landscape and broad claims of increased interest in vasectomies and contraception, this study shows that men in states where women's access to reproductive healthcare is limited appear not to have different behavior compared to their counterparts in states with protected access to abortion. Instead, men's stance on abortion seems to have a greater impact on their behaviors surrounding vasectomies and family planning.

## Abstract #115

### Differences in systemic and pelvic symptoms of patients with small fiber neuropathy

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**Introduction:** Small fiber neuropathy (SFN) affects unmyelinated Aδ and C fibers, impairing pain transmission and autonomic regulation. Our pelvic health center encounters a high volume of patients with confirmed SFN. This study aims to evaluate systemic and pelvic symptom differences at presentation among patients with a known history of SFN.

**Methods:** All new patients presenting to our urogynecology and reconstructive pelvic surgery and multidisciplinary pelvic pain clinics completed an electronic multidisciplinary intake questionnaire incorporating medical history, validated symptom measures, and a comprehensive neurologic and autonomic review of systems (ROS). Patients reporting SFN had undergone prior neurologic evaluation and diagnostic skin biopsy confirming the diagnosis. Comparisons were performed between patients with and without SFN across 1) the entire presenting population; 2) those reporting pelvic symptoms (bladder, bowel, sexual, or pelvic pain); and 3) those specifically reporting pelvic pain. Statistical analysis used t-tests for continuous variables and Chi-squared or Fisher's exact tests for categorical variables.

**Results:** Twenty-two of 600 patients (3.7%) reported a known diagnosis of SFN at presentation. The average age with and without SFN was 46±15 years vs. 54±18 years, respectively. Patients with SFN had significantly higher POPDI-6 ($p=0.014$) and GUPIQOL q9 scores ($p=0.038$) compared to those without. Additionally, patients with SFN reported significantly more neurologic symptoms ($p<0.001$), localized pelvic pain sites ($p<0.001$), extra -pelvic pain sites ($p<0.001$), and autonomic symptoms ($p<0.001$). Among patients with pelvic symptoms, concurrent presence of SFN was associated with higher POPDI-6 ($p=0.014$), more autonomic symptoms ($p=0.001$), and increased neurologic symptoms ($p<0.001$). These patients also had a higher number of localized pelvic pain sites ($p<0.001$) and

extra-pelvic pain sites (p<0.001). Concurrent SFN in patients with pelvic symptoms was associated with lower orgasm intensity (p=0.009). Among patients with pain, those with SFN exhibited more autonomic (p<0.001) and neurologic symptoms (p<0.001) compared to those without. These patients also had a higher number of localized pelvic pain sites (p=0.043) and extra-pelvic pain sites (p=0.001). SFN was associated with lower orgasm intensity (p=0.036) (Tables 1, 2, 3).

**Conclusions:** SFN is increasingly recognized in patients presenting for pelvic health evaluation. Its presence substantially increases symptom severity across pelvic, neurologic, autonomic, and sexual domains, highlighting the importance of considering SFN in the assessment and management of complex pelvic pain populations.

**Abstract #115. Table 1. Pelvic symptomatology in all patients with small fiber neuropathy (SFN) vs. patients without SFN**

| | All patients (N=600) | | |
|---|---|---|---|
| | SFN | No SFN | p |
| UDI-6 (females) | 52.8±24.8 | 46.2±22.2 | 0.332 |
| CRAD-8 | 36.2±19.9 | 29.3±20.5 | 0.153 |
| POPDI-6 (females) | 40.5±12.5 | 31.1±19.1 | 0.014* |
| Ave pain in a week | 6.16±2.36 | 5.02±2.54 | 0.057 |
| Best pain in 30 days | 3.21±2.57 | 3.43±2.61 | 0.729 |
| Worst pain in 30 days | 7.68±1.70 | 6.83±2.60 | 0.056 |
| AUAQOL | 3.86±2.03 | 3.28±2.18 | 0.197 |
| GUPIQOL q9 | 4.82±1.18 | 4.25±1.53 | 0.038* |
| PHQ-4 total | 3.86±3.06 | 2.56±3.22 | 0.063 |
| PHQ-4: anxiety | 2.05±1.62 | 1.51±1.85 | 0.146 |
| PHQ-4: depression | 1.82±1.87 | 1.04±1.64 | 0.069 |
| Neurological Sx | 5.73±3.22 | 2.04±2.44 | <0.001*** |
| Localized pelvic pain sites | 12.41±6.14 | 5.59±5.85 | <0.001*** |
| Extra-pelvic pain sites | 6.91±3.24 | 2.25±2.45 | <0.001*** |
| Autonomic ROS | 12.09±5.95 | 4.21±4.52 | <0.001*** |

High significance is denoted by *** (p<0.001), statistical significance is denoted by ** (p<0.01), and marginal significance is denoted by * (p<0.05).

**Abstract #115. Table 2. Differences in pelvic symptomatology in patients with pelvic symptoms with and without small fiber neuropathy (SFN)**

| | Patients with pelvic symptoms (N=468 ) | | |
|---|---|---|---|
| | SFN | No SFN | p |
| UDI-6 (females) | 52.8±24.8 | 46.3±22.2 | 0.340 |
| CRAD-8 | 36.2±20.0 | 29.4±20.5 | 0.157 |
| POPDI-6 (female) | 40.5±12.5 | 31.2±19.1 | 0.014* |
| Autonomic ROS | 12.2±6.1 | 4.7±4.8 | 0.001*** |
| Ave pain in a week | 6.2±2.4 | 5±2.5 | 0.053 |
| Best pain in 30 days | 3.2±2.6 | 3.5±2.6 | 0.696 |
| Worst pain in 30 days | 7.7±1.7 | 6.8±2.6 | 0.047* |
| AUAQOL | 4.0±1.9 | 4.2±1.5 | 0.698 |
| GUPIQOL q9 | 4.8±1.2 | 4.4±1.4 | 0.122 |
| PHQ-4 total | 3.9±3.1 | 2.8±3.3 | 0.150 |
| PHQ-4: anxiety | 2.1±1.7 | 1.7±1.9 | 0.315 |
| PHQ-4: depression | 1.8±1.9 | 1.2±1.7 | 0.133 |
| Neurological Sx | 5.8±3.3 | 2.3±2.5 | <0.001 *** |
| Localized pelvic pain sites | 13.0±5.7 | 7.1±5.8 | <0.001*** |
| Extra-pelvic pain sites | 6.9±3.3 | 2.5±2.6 | <0.001*** |
| Sex satisfaction | 3.3±1.5 | 3.0±1.5 | 0.399 |
| Orgasm intensity | 2.0±0.5 | 2.5±1.0 | 0.009** |

High significance is denoted by *** (p<0.001), statistical significance is denoted by ** (p<0.01), and marginal significance is denoted by * (p<0.05).

## Abstract #116

### What is normal convalescence after vasectomy?

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**Introduction:** While post-vasectomy pain syndrome (PVPS) has been assessed in the past, the time to convalescence after vasectomy has not been extensively studied. As most men do not develop PVPS, a better understanding of the normal course of men after vasectomy has value, as it constitutes the majority of men recovering from vasectomy and may be of benefit for pre-vasectomy counseling.

**Methods:** This single-center, retrospective cohort study used patient survey data collected over a seven-month period. Surveys were administered at three distinct time points after vasectomy: three days, one month, and at least three months following procedure. A total of 48 patients participated in at least one survey; 30 completed the first two, 19 completed the third, and 10 completed all three. The mean age of the cohort is 38.8 years. All men received a no-scalpel vasectomy.

**Results:** At three days post-procedure, the mean pain score was 1.8±1.4, with scores ranging from 0–7. By one month, the mean pain score significantly decreased to 0.1±0.3. One month after vasectomy, 27 patients reported no pain (0 out of 10), while three patients reported minimal pain (1 out of 10). Of the 20 patients that participated in the third survey, 19 reported no pain (0 out of 10), and one reported minimal pain (1/10) that does not affect his quality of life.

**Conclusions:** A leading reason men cite for avoiding vasectomy is the fear of pain associated with the procedure. Our results show most men have minimal pain even three days after vasectomy, with nearly all men reporting almost no pain at a month after procedure. These data are helpful in counseling men about the expected course after vasectomy.

**Abstract #115. Table 3. Differences in pelvic symptomatology in patients with pelvic pain with and without small fiber neuropathy (SFN)**

| | Patients with pelvic pain (N=267 ) | | |
|---|---|---|---|
| | SFN | No SFN | p |
| UDI-6 (females) | 50.0±24.7 | 48.7±22.3 | 0.852 |
| CRAD-8 | 34.4±18.8 | 33.9±21.3 | 0.907 |
| POPDI-6 (female) | 41.1±13.3 | 25.8±19.8 | 0.197 |
| Autonomic ROS | 12.5±6.3 | 5.9±5.4 | <0.001*** |
| Ave pain in a week | 6.2±2.4 | 5.0±2.5 | 0.057 |
| Best pain in 30 days | 3.2±2.6 | 3.4±2.6 | 0.729 |
| Worst pain in 30 days | 7.7±1.7 | 6.8±2.6 | 0.056 |
| AUAQOL | 4.0±2.0 | 4.2±1.7 | 0.657 |
| GUPIQOL q9 | 4.8±1.3 | 4.7±1.3 | 0.795 |
| PHQ-4 total | 3.8±3.3 | 3.5±3.5 | 0.651 |
| PHQ-4: anxiety | 2.1±1.8 | 2.0±2.0 | 0.954 |
| PHQ-4: depression | 1.8±2.0 | 1.5±1.8 | 0.486 |
| Neurological Sx | 6.1±3.2 | 3.1±2.7 | <0.001*** |
| Localized pelvic pain sites | 13.7±5.5 | 10.9±5.1 | 0.043 |
| Extra-pelvic pain sites | 7.1±3.3 | 3.0±2.9 | <0.001*** |
| Sex satisfaction | 3.3±1.6 | 3.1±1.4 | 0.674 |
| Orgasm intensity | 2.0±0.5 | 2.4±1.0 | 0.036* |

High significance is denoted by *** (p<0.001), statistical significance is denoted by ** (p<0.01), and marginal significance is denoted by * (p<0.05).

## Abstract #117

### The autonomic score: Correlations guiding URPS intake data on 600 patients

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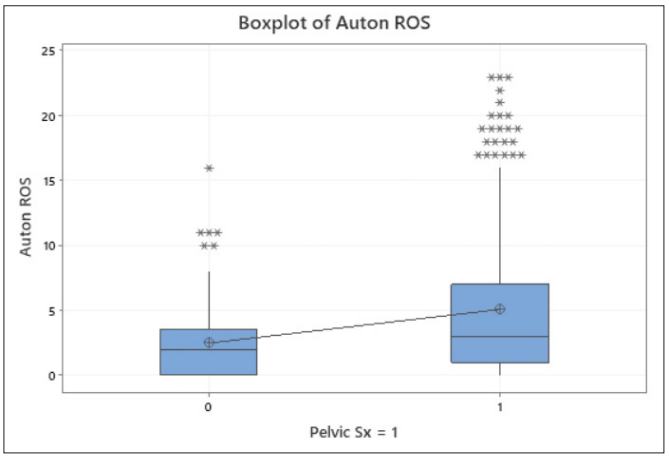
**Introduction:** Multidisciplinary pelvic symptomatology, body pain maps, and overlapping pain syndromes are emerging as relevant to patient evaluation in pelvic floor disorders, especially those with pelvic pain.

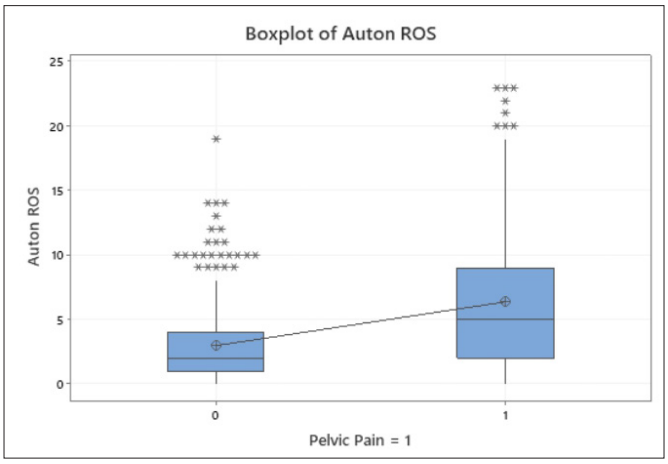
**Methods:** We developed and implemented two novel self-reported tools — an autonomic score (assessing symptoms such as postural orthostatic tachycardia syndrome [POTS], palpitations, PTSD, and bloating) and a neurological review of systems (ROS) (addressing intermittent catheterization, balance issues, and nerve-related pain from spine pathology) — as part of a comprehensive, electronic intake for patients evaluated in urology-based urogynecology and reconstructive pelvic surgery and multidisciplinary pelvic pain clinics. Statistical analyses included unpaired t-tests, Chi-squared tests, and linear regression.

**Results:** A total of 600 sequential patients (526 female, 63 male, and 11 transgender) completed 100% of the intake. The autonomic score was significantly higher in those with pelvic symptoms (mean 5.1±5.1 vs. 2.5±2.9, p<0.001) including pushing to void (mean 3.67±4 vs. 8.5±6.2) (p<0.001) and pelvic pain (mean 6.4±5.7 vs. 3.0±3.2, p<0.001) (Figures 1, 2). Higher autonomic scores correlated significantly with a worse (higher) AUAQOL score ($R^2$=0.061, p<0.001) and worse (higher) GUPIQOL q9 ($R^2$=0.042, p<0.001) as well as anxiety and depression (PHQ4) ($R^2$=0.17, p<0.001), and neurologic symptoms ($R^2$=0.60, p<0.001). The autonomic score was significantly higher in those reporting transgender gender identity (mean 9±6.7), compared to biological females (mean 4.5±4.8) and biological males (mean 3.9±4.4) (p<0.001). There was no significant difference in the autonomic score with respect to sexual activity (mean 4.6±5 vs. mean 5.4±5.2, p=0.111) or orgasm intensity in sexually active patients (N=278, $R^2$=0.00, p=0.842), SHIM q1 (hardness) ($R^2$=0.01, p=0.903), or overall SHIM scores in sexually active men (N=49, $R^2$=0.0, p=0.533). Interestingly, those with higher autonomic score had higher sexual satisfaction scores ($R^2$=0.032, p<0.001). The neurologic ROS was significantly elevated in patients with a trauma history (mean 4.4±2.9 vs. 2.0±2.4, p<0.001) and localized pelvic pain (mean 10.4±7.1 vs. 5.4±5.7, p<0.001). Orgasm intensity was not significantly affected by neurologic symptom burden ($R^2$=0.00, p=0.164).

**Conclusions:** Autonomic and neurologic symptoms are highly prevalent and clinically relevant among patients with pelvic pain and dysfunction. These findings support a holistic, systems-based approach to pelvic health that incorporates assessment of systemic contributors, particularly in complex or refractory cases.




**Abstract #117. Figure 1.** The correlation between pelvic symptoms and autonomic symptoms.




**Abstract #117. Figure 2.** The correlation between pelvic pain and autonomic symptoms.

## Abstract #118

### Reliability of AI chatbots in providing urinary tract infection health information: A comparative study of ChatGPT, Google Gemini, and DeepSeek

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**Introduction:** With the increasing reliance on artificial intelligence (AI) for medical information, concerns have emerged regarding the validity and quality of AI-generated health counseling, particularly when accessed through public platforms. Inaccurate or incomplete medical content can adversely affect patient decision-making and the integrity of physician-patient interactions. Despite their widespread use, the performance of AI tools like ChatGPT, Gemini, and DeepSeek in addressing specialized medical topics — such as urinary tract infections (UTIs) — remains underexplored. This study aimed to evaluate and compare the accuracy and completeness of responses generated by three AI models, ChatGPT, Gemini, and DeepSeek, when prompted with patient-oriented questions regarding female urinary tract infections. The findings will be measured against evidence-based clinical guidelines and publications.

**Methods:** A cross-sectional design was employed. Researchers developed five standardized, patient-focused questions on UTI management based on recent evidence and authoritative guidelines. Each question was individually submitted to ChatGPT, Gemini, and DeepSeek in a private browser session. Two medical professionals independently evaluated each AI-generated response for accuracy (1–3 scale) and completeness (1–2 scale: incomplete or complete). Both raters compared the AI response with the AUA guidelines. Inter-rater agreement was used to assess the consistency of ratings between evaluators.

**Results:** Inter-rater agreement was high across all models. Overall agreement for accuracy was 86.7%, while completeness ratings had 100% agreement. DeepSeek demonstrated the highest consistency, with 100% agreement between evaluators on both accuracy and completeness.
ChatGPT and Gemini each showed 80% agreement for accuracy but maintained full agreement for completeness.

**Conclusions:** All three AI models produced generally accurate and complete responses to UTI-related patient questions. High inter-rater agreement, especially for completeness, suggests strong reliability of the content; however, small variations in accuracy ratings highlight the importance of consistent evaluation frameworks. DeepSeek demonstrated the highest overall consistency, indicating potential for reliable patient education support.

## Abstract #119

### Intravesical polypropylene suture erosion and removal after robotic sacrocolpopexy

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**Introduction:** Robotic sacrocolpopexy (RSCP) has become the gold standard for pelvic organ prolapse repair due to its durability and minimal invasiveness; however, surgical techniques for RSCP vary widely, including differences in dissection depth, mesh selection, and suture type. Given the risk of suture erosion into the bladder, a rare but significant complication, suture material choice is an important consideration. This case series presents two patients with suture erosion following RSCP and highlights a safe, effective robotic approach for management.

**Methods:** Two patients with symptomatic polypropylene suture erosion following RSCP were identified. Diagnostic cystoscopy confirmed intravesical suture erosion, and both patients underwent robotic-assisted suture removal. Due to thinning of the posterior bladder wall, reinforcement was required to ensure wall integrity and prevent further erosions. Surgical details, postoperative outcomes, and symptom resolution were assessed to evaluate the efficacy and safety of the robotic approach

**Results:** Case 1: A 67-year-old female presented with mixed incontinence two years post-RSCP. She had minimal improvement of symptoms with vibegron for overactive bladder (OAB). Diagnostic cystoscopy revealed polypropylene sutures eroding into the bladder. She underwent robotic-assisted laparoscopic excision of the eroded sutures, which were replaced with ethibond sutures. A dermal graft was placed to prevent further erosion. Her postoperative recovery was uneventful. At followup, her OAB symptoms resolved, allowing discontinuation of vibegron. Case 2: A 75-year-old female presented with significant OAB symptoms one year after RSCP. She had minimal improvement with trials of trospium, mirabegron, and vibegron. On diagnostic cystoscopy, a 5 mm polypropylene suture tail protruding through the bladder trigone was discovered. She underwent a robotic-assisted sacrocolpopexy revision for suture excision and bladder wall reinforcement. Intraoperatively, the eroded sutures were fully removed and replaced with ethibond sutures. The bladder wall was reinforced with 3-0 Vicryl sutures. At followup, she initially reported persistent bloating and mild dysuria but denied hematuria or recurrent OAB symptoms.

**Conclusions:** Robotic-assisted excision provides a minimally invasive and effective approach for managing suture erosion following RSCP. Polypropylene suture erosion into the bladder, although rare, is a significant complication after RSCP. Clinicians should maintain a high index of suspicion for intravesical suture erosion in patients with persistent OAB symptoms following RSCP. To reduce the risk of erosion, monofilament nonabsorbable sutures should not be used under the bladder to secure the anterior vaginal mesh.

## Abstract #120

### Role of psychosocial factors of flares in patients with chronic urologic pelvic pain syndrome

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**Introduction:** Little is known about the factors associated with symptom exacerbations ("flares") in individuals with high-impact pain disorders such as urologic chronic pain syndrome (UCPPS) even though pain is their cardinal feature and defining attribute. Drawing from pain processing research, we sought to characterize how different psychosocial factors correspond with distinct flare attributes in UCPPS patients.

**Methods:** Study participants included 92 formally diagnosed UCPPS (interstitial cystitis/bladder pain syndrome or chronic prostatitis/chronic pelvic pain syndrome) patients (median age 43 years, SD 14, 82% female) with refractory pelvic pain. Data, completed as part of baseline evaluation of an NIH clinical trial, included the Pain Discomfort Scale (pain-related suffering), Coping Strategies Questionnaire Catastrophizing subscale, revised McGill Pain Inventory-Short Form (pain quality), Positive and Negative Affect Scale, Childhood Trauma Questionnaire, as well as flare and UCPPS symptom measures.

**Results:** A series of regression analyses were applied to characterize the association between psychosocial factors and flare dimensions. Psychosocial factors had a broad impact across multiple flare attributes. Their combined impact was strongest for flare severity with mood, pain-related suffering, trauma exposure during childhood, all significant predictors.

**Conclusions:** This investigation breaks new ground by linking experiential factors of pain — its personal meanings, sensations, and immediate and extended emotions — to UCPPS flares. Understanding the experiential factors that underline painful flares stands to supplement the dominant trigger (e.g., diet, physical activity) exposure approach which, by itself, has fallen short of understanding why, how, and for whom UCPPS patients are most vulnerable to symptom exacerbations and their impacts.

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## Abstract #121

### An investigation of adverse events related to male stress urinary incontinence devices: A MAUDE database analysis

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**Introduction:** Stress urinary incontinence (SUI) is treated surgically in 6–9% of cases following prostate surgery. Post-prostatectomy surgical management of SUI involves implantation of artificial urinary sphincters (AUS) or male slings. Given the complexity of these procedures, it is imperative to closely monitor the patient's postoperative course. Voluntary data sources, such as the FDA's manufacturing and user facility device experience (MAUDE), provide real-world insights into adverse events (AEs) associated with medical devices. The objective of this study is to analyze reported AEs related to the male SUI devices using the MAUDE database.

**Methods:** The MAUDE database was queried for artificial urinary sphincters using the FDA product code EZY, while cases related to male slings were generated using product code OMT. Reports generated from January 1, 2015, to December 31, 2024, were included in the study and devices, with <200 total reports excluded

from analysis. Frequencies of the five most reported AEs within self-defined patient AE categories were compared across devices using Pearson's Chi-squared test. We considered p-values <0.05 to be significant. AEs with fewer than five results were not statistically tested across devices due to small sample sizes, but descriptive frequencies were reported.

**Abstract #121. Table 1.**

| | AMS 800 artificial urinary sphincter (n=15452) | AMS AdVance sling (n=1145) | AMS AdVance XP sling (n=256) | p |
|---|---|---|---|---|
| | % of overall complication (n) | | | |
| Pain/discomfort | 2.49 (385) | 0.87 (10) | 3.13 (8) | <0.01* |
| Pain | 0.63 (218) | 0.79 (9) | 2.73 (7) | 0.04* |
| Discomfort | 0.63 (97) | 0.09 (1) | 0.39 (1) | – |
| Dysuria | 0.39 (60) | 0.00 (0) | 0.00 (0) | – |
| Burning sensation | 0.05 (8) | 0.00 (0) | 0.00 (0) | – |
| Abdominal pain | 0.01 (2) | 0.00 (0) | 0.00 (0) | – |
| Infection/inflammation | 4.08 (631) | 0.70 (8) | 1.17 (3) | |
| Unspecified infection | 3.07 (475) | 0.61 (7) | 0.39 (1) | – |
| Swelling/edema | 0.39 (61) | 0.00 (0) | 0.00 (0) | – |
| Inflammation | 0.26 (40) | 0.00 (0) | 0.00 (0) | – |
| Urinary tract infection | 0.21 (32) | 0.09 (1) | 0.78 (2) | – |
| Swelling | 0.15 (23) | 0.00 (0) | 0.00 (0) | – |
| Surgical/postoperative complications | 1.50 (232) | 0.26 (3) | 2.34 (6) | |
| Perforation | 0.78 (121) | 0.26 (3) | 1.17 (3) | – |
| Hematuria | 0.26 (40) | 0.00 (0) | 0.00 (0) | – |
| Hematoma | 0.23 (36) | 0.00 (0) | 0.39 (1) | – |
| Hemorrhage/bleeding | 0.11 (17) | 0.00 (0) | 0.78 (2) | – |
| Adhesion(s) | 0.12 (18) | 0.00 (0) | 0.00 (0) | – |
| Tissue injury | 20.33 (3141) | 2.18 (25) | 1.56 (4) | – |
| Erosion | 8.97 (1386) | 2.01 (23) | 0.78 (2) | – |
| Unspecified tissue injury | 6.99 (1080) | 0.00 (0) | 0.39 (1) | – |
| Tissue damage | 4.01 (620) | 0.09 (1) | 0.39 (1) | – |
| Scar tissue | 0.22 (34) | 0.09 (1) | 0.00 (0) | – |
| Fistula | 0.14 (21) | 0.00 (0) | 0.00 (0) | – |
| Urinary dysfunction | 42.52 (6570) | 33.36 (382) | 48.44 (124) | <0.01* |
| Urinary incontinence | 26.50 (3956) | 12.05 (138) | 20.70 (53) | <0.01* |
| Incontinence | 15.05 (2326) | 20.44 (234) | 25.00 (64) | <0.01 |
| Urinary retention | 1.66 (256) | 0.87 (10) | 1.95 (5) | 0.12* |
| Urethral stenosis/stricture | 0.16 (24) | 0.00 (0) | 0.00 (0) | – |
| Micturition urgency | 0.05 (8) | 0.00 (0) | 0.78 (2) | – |

**Results:** Our search yielded 13 688 case reports after screening for duplicates, irrelevant, and infrequently reported devices. The frequency of reports rose sharply in 2018 to 965, while peaking in 2019 at 3137. Of the cases, 16 853 AEs were identified between the AMS 800 AUS (n=15 452), AdVance (n=1145), and AdVance XP (n=256) slings. Urinary dysfunction was the most reported complication, with significantly higher proportions observed with AMS 800 (42.52%, n=6,570) and AdVance XP (48.44%, n=124) compared to AdVance (33.36%, n=382) (p<0.01). Urinary incontinence and incontinence also varied significantly between groups (p<0.01). Pain/discomfort was reported at the highest rate with AdVance XP (3.13%, n=8), driven mostly by higher rates of pain (2.73%, n=7; p=0.04), compared to other devices (Table 1).

**Conclusions:** There were significant differences of the proportion of reported AEs among the AMS 800 AUS and both AMS AdVance slings. These findings highlight the variability in reporting across devices and underscore the importance of AE reporting and post-market surveillance. These efforts help guide future studies and inform manufacturers for continuous improvement, ultimately ensuring patient safety.

## Abstract #122

### Adjustable Continence Therapy (ACT™) for stress urinary incontinence in women: Early outcomes and patient experiences

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**Introduction:** Adjustable Continence Therapy (ACT™) is currently being investigated in clinical trials for female stress urinary incontinence (SUI) secondary to intrinsic sphincteric deficiency (ISD) in the U.S. This study evaluated its role as a salvage therapy for women with refractory incontinence unresponsive to standard treatments.

**Methods:** This study evaluated women who underwent ACT implantation between July 2023 and January 2024. Device volume was adjusted every 4–6 weeks until achieving either desired continence or maximum volume. Incontinence severity was assessed via provocative pad tests, with patients classified as dry if postoperative pad weight was 0 g and improved if pad weight decreased by ≥50%. Treatment success was defined as either outcome. Statistical analyses included descriptive statistics and ANOVA.

**Results:** During the study period, seven subjects underwent ACT implantation and six met criteria for continence evaluation. Treatment success was achieved in 6/6 patients at a median of 12 months postoperatively. At the last followup, 5/6 (83.3%) were completely dry, demonstrating promising outcomes with ACT™. The one patient who was not completely dry demonstrated a 62.1% reduction in pad weight (91.8 g to 34.8 g at 12 months). At preoperative baseline, the average pad weight was 93.6 g (range 28–222). By six months the average pad weight had decreased to 35.6 g, with 3/6 (50%) dry at this time point. At six months postoperatively, the reduction in pad weight approached statistical significance (p=0.06) (Figure 1A). Average UDI-6 scores improved across all domains at six months, with reductions of 39% in irritative symptoms, 41% in stress incontinence, and 14% in obstructive symptoms (Figures 1B–D); however, one patient was removed from the study due to device erosion requiring explant of one of her balloons under local anesthesia. Level of incontinence was not measured and not achieved at the time of explantation.

**Conclusions:** ACT™ shows promise as a minimally invasive option for treating female SUI secondary to intrinsic sphincteric deficiency. Early results indicate significant symptom improvement. One subject experienced a device erosion requiring explantation of the device. At last followup, 6/7 subjects were either dry or 50% improved, highlighting the efficacy of this therapy in women with ISD.

**Funding:** Uromedica. Dr. Flynn is an investigator for Boston Scientific and Uromedica.

## Abstract #124

### Coloplast three-piece inflatable penile prosthesis failure: Is it necessary to replace all penile prosthesis components

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**Introduction:** Penile prosthesis placement offers high patient satisfaction and low failure rates; however, limited data exist on device longevity and the precise sites of failure. We conducted a retrospective, single-institution, IRB-approved study of 42 patients (2022–2025) who underwent replacement of Coloplast inflatable penile prostheses (Figure 1) due to device failure or malfunction.

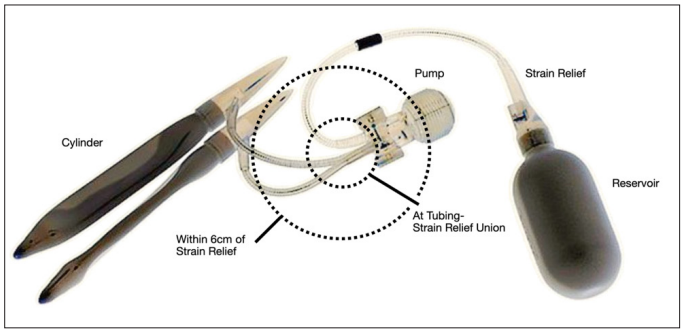
**Methods:** Intraoperative digital images were analyzed to confirm the location of device failure. Failure sites were categorized as follows: reservoir, reservoir strain relief, cylinder, cylinder strain relief, reservoir tubing, cylinder tubing, penile prosthesis pump, tubing at the pump's strain relief union, and tubing within 6 cm of the pump strain relief (Table 1)

**Results:** Device failure was identified at the tubing level in 95.2% (40/42) of cases, and 97.6% (40/41) of cases not caused by cylinder aneurism. Only one failure involved the reservoir, which was associated with instrumentation during ectopic reservoir placement. One involved cylinder aneurism. No pump failures were observed. Of the tubing failures, 85.0% (34/40) were located within 6 cm of the pump's strain relief. Additionally, 77.5% of these failures occurred in the cylinder tubing and 22.5% in the reservoir tubing; 72.5% (29/40) of tubing failures were at the pump tubing strain relief.

**Conclusions:** A clear understanding of the most common failure sites in Coloplast inflatable penile prostheses may influence surgical strategies for device revision. These findings suggest that most failures could be addressed with a targeted, low-risk tubing or pump replacement, rather than complete device removal.

**Abstract #124. Table 1**

| Location | n | % |
|---|---|---|
| All | 42 | 100.0% |
| Cylinder | 1 | 2.4% |
| Reservoir | 1 | 2.4% |
| Pump | 0 | 0.0% |
| Tubing | 40 | 95.2% |
| Cylinder tubing | 31 | 77.5% |
| Reservoir tubing | 9 | 22.5% |
| At pump's strain relief | 29 | 69.0% |
| Within 6 cm of pump's strain relief | 34 | 81.0% |
| Of tubing, within 6 cm | 34 | 85.0% |




**Abstract #124. Figure 1.**

## Abstract #125

### Perioperative glucose monitoring treatment to reduce risk of surgical site infections and postoperative complications

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**Introduction:** Patients with type 2 diabetes are at a higher risk of delayed wound healing, development of surgical site infections, and other surgical complications due to hyperglycemia and insulin resistance; however, variations in perioperative glucose control can translate to an even more significant risk in non-diabetic patients.

**Methods:** A quantitative, quasi-experimental research study was developed aimed at determining how the implementation of a perioperative glucose monitoring (POGM) and treatment protocol for hyperglycemia improves surgical patient 30-day outcomes. The goal of the protocol was to keep perioperative blood glucose below the Centers for Disease Control and Prevention's (CDC) guideline of 200 mg/dL [PB1]. Retrospective cohort analysis revealed a strong positive correlation between the length of surgery and the incidence of perioperative hyperglycemia; therefore, procedure duration lasting over two hours was an inclusion criterion for the study. Participants were monitored for hyperglycemia and treated with sliding-scale insulin lispro using existing hospital-based hyperglycemia protocols structured on the preoperative hemoglobin A1C (HgbA1c) regardless of diabetes diagnosis. Data collection included participant demographics, surgical duration, preoperative A1C, perioperative glucose readings, insulin dosing, and 30-day postop Comprehensive Complication Index (CCI).

**Results:** Results showed that no episodes of hypoglycemia occurred in the study, even with the inclusion of non-diabetic patients, as insulin dosing was patient-specific, and patients were not treated for blood glucose elevations below 150 mg/dL. There was a statistically significant association between monitoring and treating perioperative hyperglycemia with decreased incidence in surgical site infections (SSI) in the pilot study [$x^2(1)=4.18$, $p=0.041$]. There was a decrease in the rate of SSI (9.76%) in the POGM group compared to the no-POGM group (21.1%). Urinary tract infections in complex urologic cases decreased from 22.0% to 3.8%.

**Conclusions:** The POGM for perioperative hyperglycemia correlates to a reduction in the incidence of SSI while positively impacting the reduction of overall complications. Outcomes are significant enough to replicate the process among other institutions and surgical specialties.

## Abstract #126

### Understanding urologists' perceptions of prostate artery embolization in the management of benign prostatic hyperplasia

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**Introduction:** Prostate artery embolization (PAE) is a minimally invasive treatment for benign prostatic hyperplasia (BPH) performed by interventional radiologists (IR). As an alternative to traditional surgical interventions for BPH, PAE represents a unique intersection between urology and IR. Current guidelines state that PAE may be offered but acknowledge the need for further interdisciplinary investigation of its utility. This study explored how urologists perceive PAE as a BPH treatment option, how they view the role they play in patients undergoing PAE, and what changes in interdisciplinary collaboration they deem important.

**Methods:** A 22-question survey was distributed to practicing urologists across the U.S. and Canada. Questions addressed urologists' familiarity with PAE, including safety and efficacy, their views regarding the role of the urologist in referral for PAE and their opinions surrounding interdisciplinary collaboration. Urologists were stratified by years of experience in practice (<5 years, 6–15 years, and >15 years). Responses were collected using a five-point Likert scale.

**Results:** Fifty-six responses were analyzed. Nearly all (98%) urologists who provided a response reported familiarity with PAE. While the majority endorsed both the safety and efficacy of PAE (64% and 55%, respectively), only 41% of responders discuss PAE with their patients as a treatment option. Almost half (49%) of the surveyed urologists indicated a reluctance to discuss PAE with their patients due to concerns surrounding ischemic or infectious adverse events, with a considerable proportion (42%) believing the adverse events may be more severe than those associated with traditional procedures for BPH. With respect to the role of the urologist, 69% of responders believe patients are more likely to undergo PAE if they have not received formal urologic evaluation. Concern that patients are being treated for BPH prior to urologic input was most pronounced among urologists with fewer than five years of experience. Finally, although a clear majority (63%) of

the urologists reported having adequate resources for referral to and collaboration with IR, nearly four out of five (89%) called for more clear guidelines surrounding patient selection for PAE.
**Conclusions:** The findings of this study, while confirming urologists' general familiarity with PAE, suggest a hesitancy in recommending it for their patients with BPH. Moreover, the results of this survey signal a call for patients to receive formal urologic workup prior to treatment with PAE and clearer guidelines surrounding patient selection.

## Abstract #127

### Does eliminating pre-cystoscopic urine cultures affect rates of urinary tract infections? A QI initiative at the Albany, Stratton VA

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**Introduction:** Cystourethroscopy is essential in the evaluation of hematuria and voiding dysfunction. Given the risk of urinary tract infection (UTI) with this procedure, urine is typically assessed prior to proceeding. The standard operating procedure at the Albany VA has been to require a sterile urine culture within 30 days of cystoscopy. In January 2025, this was changed to spot urinalysis on the date of the procedure. We theorized that this would lead to shorter turnaround time to cystoscopy with a negligible change in the rate of UTIs.
**Methods:** We examined patients coming into the Albany Stratton VA prior to the change in protocol, August and September 2024, as well as post-change (January and February 2025). To do this, we pulled all encounters coded as 52000, the CPT code for cystoscopy for the given months. We then compared this to a list of cancelled clinic encounters that the clinic keeps, and performed chart review to look at the patients' culture data, antibiotic treatment the date of the procedure, cystoscopic findings, and pathology if biopsies were taken.
**Results:** In total, we evaluated 141 patients. There were 70 cystoscopy encounters in August and September 2024 and 71 in January and February 2025. Of the patients seen during the urine culture requirement, six patients received IV antibiotics prior to procedure, and one had a culture-proven UTI afterwards. Post-protocol alteration, two patients received IV antibiotic treatment prior to procedure, and one had a culture proven UTI.
**Conclusions:** The change in urine testing protocol for patients undergoing cystoscopy at the VA has not significantly altered UTI rates while simultaneously reducing cost burden on the system and time burden for the patient by reducing the number of patients presenting earlier for IV antibiotic treatment prior to the procedure.

## Abstract #128

### Preventable unplanned encounters after cystectomy: A retrospective study highlighting opportunities for improvement

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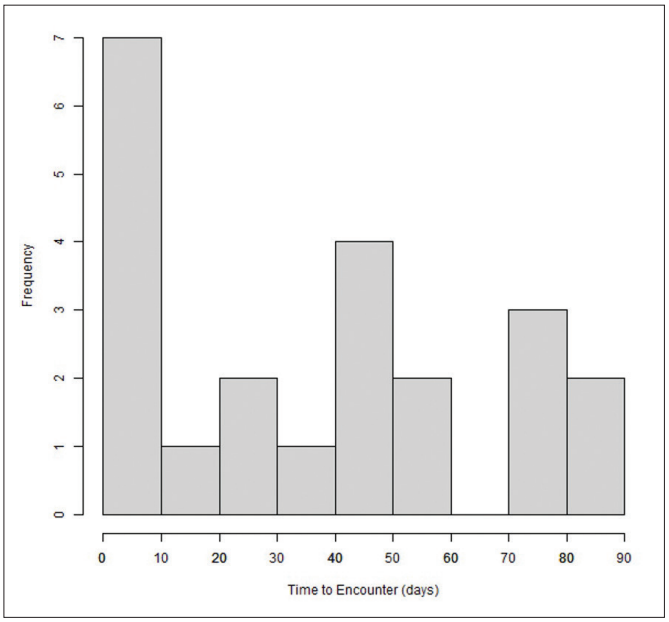
**Introduction:** Patients undergoing cystectomy often face significant challenges in navigating their care following discharge. Normal postoperative symptoms and new lifestyle adjustments, such as postoperative pain, swelling, changes in bowel habits, and ostomy management, can leave many patients feeling inadequately prepared after leaving the hospital. Consequently, there has been growing interest in using patient-centered tools, such as mobile health applications, patient portals, and remote telemedicine services, which seek to address shortcomings in postoperative education and better facilitate care team communication after surgery. In this study, we aimed to identify the frequency and timing of unplanned encounters that do not lead to readmission, with the goal of identifying potentially preventable acute care encounters following cystectomy that could be mitigated with enhanced post-discharge support.
**Methods:** We conducted a retrospective chart review of unplanned encounters among 100 consecutive cystectomy patients at a large integrated health system, spanning from June 2020 to November 2021. Unplanned encounters were defined as acute care visits (e.g., emergency department or office visits) that were not part of the patient's scheduled postoperative care plan. To compare groups, we used Fisher's exact test, with a significance threshold of $\alpha$<0.05.
**Results:** Seventy-five unplanned encounters were recorded for 46 patients within 90 days of discharge. Of these, 36 patients had 51 unplanned encounters, resulting in 50 readmissions and one death, while 19 patients had 24 unplanned encounters that led to discharge to home. Of the encounters that resulted in discharge to home, 7/22 (32%) occurred within seven days of discharge (where time-to-encounter data was available), compared to 8/51 (16%) unplanned encounters, which led to readmission; however, this difference did not reach statistical significance (p=0.13) (Figure 1).
**Conclusions:** Among 100 consecutive cystectomy patients, 24 unplanned encounters were recorded in those discharged home, with seven occurring within seven days of discharge. These findings highlight an opportunity to enhance patient education and care delivery during the early post-discharge period, which could help reduce preventable unplanned encounters and improve patient outcomes.




**Abstract #128. Figure 1.** Timing of preventable unplanned encounters following cystectomy