



ANNUAL MEETING OF THE IRISH SOCIETY of UROLOGY (ISU)

Friday 18 and Saturday 19 September 2026

Innisfallen Events Centre, Great Southern Hotel,
Killarney, Co Kerry

CPD Accreditation

Friday 18 September 2026: 6 CPD Credits

Saturday 19 September 2026: 6 CPD Credits



Message of Welcome

Dear Friends and Colleagues,

It is with great pride and pleasure that I welcome you to the Kingdom of Kerry (my home county) for our Annual Irish Society of Urology Meeting 2026.

It has been a singular honor to serve as President of the ISU over the past year.

I wish to acknowledge the great support from my fellow 12 members of the council, and indeed many other colleagues also. With the increased membership and expansion of our trainee numbers the effort and time required is significant. As a society we owe great thanks to all council members for their efforts. In particular I would like to acknowledge our new Trainee Programme Director, Frank O'Brien, our new Treasurer, Anna Walsh, and our Secretary Fardod O Kelly.

The first significant event for the ISU in 2026 was the official launch of our brand-new state of the art ISU website. I am sure all agree how professional and user friendly it is. As a society we are hugely indebted to enormous effort and many hours that our colleague Peter Ryan devoted to developing it.

During my term as president, I have had the privilege to attend and represent our society at many meetings, both at home and abroad. Indeed, as a society we have continued to exponentially grow and thus there is a very busy calendar. Without significant effort and time spent by many colleagues, many of these meetings would not occur. I will mention some by name, however I do wish to thank all colleagues who have positively contributed to our society.

The year began with a very successful restructured Charter Day Urology Session. We had 7 superb and high calibre presentations from Irish Trainees competing for the Anthony Walsh/RCSI travelling fellowship. I wish to thank Catherine Dowling, Niall Davis, Barry McGuire, Frank O'Brien, Nikita Bhatt, Anna Walsh, Kilian Walsh and Greg Nason for their efforts in making this meeting a great success.

The EAU was held in London and as always was very well attended by Irish Urologists and Trainees and indeed there were significant contributions from both.



The John Fitzpatrick meeting, once again delivered 2 great days of academia. I wish to acknowledge our Urology colleagues in the Mater Hospital for organising the same.

I had the pleasure of attending the AUA in Washington. I am sure those of us whom attended both the Hibernian academic meeting and social event would agree how successful this meeting was. I wish to thank John Sullivan on behalf of the ISU for his efforts in organizing this meeting.

I also attended the EAU National Societies Meeting in Noordwijk. I was accompanied by Niall Davis and I wish to thank him for his contributions to the delegation present. At this meeting I was acutely aware of the high-status Irish Urology is held in by the EAU. Many Irish Urologists contribute significantly to the EAU. I want to in particular to highlight Eamonn Rogers (the patient office) and David Galvin (Praise- U study investigator).

In June, I was delighted to accept an invitation to the BAUS annual meeting in London. I am extremely grateful to Ian Pearce and Joe Philip for their great hospitality. I would hope that the already strong links and further collaboration between our 2 societies can be strengthened in years ahead.

Also I wish to thank Thoms Lynch for yet again organizing a superb St James Hospital Study Day on the last Friday in June.

Finally the last event in my busy calendar year is to host this year's ISU annual meeting. This year we have received an extraordinary 184 abstract submissions. To put this in perspective, in 2025 there was a record breaking 148 abstracts submitted and 84 abstracts accepted for presentation. This posed a very difficult challenge for the selection committee, and we all owe enormous gratitude to Catherine Dowling, Niall Davis and Barry McGuire for spending significant time reviewing all abstracts and organising the programme we have for our meeting. With a re-structured programme for this year, we were able to accept 100 abstracts. Despite this, unfortunately many are disappointed. I wish to acknowledge and commiserate with all who were not accepted. We are grateful for your interest and the time you invested in your submissions, and we warmly encourage you to submit again in the future. Abstract submissions for the 2027 meeting will open next March and run through early April, details will be added on the website in early 2027.

I am delighted to welcome our guest speakers for this year, Ms Renu Eapen from Melbourne, Prof. Declan Murphy from Portumna/ Melbourne, Prof. Thierry Leuret from Paris and Prof. David Nicol from Brisbane/London. I am sure our society will make them very welcome here in Kerry. I look forward to much interaction between them and our



members, both during the academic sessions and social events. I thank them for making the time and effort to contribute to our meeting.

On behalf of the ISU I wish to acknowledge the support from the Pharma and Biomedical industry. I would like to encourage all delegates to take some time to visit and speak with them as our meeting could not take place without their very generous support.

Finally, there are 2 ladies I owe particular thanks to. Ms. Terri Reynolds is the rock that our society relies on for the successful planning and running of our annual meeting. Fortunately for Terri she only has to put up with my deliberations and indecisions for a single year! Unfortunately, my dear wife Krish has had to endure this for over 30years, and I hope for many more to come! A big thank you to both.

I would like to take this opportunity to thank all ISU members for their support and entrusting me with the role of President. It has been a privilege and career highlight. Ironically in September 2006 I took over the role of ISU hon Secretary from Hubert Gallagher. 20 years later I took over as president of our society. On Saturday evening I will hand over the chain of office to Paddy O Malley. Our Society is very fortunate to have Paddy at the helm. I wish him an enjoyable term and look forward to another ISU meeting in the West!

I hope you all enjoy the meeting

Richard Power
President ISU 2025/26

Programme at a Glance

SCIENTIFIC Programme

FRIDAY 18 SEPTEMBER 2026

07.30 - 08.15	Registration
08.20 - 08.30	Start and Welcome
08.30 - 09.50	Oral Session 1 Prostate, Penile and Testis
09.50 - 10.20	Professor Declan Murphy
10.20 - 11.00	Refreshments and Sponsors' Exhibition
11.00 - 12.20	Oral Session 2 Stones, Ureter, Transplant and Surgical-Hubs
12.20 - 12.50	Professor David Nicol
12.50 - 14.00	Refreshments and Sponsors' Exhibition
14.00 - 15.20	Video Session 1 Reconstruction, Upper Tract and Technical Innovation
15.20 - 15.50	Professor Thierry Lebreton
15.50 - 16.20	Refreshments and Sponsors' Exhibition
16.20 - 17.20	Moderated Posters and reception in Exhibitor area
17.30	End

SATURDAY 19 SEPTEMBER 2026

07.45 - 09.00	Registration
08.00 - 09.00	ISU AGM
09.00 - 10.20	Oral Session 3 Urethra, Incontinence, Paediatrics, Fertility
10.20 - 10.50	Dr Renu Eapen
10.50 - 12.00	Refreshments, Sponsors' Exhibition and Moderated Posters
12.00 - 13.20	Video Session 2 Pelvic Oncology, Complex Cancer and Service Development
13.20 - 14.10	Refreshments and Sponsors' Exhibition
14.10 - 15.30	Oral Session 4 Bladder and Renal
15.30 - 16.30	Interactive Session
16.30 - 16.40	Closing Ceremony - Prize Presentation
16.40	End

PLEASE NOTE:

CPD credits are awarded per day. You must sign in at the registration desk on each day of the meeting to receive that days credits. CPD credits cannot be awarded without a signature.

Programme at a Glance

SOCIAL Programme

FRIDAY 18 SEPTEMBER 2026

Irish Society of Urology Annual Conference Dinner

19.00	Drinks Reception, Foyer, Ballroom A Innisfallen Events Centre, Great Southern Hotel
20.00	Dinner, Ballroom A Innisfallen Events Centre, Great Southern Hotel
	Dress code: Smart Casual

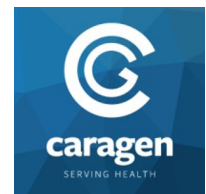
SATURDAY 19 SEPTEMBER 2026

Irish Society of Urology Annual Dinner

18.30	Drinks Reception Crowleys
20.00	Dinner Mulcahys, Kenmare
	Dress code: Smart Casual

Irish Society of Urology (ISU) Scientific Meeting

Kindly supported by:



PLEASE NOTE:

Sponsorship assists towards the scientific meeting only.

No funding received for exhibition space at this meeting is used towards the social aspects of the programme.

FRIDAY 18 SEPTEMBER 2026

REGISTRATION

07.30 - 08.15

Registration Desk

VENUE: Foyer outside Ballroom C

WELCOME AND START OF ANNUAL ISU MEETING

08.20 - 08.30

Mr Richard Power, President, ISU

VENUE: Auditorium

ORAL SESSION I | PROSTATE, PENILE AND TESTIS

08.30 - 09.50

Co - Chair: Mr Diarmuid Moran

Co - Chair: Ms Anna Walsh

VENUE: Auditorium

Oral	1	08.30 - 08.37	Complete urethral preservation in robot-assisted radical prostatectomy: Clinical outcomes from technique
Oral	2	08.37 - 08.44	Node status, PNI, and NLR predict survival and recurrence in penile Cancer: National cohort analysis
Oral	3	08.44 - 08.51	MRI prostate - Can you rely on what you are told?
Oral	4	08.51 - 08.58	Bridging the gap: Audit of PI-RADS and PSA density against EAU biopsy standards
Oral	5	08.58 - 09.05	Cancer-specific and functional outcomes following radical prostatectomy or radiotherapy for localised prostate cancer: A population-based IPCOR analysis
Oral	6	09.05 - 09.12	5-Year outcomes from Ireland's National Penile Cancer Centre 2021-2025
Oral	7	09.12 - 09.19	Final Results of PRAISE-U Irish Prostate cancer Screening Pilot
Oral	8	09.19 - 09.26	Introduction of robotic-assisted simple prostatectomy for benign prostatic obstruction: A four year, single-centre experience
Oral	9	09.26 - 09.33	Bilateral nerve sparing and erectile function outcomes following robotic prostatectomy
Oral	10	09.33 - 09.40	Post RPLND outcomes in a regional referral centre

GUEST SPEAKER: HOT TOPICS IN (THE MARKETING OF) RADICAL PROSTATECTOMY

09.50 - 10.20

Professor Declan Murphy

Consultant Urologist and Director of Genito-Urinary (GU)

Oncology at Peter MacCallum Cancer Centre, Melbourne

Professorial Fellow at the University of Melbourne

VENUE: Auditorium

REFRESHMENTS AND SPONSORS' EXHIBITION

10.20 - 11.00

VENUE: Ballroom B and C

FRIDAY 18 SEPTEMBER 2026

ORAL SESSION II | STONES, URETER, TRANSPLANT AND SURGICAL-HUBS

11.00 - 12.20

Co - Chair: Mr Brian Duggan
Co - Chair: Ms Norma Gibbons

VENUE: Auditorium

Oral	11	11.00 - 11.07	Life beyond donation - a national review of kidney function following living donor nephrectomy
Oral	12	11.07 - 11.14	Primary versus delayed ureteroscopy for obstructing ureteric calculi: A systematic review and meta-analysis
Oral	13	11.14 - 11.21	Introduction of robot assisted donor nephrectomy at the National Kidney Transplant Centre
Oral	14	11.21 - 11.28	Safety and outcomes of percutaneous nephrolithotomy at the extremes of age: A six-year single-surgeon Irish series
Oral	15	11.28 - 11.35	The 4 year outcomes of a dedicated long waitlist clinic for day case urological procedures at an elective surgery hub: The Reeves Day Surgery Centre at Tallaght University Hospital
Oral	16	11.35 - 11.42	Mortality following endoscopic management of symptomatic urolithiasis over a 10-year period: A single-centre retrospective cohort and case series
Oral	17	11.42 - 11.49	Assessment of threshold ureteric perforation forces during ureteric access sheath insertion for flexible ureteroscopy
Oral	18	11.49 - 11.56	Tranexamic acid in percutaneous nephrolithotomy (PCNL): A network meta-analysis exploring mode of administration and effect on perioperative complication rates
Oral	19	11.56 - 12.03	Early Single Surgeon (SS) Experience with CVAC 2.0 for Steerable Ureteroscopic Renal Evacuation (SURE) Using the CVAC System (CVACS) in a Community Hospital (CH) Setting
Oral	20	12.03 - 12.10	Surgical hubs in practice: The waiting list solution?

GUEST SPEAKER: UROLOGY – PERSONAL REFLECTIONS AND LOOMING CHALLENGES

12.20 - 12.50

Professor David Nicol
Consultant Urological Surgeon
The Royal Marsden NHS Foundation Trust
Professor of Surgical Oncology
Institute of Cancer Research

VENUE: Auditorium

LUNCH & SPONSORS' EXHIBITION

12.50 - 14.00

VENUE: Ballroom B and C

FRIDAY 18 SEPTEMBER 2026

VIDEO SESSION I | RECONSTRUCTION, UPPER TRACT AND TECHNICAL INNOVATION

14.00 - 15.20

Co Chair: Ms Catherine Dowling
Co Chair: Professor David Bouchier Hayes

VENUE: Auditorium

Video	1	14.00 - 14.07	Transitioning from open to robotics in challenging RPLND: Top ten tips
Video	2	14.07 - 14.14	Salvaging the solitary kidney: Robotic ileal interposition for complex radiation ureteric stricture disease
Video	3	14.14 - 14.21	Beyond urethroplasty: Buccal mucosa graft for robotic-assisted bladder neck reconstruction
Video	4	14.21 - 14.28	Modified augmented buccal mucosa ureteroplasty: A technique to reduce graft length in the management of long proximal ureteral strictures
Video	5	14.28 - 14.35	Ureteric diverticular flap ureteroplasty: A novel reconstructive approach for stricture-associated ureteric diverticulum repair
Video	6	14.35 - 14.42	Robotic-Assisted Staged Bilateral Upper-Pole Hemi-Nephroureterectomy for Bilateral Ectopic Vaginal Upper-Moiety Ureters in Duplex Kidneys
Video	7	14.42 - 14.49	Operative steps in robotic retroperitoneal partial nephrectomy
Video	8	14.49 - 14.56	Single-port robotic surgery: Early upper tract experience
Video	9	14.56 - 15.03	A standardized supine PCNL technique: Biplanar access, 26Fr tract, and trilogity lithotripsy
Video	10	15.03 - 15.10	Robot assisted donor nephrectomy, standardization of the technique in Ireland

GUEST SPEAKER: EAU LECTURE ORTHOTOPIC NEOBLADDER AFTER CYSTECTOMY FOR BLADDER CARCINOMA: HOW TO IMPROVE? ... TIPS AND TRICKS

15.20 - 15.50

Professor Thierry Lebreton
Head of the Department of Urology and Kidney Transplantation
Specialist in Urologic Oncology
Head of the VUNDE Clinical Division

VENUE: Auditorium

REFRESHMENTS AND SPONSORS' EXHIBITION

15.20 - 16.20

VENUE: Ballroom B and C

FRIDAY 18 SEPTEMBER 2026

POSTER SESSION I | MODERATED POSTERS

16.20 - 17.20

Co Chair: Mr James Forde

Co Chair: Ms Lisa Smith

VENUE: Ballroom C

Poster	1	16.20 - 16.23	Fit to Operate? Frailty assessment and team education in the older urology patient
Poster	2	16.23 - 16.26	From delay to delivery: Enhancing emergency urological care through protected emergency theatre slots
Poster	3	16.26 - 16.29	Wards Sans Frontières: Developing the urology virtual ward at St Vincent's University Hospital
Poster	4	16.29 - 16.32	A regional service review of patient outcomes and satisfaction following optilume treatment in Northern Ireland
Poster	5	16.32 - 16.35	A modular, low-cost silicone urethral model for simulation of urethral stricture disease and endoscopic management
Poster	6	16.35 - 16.38	Cystoscopy for bladder wall thickening: Towards a risk-stratified approach to referral
Poster	7	16.38 - 16.41	Further evaluation of the valve opening thresholds of the transurethral catheter (TUC) safety valve
Poster	8	16.41 - 16.44	No stent left behind: Cloud-based application development and audit of ureteric stent practice at Beaumont Hospital
Poster	9	16.44 - 16.47	Complication patterns and outcomes after penile prosthesis implantation: A 250-case single-centre series
Poster	10	16.47 - 16.50	Impact of urodynamics on clinical decision-making in men with mixed lower urinary tract symptoms: Findings from a single-centre retrospective study
Poster	11	16.50 - 16.53	Adult urologists' perspectives on transitional urology care in Europe: A cross-sectional survey
Poster	12	16.53 - 16.56	Robotic assisted ureteral reimplantation: A series from a single centre
Poster	13	16.56 - 16.59	Mechanical behaviour of human penile tissues under cyclic loading: implications for inflatable penile prosthesis inflation protocols
Poster	14	16.59 - 17.02	Awareness and management of ketamine cystitis among Irish urologists: A cross-sectional survey
Poster	15	17.02 - 17.05	Urological injuries in major pelvic trauma; the experience of a national major trauma centre
Poster	16	17.05 - 17.08	Should digital rectal examination be omitted from the assessment pathway in a Rapid Access Prostate Clinic?
Poster	17	17.08 - 17.11	Our experience with bulkamid urethral injection; a procedure performed in a model 2 hospital in UL Hospital Group
Poster	18	17.11 - 17.14	Peri-procedural antimicrobial prophylaxis in prosthetic urology: A national audit of practice patterns
Poster	19	17.14 - 17.17	Varicocele embolisation using glue: A systematic review and meta-analysis on the safety and efficacy
Poster	20	17.17 - 17.20	The customer's always right: A quality improvement project to improve urology medical student education
		17.30	End

SATURDAY 19 SEPTEMBER 2026

REGISTRATION

07.45 - 09.00

Registration Desk

VENUE: Foyer outside Ballroom C

ISU AGM

08.00 - 09.00

VENUE: Auditorium

ORAL SESSION III | URETHRA, INCONTINENCE, PAEDIATRICS, FERTILITY

09.00 - 10.20

Co Chair: Ms Elaine Redmond
Co Chair: Professor Kilian Walsh

VENUE: Auditorium

Oral	21	09.00 - 09.07	High-throughput 3D testicular cell-laden microsphere fabrication for in vitro modeling using microfluidic droplet technology
Oral	22	09.07 - 09.14	Surgical Techniques in the Management of Primary Urethral Carcinoma: A spectrum of approaches for distal tumours
Oral	23	09.14 - 09.21	Enhancing Hypospadias Care in South Vietnam: Outcomes from an RCSI-Operation Childlife Mission
Oral	24	09.21 - 09.28	Various treatment modalities exist for the management of stress urinary incontinence (SUI). We present a single centre review aimed to assess the clinical effectiveness of intra-urethral bulking and identifying patient factors for clinical success
Oral	25	09.28 - 09.35	Understanding artificial urinary sphincter–urethra interactions: A computational approach to improving continence and tissue safety
Oral	26	09.35 - 09.42	In silico study of the interaction between the female urethra and an artificial urinary sphincter: Implications for continence and tissue safety
Oral	27	09.42 - 09.49	Mechanical characterisation of urethral tissues for artificial urinary sphincter applications
Oral	28	09.49 - 09.56	Parent-reported psychological support needs in children with hypospadias
Oral	29	09.56 - 10.03	The interim 24-month outcomes from a randomized, sham-controlled study evaluating the ProVee prostatic urethral stent for LUTS secondary to BPH
Oral	30	10.03 - 10.10	Sperm counting: The burden of male factor pathology following the introduction of Ireland's publicly funded fertility pathway

GUEST SPEAKER: PSMA IMAGING & THERANOSTICS IN 2026 – A BLUFFER'S GUIDE FOR UROLOGISTS

10.20 - 10.50

Dr Renu Eapen
Director, Urology and Vascular Clinical Institute, Epworth Health
Peter MacCallum Cancer Centre
Austin Health, Olivia Newton John Cancer Centre

VENUE: Auditorium

SATURDAY 19 SEPTEMBER 2026

POSTER SESSION II | MODERATED POSTERS REFRESHMENTS AND SPONSORS' EXHIBITION

10.50 - 12.00

Co Chair: Mr Frank Darcy

Co Chair: Ms Nikita Bhatt

VENUE: Ballroom B and C

Poster	21	10.50 - 10.53	Robotic reconstructive urology: Initial data from a high volume UK single centre
Poster	22	10.53 - 10.56	Impact of ellipsoid versus bullet MRI-derived prostate volume calculation on PSA density and risk stratification
Poster	23	10.56 - 10.59	Survival trends in HPV-independent and HPV-associated Penile Squamous Cell Carcinoma at a large single site centre: A retrospective analysis of 800 patients
Poster	24	10.59 - 11.02	Optimal installation and irrigation strategies to limit recurrence following transurethral resection of bladder tumour: A systematic review and network meta-analysis
Poster	25	11.02 - 11.05	Can MRI invisible prostate cancer be clinically significant? A multi-centre review post robotic prostatectomy
Poster	26	11.05 - 11.08	Association between lymph node metastasis characteristics and biochemical recurrence following radical prostatectomy: A retrospective 5-year follow up cohort study
Poster	27	11.08 - 11.11	Fixing the front door of prostate Cancer diagnosis: A closed-loop audit delivering rapid, scalable gains in mpMRI quality
Poster	28	11.11 - 11.14	Transrectal vs transperineal prostate biopsy under local anaesthetic: A systematic review and meta-analysis
Poster	29	11.14 - 11.17	MRI pelvimetry as a predictor of functional and oncological outcomes following robotic-assisted radical prostatectomy
Poster	30	11.17 - 11.20	The perfect 10: Using an electronic checklist to standardise TURBT documentation
Poster	31	11.20 - 11.23	Systematic review of Bacillus Calmette-Guérin therapy in the management of upper tract urothelial carcinoma in-situ
Poster	32	11.23 - 11.26	Documentation of EAU risk stratification and BCG treatment adequacy in high-grade non-muscle-invasive bladder cancer: A single-centre audit
Poster	33	11.26 - 11.29	Incidental findings on prostate MRI contribute to disproportionate clinical and economic burden
Poster	34	11.29 - 11.32	Is "Low-Risk" really low risk? Recurrence and upgrading in pTa low-grade NMIBC
Poster	35	11.32 - 11.35	From risk to prognosis: Elevated BMI is common but not predictive of outcomes in penile Cancer
Poster	36	11.35 - 11.38	Antithrombotic therapy and stage of bladder Cancer at presentation: A systematic review and meta-analysis
Poster	37	11.38 - 11.41	Upper tract urothelial cancer: Are we overdoing diagnostic ureterorenoscopy in suspicious upper tract lesions?
Poster	38	11.41 - 11.44	Implementation of a local anaesthetic transperineal prostate biopsy service in HSE West: Early experience from regional Irish centres
Poster	39	11.44 - 11.47	Baseline patient-reported outcomes from the second IPCOR cohort: Benchmarking quality-of-life of prostate Cancer patients at diagnosis

SATURDAY 19 SEPTEMBER 2026

VIDEO SESSION II | PELVIC ONCOLOGY, COMPLEX CANCER AND SERVICE DEVELOPMENT

12.00 - 13.20

Co Chair: Ms Louise McLoughlin

Co Chair: Mr Stephen Connolly

VENUE: Auditorium

Video	1	12.00 - 12.07	Implementation of robotic pelvic lymphadenectomy in penile cancer: Early experience from a national referral centre
Video	2	12.07 - 12.14	Redefining groin dissection: Robotic-assisted inguinal lymphadenectomy for penile Cancer
Video	3	12.14 - 12.21	Minimally invasive approach to bladder neck reconstruction for recurrent bladder neck contracture post robotic-assisted radical prostatectomy
Video	4	12.21 - 12.28	Robotic cystectomy & neobladder formation using DaVinci Xi
Video	5	12.28 - 12.35	Organ-preservation strategies during robotic cystectomy: A video vignette
Video	6	12.35 - 12.42	Robot-assisted cytoreductive nephrectomy after immune checkpoint inhibitors for metastatic clear cell renal cell carcinoma: An educational surgical video
Video	7	12.42 - 12.49	Modern surgical techniques in testis cancer: Open extraperitoneal and robotic approaches to retroperitoneal lymph node dissection
Video	8	12.49 - 12.56	Robotic nephron-sparing surgery for multifocal bilateral papillary RCC: Triple tumour excision in a single kidney
Video	9	12.56 - 13.03	Endoscopic transvesical-assisted robotic excision of iatrogenic endometriotic utero-vesical fistula presenting with visible haematuria: A multidisciplinary video case
Video	10	13.03 - 13.10	Establishing robotic urogynaecology services in a tertiary referral centre – Initial outcomes and lessons learned
Video	11	13.10 - 13.17	Step by step bipolar enucleation of a huge prostate (≥ 80 G): A single case video demonstration

REFRESHMENTS AND SPONSORS' EXHIBITION

13.20 - 14.10

VENUE: Ballroom B and C

SATURDAY 19 SEPTEMBER 2026

ORAL SESSION IV | BLADDER AND RENAL

14.10 - 15.30

Co Chair: Ms Clíodhna Browne

Co Chair: Mr Mark Broe

VENUE: Auditorium

Oral	31	14.10 - 14.17	The WASHOUT study: Early proactive intervention in emergency haematuria reduces length of stay, mortality and readmissions
Oral	32	14.17 - 14.24	Radical nephrectomy with inferior vena cava tumour thrombectomy for Mayo level III–IV thrombus: A 10-year retrospective single-centre study
Oral	33	14.24 - 14.31	Intravesical Purastat® for haemorrhagic radiation cystitis: New hope for a urologist's worst nightmare
Oral	34	14.31 - 14.38	Ongoing experience of a robotic cystectomy program
Oral	35	14.38 - 14.45	Impact of prior pelvic radiotherapy on perioperative safety and functional outcomes of robot-assisted cystectomy and intracorporeal ileal conduit diversion: A propensity-score matched analysis
Oral	36	14.45 - 14.52	Early experience with single-port robotic surgery for upper tract reconstruction and renal surgery: A comparative study with multi-port approach
Oral	37	14.52 - 14.59	Robotic-assisted inguinal lymphadenectomy for penile Cancer: A case series of ten groins
Oral	38	12.49- 12.56	Robotic retroperitoneal partial nephrectomy (RPPN) in University Hospital Waterford: Outcomes from initial series
Oral	39	15.06 - 15.13	Implementation of a structured sexual rehabilitation pathway for patients undergoing a robot-assisted cystectomy: A quality improvement initiative
Oral	40	15.13 - 15.20	On-clamp versus off-clamp partial nephrectomy in patients with a solitary kidney: A systematic review and meta-analysis evaluating effect on postoperative renal function and perioperative complication rates

INTERACTIVE SESSION | CONTROVERSIES & CRAIC | A GU CAST LIVE EVENT

15.30 - 16.30

Co Chair: Professor Declan Murphy

Co Chair: Dr Renu Eapen

VENUE: Auditorium

PRIZE PRESENTATIONS

16.30 - 16.40

ISU Annual Meeting Best Poster Presentation

ISU Annual Meeting Best Video Presentation

ISU Annual Meeting Best Oral Presentation

ISU Annual Meeting Essay

Intercollegiate Board Examination in Urology Prize

Meeting close

VENUE: Auditorium

16.40

End

Irish Society of Urology (ISU)

Annual Meeting

GUEST SPEAKERS

PROFESSOR DECLAN G MURPHY

MB BCH BaO FRCS FRACS

Consultant Urologist and Director of Genito-Urinary (GU) Oncology at Peter MacCallum Cancer Centre, Melbourne
Professorial Fellow at the University of Melbourne

Declan Murphy is Consultant Urologist and Director of Genito-Urinary (GU) Oncology at Peter MacCallum Cancer Centre, Melbourne, and Professorial Fellow at the University of Melbourne. Declan is an internationally-recognised key opinion leader in GU Oncology, prostate cancer in particular, and is one of the world's most recognised experts working in prostate cancer. He has a h-index of 80, and has twice been named Australia's top leader in urology research. He specialises full time in prostate cancer.

Originally from Portumna, Co Galway, Declan graduated from medicine at NUI Galway in 1996, having nearly abandoned university for a career in the booming nightclub business in Salthill. He did basic surgical training at the Meath and Adelaide Hospitals (during the move to Tallaght), spent a character-building year as a general surgery registrar in Drogheda where he learned to love laparoscopy and links golf, before becoming the inaugural urology registrar at St James' in Dublin. He disappointed the late Professor Fitzpatrick frittering away a research year at the Mater, and blames the lack of a thesis on him spending a lot of time playing golf with Richie Power.

Declan moved to London in 2012 to do his urology training in the London Deanery, based at Guys Hospital (where he also became a Consultant). His golf game fell into terminal decline, but his surgical and academic careers flourished, and he did fall in love with his then anaesthetic trainee and future wife, Lisa. They have two sons and a dog and are living happily ever after in Melbourne.

Declan is very active on social media and hosts the insanely popular GU Cast and European Urology podcasts. In the old days he might be what you call a key opinion leader; these days he tries to impress his kids by claiming to be an influencer.

He has continued to support the Irish medical community by providing advanced level training in robotic surgery and genitourinary oncology to many top Irish trainees over the past 20 years.



Irish Society of Urology (ISU)

Annual Meeting

GUEST SPEAKERS

PROFESSOR DAVID NICOL

Consultant Urological Surgeon
The Royal Marsden NHS Foundation Trust
Professor of Surgical Oncology
Institute of Cancer Research

David Nicol graduated from the University of Queensland Medical School in 1983 and completed urological training in Queensland in 1990. Further training was then in an American Society of Transplant Surgeons Fellowship in Canada in 1991.

In 1992 David was appointed Senior Lecturer in Surgery (University of Queensland) and Director of Urology/Transplant Surgeon at the Princess Alexandra Hospital in Brisbane. Subsequent appointments were as Director of Renal Transplantation (1995), Statewide Director of Renal Services (2003) and Professor of Surgery (1996).

In 2009 David moved to the Royal Free Hospital as Clinical Lead for Renal Transplantation and also to UCLH where he was the sole surgeon responsible for kidney cancer surgery in the period 2010-2012.

David subsequently was recruited to the Royal Marsden Hospital in 2012 with practice restricted to kidney, testicular cancer and complex retroperitoneal surgery. His appointment included the role of Chief of Surgery and Professor of Surgical Oncology at the Institute of Cancer Research.

Other roles have included Associate Editor - BJUI (2008-2013), Consulting Editor Urologic Oncology (2009 -), Member Specialist Urology Commissioning Group NHS England (2013-2016), Member - NCRI - Kidney and Bladder Cancer Specialty Group (2017-2024), Member -European Testicular Cancer Guidelines Committee(2018 – 2021, Chairman - 2022-2025).

His research has encompassed laboratory based, translational and clinical work predominantly relating to urological oncology and renal transplantation. To date he has in excess of 200 peer reviewed publications(>16000 citations, h-index of 58 and i10 index of 139).



Irish Society of Urology (ISU)

Annual Meeting

GUEST SPEAKERS

PROFESSOR THIERRY LEBRET

MD, PhD, PU-PH

Head of the Department of Urology and Kidney Transplantation

Specialist in Urologic Oncology

Head of the VUNDE Clinical Division

Thierry Lebret is Professor of Urology in West Paris University – (Versailles St Quentin en Yvelines). He is a graduate of Rouen Medical University and of Paris Sorbonne University (Pitié Salpêtrière). Thierry is an active Member of the European and National Urology Association. As a surgeon, he is particularly involved in onco-urology. Member of the EAU guidelines (invasive bladder tumor) during many years, he has been general secretary of the French Association of Urology (AFU) during 6 years before becoming president (2017-2020).

Thierry has been working in Foch Hospital for 30 years, the urology department of this hospital is very well known for its work on orthotopic bladder replacement. The ileal neobladder was created in this unit by Pr Maurice Camey and developed by Pr Henry Botto. At the head of the department since 2012, Thierry has performed more than 1500 cystectomies and with a close-knit medical team of 21 urologists, this department continues to be the French reference in this pathology.

Thierry works on bladder and prostate cancer. More than 300 papers have been published in international scientific journals. A part of his research on superficial bladder tumours was carried out in the Conway Institute of Biomolecular and Biomedical research in Dublin with John Fitzpatrick and Bill Watson. At that time, he was focusing on Heat Shock Proteins. He has excellent memories of the year spent in Ireland where, among his Irish friends, he rediscovered the Celtic atmosphere of his Breton roots.



Irish Society of Urology (ISU)

Annual Meeting

GUEST SPEAKERS

DR RENU EAPEN

MBBS PhD FRACS (Urol)

Urological Surgeon

Director, Urology and Vascular Clinical Institute, Epworth Health

Peter MacCallum Cancer Centre

Austin Health, Olivia Newton John Cancer Centre

Dr Renu Eapen is the Director of the Urology Clinical Institute at Epworth Health and a Consultant Urologist in the Genitourinary Oncology service at the Peter MacCallum Cancer Centre and the Austin Hospital.

Dr Eapen completed her urology training in 2014. She undertook her robotics and uro-oncology fellowship at University of California, San Francisco (UCSF). Prior to this, she completed a fellowship in urodynamics, incontinence, voiding dysfunction and pelvic reconstruction at the University of Toronto, Canada.

She has completed her PhD at the University of Melbourne in high risk prostate cancer in collaboration with the Prostate Cancer Theranostics and Imaging Centre of Excellence at Peter MacCallum Cancer Centre.

Dr Eapen is the recipient of the 2022 Michael and Lori Milken Prostate Cancer Foundation (PCF) Young Investigator Award.

She is co-host of GU Cast, a regular podcast series, focusing on all things related to the world of Genito-Urinary oncology. www.gucast.org



ABSTRACTS

Friday 18 September PROSTATE, PENILE AND TESTIS TIME: 08.30 – 09.50

ORAL 1

Complete urethral preservation in robot-assisted radical prostatectomy: Clinical outcomes from technique

Kevin Byrnes¹, Azka Yousaf¹, Ricardo Almeida-Magana¹, Eoin Dinneen¹, Tarek Al-Hammouri¹, Zafer Tandogdu¹, Greg Shaw¹

¹University College London Hospital, London, UK

Introduction: Our aim was to evaluate the functional and oncological outcomes of complete urethral preservation (CUP) technique during robot-assisted radical prostatectomy (RARP).

Methods: Prospective data collection was conducted on a cohort of 466 men who underwent RARP utilizing the CUP technique between June 2021 and October 2025. Data regarding clinicopathological outcomes, PSA kinetics, continence recovery profiles were analysed. Cochran–Armitage trends were used for urethral quality and functional outcomes.

Results: The cohort (n=466) had a mean age of 60.7 years (SD 7.4), mean gland volume of 42cc (SD 24.8), median BMI of 28 (IQR 25-30), and median PSA of 6.6 (IQR 5-9.9). 54.7% were training cases. Mean operative time was 149.57 minutes (SD 35.68). Nerve-sparing was bilateral in 254 (54.5%), unilateral in 142 (30.5%), and none in 66 (14.2%). Mean MUL was 14.66mm (SD 3.31). Positive surgical margins >1mm were observed in 56/466 (12%). At 3 months, PSA (≤ 0.01) was undetectable in 330/426 (77.5%), and PSA was < 0.2 at 12 months in 289/304 (95.1%). Immediate continence was observed in 144/402 (64.2%), 325/437 (74.4%) at 3-month follow-up, and 176/215 (81.9%) at 1 year. High urethral quality dissections demonstrated higher immediate continence rates (65/163; 39.9%) versus

lower quality dissections (13/44; 29.5%), with evidence of an increasing trend in immediate continence with higher urethral quality ($p = 0.041$), seen again at 3 month follow-up (81.4% vs 71.7%, $p = 0.01$).

Conclusion: These preliminary data demonstrate safety of CUP, including within training settings. Anatomical dissection quality influences functional outcomes in this cohort.

ORAL 2

Node status, PNI, and NLR predict survival and recurrence in penile Cancer: National cohort analysis

Ibrahim Haidaran¹, Diarmuid D Sugrue², Charles Eddershaw¹, Dearbhail Ní Chaoimh³, Eilis Ní Chinneide⁴, Min Yuen Teo³, Niall Davis¹, Ivor M Cullen^{1,5,6}

¹Department of Urology and Transplant Surgery, Beaumont Hospital, Dublin, Ireland, ²Strategic Academic Recruitment Programme, RCSI, Dublin, Ireland, ³Department of Oncology, Beaumont Hospital, Dublin, Ireland, ⁴Department of Pathology, Beaumont Hospital, Dublin, Ireland, ⁵National Penile Cancer Centre, Beaumont Hospital, Dublin, Ireland, ⁶National Cancer Control Programme, Dublin, Ireland

Introduction: Lymph node metastasis (LNM) is one of the the strongest predictors of prognosis in penile squamous cell carcinoma (PSCC). We compared survival and progression in node-positive vs node-negative disease, quantity of node retrieval and characteristics, and recurrence risk factors in NO patients.

Methods: A retrospective analysis of a prospectively maintained database (2017-2026) was undertaken of patients who underwent surgery for PSCC at a National centre. Non-parametric testing (Chi-square/Kruskal-Wallis) was

used to compare groups. Multivariate logistic and Cox regression tested the association between nodal stage and survival.

Results: 309 patients were included with a median follow-up time of 32.7 months (IQR 13.5-85.5) Median age was 66 years (56-74) with 64 patients (20%) node positive at diagnosis. Pathological factors namely T stage, grade, lymphovascular invasion (LVI), and perineural invasion (PNI) showed statistically significant associations with node positivity (all $p < 0.05$). PNI independently predicted mortality risk on multivariate analysis (OR 4.15 95% CI 1.76-9.78 $p=0.001$). The number of nodes retrieved at lymph node dissection (LND) did not predict mortality (OR 1.37 95% CI 0.79-2.38 $p=0.261$). Among NO patient (n=115), 20% recurred (median 12.8 months, IQR 7.3-25.1). Raised Neutrophil to Lymphocyte Ratio (NLR) predicted recurrence for NO patient (OR 1.49 95% CI 1.07-2.07 $p=0.017$) when controlling for LVI, PNI and T stage.

Conclusion: PNI independently drives mortality in node-positive PSCC. NLR appears to predict risk of recurrence in node negative PSCC. NLR>3 may identify high-risk patients for closer surveillance or adjuvant therapy.

ORAL 3

MRI prostate - Can you rely on what you are told?

Eve Ryan¹, Conor Bogue¹, David Glynn¹, Michael Murphy¹, Kevin O'Connor^{1,2,3}, Owen O'Connor¹, Paul O'Sullivan¹, Peter Ryan^{1,2}, Philip Cornford^{1,2}

¹Bon Secours Hospital, Cork, Ireland, ²UCC, Cork, Ireland, ³Cork University Hospital, Cork, Ireland

Introduction: In men with suspected prostate cancer pre-biopsy MRI of the prostate is recommended by the NCCP [1]. However, although the data from

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academic teaching centres is clear the reproducibility of mpMRI has been questioned.

Methods: 419 consecutive patient referred to the rapid access prostate cancer clinic between 1/1/2023 and 31/12/25 are included. Of these 405 were offered an MRI prior to attending clinic and 386 had a mpMRI. MRI was performed using a 1.5T scanner with the addition of gadolinium contrast agent. MRIs were categorised according to the Prostate Imaging-Reporting and Data System version 2 (PIRADS v2) [2]. In line with the EAU guidelines all patients with PIRADS 4 or 5 lesions were offered a biopsy if fit enough to be considered for radical treatment. For patients with PIRADS 3 lesions PSA density (>0.12 ng/ml/ml) was used to determine who should be offered intervention. Both transrectal and transperineal biopsies were used during this period.

Results: In 386 men who had an MRI 129 (33.33%) avoided a biopsy and 143 (37%) were found to have clinically significant prostate cancer (ISUP GG 2+). Just 53 (13.7%) had indeterminate scans (PIRADS 3). Of those that had biopsies, 38% of the prostates reported as PIRADS 3, 50% of prostates with a PIRADS 4 lesions and 83% of those with a PIRADS 5 lesion contained significant cancer.

Conclusion: Our results are comparable to those reported in PRECISION. Therefore we feel confident that we can trust what we see the challenge is can you?

References:

- [1] NCCP guidelines on Diagnosis and staging of patients with prostate cancer <https://www2.healthservice.hse.ie/files/208/> accessed 4/4/26
- [2] Weinreb JC, Barentsz JO, Choyke PL, et al. PI-RADS Prostate Imaging — Reporting and Data System: 2015, Version 2. *Eur Urol* 2016;69:16-40
- [3] Kasivisvanathan V et al MRI-Targeted or standard biopsy for prostate cancer diagnosis. *NEJM* 2018; 378:1767-77

ORAL 4

Bridging the gap: Audit of PI-RADS and PSA density against EAU biopsy standards

Cara Pirie¹, Conor McCollam², Jay Atkinson², David Curry²

¹Queen's University Belfast, Belfast, UK, ²Belfast Health & Social Care Trust, Belfast, UK

Introduction: This audit aimed to assess how closely biopsy decisions made in our tertiary uro-oncology centre based on clinical acumen align with EAU guideline standards using MRI PI-RADS and PSA Density. We aimed for $>90\%$ compliance with EAU guidelines.

Methods: The authors reviewed 369 multiparametric MRI scans of the prostate carried out in our centre between 01/01/2025 and 30/03/2025. We compared our decision making in the cases of 216 suitable MRI-naïve men to recommendations in EAU 2025 Guidelines on Prostate Cancer. Men with prior prostate cancer diagnosis or prior prostate MRI/biopsies were excluded from this study. EAU decision matrix thresholds were the audit gold standard, utilising PI-RADS and PSA density to stratify men to 4 groups based on risk of finding an ISUP GG2 prostate cancer at transperineal biopsy.

Results: Our centre's data demonstrated high compliance with EAU guidelines overall. Decision to "perform biopsy" was compliant in 94.5% of cases, however "no biopsy" was compliant in 88.2% of cases – just missing our 90% compliance target. The over biopsy rate (13.9%) slightly exceeds the under-biopsy rate (8.3%), suggesting a modest bias towards biopsy when EAU guidance is not prescriptive. 77 ISUP GG2 cases were identified, representing 66% of all biopsies and 76% of cases in the "perform biopsy" group. **Conclusion:** Our results show that our decision making is in keeping with EAU guidelines, though a modest trend to over biopsy exists. Stricter guideline adherence could safely reduce biopsy burden. Uncertainty in the model highlights the importance of shared decision-making.

References:

- [1] EAU Guidelines on Prostate Cancer - Uroweb [Internet]. Uroweb - European Association of Urology. Available from: <https://uroweb.org/guidelines/prostate-cancer>
- [2] Kortenbach, K.C., et al. Early experience in avoiding biopsies for biopsy-naïve men with clinical suspicion of prostate cancer but non-suspicious

biparametric magnetic resonance imaging results and prostate-specific antigen density < 0.15 ng/mL(2): A 2-year follow-up study. *Acta Radiol Open*, 2022. 11: 20584601221094825 [3] Sigle, A., et al. Prediction of Significant Prostate Cancer in Equivocal Magnetic Resonance Imaging Lesions: A High-volume International Multicenter Study. *Eur Urol Focus*, 2023. 9: 606

ORAL 5

Cancer-specific and functional outcomes following radical prostatectomy or radiotherapy for localised prostate cancer: A population-based IPCOR analysis

Rowan Kearns¹, Noa Gordon¹, Wasfa Farooq¹, William Watson¹, David Galvin¹
¹University College Dublin, Dublin, Ireland

Introduction: For men with localised prostate cancer, radical prostatectomy (RP) and radiotherapy (RT) are established curative options. Contemporary evidence suggests comparable cancer control, with treatment decisions increasingly guided by functional outcomes. We evaluated survival and patient-reported outcomes in a national population-based cohort.

Methods: Men diagnosed with localised prostate cancer (2016–2020) were identified from the Irish Prostate Cancer Outcomes Research (IPCOR) registry. Overall survival (OS) and prostate cancer-specific survival (PCSS) were analysed using Kaplan–Meier methods and multivariable Cox regression adjusting for baseline characteristics. Patient-reported outcomes were assessed using EPIC-26 overall bother items and analysed cross-sectionally.

Results: A total of 3,523 men met eligibility criteria, with 2,478 included in survival analyses. Men undergoing RT were older and had higher-risk disease at baseline. Prostate cancer-specific mortality was low (27 events), with no clear difference in PCSS between RP and RT ($>98\%$ at 5 years). Overall survival was lower in the RT group; however, these baseline differences suggest residual confounding. Post-treatment patient-reported outcome data were available

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for 1,083 men and analysed cross-sectionally, with 474 contributing to the final PROM analytic sample following restriction to one post-treatment assessment per patient. Functional outcomes differed by treatment modality, with RP associated with greater urinary and sexual bother, and RT associated with greater bowel bother. No treatment was superior across all domains.

Conclusion: RP and RT provide excellent cancer-specific outcomes for localised prostate cancer. Differences between treatments are primarily functional rather than oncological. These findings support shared decision-making incorporating patient preferences, comorbidity, and expected quality-of-life outcomes.

References:

- [1] Hamdy FC, Donovan JL, Lane JA, et al. Fifteen-year outcomes after monitoring, surgery, or radiotherapy for prostate cancer. *N Engl J Med.* 2023;388:1547–1558
- [2] Donovan JL, Hamdy FC, Lane JA, et al. Patient-reported outcomes after monitoring, surgery, or radiotherapy. *N Engl J Med.* 2016;375:1425–1437
- [3] Sooriakumaran P, Nyberg T, Akre O, et al. Comparative effectiveness of radical prostatectomy and radiotherapy. *BMJ.* 2014;348:g1502

ORAL 6

5-Year outcomes from Ireland's National Penile Cancer Centre 2021-2025

Diarmuid D Sugrue¹, Charles Eddershaw², Mohammad Salah², Dearbhail Ní Chaoimh³, Eilis Ní Chinneide⁴, Min Yuen Teo³, Niall David², Ivor Cullen^{2,5,6}

¹Strategic Academic Recruitment Programme, Royal College of Surgeons in Ireland, Dublin, Ireland, ²Department of Urology and Transplant Surgery, Beaumont Hospital, Dublin, Ireland, ³Department of Oncology, Beaumont Hospital, Dublin, Ireland, ⁴Department of Pathology, Beaumont Hospital, Dublin, Ireland, ⁵National Penile Cancer Centre, Beaumont Hospital, Dublin, Ireland, ⁶National Cancer Control Programme, Dublin, Ireland

Introduction: Penile cancer is a rare disease, with an incidence of 3.1 per 100,000. Case numbers have sustained an increase across all age groups over the last 20 years, while 5-year survival has risen modestly 1990s. Penile cancer care in Ireland was centralized in 2021 to the National Penile Cancer Centre. Herein we present our initial experience and 5-year outcomes.

Methods: A retrospective review of a prospectively maintained database was conducted. All patients undergoing surgery for known or suspected penile cancer at the National Centre from 2021 to 2025 were included. Outpatient or office-based treatments were excluded. A multivariate regression model with predefined covariates assessed risk factors for advanced disease stage, progression, and worse overall survival.

Results: Between 2021 and 2025, 222 new patients underwent at least one procedure, with 73% receiving organ-sparing surgery (OSS). One-quarter presented at stage 3 or 4, and nodal sampling was required in two-thirds of patients. Median follow-up was 27 months, yielding a 3-year crude overall survival (OS) of 82.0%, comparable to other centralized services in Europe. Higher-stage disease predicted worse survival (3-year OS 64% for stage 4); node-negative patients had superior 3-year survival versus node-positive.

Conclusions: Our caseload exceeds previous national estimates, likely reflecting improved detection, reporting, and potentially a true increase in incidence. Centralization enables accurate data collection with patient-level data allowing superior subgroup analyses and time-to-event outcomes over aggregated sources, despite the dataset's relative immaturity. Further research on prognostic factors is required to further characterise and risk stratify this population.

ORAL 7

Final results of PRAISE-U Irish Prostate Cancer screening pilot

David Galvin¹, Gillian Horgan¹, William Watson¹, Patrick Murray¹, Patricia Fitzpatrick¹, Brenda Molloy¹, Paul Sweeney², Alan Smith³

¹University College Dublin, Dublin,

Ireland, ²Mercy University Hospital, Cork, Ireland, ³National Screening Service, Dublin, Ireland

Introduction: The EU Council recommendation in December 2022, included prostate cancer as a suitable disease for organised screening, and invited countries to proceed with pilots and further research. An EU-wide consortium (involving 14 countries and 26 Institutions has been established) under the PRAISE-U initiative and five pilot programs have been established including in Ireland.

Methods: Men aged 50-69 years of age were identified by the National Screening service using amalgamated national welfare databases and invited to register online (www.prostatecheck.ie) for a home capillary PSA test. Using the EAU algorithm, based on the PSA value, men with a PSA >3 are referred directly to the Rapid access prostate service.

Results: A total of 9,450 men were invited and 1,668 men were recruited (18%). 87% had a PSA <3 and are for repeat testing in 2 to 5 years. 13%(125) had a PSA level >3 and were referred to the RAPC. So far, 89 men attended for risk stratification, of which 19 were deemed low risk. 70 men were referred for MRI demonstrating PIRADS 1-2 (57%), PIRADS 3 (12%) and PIRADS 4-5 (31%). 12 of 17 are referred for a biopsy, ISUP grade 1 (n=5), ISUP grade 2 (n=5) and >ISUP grade 3 (n=1).

Conclusion: A pilot prostate cancer screening has been implemented and completed as intended, with a low response rate. Using risk stratification, MRI requirements were reduced by 21% and Prostate biopsy reduced by 25%. Home testing offers convenience and potential cost advantages for both men and the health service.

ORAL 8

Introduction of robotic-assisted simple prostatectomy for benign prostatic obstruction: A four year, single-centre experience

David T. Hopkins¹, Sneha Thomas², Kieran Breen¹

¹Department of Urology, St Vincent's University Hospital, Dublin, Ireland, ²School of Medicine, Trinity College Dublin, Dublin, Ireland

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Introduction: Robot-assisted simple prostatectomy (RASP) is an established, minimally-invasive option for large-volume benign prostatic obstruction (BPO). RASP offers potential advantages over traditional open prostatectomy, including reduced estimated blood loss (EBL), shorter length of stay (LOS), and quicker recovery while maintaining equivalent functional outcomes.¹ We evaluated the introduction of RASP by a single surgeon at a tertiary centre.

Methods: Retrospective analysis of a prospectively maintained database of RASP patients between 2022 and 2026 was performed. Demographic, perioperative and functional outcomes were analysed. The International Prostate Symptom Score (IPSS) was employed for patient reported outcome measure.

Results: Seventy-eight patients underwent RASP. Median prostate volume was 132cm³ (IQR 114–173) and median resection weight was 81.1g (IQR 64.9–110.0). Median operative time was 177 mins (IQR 145–216) and console time was 135 mins (IQR 107–165). Median EBL was 150mL (IQR 100–250). Median LOS was 3 days (IQR 2–4). Functional outcomes improved significantly, with a median IPSS urinary symptom improvement of 17 points (p=0.001) and quality of life improvement of 4 points (p=0.001). Median serum PSA reduction was 92.3% (IQR 79.4–94.5%). There were 10 adverse events recorded (12.8%), all of which were Clavien–Dindo grade I–II. Postoperative catheter dependence occurred in two cases. One patient reported using a single safety pad for incontinence at six months.

Conclusion: The introduction of RASP demonstrated low perioperative morbidity and significant improvement in early functional outcomes. Our findings are in keeping with large published international series² and support the role of RASP as an effective, minimally-invasive option for large-volume BPO.

References:

- [1] Sotelo R, Clavijo R, Carmona O, et al. Robotic simple prostatectomy. *Journal of Urology*. 2008
- [2] Autorino R, Zargar H, Mariano MB,

et al. Autorino R, Zargar H, Mariano MB, et al. Perioperative Outcomes of Robotic and Laparoscopic Simple Prostatectomy: A European–American Multi-institutional Analysis. *European Urology*. 2015

ORAL 9

Bilateral nerve sparing and erectile function outcomes following robotic prostatectomy

Peter Benson¹, Lauren Nicole Crone², Mary Nevin², Denise Murray², Aisling Looney², Kieran Breen²

¹School of Medicine, University College Dublin, Dublin, Ireland, ²Department of Urology, St Vincent's University Hospital, Dublin, Ireland

Introduction: Bilateral nerve-sparing (NS) during robot-assisted radical prostatectomy (RARP) aims to optimise post-operative erectile function while maintaining oncological safety. We audited the impact of bilateral nerve sparing on erectile function outcomes prior to the introduction of a dedicated survivorship clinic.

Methods: A prospectively maintained database of patients undergoing RARP from December 2021–November 2025 was analysed. Data included nerve-sparing status, age, post-operative phosphodiesterase-5 inhibitor (PDE5i) use, and histopathological variables (ISUP grade, T stage, margin status). Nerve sparing was graded 2–10, with 9 and 10 representing full bilateral preservation. Patients were stratified into full bilateral NS (9/10 and 10/10) versus less than full NS. Pre- and maximal post-operative International Index of Erectile Function-5 (IIEF-5) scores at 12 months were assessed.

Results: 178 patients underwent RARP over a 4-year period, with a median age of 63 years (range: 44–78). Post-operative IIEF-5 data was available for 96 patients. Among full bilateral NS, mean IIEF-5 declined from 18.61 to 13.14 (Δ –5.47), with 38.8% achieving IIEF-5 $\geq$ 17. Full bilateral NS demonstrated superior post-operative erectile function compared to less than full NS (12.04 vs 8.6; p=0.0018). Less than full NS (p=0.0042) and increasing age (p=0.003) predicted worse outcomes.

Conclusion: Full bilateral nerve-sparing RARP is associated with better

post-operative erectile function compared to less extensive nerve preservation. Our outcomes are comparable to recent series (NeuroSAFE, CEASAR) demonstrating superior sexual function outcomes with bilateral nerve-sparing, particularly in men with higher baseline function, supporting maximal nerve preservation where oncologically appropriate. [1,2]

References:

- [1] Avulova S, Zhao Z, Lee D, Huang LC, Koyama T, Hoffman KE, et al. The Effect of Nerve Sparing Status on Sexual and Urinary Function: 3-Year Results from the CEASAR Study. *Journal of Urology*. 2018 May;199(5):1202–9
- [2] Dinneen E, Almeida-Magana R, Al-Hammouri T, Pan S, Leurent B, Haider A, et al. Effect of NeuroSAFE-guided RARP versus standard RARP on erectile function and urinary continence in patients with localised prostate cancer (NeuroSAFE PROOF): a multicentre, patient-blinded, randomised, controlled phase 3 trial. *The Lancet Oncology*. 2025 Mar

ORAL 10

Post RPLND outcomes in a regional referral centre

Ibrahim Haidaran¹, Robert A. Keenan¹, Ashwini Tittawella¹, Caitriona O'Sullivan¹, Joseph Dilworth¹, Derek Power^{2,3}, Paul Sweeney¹

¹Department of Urology, Mercy University Hospital, Cork, Ireland,

²Department of Medical Oncology, Mercy University Hospital, Cork, Ireland,

³Department of Medical Oncology, Cork University Hospital, Cork, Ireland,

⁴Beaumont Hospital, Dublin, Ireland

Introduction: Testicular cancer is the most common solid malignancy in young men, with excellent survival rates when managed through multidisciplinary approach. Retroperitoneal lymph node dissection (RPLND) remains an essential component of treatment in selected patients with non-seminomatous germ cell tumours (NSGCT), particularly in post-chemotherapy residual disease. This study reports outcomes following RPLND performed in a tertiary referral centre.

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Methods: A prospectively maintained uro-oncology database was analysed for all patients undergoing RPLND between June 2011 and March 2023. Demographic, clinicopathological, and oncological data were collected. Relapse was defined as radiological and histological recurrence following RPLND. Follow-up duration was calculated from the date of surgery to the latest clinical or radiological review.

Results: Forty-eight patients underwent RPLND, predominantly for post-chemotherapy residual disease. Median age was 32.9 years, and median follow-up was 57 months. Bilateral template dissection was performed in 79.2% of cases, with a median nodal yield of 30. Final histology demonstrated mature teratoma in 41.7% and necrosis in 16.7%. Six patients (12.5%) developed recurrence, of which five were out-of-field. Two patients (4.2%) had unresectable disease and died due to disease progression; overall mortality was 8.3%. Concomitant procedures included nephrectomy (n=3) and IVC resection (n=1). Median hospital stay was 8 days.

Conclusion: RPLND performed in a specialised centre achieved outcomes consistent with international series, with low relapse and acceptable morbidity despite surgical complexity. These results support centralisation of RPLND surgery and multidisciplinary collaboration to optimise oncological and surgical outcomes in advanced testicular cancer.

STONES, URETER, TRANSPLANT AND SURGICAL-HUBS

TIME:11.00 - 12.20

ORAL 11

Life beyond donation - a national review of kidney function following living donor nephrectomy

Cathal Flood^{1,2}, Steven Anderson^{1,2}, Ann Cooney³, Patrick O'Kelly³, Ian Robertson², Dilly Little², Niall Davis^{1,2}

¹Royal College of Surgeons in Ireland, Dublin, Ireland, ²Transplant, Urology & Nephrology Department, Beaumont Hospital, Dublin, Ireland, ³National Kidney Transplant Service, Beaumont Hospital, Dublin, Ireland

Introduction: Living donor kidney transplantation (LDKT) offers superior outcomes over dialysis and deceased donor transplantation but exposes healthy individuals to long-term risks. The Human Tissue Act 2024 enables altruistic donation in Ireland, making contemporary donor outcome data essential. This study evaluated long-term renal function and hypertension following living donor nephrectomy (LDN) in the Irish national programme.

Methods: An IRB-approved retrospective cohort study included all LDNs performed at the national kidney transplant centre (Beaumont Hospital, Dublin) from 1979–2023. Pre-donation demographics and clinical variables were extracted from the prospective transplant database. Five-year change in estimated glomerular filtration rate (eGFR) was analysed using linear models. Time to post-donation hypertension (PDH), defined as initiation of antihypertensive therapy, was examined using Kaplan–Meier and Cox proportional hazards models.

Results: Among 584 LDNs, 54% of donors were female and 58% were overweight or obese. Five-year eGFR data were available for 314 donors. No pre-donation variable significantly predicted five-year eGFR change. Overall cumulative incidence of PDH rose from 3.0% at one year to 27% at ten years ($p=0.00013$). Overweight (HR 2.99, $p=0.005$) and obese donors (HR 4.35, $p=0.001$) faced significantly higher hypertension risk. Older age (HR 1.07/year, $p<0.001$), elevated pre-donation systolic (HR 1.03/mmHg, $p<0.001$) and diastolic blood pressure (HR 1.03/mmHg, $p=0.045$) were additional independent predictors.

Conclusion: Living kidney donation in Ireland appears safe with low long-term risk of renal impairment. However, elevated BMI, older age and higher pre-donation blood pressure increase PDH risk, supporting targeted counselling, weight optimisation and structured long-term follow-up.

ORAL 12

Primary versus delayed ureteroscopy for obstructing ureteric calculi: A systematic review and meta-analysis

Diarmuid D Sugrue^{1,2}, Orla Cullivan^{1,2}, Fintan Ryan¹, Andres Skolarikos^{3,4}, Bhaskar Somani⁵, Niall Davis^{1,2,6}

¹Strategic Academic Recruitment Programme, Royal College Of Surgeons In Ireland, Dublin, Ireland, ²Department of Urology, Blackrock Clinic, Dublin, Ireland, ³Department of Urology, National and Kapodistrian University of Athens, Athens, Greece, ⁴Department of Urology, Sismanogleio Hospital, Athens, Greece, ⁵Department of Urology, University Hospital Southampton NHS Foundation Trust, Southampton, UK, ⁶Department of Urology and Transplant Surgery, Beaumont Hospital, Dublin, Ireland

Introduction: Emergent primary ureteroscopy (P-URS) for obstructing ureteric stones requires stone retrieval within 24-48 hours of acute onset. This study compared the efficacy of emergent P-URS against delayed or staged ureteroscopy (D-URS) for managing obstructing ureteric stones.

Methods: We conducted a systematic review through October 2025 via PubMed, Embase, Cochrane Library, and Scopus. Included studies compared clinical outcomes between P-URS and D-URS treatment for obstructing ureteric stones. Primary endpoints were stone-free rate (SFR) and complications; secondary endpoints included sepsis, retreatment rate, stent placement, readmissions, and costs. Random-effects meta-analysis with meta-regression assessed predefined moderators of effect.

Results: Fifteen studies were selected, including 23,068 patients. Pooled SFR for P-URS reached 88.7% (CI 80.2-95.1%), compared to 86.5% (CI 76.7-94.1%) for

D-URS. No significant SFR difference emerged between groups (OR 1.20; 95% CI 0.75-1.92; $p=0.45$). Complication rates were 5.7% (95% CI 3.5-8.3%) in P-URS versus 6.3% (95% CI 4-8.9%) in D-URS, with equivalence between groups (OR 1.02; 95% CI 0.84-1.25; $p=0.82$). Mean length of stay favoured P-URS at 1.77 days versus 2.08 days for D-URS (WMD 0.31 days, $p=0.003$). Retreatment, sepsis, stent use, and readmission rates showed no differences. Direct-cost analyses from three countries indicated lower expense with P-URS.

Conclusions: P-URS offers a safe, effective alternative for obstructing ureteric stones, matching D-URS in stone clearance and complication profiles. Upcoming studies should emphasize patient-reported outcomes and economic comparisons.

ORAL 13

Introduction of robot assisted donor nephrectomy at the National Kidney Transplant Centre

Mohammed Ibnoufi¹, Neal Dugal¹, Mutaz Elamin¹, Mohamed Mohamed¹, Usman M Haroon¹, Razan Ahmed¹, Richard Power¹, Gordon Smyth¹

¹Beaumont Hospital, Dublin, Ireland

Introduction: Laparoscopic donor nephrectomy (LDN) was preferred method for kidney donation from living donors. Early research suggests that robotic techniques may provide a better safety profile for the donor and surgeon. Over the last 2 years, we have transitioned from the majority of surgeons in our department performing HALDN to all surgeons now performing RDN. The da Vinci X or Xi systems were used in all cases, with standardisation of the technique between all surgeons.

Methods: Quasai study comparing 20 cases of robotic donor nephrectomy (RDN) to 20 age-matched cases of hand-assisted laparoscopic donor nephrectomy (HALDN) performed in the same 2-year period.

Results: 40 cases were involved in this study, 20 HALDN and 20 RDN, Median age was 44 (31-60) years for RDN and 48 (32-62) years for HALDN. Warm ischemia time was shorter in HALDN, but this had no deleterious effect on the transplant

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outcomes. Length of hospital stay was shorter in RDN group. Requirement for IV opioid analgesia was less with RDN but this was not statistically significant and there has been no difference in complications rate.

Conclusion: We have safely implemented robotic donor nephrectomy within the National Kidney Transplant Service of Ireland. Warm ischemia time was longer compared to HALDN, in keeping with published literature, but this was not clinically significant. RDN may offer improved outcomes in terms of post-operative pain. All 4 surgeons performing RDN feel that it has advantages in terms of dexterity, surgeon comfort and the ability to provide optimal length renal vessels for transplant.

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ORAL 14

Safety and outcomes of percutaneous nephrolithotomy at the extremes of age: A six-year single-surgeon Irish series

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Introduction: Percutaneous nephrolithotomy (PCNL) is the gold standard treatment for large renal calculi. However, evidence regarding its

safety and effectiveness at the extremes of age remains limited. This study evaluates the safety, effectiveness, and peri-operative outcomes of PCNL at the extremes of age and compare paediatric and geriatric cohorts with standard-age adults.

Methods: A retrospective consecutive case series of PCNL procedures (2019–2025) performed by a single high-volume endourologist across two tertiary referral centres was analysed. Patients were stratified into paediatric (<17 years), adult (18–69 years), and geriatric (>70 years) groups. Demographic and peri-operative variables were assessed. Outcomes included stone-free rate, complications classified by the Clinical Research Office of the Endourological Society–Clavien-Dindo system, sepsis and length of stay. Statistical analysis was performed using SPSS, with $p < 0.05$ considered significant.

Results: A total of 126 patients were included: paediatric 4.8% ($n=6$), geriatric 20.6% ($n=26$), and adult 74.6% ($n=94$). Geriatric patients demonstrated a higher comorbidity burden, with increased ASA III–IV prevalence ($p < 0.001$). Stone-free rates were 96.6%, 94%, and 70% in paediatric, adult, and geriatric groups, respectively ($p=0.81$). Mean operative time increased with age (72.5, 103.3, 107.8 minutes), as did blood loss (25, 82, 129 mL) and LOS (48.0, 45.4, 66.2 hours), although not statistically significant. Complication rates were comparable across groups (20%, 11.8%, 11.1%), with low transfusion rates (0%, 1.0%, 7.0%) and no mortality.

Conclusions: PCNL maintains technical safety across the age spectrum despite increased comorbidity in geriatric patients. Age-related differences primarily reflect variations in physiology, recovery, and peri-operative management rather than the inherent safety of the procedure.

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ORAL 15

The 4 year outcomes of a dedicated long waiter clinic for day case urological procedures at an elective surgery hub: The Reeves Day Surgery Centre at Tallaght University Hospital

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Introduction: Day-case surgery provides a safe and efficient way of carrying out many urological procedures. To address waiting lists, the HSE has invested in six elective day-surgery hubs nationally. At Tallaght University Hospital, a consultant led “long waiter” clinic for patients requiring potential day-case procedures was established in 2021. The aim of this study was to evaluate outcomes and assess the impact of this clinic over a four-year period.

Methods: A retrospective analysis of prospectively maintained data between September 2021 and September 2025 was performed. Data included demographics, procedures, time from referral-to-clinic and clinic-to-surgery. The primary outcome was referral-to-clinic waiting time. Secondary outcomes included surgeries performed, time to surgery, and complications.

Results: A total of 637 patients were included. Of these, 210 patients (33%) underwent surgery, 279 (44%) required no operative intervention and were discharged, and 148 (23%) did not attend. The most common procedures performed were circumcision (141, 67%), vasectomy (32, 15%), and hydrocelectomy (15, 7%). Median time from referral to clinic review decreased from 3.7 years in 2021 to 0.4 years in 2025, representing an 89% reduction in waiting time. Median time from clinic review to surgery was 7 weeks (IQR 3–12). All procedures were performed as day cases with no admissions post operatively.

Conclusions: The findings from this study show the safe delivery of day-case urological surgery in a standalone surgical unit, which led to a reduction in waiting times. This approach can be adopted across other centres to maximise the utilisation of surgical hubs

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ORAL 16

Mortality following endoscopic management of symptomatic urolithiasis over a 10-year period: A single-centre retrospective cohort and case series

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Introduction: Endoscopic management, ureteroscopy (URS), retrograde intrarenal surgery (RIRS), and ureteric stenting, is central to treating symptomatic urolithiasis. Serious complications, particularly with infected obstruction, remain a concern. Accurate estimation of procedure-related mortality is limited by heterogeneous reporting, selected cohorts, and incomplete capture of emergency presentations. Population-level data over extended periods are required to define real-world mortality risk.

Methods: We conducted a 10-year retrospective cohort study of all endoscopic interventions for symptomatic ureteric or renal calculi at a tertiary centre (1 January 2015–30 June 2025). Procedures were categorised as URS/RIRS or ureteric stent insertion alone. Demographic and operative variables were obtained from a complete theatre registry. All in-hospital deaths were identified and reviewed as a structured case series. Analyses were descriptive and based on complete procedural activity.

Results: A total of 3,656 procedures were performed: 3,244 (88.8%) URS/RIRS and 412 (11.2%) stent-only; 58.4% (n=2,136) were emergency cases. Five in-hospital deaths occurred (0.14%; 1.37 per 1,000; 95% CI 0.44–3.19). Three followed emergency decompression for infected obstruction (0.14%; 1.40 per 1,000; 95% CI 0.29–4.10), all with profound sepsis at presentation. Two deaths followed elective URS in patients with significant cardiovascular or multisystem comorbidity (0.13%; 1.32 per 1,000; 95% CI 0.16–4.74). No deaths occurred after elective stenting or in patients without systemic inflammatory features.

Conclusion: Mortality after endoscopic management of urolithiasis is rare and confined to patients with advanced sepsis or major physiological

vulnerability. Early sepsis recognition, prompt decompression, and targeted peri-operative optimisation are critical in high-risk patients.

ORAL 17

Assessment of threshold ureteric perforation forces during ureteric access sheath insertion for flexible ureteroscopy

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Introduction: Flexible ureteroscopy is a widely-used approach in the management of ureteric and renal calculi. A ureteric access sheath (UAS) is a causative factor for ureteric injuries occurring during the procedure. Despite the wide use of UAS, safe insertion force thresholds have not been described. Here, we assessed perforation forces of the ureteral access sheath tip in ex-vivo lamb and porcine proximal ureteric tissue.

Methods: We performed ex-vivo perforation force testing on porcine and lamb ureters in both thawed and frozen states. Testing was performed using the inner obturator tip of the sheath, moved towards the tissue at a fixed speed, with continuous force measurement. Testing was performed at speeds of 100mm/min, 200mm/min, and 300mm/min, and with sheath sizes of 10/12Fr, 11/13Fr, and 12/14Fr.

Results: Ten thawed porcine ureters underwent testing at 200mm/min with 11/13Fr sheath. Perforation was observed in one specimen at 15.72N. Twelve thawed lamb ureters

underwent testing at 200mm/min with 11/13Fr sheath, with perforation in all specimens. Mean perforation force was 7.67±1.62N. In porcine subgroups (n=20), there were perforations in the 11/13Fr 100mm/min subgroup at 15.2 N, the 11/13Fr 300mm/min group at 18.14 N, 10/12Fr at 200mm/min group, at forces of 18.47 N and 26.21 N, and 12/14Fr at 200mm/min group, at a force of 25.61 N.

Conclusion: Our study demonstrates a range of ureteric perforation forces in ureteric tissue associated with differing UAS insertion characteristics.

ORAL 18

Tranexamic acid in percutaneous nephrolithotomy (PCNL): A network meta-analysis exploring mode of administration and effect on perioperative complication rates

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Introduction: Perioperative bleeding is a leading cause of morbidity in percutaneous nephrolithotomy (PCNL). Tranexamic acid (TXA) is a commonly utilised pharmacological adjunct aimed at reducing perioperative blood-loss, transfusion requirements, and associated complications.

Methods: A systematic search was performed in accordance with PRISMA-NMA guidelines. Randomised controlled trials (RCTs) investigating intravenous TXA (IV-TXA) or irrigation containing TXA (Irr-TXA) in PCNL were identified. Primary outcome measures related to blood loss with secondary outcome measures focusing on perioperative complication rates.

Results: Twelve RCTs met inclusion criteria reporting data pertaining to n=1,839 patients undergoing PCNL. One study evaluated TXA with IV-TXA, Irr-TXA and control arms. Nine studies compared IV-TXA to control, while a further n=2 studies evaluated the role of Irr-TXA compared to IV-TXA (n=1) and control (n=1). The risk of requiring

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blood transfusion following PCNL was significantly reduced with both Irr-TXA (RR=0.34, CI= 0.17, 0.68) and IV-TXA administration (RR=0.39, CI= 0.22, 0.67), with no significant difference between IV-TXA and IR-TXA (RR=1.14, SE=0.40, CI= 0.53, 2.46, p=0.73). Intraoperative blood loss was reduced significantly with IV-TXA (MD= -106.29mL, CI= -193.73, -18.85mL), and Irr-TXA (MD= -58.06mL, CI= -211.87, 95.75mL). Operative time was significantly reduced with TXA, with IV-TXA demonstrating shorter mean operative times than both standard of care/control (MD=-10.47mins, CI: -14.12, -6.83) and Irr-TXA (MD= -8.69mins, CI: -17.51, 0.12).

Conclusion: TXA significantly decreases intraoperative blood loss, and subsequent blood transfusion requirements. TXA, when administered via irrigation solution is at least equivocal to IV TXA in PCNL, with a consistent trend toward improved outcomes across several domains.

ORAL 19

Early Single Surgeon (SS) Experience with CVAC 2.0 for Steerable Ureteroscopic Renal Evacuation (SURE) Using the CVAC System (CVACS) in a Community Hospital (CH) Setting

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Introduction: SURE with the CVACS is a first-of-its-class endourology technology consisting of a single-use aspiration system and ureteroscope (URS) integrated into one instrument. The device incorporates microjet irrigation with concurrent fluid flow and aspiration via a 7 Fr vacuum lumen for stone fragment removal. This system has Level 1 clinical evidence conducted at academic centers demonstrating superior stone clearance compared to standard URS.¹ We report a SS experience using CVAC 2.0 in a CH.

Methods: Retrospective analysis of SURE cases was performed by a SS at a CH between December 2025 and April 2026. Variables collected included stone

size, operative time (OT), stone free rate (SFR), need for adjunctive techniques, and perioperative safety outcomes. Results: Twenty-seven patients (30 kidneys) underwent SURE. Mean linear stone burden was 22 mm (range 10–57 mm) with a mean OT of 77 minutes (range 27–146 minutes). The SFR by 30-day imaging was 69.2% (zero residual fragments), and 84.6% for fragments < 2 mm. No stone basketing was required in any case. Initial ureteral sheath placement was successful in all procedures. Three kidneys were pre-stented. All cases were completed without the need for additional capital equipment (CE) or specialized staffing. No emergency department visits or hospital admissions were observed.

Conclusion: In our early experience, SURE with CVAC enabled consistent and efficient stone clearance in a CH, without increasing CE or staffing costs. Outcomes were comparable to those reported in academic series¹, supporting the reproducibility of this approach.

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ORAL 20

Surgical hubs in practice: The waiting list solution?

Zakya Penny¹, Phil Maher¹, Caroline Kelly¹, Olwyn Lynch¹, John Sullivan¹, Rustom Manecksha¹, Peter Lonergan¹, Louise McLoughlin¹

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Introduction: The Health Service Executive (HSE) has championed the concept of dedicated surgical hubs as the answer to the ever-growing waiting list and access to care challenges faced by surgeons nationwide. The focus at surgical hubs is on elective high-volume, low complexity cases. [1] The National Treatment Purchase Fund (NTPF) facilitates elective surgery at private hospitals and is in receipt of €200 million annually from the Department of Health to facilitate this. [2]

Methods: A six-month retrospective audit of day case surgeries performed at a tertiary referral centre was compared to a time-matched period of day case surgeries that were prospectively recorded at a dedicated surgical hub.

Results: Day surgery case numbers at the surgical hub trebled in comparison to the number of day case operations performed at a level four hospital over the 6-month period (N = 153). The most common procedures performed at the surgical hub were ureteroscopies (49/153), circumcisions (43/153), scrotal surgeries (32/153) and cystoscopies (29/153). 153 day beds were repurposed for emergency surgical admissions. Activity-based funding (ABF) estimates the associated cost over this six-month period at €856,184. While no comparative costing data are available from the NTPF we would estimate the cost of care in the public surgical hub to surpass that of the private sector.

Conclusion: Surgical hubs provide excellent learning opportunities for surgeons in training and should be rolled out nationwide. An exponential number of cases remain outsourced to the private sector and training opportunities at these sites should be considered by training bodies.

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[3] https://assets.hse.ie/media/documents/ABF_2025_Admitted_Patient_Price_List_-_Inpatient_Only.pdf

VIDEO SESSION - RECONSTRUCTION, UPPER TRACT AND TECHNICAL INNOVATION

TIME: 14.00 - 15.20

VIDEO 1

Transitioning from open to robotics in challenging RPLND: Top ten tips

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Introduction: Robot-assisted retroperitoneal lymph node dissection (R-RPLND) is an established alternative to open surgery for straightforward cases in high volume centres, offering less morbidity and shorter recovery times. We present our six-year institutional experience transitioning from open to robotic for more complex RPLND, highlighting key technical lessons through a three-case video demonstration.

Methods: The data presented in this video included all RPLNDs performed at a tertiary referral centre from 2019 - 2025. The video includes 3 cases which demonstrate the spectrum of challenging aspects of complex RPLND.

Results: Between 2019 and 2025, 120 RPLNDs were performed at our tertiary referral centre—90 robotically and 30 open. Annual case volume increased from 11 cases in 2019 (6 robotic) to 20 in 2025 (18 robotic), reflecting a paradigm shift toward a robotic approach. Median operative time was 4.5 hours (range 2–6), with median estimated blood loss of 76 mL (range 0–3.5 L). Two cases required en-bloc nephrectomy, and one conversion to open. Median hospital stay was 2 days (range 1–5). No mortalities occurred. The video presents three challenging cases involving distinct residual masses within the paracaval, interaortocaval, and para-aortic regions. Each case illustrates one or more of our Top Ten Technical Tips for safe dissection of residual mass off surrounding vital structures.

Conclusions: Adopting robotic surgery for complex post-chemotherapy RPLND requires a gradual assimilation of skills. Sharing reproducible technical principles may help other centres adopt robotics for advanced retroperitoneal germ cell tumour surgery.

VIDEO 2

Salvaging the solitary kidney: Robotic ileal interposition for complex radiation ureteric stricture disease

Robert Keenan¹, Paul Ryan¹, Sorcha O'Meara¹, Diarmaid Moran¹, Kieran Breen¹, Nikita Bhatt¹, Barry McGuire¹

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Introduction: Management of long ureteric strictures remains challenging, particularly in patients with prior pelvic radiation and a solitary functioning kidney. Conventional reconstructive options may be limited, and preservation of renal function is paramount. Ileal interposition offers a durable solution, and the application of robotic techniques may enhance precision and recovery. We present a video demonstrating robotic ileal ureter substitution in this complex clinical scenario.

Methods: A patient with a history of pelvic radiotherapy for cervical cancer and a solitary functioning kidney developed a nephrostomy-dependent long-segment ureteric stricture unsuitable for endoscopic or primary reconstructive techniques. A fully robotic ileal interposition was performed. Key steps included preoperative work-up, ureteric dissection, isolation of an ileal segment, bowel continuity restoration, and uretero-ileal and ileo-vesical anastomoses. Operative metrics and perioperative outcomes were recorded.

Results: The procedure was completed robotically by two specialist robotic reconstructive surgeons with a total operative time of 7 hours. There were no intraoperative or postoperative major complications. The patient had a febrile UTI post-op requiring antibiotics. Postoperative imaging confirmed successful reconstruction with unobstructed urinary drainage and the patient was rendered stent and nephrostomy free.

Conclusion: Robotic ileal interposition is a feasible and safe option in specialist centres for managing complex ureteric strictures in high-risk patients, including those with prior radiation and solitary

kidneys. The robotic platform facilitates multiquadrant work and intracorporeal reconstruction. This case highlights the role of advanced minimally invasive techniques in achieving favourable functional outcomes in challenging reconstructive.

VIDEO 3

Beyond urethroplasty: Buccal mucosa graft for robotic-assisted bladder neck reconstruction

Sorcha O'Meara¹, Robert Keenan¹, Diarmaid Moran¹, Kieran Breen¹, Barry McGuire¹, Eabhann O'Connor¹, Lee C. Zhao², Nikita Bhatt¹

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Introduction: Bladder neck contracture occurs in 0.5-3.7% of patients following prostatectomy, with higher rates reported in the setting of adjuvant radiotherapy (Tan et al., 2010). Management options include endoscopic approaches, as well as open or robotic reconstruction with a Y-V plasty, redo anastomosis or Tanagho repair. Buccal mucosa has been utilised successfully as an autologous graft in the setting of ureteric and urethral stricture disease². We present the first reported case of a robotic buccal mucosal graft (BMG) augmented bladder neck reconstruction in Ireland and the UK.

Methods: This case was performed in a robotic reconstructive surgical unit with a visiting proctor, and three fellowship-trained robotic or reconstructive urologists. A 59-year-old man underwent a robotic transvesical bladder neck reconstruction with BMG following prostatectomy and adjuvant radiotherapy for high-risk prostate cancer. He had previously undergone endoscopic dilations and was suprapubic catheter dependent pre-operatively. This was performed in the low lithotomy position, with the patient Trendelenburg on the Da Vinci system.

Results: No immediate post-operative complications were reported with a length of stay of 2 days and urethral catheter removed day 2 post-operation. Following catheter removal, complete

VIDEO SESSION - RECONSTRUCTION, UPPER TRACT AND TECHNICAL INNOVATION

bladder emptying was recorded, with expected stress incontinence. A staged insertion of artificial urinary sphincter is planned.

Conclusions: This case demonstrates the additional utility of robotic assisted approaches in lower tract reconstruction and further uses of BMGs, with acceptable short-term outcomes.

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VIDEO 4

Modified augmented buccal mucosa ureteroplasty: A technique to reduce graft length in the management of long proximal ureteral strictures

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Introduction: Long strictures in the proximal ureter are technically challenging to repair. We present the case of a nephrostomy dependent 50-year-old gentleman with a proximal left ureteral stricture, who underwent a robotic-assisted ureteroplasty.

Methods: The procedure was performed using the da Vinci robot, LithoVue ureteroscope, indocyanine green (ICG) dye, and buccal mucosal graft.

Results: The stricture spanned approximately 5cm, resulting in complete ureteral obliteration. Typically, this would require either a dorsal onlay buccal graft or an augmented

buccal graft (excision of the stricture, reconstruction of the back wall, and dorsal onlay of graft). However, we modified the technique by reducing the length of the stricture without excising any ureteral tissue. A modified augmented buccal mucosa ureteroplasty was performed, with healthy mucosa proximal and distal to the stricture sutured together. This approach meant only a 1cm graft was required, reduced potential morbidity, and preserved blood supply to the ureter, preventing retraction of the ends. The patient had an unremarkable postoperative course and had his ureteral stent removed 3 weeks later with no complications.

Conclusion: This step-by-step video demonstrates a buccal mucosa ureteroplasty using a small graft to repair a long segment of strictured ureter.

VIDEO 5

Ureteric diverticular flap ureteroplasty: A novel reconstructive approach for stricture-associated ureteric diverticulum repair

David T. Hopkins¹, Maria Sullivan¹, Robert Keenan¹, Sorcha O'Meara¹, Paul Ryan¹, Lauren Crone¹, Jan Mares¹, Liaqat Ullah¹, Nicholas Hegarty², Nikita Bhatt¹, Kieran Breen¹, Diarmaid Moran¹, Barry McGuire^{1,3}

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Introduction: Ureteric diverticula constitute a rare pathology that may manifest with ureteric obstruction by concomitant strictures. Established reconstructive strategies, including segmental ureterectomy or ureteric reimplantation, carry a risk of stenosis up to 15%, which may be further exacerbated by unreliable vascularity in chronically obstructed ureteric tissue. We describe a novel reconstructive technique in which redundant ureteric diverticulum tissue is repurposed as an onlay flap to achieve augmentation ureteroplasty for diverticulum-associated ureteric stricture.

Methods: A man in his twenties presented with a four-year history of severe intermittent left flank pain. Cross-sectional imaging revealed left hydroureteronephrosis secondary to a distal ureteric diverticulum with adjacent short-segment stricture and proximal megaureter appearance. Renography demonstrated preserved split function with delayed drainage from the affected side. Robot-assisted left ureteroplasty was undertaken. The diverticulum was dissected and the redundant diverticular sac was mobilized to create a well-vascularized ureteric flap. The flap was rotated and sutured as an onlay patch to augment the incised ureter.

Results: The procedure was completed uneventfully. The patient was discharged on postoperative day two. JJ stent was removed four weeks postoperatively with complete resolution of symptoms post. Follow up CT urogram demonstrated complete resolution of hydroureteronephrosis.

Conclusion: Diverticular flap ureteroplasty represents a novel reconstructive approach that employs native ureteric tissue to restore luminal continuity in cases of diverticulum-associated ureteric stricture. By repurposing the diverticular wall as a vascularized onlay flap, the approach preserves both urothelial and vascular integrity, thereby mitigating the risks inherent to free grafts or segmental ureteric resection.

VIDEO 6

Robotic-assisted staged bilateral upper-pole heminephroureterectomy for bilateral ectopic vaginal upper-moiety ureters in duplex kidneys

Fintan R Ryan¹, Ishapreet Kaur¹, Charles O'Connor¹, Ahmed Salama¹, Claudiu Cozman¹

¹University Hospital Waterford, Waterford, Ireland

Introduction: Ectopic ureters in duplex collecting systems classically arise from the upper pole moiety and are frequently associated with a poorly functioning or dysplastic renal segment. In females, ectopic insertion distal to the external urethral sphincter may result in persistent urinary leakage

VIDEO SESSION - RECONSTRUCTION, UPPER TRACT AND TECHNICAL INNOVATION

despite otherwise normal voiding, often with recurrent urinary tract infections [1]. Robotic surgery offers a minimally invasive approach for managing this complex congenital anomaly [2].

Methods: We demonstrate this technique in a 28-year-old female with bilateral complete duplex kidneys, atrophic upper moieties, and bilateral ectopic upper-moiety ureters inserting into the vagina. She underwent staged robotic-assisted upper-pole hemi-nephroureterectomy on each side. Each procedure was undertaken in the lateral decubitus position using five laparoscopic ports, with pneumoperitoneum established at 12 mmHg. Surgery was performed using the DaVinci Xi® (Intuitive, USA).

Results: The renal hilum was identified, segmental hilar vessels were controlled, and upper-pole heminephrectomy was completed. The ectopic ureter was dissected distally and divided above the bladder. There were no intra-operative or post-operative complications. Following staged bilateral surgery, the patient had complete resolution of vaginal urinary leakage and no further urinary tract infections at follow-up.

Conclusion: Staged robotic-assisted upper-pole hemi-nephroureterectomy is a safe and feasible option in selected adults with bilateral duplex systems and ectopic upper-moiety ureters, offering precise dissection and excellent symptomatic outcomes.

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VIDEO 7

Operative steps in robotic retroperitoneal partial nephrectomy

Charles O'Connor¹, Fintan Ryan¹, Dunamis Akinyemi¹, Shane Considine¹, Claudiu Cozman¹, Lee Yap¹

¹University Hospital Waterford, Waterford, Ireland

Introduction: Partial Nephrectomy (PN) is recommended for localised renal tumours with a robotic approach offering benefits over conventional open or laparoscopic surgery. Most PN cases are performed via a transperitoneal approach however a retroperitoneal approach can also be used in select cases which can offer better access to posterior and lateral tumours, easier access to the renal hilar vessels and negate the need to enter the abdominal cavity thus reducing the risk of bowel injury and post operative ileus [1][2]. While this approach has increased in popularity it has a steeper learning curve with fewer anatomical landmarks and less space to manoeuvre than a transperitoneal approach. Being able to offer both transperitoneal and retroperitoneal surgery for PN allows a tailored approach depending on the size and location of tumours as well as certain patient factors.

Methods: A 58-year-old male with an incidental 3.1cm exophytic lesion arising from the posterior interpolar region of the right kidney. A retroperitoneal partial nephrectomy was performed using the Intuitive DaVinci X robotic platform.

Results: Operative time for this procedure was 220mins. Console time was 137 mins. Blood loss was <100mls. Warm ischaemic time was 23 minutes. Length of stay was 3 days. There were no post-operative complications. The histopathology revealed a pT1a clear cell renal cell carcinoma, Grade II with negative surgical margins.

Conclusion: This case highlights the set-up, operative steps and surgical technique for robotic retroperitoneal PN. We demonstrate this to be an effective and safe approach to PN in select cases.

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VIDEO 8

Single-port robotic surgery: Early upper tract experience

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Introduction: The Da Vinci Single Port (SP) platform allows retroperitoneal and extraperitoneal approaches to the urologic organs, facilitating completely regionalised surgery without pneumoperitoneum. Docking via a low anterior access point for kidney surgery allows the patient to remain supine. Although requiring adaptations in technique when transitioning from the multiport platform, an SP approach has distinct advantages in certain cases.

Methods: We illustrate our early experience with the SP robot for pyeloplasty and partial nephrectomy. Low anterior access is established via a 3cm McBurney incision, superomedial to the anterior superior iliac spine. Following development of the retroperitoneal plane, the SP access kit is docked to the wound, and the SP robot docked therein. An separate assistant port was not used. Leveraging the platform's connectivity tools, we used Da Vinci Telepresence for remote mentoring in an early case. We discuss the SP approach in comparison with the multiport platform, and highlight some of its benefits and challenges.

Results: This video demonstrates low anterior access, docking, and the key steps in SP pyeloplasty and partial nephrectomy. Both patients had a short post-procedure stay with no recorded complications.

Conclusion: Use of the SP platform for selected cases is feasible and safe in our experience, with a short learning curve for an established multiport surgeon. Our early experience supports SP surgery as a valuable adjunct to established multiport techniques.

VIDEO SESSION - RECONSTRUCTION, UPPER TRACT AND TECHNICAL INNOVATION

VIDEO 9

A standardized supine PCNL technique: Biplanar access, 26Fr tract, and trilogy lithotripsy

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Introduction: Percutaneous nephrolithotomy (PCNL) remains the gold standard for large and complex renal calculi. The modified supine approach, combined with advanced imaging and modern lithotripsy platforms, enables a streamlined, reproducible, and ergonomically efficient workflow. We present a standardized supine PCNL technique incorporating biplanar fluoroscopic access, a 26Fr tract, and Trilogy lithotripsy.

Methods: A stepwise supine PCNL is demonstrated in the modified supine position. Percutaneous access is achieved using biplanar fluoroscopic guidance, facilitating precise calyceal targeting and depth control to maximise first-pass success. Following guidewire placement, tract dilation is performed to 26Fr, ensuring stable sheath positioning and optimal intrarenal alignment. Stone fragmentation is undertaken using the Trilogy lithotripter, combining ultrasonic and ballistic energy with continuous suction to enable simultaneous fragmentation and evacuation. Flexible nephroscopy and selective retrograde assistance are utilized to achieve complete clearance. Key technical nuances, decision-making strategies, and troubleshooting techniques are highlighted.

Results: The described approach enabled consistent first-pass access, excellent visualization, and efficient stone clearance. Biplanar imaging improved access accuracy and reduced multiple punctures. The 26Fr tract provided stability and optimal instrument control while Trilogy lithotripsy facilitated rapid fragmentation with active clearance, reducing operative time and intrarenal pressure. The procedure was completed without complication.

Conclusion: Supine PCNL using biplanar access, 26Fr tract, and Trilogy lithotripsy represents a safe, efficient,

and reproducible technique. This structured approach optimizes access, enhances clearance efficiency, and supports improved patient outcomes in contemporary endourological practice

VIDEO 10

Robot assisted donor nephrectomy, standerization of the technique in Ireland

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Introduction: In 1995, laparoscopic donor nephrectomy (LDN) was introduced and has since become the preferred method for kidney donation from living donors [1]. This is due to several benefits for the donor, including less post-operative pain, a shorter hospital stay, and better cosmetic outcomes. Various methods of LDN have been developed, such as intra-abdominal and retroperitoneal approaches, with or without hand assistance. The safety and well-being of the donor remain the most important factors [2].

Methods: Despite its effectiveness, laparoscopic surgery has some drawbacks, such as 2-D imaging, limited instrument movement, and surgeon discomfort. As robotic surgery becomes more common, its use in living kidney donation is being explored to see if it offers advantages over traditional methods [3]. Early research suggests that robotic techniques may provide a better safety profile for the donor and surgeon and more consistent surgical outcomes.

Results: Over the last 2 years, we have transitioned from the majority of surgeons in our department performing HALDN to all surgeons now performing RDN. The da Vinci X or Xi systems were used in all cases, with standardisation of the technique between all surgeons.

Conclusion: We are presenting various techniques of RDN, and highlighting the standard in Ireland in a step by step video.

References:

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MODERATED POSTERS

TIME: 16.20 - 17.20

POSTER 1

Fit to Operate? Frailty assessment and team education in the older urology patient

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Introduction: Frailty predicts adverse outcomes in older surgical patients, including prolonged length of stay (LOS), delirium, and postoperative complications. Despite this, routine frailty screening is not consistently performed in urology patients.

We conducted a full-cycle audit to compare outcomes in urology patients aged ≥ 65 years before and after the implementation of frailty screening and a team education programme.

Methods: A prospective full-cycle audit was conducted from September to November 2025, including all urology admissions aged ≥ 65 years. Data on co-morbidities, length of stay, discharge location, complications, and multidisciplinary team input were collected before and after the intervention. Data was analysed using GraphPad (Prism V10).

Results: A total of 88 patients were included over a 2-month period with a mean age of 74 years (range 65-101) and a median clinical frailty score of 4 (range 2-7). The median LOS was shorter post-intervention with a median of 3 vs. 4 days ($p=0.651$). A higher number of patients were referred for MDT in the second cycle (11 (22%) vs 4 (10%)), however this was not statistically significant ($p=0.389$).

Conclusion: The implementation of frailty screening enhanced the identification of frail inpatients with increased MDT referrals and a shorter LOS. Future research should focus on optimising the integration of comprehensive geriatric assessment with frailty screening to refine prognostication and tailor perioperative management strategies in this susceptible population.

References:

- [1] Panayi AC, Orkaby AR, Sakthivel D, Endo Y, Varon D, Roh D, Orgill DP, Neppl RL, Javedan H, Bhasin S, Sinha I. Impact of frailty on outcomes in surgical patients: A systematic review and meta-analysis. *Am J Surg.* 2019 Aug;218(2):393-400. doi: 10.1016/j.amjsurg.2018.11.020. Epub 2018 Nov 27. PMID: 30509455; PMCID: PMC6536365
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POSTER 2

From delay to delivery: Enhancing emergency urological care through protected emergency theatre slots

Irfan Qadir Afridi¹, Tauqir Aslam Waraich¹, David Canny¹, Cathal Flood¹, Gavin Calpin¹, Frank T. D'Arcy¹, Garrett Durkan¹, Syed Jaffry, Patrick O'Malley¹, Catherine Dowling¹

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Introduction: Emergency urological conditions, particularly ureteric calculi requiring urgent intervention; often compete for operating theatre access with other surgical specialties. Due to prioritization dynamics, urology cases may be assigned lower urgency, resulting in prolonged waiting times, extended hospital stays, and increased patient morbidity. Galway University Hospital introduced protected emergency urology theatre slots in 2018 (Kaizen initiative) to address these delays. Following this initiative, the average wait to theatre for ureteroscopy reduced from 5.4 to 2.8 days. The current study seeks to clarify if this improvement has been sustained.

Methods: This retrospective study evaluated the impact of introducing protected urology emergency theatre slots. The number of emergency ureteric calculi cases requiring surgical

intervention, along with their respective waiting times, were recorded from emergency theatre log book and were compared to pre-Kaizen and previously published poster presentation in 2018. In this study 6 months data was re-audited to assess both the initial improvement and the sustainability of these changes.

Results: A total 125 cases in the 6-month post-Kaizen period from Jan 2025 till July 2025. The average waiting time for surgical intervention was 2.05 which is significantly reduced from 5.2 days pre-Kaizen and from 2.8 as per poster presentation.

Conclusion: The introduction of protected scheduled urology emergency theatre slots demonstrates a significant reduction in waiting times for emergency procedures. This intervention improved access to timely care, with potential reductions in patient morbidity and hospital length of stay. This improvement initiative highlights the value of structured process improvement in optimizing surgical service delivery.

POSTER 3

Wards Sans Frontières: Developing the urology virtual ward at St Vincent's University Hospital

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Introduction: Rising healthcare demands and limited inpatient capacity have driven the need for innovative patient flow models. Virtual wards introduced by HSE in 2024 and pioneered in St Vincent's University Hospital and University Hospital Limerick. Initially utilised by the medical services Urology at St. Vincent's is the first surgical team nationally to pilot the service.

Methods: A service evaluation was conducted using data collected from

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October 2025 to March 2026 of patients admitted to the virtual ward. Patients are cared for using a consultant-governed model with 24 hour digital monitoring using an electronic tablet. Data analysed included patient numbers, indication, active care days, beds saved days and compliance rates.

Results: In total, 1658 patients were managed through the Virtual Ward accounting for over 6000 active bed days saved. The service demonstrated consistent operational load with a daily census of approximately 30 patients. Urology virtual ward pathway established a proof-of-concept for surgical integration. Since its expansion, 65 Urology patients have been successfully managed in the community (mean of 5.8 day stay). Leaving 377 active bed days saved. Specific Urology protocols/questionnaires have been developed to assess these patients virtually.

Conclusion: The Virtual Ward at SVUH demonstrates a transformative model for acute urology care. High levels of compliance with remote monitoring and consultant clinical oversight supported the safety and feasibility of delivering Urology peri-operative care outside the traditional hospital setting. The Virtual Ward safely substitutes inpatient admission, promotes enhanced recovery after surgery, and improves patient experience all the while freeing inpatient capacity.

References:

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POSTER 4

A regional service review of patient outcomes and satisfaction following optilume treatment in Northern Ireland

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Introduction: Urethral stricture disease can significantly impair urinary flow and quality of life. Conventional urethoplasty and endoscopic

interventions, while effective, can be associated with variable patient satisfaction, procedural complications, and need for repeated procedures, including temporary urinary diversion with suprapubic catheterisation.

Methods: The Optilume drug coated balloon is a novel minimally invasive treatment option for urethral stricture disease, combining mechanical dilatation with localised delivery of an antiproliferative agent to reduce re-stenosis. This audit aims to assess patient outcomes and satisfaction of this treatment through a post-procedure validated questionnaire.

Results: A total of 40 patients undergoing treatment with Optilume were identified during a study period of 28 months. A validated questionnaire, adapted from the International Prostate Symptom Score (IPSS), was utilised to assess symptom severity related to urethral stricture disease. Patient-reported outcomes were collected at 3 months, 12 months, and 24 months post-procedure. Patient satisfaction was also assessed. Overall, there was a significant improvement in urinary symptoms and reported quality of life when compared to pre-treatment baseline, with 81% of patients reporting satisfaction with the procedure. While most patients demonstrated sustained symptomatic benefit, a gradual recurrence of symptoms was noted at 2 years in a small cohort of patients.

Conclusion: Treatment of urethral stricture disease with Optilume appears to be a safe and effective minimally invasive option for the management of these patients, with high patient satisfaction and significant symptomatic improvement.

POSTER 5

A modular, low-cost silicone urethral model for simulation of urethral stricture disease and endoscopic management

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Introduction: Simulation-based training in urethral surgery remains

limited by cost, lack of anatomical realism, and poor reproducibility of stricture pathology. We aimed to develop a novel, modular silicone urethral model that replicates urethral anatomy and allows interchangeable stricture segments for endoscopic training.

Methods: A three-dimensional mould of the male urethra was designed in Fusion 360 based on anatomical urethral diameters and produced using fused deposition modelling in PLA. The mould was cast using Shore 15A platinum-cure silicone (1:1 ratio), degassed at 10°C for 40 minutes, and cured at 25°C for 14 hours. Multiple lumen configurations were developed to simulate varying stricture lengths and severities. To enable modularity, the bulbar urethral stricture segment was isolated within an interchangeable system. Ring-shaped connectors were also designed and fabricated using SLA 3D printing with ABS-like resin. Post-processing included water bath rinsing and UV curing. The final model accommodates standard flexible endoscopic instruments, allowing simulation of flexible cystoscopy, urethral dilation, and optical urethrotomy.

Results: The model demonstrated high procedural fidelity, permitting realistic urethral and reproducible simulation of stricture disease across mild, moderate, and severe configurations. Modular connectors enabled rapid exchange of stricture segments, facilitating repeated practice and objective comparison of techniques. The silicone composition provided appropriate tactile feedback during instrumentation and incision. The model was durable, reusable, and low-cost compared to commercially available simulators.

Conclusion: This modular silicone urethral model represents a scalable, cost-effective solution for training in urethral stricture management. However, formal validation studies assessing construct validity, face validity, and educational impact are required.

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POSTER 6

Cystoscopy for bladder wall thickening: Towards a risk-stratified approach to referral

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Introduction: Bladder wall thickening (BWT) identified on cross-sectional imaging frequently prompts referral for cystoscopy, even when detected incidentally in the absence of haematuria. The diagnostic yield and optimal prioritisation of these patients remain unclear [1].

Methods: A retrospective analysis of 3,735 flexible cystoscopies performed between 2021 and 2023 was undertaken. Of these, 72 patients underwent cystoscopy for BWT on CT or MRI. Patients without visible (VH) or non-visible haematuria (NVH) formed the incidental cohort, while those with VH/NVH were analysed as a comparator group. Demographics, imaging, cystoscopic and histological data were collected.

Results: Seventy-two patients were included: 52 (72.2%) incidental and 20 (27.8%) with haematuria. Median age was 71 years and 76.4% (n=55) were male. Median time to cystoscopy was 66 days. In the incidental cohort, 10/52 (19.2%) had suspicious cystoscopy and 5/52 (9.6%) were diagnosed with bladder cancer. In the haematuria group, 11/20 (55.0%) had suspicious findings and 6/20 (30%) had cancer. Suspicious cystoscopy was more common with haematuria (p=0.0076). Higher cancer detection in the haematuria group showed a trend toward statistical significance (p=0.061). Focal BWT was associated with higher cancer detection than diffuse thickening (30.8% vs 2.6%, p=0.011).

Conclusion: BWT carries variable malignancy risk depending on clinical and radiological context. Risk is highest in patients with haematuria and focal or nodular abnormalities, while asymptomatic diffuse thickening has a lower yield. These findings support a risk-stratified approach, prioritising urgent cystoscopy for haematuria-associated or focal BWT, and non-urgent

evaluation for asymptomatic diffuse thickening.

References:

[1] Song W, Jeon HG, Jeong BC, Seo SI, Jeon SS, Choi HY, et al. Clinical significance of incidentally detected bladder wall thickening on computed tomography. *Int Urol Nephrol*. 2017;49(2):191-6

POSTER 7

Further evaluation of the valve opening thresholds of the transurethral catheter (TUC) safety valve

Cathal Flood¹, Michael Walsh^{2,5}, Jay Budrewicz³, Barry Rickman³, Niall Davis^{1,4,5}, Hugh Flood^{2,5}

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Introduction: Inadvertent misplacement of a urethral catheter balloon with subsequent inflation can generate high pressures, causing urethral injury with potentially devastating sequelae. A pressure relief valve has been developed to guard against this, with an opening pressure set at 150kPa (range 140–170kPa). We compared urethral tissue responses to balloon inflation at 100kPa and 170kPa in ex vivo porcine models to confirm no significant additional injury at the upper end of the range.

Methods: Under Good Laboratory Practice conditions, proximal urethrae from 5 male Yorkshire Swine (6–7 months) were harvested. A commercially available 14Ch, 5ml, 100% silicone Foley catheter balloon was inflated to 100kPa (control) or 170kPa (test) using a proprietary inflation device. Each urethra received both treatments at proximal and distal sites per a predefined matrix. Post test macroscopic damage scores were assigned. Balloon site and adjacent tissues underwent histopathological examination, and morphometric urethral wall thickness measurements were recorded at proximal and distal regions.

Results: Target pressures were achieved in all inflations. No external trauma occurred during inflation,

deflation or catheter removal. No macroscopic mucosal injury of the opened urethra was identified. Histology demonstrated no mucosal, submucosal or muscular tears and no structural disruption of collagen or elastin at either pressure. Urethral wall thickness measurements were comparable between groups.

Conclusion: In this ex vivo porcine model, there was no evidence of micro or macroscopic urethral injury following balloon inflation at 100 or 170kPa. These findings support the safety of a pressure relief valve with a venting pressure window up to 170kPa.

POSTER 8

No stent left behind: Cloud-based application development and audit of ureteric stent practice at Beaumont Hospital

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Introduction: Retained ureteric stents are a recognized source of preventable morbidity[1]. At Beaumont Hospital, stent records have historically relied on paper logbooks — inherently prone to loss, illegibility, and missed follow-up[2]. We sought to address this by developing a dedicated mobile application, JJ Stent Tracker, while simultaneously auditing our unit's stent practice over a three-month period.

Methods: JJ Stent Tracker was developed in SwiftUI for iOS 17+ using Apple CloudKit with AES-256-level encryption, role-based access, automated overdue alerts, urine culture sensitivity, audit logging, and consultant-specific dashboard. HSE Data Protection and Digital Health Committee approvals were obtained. In parallel, all JJ stent insertions at Beaumont Hospital between January and March 2026 were recorded retrospectively and prospectively. Statistical analysis was performed with SPSS.

Results: The application was successfully developed and tested in a simulated environment. Initial validation

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confirmed automated overdue alerts, consultant-filtered dashboards, and exportable PDF reporting. 125 stents were inserted (60% stone, 36% other, 4% stricture) across 14 consultants. Median age was 54 years; 58% male. Stone size differed significantly by anatomical location ($p=0.007$), with intra-renal stones significantly larger than proximal ureteric ($p=0.006$) and mid-ureteric ($p=0.018$) stones. Median dwell time was 32 days (IQR 26–39) among stents with confirmed removal.

Conclusion: JJ Stent Tracker offers a viable alternative to paper-based stent logbooks. Our findings reflect real-world stent practice at an Irish tertiary centre and highlight the value of a standardised digital approach to stent management. A live application demonstration and video walkthrough of JJ Stent Tracker will accompany this presentation.

References:

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POSTER 9

Complication patterns and outcomes after penile prosthesis implantation: A 250-case single-centre series

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Introduction: Penile prosthesis implantation (PPI) provides durable treatment for refractory erectile dysfunction; however, complications requiring revision remain clinically relevant. While infection and mechanical failure are well described, anatomical patterns of device erosion are less clearly characterised. We aimed to

evaluate complication profiles in a large contemporary cohort, with emphasis on erosion phenotypes and clinical outcomes.

Methods: We conducted a retrospective review of 250 consecutive primary and revision PPIs performed over a 20-year period (20–22 implants annually) at a high-volume centre. Data collected included indications, operative details, infection-prevention strategies, and early and late complications. Complications were stratified by type and anatomical site, including lateral corporal defects, scrotal pump erosion, and distal/glans involvement. Dual implantation cases (AUS + PPI) were analysed separately.

Results: Infection represented the most frequent complication, remaining within contemporary low reported rates. Erosion and extrusion occurred in reproducible anatomical patterns, most commonly involving lateral corporal defects, scrotal pump erosion, and distal/glans involvement. Mechanical failure requiring revision occurred in a minority of cases, while hematoma, seroma, and reservoir-related complications were uncommon. Eight patients underwent dual AUS and PPI implantation, with acceptable functional outcomes. Overall patient satisfaction remained high.

Conclusion: In this large single-centre series, PPI demonstrated favourable safety and durable outcomes. Distinct anatomical erosion patterns were consistently observed and represent an under-recognised but clinically important aspect of device-related morbidity. Improved recognition of these patterns may facilitate earlier intervention, optimise counselling, and inform surgical technique. These findings support refinement of complication prevention strategies and warrant further prospective evaluation.

References:

- [1] Carson CC, Mulcahy JJ, Govier FE. Efficacy, safety and patient satisfaction outcomes of the AMS 700CX inflatable penile prosthesis: results of a long-term multicenter study. *AMS 700CX Study Group. J Urol.* 2000 Aug;164(2):376-80. PMID: 10893589
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POSTER 10

Impact of urodynamics on clinical decision-making in men with mixed lower urinary tract symptoms: Findings from a single-centre retrospective study

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Introduction: The role of urodynamics in influencing management in men with mixed lower urinary tract symptoms (LUTS) remains uncertain. Evidence from the UPSTREAM trial states that urodynamic studies (UDS) can serve to clarify diagnostic uncertainty in this complex cohort of patients (1).

Methods: This study aimed to evaluate the impact of UDS on clinical decision-making in a retrospective single-centre cohort study. All patients that underwent UDS in this study had refractory symptoms despite prior pharmacotherapy or surgical intervention. The primary outcome was to identify a change in management, defined as any alteration between pre- and post-UDS treatment plan.

Results: A total of 94 patients with mixed LUTS were included (mean age 68 years). 96% of patients were on an α -blocker or a 5- α reductase inhibitor. 93% were on an antimuscarinic agent. 99% of patients were on two pharmaceutical agents prior to UDS. 5 patients underwent bladder outlet surgery and four patients intermittently self-catheterised prior to UDS. 64% of patients had their management

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fine-tuned after UDS assessment. UDS demonstrated detrusor overactivity (DO) in 26%, bladder outlet obstruction (BOO) in 32%, BOO and DO in 23%, detrusor failure in 4%, and normal findings in 15%. Changes included modification of pharmacotherapy (22%), progression to bladder outlet surgery (28%), and escalation to intravesicular Botulinum toxin injection (50%).

Conclusion: UDS resulted in a change in management and resultant in symptom improvement in 93% (n=56) of men. This study signals the value of UDS in informing better consent and therapeutic confidence when counselling patients living with mixed LUTS.

References:

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POSTER 11

Adult urologists' perspectives on transitional urology care in Europe: A cross-sectional survey

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Introduction: Advances in healthcare have improved survival in children with congenital urological anomalies, creating a growing need for lifelong, developmentally appropriate care. In Ireland, transition occurs on an ad hoc basis, which may result in fragmented care, suboptimal patient outcomes and increased provider burden.¹ The aim of this study was to evaluate how transitional urology services are currently structured across European institutions.

Methods: Urologists involved in the care of adults with congenital urological conditions in centres across Europe were invited to complete an online survey. Participants were surveyed regarding the structure of transitional care

pathways in their institution, presence of multidisciplinary care teams (MDTs) and availability of combined paediatric-adult transitional clinics.

Results: Seventy-eight respondents across 24 European countries completed the survey. Among respondents describing their transition process, 55.6% reported a formalised transition pathway (30/54), while 25.9% described ad hoc referral processes (14/54). A designated transitional MDT was present in 42.1% of institutions (24/57) and 47.4% reported combined paediatric-adult transitional clinics (27/57). Reconstructive urology was ranked the most appropriate subspecialty interest for urologists managing adult congenital urology patients (mean rank 1.63, p<0.001). Commonly identified institutional strengths included specialised care teams and collaboration between paediatric and adult services, while limitations included limited clinic capacity and lack of standardised transition pathway.

Conclusions: Transitional urology services in Europe remain variable in structure and organisation. Development of formalised transitional pathways and strengthened multidisciplinary collaboration may improve continuity of care for patients transitioning to adult services.

References:

[1] Dr. Fardod O' Kelly, "Is Adolescent and Transitional Urology a Healthcare Right or a Privilege?", *Paediatric Urology*, 12 Oct. 2020, *Medical Independent: Paediatric and Adolescent Urological Surgery*

POSTER 12

Robotic assisted ureteral reimplantation: A series from a single centre

Eva Browne¹, Michael Rafeh¹, Neehar Shetty¹, Nikita Bhatt¹, Arjun Nambiar¹

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Introduction: Ureteric reimplantation is a procedure aimed at restoring function of the urinary tract following stricturing or injury of the ureter(1). This has been traditionally been done as an open procedure but recent advancements in minimally invasive

surgery means that robotic-assisted surgery offers several technical advantages [1][2].

Methods: We analysed a prospectively maintained database of patients undergoing robotic assisted ureteral reimplantation between March 2022 and October 2025. Data recorded included type of procedure, indication for surgery, pre and post operative renal function, major complication rate and length of stay were recorded.

Results: A total of 26 cases were performed. 8 involved creation of a Boari flap, 12 just required a psoas hitch, 3 were direct ureteric reimplants and 3 buccal patch ureteroplasties were performed. Information regarding pre and post operative renal function was available for 18 patients (69.2%) demonstrating preservation or improvement of renal function in 15 (83.3%). Of 3 patients with ongoing deterioration in function, none required re-stenting or further intervention for obstruction. Of the 8 remaining patients, 6 had preserved split function on post operative imaging and 2 are awaiting follow up. No patients had a major complication (CD 3). Mean length of stay was 3.8 days (median 3).

Conclusion: Our series demonstrates that robotic-assisted ureteric reimplantation is associated with a short median length of stay and low complication rate. In addition to this we have demonstrated high rates of preservation of renal function post intervention with no reinterventions so far.

References:

[1] Hassan AA, Mady AM, Abozied H, Algammal MI, Hassan AA, Salman M, et al. Robotic assisted vs. open ureteral reimplantation in adults: a systematic review and meta-analysis. *J Robot Surg*. 2025;19(1):373

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MODERATED POSTERS

POSTER 13

Mechanical behaviour of human penile tissues under cyclic loading: implications for inflatable penile prosthesis inflation protocols

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Introduction: Erectile dysfunction affects more than 50% of men over 40, and inflatable penile prostheses (IPPs) are the gold standard for patients unsuitable for drug treatment [1]. Despite high satisfaction rates, complications such as tissue damage and erosion have been reported, possibly related to mechanical interactions with surrounding penile tissues [2]. The tunica albuginea (TA) and corpus cavernosum (CC) are the main tissues loaded by IPP implantation and inflation, yet their behaviour is poorly understood [3]. This study aims to characterise the cyclic viscoelastic behaviour of these tissues and investigate the effect of strain rate on prosthesis inflation pressures.

Methods: Human penile tissues were obtained from three donors (75–89 years). TA and CC samples were prepared for mechanical testing. TA samples were subjected to uniaxial tensile loading to 10% strain, while CC samples were compressed to 50% strain. The samples were loaded and held for 10 minutes and then unloaded and held for 10 minutes, and this procedure was repeated three times. Various parameters were considered to characterize tissue viscoelasticity and stress-strain response.

Results: TA and CC demonstrated nonlinear stress-strain behaviours and viscoelastic strain-rate dependency. CC samples partially recovered after relaxation. Both tissues demonstrated viscoelastic, time-dependent, and strain rate-dependent behaviour, which is important for understanding prosthesis-tissue mechanical interactions and loading cycles of IPP post implantation.

Conclusion: Penile tissues exhibit viscoelastic and strain rate-dependent behaviour, understanding these properties and parameters can inform the optimal design of future IPP devices, with a view to minimising tissue damage and improving device longevity.

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POSTER 14

Awareness and management of ketamine cystitis among Irish urologists: A cross-sectional survey

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Introduction: Ketamine is a dissociative anaesthetic that acts as an N-Methyl-D-aspartate receptor antagonist^{1,2}. Chronic recreational use can lead to significant urological complications. These include lower urinary tract symptoms (LUTS), bladder

dysfunction and can progress to upper tract uropathy^{1,2}. Despite its growing prevalence, ketamine cystitis remains under-recognised, and management strategies are variable. This study aims to evaluate awareness, diagnostic, and management approaches to ketamine cystitis among Irish urologists and trainees.

Methods: A cross-sectional online survey was conducted among Irish urologists and trainees. The survey assessed awareness of ketamine cystitis, including recognition, prevalence, diagnostic approaches, common symptoms, and current management strategies. Additionally, perceived challenges and the need for further guidance were evaluated.

Results: Fifty surveys were distributed to participants, with a response rate of 84% (n = 42). Respondents comprised 78.6% consultants and 21.4% registrars. 61.9% reported an increase in presentations of ketamine cystitis over the preceding 12 months. A majority (71.4%) did not feel confident managing a new referral. Lack of guidance was identified as a key barrier by 71.4% of respondents, while 66% reported that disease stage at presentation made management challenging. There was considerable variability in reported treatment approaches.

Conclusions: This study demonstrates variability in both awareness and management of ketamine cystitis among Irish urologists and urology trainees, alongside low confidence in managing new referrals. These findings highlight the need for standardised diagnostic criteria and evidence based management guidelines to improve patient outcomes.

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MODERATED POSTERS

POSTER 15

Urological injuries in major pelvic trauma; the experience of a national major trauma centre

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Introduction: Urological injury is a well-recognised complication of high energy pelvic trauma. Clinical presentation varies and should thus be considered in all pelvic fracture presentations. Careful management under the care of a service equipped to manage trauma associated urological injuries offers the best clinical outcomes for patients.

Methods: A retrospective review of all significant urological injuries in major pelvic trauma presentations to a newly designated national major trauma centre in the Republic of Ireland between April 2023 and April 2025.

Results: A total of 74 patients with pelvic fracture were identified for retrospective review during this period. A total of 17 cases featured some Urological input and were eligible for inclusion in this study. Clinical course, treatment options and functional outcome varied depending on the nature and degree of injury. Two cases required procedural intervention in the form of flexible cystoscopy, five required or will require definitive surgical intervention and the remaining ten cases were managed conservatively.

Discussion: Pelvic trauma is a significant risk factor for urological injury. In high energy events with signs of urological injury, a high index of suspicion should always be adopted. These injuries may require the expertise of a limited subspecialty service placing significant demand on day to day service provision. Adequate resource provision and service support is essential to optimise patient care.

POSTER 16

Should digital rectal examination be omitted from the assessment pathway in a Rapid Access Prostate Clinic?

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Introduction: Men aged 50–70 with suspected prostate cancer based on abnormal digital rectal examination (DRE) and/or elevated prostate-specific antigen (PSA) are referred to the Rapid Access Prostate Clinic (RAPC). Assessment includes PSA and DRE, with abnormalities prompting magnetic resonance imaging (MRI). The necessity of DRE in this pathway remains uncertain. This study evaluated whether DRE can be safely omitted.

Methods: A retrospective review of all RAPC referrals over 6 months in 2024 was performed. Demographics, PSA, and DRE findings from referring GPs and urologists were recorded. Patients were stratified by urologist-performed DRE (normal vs abnormal). MRI (PI-RADS) and biopsy outcomes were analysed. Age-specific PSA thresholds were defined according to NCCP RAPC referral guidelines. Clinically significant prostate cancer (csPCa) was defined as Grade Group (GG) ≥ 2 .

Results: A total of 316 men were included. Mean age was 62 years (range 58–68) and mean PSA 7.02 ng/mL. Elevated PSA was present in 243 men (76.9%). Abnormal DRE was identified in 89 men (28.2%), including 34 (40.4%) with normal PSA. In the abnormal DRE group, 36 men (40.4%) had csPCa (GG2 n=17, GG3 n=4, GG4 n=4, GG5 n=11). Three patients (1%) with abnormal DRE and normal PSA were diagnosed with csPCa (GG2 n=2, GG3 n=1). GP–urologist agreement was moderate ($\kappa=0.57$).

Conclusion: Omission of DRE would miss 1% of csPCa cases not meeting MRI criteria based on PSA alone. DRE showed limited incremental yield and moderate agreement; it should not determine MRI referral alone but may retain a selective role.

POSTER 17

Our experience with bulkamid urethral injection; a procedure performed in a model 2 hospital in UL Hospital Group

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Introduction: Stress urinary incontinence (SUI) significantly impacts quality of life. Bulkamid, a hydrophilic polyacrylamide hydrogel, has emerged as a promising urethral bulking agent for SUI. This study evaluates the effectiveness and safety of Bulkamid injections for SUI treatment.

Methods: A prospective study from 2020 to 2024 included 38 patients with SUI who received Bulkamid injections. Procedures were performed under general (n = 31) or local anesthesia (n = 7). Treatment success was determined by the reduction in incontinence pad use. Patients with persistent symptoms were offered repeat procedures. Complications and adverse events were monitored.

Results: At initial follow-up, 58% of patients (n = 22) achieved complete dryness. However, 30% (n = 11) required repeat injections due to ongoing symptoms. The remaining 12% (n = 5) showed no improvement and declined further intervention. Complications included urinary tract infections (8%, n = 3), visible haematuria (1.5%, n = 1), and Bulkamid migration (15%, n = 4) in those requiring repeat procedures.

Conclusion: Bulkamid injection offers a promising treatment for SUI, with 58% of patients achieving success and a low complication rate. However, 30% required repeat injections, and migration of the bulking agent was observed in some cases. Larger studies with long-term follow-up are needed to optimize patient selection and outcomes.

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POSTER 18

Peri-procedural antimicrobial prophylaxis in prosthetic urology: A national audit of practice patterns

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Introduction: Peri-operative antimicrobial prophylaxis is critical in preventing infection following prosthetic surgery. Current practices vary and are largely driven by clinician preference rather than evidence-based consensus. This study aimed to evaluate national practice patterns among Irish implanters.

Methods: A 17-question survey was distributed electronically to Irish Society of Urology consultant members assessing antimicrobial prophylaxis strategies for all genitourinary implant surgery. Data obtained included surgeon experience, case volume and mix, pre-operative screening tests, peri-operative antimicrobial protocols and institutional antibiotic stewardship awareness. Responses were anonymised and descriptive analysis performed.

Results: Eighteen of 93 individuals responded (19%), representing the majority of implanters nationally. Clinical experience: 44% (< 5 years), 39% (5 – 15), 16.7% (15 +). 17% implant 30+ cases yearly, with 22% performing both penile and continence surgeries. Pre-op MRSA screening is performed by 67%, while 78% obtain urine cultures. HBA1c thresholds: 35% <7.5%, 18% <8.5%, 12% <9.5%, and 35% no cut-off. 40% prescribe antimicrobials prior to admission, with 60% providing on discharge. Intraoperative antibiotic regimens: aminoglycoside + penicillin (56%), aminoglycoside + vancomycin (22%), single cephalosporin (11%), or quinolone (11%). 83% do not routinely administer antifungals. 44% state their hospital does not have a policy for antibiotics in prosthetic urology procedures, with a further 39% unsure.

Conclusion: This audit has identified significant variability in peri-procedural antimicrobial protocols nationally,

reflecting lack of clarity in international guidelines. We propose the creation of a national registry of prosthetic Urology cases to better inform current practice, assess predictors of implant infection and complications and improve patient outcomes.

POSTER 19

Varicocele embolisation using glue: A systematic review and meta-analysis on the safety and efficacy

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Introduction: Varicocele, a dilation of the pampiniform plexus, is a common and potentially reversible cause of male infertility, contributing to up to 50% of cases. Symptoms may include scrotal pain, heaviness, and cosmetic concerns. Percutaneous embolization is a minimally invasive treatment with high success rates. N-butyl cyanoacrylate (NBCA) glue is increasingly used due to improved safety. This meta-analysis evaluates the technical and clinical success of NBCA embolization in varicocele-related infertility.

Methods: A systematic review and proportional meta-analysis were conducted per PRISMA guidelines (PROSPERO: CRD420261332073). PubMed, Embase, and CENTRAL were searched to March 4, 2026. Retrospective and prospective studies reporting NBCA embolization outcomes were included. Screening, data extraction, and bias assessment were performed independently. Primary outcomes were technical and clinical success; secondary outcomes included recurrence and complications.

Proportions were pooled using a random-effects model with Freeman–Tukey transformation, and heterogeneity assessed using I².

Results: Twelve studies (5 prospective, 7 retrospective) composed of 535 patients were included for analysis. Technical success was 100% across 11 studies (I²=0%; pooled 1.00, 95% CI: 1.00–1.00). Recurrence (9 studies) was 2% (I²=69.6%; 95% CI: 0–5%). Fertility improvement (4 studies) was 0.79 (I²=89.3%; 95% CI: 0.54–0.96). Pain improvement (4 studies) was 0.99 (I²=60.2%; 95% CI: 0.90–1.00).

Conclusions: Overall, embolisation demonstrated high technical success, low recurrence rates, and favourable clinical outcomes in both fertility improvement and pain control.

POSTER 20

The customer's always right: A quality improvement project to improve urology medical student education

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Introduction: Clinical attachments in urology offer valuable exposure, yet students often report limited engagement on fast-paced ward rounds and inconsistent access to teaching. This quality improvement project (QIP) aimed to evaluate students' experiences on the urology rotation and implement NCHD-driven targeted interventions to enhance learning opportunities.

Methods: A pre-intervention survey was completed anonymously by medical students at the end of their urology week. Questions assessed overall enjoyment, achievement of learning goals, understanding of core urological topics, and satisfaction from outpatient clinics, ward round, theatre and cystoscopy as well as opportunities to present histories and receive feedback. Interventions were then introduced: (1) dedicated "slow rounds" to provide protected time for discussion and student involvement during ward rounds, (2) weekly urology-focused

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tutorials delivered by interns and senior team members and (3) bespoke educational videos on urological procedures. A post-intervention survey was subsequently distributed using a modified questionnaire.

Results: Post-intervention survey responses demonstrated improvements across all domains. Students reported greater enjoyment of the week, clearer achievement of learning goals, and increased confidence in urology concepts. Engagement in clinical activities rose, with more students presenting cases and receiving constructive feedback. Qualitative comments highlighted the value of slow rounds in supporting active learning and the benefits of consistent, structured tutorials in reinforcing key topics.

Conclusions: This QIP demonstrates that by establishing a baseline and introducing targeted educational interventions, meaningful enhanced teaching quality and student satisfaction on clinical rotations can be achieved while significantly improving the overall student learning experience.

ABSTRACTS

Saturday 19 September

URETHRA, INCONTINENCE, PAEDIATRICS, FERTILITY

TIME: 09.00 - 10.20

ORAL 21

High-throughput 3D testicular cell-laden microsphere fabrication for in vitro modeling using microfluidic droplet technology

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Introduction: Male infertility is a major global health challenge, with current therapies failing to capture the complexity of spermatogenesis and testicular architecture [1]. Developing physiologically relevant models is essential. This study proposes a microfluidic platform for high-throughput fabrication of testicular cell-laden microgels that better mimic the native microenvironment for research and therapeutic development [2].

Methods: Hydrogel Fabrication and Characterisation: Gelatin Methacryloyl hydrogels were prepared and photo-crosslinked using visible-light Ruthenium (II) tris(bipyridyl) chloride/Sodium Persulfate (Ru/SPS) initiator system and were assessed rheologically. Microsphere Fabrication Using a Microfluidic T-Junction: GelMA containing primary human testicular cells was emulsified in fluorinated oil (HFE-7500 with 2% Span 80) using a T-junction microfluidic system using optimized flow rates generating uniform GelMA droplets. Cell-Laden Microsphere Analysis: Cell viability was evaluated using Calcein AM/Ethidium Homodimer. Whole-mount immunofluorescent staining was performed to identify germ cells and somatic cell populations after 34 days.

Results: Rheological measurements demonstrate that increasing Ru/SPS concentration accelerated the gelation kinetics of 7% GelMA. Microfluidic emulsification produced highly uniform GelMA microspheres with consistent size. Encapsulated human testicular cells-maintained viability over 34 days of culture. Live/dead staining confirmed sustained cell viability. Whole-mount immunofluorescent staining verified the presence of germ and somatic cell populations through expression of DDX4 and ACTA2, respectively.

Conclusion: This study demonstrates a robust microfluidic approach for producing GelMA microspheres containing human testicular cells. The platform supports long-term cell survival and phenotype maintenance, establishing foundation for physiologically relevant testis models for investigating infertility mechanisms and advancing regenerative therapies for male reproductive health.

References:

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- [2] Vollset (et al.), The Lancet. Vol 396, Pages 1285-1306. 2020

ORAL 22

Surgical techniques in the management of primary urethral carcinoma: A spectrum of approaches for distal tumours

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Introduction: Primary urethral carcinoma (PUC) is a rare urological

malignancy, accounting for <1% of malignancies globally. Risk factors for the disease include urethral stricture disease, recurrent urinary tract infections, and sexually-transmitted diseases. In recent years, a number of penile-sparing surgical approaches have been described, with satisfactory outcomes. However, due to the rare nature of the disease, there exists only a small amount of literature and limited direction in international guidelines to aid the clinician in determining the appropriate treatment course.

Methods: In this presentation we describe four surgical approaches for managing primary urethral carcinoma in the anterior urethra. These include meatectomy, distal urethrectomy with creation of a neo-hypospadias, radical urethrectomy, and radical penectomy with urethrectomy.

Results: Penile-sparing techniques allow for preservation of urinary and sexual function and satisfactory cosmesis, while achieving disease control. Creation of a neo-hypospadias also facilitates the application of topical treatments if required.

Conclusion: PUC is a rare malignancy, and identifying the appropriate management pathway for patients can be challenging. Here, we demonstrate a variety of approaches in the management of distal urethral tumours.

ORAL 23

Enhancing Hypospadias Care in South Vietnam: Outcomes from an RCSI-Operation Childlife Mission

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URETHRA, INCONTINENCE, PAEDIATRICS, FERTILITY

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Introduction: Paediatric urological care in lower-middle-income countries (LMICs) faces significant challenges, including limited access to specialized surgical training. This presentation describes a 10-day medical mission to Vietnam in November 2025, organized by Operation Childlife in conjunction with the Royal College of Surgeons in Ireland (RCSI). The aim was to deliver essential urological interventions to underserved children and enhance local service capabilities.

Methods: A multidisciplinary team of RCSI-affiliated urologists, anaesthetists, and nurses conducted outreach at Children's Hospital 2 (Benh vien Nhi Dong 2), a tertiary centre in Ho Chi Minh City. A three-day didactic and live surgical workshop on advanced hypospadias repair was undertaken with regional paediatric urologists. Preoperative assessments, intraoperative techniques, and postoperative follow-up are described.

Results: Nine complex hypospadias repairs were completed successfully in children aged 1-8 years. These included three single-stage distal cases, three proximal cases, and three recurrent/multi-stage cases. No immediate postoperative complications occurred. Patient satisfaction was high, with 80% showing sustained improvements at follow-up. Participants reported that the programme advanced their knowledge and surgical capabilities in complex hypospadias care.

Conclusion: This mission demonstrated the feasibility of short-duration, high-impact urological outreach in bridging local expertise gaps in LMIC settings. Despite resource constraints, high-quality surgical care proved achievable. Future efforts should incorporate telemedicine for assessment and follow-up.

ORAL 24

Various treatment modalities exist for the management of stress urinary incontinence (SUI). We present a single centre review aimed to assess the clinical effectiveness of intra-urethral bulking and identifying patient factors for clinical success

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Introduction: Various treatment modalities exist for the management of stress urinary incontinence (SUI). We present a single centre review aimed to assess the clinical effectiveness of intra-urethral bulking and identifying patient factors for clinical success.

Methods: A retrospective review was conducted of a prospectively maintained database of patients undergoing intra-urethral bulking in our institute between 2022-2026.

Results: Amongst the 75 patients included, the median age of the patients were 52 (24-84) and average BMI was 26.7 (20-36.50). 85.3% had a positive standing or supine stress test. Urodynamic results varied, 62.7% (n=47) demonstrating SUI, 21.3% (n=16) mixed urinary incontinence (n=16), 5.3% (n=4) demonstrating detrusor overactivity alone and 10.7% (n=8) had no findings elicited. 8% (n=6) had a transient episode of urinary retention post operatively. At time of follow up, 42.7% (n=32) of patients reported clinical success, 37.3% (n=28) reported an improvement and 20% (n=15) reported failure. In subgroup analysis, there was a statistically significant difference between the levels of clinical success between those with a pre-operative BMI of under 25 in comparison to the higher BMI cohort (p=0.04). 37.3% went on to have a further intra-urethral bulking at a later date and 5.3% (n=4) proceeded to rectus fascial sling procedure.

Conclusion: This series highlights the clinical effectiveness of intra-urethral bulking as a minimally invasive technique for the management of SUI. Ongoing data collection and analysis aims to highlight subgroups of patients best selected for this procedure.

ORAL 25

Understanding artificial urinary sphincter-urethra interactions: A computational approach to improving continence and tissue safety

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Introduction: Artificial urinary sphincters (AUS), particularly the AMS 800, are the gold-standard treatment for severe stress urinary incontinence, especially in men^{1,2}. Despite strong clinical efficacy, complications such as urethral erosion and tissue atrophy remain significant and are thought to result from excessive mechanical loading on the urethra^{2,3}. Direct assessment of these stresses in vivo is not possible, limiting the ability to optimise device settings for individual patients.

Methods: We developed a computational (in silico) model to simulate AUS-urethra interactions under clinically relevant conditions. The model incorporates patient-specific anatomy and experimentally derived urethral tissue properties, enabling simulation of cuff inflation, urinary flow, and sudden pressure events such as coughing. Device parameters, including cuff size and pressure, were varied to assess their impact on urethral behaviour.

Results: The model reproduced urethral closure and reopening under physiological loading conditions. Increasing cuff pressure improved continence by maintaining urethral occlusion but also increased tissue stress. The simulations demonstrated how anatomical variability and device settings influence both continence performance and tissue loading, highlighting the balance required between efficacy and safety.

URETHRA, INCONTINENCE, PAEDIATRICS, FERTILITY

Conclusion: This computational framework provides a non-invasive tool to better understand AUS function and its interaction with urethral tissue. It has the potential to support clinicians in selecting optimal device settings and to guide the design of safer, more effective AUS systems, ultimately improving patient outcomes.

References:

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ORAL 26

In silico study of the interaction between the female urethra and an artificial urinary sphincter: Implications for continence and tissue safety

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Introduction: The implantation of an artificial urinary sphincter (AUS), particularly the AMS 800 device (Boston Scientific, Boston, USA), represents a well-established treatment for severe stress urinary incontinence in males [1]. Its use in females remains limited due to anatomical differences and risk of complications such as urethral erosion and atrophy [2]. The biomechanics of the female urethra and its response to the device are poorly understood [2]. This study aims to develop an in silico model of the female urethra–AUS interaction to investigate continence performance and tissue safety.

Methods: A finite element model of the female urethra and AMS 800 cuff was developed. Cuff inflation was simulated at different pressures to

reproduce urethral compression, while intraluminal pressure was applied simulating voiding and sudden pressure events such as coughing/sneezing. The relationship between cuff pressure, tissue mechanical response, and continence performance was analysed.

Results: Cuff inflation up to 80 cmH₂O enabled urethral lumen occlusion.

Tissue response was quantified in terms of stress and strain magnitude and distribution, identifying the highest mechanical loads at different pressures. Under voiding and sudden pressure events, the simulations assessed the cuff's ability to maintain urethral occlusion, providing a measure of device performance.

Conclusion: This approach provides a non-invasive preclinical tool to test different inflation pressures, cuff designs, and anatomical variations. Due to the potential to balance continence efficacy and tissue safety, it could guide the development of AUS devices specifically optimised for the female anatomy and, support surgeons in selecting cuff size and settings to ultimately improve surgical outcomes.

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ORAL 27

Mechanical characterisation of urethral tissues for artificial urinary sphincter applications

Carolina Martins^{1,2,3}, Conall Quinn^{1,2,3}, Maria Vittoria Mascolini^{1,2}, Jhaleh Amirian^{1,2,3}, Majid Akbarzadeh Khorshidi^{1,2,3,6}, Brian Watschke⁵, Thomas Sinnott⁴, Noel Smith⁴, Caitríona Lally^{1,2,3}
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Introduction: Urinary incontinence affects up to one-third of men over 65 and is commonly managed using artificial urinary sphincters (AUS) such as the AMS800 [1]. Despite clinical success, complications including urethral atrophy and erosion remain significant and are linked to device–tissue interactions. While urethral mechanical properties have been reported [2], quasi-static behaviour under device-relevant loading remains poorly understood. Here, we investigate urethral mechanics under physiologically relevant conditions, including testing with the AMS800 in place.

Methods: Tensile, compression, and inflation testing of human urethral tissue were performed, complemented by histology. Tensile specimens were prepared in longitudinal and circumferential orientations, while compression samples were biopsy punched. All tests were conducted under quasi-static conditions at a strain rate of 0.2%/s. For inflation, urethral segments were cannulated, secured and infused with PBS at 1 mL/min. Pressure, volume, diameter, and ultrasound data were collected to assess lumen expansion during inflation and under constriction using the AMS800.

Results: Inflation testing showed progressive stiffening with increasing inner diameter, demonstrating a nonlinear pressure–volume response. Tensile testing exhibited a bilinear stress–strain response with no significant differences between orientations. Compression testing revealed lower radial stiffness compared to circumferential and longitudinal tensile stiffness. Notably, urethral opening occurred with the AUS cuff at 80 cmH₂O once intraluminal pressure exceeded a critical threshold.

Conclusion: These findings provide a framework for evaluating urethral mechanics under device-relevant

URETHRA, INCONTINENCE, PAEDIATRICS, FERTILITY

conditions and inform computational and benchtop modelling of device–tissue interactions, allowing for controlled testing and optimisation of AUS design to reduce tissue damage, erosion, and atrophy.

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ORAL 28

Parent-reported psychological support needs in children with hypospadias

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Introduction: Hypospadias is a urogenital anomaly affecting 1 in 250 male births¹. This condition carries a notable psychological burden which can lead to challenges with body image, peer interactions, and psychosexual development². As surgical repair is typically performed in infancy, parents play a central role in the treatment journey and may also experience psychological stress³. The aim of this study was to evaluate parent-reported psychological support needs and identify gaps in care.

Methods: Parents of children aged 4-14 years who previously underwent hypospadias repair at Cork University Hospital were invited to complete a structured 30-item questionnaire. Open-text responses explored perceived impact on quality of life.

Results: In total, 102 parents responded to the survey (51.7%). Twenty-one reported persistent urinary symptoms (21/102, 21%) and 30 (30/102, 30%) reported concerns over penile appearance. Eleven parents had received negative comments

regarding their son's penile appearance and urinary function (11/102, 11%). One parent received psychological counselling, with a significant proportion of the remainder expressing a desire for counselling for themselves (47%, 48/102) or their child (40%, 41/102). Most respondents felt psychological support at the time of diagnosis (70%, 68/98) and surgery 58% (56/97) was inadequate. Many were concerned about the potential impact on their child's psychosocial development (60%, 56/94) and 63% (59/83) felt their child would benefit from additional support in navigating these issues.

Conclusion: Hypospadias is associated with significant unmet psychological support needs for both children and their parents. Structured psychological support should be integrated into multidisciplinary care pathways throughout the patient journey.

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ORAL 29

The interim 24-month outcomes from a randomized, sham-controlled study evaluating the ProVee prostatic urethral stent for LUTS secondary to BPH

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Introduction: ProVide is a prospective, randomised, double-blind, sham-controlled study evaluating the safety and effectiveness of the ProVee Urethral Expander System for lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH). 12-month outcomes have been published¹; here we report interim 24-month outcomes.

Methods: 221 subjects with symptomatic BPH were randomised 2:1 at 17 centres in North America and Ireland. Subjects and research personnel, excluding the operating surgeon, were blinded through 3 months. Outcomes included IPSS, Qmax, and post-void residual. Adverse events were prospectively collected and adjudicated by an independent blinded clinical events committee.

Results: All primary endpoints were met. In the ITT population, mean IPSS improvement at 3-months was greater with ProVee than sham (9.5 vs 5.6; p=0.001). Mean IPSS improvement at 12 months was 38.3% versus baseline (p=0.002). To date, 104 subjects have completed 24-month follow-up. At 24 months, the ProVee arm demonstrated 45% improvement in mean IPSS and 80% improvement in mean Qmax. There were no device- or procedure-related serious adverse events through 24 months, no de novo sustained retrograde ejaculation

URETHRA, INCONTINENCE, PAEDIATRICS, FERTILITY

or erectile dysfunction, and no subject required catheterisation at discharge.

Conclusion: ProVee achieved statistically superior symptom improvement versus sham at 3 months, with durable, clinically meaningful improvements in LUTS and Qmax through 24 months with a favourable safety and sexual function profile. The procedure can be performed under local anaesthesia without urinary catheterisation.

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ORAL 30

Sperm counting: The burden of male factor pathology following the introduction of Ireland's publicly funded fertility pathway

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Introduction: Publicly-funded assisted human reproduction was introduced in the Republic of Ireland in October 2023 via six fertility hubs. Couples with male-factor subfertility were referred to our tertiary andrology service on an ad-hoc basis, representing a major development in public male-factor evaluation. We aimed to characterise men referred under this pathway and assess service implications.

Methods: A retrospective review of men referred for fertility assessment to a single andrologist over a twelve-month period was performed. Referral data, clinical records, laboratory investigations and imaging were reviewed. Demographics, imaging findings, laboratory results and management plans were analysed.

Results: Seventy men were included (mean age 37 years). 65 patients (93%) underwent ultrasound, with testicular volume reported in 16 cases (24.6%). Varicoceles were radiologically diagnosed in 23 patients (35.4%). Genetic abnormalities included AZFc microdeletions (4 cases, 5.7%), cystic

fibrosis carrier (1 case, 1.4%), and karyotype variants (7 cases, 10%). Six patients (8.6%) required transurethral resection of ejaculatory ducts. Five (7.1%) had testicular lesions requiring surveillance or orchidectomy; two (2.8%) underwent oncological sperm extraction. The mean testosterone was 16.5nmol/L (range 4.5–52nmol/L); 41 patients (63%) had hypogonadism, and one patient was discovered to be taking exogenous testosterone. Rare diagnoses included Young syndrome (1, 1.4%) and Zinner syndrome (2, 2.9%).

Conclusion: Public fertility funding has resulted in identification of substantial genetic, obstructive and spermatotoxic pathologies within the public system. These findings highlight the need for formalised referral pathways, dedicated andrology resources and integrated fertility services to support comprehensive evaluation and management.

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TIME: 10.50 - 10.00

POSTER 21

Robotic reconstructive urology: Initial data from a high volume UK single centre

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Introduction: The applications for Robotic-assisted surgery (RAS) have expanded hugely since its introduction with RAS becoming standard of care for many procedures. In more recent years RAS has been further utilised in functional and reconstructive urology. Here we present data from the first 4 years of a robotic reconstructive service in the UK.

Methods: We analysed a prospectively maintained database of patients undergoing robotic assisted reconstructive urological procedures between December 2021 and October 2025. Surgeries were performed by a single surgeon with dual training in FRU and robotic pelvic oncology. Data recorded included type of procedure, indication for surgery, major complication rate and length of stay were recorded.

Results: Over this time period we performed 95 intracorporeal ileal conduits, 8 orthotopic neobladders, 20 partial cystectomies (for bladder diverticula or urachal remnants), 22 robotic-assisted ureteric reimplantations, 2 uretero-ureterostomies, 2 bladder neck reconstructions, and 11 colposuspensions. 3 robot-assisted ileocystoplasty and 4 continent catheterisable channels were formed. 17 patients had major complications (CD >3), 16 of which were associated with radical cystectomy and urinary diversion.

Conclusion: Our initial 4 years of data demonstrates the expanding role of robotic surgery in reconstructive urology. Robotic surgery is a valuable tool that allows improved precision, decreased morbidity and promising outcomes for this patient cohort. With increased training and bespoke fellowship and mentorship programs it is an area that will continue to expand with significant potential.

POSTER 22

Impact of ellipsoid versus bullet MRI-derived prostate volume calculation on PSA density and risk stratification

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Introduction: Prostate volume estimation is central to contemporary diagnostic pathways, particularly where PSA density (PSA-D) thresholds guide biopsy decisions. Ellipsoid and bullet formulas are commonly used to estimate prostate volume from MRI and are often considered interchangeable despite differing geometric assumptions. We aimed to compare these methods and evaluate their impact on PSA-D and risk stratification.

Methods: This retrospective single-centre study included 125 patients undergoing robot-assisted radical prostatectomy with complete MRI-derived prostate volume and PSA data. Prostate volume was calculated using ellipsoid and bullet formulas, and PSA-D derived for each method. Volumes were compared using paired t-tests, correlation with specimen weight assessed using Pearson correlation, and agreement evaluated using Bland–Altman analysis. Subgroup analysis was performed across predefined specimen weight categories. Upward PSA-D risk reclassification was defined as movement to a higher risk band using ellipsoid-derived PSA-D.

Results: Mean ellipsoid volume was 37.87 cc versus 47.33 cc for bullet volume, with a mean paired difference of 9.46 cc ($p < 0.001$). Both methods demonstrated strong correlation with specimen weight (ellipsoid $r = 0.733$; bullet $r = 0.721$). Bland–Altman analysis showed systematic disagreement, with increasing divergence at larger gland sizes. Mean PSA-D was higher using ellipsoid volume (0.2299 vs 0.1777 ng/mL/cc; $p < 0.001$). Overall, 40.8% of patients were reclassified upward, including 27.3% of PI-RADS 3 cases

Conclusion: Ellipsoid and bullet

MRI-derived prostate volumes are not interchangeable. Systematic differences affect PSA-D and result in substantial risk reclassification, which may influence biopsy decision-making.

POSTER 23

Survival trends in HPV-independent and HPV-associated Penile Squamous Cell Carcinoma at a large single site centre: A retrospective analysis of 800 patients

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²Department of Pathology, Christie NHS Foundation Trust, Manchester, UK

Introduction: Penile squamous cell carcinoma (PSCC) is a rare malignancy with variable clinical behaviour. Since 2016, the World Health Organization has classified PSCC into HPV-associated and HPV-independent subtypes, with p16 immunohistochemistry (IHC) used as a surrogate marker. Emerging evidence suggests improved outcomes in HPV-associated disease. We evaluated trends in p16 positivity and its impact on survival in a large single-centre cohort.

Methods: A total of 925 pathological specimens from 800 patients with penile cancer were identified. Cases were reviewed for p16 IHC status. Clinicopathological data, including age, tumour grade, stage, and survival outcomes, were collected. Retrospective IHC staining was performed in 115 cases; 37 external cases lacked p16 data. Survival was analysed using Kaplan–Meier and Cox regression models, adjusting for age, grade, and stage.

Results: From 2013 to 2023, p16 positivity accounted for 40–50% of cases annually. Among 762 patients with complete data, 264 deaths occurred. Median overall survival was significantly higher in p16-positive patients (91 vs 76 months). On univariate analysis, p16 positivity was associated with reduced mortality risk (HR 0.65; 95% CI 0.51–0.83; $p = 0.00062$). This remained significant on multivariate

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analysis. Increasing age, higher grade, and advanced T stage predicted worse survival.

Conclusion: p16 positivity is an independent predictor of improved survival in PSCC. These findings support its role in prognostication and suggest a need for future risk-stratified management approaches.

POSTER 24

Optimal installation and irrigation strategies to limit recurrence following transurethral resection of bladder tumour: A systematic review and network meta-analysis

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²Department of Surgery, Royal College of Surgeons in Ireland, Dublin, Ireland

Introduction: Single instillation of chemotherapy after transurethral resection of bladder tumour (TURBT) has been shown to reduce recurrence rates in low-risk non-muscle-invasive bladder (NMIBC). Continuous saline bladder irrigation (CSBI) is suggested to be of benefit in reducing recurrences where patients are not suitable to receive a single instillation of chemotherapy. We reviewed and analysed data available in the literature to compare no irrigation/instillation, CSBI and single instillation of chemotherapy after TURBT.

Methods: This systematic review was conducted in accordance with PRISMA-NMA guidelines. Multi-arm studies comparing CSBI to control or alternative intervention were included.

Results: There were 9 studies included with a combined 1,723 patients who received no irrigation, CSBI or a single instillation of chemotherapy (SIC). CSBI had significantly lower recurrence rates compared to no irrigation (25% vs 41%, RR=0.62, 95% CI 0.48-0.78, P<0.0001). While the risk ratio suggested a benefit in recurrence rates associated with SIC, there was no statistically significant difference when compared to CSBI at 1- (P=0.59), 2- (P=0.63), 3- (P=0.31), 4- (P=0.36), and 5-year (P=0.84) follow-up

timepoints. Progression free survival was comparable at 1- (P=0.68) and 5-years (P=0.69) but was significantly higher in those who had SIC compared with those who had CSBI (96% vs 87%, RR 0.90, 95% CI 0.84-0.97, P=0.007).

Conclusion: SIC is likely associated with superior recurrence and progression free survival when compared to CSBI post-TURBT. In cases not suitable for SIC, current literature suggests CSBI helps to limit recurrence of NMIBC following TURBT when compared to no irrigation.

POSTER 25

Can MRI invisible prostate cancer be clinically significant? A multi-centre review post robotic prostatectomy

James Connor¹, Olwyn Lynch², Stefano Parodi², Jasim Siddiqui², Gregory Nason^{1,3}, Kieran O'Malley^{1,3}, Peter Lonergan², Louise McLoughlin²

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Introduction: Magnetic Resonance Imaging (MRI) is used in the evaluation of clinically suspected prostate cancer. Negative MRI studies (PI-RADS ≤2) are considered reassuring and progression to biopsy is based on elevated PSA density. Evaluation of an MRI lesion is with target biopsy alongside a systematic biopsy. Systematic biopsies alone are taken to evaluate a high PSA density when no MRI target exists. MRI invisible disease is prostate cancer identified outside the target lesion. This study aims to evaluate whether MRI invisible disease is clinically significant.

Methods: A multicentre retrospective cohort of 272 consecutive patients undergoing robotic-assisted laparoscopic prostatectomy was analysed. Radiological and pathological results were collected. In patients with negative preoperative MRI (PI-RADS ≤2), biopsy and final histopathology was reviewed. Grade group ≥2 disease was considered clinically significant. Concordance between MRI and biopsy for tumour laterality was also assessed.

Results: Ten percent (n=29) of patients had a negative MRI. Of these, final histopathology demonstrated pT2 disease in 82.8% and pT3 disease in 17.2% with between 5-60% involvement of the gland. Clinically significant cancer was identified in 86% on final histology. Unilateral disease was identified in 38% and 62% had bilateral disease. The remainder of patients had an MRI target lesion (PI-RADS >2). MRI underestimated bilateral disease in 46% of cases initially deemed unilateral. MRI failed to detect extraprostatic disease in 20.45% of these cases.

Conclusions: MRI invisible disease can be clinically significant and therefore we cannot safely obviate biopsy or treatment in the case of negative MRI findings.

POSTER 26

Association between lymph node metastasis characteristics and biochemical recurrence following radical prostatectomy: A retrospective 5-year follow up cohort study

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Introduction: Following radical prostatectomy, biochemical recurrence (BCR) occurs in 20-40% of patients and represents the earliest indicator of disease recurrence. The number of positive lymph nodes and size of metastatic deposits are established prognostic factors, yet these have never been validated in an Irish population. This study compared time-to-BCR in patients with a single positive lymph node versus multiple positive lymph nodes, and to evaluate the prognostic significance of the 2mm metastatic deposit size threshold.

Methods: A retrospective cohort study was conducted at Cork University

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Hospital including patients who underwent radical prostatectomy with pelvic lymph node dissection between 2014–2020. Thirty-five node-positive patients were stratified by number of positive lymph nodes (1 node vs ≥ 2 nodes) and metastatic deposit size (≤ 2 mm vs >2 mm vs ≥ 2 nodes). Time-to-BCR was analysed using Kaplan–Meier survival analysis, and Cox proportional hazards regression. BCR was defined as two consecutive PSA measurements ≥ 0.05 ng/mL.

Results: Median follow-up was 21 months. Eight did not have BCR and were censored. No statistically significant difference in BCR-free survival was observed between single and multiple positive node groups ($p=0.98$) or across three-group stratification by deposit size ($p=0.63$). Cox regression confirmed non-significant associations on both univariable ($HR=1.01$, $p=0.98$) and multivariable analysis ($HR=1.06$, $p=0.89$; accounting for ISUP grade group and margin positivity).

Conclusion: Neither lymph node count nor a 2mm metastatic deposit size threshold is significantly associated with earlier BCR in this node-positive prostate cancer cohort. Multicentre collaboration is warranted to enable adequate validation of these prognostic parameters in an Irish population.

POSTER 27

Fixing the front door of prostate Cancer diagnosis: A closed-loop audit delivering rapid, scalable gains in mpMRI quality

Irfan Afridi¹, Gavin Calpin¹, David Canny¹, Orla Cullivan¹, Catherine Dowling¹, Garrett Durkan¹, Ellie Fahy¹, Edward Lawrence², Patrick O'Malley¹, Tauqir Aslam Waraich¹

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Introduction: Multiparametric MRI (mpMRI) guides prostate biopsy decision-making, yet its effectiveness is frequently undermined by incomplete referrals and inconsistent reporting. We evaluated the quality of mpMRI requests and reports in our centre and assessed the impact of targeted, low-

cost interventions to deliver meaningful improvements in mpMRI reporting quality.

Methods: A retrospective closed-loop audit was conducted at a high-volume tertiary referral centre. Cycle 1 (2019–2020) established baseline performance; Cycle 2 (2024–2025) assessed outcomes following focused interventions, including clinician feedback, education, and standardisation of reporting expectations. Requests were analysed for prostate-specific antigen (PSA) and digital rectal examination (DRE) documentation. Reports were assessed for PI-RADS score, prostate volume, and PSA density (PSAD).

Results: A total of 1,059 mpMRI scans were included. Following intervention, substantial and clinically meaningful improvements were observed. PI-RADS reporting increased from 41% to 82.2%, prostate volume documentation from 32.5% to 85.7%, and PSAD reporting from 19.2% to 45.5%. DRE documentation improved from 65% to 78.7%, with consistently high PSA documentation across both cycles.

Conclusions: This study demonstrates that simple, reproducible interventions can rapidly improve mpMRI quality at scale. By strengthening the diagnostic “front door,” these changes enhance risk stratification, support multidisciplinary decision-making, and align practice with international standards. Small changes in process can deliver large gains in cancer care quality.

POSTER 28

Transrectal vs transperineal prostate biopsy under local anaesthetic: A systematic review and meta-analysis

Gavin Calpin^{1,2}, Cian Hehir², Mariyah Alzayer², Benjamin MacCurtain³, Fintan Ryan^{1,2}, Mohammud Shakeel Inder^{1,2}, Diarmaid Moran^{1,2}, David Galvin^{1,2}, Kieran Breen^{1,2}

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Introduction: Several high-quality studies have been published in recent times which compare transrectal ultrasonography (TRUS)

and transperineal biopsy under local anaesthetic (LATP) in terms of feasibility, tolerability, patient-reported outcomes, complications and cancer detection rates. We sought to collate the high-quality data available in the literature to determine the advantages and disadvantages of both techniques.

Methods: A systematic review of prospective and randomised control trials meeting eligibility criteria was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.

Results: A total of 12 studies with 8497 patients were included. LATP biopsy was performed in 3961 patients and TRUS biopsy in 4536. Patient characteristics were comparable in both groups. Infection (risk ratio [RR] 0.68, 95% confidence interval [CI] 0.56–0.84, $P<0.001$) and sepsis rates were significantly lower in the LATP group (RR 0.16, 95% CI 0.08–0.33, $P<0.001$) and urinary retention rates were comparable (RR 0.87, 95% CI 0.61–1.25, $P=0.46$). Overall cancer detection rates were significantly higher in LATP biopsy (RR 1.07, 95% CI 1.03–1.10, $P<0.001$) as were Gleason Grade Group 2–5 or clinically significant cancer detection rates (RR 1.12, 95% CI 1.06–1.18, $P<0.001$). Gleason Grade Group 1 detection rates were similar (RR 0.92, 95% CI 0.82–1.04, $P=0.20$). Pain scores were comparable in the two groups ($P=0.26$).

Conclusion: LATP biopsy is well tolerated and is associated with lower rates of infection and sepsis compared to TRUS biopsy. LATP biopsy also detects a higher overall incidence of prostate cancer and clinically significant prostate cancer (Gleason Grade Group 2–5).

POSTER 29

MRI pelvimetry as a predictor of functional and oncological outcomes following robotic-assisted radical prostatectomy

Gavin Calpin¹, Eamonn O'Reilly^{2,3}, Cathal Flood¹, Muireann Hickey¹, Gordon Treacy¹, Izehi Lauryn Akeme¹, Simi Adesokan¹, Helena Geleff³, Tauqir Waraich¹, David Canny¹, Patrick O'Malley¹, Garrett Durkan¹, Edward Lawrence^{2,3}, Catherine Dowling^{1,3}

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Introduction: Magnetic resonance imaging (MRI) has been proposed as a tool for predicting technical difficulty in pelvic surgery. This study evaluated functional and oncological outcomes following robotic-assisted radical prostatectomy (RARP) at our centre and assessed whether pre-operative MRI pelvimetry is associated with adverse outcomes.

Methods: We conducted a retrospective study of all patients undergoing RARP at a high-volume tertiary referral centre between January 2020 and October 2025. Demographic, histopathological, and functional outcome data were collected, including urinary continence and erectile function at serial follow-up up to 3 years. Pre-operative MRI scans were reviewed to measure pelvic outlet diameter, interspinous distance, intertuberos distance, sacral length, and pubic symphysis extension. Associations between pelvimetric parameters and outcomes were analysed using multivariate logistic regression.

Results: A total of 804 patients underwent RARP, of whom 82 had complete data available for interim analysis. Median age was 64 years (range 39–75). Pelvimetric parameters were not associated with intra-operative complications or length of hospital stay. Increased pubic symphysis extension was associated with a higher rate of positive surgical margins ($P=0.04$). Shorter intertuberos distance was associated with increased pad use at 6 months ($P=0.03$), but not at 2 years. No association was observed between pelvimetry and erectile function at 3 years.

Conclusion: Interim findings suggest that pre-operative MRI pelvimetry may help predict selected functional and oncological outcomes following RARP. These measures may serve as a useful adjunct in pre-operative patient counselling for organ-confined prostate cancer.

POSTER 30

The perfect 10: Using an electronic checklist to standardise TURBT documentation

Cathal Flood¹, Gavin Calpin¹, Gordon Treacy¹, Orla Kneafsey¹, Tauqir Waraich¹, Osman Mohammedzain¹, David Canny¹, Irfan Afridi¹, Cristian Albu¹, Paddy O'Malley¹, Eamon Rogers¹, Garrett Durkan¹, Syed Jaffry¹, Kilian Walsh¹, Frank D'Arcy¹, Niall Kelly¹, Catherine Dowling¹

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Introduction: Bladder cancer (BC) is the most common urothelial malignancy, and risk of recurrence or progression depends on several clinicopathological variables. Many are first identified at Transurethral Resection of Bladder Tumour (TURBT), making operative documentation essential for risk stratification. Despite this, TURBT notes are often incomplete. This project aimed to implement an Electronic Operation Note (EON) incorporating a 10 item TURBT checklist to improve documentation in a regional BC centre.

Methods: A retrospective review of 50 TURBT notes assessed baseline compliance with a peer reviewed 10 item checklist. An EON with mandatory fields for each item was then designed and integrated into the electronic patient record. All TURBT procedures documented using the EON over the first 3 months were reviewed ($n = 25$). Primary outcome was number of checklist items documented per case; secondary outcome was proportion with complete (10/10) documentation. Mann–Whitney U and chi square tests were used.

Results: Pre EON, the mean number of items documented was 5.82/10 (median 6/10). Post EON, this increased to 9.92/10 (median 10/10). The distribution of scores was significantly higher post EON (Mann–Whitney U = 2, $Z \approx -7.0$, $p < 0.001$). Complete documentation improved from 0% (0/50) to 92% (23/25) ($\chi^2 \approx 66.4$, $df = 1$, $p < 0.001$). Additional benefits included availability in the electronic record, clearer communication, and a searchable dataset.

Conclusions: An EON with mandatory TURBT checklist items is a simple, effective intervention that markedly improves operative documentation and supports accurate BC risk stratification.

POSTER 31

Systematic review of Bacillus Calmette-Guérin therapy in the management of upper tract urothelial carcinoma in-situ

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Introduction: Upper urinary tract carcinoma in-situ (UUT-CIS) is an aggressive disease traditionally managed with radical nephroureterectomy (RNU), often resulting in loss of renal function. Topical Bacillus Calmette-Guérin (BCG) therapy has been explored as a kidney-sparing alternative, although evidence remains limited. This review synthesised oncological and safety outcomes of topical BCG therapy for UUT-CIS.

Methods: A systematic search of PubMed, Embase, Cochrane Central, Web of Science, and grey literature was conducted per PRISMA. Eligible studies (01/01/2000–14/09/25) included adults with UUT-CIS treated with topical BCG reporting oncological or toxicity outcomes. Primary outcomes were rates of complete response, recurrence and progression. If methodological homogeneity permitted, meta-analysis was planned. Risk of bias was assessed using ROBINS-I V2.

Results: Fourteen observational studies comprising 298 renal units (267 patients) were included. Complete response rates following BCG induction ranged 59–100% per renal unit. Recurrence rates after initial response ranged 0–70% and progression rates ranged 0–43%. The proportion of renal units requiring salvage RNU ranged 0–25%. Renal unit preservation ranged 45–100%. Median follow-up ranged 13–88 months. Adverse events were predominantly local; severe systemic toxicity was uncommon, and treatment-related mortality was reported in one patient.

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Substantial heterogeneity existed in follow-up duration, delivery technique, surveillance protocols, and outcome definitions, negating meta-analysis.

Conclusions: Topical BCG therapy for UUT-CIS is associated with high initial response rates and renal preservation, and may represent a kidney-sparing option in carefully selected or imperative clinical scenarios. However, recurrence and progression rates remain variable. Topical BCG therapy should not be considered equivalent to RNU, which remains the oncological standard of care.

References:

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POSTER 32

Documentation of EAU risk stratification and BCG treatment adequacy in high-grade non-muscle-invasive bladder cancer: A single-centre audit

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Introduction: Accurate risk stratification using the EAU NMIBC risk calculator is essential for guiding adjuvant therapy in high-grade non-muscle-invasive bladder cancer (HG-NMIBC). We audited EAU risk calculator documentation and BCG treatment adequacy according to European Organisation for Research and Treatment of Cancer (EORTC) and Southwest

Oncology Group (SWOG) criteria.

Methods: Retrospective audit of 100 consecutive HG-NMIBC patients at a single centre. Primary outcome was EAU risk calculator documentation. Secondary outcomes included BCG adequacy, complete SWOG protocol completion, recurrence and progression to muscle-invasive bladder cancer (MIBC). Adequate induction was defined as >5 instillations within 70 days; adequate maintenance as >7 instillations within 274 days.

Results: Of 100 patients (median age 71 years; 65% male), risk stratification was: Intermediate 22%, High 61%, Very High 17%. EAU risk calculator documentation was present in 22% (22/100), with rates lowest in Very High risk (13%) compared to High (21%) and Intermediate (40%) groups. Among 70 patients receiving BCG, adequate induction was achieved in 49% (34/70), adequate maintenance in 60% (42/70), and complete SWOG protocol in 4% (3/70). Recurrence occurred in 30% (30/100) and progression to MIBC in 2% (2/100).

Conclusions: This audit demonstrates favourable oncological outcomes with low progression rates despite variability in documentation and treatment delivery. Clear opportunities exist for quality improvement, particularly in formalising EAU risk calculator documentation. Standardised proformas and enhanced BCG scheduling pathways may further optimise outcomes. A prospective re-audit is underway to evaluate these quality improvement measures.

POSTER 33

Incidental findings on prostate MRI contribute to disproportionate clinical and economic burden

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Introduction: The Rapid Access Prostate Clinic (RAPC) enables timely assessment of patients with suspected prostate cancer. However, the

widespread use of multi-parametric MRI (mpMRI) has resulted in frequent detection of incidental extra-prostatic findings, prompting additional investigation and follow-up. This study aimed to determine the prevalence, spectrum, and clinical burden of incidental findings in RAPC.

Methods: A single-centre retrospective cohort study was conducted at University Hospital Galway, including all patients referred to RAPC in 2023. Among 686 patients who underwent mpMRI, 218 (31.7%), with a mean age of 50.2 years, were analysed. Incidental findings were recorded. Clinical burden was assessed by downstream imaging, specialist referral, intervention, and follow-up duration. Cost estimates were derived from representative Irish healthcare data.

Results: Incidental findings were identified in 53 patients (25.2%). The most common findings included diverticular disease, inguinal hernias, renal cysts, musculoskeletal abnormalities, benign scrotal pathology, and hepatobiliary cysts. Clinically significant findings occurred in 2 cases (3.8%), including renal cell carcinoma and a common iliac artery aneurysm, both requiring intervention. Incidental findings prompted additional imaging, endoscopy, referral, and prolonged surveillance, often without clinically significant prostate disease. Notably, 17 patients (32.1%) remained under prolonged RAPC follow-up for non-prostatic conditions, representing a significant and avoidable burden on clinic capacity. Estimated downstream costs exceeded €120,000.

Conclusion: Incidental findings on mpMRI are common and impose a disproportionate clinical and economic burden relative to their diagnostic yield, with significant implications for RAPC capacity, resource utilisation, and timely patient access.

POSTER 34

Is “Low-Risk” really low risk? Recurrence and upgrading in pTa low-grade NMIBC

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MODERATED POSTERS

Introduction: Low-risk non-muscle invasive bladder cancer (NMIBC), defined as pTa low-grade (pTaLG), is associated with high recurrence but low progression risk (1, 2). European Association of Urology (EAU) guidelines recommend risk-adapted surveillance with discharge after 5 years in recurrence-free patients(3). This study evaluated recurrence, histological upgrading, and adherence to surveillance guidelines in a contemporary cohort.

Methods: A retrospective audit was conducted of all patients undergoing cystoscopic surveillance between January and March 2026 in our institution. Patients with initial pTaLG histology were included. Data collected included demographics, smoking status, recurrence, histological upgrading, time to upgrading, and adherence to EAU surveillance intervals.

Results: Forty-seven patients were included (mean age 74 years; 75% male). Recurrence occurred in 27/47 patients (57.4%), of whom 10/27 (37.0%) demonstrated histological upgrading to higher-risk disease (pTa high-grade n=7, pT1 high-grade n=2, carcinoma in situ n=1). Median time to upgrading was 45.3 months (range 3.4-171.0). Upgrading rates were similar between smokers and non-smokers (22.7% vs 21.7%). Adherence to EAU surveillance intervals was observed in 44/47 patients (93.6%).

Conclusion: Recurrence is common in pTaLG NMIBC. Over one-third of recurrences in this cohort demonstrated progression to higher-risk disease, occurring across a wide timeframe including late events. These findings challenge assumptions regarding uniformly low-risk behaviour in pTaLG disease and support continued risk-adapted surveillance. High adherence to guideline-recommended surveillance intervals was observed.

References:

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Necessary? *European Urology Focus*. 2024;10(1):189-96

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POSTER 35

From risk to prognosis: Elevated BMI is common but not predictive of outcomes in penile Cancer

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Introduction: Obesity is increasingly recognised as a risk factor for penile squamous cell carcinoma (PSCC), likely through chronic inflammation, metabolic dysfunction, and reduced genital hygiene. However, whether elevated body mass index (BMI) influences pathological features or survival after diagnosis remains unclear. We evaluated the association between BMI, comorbidity burden, and oncological outcomes in a national PSCC cohort.

Methods: We performed a retrospective analysis of a prospectively maintained database of patients treated at the National Penile Cancer Centre between 2021 and 2025. Clinicopathological variables, BMI, and Charlson Comorbidity Index (CCI) were recorded. Patients were stratified by BMI category. Associations between BMI and pathological features, nodal metastases, and survival were assessed using Chi-squared and Kruskal–Wallis tests. Multivariable logistic and Cox regression analyses evaluated predictors of overall survival.

Results: A total of 109 patients were included, with a median age of 67 years (IQR 58–74). Median BMI was 28.4

kg/m² (IQR 25.3–32), and 79% were overweight or obese. BMI was not significantly associated with tumour T-stage (p=0.284), grade (p=0.703), lymphovascular invasion (p=0.428), perineural invasion (p=0.452), or nodal metastases (p=0.204). Obese patients were more likely to have p16-negative disease (p=0.042). On multivariable analysis, CCI independently predicted worse overall survival (HR 1.35, 95% CI 1.03–1.77, p=0.029), whereas BMI was not associated with mortality (HR 1.06, 95% CI 0.92–1.23, p=0.398).

Conclusion: Elevated BMI is common in PSCC but does not appear to influence pathological features or survival after diagnosis. In contrast, comorbidity burden independently predicts mortality. optimisation of comorbid conditions may be more clinically relevant than BMI alone

References:

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- [2] European Association of Urology. EAU Guidelines on Penile Cancer. Arnhem: EAU; current online edition

POSTER 36

Antithrombotic therapy and stage of bladder Cancer at presentation: A systematic review and meta-analysis

Eisten Keogh^{1,2}, Ahmed Salama^{1,2}, Gavin Calpin^{2,3}, Dunamis Akinyemi¹, Eibhleann Connaughton¹, Fintan Ryan^{1,2}, Ishapreet Kaur^{1,2}, Aoibheann McDermott², Shane Considine², Claudiu Cozman², Lee Yap², John Keane², Padraig Daly^{1,2}

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Introduction: Antithrombotic therapy is commonly prescribed and is associated with haematuria. It has been hypothesised that antithrombotic-associated haematuria may lead to earlier detection of bladder cancer, resulting in more favourable pathological features at diagnosis.

MODERATED POSTERS

Methods: To systematically review and meta-analyse the association between antithrombotic therapy use and bladder cancer stage and grade at diagnosis. A systematic review was conducted in accordance with PRISMA guidelines. PubMed, Scopus, Embase, and MEDLINE were searched from inception to January 2026 for studies comparing bladder cancer characteristics at diagnosis in patients receiving antithrombotic therapy and those not receiving therapy.

Results: Four retrospective cohort studies including 1,406 patients were identified, of whom 528 (37.6%) were receiving antithrombotic therapy. Antithrombotic therapy use was associated with lower odds of muscle-invasive bladder cancer ($\geq T2$) at diagnosis (pooled OR 0.37, 95% CI 0.09–1.48; $I^2 = 31\%$), although this did not reach statistical significance ($P=0.16$). Including a study in which antithrombotic exposure was defined at cancer diagnosis resulted in a weaker observed association (pooled OR 0.51, 95% CI 0.28–1.14). Tumour grade outcomes were heterogeneous, and meta-analysis of adjusted estimates showed no significant association with high-grade disease (pooled OR 1.12, 95% CI 0.26–4.85; $I^2 = 91\%$).

Conclusion: Antithrombotic therapy may be associated with a consistent trend toward lower stage bladder cancer at diagnosis, particularly when antithrombotic use is assessed at the time of haematuria presentation. Findings relating to tumour grade were inconclusive, supporting the hypothesis that haematuria in patients on antithrombotic medication may facilitate earlier detection rather than alter tumour biology.

POSTER 37

Upper tract urothelial cancer: Are we overdoing diagnostic ureterorenoscopy in suspicious upper tract lesions?

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Introduction: Upper tract urothelial carcinoma (UTUC) is a rare but aggressive malignancy involving the renal pelvis and ureter. While Computerized tomography (CT) is sensitive, it may miss small or flat lesions and cannot reliably stage disease. Ureterorenoscopy (URS) remains the diagnostic gold standard but is invasive, carries procedural risks, and may delay definitive treatment (1). We aim to evaluate the diagnostic yield of URS in patients with suspicious upper tract lesions and identify factors that may optimise patient selection.

Methods: A retrospective cohort study of 400 patients discussed at a multidisciplinary team meeting between 2013 and 2022 in a District General Hospital was conducted. All patients had radiologically suspicious upper tract lesions. Data on demographics, clinical presentation, imaging, urine cytology, URS findings, and histopathology were analysed.

Results: Of the 400 patients, 209 (52.2%) underwent URS. Malignancy was confirmed in 61 patients (29.1%). Significant predictors of malignancy included older age (≥ 60 years), smoking status, visible haematuria, highly suspicious CT findings. The multivariable model was statistically significant (Likelihood Ratio $\chi^2 = [159]$, $p < 0.001$). Multivariable logistic regression using Firth's penalized likelihood method was performed. This demonstrated individual associations for smoking history, visible haematuria, and highly suspicious CT findings.

Conclusion: More than two third of URS didn't reveal UTUC. Incorporating clinical and radiological risk factors into a stratified approach may improve patient selection for URS, reduce unnecessary invasive procedures, and optimise management pathways.

References:

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POSTER 38

Implementation of a local anaesthetic transperineal prostate biopsy service in HSE West: Early experience from regional Irish centres

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Introduction: Transrectal ultrasound-guided (TRUS) prostate biopsy has historically been the standard diagnostic method for suspected prostate cancer but carries a recognised risk of infectious complications due to rectal approach. Contemporary evidence and European Association of Urology (EAU) guidelines favour the transperineal approach, due to better diagnostic accuracy, better post-op infection rates without antibiotic cover, and comparable overall rates of complications. Multiple studies including the TRANSLATE, PREVENT, and ProBE-PC trials have demonstrated these results.

Methods: A LATP biopsy pathway was established at Galway University Hospital and Roscommon University Hospital, enabling Transperineal prostate biopsies to be performed in an outpatient setting under local anaesthesia. Patients referred with suspected prostate cancer underwent clinical assessment including PSA testing, digital rectal examination, and multiparametric MRI where indicated. Transperineal biopsies were performed under local anaesthesia using a systematic sampling approach. Data regarding patient demographics, peri-procedural outcomes, and complications were prospectively collected and analysed.

Results: Between service initiation and the current review period, approximately 200 patients underwent LATP prostate biopsy across both centres. The procedure demonstrated a favourable safety profile. Post-biopsy urinary retention occurred in three patients, all managed conservatively. One patient developed a post-op infection, with no cases of sepsis observed. Analysis of cancer detection rates, biopsy characteristics, and additional descriptive statistics will be presented.

MODERATED POSTERS

Conclusions:

Local Anaesthetic Transperineal prostate biopsy service is safe and consistent with contemporary international evidence supporting transperineal biopsy as the preferred diagnostic approach. Early outcomes support wider adoption of LATP biopsy pathways within regional urological services in Ireland.

References:

- [1] Bryant R, Marian I, Williams R et al. Local anaesthetic transperineal biopsy versus transrectal prostate biopsy in prostate cancer detection (TRANSLATE): a multicentre, randomised, controlled trial *The Lancet Oncology*, 2025; 26, 583-595
- [2] Hu, J. C., Assel, M., Allaf, M. E., Ehdaie, B., Vickers, A. J., Cohen, A. J., Ristau, B. T., Green, D. A., Han, M., Rezaee, M. E., Pavlovich, C. P., Montgomery, J. S., Kowalczyk, K. J., Ross, A. E., Kundu, S. D., Patel, H. D., Wang, G. J., Graham, J. N., Shoag, J. E., Ghazi, A., ... Schaeffer, E. M. (2024). Transperineal Versus Transrectal Magnetic Resonance Imaging-targeted and Systematic Prostate Biopsy to Prevent Infectious Complications: The PREVENT Randomized Trial. *European urology*, 86(1), 61–68. <https://doi.org/10.1016/j.eururo.2023.12.015>
- [3] Mian, B. M., Feustel, P. J., Aziz, A., Kaufman, R. P., Jr, Bernstein, A., Avulova, S., & Fisher, H. A. G. (2024). Complications Following Transrectal and Transperineal Prostate Biopsy: Results of the ProBE-PC Randomized Clinical Trial. *The Journal of urology*, 211(2), 205–213. <https://doi.org/10.1097/JU.00000000000003788>

POSTER 39

Baseline patient-reported outcomes from the second IPCOR cohort: Benchmarking quality-of-life of prostate Cancer patients at diagnosis

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Introduction:

Patient-reported outcome measures (PROMs) are vital for understanding symptom burden and quality-of-life. Baseline assessment of prostate cancer (PCa) patients provides context for treatment decisions and changes in urinary, bowel and sexual domains. In the second phase of Irish Prostate Cancer Outcomes Research (IPCOR), PROM collection at biopsy referral helps characterise outcomes among men investigated for suspected PCa in Ireland.

Methods: Descriptive analyses outline demographic and clinical characteristics. Baseline PROM scores from EPIC-26 are summarised and compared by tumour positivity at biopsy, symptomatic presentation, and treatment paths (active surveillance, surgery, radiotherapy), where applicable. Kruskal–Wallis tests examined differences.

Results: Baseline PROMs were available for 269 participants undergoing prostate biopsy, of whom 68% were positive. 123 (46%) men were aged 60–69 years, 231 (90%) identified as Irish. Baseline function was highest in bowel (median 100, IQR 90–100) and urinary incontinence domains (median 100, IQR 85–100), while sexual function was lower (median 73, IQR 33–85). Tumour-positive men reported higher urinary irritative (93.8 vs 87.5, $p=0.01$) and overall urinary scores (93.8 vs 88.5, $p=0.04$), with no differences in bowel, sexual, or hormonal domains. Among tumour-positive men, scores were similar across treatment pathways, with all p -values >0.05 and negligible effect sizes, indicating comparable functional status at diagnosis.

Conclusion: This study establishes an early benchmark for patient-reported outcomes among men investigated for PCa in Ireland. Preliminary findings will guide supportive care programmes and identify patient groups at risk of poorer quality-of-life at diagnosis. Updated results will be presented at the September conference.

VIDEO SESSION - PELVIC ONCOLOGY, COMPLEX CANCER AND SERVICE DEVELOPMENT

TIME: 12.00 - 13.20

VIDEO 11

Implementation of robotic pelvic lymphadenectomy in penile cancer: Early experience from a national referral centre

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Introduction:

Pelvic lymphadenectomy is indicated in selected patients with penile cancer and advanced nodal disease, but is technically demanding and traditionally performed through an open approach with significant morbidity. Challenges include distorted anatomy, proximity to major vessels, template-based dissection, and operating in previously treated fields. Robotic surgery may help overcome these obstacles through improved visualisation and precision. This video demonstrates our technique and early experience from a national centre, where high case volume and a multi-surgeon specialist team make this complex procedure feasible.

Methods: We present three patients with FDG-avid pelvic nodal metastases on PET-CT who underwent robotic pelvic lymphadenectomy via a transperitoneal, template-based approach. The video demonstrates patient positioning, port placement, pelvic dissection, vascular control, and en bloc specimen retrieval. Perioperative outcomes, complications, and histopathological findings were reviewed retrospectively.

Results: Three patients underwent robotic pelvic lymphadenectomy, including one bilateral and two unilateral dissections. Two had pT3N3 disease, including one with an enlarging FDG-avid left pelvic node on PET-CT, and one had recurrent nodal disease following pT1b penile cancer. All procedures were completed robotically without conversion or intraoperative complication. Recovery

was uncomplicated, and all patients proceeded to planned adjuvant therapy without delay. Histopathology confirmed metastatic pelvic nodal involvement in all cases, with extracapsular extension in one.

Conclusion: Robotic pelvic lymphadenectomy is a feasible, safe, and technically advantageous option for selected patients with metastatic penile cancer. This complex procedure may be best undertaken in specialised high-volume centres. Further evaluation in larger cohorts with long-term oncological follow-up is warranted.

References:

- [1] Matin SF, et al. Robotic-assisted pelvic lymph node dissection in urologic oncology: feasibility and oncologic outcomes. *J Endourol.* 2013;27(4):466-72
- [2] Davis NF, et al. The role of robotic surgery in penile cancer management: a contemporary review. *World J Urol.* 2022;40(5):1255-64

VIDEO 12

Redefining groin dissection: Robotic-assisted inguinal lymphadenectomy for penile Cancer

Ken Patterson¹, Pangiotis Christopolous¹, Vijay Sangar¹, Maurice Lau¹, Arie Parnham¹

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Introduction: Inguinal lymphadenectomy is critical in the management of penile cancer with nodal involvement but carries significant morbidity. Robotic-assisted inguinal lymphadenectomy (RAIL) offers a minimally invasive alternative with potential to reduce complications while maintaining oncological outcomes. We present a video demonstration of RAIL in a patient with node-positive penile cancer.

Methods: This video demonstrates the case of a 58-year-old male presenting with a glans penile lesion. Fine needle aspiration of bilateral inguinal nodes confirmed metastatic squamous cell carcinoma. The patient underwent

glandectomy with bilateral RAIL. Indocyanine green (ICG) fluorescence was utilised to aid intraoperative identification of inguinal lymph nodes. Operative steps of robotic inguinal lymphadenectomy are demonstrated in detail.

Results: Total operative time was 310 minutes, with a mean console time of 126 minutes per groin. Estimated blood loss was minimal. The patient mobilised on postoperative day 0 and was discharged on day 1 with bilateral groin drains, which were removed on day 8. Final histology demonstrated pT1b G3 R0 squamous cell carcinoma with N3 disease, including extracapsular extension in 1/7 nodes on the right and 1/9 nodes on the left. No major complications (Clavien-Dindo >II) occurred. There was no clinical evidence of lymphoedema at 4 weeks, 3 months, or 6 months. At 6-month follow-up, there was no local or radiological recurrence.

Conclusion: RAIL is a safe and feasible approach for management of node-positive penile cancer, with favourable perioperative and early oncological outcomes. This video highlights key technical steps and supports wider adoption of this technique in specialised centres.

VIDEO 13

Minimally invasive approach to bladder neck reconstruction for recurrent bladder neck contracture post robotic-assisted radical prostatectomy

Brian Gilmartin¹, Killian Daly¹, Karl Ringrose¹, James Connor¹, Gregory Nason^{1,2}, Kieran O'Malley^{1,2}

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Introduction: Bladder neck contracture (BNC) post robotic-assisted radical prostatectomy (RARP) has a reported incidence of 1.1% [1]. Optimal anastomotic closure involves creating a watertight, tension-free anastomosis with well-vascularized, mucosal

VIDEO SESSION - PELVIC ONCOLOGY, COMPLEX CANCER AND SERVICE DEVELOPMENT

apposition and correct realignment of the urethra. The cause of bladder neck contracture is poorly understood [2]. This condition can be devastating for patients and has a significant impact on quality of life.

Methods: We present two cases of patients who underwent robotic-assisted bladder neck reconstruction for refractory BNC. One case of obliterative BNC and another case non-obliterative BNC. Both patients had multiple interventions in the years prior to bladder neck reconstruction.

Results: The da Vinci Xi robotic platform was used. The obliterative BNC case was almost 3 years post RARP with a suprapubic catheter in-situ. The bladder was mobilised down to the anastomosis. Flexible cystoscopy was utilised. The obliterated vesico-urethral anastomosis was excised and the bladder was anastomosed to healthy urethra. He had a flexible cystoscopy prior to catheter removal. The non-obliterative BNC case was almost 4 years post RARP. He had a urethral catheter in-situ. The bladder was mobilised to expose the anterior surface of the vesico-urethral anastomosis. A flexible cystoscope was used to demarcate the stenosis. A Y-V-plasty reconstruction was performed. A CT cystogram was done prior to catheter removal.

Conclusion: Robotic-assisted bladder neck reconstruction is a feasible option for refractory BNC following RARP. We present our early experience. A wide variety of techniques can be utilised to treat this condition and surgeons need to be adaptable.

References:

- [1] Msezane LP, W. Stuart Reynolds, Gofrit ON, Shalhav AL, Zagaja GP, Zorn KC. Bladder Neck Contracture after Robot-Assisted Laparoscopic Radical Prostatectomy: Evaluation of Incidence, Risk Factors, and Impact on Urinary Function. *Journal of Endourology*. 2008 Feb 1;22(2):377–84
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VIDEO 14

Robotic cystectomy & neobladder formation using DaVinci Xi

Jan Mares¹, Nikita Bhatt¹, Kieran Breen¹, Diarmaid Moran¹

¹St Vincent's University Hospital, Dublin, Ireland

Introduction: Robot-assisted radical cystectomy (RARC) with intracorporeal urinary diversion presents minimally invasive option to traditional open surgery. Robotic assisted operations are favoured options by surgeons and patients for shorter hospital stay, faster recovery and better cosmetic outcomes. Earlier recovery of urinary function (1) and superior body image is achieved with intracorporeal robotic techniques (2,3).

Methods: A 44-year-old male muscle invasive bladder cancer underwent Robotic Assisted nerve sparing Radical Cystectomy and Studer Neobladder formation in a tertiary university hospital with a high volume robotic reconstructive service. A segment of ileum approximately 50–60 cm in length was isolated 20 cm from ileocecal anastomosis, detubularized and reconstructed into a modified Studer pouch including spherical reservoir and a chimney. Wallace technique was used for the ureteroileal anastomosis.

Results: The console time reached 7 hours, no perioperative complications were recorded. Enhanced Recovery Programme was employed, the patient was discharged on day 7. Ureteric stents were removed on day 14 and urinary catheter was successfully removed on day 21 post fluoroscopic cystogram which demonstrated no leak. Patient was taught self-intermittent catheterisation and pelvic floor exercises preoperatively to help with continence postoperatively.

Conclusion: Robotic Assisted Radical Cystectomy with Studer neobladder reconstruction is a safe and feasible option for carefully selected patients. Performing intracorporeal surgery, supported by appropriately trained postoperative staff can yield favourable early outcomes, including minimal complications and early recovery.

References:

- [1] Khan A, Vuppapapati JK, Sarath

LR, Mujeeburahiman M, D'Souza N. Functional outcome of robotic-assisted intracorporeal versus extracorporeal neobladder following radical cystectomy: Initial experience. *Urol Ann*. Jan-Mar 2021;13(1):9-13. doi:10.4103/ua.Ua_132_19

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[3] Shim B, Kim KH, Yoon H, Park YY, Lee DH. Body image following radical cystectomy and ileal neobladder or conduit in Korean patients. *Korean J Urol*. Mar 2014;55(3):161-6. doi:10.4111/kju.2014.55.3.161

VIDEO 15

Organ-preservation strategies during robotic cystectomy: A video vignette

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Introduction: Long term sexual side effects arising post radical cystectomy such as erectile dysfunction, vaginal shortening & surgical menopause may be considerable. In the appropriately selected patient, erectile function can be optimized via preservation of the neurovascular bundles or prostate capsule. Similarly, evidence supports the oncological safety of preserving female reproductive organs where possible and should also be considered in the older or frailer patient owing to less blood loss and quicker bowel recovery. We highlight factors influencing case selection and technical aspects via a video case series.

Methods: Review of a prospectively maintained database on robotic cystectomy with intracorporeal urinary diversion was performed between October 2025 to April 2026 was performed. Preoperative histological and radiological parameters as well as perioperative surgical metrics were assessed. A video demonstrating technical aspects of the procedure is shown.

VIDEO SESSION - PELVIC ONCOLOGY, COMPLEX CANCER AND SERVICE DEVELOPMENT

Results: Eleven cystectomies performed for bladder cancer (n=8, 73%), rectourethral fistula (n=1, 9%), interstitial cystitis (n=1) and incontinence (n=1) were included. Six patients (55%) had a sexual organ preservation strategy utilised; four vaginal sparing, one complete gynaecological organ sparing and one nerve-sparing procedures. Median blood loss across the group was 250mls, console time 4hrs 36mins, 3.5 days to bowel motion and length of stay 6 days. Two (18%) CD grade 3 complications were seen. The negative oncological margin rate was 100% (n=4).

Conclusion: In the appropriately selected patient, sexual organ preservation is feasible and oncologically safe and should be utilised where possible to improve post-cystectomy sexual function. Our video details technical tips and approaches.

VIDEO 16

Robot-assisted cytoreductive nephrectomy after immune checkpoint inhibitors for metastatic clear cell renal cell carcinoma: An educational surgical video

Karl Ringrose¹, James Connor¹, Nika Khajehdehi¹, Killian Daly¹, Brian Gilmartin¹, Aisling Moriarty¹, Jack McDermott¹, Stephen Connolly¹

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Introduction: Immune checkpoint inhibitors (ICI) are the standard first-line systemic therapy for metastatic clear cell renal cell carcinoma (ccRCC). In select responders, interval nephrectomy may be considered, however, treatment-related desmoplastic and inflammatory changes can distort tissue planes and increase operative complexity.¹

Methods: We present an educational video demonstrating a stepwise approach to left-sided robot-assisted laparoscopic cytoreductive nephrectomy, adrenalectomy and para-aortic lymphadenectomy following prolonged ICI therapy, highlighting technical strategies to facilitate safe dissection in the setting of post-immunotherapy fibrosis.

Results: A 68-year-old man with IMDC intermediate-risk metastatic ccRCC presented with a 12-cm left renal mass, renal vein thrombus, 8cm para-aortic lymphadenopathy, and bilateral adrenal metastases. After 18 months of ipilimumab plus nivolumab, he achieved a marked radiological response, with reduction in tumour size from 12 to 5 cm, nodal disease from 8 to 3 cm, and complete radiological resolution of adrenal metastases. Robot-assisted cytoreductive surgery was subsequently performed. Dense fibrosis with distortion of normal tissue planes, particularly at the renal hilum, was encountered. Careful landmark-guided dissection with optimisation of exposure enabled safe vascular control and resection. Final histopathology demonstrated complete pathological response (ypT0, N0). There was extensive fibrosis and necrosis seen and all 13 lymph nodes were reactive.

Conclusions: ICIs can induce profound tumour regression but also can create altered, fibrotic tissue planes. Recognition of these changes and adaptation of surgical strategy are critical for safe cytoreductive nephrectomy. References:

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VIDEO 17

Modern surgical techniques in testis cancer: Open extraperitoneal and robotic approaches to retroperitoneal lymph node dissection

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Introduction: Retroperitoneal lymph node dissection (RPLND) is indicated in a subset of testis cancer patients, and remains one of the most technically challenging urologic operations. RPLND traditionally mandated an incision from xiphisternum to pubic symphysis, and extensive bowel mobilisation to access

the para-aortic, interaortocaval, and para-caval nodal packets. High ileus rates and pain scores are an obstacle in the recovery of these otherwise typically fit young men. In an effort to address this, minimally invasive and open extraperitoneal approaches have been described. Size of nodal mass and relationship to major vessels influences choice of approach.

Methods: We present 2 recent retroperitoneal lymph node dissections. The first case demonstrates the minimally invasive approach for RPLND. The second case demonstrates open extraperitoneal RPLND for larger nodal masses.

Results: Both patients were discharged on post-operative day 5 after an uncomplicated recovery.

Conclusion: These cases demonstrate our adoption of two modern approaches to RPLND surgery, aiming to minimise operative morbidity for these testis cancer patients.

VIDEO 18

Robotic nephron-sparing surgery for multifocal bilateral papillary RCC: Triple tumour excision in a single kidney

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Introduction: Papillary renal cell carcinoma (pRCC) accounts for 10–15% of renal malignancies and is associated with multifocal and bilateral disease. Nephron preservation is critical to avoid long-term renal replacement therapy. We present a case of robotic partial nephrectomy involving sequential excision of three tumours in a single kidney in the context of bilateral multifocal pRCC.

Methods: A 56-year-old male had an incidental finding of bilateral multifocal renal masses. Imaging demonstrated three clinically significant tumours within the right kidney, including a dominant 5 cm upper pole lesion, with multiple lesions in the contralateral kidney. A staged approach was adopted with right robotic partial nephrectomy performed to maximise nephron preservation in anticipation of future left radical nephrectomy.

VIDEO SESSION - PELVIC ONCOLOGY, COMPLEX CANCER AND SERVICE DEVELOPMENT

Results: Robotic-assisted partial nephrectomy was performed using the Da Vinci™ Xi multi-port platform with sequential enucleo-resection of three tumours. Selective clamping and staged reperfusion were utilised. Renorrhaphy was limited to an inner layer closure, without outer cortical suturing. Haemostasis was achieved using a haemostatic patch (Veriset™) and tissue sealant (PuraBond®). In total 10.5cm of tumour was excised. Histopathology confirmed multifocal pRCC (grade 2–3). Renogram at six weeks demonstrated preserved right renal function (31%). Creatinine rose from 96 pre-operatively to 111 eight weeks post-operatively.

Conclusion: This case demonstrates the feasibility of complex robotic partial nephrectomy in multifocal pRCC. In the setting of bilateral disease, an aggressive nephron-sparing approach can preserve renal function while enabling staged management. Careful operative planning allowed multiple tumours to be addressed within a single kidney, reducing the risk of future dialysis.

VIDEO 19

Endoscopic transvesical-assisted robotic excision of iatrogenic endometriotic utero-vesical fistula presenting with visible haematuria: A multidisciplinary video case

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Introduction: Utero-Vesical Fistula (UVF) is an abnormal communication between the bladder and the anterior wall of the uterus, usually following caesarean section (CS). UVF commonly presents with a urine leak but may present with cyclical hematuria. This video demonstrates the key urological steps of endoscopic transvesical-assisted Robotic excision of UVF, followed by robotic hysterectomy in a multidisciplinary setting.

Method: A 44-year-old woman

presented with intermittent visible haematuria and pelvic pain 6 months after her fourth CS and severely impacting her QOL. Flexible cystoscopy during the menstrual period demonstrated an oedematous abnormality in the posterior bladder wall with active pulsatile bleeding from the centre of the lesion. Following discussion at our multi-disciplinary meeting, a decision was made to excise the bladder abnormality with the adjacent fistulous tract, followed by hysterectomy.

Result: The affected area with a 1 cm rim of bladder tissue was incised deep into the peri-vesical fat around the endometriotic fistulous tract using a bipolar transurethral resectoscope. Then, the fistulous tract with surrounding densely scarred tissue was excised using a robotic transperitoneal approach. The bladder defect is closed in two layers, and intraoperative leak testing is demonstrated. Our gynaecology colleague performed a robotic hysterectomy. Total operative time was 120 min, and blood loss was 100 ml.

Conclusion: UVF is a rare entity, mostly iatrogenic after CS. Diagnosis is based on history and cystoscopy during the episode of cyclical haematuria. Endoscopic transvaginal-assisted robotic excision of the tract and affected tissue, along with hysterectomy, offers an excellent opportunity for cure.

VIDEO 20

Establishing robotic urogynaecology services in a tertiary referral centre – Initial outcomes and lessons learned

Sorcha O'Meara¹, Robert A. Keenan¹, Aimee Brennan¹, Diarmaid Moran¹, Kieran Breen¹, Barry McGuire¹, Eabhann O'Connor¹, Nikita Bhatt¹

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Introduction: Robot assisted surgery (RAS) is considered a standard approach for cystectomy and prostatectomy with improved short term outcomes, reduced blood loss (BL) and length of stay (LOS). Additional uses of RAS include in urogynaecology and reconstructive urology, although uptake has been limited by lack of access to robotic

consoles, a need for subspecialty training and limited evidence to demonstrate benefit. We present a video series demonstrating initial series of urogynaecology cases in a tertiary referral centre.

Methods: A prospectively maintained robotic surgery database in a Robotic Reconstructive surgical unit was reviewed to identify urogynaecology cases. Data including indication for surgery, patient demographics, intra-operative and peri-operative outcomes and short term functional outcomes were recorded.

Results: Our initial series successfully demonstrates complex urogynaecology cases performed via transabdominal robotic approaches using the Da Vinci System, highlighting the feasibility and versatility of robotic platforms in this subspecialty. The diverse case mix included vesicovaginal fistula repair (N=3), paraurethral leiomyoma excision (N=1), sacrocolpopexy, and vaginal mesh excision (N=2). Median length of stay was 2 days (range 2-3). All cases were performed collaboratively by two surgeons with subspecialty training in robotic surgery, one required a combined vaginal and transabdominal robotic approach to harvest a Martius fat pad, underscoring the adaptability of hybrid techniques. At a median follow-up of 8 weeks all patients were catheter-free with no complications reported.

Conclusions: Our initial series showcases the expanded utility and feasibility of robotic platforms in urogynaecology when performed by subspecialty-trained surgeons, as evidenced by successful outcomes across complex cases.

VIDEO 21

Step by step bipolar enucleation of a huge prostate (≥80 G): A single case video demonstration

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Introduction: Bipolar enucleation of the prostate (BipolEP) is an effective minimally invasive technique for large

VIDEO SESSION - PELVIC ONCOLOGY, COMPLEX CANCER AND SERVICE DEVELOPMENT

benign prostatic enlargement, but many surgeons still lack a clear, visual reference for the enucleation sequence. We present a full length video of a step by step BipolEP for a huge gland to standardize teaching and adoption.

Methods: We performed transurethral bipolar enucleation on a 68 year old man with a 110 g prostate (TRUS), IPSS 28, Qmax 7 mL/s, and recurrent retention. The procedure was carried out under spinal anesthesia using a bipolar resectoscope and mechanical morcellator. Our step by step approach was cystoscopy and mucosal incision at the bladder neck and verumontanum; early apical release and median lobe enucleation; sequential lateral lobe enucleation (5 and 7 o'clock) in the plane between adenoma and capsule; and meticulous haemostasis and morcellation of the enucleated tissue. The entire procedure was recorded endoscopically and annotated with on screen labels and voiceover commentary.

Results: Total operative time was 75 minutes; enucleation time was 50 minutes. The catheter was removed on postoperative day 2; the patient was discharged on day 3. At 3 months, IPSS improved to 8 and Qmax increased to 22 mL/s without significant complications. The video clearly demonstrates plane identification, early apical release, and sequential lobar enucleation, highlighting tips for avoiding capsular perforation and maintaining haemostasis.

Conclusion: This single case video of step by step bipolar enucleation for a huge prostate provides a reproducible teaching model for urologists adopting BipolEP. The technique shows excellent functional outcomes and can be safely performed with standard bipolar instrumentation.

BLADDER AND RENAL

TIME: 14.10 - 15.30

ORAL 31

The WASHOUT study: Early proactive intervention in emergency haematuria reduces length of stay, mortality and readmissions

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Introduction: No evidence-based guidelines for emergency haematuria management exist. Consequently, clinical practice is variable and dependent on multiple factors. The WASHOUT study investigated variations in emergency haematuria management and evaluated patient outcomes.

Methods: A prospective, international, multi-centre cohort study was conducted using the British Urology Researchers in Surgical Training (BURST) collaborative model. Primary outcome was length of stay (LoS). Secondary outcomes included overall mortality and readmission rate. Ninety days of follow-up was completed. Outcomes were analysed using statistical models adjusted for relevant covariates. Poisson regression models estimated adjusted relative risk of increased LoS and logistic regression estimated adjusted relative risk of mortality and readmission.

Results: Data from >8,500 patients across 382 centres over 12-months were included. Higher number of days between admission and definitive management was significantly associated with increasing LoS, readmission risk, and death (OR 1.02) ($p = 0.00$). Patients with >2 days between admission and management completion had average LoS increase of 5.6 days, 2.5% greater probability of death, 3.1% greater probability of readmission. Independent

factors for prolonged LoS and increased mortality included frailty, sepsis, upper tract obstruction. Mortality was higher among patients who did not undergo emergency department imaging, or had malignancy as haematuria cause.

Conclusion: WASHOUT is the first study to evaluate influencing factors in patients with emergency haematuria. We propose that patients with emergency haematuria should have emergent imaging on admission and intervention within 2 days of admission if failing conservative measures. Evidence-based guidelines to standardise practice and improve patient outcomes are urgently needed.

ORAL 32

Radical nephrectomy with inferior vena cava tumour thrombectomy for Mayo level III–IV thrombus: A 10-year retrospective single-centre study

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Introduction: Renal cell carcinoma (RCC) with tumour thrombus (TT) extending into inferior vena cava (IVC), particularly at Mayo levels III–IV, presents a complex surgical challenge. Radical nephrectomy with IVC thrombectomy remains the standard of care, although perioperative morbidity increases with thrombus extent. Cardiopulmonary bypass (CPB) is an established operative adjunct in select cases of high-level TT.

Methods: We conducted a retrospective analysis of 18 patients undergoing radical nephrectomy with IVC thrombectomy for Mayo level III–IV TT between 2016 and 2026. Demographics, tumour characteristics, operative variables and outcomes were recorded.

Results: Median age was 66 years (IQR 54–70), 83% (15/18) were male. Ten patients had level III and eight patients had level IV thrombus. CPB was utilised

in four of the level IV cases including two with hypothermic circulatory arrest. Median tumour size 9cm, operative time 384 min, blood loss 2200 mL, and length of stay was 11 days. Five patients (28%) had metastatic disease at diagnosis. Clear cell RCC was predominant histology (88%). Clavien–Dindo grade ≥ 3 complications occurred in four patients. There were no intraoperative deaths; one patient died on postoperative day 8 from myocardial infarction. Three patients developed RCC recurrence, median time to recurrence 17 months. One-year overall survival was 78% (14/18), with deaths predominantly occurring in patients presenting with metastatic disease.

Conclusions: Radical nephrectomy with high level IVC thrombectomy can be done safely and achieve meaningful oncological outcomes. CPB remains a valuable and safe adjunct in select cases; these findings are consistent with published literature.¹

References:

[1] Nguyen HG, Tilki D, Dall'Era MA, Durbin-Johnson B, Carballido JA, Chandrasekar T, et al. Cardiopulmonary bypass has no significant impact on survival in patients undergoing nephrectomy and level III–IV inferior vena cava thrombectomy: a multi-institutional analysis. *J Urol*. 2015;194(2):304–308. doi:10.1016/j.juro.2015.02.2948

ORAL 33

Intravesical Purastat® for haemorrhagic radiation cystitis: New hope for a urologist's worst nightmare

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Introduction: PuraStat, a self-assembling peptide hydrogel with haemostatic and mucosal healing properties, represents a novel intravesical approach for managing haemorrhagic radiation cystitis(HRC).

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Herein, we report our experience using this novel treatment for HRC.

Methods: All patients treated with intravesical purastat for HRC between February 2024 and March 2026 were included for analysis. Data collected included patient demographics, radiotherapy history, anticoagulation, transfusion history, haematuria. The primary outcome was the 1-, 3- and 12 month readmissions with haematuria. Secondary endpoints included self-reported haematuria severity, urinary incontinence rates, complications.

Results: Thirty-six patients received intravesical purastat for HRC over the study period. Median follow up was 7 (3-12) months. Thirty-three (91.6%) patients had received radiotherapy for Prostate cancer. Seventeen (47.2%) had received salvage radiotherapy. Thirteen (36.1%) were taking antiplatelet or anticoagulation medications. The median time from radiotherapy to treatment was 6 (3.25-9.5) years. Thirty-one (86.1%) patients had previous hospital admissions for haematuria. Thirteen (36.1%) patients had received a blood transfusion and 15 (41.6%) patients had undergone endoscopic procedures for haematuria. Twenty-eight (77%) cases were performed electively. Fourteen (38.8%) patients had an adjunct to purastat (e.g laser ablation). There was one Clavien-Dindo 2 and 5 CD 3 complications. The 1-, 3- and 12- month readmission rate was 2.8%, 12.5% and 25% respectively. Five (13.8%) had reapplication of purastat. At 6 weeks post treatment 15 (41.6%) had ongoing haematuria. At 6 months post-surgery 8/24 (33%) had experienced haematuria. Conclusion: Intravesical purastat represents an effective new approach for managing haematuria in this challenging cohort of patients.

References:

[1] Kam, J., Abu-Ghanem, Y., Del Guidice, F., Ibrahim, Y., Mensah, E., Nair, R., Khan, M.S. and Thuraija, R. (2026), Cystoscopic application of RADA16 peptide for refractory haematuria from radiation cystitis. *BJU Int*, 137: 466-472. <https://doi.org/10.1111/bju.70075>

ORAL 34

Ongoing experience of a robotic cystectomy program

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Introduction: There is level 1 evidence supporting robotic assisted radical cystectomy for the management of bladder cancer. This study aims to report the ongoing experience of RARC in one of the cystectomy centres.

Methods: The first RARC was performed in the Mater in February 2022. All cystectomies since have been performed robotically. We performed a review of a prospectively maintained database. Data were collected for patient demographics, perioperative data, length of stay and complications.

Results: To date, 88 RARC have been performed with a median age of 70.7 years (Range 50–84). The majority (n=84, 95%) have been performed for bladder cancer. The median BMI was 28 (Range 14-36). The median console operative time was 320mins (120-510mins). The median blood loss was 150mls (Range 50–1500 mls). The median length of stay was 7 days (Range 4–41). All but one patient (n = 67) underwent an intracorporeal reconstruction. Complications were recorded using Clavien Dindo classification, Three (3.4%) patients developed Clavien-Dindo 3b complications within 90 days. There were two (2.3%) mortalities within 90 days. Six (6.8%) patients developed ureteric strictures.

Conclusion: This case series demonstrates the ongoing experience of a RARC program. While RARC remains a complex procedure, growing experience has led to refinements in operative technique with the aim of improving patient outcomes. The results suggest it is a safe and effective treatment option.

ORAL 35

Impact of prior pelvic radiotherapy on perioperative safety and functional outcomes of robot-assisted cystectomy and intracorporeal ileal conduit diversion: A propensity-score matched analysis

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Introduction: This study aimed to evaluate peri-operative and long-term functional outcomes of robot-assisted cystectomy with intracorporeal ileal conduit diversion (RAC+ICIC) in patients previously exposed to pelvic radiotherapy exposed (RE) patients, compared to radiotherapy-naïve (RN) controls.

Methods: All RE patients undergoing RAC+ICIC between 2014 and 2024 were identified from a prospectively maintained database. RN controls were selected from the same cohort and matched 1:2 by propensity scores including age, sex, BMI, Charlson Comorbidity Index, and previous abdominal surgery. Operative metrics, early (<90 days) and late (≥90 days) complications were compared. Multivariable regression modeling was adopted to identify predictors of early and late postoperative complications. Results: From 770 cystectomies, 45 RE patients were matched to 90 RN controls. Baseline characteristics were similar. Median operative time was 360 vs 330 minutes (p=0.2603), with comparable intra-operative complication rates. Median length of stay (9 vs 8 days, p=0.4820) and 30-day readmission (17.8% vs 12.7%, p=0.3820) were not significantly different. Early complications occurred more frequently in RE (48.9% vs 25.6%; p=0.0067), no 90-day mortality occurred. Over median follow-up of 24.5 months (IQR 12.4–62.8), late complications were also higher in RE (31.1% vs 14.4%; p=0.0225), including uretero-ileal strictures (13.3% vs 2.2%; p=0.0167), fistulae (11.1% vs 0%; p=0.0035), and stoma-related morbidity (15.6% vs 4.4%; p=0.0417).

BLADDER AND RENAL

At multivariable analysis, RE was the only independent predictor of higher rate of early (OR: 4.23; 95%CI 1.82-9.79) or late (OR: 2.83; 95%CI 1.09-7.32) postoperative complications.

Conclusions: Robot-assisted cystectomy with intracorporeal urinary diversion following prior pelvic irradiation is a safe and feasible surgical approach.

ORAL 36

Early experience with single-port robotic surgery for upper tract reconstruction and renal surgery: A comparative study with multi-port approach

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Introduction: Single-port (SP) robotic surgery represents an evolution in minimally invasive urology, with potential advantages in postoperative recovery and pain. Early adoption data in upper tract surgery remain limited. We report our initial institutional experience and compare outcomes with a contemporary multi-port (MP) cohort.

Methods: A retrospective comparative study of the first seven consecutive SP robotic cases (partial nephrectomy and pyeloplasty) was performed. These were compared with the ten most recent MP cases by the same surgeon. Baseline demographics, operative variables, and postoperative outcomes were collected. Primary outcomes were length of stay and postoperative opioid requirement (morphine milligram equivalents [MME]). Secondary outcomes included operative time, estimated blood loss, and postoperative pain scores.

Results: A total of 17 patients were included (SP: n=7; MP: n=10). Baseline characteristics were comparable between groups. Median length of stay was significantly shorter in the SP group (2 vs 4 days, p=0.002). Postoperative opioid requirement was lower in the SP cohort (0 vs 47.5 MME, p=0.009). Pain scores on postoperative day one were significantly lower in the SP group (0 vs 7, p=0.010). There were no significant

differences in operative time (190 vs 202.5 minutes, p=0.696) or estimated blood loss (100 vs 87.5 mL, p=1.000). No complications were seen in either cohort. No cases required conversion to open surgery.

Conclusion: SP robotic surgery is safe and feasible, with comparable operative outcomes and significantly reduced length of stay, pain, and opioid use. These findings support its role in enhanced recovery, though larger studies are required.

ORAL 37

Robotic-assisted inguinal lymphadenectomy for penile Cancer: A case series of ten groins

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Introduction: Inguinal lymphadenectomy remains the gold standard for staging and management of penile cancer with nodal involvement, but is associated with significant morbidity. Robotic-assisted approaches aim to reduce complications while maintaining oncological efficacy. We present our initial experience with robotic-assisted inguinal lymphadenectomy (RAIL) in a case series of ten groins.

Methods: A retrospective review was performed of ten consecutive robotic assisted inguinal lymphadenectomy procedures for penile cancer at a single centre. Patient demographics, tumour characteristics, operative parameters, perioperative outcomes, and complications were analysed. Data was collected from a prospectively maintained database and evaluated descriptively.

Results: All procedures were completed robotically without conversion to open surgery. The case series includes 6 patients, Bilateral groin dissections were performed in 4 of the patients. Median console time was 126 minutes and estimated blood loss was minimal. The median lymph node yield per groin was 6.2, with 100% of patients demonstrating nodal

metastases. Postoperative complications were low, with no major (Clavien-Dindo ≥III) complications observed. Minor complications included lymphocele, penoscrotal lymphoedema, managed conservatively. Median length of stay was 1.33 days. Early oncological outcomes were favourable, with no local recurrences observed at a median follow-up of 5.5 months.

Conclusion: RAIL is a safe and feasible minimally invasive alternative to open inguinal lymphadenectomy, demonstrating reduced morbidity while maintaining adequate nodal yield. Our early experience supports its adoption in appropriately selected patients. Larger studies with longer follow-up are required to confirm long-term oncological outcomes.

ORAL 38

Robotic retroperitoneal partial nephrectomy (RPPN) in University Hospital Waterford: Outcomes from initial series

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Introduction: Robotic retroperitoneal partial nephrectomy (RPPN) is a useful approach for partial nephrectomy, particularly in well selected patients with posterior and lateral tumours. A recent meta-analysis has shown that this technique may result in shorter operating times, shorter length of stay (LOS), less blood loss and fewer post-operative complications. (1) We aim to demonstrate our outcomes from an initial series.

Methods: A retrospective review of all RPPNs was completed from Mar 2024 to March 2026. Data was captured from patients' medical/operative notes and the Surgeons Intuitive application. All tumour resections were completed using an enucleation or enucleo-resection technique.

Results: During the study period, 20 RPPNs were completed using the Intuitive Davinci Xi robot. Initial cases were performed with a proctor present. The median age was 58 years. Eleven were male, 9 were female. Twelve of these tumours were right sided and

BLADDER AND RENAL

8 were left sided. The median size of tumour was 4.2cm. 16.6% (n=3) of patients had a pre-operative renal biopsy confirming malignancy. 44% (n=8) had prior abdominal surgery. Median ASA was 2 and median BMI was 32.5. The median operative time was 227mins with a median console time of 150mins. The median warm ischaemic time was 27 minutes. The median bloods loss was 100mls. The median LOS was 2 days. The readmission rate was 11% (n=2).

Conclusion: This review demonstrates the successful introduction of RRPN at our institution. The retroperitoneal approach, while it does have an initial learning curve, can offer benefits over a transperitoneal approach in select cases.

References:

[1] Rong, RZ., Zhang, P., Zhao, M. et al. Transperitoneal vs retroperitoneal robotic partial nephrectomy: a meta-analysis and systematic review of propensity-matched studies. *J Robotic Surg* 19, 56 (2025). <https://doi.org/10.1007/s11701-025-02217-4>

ORAL 39

Implementation of a structured sexual rehabilitation pathway for patients undergoing a robot-assisted cystectomy: A quality improvement initiative

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Introduction: Sexual dysfunction following radical cystectomy is common yet remains under-recognised and undertreated in Ireland [1]. We aimed to evaluate baseline sexual function outcomes and implement a structured, time-based sexual rehabilitation pathway to improve care.

Methods: A retrospective audit of cystectomy patients over two years was performed. Sexual function was assessed using validated questionnaires (the International Index of Erectile Function (IIEF-5) or the Female Sexual Function Index (FSFI)). Data including postoperative counselling and phosphodiesterase-5 inhibitor (PDE5i) use were collected. A structured

pathway was introduced, incorporating preoperative counselling, early postoperative review, and early vaginal or penile rehabilitation. Interventions offered (topical oestrogen, vaginal dilatation, PDE5i, vacuum therapy) were delivered via a staged checklist at defined time-points. Re-audit followed implementation.

Results: Ten male cystectomy patients were identified from 2024 to 2025, with a median IIEF-5 score of 5 after a median of 10 months (range 5-17 months). No patient received post-operative sexual counselling or PDE5i therapy. Following pathway implementation, fifteen patients underwent cystectomy. 100% of patients received structured counselling, and all male patients were offered PDE5i therapy. Six of seven female patients (86%) underwent vaginal-sparing surgery, with one having complete female organ preservation. Two of eight male patients (25%) underwent nerve-sparing cystoprostatectomies.

Conclusion: Sexual dysfunction after cystectomy is common and can frequently be overlooked [1]. A simple, structured rehabilitation pathway led to immediate increased uptake of sexual health interventions. This model is low-cost, reproducible, and should be considered a standard component of cystectomy pathways, with an ongoing focus on improving functional outcome measurement.

References:

[1] Day E, Bizzarri FP, Waine E, Martin R, Nelson AW, Colquhoun AJ, et al. Contemporary practice patterns in female radical cystectomy: results of a UK and Ireland survey. *BJU Int*. 2026;137(3):e70159

ORAL 40

On-clamp versus off-clamp partial nephrectomy in patients with a solitary kidney: A systematic review and meta-analysis evaluating effect on postoperative renal function and perioperative complication rates

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Introduction: Nephron sparing surgery constitutes the cornerstone of managing patients with renal masses in a solitary kidney (SK). Prolonged warm ischaemia time is a known predictor of diminished postoperative renal function. Off-clamp partial nephrectomy (PN) is an established technique aimed at mitigating the potential for ischaemia mediated nephron loss. The SK patient population stands to benefit most from nephron sparing efforts. The role of off-clamp PN remains poorly delineated in this cohort.

Methods: A PRISMA compliant systematic review and meta-analysis was performed evaluating on-clamp versus off-clamp PN in patients with SK. Primary outcomes related to postoperative renal function and dialysis dependence. Secondary outcomes focused on perioperative complication rates.

Results: Seven observational cohort studies met inclusion criteria. The pooled warm-ischaemia time in the on-clamp comparator was 23.4 ± 11.4 min. There was no significant increased risk of requiring temporary postoperative dialysis (RR = 1.35, 95% CI 0.52-3.48, p=0.53) nor permanent dialysis dependence (RR = 1.02, 95% CI 0.61-1.72, p=0.94) with on-clamp PN. The off-clamp approach was associated with a significant increase in risk of blood transfusion requirement (RR= 1.85, 95% CI 1.45-2.36, p<0.001), with a mean increase in estimated blood loss of 145mL. The rate of urine leak was significantly higher with on-clamp PN (RR=2.84, 95% CI 1.48-5.45, p=0.002). Conclusion: There is no clear evidence to support the role of off-clamp PN in preserving renal function in the SK patient population. Off-clamp PN is associated with greater blood loss and blood transfusion requirement but may reduce the risk of postoperative urine leak.

