PAPERS PRESENTED FOR THE EAST ANGLIAN TRAINEES' PRIZE

Wednesday 9 December 2009
Homerton College, Cambridge

Presentations to commence at approximately 14.30hr
15 minutes per presentation (including questions)

PRESENTER	TITLE
1. Satoshi Hori	Changing antibiotic prophylaxis for transrectal ultrasound guided biopsies of the prostate: are we putting our patients at risk?
2. Barnaby Barrass	Intra-vesical Botulinum-A toxin for lower urinary tract symptoms – a prospective audit
3. Thomas Madden	Audit of antibiotic prophylaxis for transrectal ultrasound-guided prostate biopsies at Addenbrooke's Hospital
4. Naomi Sharma	Robotic-assisted radical prostatectomy: learning curves of two surgeons in a single centre
5. Mark Rochester	Renal function after nephron-sparing surgery: what is the outcome and can we predict it?
6. Christine Reus	Audit of the management of emergency nephrolithiasis and ureterolithiasis
7. Mark Cutress	Clinical evaluation of contrast-enhanced ultra-low dose CT In patients presenting with acute ureteric colic
8. William Finch	Audit of PDD and Hexvix Pilot – lessons learnt from a learning curve?
9. Claire Dawkins	ESWL in the management of ureteric stones: a 2-year audit of results with the Wolf Piezolith 3000
10. Sarah Wood	An audit of the timing of Mitomycin C
11. James Armitage	Maintenance BCG immunotherapy for high-risk non-muscle invasive bladder cancer: improving compliance using an individualised regimen
12. Srijit Bannerjee	Is investigating under-50s with microscopic haematuria justified? An audit of patients presenting to the haematuria clinic over a 1-year period
13. George Yardy	An audit of patient satisfaction with urological services delivered at an NHS unit and a non-NHS provider: implications for the Free Choice Network

Changing antibiotic prophylaxis for transrectal ultrasound guided biopsies of the prostate: are we putting our patients at risk?

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PRESENTER: **SATOSHI HORI**

Introduction: To evaluate whether changing antibiotic prophylaxis from quinolone to penicillin antibiotics has affected sepsis rates in those patients undergoing transrectal ultrasound guided biopsies of the prostate (TRUSP).

Patients and Methods This interventional study was designed to determine whether changing antibiotic prophylaxis had any bearing on urinary sepsis rates. As a secondary aim, we also investigated *Clostridium difficile* (*C.difficile*) rates in the same groups of men undergoing TRUSP biopsies. Patients historically received ciprofloxacin 500mg orally 1 hour prior to their procedure followed by a 3 day course of 500mg given twice daily (group A). Due to increasing local patterns of antimicrobial resistance to quinolones and concerns regarding potential antibiotic induced *C.difficile* infection, antibiotic prophylaxis was changed to a penicillin based regime comprising of Co-Amoxiclav 625mg given orally 1 hour prior to their procedure followed by a three times daily course for 3 days (group B). Excluded from the study were those patients given an alternative antibiotic prophylaxis than those given within the 2 distinct groups due to reasons of previous hypersensitivity reactions and / or clinical decision by the attending Urologist. Comparisons were made between these 2 groups using two tailed Fisher's exact tests with $p<0.05$ considered statistically significant.

Results: 119 and 110 patients were identified in groups A and B respectively. 2 patients in group A (2/119, 1.68%) developed post TRUSP sepsis requiring hospital admission and IV antibiotic treatment. The sepsis rate in group B was noted to be significantly higher than that of group A (8/110, 7.27%, $p=0.036$). *Escherichia coli* (*E.coli*) was the only organism isolated from our cohort of patients who developed sepsis. There were no incidences of *C.difficile* infections in either antibiotic prophylaxis groups.

Conclusions: Ciprofloxacin appears to provide superior prophylaxis than co-Amoxiclav in patients undergoing TRUSP and was not associated with an increased risk of quinolone induced *C.difficile* infections. Changing antibiotic prophylaxis from a quinolone based regime may therefore be putting our patients at an increased risk of serious urinary sepsis.

Notes:

Intra-vesical Botulinum-A toxin for lower urinary tract symptoms – a prospective audit

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PRESENTER: **BARNABY BARRASS**

Introduction: Intra-vesical Botulinum-A toxin (Botox) has been demonstrated to be a successful treatment for patients with storage lower-urinary tract symptoms (LUTs). However this treatment is still an off-licence use of Botox and the NICE guidelines advise it should be used as part of an audit. We present the interim results of a prospective audit of the use of intra-vesical Botox for LUTs.

Patients and Methods A protocol was developed and a consecutive series of patients presenting with storage LUTs refractory to medication were recruited and treated with intra-vesical Botox. Patients completed validated symptom and quality of life (QOL) questionnaires specific to storage LUTs before and following treatment. Standards were set for efficacy (symptoms & quality of life), morbidity and duration of benefit and our results compared to standards.

Results: During a 12-month period, 58 patients were recruited, 38 were treated and, to date, follow-up efficacy data are available about half. Following treatment, evaluable patients demonstrated improved symptoms (82% improved by a mean of 22%) and QOL (87% improved by a mean of 35%) which compared favourably with standards. Treatment was reasonably well tolerated with a mean pain score of 4.1/10 although 5% could not tolerate the procedure under LA and 37% had a planned GA or sedation. Patients experienced the following side effects: retention needing CISC (31%), dysuria (6%), voiding dysfunction (31%) and UTI (19%). Compared to standards there was an excess in infection and voiding symptoms but fewer episodes of haematuria and dysuria.

Conclusions: Although data accrual continues, the initial findings of this audit appear to confirm that intra-vesical Botox can be an effective treatment for storage LUTs refractory to medical therapies and our local results appear similar to those reported in the literature. The treatment is well tolerated by most with acceptable side-effects (although a significant proportion require sedation or general anaesthesia) and should be available in all urology units.

Notes:

Audit of antibiotic prophylaxis for transrectal ultrasound-guided prostate biopsies at Addenbrooke's Hospital

Madden T, Doble A

PRESENTER: **THOMAS MADDEN**

Introduction: This is a retrospective study to compare the rates of infective complications between two different antibiotic prophylactic regimes for trans-rectal ultrasound guided (TRUS) prostate biopsies.

Patients and Methods The audit was performed retrospectively. All patients undergoing TRUS biopsy during 2008 were identified from clinic records. A computer record search was undertaken to identify patients who developed complications after biopsy.

Results: Patients were divided into two groups: Group 1 comprised patients who received prophylaxis with Ciprofloxacin and Group 2 received Gentamicin with Augmentin. There is a statistically significant difference between the overall complication rates of the two groups.

Group	n	Admitted	Not Admitted	Total (%)
1 (Cipro)	271	1	5	6 (2%)
2 (Gent & Aug)	232	9	12	21 (9%)

Table: Rates of infective complications
$P < 0.001$ for the total infective complications using Chi Squared test

Conclusions: Even though TRUS prostate biopsies are a common urological procedure performed in every centre there are currently no national guidelines regarding antibiotic prophylaxis.

This is the first audit to compare the use of Augmentin with Gentamicin to Ciprofloxacin for trans-rectal ultrasound biopsy of the prostate. Patients given Ciprofloxacin experienced significantly fewer infective complications (2%) compared with the other group (9%). This audit supports the use of Ciprofloxacin as part of a prophylactic regime for this procedure.

Notes:

Robotic-assisted radical prostatectomy: learning curves of two surgeons in a single centre

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PRESENTER: **NAOMI SHARMA**

Introduction: Robotic-assisted radical prostatectomy (RALP) is increasingly used by many centres throughout the world. As with laparoscopic prostatectomy, its introduction is associated with a learning curve. In our centre, a structured mentoring programme has been used to implement RALP and we here report on the outcomes of two surgeons' learning curves, including oncological and functional outcomes, for a total of 500 cases.

Patients and Methods A structured mentoring programme was adopted for the training of two consecutive surgeons (one with previous open prostatectomy experience and one with previous laparoscopic experience), by two experienced robotic-trained surgeons and by an experienced laparoscopic radical prostatectomy surgeon. Patients eligible for a radical retropubic prostatectomy were offered RALP and absolute contraindications included patient preference for open surgery and previous complex major abdominal surgery. The 3-arm daVinci robot system was used for all cases and the technique is based on that described by the Vattkikuti Institute with some modifications, including the use of the Rocco stitch.

Using a prospective, ethically-approved database, we evaluated 500 cases of RALP using patient demographics, pre-operative PSA, pre- and post-operative Gleason score, clinical and pathological stage, operative time and procedure, positive margins, complications, hospital stay and urinary (ICS SF) and sexual function (IIEF).

Results: The majority of patients were in the intermediate D'Amico risk group. The mean age of the men was 61 years and the majority underwent bilateral nerve-sparing RALP. Operative time and blood loss were reduced with greater surgeon experience. 50% of patients had pT3-pT4 disease. The overall positive margin rate (PMR) was 20%, with PMRs showing a direct relationship with both stage and D'Amico risk group.

For both surgeons, over 94% of men are fully continent or wearing only 1 pad and 75% of men are potent sufficient for intercourse, at a minimum of 12 months follow-up

Conclusions: We have compared the learning curves of two surgeons performing RALP in a single centre. Overall results are comparable to those from experienced surgeon series and we attribute this to our structured mentoring approach. Both oncological and functional outcomes continued to improve up to 250 cases, suggesting the learning curve for RALP is higher than previously considered.

Notes:

Renal function after nephron-sparing surgery: what is the outcome and can we predict it?

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PRESENTER: MARK ROCHESTER

Introduction: Preservation of renal function is a primary goal of nephron-sparing surgery (NSS). When considering management options, it is important to assess renal function accurately, together with the risk of postoperative chronic kidney disease, to enable accurate preoperative counselling. The aim of this pilot study was to assess change in estimated glomerular filtration rate (eGFR) after NSS at this centre and to develop a model to predict change in eGFR based on preoperative renal and tumour volume.

Patients and Methods Individual surgeon's databases and coding records were used to identify patients who underwent partial nephrectomy between 2005 and 2008. GFR was estimated using the MDRD equation and was calculated both pre-operatively and 12 months post-operatively. Total renal volume and tumour volume were estimated from pre-operative CT scans using the prolate ellipse method ($\Pi/6$ x length x width x height). Correlation was assessed using the Pearson correlation coefficient and linear regression performed to illustrate the relationship between loss of renal volume and fall in eGFR.

Results: 48 partial nephrectomies were performed in this period. Full data were available for 31 patients. The mean ± SD age was 5± 22 years. 27/31 cases (87%) were renal cell carcinomas. The mean ± SD estimated preoperative total renal volume was 400 ± 210cc and mean tumour volume was 12.7 ± 11.9cc. The mean ± SD pre-operative and 12 month post-operative eGFR were 67.2 ± 16.7 ml/min and 50.8 ± 14.6ml/min respectively. The mean ± SD percentage change in eGFR was 12.8 ± 23.4%.

The relationship between percentage loss of renal volume after partial nephrectomy and fall in eGFR was plotted on a scatter graph and linear regression performed. The relationship was significant ($p=0.0002$) with a slope of 2.6 (95% confidence interval 1.4-3.9). The Pearson correlation coefficient was 0.45, a significant correlation ($p=0.04$).

Conclusions: The fall in renal function after nephron-sparing surgery in our institution compares favourably with published data. It is possible to predict the fall in eGFR after NSS with reasonable accuracy which should allow better pre-operative patient counselling for patients with T1 renal tumours.

Notes:

Audit of the management of emergency nephrolithiasis and ureterolithiasis

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PRESENTER: **CHRISTINE REUS**

Introduction: Nephrolithiasis and ureterolithiasis are responsible for a significant proportion of urological emergency admissions. Optimal management is not always possible due to lack of available operative and nursing expertise in the emergency setting. We set out to audit the management of these patients in our hospital.

Patients and Methods In this prospective audit, the case notes of all patients admitted between May and August 2009 with renal or ureteric colic were reviewed. We determined whether patients were managed operatively or conservatively together with the delays and success rates associated with both. We also determined whether emergency ESWL would have been suitable for patients with upper ureteric stones.

Results: Of 87 patients identified, 63% were treated conservatively. 100% were prescribed alpha blockers. 63% benefited from a successful conservative management. 5% failed conservative management. The remainder were lost to follow up.

32% were treated operatively, of whom 68% had primary ureteroscopy (URS) and laser stone fragmentation, 28% had a ureteric stent insertion and 4% had a PCNL arranged on discharge. Only 1% of patients had ESWL, although ESWL would have been suitable in 18% of cases. 4% had a radiological interventional procedure. 71% of patients were managed operatively in the specialist urology theatres whilst 29% were treated in the general operating theatre; access to a specialst urology theatre had a direct bearing upon our ability to perform primary URS.

Conclusions: This audit highlights successful conservative management in the majority of cases with a high rate of alpha blocker prescription. A high number of patients who required operative intervention underwent primary URS, indicating good access to the required equipment in the emergency setting but better access would ensure a higher percentage are treated with primary URS. The audit also underlines the need to have access to urgent ESWL.

Notes:

Clinical evaluation of contrast-enhanced ultra-low dose CT In patients presenting with acute ureteric colic

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PRESENTER: **MARK CUTRESS**

Introduction: Unenhanced CT of the renal tract (CT-KUB) has replaced IVU in many centres as the standard imaging for patients presenting with acute ureteric colic. However, concerns over the high radiation exposure with CT-KUB (8-16mSv; Niemann et al, AJR 2008; 191: 396-401) justifies evaluation of protocols with lower exposures. We report the use of ultra-low dose contrast-enhanced CT (ULDCECT) in the nephrographic phase of enhancement using a reduced radiation protocol equivalent to IVU. The objective was to determine the diagnostic accuracy ULDCECT and compare this to IVU for patients presenting clinically with acute ureteric colic.

Patients and Methods 53 patients with presenting features of acute ureteric colic underwent ULDCECT and IVU on the same day as their hospital admission. Diagnostic accuracy of ULDCECT and IVU were compared against surgical findings and long-term clinical outcome, including any intervention.

Results: ULDCECT had superior sensitivity (97%) and specificity (100%) in the identification of renal tract stone disease to IVU (84% and 95% respectively), with comparable radiation exposure (1.5mSv versus 1.4mSv). Furthermore, ULDCECT revealed non-stone disease in 8 patients (15%), including renal tumour, acute appendicitis, perforated diverticulitis and common bile duct stone, two of whom required emergency general surgery.

Conclusions: ULDCECT provides diagnostically accurate imaging in patients presenting with acute ureteric colic and significantly outperforms IVU for an equivalent radiation burden both for renal stone disease and other acute pathologies. The use of ULDCECT instead of conventional CT-KUB may significantly reduce lifetime radiation exposure of renal colic patients without loss of diagnostic accuracy.

Notes:

Audit of PDD and Hexvix Pilot – lessons learnt from a learning curve?

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PRESENTER: **WILLIAM FINCH**

Introduction: Photodynamic technology has been developed to improve the detection of bladder tumours. Hexyl 5-aminolevulinic acid (Hexvix) is metabolised in all nucleated cells but preferentially within tumour cells with the accumulation of the fluorescent metabolite protoporphyrin IX. Under "blue light" cystoscopy, fluorescence from abnormal urothelium is readily visualised enabling more thorough resection. Data supports the hypothesis that photodynamic diagnosis (PDD) of bladder cancer improves detection rates, leads to more complete tumour resection and reduces recurrence rates. We present our findings and experience from a pilot study of PDD and Hexvix.

Patients and Methods 21 patients over a 3-week period were selected to receive Hexvix and "blue light" cystoscopy. Patients were selected to evaluate different indications for cystoscopy. The group comprised of initial TURBT, relook TURBT, cystoscopy and biopsy and check cystoscopy. All bladders were mapped with white light and blue light. Our outcomes were:

1. the numbers of lesions seen with each light source
2. whether extra biopsies were taken on the basis of "blue light" findings
3. whether blue light changed what would have been routinely done under "white light" cystoscopy.

Results: TURBT for a new bladder tumour was performed in 10 patients (47.6%), check cystoscopy in 9 patients (42.9%), diagnostic cystoscopy and biopsy in 1 patient and a redo TURBT in 1 patient. Extra lesions were seen with PDD in 7 patients (33.3%). However "blue light" findings were unchanged from "white light" findings in 11 patients (52.4% $p=0.1$). A lesion seen on "white light" but not on "blue light" was biopsied in 3 patients (14.3%). Our management was changed by "blue light" in 7 patients (33.3%) and, on average, 3 extra lesions were identified (range 1-6). Of these extra lesions biopsied none were of higher grade or CIS. Of the 3 lesions seen with "white light" but not "blue light", all were benign. It was generally felt that, in addition, "blue light" cystoscopy provided more information on the size of the tumour base, allowing for more thorough resection/diathermy.

Conclusions: In this small pilot study of Hexvix and PDD, more tumours were identified than with "white light" cystoscopy. Of the lesions seen with "white light" but not with "blue light", reassuringly, these all proved to be benign. Our cystoscopic management was changed in 33.3% ($p=0.1$) of cases and, although not statistically significant, this was felt to have resulted in a more thorough resection and clearance of lesions in the bladder. We feel "blue light" cystoscopy does have an important and beneficial role to play for Urology departments.

Notes:

ESWL in the management of ureteric stones: a 2-year audit of results with the Wolf Piezolith 3000

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PRESENTER: **CLAIRE DAWKINS**

Introduction: To evaluate the performance of ESWL in the management of ureteric stones over a 2 year period since the introduction of the static Wolf Piezolith 3000 at Addenbrooke's Hospital.

Patients and Methods We reviewed the records of the 54 patients who had ESWL for ureteric stones following the introduction of the static Wolf Piezolith 3000 in September 2007. Of these, six patients were lost to follow up. The maximum presenting stone diameter was measured on CT (or KUB X-ray where CT was not available) for the remaining 48 patients and the success of their treatment was recorded. Stents were in situ in 8 patients (20%) overall. Success of treatment was determined according to stone size and location.

Results: The mean number of treatment was 1.2. Seven patients with distal ureteric stones (1 ≤5mm, 6 6-9mm) and 41 patients with upper ureteric stones were treated (7 patients ≤5mm, 25 patients 6-9mm, 9 patients ≥ 10mm).

In the distal ureter there was an 86% success rate, and in the upper ureter there was an 80% success rate. However, the success rate in the upper ureter was dependent on stone size, with stones ≤5mm being successfully cleared in 86% while 6-9mm stones were cleared in 88% and stones greater than 1cm cleared in 56%. Although the numbers are small, the data suggests that ESWL success is lower for patients with stones under 1cm who have a ureteric stent in situ.

Conclusions: Our audit has shown that the success rates for the clearance of ureteric stones by ESWL since the introduction of the Wolf Piezolith 3000 have been comparable to published results, and are excellent for stones under 1cm. Success rates are lower for stones greater than 1cm, which is in keeping with current guidelines, and are also lower for patients with a ureteric stent in situ.

Notes:

An audit of the timing of Mitomycin C

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PRESENTER: **SARAH WOOD**

Introduction: Intravesical chemotherapy has been used to treat bladder cancer for over 40 years. A single instillation of Mitomycin (MMC) after 1st TUR reduces the risk of recurrence by 39% in patients with stage Ta and T1 bladder cancer (Tolley 1996, Sylvester 2004). Timing of the instillation is thought to be crucial. In most studies it is given within 24hrs. The EUA guidelines recommend an immediate post-operative instillation (EAU 2008). The EAU 2003 guidelines had recommended that it should be given within 6 hours. Contra-indications include suspected perforation or heavy bleeding and relative contra-indications include suspected invasive tumour or a large resected area.

Because of concerns that patients at the N&N might not all be getting their intravesical chemotherapy within the recommended 6 hours, or at least within 24 hours, we undertook an audit to look at the timing of single dose Mitomycin following all first time TURBTs over the two month period of February and March 2009.

Patients and Methods Every patient admitted for their first TURBT in February and March 2009 had a record taken of whether MMC was planned or the reason it was not to be given; the time difference between arrival into recovery and MMC being given on the ward; reason for delay if any and final histology.

Results: Thirty five patients underwent first-time TURBT. Twenty three were expected to receive MMC. Thirteen (56.6%) received it within 24hr (4 within 6hrs). Eight (34.8%) had MMC beyond 24hrs and 2 did not receive it all. Reasons for delay included lost script by pharmacy, delayed production of MMC, persistent haematuria. Many reasons were not documented. One patient did not receive MMC because no trained nurse was available to give it.

Conclusions: This audit has small numbers but it still illustrates the difficulties with planning the instillation of MMC post-operatively. We have considered a number of methods to try to improve this. For example, ordering MMC in advance of the surgery, early ordering by the surgeon once the operation is complete, use of the Mito–In device (Kyowa Kirin) on the ward or in theatre. Discussion continues with Pharmacy but we hope to start using the Mito–In device on the ward in the near future. The audit will be repeated once this has been set up.

Notes:

Maintenance BCG immunotherapy for high-risk non-muscle invasive bladder cancer: improving compliance using an individualised regimen

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PRESENTER: **JAMES ARMITAGE**

Introduction: Intravesical BCG immunotherapy reduces the risk of tumour recurrence and progression in patients with high-risk non-muscle invasive bladder cancer. However, toxicity limits compliance with maintenance therapy. We report outcomes and present our department's strategies for improving compliance.

Patients and Methods Between 2001 and 2008, 85 patients with high-risk non-muscle invasive bladder cancer commenced a maintenance BCG schedule that comprised three consecutive weekly treatments at the 3rd, 6th, 12th, 18th, 24th, 30th, and 36th month. Patients received written information about their treatment. A specialist nurse administered BCG and offered telephone support. The number of instillations given at each cycle was adjusted according to side-effects.

Results: Patients were at high risk of recurrence and progression - 41 patients (48%) had CIS, 36 (42%) T1 disease, and 43 (51%) grade 3 tumours. After a median follow-up of 36 months, 28 patients (33%) experienced recurrence and 6 (7%) had progression. 24 patients (28%) have completed a full course of maintenance BCG that incorporated all seven cycles of treatment comprising at least 17 instillations. 31 patients (36%) are currently receiving BCG maintenance. Overall, 27 patients (32%) reported toxicity: 22 (25%) had cystitis, 10 (12%) malaise, 4 (5%) haematuria, and 2 (2%) urinary tract infections. 12 patients (14%) required dose reduction and 6 (7%) stopped treatment because of side-effects.

Conclusions: This study emphasises the importance of an 'individualised' maintenance BCG regimen to enable high levels of compliance. In turn this may reduce the long-term risk of recurrence and progression of high-risk non-muscle invasive bladder cancer.

Notes:

Is investigating under-50s with microscopic haematuria justified? An audit of patients presenting to the haematuria clinic over a 1-year period

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PRESENTER: **SRIJIT BANNERJEE**

Introduction: Use of microscopic haematuria as a screening tool to identify urothelial cancer has been widely debated. Current evidence has confirmed that positive predictive value of microscopic haematuria as a screening tool is quite low (around 0.5%) more so in younger individuals. Current EAU guidelines state that persons under the age of 50 should not be investigated for suspected urothelial cancer based only on asymptomatic microscopic haematuria. Like most hospital trust in UK, Norfolk and Norwich University hospital also has a fast track 2 week wait pathway for patient suspected with urothelial cancer. These patients are seen in one-stop Haematuria Clinics and are investigated with an ultrasound of urinary tract and a flexible cystoscopy on the same day.

The purpose of the audit was to identify how many under 50s were needlessly investigated in the haematuria clinic and whether any of them had any positive urothelial malignancy.

Patients and Methods Patients under the age of 50 years who were investigated in the one stop haematuria clinic between 28 May 2008 and 29 May 2009 were identified and their results checked to identify any positive malignancy. Clinic letter (including GP referral letter), case notes, operation notes and USS results were studied to identify patients and gather information on outcome. Patients presenting with haematuria from other sources such as A &E, and ward admissions etc. were excluded from the audit.

Results: A total of 780 patients were seen in the haematuria clinic. 380 patients had microscopic haematuria and 400 patients had macroscopic haematuria. 49 patients were under the age of 50 and had USS and flexible cystoscopy. None of these 49 patients were found to have urothelial malignancy or any other major pathology. In the rest of the patients over the age of 50 presenting with microscopic haematuria, a total of 18 patients were diagnosed with urothelial malignancy (16 bladder tumours, 1 ureteric and 1 renal tumour). 7 patients were newly diagnosed with prostate cancer based on clinical examination and subsequent PSA test and TRUS biopsy. Other benign pathologies, including renal and bladder calculi, chronic cystitis, prostatitis, angiomyolipoma and colovesical fistula etc were detected in another 50 patients.

Conclusions: The audit clearly demonstrates that, in spite of clear guidelines, a lot of people are still investigated needlessly when they present with microscopic haematuria. This is mainly because of inappropriate referrals of the patients by GPs to the cancer services and also due to no- implementation of guidelines by the urologist .It also shows that, in appropriate age groups, microscopic haematuria is still an important screening tool in picking up urothelial malignancy and other non-malignant pathologies.

Notes:

An audit of patient satisfaction with urological services delivered at an NHS unit and a non-NHS provider: implications for the Free Choice Network

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PRESENTER: **GEORGE YARDY**

Introduction: Patient-reported outcome measures (PROMs) are an important component of the revalidation / recertification process. The Sheffield Patient Assessment Tool (SHEFFPAT) is a questionnaire which was developed to study patient satisfaction with Paediatric outpatient consultations. It is validated for use in Urology clinics.

Some patients seen in our NHS outpatients department are allocated to undergo surgery at nearby non-NHS hospitals as NHS patients. We used a postal survey to assess the satisfaction of a series of such patients; and compare it with that of a similar group of patients who underwent surgery at the NHS unit.

Patients and Methods A questionnaire including the SHEFFPAT and other questions was posted to 65 patients who had recently undergone urological surgery at a non-NHS unit as NHS patients; and 68 patients treated at a NHS unit.

Results: Replies were received from 32 (49.2%) patients treated at a non-NHS unit and 36 (52.9%) patients treated at a NHS unit. Across all domains of the SHEFFPAT, mean scores indicated a high degree of satisfaction and did not differ significantly between the two groups.

94% of non-NHS patients would prefer to have further procedures, if necessary, at a non-NHS unit, although 84% of NHS patients would prefer further surgery at the NHS unit. 57% of non-NHS patients would prefer a follow-up outpatient appointment at a non-NHS unit, while 82% of NHS patients favoured review in a clinic at the NHS unit. Three quarters of all patients would prefer a follow-up appointment with an Urologist, rather than a General Practitioner. When asked their preference for a new outpatient appointment, 76% of NHS patients favoured their local NHS department and 55% of patients who had been treated as NHS patients in a non-NHS unit indicated that they would choose an appointment in a non-NHS unit.

Conclusions: The satisfaction of patients in both groups was high and equivalent. Patients treated at the NHS unit more frequently indicated a preference for further treatment at the same unit than those treated at a non-NHS unit chose further treatment at the non-NHS unit. The study indicates that increasing patient choice may not disadvantage NHS units.

Notes: