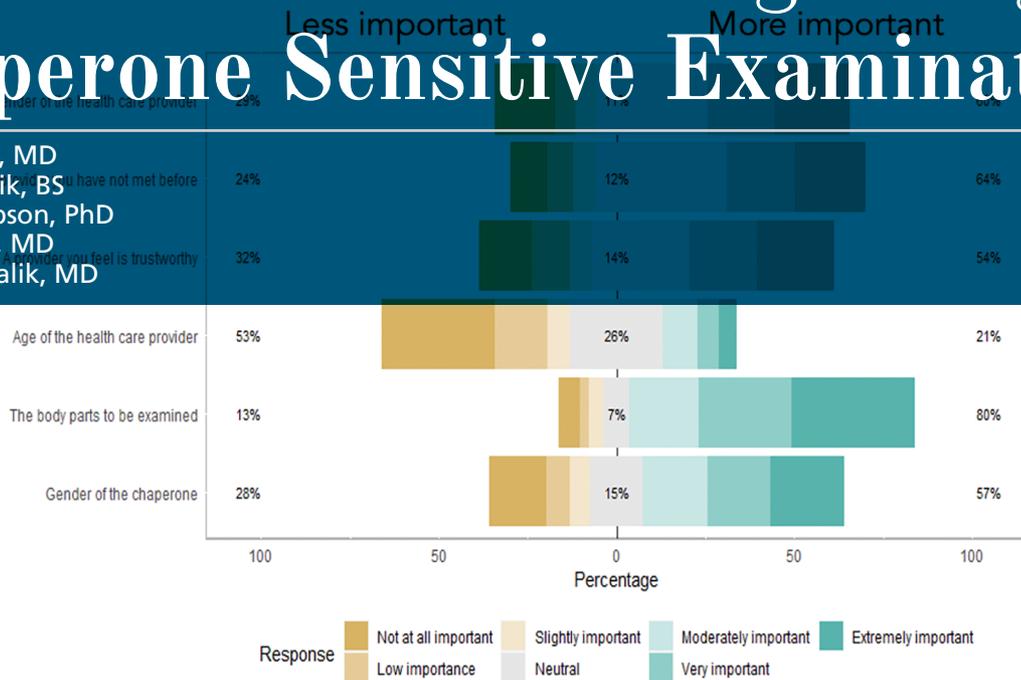




THE OFFICIAL NEWSMAGAZINE OF THE AMERICAN UROLOGICAL ASSOCIATION

Patient Preferences Regarding Chaperone Sensitive Examinations

Syed M. Alam, MD
Mahnoor Malik, BS
Jeffrey Thompson, PhD
Moben Mirza, MD
Casey G. Kowalik, MD



INSIDE THIS ISSUE

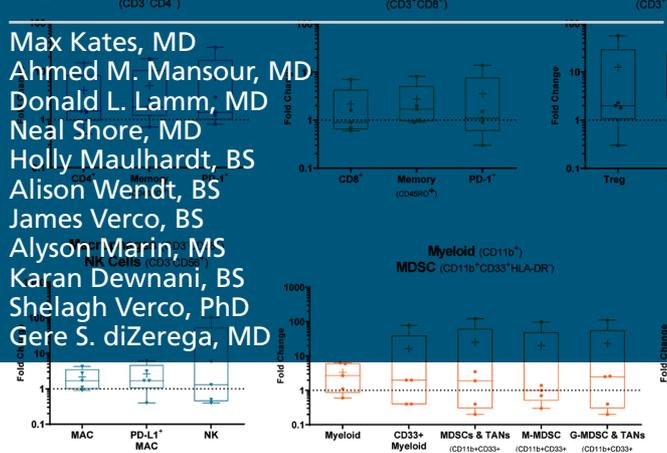
Survival Impact of Variant Histology Diagnosis in Upper Tract Urothelial Carcinoma

Intravesical Instillation of OnabotulinumtoxinA in the Treatment of Refractory Overactive Bladder in Participants with Urinary Incontinence

Advanced Practice Providers and Wait Times in Urology Offices: A Secret Shopper Study

Phase 1/2 Trial Results of a Large Surface Area Microparticle Docetaxel for the Treatment of High-Risk Nonmuscle-Invasive Bladder Cancer

Max Kates, MD
Ahmed M. Mansour, MD
Donald L. Lamm, MD
Neal Shore, MD
Holly Maulhardt, BS
Alison Wendt, BS
James Verco, BS
Alyson Marin, MS
Karan Dewnani, BS
Shelagh Verco, PhD
Gere S. diZerega, MD



Procedural Benzodiazepine and Post-Vasectomy Opioid and Nonopioid Prescribing Variation in a Large Health Care System

Robert Webber, MD
Michael S. Patzkowski, MD, MHA
Ryan C. Costantino, PharmD, MS
Alexander G. Velosky, MHI
Vivian Lee, MD
Kyle L. Cyr, MD
Lisa M. Harris, DO
Maya Scott-Richardson, PhD
Krista B. Highland, PhD



CLINICAL NEWS

- Acute Lower Back Pain after Intravesical Injection of Collagenase *Clostridium histolyticum* for Peyronie's Disease
- Does Antimicrobial Prophylaxis in Patients with Specific Comorbidities Reduce the Risk of Infection after Simple Cystourethroscopy? A Comparison of Percutaneous Ablation Therapy to Partial Nephrectomy for cT1a Renal Cancers: Results from the Canadian Kidney Cancer Information System
- Gender and Racial Diversity among U.S. Urology Residency Programs and Efforts to Improve It: You Can't Be What You Can't See
- Cost Implications of Routine Preoperative Blood Typing and Crossmatching Prior to Robot-Assisted Laparoscopic Partial Nephrectomy
- Risk of Postoperative Thromboembolism in Men Undergoing Urological Prosthetic Surgery: An Assessment of 21,413 Men
- Professional Burnout of Advanced Practice Providers Based on 2019 American Urological Association Census Data
- Neoadjuvant Novel Hormonal Therapy Followed by Prostatectomy versus Up-Front Prostatectomy for High-Risk Prostate Cancer: A Comparative Analysis
- Associations between Race and Erectile Dysfunction Treatment Patterns

NEWS FROM AUA

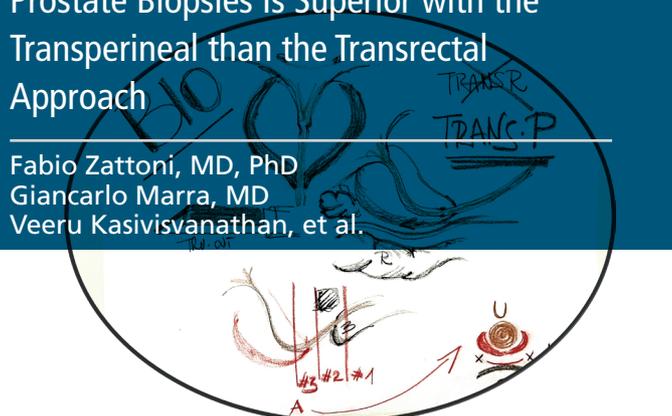
The House of Medicine of the American Medical Association: A Strategic Imperative for AUA Public Policy around the American Medical Association's Dinner Table

ON THE PERSONAL SIDE

Art with a capital "A"
Have You Read?

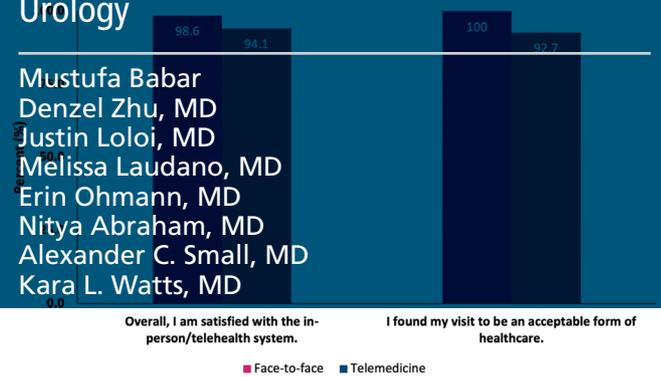
The Detection of Prostate Cancer with Magnetic Resonance Imaging-Targeted Prostate Biopsies Is Superior with the Transperineal than the Transrectal Approach

Fabio Zattoni, MD, PhD
Giancarlo Marra, MD
Veeru Kasivisvanathan, et al.



Comparison of Patient Satisfaction and Safety Outcomes for Postoperative Telemedicine vs Face-to-Face Visits in Urology

Mustufa Babar
Denzel Zhu, MD
Justin Loloj, MD
Melissa Laudano, MD
Erin Ohmann, MD
Nitya Abraham, MD
Alexander C. Small, MD
Kara L. Watts, MD



AUANews

October 2022, Volume 27 | Issue 10

EDITOR IN CHIEF

John D. Denstedt, MD, FRCS, FACS, FCAHS
Western University

ASSOCIATE EDITORS

Endourology

Amy E. Krambeck, MD, Northwestern University School of Medicine

Genitourinary Reconstruction

Jeremy B. Myers, MD, University of Utah

Outcomes

David F. Penson, MD, MPH, Vanderbilt University Medical Center

Female Urology

David Rapp, MD, University of Virginia Health

Men's Health

Hossein Sadeghi-Nejad, MD, CM, FACS, Rutgers NJMS, Hackensack University Medical Center

Pediatrics

Aseem R. Shukla, MD, Children's Hospital of Philadelphia

Oncology

Kelly L. Stratton, MD, University of Oklahoma

SECTION EDITORS

Practice Tips & Tricks

Neil Baum, MD, Tulane Medical School

Medicolegal Connection

Glenn W. Dopf, JD, LLM and Martin B. Adams, JD, DOPF, P.C.

Office & Surgical Technologies

Bodo Knudsen, MD, FRCS, The Ohio State University, Wexler Medical Center

Have You Read?

Craig Niederberger, MD, FACS, UIC College of Medicine and UIC College of Engineering

Medical Ethics

Raj Pruthi, MD, MHA, FACS, University of California, San Francisco

From the History Committee: Taking a History

Ronald Rabinowitz, MD, University of Rochester Medical Center

Radiology Corner

Ardeshir R. Rastinehad, DO, Smith Institute for Urology at Northwell Health

Coding Tips & Tricks

Jonathan Rubenstein, MD, Chair, AUA Coding and Reimbursement Committee

PORTUGUESE EDITION EDITOR

Fernando J. Kim, MD, MBA, FACS
Denver Health Medical Center

SPANISH EDITION EDITOR

Alejandro Remigio Rodriguez, MD
Rochester Regional Health

EXECUTIVE EDITORS

Patricia Banks, Executive Vice President and Chief Marketing and Development Officer
Jennifer Regala, Director of Publications

MANAGING EDITORS

Irene B. Connor
Martha Keyes
Scott D. Morrow
Jon Munn
Kathleen Warshawsky

PUBLICATIONS DEPARTMENT

American Urological Association
publications@AUAnet.org

PRODUCTION

KnowledgeWorks Global Ltd.
2905 Byrdhill Road, Richmond, VA 23228

ADVERTISING SALES

The Walchli Tauber Group
(443) 512-8899
stephen.tauber@wt-group.com

AMERICAN UROLOGICAL ASSOCIATION

2022–2023 AUA Officers

President

Edward M. Messing, MD, FACS

President-elect

Randall B. Meacham, MD

Immediate Past President

Raju Thomas, MD, FACS, FRCS, MHA

Secretary

John D. Denstedt, MD, FRCS, FACS, FCAHS

Secretary-elect

David F. Penson, MD, MPH

Treasurer

Thomas F. Stringer, MD, FACS

UPJ INSIGHT

Patient Preferences Regarding Chaperone Sensitive Examinations

Syed M. Alam, MD

University of Kansas Health System, Kansas City

Mahnour Malik, BS

University of Missouri-Kansas City School of Medicine

Jeffrey Thompson, PhD

University of Kansas School of Medicine, Kansas City

Moben Mirza, MD

University of Kansas Health System, Kansas City

Casey G. Kowalik, MD

University of Kansas Health System, Kansas City

Alam SM, Malik M, Thompson J, Mirza M, Kowalik CG. Patient preferences regarding chaperone use for sensitive examinations. *Urol Pract.* 2022;9(5)379-388.

Study Need and Importance

Chaperones are routinely employed during sensitive or private physical examinations, many of which are common in the field of urology. Currently, no guidelines exist regarding chaperone use within the field of urology.

What We Found

We found that the majority of patients (52.9%) do not want a chaperone during sensitive examinations. Reasons for not wanting a chaperone included trust with the provider (80%), comfort with the physical examination (70.4%), and embarrassment/discomfort with having a chaperone present (33%). Several factors relating to the provider and type of examination were assessed for relative im-

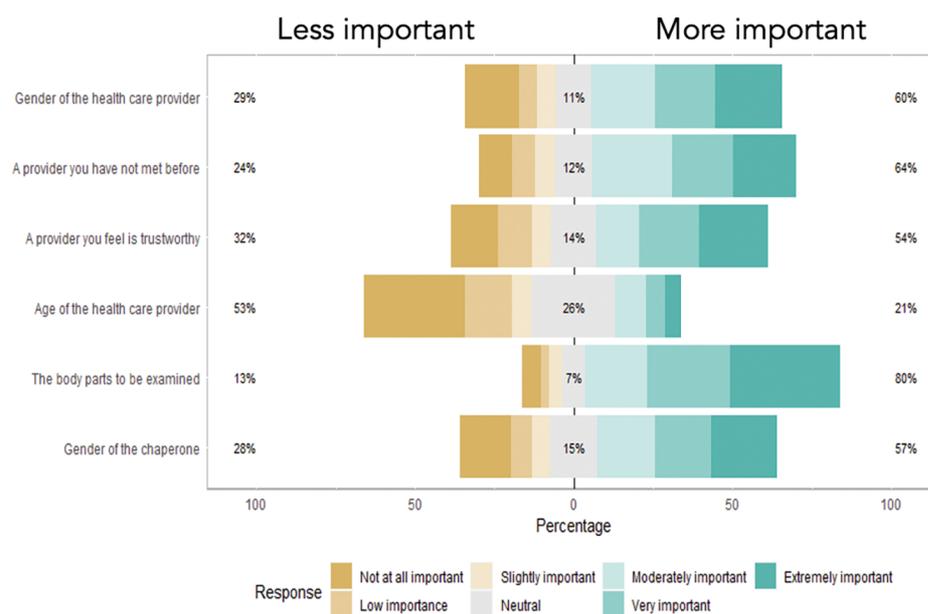


Figure. Relative importance of provider factors affecting an individual's desire to have a chaperone present (913 participants).

“We found that the majority of patients (52.9%) do not want a chaperone during sensitive examinations.”

portance in a patient's preference for having a chaperone present (see Figure).

Limitations

Respondents to the survey primarily self-identified as female (71.5%), while urology patients tend to be predominately male. Also, most participants identified as Caucasian (86.0%) and had at least

some college education (62.2%); therefore, generalizing these data to more at-risk (minority and less educated) populations is less impactful.

Interpretation for Patient Care

The results of this study highlight the need for individualized care when it comes to chaperone use during sensitive examinations, which are a common aspect of urological care. Many variables play a role in whether a patient prefers to have a chaperone or not. We hope that the results of this study will provide new insight into the use of chaperones to promote patient-centered care and potentially guide future health care policy. ■

JU INSIGHT

Phase 1/2 Trial Results of a Large Surface Area Microparticle Docetaxel for the Treatment of High-Risk Nonmuscle-Invasive Bladder Cancer

Max Kates, MD

James Buchanan Brady Urological Institute, Johns Hopkins Medical Institutions, Baltimore, Maryland

Ahmed M. Mansour, MD

UT Health San Antonio, San Antonio, Texas

Donald L. Lamm, MD

BCG Oncology, PC, Phoenix, Arizona

Neal Shore, MD

Carolina Urologic Research Center, Myrtle Beach, South Carolina

Holly Maulhardt, BS

US Biotest, Inc., San Luis Obispo, California

Alison Wendt, BS

US Biotest, Inc., San Luis Obispo, California

James Verco, BS

US Biotest, Inc., San Luis Obispo, California

Alyson Marin, MS

US Biotest, Inc., San Luis Obispo, California

Karan Dewnani, BS

DFB Pharmaceuticals, Inc., Fort Worth, Texas

Shelagh Verco, PhD

US Biotest, Inc., San Luis Obispo, California

Gere S. diZerega, MD

US Biotest, Inc., San Luis Obispo, California
Nanology, LLC., Fort Worth, Texas

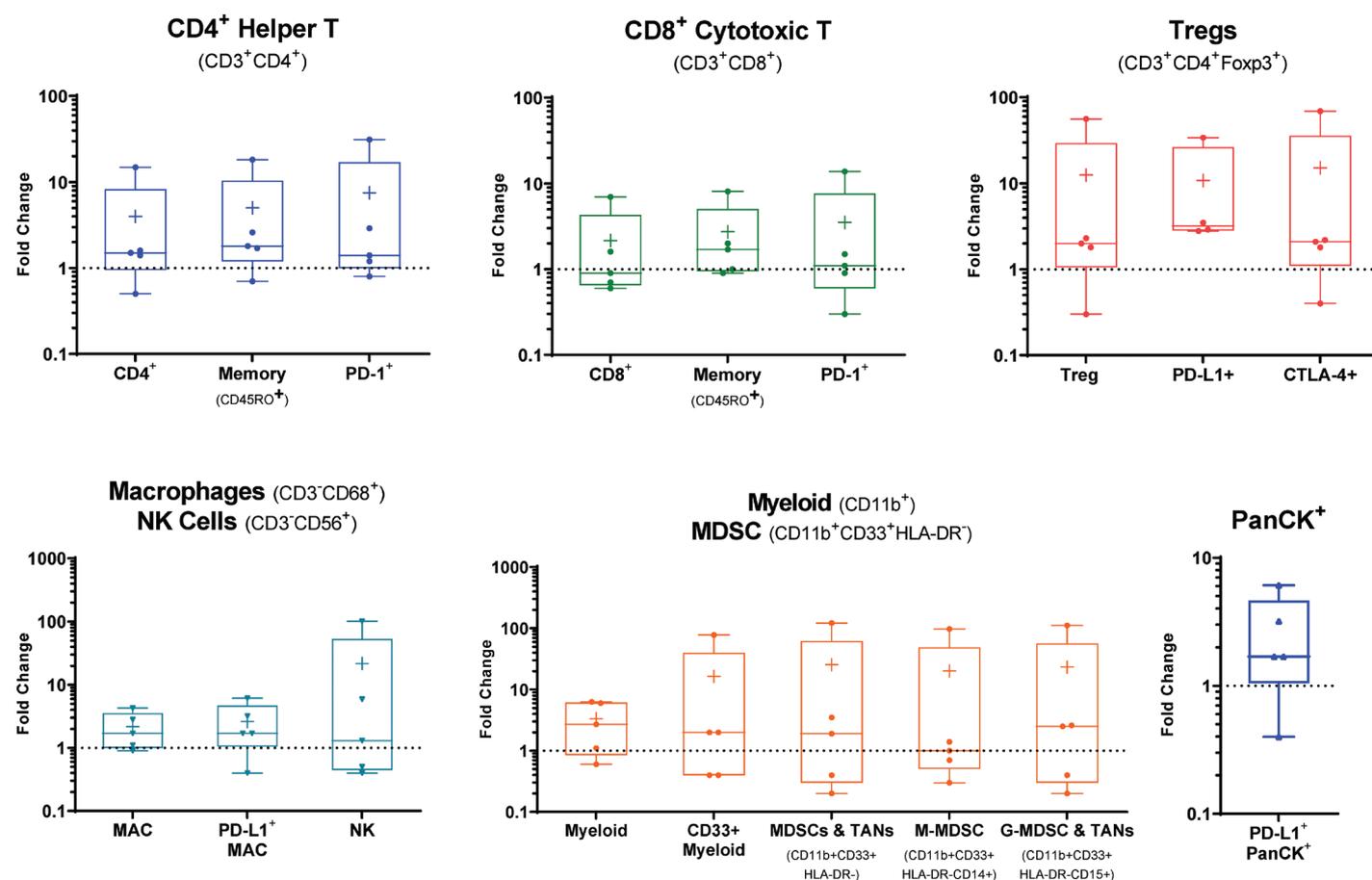


Figure. Fold-change in immune cell densities (cells/mm²) from bladder biopsies collected before and after LSAM-DTX therapy as determined by multiplex immunofluorescence. Boxplots show minimum to maximum fold-changes (extremes), per subject data (dots), mean (+), and median (line) for 5 subjects analyzed. Cell types are identified using marker (CD11b, CD14, CD15, CD3, CD4, CD8, CD20, CD33, CD45RO, CD56, CD68, HLA-DR, FOXP3, CTLA4, PD-1, PD-L1, and pan-cytokeratin) co-expression over an average of 24 regions of interest (ROIs; range 7 to 37) within the tumor microenvironment per slide. ROI was selected by a pathologist blinded to treatment status on a hematoxylin and eosin-stained slide. Cell type density is the total number of cells counted divided by the total area (sum of all ROI areas) per slide. In cases where the pre-LSAM-DTX cell density was 0 cells/mm², no data are reported and number of patients is less than 5.

Kates M, Mansour AM, Lamm DL, et al. Phase 1/2 trial results of a large surface area microparticle docetaxel for the treatment of high-risk nonmuscle-invasive bladder cancer. *J Urol.* 2022;208(4):821-829.

Study Need and Importance

Most patients with high-risk nonmuscle-invasive bladder cancer (NMIBC) are treated with transurethral resection of bladder tumor (TURBT) followed by bacillus Calmette-Guérin (BCG) intravesical therapy. Despite moderate efficacy with intravesical chemotherapy for BCG-exposed NMIBC, there remains a need to enhance therapeutic options to improve the efficacy of these treatments. We discuss our experience with large surface area microparticle docetaxel (LSAM-DTX) administered via direct injection at the

site of TURBT followed by intravesical instillation for the treatment of high-risk NMIBC.

What We Found

Nineteen subjects were enrolled, 14 with prior BCG exposure and 16 with ≥ 1 prior TURBT. Post-TURBT direct injection and intravesical LSAM-DTX were well tolerated and demonstrated clinical response for patients with high-risk NMIBC. In the 3 lowest dose escalation cohorts the median recurrence-free survival was 5.4 months (10 patients, median followup 8.6 months). In the high-dose and expansion cohorts median recurrence-free survival was significant-

ly increased ($p < 0.05$; hazard ratio 0.29) to 12.2 months (9 patients, median followup 12.4 months). Systemic docetaxel exposure was negligible, and increases in antitumor immune cells were found in the tumor microenvironment along with elevations in the PD-1, PD-L1 and CTLA-4 immune checkpoint inhibitor targets (see Figure).

Limitations

Although 14/19 subjects in this study were BCG-exposed, the type of BCG failure was not defined. Other limitations included small sample size, heterogeneous tumor stage, wide range of number of pri-

or TURBT procedures, limited immune analysis, short maintenance period, and short study followup period.

Interpretations for Patient Care

The unique route of administration, direct injection immediately after TURBT followed by intravesical administration, was shown to be safe and well tolerated. Favorable immune cell infiltration and checkpoint receptor increases following LSAM-DTX treatment warrant investigation alone as well as in combination with immune checkpoint inhibitor therapy. ■

UPJ INSIGHT

Procedural Benzodiazepine and Post-Vasectomy Opioid and Nonopioid Prescribing Variation in a Large Health Care System

Robert Webber, MD

School of Medicine, Uniformed Services University, Bethesda, Maryland

Michael S. Patzkowski, MD, MHA

Brooke Army Medical Center, Fort Sam Houston, Texas

Uniformed Services University, Bethesda, Maryland

Ryan C. Costantino, PharmD, MS

Enterprise Intelligence and Data Solutions (EIDS) Program Office, San Antonio, Texas

Alexander G. Velosky, MHI

Uniformed Services University, Bethesda, Maryland
Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., Bethesda, Maryland

Vivian Lee, MD

Walter Reed National Military Medical Center, Bethesda, Maryland

Kyle L. Cyr, MD

Walter Reed National Military Medical Center, Bethesda, Maryland

Lisa M. Harris, DO

Uniformed Services University, Bethesda, Maryland

Maya Scott-Richardson, PhD

Uniformed Services University, Bethesda, Maryland
Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., Bethesda, Maryland

Krista B. Highland, PhD

Uniformed Services University, Bethesda, Maryland
Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., Bethesda, Maryland

Webber R, Patzkowski MS, Costantino RC, et al. Procedural benzodiazepine and post-vasectomy opioid and nonopioid prescribing variation in a large health care system. *Urol Pract.* 2022;9(5)431-440.

Study Needs and Importance

The American Urological Association does not provide explicit recommendations for procedural benzodiazepine use or post-vasectomy pain management, but recommends prescribing opioids only when necessary, at the lowest effective dose. In this study, we described variation in procedural benzodiazepine and post-vasectomy nonopioid pain and opioid prescription dispense events of 40,584 patients within the U.S. Military Health System.

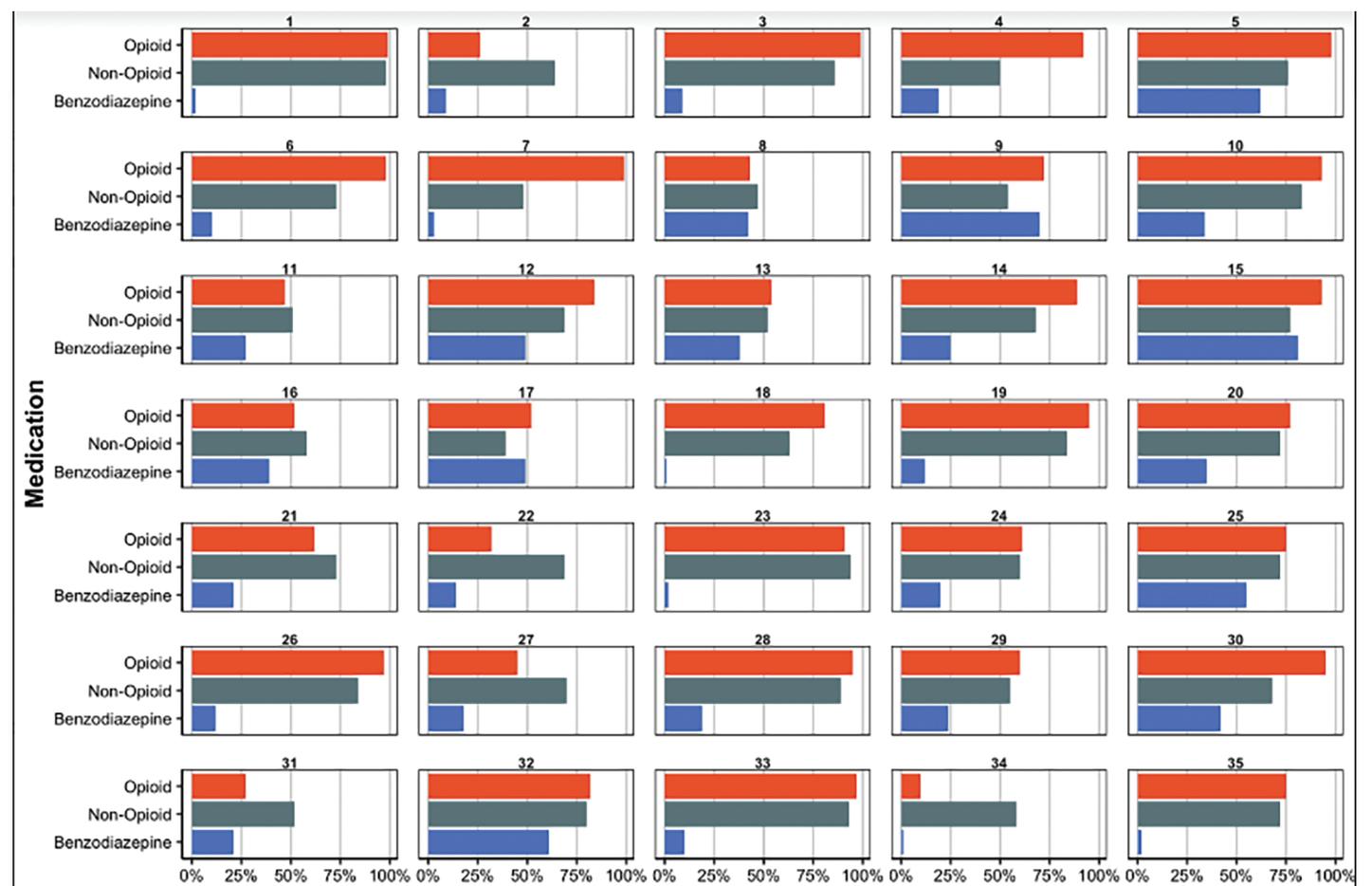


Figure. Variation by treatment facility in dispensed procedural benzodiazepine and post-vasectomy nonopioid and opioid prescriptions. Note facilities are ordered by vasectomy volume from low (1, top left) to high (35, bottom right).

What We Found

Whereas 32% of patients received a procedural benzodiazepine prescription (eg 1 pill), the majority were dispensed a nonopioid (71%) and/or an opioid (73%) prescription (see Figure). Most commonly, patients received both a nonopioid and opioid (34%) or all 3 medications (23%). A small proportion of patients dispensed a vasectomy-related opioid prescription later received an opioid refill within 30 days post-vasectomy (5%). Significant inequities in care pathways were identified for Black, Latino and Asian patients, and those whose race was Other relative to White patients. Patients were more likely to receive an opioid refill if they did not receive a nonopioid pain medication prescription.

“Patients were more likely to receive an opioid refill if they did not receive a nonopioid pain medication prescription.”

Limitations

The use of electronic health record data may limit conclusions and scope of findings due to data missingness (eg race and ethnicity), lack of data on procedural techniques and lack of patient-reported outcomes. It is also unclear whether prescription dispense variation is due to variation

in provider assessment, default order sets, prescribing patterns, patients’ choice to fill or not fill a prescription and the possibility that patients may have declined a nonopioid prescription offer due to having the medication at home. The Military Health System provides care to active duty service members, military retirees and their family members; generalizability is limited.

Interpretation for Clinical Care

Low rates of opioid refill and inequities in vasectomy-related prescribing practices highlight the need for system-level intervention to address excessive opioid prescribing and reduce unwarranted health care variation. ■

JU INSIGHT

Acute Lower Back Pain after Intralesional Injection of Collagenase *Clostridium histolyticum* for Peyronie's Disease

John T. Sigalos, MD

David Geffen School of Medicine at UCLA,
Los Angeles, California

Michelle K. Li, BA

David Geffen School of Medicine at UCLA,
Los Angeles, California

Dar A. Yoffe, BS

David Geffen School of Medicine at UCLA,
Los Angeles, California

Neilufar Modiri, BA

David Geffen School of Medicine at UCLA,
Los Angeles, California

Ming-Yeah Y. Hu, BS

David Geffen School of Medicine at UCLA,
Los Angeles, California

Dyvon T. Walker, MD

University of Colorado School of Medicine, Aurora,
Colorado

Thomas W. Gaither, MD

David Geffen School of Medicine at UCLA,
Los Angeles, California

Alvaro Santamaria, MD

David Geffen School of Medicine at UCLA,
Los Angeles, California

Keith V. Regets, PA-C

David Geffen School of Medicine at UCLA,
Los Angeles, California

Sriram V. Eleswarapu, MD, PhD

David Geffen School of Medicine at UCLA,
Los Angeles, California

Jesse N. Mills, MD

David Geffen School of Medicine at UCLA,
Los Angeles, California

Sigalos JT, Li MK, Yoffe DA, et al., Acute lower back pain after intralesional injection of collagenase *clostridium histolyticum* for Peyronie's disease. *J Urol.* 2022;208(4):872-877.

Study Need and Importance

In spring of 2021, the U.S. Food and Drug Administration safety label for collagenase *Clostridium histolyticum* was changed to include acute onset lower back pain as a potential adverse event when used for intralesional treatment of Peyronie's disease. While this adverse event was not seen in the original IMPRESS trials, post-marketing evaluation of intralesional collagenase in the

Table. Demographic and clinical correlates of acute lower back pain after intralesional injection of collagenase *C. histolyticum* for Peyronie's disease

	Back Pain (n=19)	No Back Pain (n=311)	p Value
Mean yrs (SD)	60.2 (12.4)	58.9 (11.1)	0.62
Race, no. (%)			
American Indian/Alaska Native	0	2 (0.6)	0.90
Asian	0	4 (1.0)	
Black	0	5 (2.0)	
Other	1 (5.0)	23 (7.0)	
White	15 (79)	217 (70)	
Refused/unknown	3 (16)	60 (19)	
Ethnicity, no. (%)			
Hispanic/Latino	1 (5.0)	16 (5.0)	0.98
Diabetes mellitus, no. (%)			
Yes	2 (11)	31 (10)	0.94
Hypertension, no. (%)			
Yes	5 (26)	74 (24)	0.80
Hyperlipidemia, no. (%)			
Yes	6 (32)	72 (23)	0.40
BMI, no. (%)			
Normal	12 (63)	179 (58)	0.51
Overweight	6 (32)	86 (28)	
Obese	1 (5.0)	46 (15)	
History of Dupuytren's, no. (%)			
Yes	1 (5.0)	14 (5.0)	0.88
Concomitant erectile dysfunction, no. (%)			
Yes	14 (74)	173 (56)	0.12
Smoking history, no. (%)			
Never	13 (68)	222 (71)	0.61
Former	6 (32)	78 (25)	
Current	0	11 (4.0)	
Initial degree of curvature, mean(SD)	51.0 (15.0)	44.4 (15.2)	0.07
Any genitourinary surgery, no. (%)			
Yes	5 (26)	57 (18)	0.39
Duration of Peyronie's disease, median mos (IQR)	12 (9-18)	12 (6-36)	0.30
History of back pain, no. (%)			
Yes	5 (26)	100 (32)	0.60
History of back pain surgery, no. (%)			
Yes	0	34 (11)	0.13

nonclinical trial setting uncovered reports of postinjection acute lower back pain. To date, there has been no published work describing this phenomenon.

What We Found

Of our cohort 6% experienced back pain with intralesional treatment of collagenase *C. histolyticum* for Peyronie's disease. Prevalence of this side effect was 1.3% during the first course of 8 injections. Back pain incidence increased to 8.7% if patients received a second course of treatment. When investigating potential risk factors for back pain post injection, we found no statistically significant relationship with comorbidities, lifestyle factors, or history of back pain or surgery (see Table). All cases of back pain self-resolved within 20 minutes or abated rapidly with a single injection of ketorolac. There were no cases of long-term back pain related to treatment.

Limitations

This is a retrospective review of a single high-volume center in an affluent geographic area with mostly commercial insurance and may not be generalizable to all populations. Sample size was sufficient to make conclusions regarding acute lower back pain incidence; however, the low rate of back pain limits definitive conclusions about potential predictive factors.

Interpretation for Patient Care

Men who elect intralesional collagenase *C. histolyticum* for the treatment of Peyronie's disease should be aware of this potential adverse event. Additionally, providers should be aware if providing a second course of treatment off-label that the incidence of acute lower back pain increases. ■

UPJ INSIGHT

Does Antimicrobial Prophylaxis in Patients with Specific Comorbidities Reduce the Risk of Infection after Simple Cystourethroscopy?

Brenton G. Sherwood, MD

University of Iowa Hospitals and Clinics, Iowa City

Elizabeth B. Takacs, MD

University of Iowa Hospitals and Clinics, Iowa City

Bradley A. Ford, MD, PhD

University of Iowa Hospitals and Clinics, Iowa City

Sarah L. Mott, MS

Holden Comprehensive Cancer Center, University of Iowa Hospitals and Clinics, Iowa City

Bradley T. Loeffler, MS

Holden Comprehensive Cancer Center, University of Iowa Hospitals and Clinics, Iowa City

Gina M. Lockwood, MD

University of Iowa Hospitals and Clinics, Iowa City

Sherwood BG, Takacs EB, Ford BA, Mott SL, Loeffler BT, Lockwood GM. Does antimicrobial prophylaxis in patients with specific comorbidities reduce the risk of infection after simple cystourethroscopy? *Urol Pract.* 2022;9(5)414-422.

Study Need and Importance

The current AUA Best Practice Statement for antimicrobial prophylaxis (AP) generally does not

“Overall, AP decreased the rate of post-procedural infection (OR 0.51, 95% CI 0.35-0.76; $p < 0.01$), though the overall rate of post-procedural infection was low (0.9%) and the number needed to treat to prevent 1 infection was 100.”

Table. Odds ratios for developing PPI based on whether AP was given for each comorbidity group

Comorbidity	Received AP?	Odds Ratio for Developing PPI*	95% CI		P-value**
Advanced Age (≥ 75 years)	Y	1.00	0.51	1.94	0.76
	N	1.14	0.51	2.56	
Diabetes	Y	1.45	0.74	2.83	0.55
	N	1.11	0.49	2.50	
Chronic obstructive pulmonary disease	Y	1.56	0.63	3.89	0.25
	N	0.81	0.24	2.75	
Malnutrition	Y	4.79	1.71	13.44	0.84
	N	4.19	1.23	14.23	
Immunodeficiency	Y	4.06	1.92	8.58	0.38
	N	2.55	0.97	6.69	
Current Smoker	Y	0.51	0.17	1.57	0.83
	N	0.61	0.16	2.30	
Upper Tract Anatomic Anomaly	Y	1.86	0.64	5.44	0.06
	N	5.81	2.51	13.43	
Cardiovascular Disease	Y	0.97	0.43	2.19	0.90
	N	1.03	0.41	2.54	
Female Gender (compared to Male)	Y	2.26	1.24	4.13	0.94
	N	1.92	0.94	3.95	

*Each odds ratio represents the odds of developing a PPI in a group of patients who have the listed comorbidity and either received or did not receive AP, as indicated.

**The p value represents the significance of the difference between the odds ratios for AP vs no AP for each comorbidity.

recommend AP for simple office cystourethroscopy, but also references a large list of comorbidities and risk factors that may increase the risk of post-procedural infection (PPI) which may be used to encourage AP for these patients. However, this list of risk factors is not specific to cystourethroscopy, and evidence that AP reduces the risk of infection after cystourethroscopy for patients with these risk factors is limited. The purpose of our study was to evaluate many of these risk factors to determine whether AP decreases the rate of

infection after simple office cystourethroscopy.

What We Found

Overall, AP decreased the rate of post-procedural infection (OR 0.51, 95% CI 0.35-0.76; $p < 0.01$), though the overall rate of post-procedural infection was low (0.9%) and the number needed to treat to prevent 1 infection was 100. None of the comorbidities evaluated showed significant benefit from AP for prevention of post-procedural infection (see Table).

“Our data support the AUA Best Practice Statement to not recommend AP for simple office cystourethroscopy in the absence of signs or symptoms of an active urinary tract infection.”

Limitations

Our data were collected via Epic[®] reporting software that queried data from our single-hospital system and therefore did not include patients who may have been diagnosed with an infection after cystourethroscopy by a provider outside our hospital system. Our analysis is also limited by the low number of post-cystourethroscopy infections, which may have limited our ability to detect clinically significant effects of AP for some comorbidities.

Interpretation for Patient Care

Our data support the AUA Best Practice Statement to not recommend AP for simple office cystourethroscopy in the absence of signs or symptoms of an active urinary tract infection. Our findings suggest that the comorbidities evaluated in our study should not be used to recommend AP for patients undergoing simple office cystourethroscopy. ■

JU INSIGHT

The Detection of Prostate Cancer with Magnetic Resonance Imaging-Targeted Prostate Biopsies Is Superior with the Transperineal than the Transrectal Approach. A European Association of Urology-Young Academic Urologists Prostate Cancer Working Group Multi-Institutional Study

Fabio Zattoni, MD, PhD
University of Padova, Padua, Italy

Giancarlo Marra, MD
Institut Mutualiste Montsouris, Paris, France

Veeru Kasivisvanathan
University College London, UK
University College London Hospitals
NHS Foundation Trust, UK

Jeremy Grummet
Monash University, Melbourne, Australia

Rohan Nandurkar, MD
Monash University, Melbourne, Australia

Guillaume Ploussard, MD, PhD
La Croix du Sud Hospital, Toulouse, France

Jonathan Olivier, MD
Lille University, France

Peter K. Chiu, MD
The Chinese University of Hong Kong

Massimo Valerio
Lausanne University Hospital,
Lausanne, Switzerland
Lille University, France

Paolo Gontero
University of Turin, Molinette Hospital, Italy

Hongqian Guo
Nanjing Drum Tower Hospital, Medical School of
Nanjing University, Nanjing University, Jiangsu,
People's Republic of China

Junlong Zhuang
Nanjing Drum Tower Hospital, Medical School of
Nanjing University, Nanjing University, Jiangsu,
People's Republic of China

Francesco Barletta, MD
URI, IRCCS Ospedale San Raffaele, Milan, Italy

Riccardo Leni, MD
URI, IRCCS Ospedale San Raffaele, Milan, Italy

Mark Frydenberg, MD
Monash University, Melbourne, Australia
Cabrini Institute, Cabrini Health, Melbourne, Australia

Daniel Moon, MD
University of Melbourne, Peter MacCallum Cancer
Centre, Australia
Epworth Healthcare, Melbourne, Australia

Uri Hanegbi, MD
Monash University, Melbourne, Australia
Cabrini Institute, Cabrini Health,
Melbourne, Australia

Adam Landaumailto, MD
Eastern Health, Melbourne, Australia

Ross Snow, MD
The Alfred Hospital, Prahran, Australia

Maria Apfelbeck, MD
University Hospital Munich, Campus Großhadern,
Ludwig-Maximilians University, Munich, Germany

Alexander Kretschmer, MD
University Hospital Munich, Campus Großhadern,
Ludwig-Maximilians University, Munich, Germany

Roderick van den Bergh, MD, PhD
St Antonius Hospital, Utrecht, The Netherlands

Giacomo Novara
University of Padova, Padua, Italy

Alberto Briganti
URI, IRCCS Ospedale San Raffaele, Milan, Italy

Fabrizio Dal Moro
University of Padova, Padua, Italy

Giorgio Gandaglia, MD, PhD
URI, IRCCS Ospedale San Raffaele, Milan, Italy

Zattoni F, Marra G, Kasivisvanathan V, et al. The detection of prostate cancer with magnetic resonance imaging-targeted prostate biopsies is superior with the transperineal than the transrectal approach. A European Association of Urology-young academic urologists prostate cancer working group multi-institutional study. *J Urol.* 2022;208(4):830-837.

Study Need and Importance

The most common approach for MRI-targeted prostate biopsy was the transrectal (TR) route until the results of the recent international guidelines on prostate cancer. Due to concern regarding the risk of sepsis, transperineal (TP) biopsy has been recommended. For this reason, TP is gaining wider acceptance

and becoming more commonly used, although the detection rate of TP prostate biopsies compared to TR biopsies in large series of multiparametric MRI targeted biopsies has been poorly addressed so far.

What We Found

The use of TP MRI-targeted prostate biopsy might increase the detection of clinically significant prostate cancer (csPCa) compared to TR MRI-targeted prostate biopsy, in particular for cancers located in the apex, transition/central zone, and anterior zone.

Limitations

Limitations were that this was a retrospective study, the wide array of biopsy options available to compare, and different clinical settings in which they were used. Baseline characteristics differ between

groups for Prostate Imaging-Reporting and Data System[®] distribution, prostate volume, lesion size, and tumor location. Also, more needle deployments are invoked in the TP approach, resulting in a possible lower sampling efficiency and higher detection rates, and grade increase might lead to the Will Rogers phenomenon.

Interpretation for Patient Care

MRI-targeted biopsy with a TP route may improve detection of csPCa compared to the TR approach, especially for tumors located in the apex, transition/central zone, and anterior zone (see Figure). Further advantages of implementing MRI target biopsies with TP fusion software and grid-guided biopsies, in terms of csPCa detection, still need to be explored with randomized prospective studies. ■

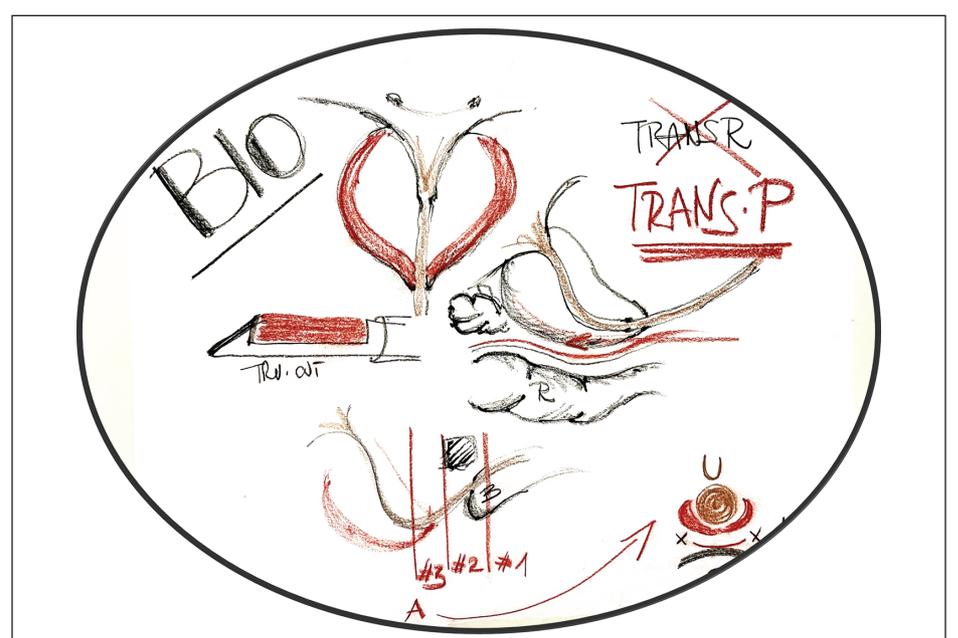


Figure. TP fusion biopsy (TRANSP) should be preferred to TR prostate biopsy (TRANSR) to increase detection of csPCa.

UPJ INSIGHT

Comparison of Patient Satisfaction and Safety Outcomes for Postoperative Telemedicine vs Face-to-Face Visits in Urology: Results of the Randomized Evaluation and Metrics Observing Telemedicine Efficacy (REMOTE) Trial

Mustufa Babar

Albert Einstein College of Medicine, Bronx, New York

Denzel Zhu, MD

Albert Einstein College of Medicine, Bronx, New York

Justin Loloj, MD

Montefiore Medical Center, Bronx, New York

Melissa Laudano, MD

Albert Einstein College of Medicine, Bronx, New York
Montefiore Medical Center, Bronx, New York

Erin Ohmann, MD

Albert Einstein College of Medicine, Bronx, New York
Montefiore Medical Center, Bronx, New York

Nitya Abraham, MD

Albert Einstein College of Medicine, Bronx, New York
Montefiore Medical Center, Bronx, New York

Alexander C. Small, MD

Albert Einstein College of Medicine, Bronx, New York
Montefiore Medical Center, Bronx, New York

Kara L. Watts, MD

Albert Einstein College of Medicine, Bronx, New York
Montefiore Medical Center, Bronx, New York

Babar M, Zhu D, Loloj J, et al. Comparison of patient satisfaction and safety outcomes for postoperative telemedicine vs face-to-face visits in urology: results of the Randomized Evaluation and Metrics Observing Telemedicine Efficacy (REMOTE) trial. *Urol Pract.* 2022;9(5)371-378.

Study Need and Importance

The recent COVID-19 pandemic dramatically heightened the role of telemedicine (TM) in health care when face-to-face (F2F) office visits were not feasible. In

turn, there is an urgent need to better understand the indications for postoperative urological F2F vs TM visits. The REMOTE (Randomized Evaluation and Metrics Observing Telemedicine Efficacy) trial was an unblinded, prospective, randomized-controlled trial assessing patient satisfaction, time and cost savings, and safety outcomes of postoperative TM vs F2F visits for adult ambulatory urological surgeries.

What We Found

A total of 76 patients were randomized to F2F followup and 89 to TM followup. Greater than 90% of patients reported feeling satisfied with their followup (F2F 98.6% vs TM 94.1%, $p=0.28$) and agreed that their followup was an acceptable form of health care (F2F 100% vs TM 92.7%, $p=0.06$; see Figure). The majority of TM patients reported that the total time associated with traveling to and attending the appointment was <15 minutes (66.2%), while the majority of F2F patients reported they spent between 1–2 hours (43.1%) attending their appointment ($p < 0.0001$). Further-

“There was no difference in the rates of 30-day safety complications between the 2 arms ($p > 0.05$).”

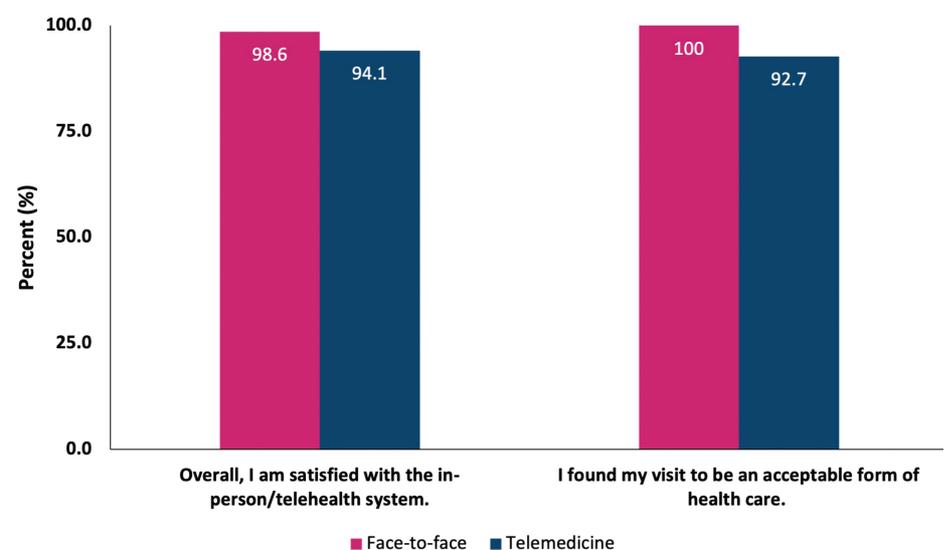


Figure. Patient satisfaction between the F2F and TM arms.

more, 44.1% of TM patients reported that they saved between \$5 and \$25 on travel costs. There was no difference in the rates of 30-day safety complications between the 2 arms ($p > 0.05$).

Limitations

Patient satisfaction was assessed by administering nonanonymous surveys through the telephone. This may introduce interviewer and response bias, and therefore may discourage patients from revealing negative feelings. Furthermore, the sample size in each arm was small, and we may see different results with larger sample sizes.

Interpretation for Patient Care

TM for postoperative visits after adult urological surgery saves patients time and money and is equiv-

“TM for postoperative visits after adult urological surgery saves patients time and money and is equivalent in safety and patient satisfaction when compared to F2F visits.”

alent in safety and patient satisfaction when compared to F2F visits. TM is a feasible option for routine postoperative care in urology and should be offered to patients as an alternative to F2F followup, even as the pandemic restrictions continue to lift. ■

JU INSIGHT

A Comparison of Percutaneous Ablation Therapy to Partial Nephrectomy for cT1a Renal Cancers: Results from the Canadian Kidney Cancer Information System

Braden Millan, MD

McMaster University, Hamilton, Ontario, Canada

Rodney H. Breau, MD

University of Ottawa, Ontario, Canada

Bimal Bhindi, MD

University of Calgary, Alberta, Canada

Ranjeeta Mallick

School of Epidemiology and Public Health, University of Ottawa, Ottawa, Ontario, Canada

Simon Tanguay, MD

McGill University, Montreal, Quebec, Canada

Antonio Finelli, MD

University of Toronto, Toronto, Ontario, Canada

Luke T. Lavallée, MD

University of Ottawa, Ontario, Canada

Frédéric Pouliot, MD

Université Laval, Quebec City, Quebec, Canada

Ricardo Rendon, MD

Dalhousie University, Halifax, Nova Scotia, Canada

Alan I. So, MD

The University of British Columbia, Vancouver, British Columbia, Canada

Lucas Dean, MD

Alberta Urology Institute Research Center, University of Alberta, Edmonton, Canada

Jean-Baptiste Lattouf, MD

University of Montreal, Montreal, Quebec, Canada

Naveen S. Basappa, MD

University of Alberta, Cross Cancer Institute, Edmonton, Canada

Anil Kapoor, MD

McMaster University, Hamilton, Ontario, Canada

Millan B, Breau RH, Bhindi B, et al. A Comparison of Percutaneous Ablation Therapy to Partial Nephrectomy for cT1a Renal Cancers: Results from the Canadian Kidney Cancer Information System. *J Urol.* 2022;208(4):804-812.

Study Need and Importance

Percutaneous ablation therapy (AT) and partial nephrectomy (PN) are accepted treatments for T1a renal cancer; however, the strength of evidence comparing these remains limited by patient selection bias. Furthermore, randomized feasibility studies have shown poor recruitment rates with early trial termination. As such, large multicenter observational studies remain the highest

“Percutaneous ablation therapy (AT) and partial nephrectomy (PN) are accepted treatments for T1a renal cancer; however, the strength of evidence comparing these remains limited by patient selection bias. Furthermore, randomized feasibility studies have shown poor recruitment rates with early trial termination”

level of evidence comparing these treatments.

What We Found

In a large multi-institutional prospective cohort, as expected, significant clinical selection bias was present for patients who received AT (275 patients) compared to PN (2,001). Using propensity score adjustment, we reduced the effect of selection bias, which is reflected in similar overall survival between propensity-adjusted cohorts (5-year overall survival was 94.2% and 95.1% for AT and PN, respectively; $p=0.7$). Risk of recurrence, although low with both approaches, was significantly higher in those treated with AT compared to PN, with a 5-year recurrence-free survival following propensity score adjustments of 86.0% and 95.1%, respectively ($p=0.003$).

Limitations

In observational studies, the allocation of patients to treatment groups is impacted by patient and physician factors. Historically, and as we observed, AT cohorts are enriched with patients with shorter life expectancy due to more advanced age and increased comorbidities compared to PN cohorts. Using propensity score adjustment, we reduced this confounding, although residual confounding due to unmeasured factors such as tumor location and complexity may remain. Relatively short followup

“Historically, and as we observed, AT cohorts are enriched with patients with shorter life expectancy due to more advanced age and increased comorbidities compared to PN cohorts. Using propensity score adjustment, we reduced this confounding, although residual confounding due to unmeasured factors such as tumor location and complexity may remain.”

and loss to followup are also limitations to these data.

Interpretation for Patient Care

Recurrence rates after AT and PN for pT1a renal cancers are low. In a large multicenter prospective cohort, patients receiving AT had a higher risk of recurrence compared to PN. ■

UPJ INSIGHT

Gender and Racial Diversity among U.S. Urology Residency Programs and Efforts to Improve it: You Can't Be What You Can't See

Charles R. Powell, MD

Indiana University School of Medicine,
Indianapolis

Anne P. Cameron, MD

The University of Michigan, Ann Arbor

Meidee Goh, MD

The University of Michigan, Ann Arbor

Chemen Neal, MD

Indiana University School of Medicine,
Indianapolis

Richard Memo, MD

N.E.O. Urology, Boardman, Ohio

Kyle A. Richards, MD

The University of Wisconsin-Madison

Powell CR, Cameron AP, Goh M, Neal C, Memo R, Richards KA. Gender and racial diversity among U.S. urology residency programs and efforts to improve it: you can't be what you can't see. *Urol Pract.* 2022;9(5)466-473.

Study Need and Importance

The United States urology workforce lacks ethnic, racial and gender diversity. This lack of diversity may negatively impact the delivery of high-quality urological care across a broad spectrum of demographics. The aim of this study was to assess the landscape of programs that have been created to increase diversity at the institutional level and assess the attitudes and concerns of underrepresented in medicine (URiM) and female students.

What We Found

The response rate for the program directors survey was 43%. Most urology programs offer a wide array of initiatives to increase diversity, with unconscious bias training being the most frequent

(78.7%). Programs with no female faculty or no URiM faculty had a very difficult time matching female (see Figure) or URiM medical students over time. The response rate for the medical student survey was 10.5%. A majority of these respondents (79.2%) were unaware of any programs geared toward URiM or female students at their institutions. Match data from 2019 to 2021 revealed that female applicants were more likely to match, but URiM applicants were less likely to match.

Limitations

This study is limited by its design, as the data collected were largely via surveys, which can lead to responder bias. The response rate

“Most urology programs offer a wide array of initiatives to increase diversity, with unconscious bias training being the most frequent (78.7%). Programs with no female faculty or no URiM faculty had a very difficult time matching female (see Figure) or URiM medical students over time.”

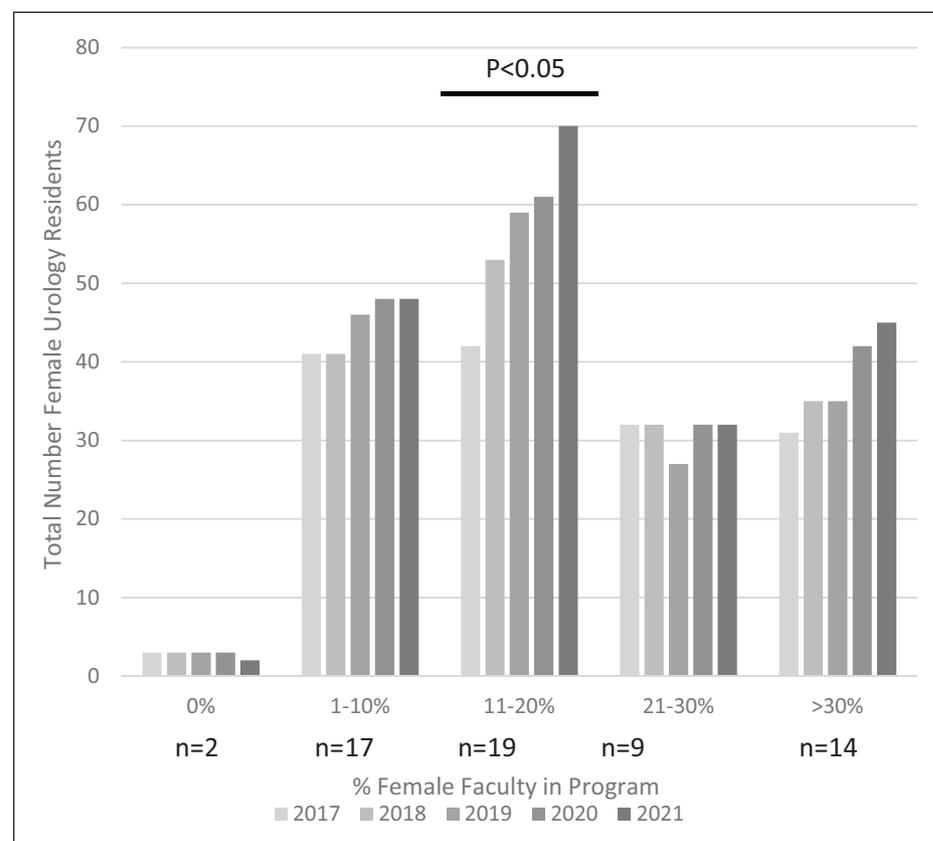


Figure. Proportion of female urology faculty compared to female residents over time. All programs having at least 1 female faculty member were able to recruit female residents more effectively than programs with none. Programs with 11%–20% female faculty exhibited significant year-to-year growth from 2017 to 2021 ($p < 0.05$).

was low for students and therefore may not be as generalizable. The 2021 Match rates may have been influenced by the virtual interview process and could have had a negative impact on URiM students.

Interpretation for Patient Care

Urology programs are making substantive efforts to improve diversity, but the message may not be reaching its intended audience. Having a diverse faculty does seem to help in recruitment of a diverse group of residents. Organized urology should be leading the way to create a more diverse

“Organized urology should be leading the way to create a more diverse workforce to match the needs of the changing demographics of the United States.”

workforce to match the needs of the changing demographics of the United States. ■

JU INSIGHT

Survival Impact of Variant Histology Diagnosis in Upper Tract Urothelial Carcinoma

Lucas M. Nogueira, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Wesley Yip, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Melissa J. Assel, MS

Memorial Sloan Kettering Cancer Center, New York, New York

Andrew T. Tracey, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Nathan C. Wong, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Ricardo G. Alvim, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Hikmat Al-Ahmadie, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Dean F. Bajorin, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Jonathan A. Coleman, MD

Memorial Sloan Kettering Cancer Center, New York, New York

Nogueira LM, Yip W, Assel MJ, et al. Survival impact of variant histology diagnosis in upper tract urothelial carcinoma. *J Urol.* 2022;208(4):813-820.

Study Need and Importance

Variant histology is present in up to a third of bladder cancer cases, which is associated with adverse pathological features and worse oncologic outcomes. The impact of variant histology in upper tract urothelial carcinoma (UTUC) is still not well defined, and most disease management is extrapolated from the bladder cancer data. As diagnosis of variant histology is in-

“Variant histology is present in up to a third of bladder cancer cases, which is associated with adverse pathological features and worse oncologic outcomes.”

creasing in UTUC, it is important to define its impact on patient outcomes to help tailor disease management, adjuvant therapy, and followup strategy. In this study, we sought to evaluate the impact of variant histology pathological diagnosis on survival outcomes at our institution.

What We Found

We included 705 unique radical nephroureterectomy patients in our analysis, of whom 47 patients (6.7%) had variant histology in their specimens. A higher proportion of cases was diagnosed after the departmental subspecialization of genitourinary pathologists. The presence of variant histology was associated with an increased risk for the outcome of both cancer-specific and overall survival. However, after adjusting for pathological T stage, variant histology was not significantly associated with survival outcomes (see Figure).

Limitations

Our study is limited by the homogeneity of data afford-

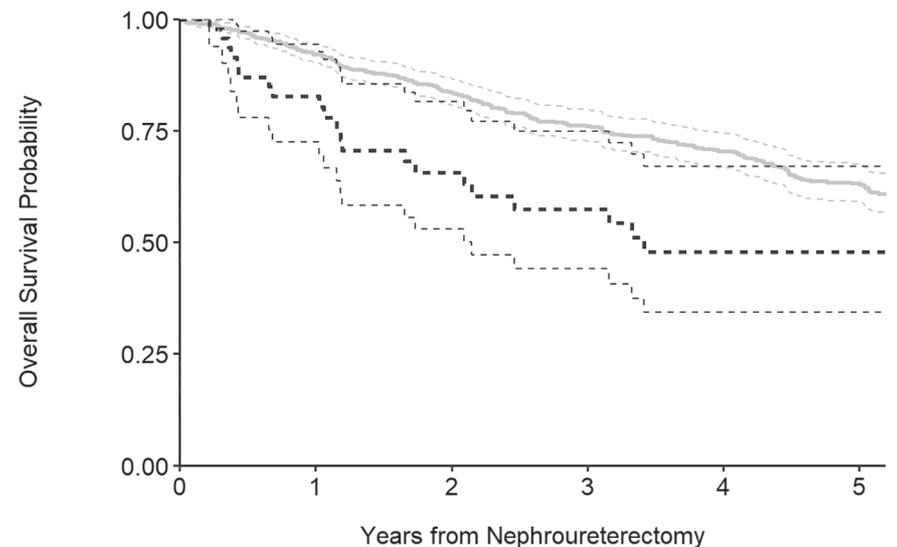


Figure. Kaplan-Meier plot for overall survival after nephroureterectomy, separately for patients with no variant histology (gray line) and those with any variant histology on pathology (black line).

ed by a single-institution study, and patients selected for radical nephroureterectomy usually present with more advanced and aggressive disease. We relied on pathological findings at the time of initial surgery and re-review was not performed, which might impact the observed prevalence of histological subtypes.

Interpretation for Patient Care

Data from this series suggest that variant histology in UTUC is a useful biomarker associated with higher stage and poor oncologic outcomes when pathological stage is unknown, such as in the pretreatment biopsy setting. However, finding variant histology on surgical pathology does not provide additional prognostic information beyond

“Data from this series suggest that variant histology in UTUC is a useful biomarker associated with higher stage and poor oncologic outcomes when pathological stage is unknown, such as in the pretreatment biopsy setting.”

TNM staging risk after nephroureterectomy. ■

UPJ INSIGHT

Cost Implications of Routine Preoperative Blood Typing and Crossmatching Prior to Robot-Assisted Laparoscopic Partial Nephrectomy

Matthew M. Banti, MD

University of Kansas Health System, Kansas City

Atiyeh Samadi, MS

University of Kansas School of Medicine, Kansas City

Mihaela E. Sardi, PhD

University of Kansas Medical Center, Kansas City

Hadley Wyre, MD

University of Kansas Health System, Kansas City

Moben Mirza, MD

University of Kansas Health System, Kansas City

David Duchene, MD

University of Kansas Health System, Kansas City

Jeffrey M. Holzbeierlein, MD

University of Kansas Health System, Kansas City

Eugene K. Lee, MD

University of Kansas Health System, Kansas City

Banti MM, Samadi A, Sardi ME, et al. Cost implications of routine preoperative blood typing and crossmatching prior to robot-assisted laparoscopic partial nephrectomy. *Urol Pract.* 2022;9(5)357-363.

Study Need

Robot-assisted laparoscopic partial nephrectomy (RAPN) is asso-

ciated with a lower transfusion risk than open partial nephrectomy. The extent of preoperative blood typing and crossmatching necessary for patients undergoing RAPN remains unknown. Routine preoperative testing is associated with significant financial cost. In this study, we aimed to define the perioperative transfusion rate in a high-volume RAPN practice, the factors that portend this outcome and the monetary resources involved.

What We Found

In 804 patients undergoing RAPN in a large academic practice, the observed rate of perioperative transfusion was 1.1%. No significant difference in tumor size, stage or location was observed between transfused and nontransfused patients. Multiple variables were shown to have predictive capacity using logistic regression (see Table). Routine blood typing and crossmatching cost \$1,320 U.S. dollars per patient, with a scaled cost of \$1,061,280 for the entire cohort.

Table. Logistic regression for predictive capacity

Variable	Odds Ratio (95% CI)	p Value
Estimated blood loss (ml)	1.01 (1.00–1.01)	0.001
Nephrometry score	1.47 (1.01–2.22)	0.05
Preop hemoglobin	0.51 (0.34–0.73)	0.0006
Preop hematocrit	0.77 (0.65–0.88)	0.0007

“No significant difference in tumor size, stage or location was observed between transfused and nontransfused patients.”

Limitations

The study was performed using retrospective data, which have inherent limitations. The vast majority of RAPN procedures were performed for stage 1 renal mass-

es, and our conclusions may not be applicable to practices that utilize RAPN for patients with higher-complexity tumors. Hospital charges differ greatly between institutions, and cost savings may vary.

Implications for Patient Care

This study indicates that routine blood typing and crossmatching may not benefit most patients undergoing RAPN due to the low observed transfusion rate. Tumor complexity and the presence of preoperative anemia are factors that can be identified before surgery and should be used to guide the extent of preoperative testing. ■

JU INSIGHT

Intravesical Instillation of OnabotulinumtoxinA in the Treatment of Refractory Overactive Bladder in Participants with Urinary Incontinence

Christopher J. Chermansky, MD

University of Pittsburgh Medical Center, Pennsylvania

Holly E. Richter, PhD, MD

University of Alabama at Birmingham

Karny Jacoby, MD

Overlake Hospital Medical Center & Clinics, Kirkland, Washington

Wilson Titanji, PhD

Allergan, an AbbVie company, Irvine, California

Brenda Jenkins, BS

Allergan, an AbbVie company, Irvine, California

Till Geib, PhD

Allergan, an AbbVie company, Irvine, California

Benjamin M. Brucker, MD

NYU Langone Health, New York, New York

Chermansky CJ, Richter HE, Jacoby K, et al. Intravesical instillation of onabotulinum-

toxinA in the treatment of refractory overactive bladder in participants with urinary incontinence. *J Urol.* 2022;208(4)855-862.

Study Need and Importance

Intradetrusor injections of on-

abotulinumtoxinA are efficacious for the treatment of adults with urgency urinary incontinence from overactive bladder refractory to or intolerant of anticholinergics. Intravesical instillation an admixture of onabotulinumtoxinA and hydrogel via instillation was

→ Continued on page 13

INTRAVESICAL INSTILLATION OF ONABOTULINUMTOXINA

→ Continued from page 12

expected to allow for prolonged drug residence time in the bladder thereby allowing delivery into the bladder wall. This was hoped to result in a more accessible, simpler, and convenient mode of administration compared to intradetrusor injections, and it was hoped that this delivery would result in lower rates of urinary retention and urinary tract infection.

What We Found

Intravesical onabotulinumtoxinA and hydrogel admixture was well tolerated across treatment arms of different doses, with no indication of a safety dose response. Asymptomatic bacteriuria was the most frequently reported adverse event (6.7%–15.5%). There were no reports of urinary retention or elevated post-void residual volume. No active treatment arm separated from placebo for any of the efficacy end points. Change from baseline to week 12 for the primary end point of num-

ber of urinary incontinence episodes was -2.72 with placebo and ranged from -0.89 to -1.85 in the onabotulinumtoxinA + hydrogel treatment groups (see Figure).

Limitations

A limitation of this trial was the small number of male patients, which was to be expected in an overactive bladder study requiring treatment through a transurethral catheter.

Interpretation for Patient Care

This multicenter trial showed that intravesical instillation of an onabotulinumtoxinA + hydrogel admixture for the treatment of urgency urinary incontinence from overactive bladder was well tolerated; however, it had little observed efficacy and it had a high placebo response. The observed lack of efficacy might be due to the very large

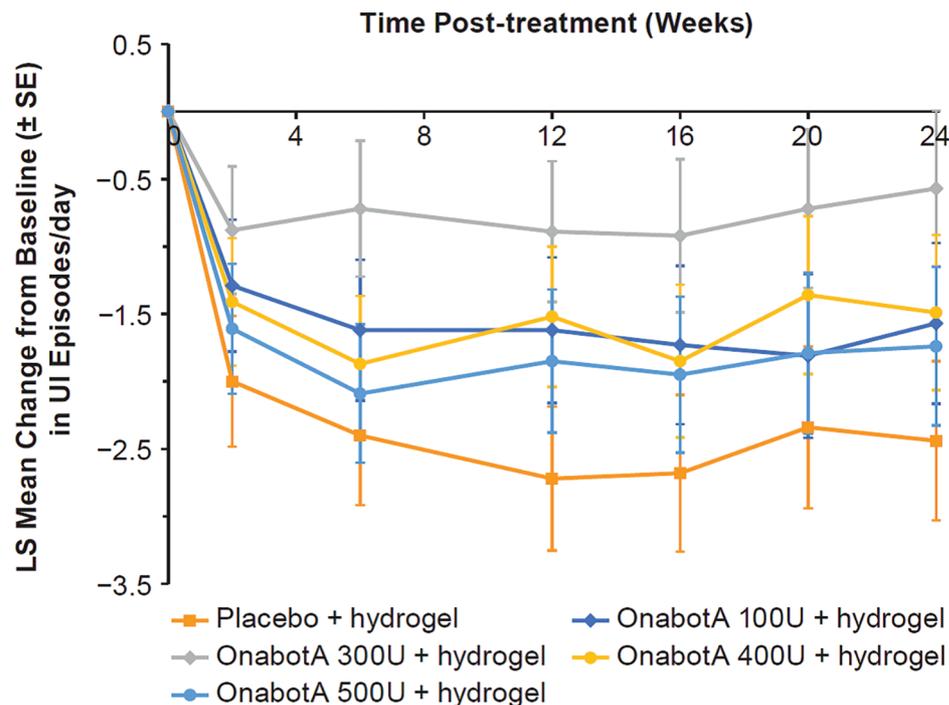


Figure. Change in urinary incontinence (UI) episodes/day over time (primary end point). For all dose groups vs placebo at the primary time point of week 12, $p > 0.05$, except 300 U onabotulinumtoxinA (OnabotA) + hydrogel versus placebo + hydrogel, for which $p = 0.0041$. LS, least squares.

size of onabotulinumtoxinA (approximately 900 kDa), too large to diffuse across the urothelium. Future injection-free studies for

the delivery of onabotulinumtoxinA to the bladder should focus on a more effective delivery method. ■

UPJ INSIGHT

Advanced Practice Providers and Wait Times in Urology Offices: A Secret Shopper Study

Armaan Singh, BA
Pritzker School of Medicine, University of Chicago, Illinois

Jared W. Lassner, BA
Pritzker School of Medicine, University of Chicago, Illinois

Marc G. Sleiman, BS
Pritzker School of Medicine, University of Chicago, Illinois

Ashley Diaz, BS
Pritzker School of Medicine, University of Chicago, Illinois

Susanne Quallich, PhD, ANP-BC, NP-C, CUNP, FAANP
Michigan Medicine, Ann Arbor

Parth K. Modi, MD, MS
University of Chicago Medicine, Illinois

Singh A, Lassner JW, Sleiman MG, Diaz A, Quallich S, Modi PK. Advanced practice providers and wait times in urology offices: a secret shopper

study. *Urol Pract.* 2022;9(5)389-395.

Study Need and Importance

Almost three-quarters of urologists in the United States work directly with an Advanced Practice Provider (APP), such as a nurse practitioner or physician assistant. However, the impact of APPs on improving new patient access is not well understood.

In this study, we examined the impact of APPs on new patient wait times in a real-world sample of urology offices. To simulate a real-world scenario, we used a simulated patient (or “secret-shopper”) methodology to

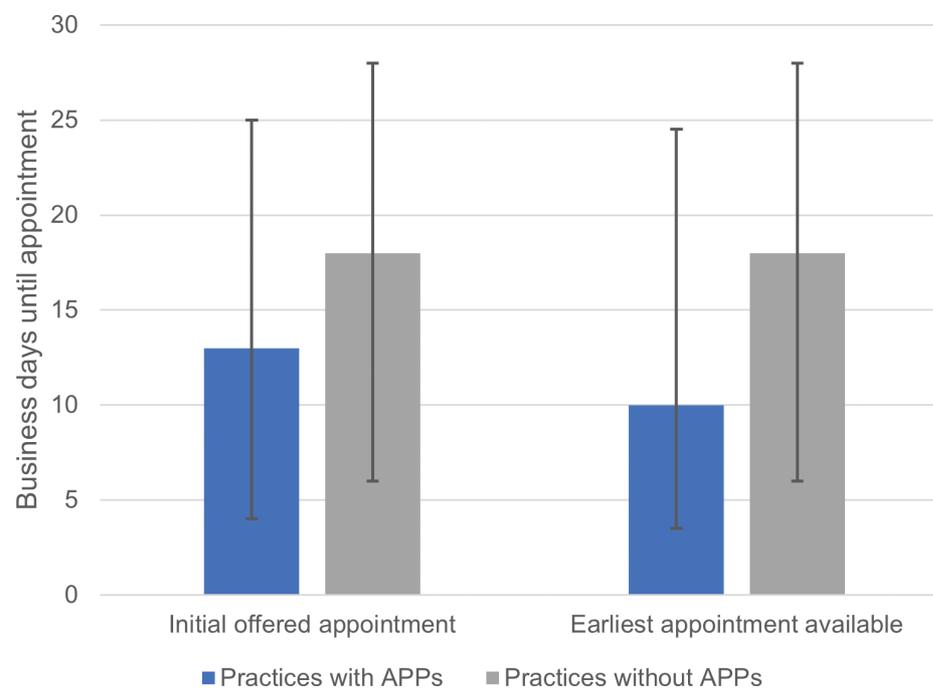


Figure. Median wait times for initial offered appointment and earliest appointment available, based on practice type. Error bars represent 25th and 75th percentile.

→ Continued on page 14

ADVANCED PRACTICE PROVIDERS AND WAIT TIMES IN UROLOGY OFFICES

→ Continued from page 13

collect data regarding wait times and provider type for new patient office visits.

What We Found

Of 86 urology offices in the Chicago metropolitan area with which we scheduled appointments, 55 (64%) employed at least 1 APP but only 18 (21%) allowed for new patient

appointments with APPs. When the earliest appointment regardless of provider type was requested, offices with APPs could offer shorter wait times compared to physician-only offices (10 vs 18 days; $p=0.09$; see Figure). Offices offering initial appointments with an APP were available with a significantly shorter wait than those with a physician (5 vs 15 days; $p=0.04$).

Limitations

This study was limited to a chief complaint of gross hematuria, which may not be generalizable to all new patient visits in urology. Further, our study does not address the quality of care or appropriateness of new patient visits with APPs. These issues are essential to further understanding the role of APPs in the urological workforce.

Interpretations for Patient Care

Our results highlight the prevalence of APP employment in urology offices coupled with low use in new patient visits. There may be unrealized opportunities for urologists to improve patient access by offering new patient appointments with APPs. ■

JU INSIGHT

Risk of Postoperative Thromboembolism in Men Undergoing Urological Prosthetic Surgery: An Assessment of 21,413 Men

Kevin J. Hebert, MD
University of Utah, Salt Lake City

Rano Matta, MD, MSc
University of Utah, Salt Lake City

Joshua J. Horns, PhD
University of Utah, Salt Lake City

Niraj Paudel, MS
University of Utah, Salt Lake City

Rupam Das, MBA, MS
University of Utah, Salt Lake City

Tobias S. Kohler, MD, MPH
Mayo Clinic, Rochester, Minnesota

Alexander W. Pastuszak, MD, PhD
University of Utah, Salt Lake City

Benjamin J. McCormick, MD
University of Utah, Salt Lake City

James M. Hotaling, MD, MS
University of Utah, Salt Lake City

Jeremy B. Myers, MD
University of Utah, Salt Lake City

Hebert KJ, Matta R, Horns JJ, et al. Risk of postoperative thromboembolism in men undergoing urological prosthetic surgery: an assessment of 21,413 men. *J Urol*; 2022;208(4):878-885.

Study Need and Importance

There are a lack of guideline-based recommendations on perioperative venous thromboembolism (VTE) prophylaxis in the

Table. Multivariable model for incidence of DVT or PE in the AUS and IPP cohorts

Cofactor	AUS Surgery			IPP Surgery		
	HR	95% CI	p Value	HR	95% CI	p Value
Region:			0.8			0.8
Midwest	0.72	0.34–1.52	0.4	0.83	0.53–1.32	0.4
South	0.87	0.44–1.70	0.7	0.78	0.51–1.19	0.2
West	0.63	0.27–1.46	0.3	0.82	0.46–1.46	0.5
Other	0.89	0.12–6.90	0.9	1.12	0.34–3.68	0.9
Bladder Ca	1.21	0.58–2.54	0.6	0.79	0.32–1.96	0.6
Prostate Ca	1.41	0.73–2.73	0.3	1.16	0.81–1.65	0.4
Prostatectomy	0.32	0.15–0.68	0.003	0.65	0.38–1.13	0.13
Diabetes mellitus	1.27	0.76–2.10	0.4	0.74	0.53–1.02	0.067
Peripheral vascular disease	0.49	0.21–1.20	0.11	1.08	0.71–1.64	0.7
Cardiovascular disease	0.82	0.49–1.37	0.5	1.22	0.88–1.71	0.2
Hypertension	1.17	0.64–2.12	0.6	1.16	0.79–1.72	0.4
Varicose veins	2.76	1.12–6.79	0.02	0.92	0.50–1.71	0.8
Smoking	0.54	0.19–1.55	0.3	0.91	0.55–1.51	0.7
Previous DVT	13.7	7.40–25.19	<0.001	12.6	7.99–19.93	<0.001
Previous PE	7.65	4.01–14.60	<0.001	8.90	5.60–14.13	<0.001
Age	0.99	0.97–1.02	0.6	0.99	0.99–1.01	0.5

Effect of region relative to Northeast; effect of comorbidities relative to patients without; effect of age effect of 1-year increase at time of surgery. Statistically significant results in bold.

tificial urinary sphincter (AUS) and inflatable penile prosthesis (IPP) surgery populations. Previous attempts to characterize VTE risk in this population have been limited by underpowered studies. Given the

elective nature of urological prosthetic surgery, accurate estimates of postoperative morbidity are important not only to appropriately counsel patients in the preoperative setting, but also to mitigate risk.

What We Found

Among 4,870 men undergoing AUS surgery and 16,543 men

→ Continued on page 15

RISK OF POSTOPERATIVE THROMBOEMBOLISM IN MEN UNDERGOING UROLOGICAL PROSTHETIC SURGERY

→ Continued from page 14

undergoing IPP surgery, the prevalence of preoperative VTE was 3.7% and 2.6%, respectively. Within 90 days of surgery, deep vein thrombosis (DVT) and/or pulmonary embolism (PE) occurred in 1.54% (AUS) and 1.04% (IPP) of cases. Preoperative variables independently associated with increased risk of postoperative VTE included prior history of PE (HR 7.7 AUS; HR 8.9 IPP), DVT (13.7 AUS; 12.6 IPP), and varicose

veins (HR 2.8, AUS; see Table).

Limitations

While utilization of an insurance claims database allows followup across hospital systems, its main limitation relates to the lack of access to individual patient medical records. Likewise, this study population is limited to men with health insurance and may not adequately represent risk in

“Our findings reveal a higher than expected risk of postoperative DVT and PE following AUS and IPP surgery.”

men without insurance.

Interpretation for Patient Care

Our findings reveal a higher than expected risk of postoperative DVT and PE following AUS and IPP surgery. Preoperative risk stratification should be considered as men with a prior history of DVT, PE, and varicose veins appear to be at highest risk for postoperative VTE and may benefit from perioperative VTE prophylaxis. ■

UPJ INSIGHT

Professional Burnout of Advanced Practice Providers Based on 2019 American Urological Association Census Data

Kavita Gupta, MD

Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, New York

Kevin Tang, MS

Albert Einstein College of Medicine, Bronx, New York

Justin Loloi, MD

Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, New York

Raymond Fang

Data and Statistics, American Urological Association, Linthicum, Maryland

William Meeks

Data and Statistics, American Urological Association, Linthicum, Maryland

Amanda North, MD

Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, New York

Gupta K, Tang K, Loloi J, Fang R, Meeks W, North A. Professional burnout of advanced practice providers based on 2019 American Urological Association census data. *Urol Pract.* 2022;9(5)491-497.

Study Need and Importance

Burnout has been recognized as an occupational hazard among health care professionals. Ad-

vanced practice providers (APPs), specifically nurse practitioners or physician assistants, have increased in both number and practice responsibilities in urological care in the past 20 years. However, unlike physician burnout, there is a relative paucity of information regarding incidence and factors associated with burnout among APPs. The increasing presence of APPs in medical practice has prompted a need to investigate burnout in this population.

What We Found

We found that in 199 APPs, slightly more than 1 in 4 APPs experienced professional burnout. Observed higher burnout rates were seen in APPs who were aged 45 to 54 (34.3%), women (29.6% vs 10.8% in men, p value <0.05), non-White (33.3% vs 24.9% in White), those who had 4–9 years of practice (32.4%) and those who practiced in academic medical centers (31.7%). Except for gender, none of the above observed differences were statistically significant. Using a

“Burnout has been recognized as an occupational hazard among health care professionals. Advanced practice providers (APPs), specifically nurse practitioners or physician assistants, have increased in both number and practice responsibilities in urological care in the past 20 years.”

multivariate logistic regression model, gender remained the only significant factor associated with burnout.

Limitations

First, samples from APPs were directly analyzed without the adjustment for nonresponse bias. Therefore, the rates of burnout may be underrepresented due to the nonresponses. Second, there was a relatively small sample size, which may only help draw conclusions on the APPs who participated in the American Urological Association Census. Thus, the findings in this report may not be generalizable to APPs in other specialties or APPs in urology at large.

Interpretation for Patient Care

Burnout has been well recognized as a problem in urology. APPs, who have played an important role in the fight against physician burnout, are also prone to burnout. Thus, addressing burnout among APPs will be an important part of retaining APPs in the workforce, especially as there is an increased demand for APPs to provide care for patients. ■

JU INSIGHT

Neoadjuvant Novel Hormonal Therapy Followed by Prostatectomy versus Up-Front Prostatectomy for High-Risk Prostate Cancer: A Comparative Analysis

Praful Ravi, MB, BChir

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Lucia Kwak, MS

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Wanling Xie, MS

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Kaitlin Kelleher, MD

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Andres M. Acosta, MD

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Rana R. McKay, MD

University of California, San Diego, La Jolla

Adam S. Kibel, MD

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Mary-Ellen Taplin, MD

Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts

Ravi P, Kwak L, Xie W, et al. Neoadjuvant novel hormonal therapy followed by prostatectomy versus up-front prostatectomy for high-risk prostate cancer: a comparative analysis. *J Urol*. 2022;208(4):838-845.

Study Need and Importance

Neoadjuvant therapy has been proposed as a means to improve outcomes in men with high-risk prostate cancer (HRPC). Though trials evaluating neoadjuvant androgen deprivation therapy did not show improved survival compared to radical prostatectomy (RP) alone, encouraging rates of pathological response have been seen in recent phase 2 trials evaluating novel hormonal agents (NHAs). These have led to the ongoing phase 3 PROTEUS trial where men with HRPC are randomized to neoadjuvant (and adjuvant) androgen deprivation therapy with

or without apalutamide. However, this study will not directly compare outcomes between neoadjuvant therapy and up-front RP. We therefore assessed oncologic outcomes in a cohort of patients with HRPC treated on a clinical trial at our institution with a neoadjuvant NHA (neo-RP, 112) and a comparator cohort of patients who received up-front RP (259), and used the inverse probability of treatment weighting (IPTW) method to minimize confounding between the 2 cohorts.

What We Found

Median followup after RP was 4 years in both cohorts. After IPTW, time to biochemical recurrence was significantly longer in the neo-RP group compared to the RP group (HR=0.25,

“Though trials evaluating neoadjuvant androgen deprivation therapy did not show improved survival compared to radical prostatectomy (RP) alone, encouraging rates of pathological response have been seen in recent phase 2 trials evaluating novel hormonal agents (NHAs).”

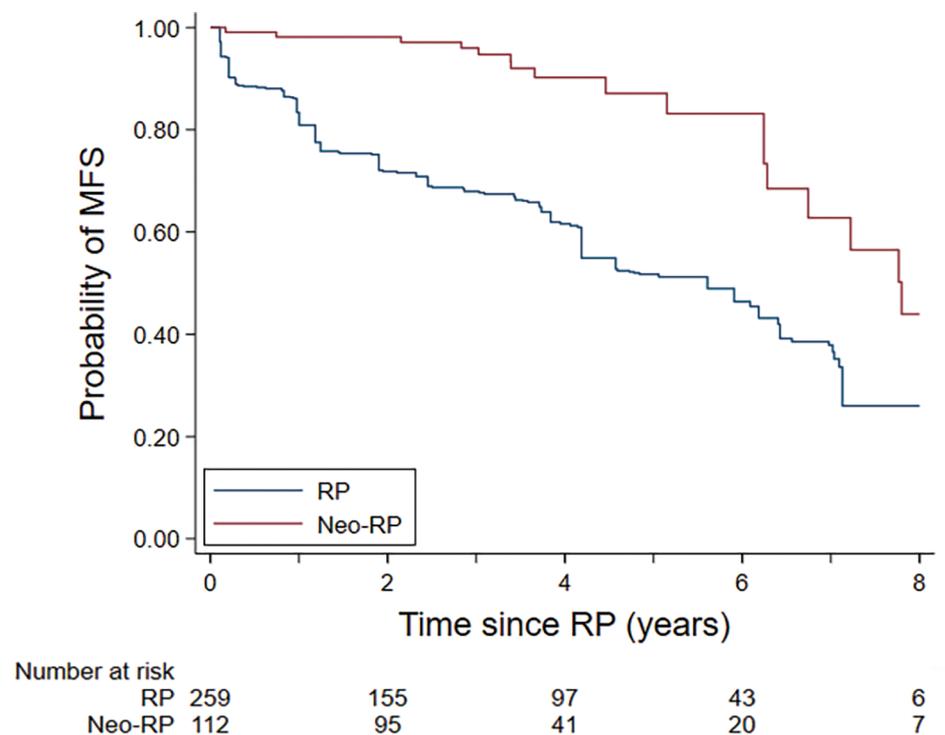


Figure. MFS in the neo-RP and RP cohorts after IPTW. The number of participants at risk is based on unweighted population.

$p < 0.01$). The neo-RP group had significantly improved metastasis-free survival (MFS; HR=0.26, $p < 0.01$), with a 3-year MFS of 96% compared to 68% in the RP group (see Figure).

Limitations

This was a comparative analysis between a clinical trial cohort (neo-RP) and an observational, retrospective cohort (RP) and there are likely unmeasured confounders beyond those addressed by IPTW. There was selection bias in that the RP group met eligibility criteria for the neoadjuvant trials but underwent up-front RP.

Interpretation for Patient Care

Neoadjuvant therapy with an NHA significantly improved oncologic outcomes compared to up-front RP for men with HRPC.

“This was a comparative analysis between a clinical trial cohort (neo-RP) and an observational, retrospective cohort (RP) and there are likely unmeasured confounders beyond those addressed by IPTW.”

These are hypothesis-generating findings and need validation in a randomized trial before neoadjuvant therapy can become a standard-of-care in the treatment of HRPC. ■

UPJ INSIGHT

Associations between Race and Erectile Dysfunction Treatment Patterns

Tony Chen, MD

Stanford University School of Medicine, California

Shufeng Li, MS

Stanford University School of Medicine, California

Michael L. Eisenberg, MD

Stanford University School of Medicine, California

Chen T, Li S, Eisenberg ML. Associations between race and erectile dysfunction treatment patterns. *Urol Pract.* 2022;9(5):423-430.

Study Need and Importance

Erectile dysfunction (ED) is a highly prevalent condition that affects over 50% of men over the age of 40. Fortunately, there are many effective and readily available treatments for ED that range from oral medications to surgical intervention. Previous studies have shown that racial differences exist for ED risk factors, incidence, as well as severity, but none have examined whether these differences influence how men might receive treatment for ED. In this study, we sought to investigate whether there are racial differences in the types of ED treatments men receive.

What We Found

We analyzed administrative claims data from over 800,000 men in the United States between 2003 and 2018, out of which 3.1% of were Asian, 10.5% were African American, 11.5% were Hispanic and 74.9% were Caucasian. After controlling for certain patient comorbidity and socio-demographic factors, we found that compared to Caucasians, Asian and Hispanic men had a lower probability of receiving any ED treatment, while African Americans had a higher probability. Asian and Hispanic men also tended to have longer delays to receiving ED treatment after (see Figure).

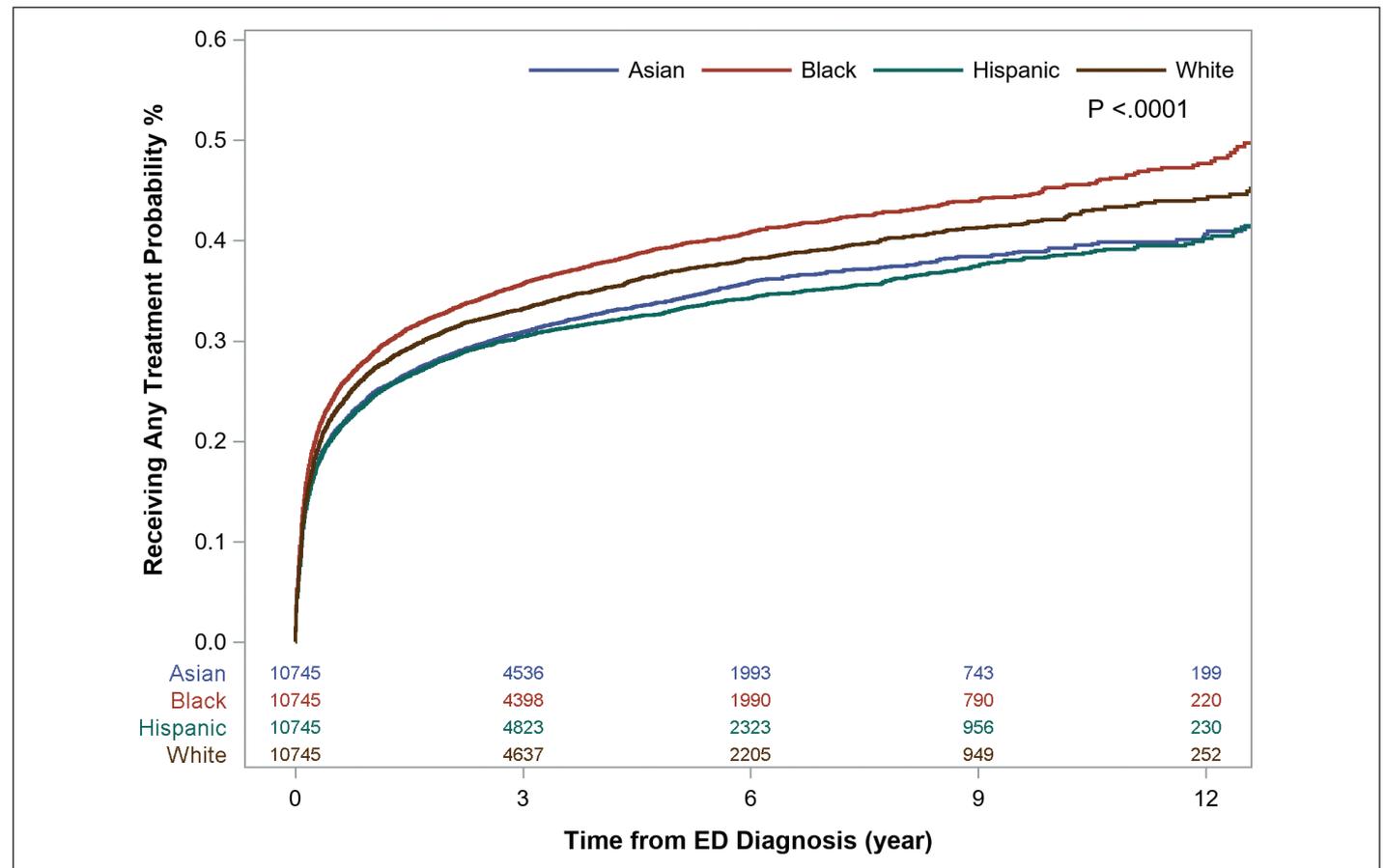


Figure. Kaplan-Meier curves for time to receiving any ED treatment for erectile dysfunction treatment by race.

“After controlling for certain patient comorbidity and sociodemographic factors, we found that compared to Caucasians, Asian and Hispanic men had a lower probability of receiving any ED treatment, while African Americans had a higher probability.”

Limitations

As with any administrative claims data research, our analysis is dependent on accurate coding of diagnoses and treatments, and doesn't capture treatments not paid for by commercial or Medicare insurers. Available racial categories used in population-based research are imperfect embodiments of identity and will often lack granular variables like preferred language. Finally, causality cannot be inferred from the retrospective nature of this work.

Interpretations for Patient Care

The results of this study demonstrate that there exist racial differ-

“The results of this study demonstrate that there exist racial differences in how men are receiving treatments for ED.”

ences in how men are receiving treatments for ED. This study may hopefully serve as an impetus to further investigate factors that may influence patient decision making regarding ED treatment, as well as potential barriers to seeking ED treatment. ■

JU INSIGHT

Dementia Associated with Anticholinergic Drugs Used for Overactive Bladder: A Nested Case-Control Study Using the French National Medical-Administrative Database

Marie France Malcher, MD, MSc
CHU Nîmes, University of Montpellier,
France

Stephane Droupy, MD, PhD
CHU Nîmes, University of Montpellier,
France

Claudine Berr, MD, PhD
University of Montpellier, INSERM, INM (Institute
for Neurosciences of Montpellier), France

Abdelkrim Ziad, MD, PhD
ClinSearch-110, Malakoff, France

Helena Huguet, MSc
CHU de Montpellier, University of Montpellier,
France

Jean-Luc Faillie, MD, PhD
CHU Montpellier University Hospital,
France
Institute Desbrest of Epidemiology and Public Health,
UMR UAT11 INSERM, University of Montpellier,
France

Chris Serrand, MD, MSc
CHU Nîmes, University of Montpellier,
France

Thibault Mura, MD, PhD
CHU Nîmes, University of Montpellier,
France
University of Montpellier, INSERM, INM (Institute
for Neurosciences of Montpellier), France

Malcher MF, Droupy S, Berr C, et al. Dementia associated with anticholinergic drugs used for overactive bladder: a nested case-control study using the french national medical-administrative database. *J Urol.* 2022;208(4):863-871.

Study Need and Importance

Overactive bladder (OAB) is a common condition in older patients, for which first-line treatment includes anticholinergic drugs. However, these drugs are suspected of increasing the risk of dementia. The American Urological Association has highlighted the lack of stud-

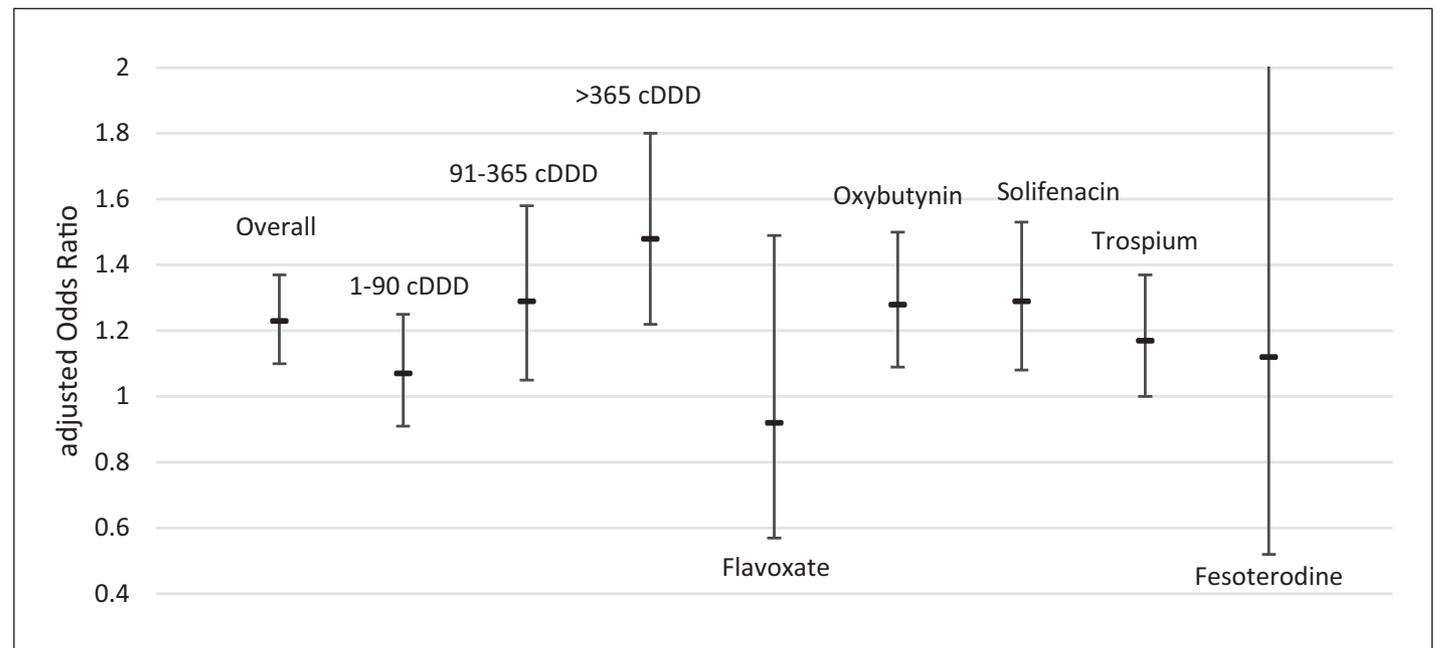


Figure. Association between OAB anticholinergic drugs and dementia (adjusted OR with 95%CI).

ies on the long-term cognitive effects of OAB anticholinergic drugs overall and for each drug separately.

What We Found

In our nested case-control study using the French National Medical-Administrative Database, cumulative use of OAB anticholinergic drugs over a 5-year period was associated with an increased risk of dementia (adjusted OR=1.23). Furthermore, we found a cumulative dose-response relationship: aOR=1.07 for 1-90 cumulative defined daily doses (cDDD) over the exposure period, aOR=1.29 for 91-365 cDDDs, and aOR=1.48 for >365 cDDDs. Oxybutynin showed a particularly marked increased risk of dementia (aOR=1.28), followed by solifenacin (aOR=1.29), but trospium showed no statistically sig-

“Overactive bladder (OAB) is a common condition in older patients, for which first-line treatment includes anticholinergic drugs. However, these drugs are suspected of increasing the risk of dementia.”

nificant increased risk (aOR=1.17; see Figure).

Limitations

The limitations of our study are

due to the medical-administrative nature of the data. Although we had complete information of drug dispensing, we lacked information on treatment adherence, and so cannot exclude misclassification bias. In addition, our analyses were adjusted for available potential confounders; however, we may have missed important confounders and others may have been imperfectly reported.

Interpretation for Patient Care

When treating OAB in older patients, OAB anticholinergic drugs should be used with caution, taking into account the patient's cognitive status, the anticholinergic load, and the different therapeutic options, especially for oxybutynin and solifenacin. ■

UPJ INSIGHT

Naloxegol versus Alvimopan for Enhancing Postoperative Recovery following Radical Cystectomy for Bladder Cancer

Peter S. Kirk, MD, MS
University of Washington, Seattle

Austin Wang, PharmD
University of Washington, Seattle

Dima Raskolnikov, MD
University of Washington, Seattle

Sarah P. Psutka, MD, MSc
University of Washington, Seattle

John L. Gore, MD, MS
University of Washington, Seattle

Yaw A. Nyame, MD, MS, MBA
University of Washington, Seattle
Fred Hutchinson Cancer Research Center,
Seattle, Washington

Janet Kelly, PharmD
University of Washington, Seattle

Jonathan L. Wright, MD, MS
University of Washington, Seattle
Fred Hutchinson Cancer Research Center,
Seattle, Washington
Veterans Affairs Puget Sound Healthcare System,
Seattle, Washington

Kirk PS, Wang A, Raskolnikov D, et al. Naloxegol versus alvimopan for enhancing postoperative recovery following radical cystectomy for bladder cancer. *Urol Pract.* 2022;9(5)364-370.

Study Need and Importance

Radical cystectomy, the standard of care for muscle-invasive bladder cancer, is a complex procedure associated with significant morbidity and frequent complications. In order to reduce complications and postoperative hospital stays, enhanced recovery after surgery (ERAS) pathways have been widely implemented. One important component of these is the use of a μ -opioid receptor antagonist, alvimopan, to reduce the occurrence of ileus and hasten return of bowel function. Naloxegol is a significantly less expensive medi-

cation within the same class which is currently used in the treatment of opioid-induced constipation. We undertook this study to compare the effects of these 2 medications among patients following radical cystectomy at a single institution.

What We Found

There were 117 patients included in this study over 20 months, halfway through which our practice was transitioned from alvimopan to naloxegol as the standard medication in our ERAS pathway. A total of 59 patients received alvimopan and 58 received naloxegol. We did not observe significant differences in baseline factors between the 2 groups. Both groups had a median postoperative length of stay of 6 days ($p=0.3$; see Figure) and time to flatus of 2 days ($p=0.2$), and similar rates of ileus (14% versus 17%, $p=0.6$). μ -Opioid receptor antagonist was not associated with ileus or postoperative length of stay in multivariable models. Cost difference was $-\$344.20/\text{day}$, equivalent to a $\$2,065.20$ savings over a 6-day hospital stay with naloxegol.

“ μ -Opioid receptor antagonist was not associated with ileus or postoperative length of stay in multivariable models.”

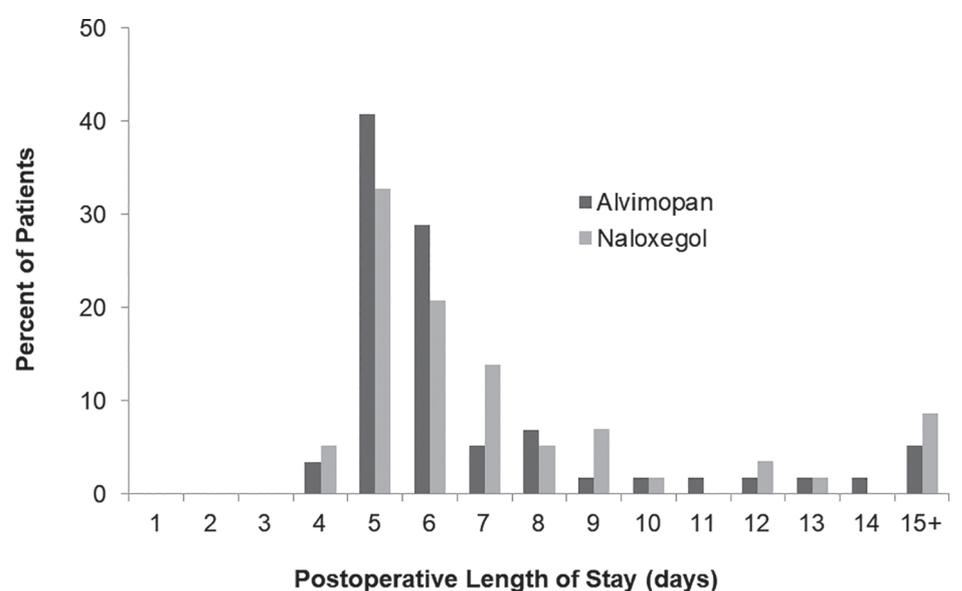


Figure. Distribution of postoperative length of stay.

Limitations

This is a nonrandomized, retrospective, single-institution study which utilizes one of these medications in an off-label fashion. In order to better understand the differences between medications in this setting prior to more widespread adoption of our approach, future work will need to incorporate prospective, randomized approaches adequately powered to assess equivalence.

Interpretation for Patient Care

There were no observed differences in postoperative outcomes or length of stay following the substitution of naloxegol for alvimopan in an ERAS pathway for radical cystectomy patients; however, there were significant cost savings associated with this change. Future work is needed to more rigorously

“There were no observed differences in postoperative outcomes or length of stay following the substitution of naloxegol for alvimopan in an ERAS pathway for radical cystectomy patients; however, there were significant cost savings associated with this change.”

compare these medications in this setting. ■

JU INSIGHT

Active Surveillance versus Immediate Intervention for Small Renal Masses: A Cost-Effectiveness and Clinical Decision Analysis

Zhuo T. Su, MD

*The James Buchanan Brady Urological Institute,
Johns Hopkins University School of Medicine,
Baltimore, Maryland*

Hiten D. Patel, MD, MPH

Loyola University Medical Center, Maywood, Illinois

Mitchell M. Huang, MD

*Northwestern University Feinberg School of Medicine,
Chicago, Illinois*

Ridwan Alam, MD, MPH

*The James Buchanan Brady Urological Institute,
Johns Hopkins University School of Medicine,
Baltimore, Maryland*

Joseph G. Cheaib, MD, MPH

*The James Buchanan Brady Urological Institute,
Johns Hopkins University School of Medicine,
Baltimore, Maryland*

Christian P. Pavlovich, MD

*The James Buchanan Brady Urological Institute,
Johns Hopkins University School of Medicine,
Baltimore, Maryland*

Mohamad E. Allaf, MD

*The James Buchanan Brady Urological Institute,
Johns Hopkins University School of Medicine,
Baltimore, Maryland*

Phillip M. Pierorazio, MD

*Pennsylvania Presbyterian Medical Center, University
of Pennsylvania, Philadelphia*

Su ZT, Patel HD, Huang MM, et al. Active surveillance versus immediate intervention for small renal masses: a cost-effectiveness and clinical decision analysis. *J Urol.* 2022;208(4):794-803.

Study Need and Importance

Patients with incidentally diagnosed small renal masses (SRMs) traditionally undergo immediate intervention, such as radical nephrectomy (RN), partial nephrectomy (PN), and thermal ablation (TA). Active surveillance (AS) as the initial management strategy with the possibility of delayed intervention (DI) is emerging as a safe alternative to immediate intervention for many patients with SRMs. However, limited compar-

“Using decision analytic Markov modeling to estimate the health outcomes and costs of 4 competing empirical management strategies for patients with an incidental SRM (AS with the possibility of DI, immediate PN, RN, or TA), we showed that the 10-year all-cause mortality for AS (22.6%) was similar to immediate PN (21.9%) and RN (22.4%), and lower than immediate TA (23.7%). At a willingness-to-pay threshold of \$100,000 per quality-adjusted life year, AS was the most cost-effective management strategy.”

ative data exist to inform the most appropriate management strategy for SRMs.

What We Found

Using decision analytic Markov modeling to estimate the health outcomes and costs of 4 competing empirical management strategies for patients with an incidental SRM (AS with the possibility of DI, immediate PN, RN, or TA), we showed that the 10-year all-cause mortality for AS (22.6%) was similar to immediate PN (21.9%) and RN (22.4%), and lower than immediate TA (23.7%). At a willingness-to-pay threshold of \$100,000 per quality-adjusted life year, AS was the most cost-effective management strategy. The cost-effectiveness analysis is robust to alternative input specifications. In particular, for the subset of patients harboring SRMs of likely very low metastatic potential, such as those SRMs <2 cm in size, AS may lead to better health utility outcomes than immediate intervention. Our modeling also demonstrated that the tumor’s metastatic potential and patient age, individual preferences, and health status were important factors influencing the optimal management strategy.

Limitations

The Markov model has inherent limitations, including the assumption that transition between health states only depends on the present but not the past. Our results may not be generalizable to all countries since we used data derived from patients in the United States. Our results were limited by data limitations, such as using certain data from retrospective studies, relying

on some assumptions by clinical experts, and extrapolating some clinical event probabilities beyond original study durations.

“Active surveillance (AS) as the initial management strategy with the possibility of delayed intervention (DI) is emerging as a safe alternative to immediate intervention for many patients with SRMs. However, limited comparative data exist to inform the most appropriate management strategy for SRMs.”

Interpretation for Patient Care

Compared to immediate intervention, AS with timely DI offers a safe and cost-effective approach to managing patients with SRMs. For patients harboring tumors of very low metastatic potential, AS may lead to better patient outcomes than immediate intervention. Management decisions should be individualized based on the tumor’s metastatic potential and patient age, individual preferences, and health status. ■

UPJ INSIGHT

Quality of Web-Based Patient Information on Robotic Radical Cystectomy Remains Poor: A Standardized Assessment

Savio Domenico Pandolfo, MD
VCH Health, Richmond, Virginia
Federico II University, Naples, Italy

Achille Aveta, MD
Federico II University, Naples, Italy

Davide Loizzo, MD
VCH Health, Richmond, Virginia
University of Bari, Bari, Italy

Fabio Crocerossa, MD
VCH Health, Richmond, Virginia
Magna Graecia University of Catanzaro, Italy

Roberto La Rocca, MD
Federico II University, Naples, Italy

Francesco Del Giudice, MD
School of Medicine, Stanford University, California

Benjamin I. Chung, MD
School of Medicine, Stanford University, California

Zhenjie Wu, MD
Changhai Hospital, Naval Medical University, Shanghai, China

Giuseppe Lucarelli, MD
University of Bari, Italy

Vincenzo Mirone, MD
Federico II University, Naples, Italy

Ciro Imbimbo, MD
Federico II University, Naples, Italy

Riccardo Autorino, MD, PhD
VCH Health, Richmond, Virginia

Pandolfo SD, Aveta A, Loizzo D, et al. Quality of web-based patient information on robotic radical cystectomy remains poor: a standardized assessment. *Urol Pract.* 2022;9(5)498-503.

Study Need and Importance

The Internet has become a central source of health-related information for patients. Over 70% of Internet users look for health-related information online to get a second opinion. However, websites are not subject to peer review and, for this reason, the information they provide can be largely unsubstantiated. The first analysis of Internet-based information on robot-assisted radical cystectomy (RARC) was reported in 2011. Over the past decade this procedure has gained an increasing role in the management of bladder cancer patients. Therefore, we sought

to assess the quality of RARC-related content that can be found online by using standardized validated tools.

What We Found

Despite the increased clinical implementation of this procedure, the overall quality of web-based information about RARC remains poor. The readability of the content provided by websites is very low. Academic and physician websites also fail to offer good quality information. Commercial websites may have a more patient-focused approach, as they use more “lay terms.”

Limitations

There are some limitations to note in our study. First, search results may change frequently considering the dynamic nature of the Internet. In addition, even if we used the most common search terms, some patients might use dif-

“The overall quality of web-based information about RARC remains poor.”

ferent words to look for information about RARC.

Interpretation for Patient Care

The overall quality of web-based information about RARC remains poor. An effort should be made by different stakeholders, especially academic and physician websites, to offer trustworthy information that is reliable and readable for a large audience. This will enable patients and their families to validly consent to decisions regarding the treatment and management of bladder disease. ■

UPJ INSIGHT

Oncologic Outcomes of cT1 and cT2 Micropapillary Variant Compared with cT1 and cT2 Conventional Urothelial Carcinoma Treated with Radical Cystectomy

Kevin B. Ginsburg, MD, MS
Fox Chase Cancer Center, Philadelphia, Pennsylvania
Wayne State University School of Medicine, Detroit, Michigan

Jared P. Schober, MD
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Laura Bukavina, MD, MPH
Fox Chase Cancer Center, Philadelphia, Pennsylvania
Case Western School of Medicine, University Hospitals Cleveland Medical Center, Urology Institute, Cleveland, Ohio

Nicole Murray, MPH
Wayne State University School of Medicine, Detroit, Michigan

Akhil A. Chandra, MPH
Fox Chase Cancer Center, Philadelphia, Pennsylvania

David Y. T. Chen, MD
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Richard E. Greenberg, MD
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Rosalia Viterbo, MD
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Robert G. Uzzo, MD, MBA
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Marc C. Smaldone, MD, MSHP
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Alexander Kutikov, MD
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Andres F. Correa, MD
Fox Chase Cancer Center, Philadelphia, Pennsylvania

Ginsburg KB, Schober JP, Bukavina L, et al. Oncologic outcomes of ct1 and ct2 micropapillary variant compared with ct1 and ct2 conventional urothelial carcinoma treated with

ONCOLOGIC OUTCOMES OF CT1 AND CT2 MICROPAPILLARY

→ Continued from page 21

radical cystectomy. *Urol Pract.* 2022;9(5)396-404.

Study Need and Importance

Guideline statements tend to favor early radical therapy for patients with clinical T stage (cT) 1 micropapillary bladder cancer (MPBC) as opposed to bladder preservation with transurethral resection of bladder tumor (TURBT) and intravesical therapy, which is the accepted standard for cT1 urothelial cell bladder cancer (UCBC). We aimed to compare the difference in oncologic outcomes of patients with cT1 and cT2 MPBC and UCBC treated with radical cystectomy (RC). We compared patients with cT1 MPBC and *de novo* cT2 MPBC to infer the oncologic risk associated with progression from cT1 to cT2 disease that may occur while attempting bladder preservation with TURBT and intravesical therapy.

What We Found

In 23,871 patients with MPBC (1.6%) and UCBC (98%) in the National Cancer Database treated with RC, patients with MPBC had more upgrading to advanced pathological stage at RC ($\geq pT3$ —cT1 MPBC: 31%; cT2 MPBC: 44%; cT1 UCBC: 18%; cT2 UCBC:

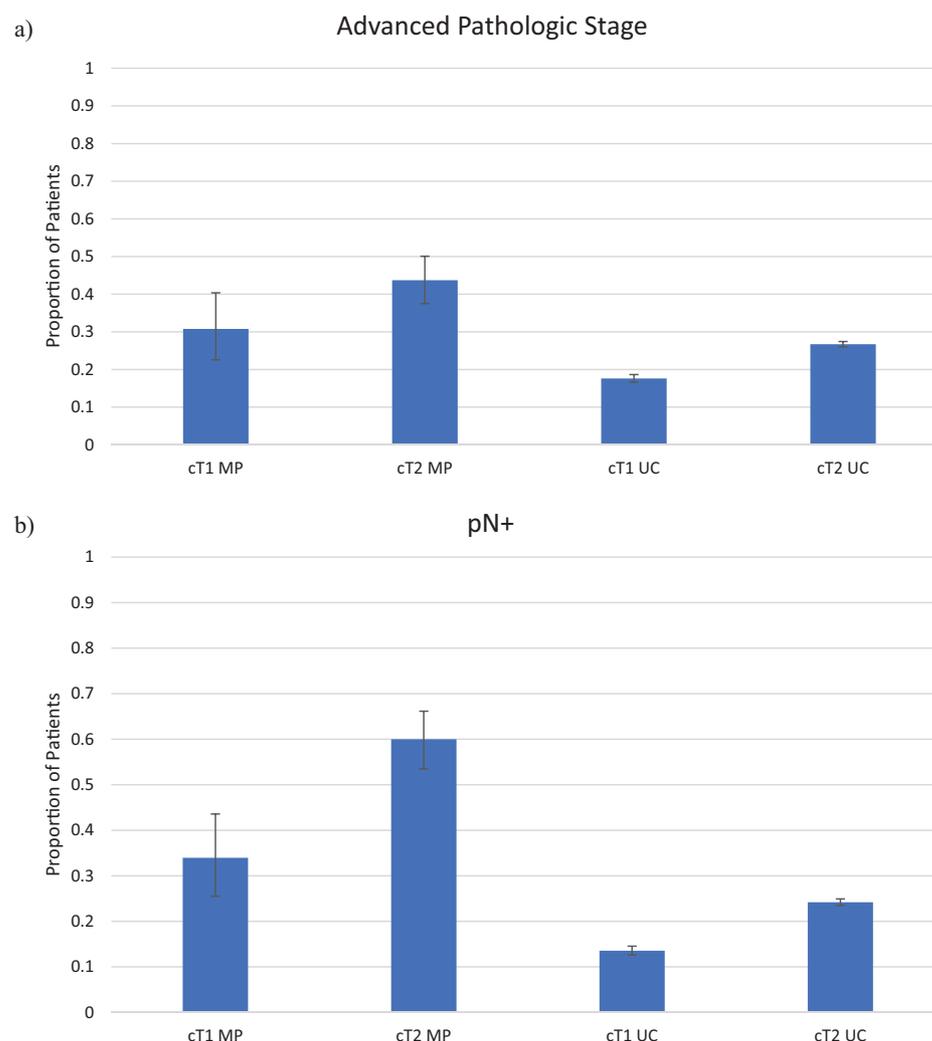


Figure. Proportion of patients with advanced pathological stage (a) and pathological node positive disease (b). Error bars display the 95% CI.

27%) and pathologically node positive disease (cT1 MPBC: 34%; cT2 MPBC: 60%; cT1 UCBC: 14%; cT2 MPBC: 24%) compared with UCBC (see Figure). Overall surviv-

al probability was similar between patients with cT1 MPBC and cT1 UCBC. Patients with cT2 MPBC had worse survival than patients with cT2 UCBC.

“Overall survival probability was similar between patients with cT1 MPBC and cT1 UCBC.”

Limitations

The National Cancer Database records treatments administered or planned in the first treatment course prior to recurrence or progression. We are unable to include in this study a group of patients with cT1 MPBC who were treated with TURBT and intravesical therapy who progressed to cT2 disease prior to RC for comparison.

Interpretation for Patient Care

The difference in oncologic outcomes for cT1 and cT2 MPBC exceeds the observed risk of progression from cT1 to cT2 UCBC. Patients should consider the degree that oncologic control is diminished when treating an MPBC at stage cT2 compared with cT1 when considering treatment options for cT1 MPBC. ■

OUT OF OFFICE

Art with a Capital “A”

Mary Garthwaite, MBBS, PhD, FRCS(Urol)

BAUS Virtual Art Gallery
Chair of The Urology Foundation, United Kingdom

In early 2018 I was in my early 40s and enjoying a busy, expanding, and fulfilling career as a consultant urological surgeon in the north of England. I had chosen surgery probably because of a lifelong love of being creative with my hands and an innate desire to be useful to others. Then I was diagnosed with breast cancer and everything

changed. Life went on hold during 18 months of rigorous treatment. During the initial months of treatment, I unexpectedly lost both my mother and father in quick succession. Normally a highly resilient person, seemingly in complete control of my life, I now felt like a hollow vessel made of wafer-thin glass that could shatter into a million pieces at any moment. So what got me through this dark time? The answer in my case was art.

Luckily for me, 6 months before

my diagnosis I did something to help remedy what I can now see as a woe-ful work-life balance. I signed up for a 1-day portrait painting course having not painted anything for over 20 years, let alone painted a portrait. The evening before, I dashed to my local art shop and stood there trying to figure out which of an endless array of paintbrushes, paints, and canvases would suffice. In the end it didn't really matter, because it was the act of making art that was so transformative. Whilst engrossed in

the process I hadn't thought about anything else. The workshop transported me to a different world and I came away energized, having re-discovered the importance of art in my life. Happily, my initial effort drew positive gasps of amazement from family and friends, and the tutor promptly signed me up for her regular evening class, which I promised to make as often as work would allow.

→ Continued on page 23

ART WITH A CAPITAL "A"

→ Continued from page 22

During my cancer journey I used art whenever I could to escape from the realities of treatment and grief. Unfortunately, my confrontation with cancer was harsh and it has sadly brought my career as a urologist to an untimely end. However, art helped me find my way through the grief that comes with losing health, a career, and loved ones. It now sustains me, makes me happy, and has given me the motivation to find new ways to help others who are facing their own challenges.

I remember back to my 16-year-old self, rationalizing her life choices by telling herself that "art can always be a hobby, but medicine can't." Then the realities of a career in surgery kick in; you blink and 20 years pass and you've only picked up a paintbrush once or twice. Work-life balance is an art in itself, and one that few of us get right. Burnout is prolific amongst high-achieving professionals, yet it is only recently that it started to be recognized as an issue within the UK surgical workforce. It is likely to be under-reported due to the stigmatization, often self-imposed, of surgeons failing to cope with the ever-increasing demands of the job, on top of the responsibilities and burdens they may carry in their personal lives. We are meant to be able to be on top of it all, at all times, and then some.

Art, in its myriad forms, can have enormously positive effects on both those who make it and those who observe it. Whilst recovering from a brutal round of chemotherapy, my thoughts turned to how I could promote art within urology. The British Association of Urologists (BAUS) website has a fantastic virtual museum (<https://www.baus.org.uk/museum/>), developed and curated by my good friend Jonathan Goddard. If we could have a virtual museum, why not a virtual art gallery? In 2020 we built an "upstairs" extension to the virtual museum, now home of the BAUS virtual art gallery. It encompasses 3 exhibition halls covering all types of 2D and 3D art. It is still in its infancy. Getting former colleagues to exhibit is a challenge, even though there is a wealth of talent out there. Examples of artwork exhibited in the gallery can be seen in Figures 1–3.

"Many things have changed over the last 2 years and we have learned a lot about ourselves and all the different communities to which we belong—family, local, workplace, national, and global."

In addition to the virtual gallery, we established a BAUS Members' Photographic Competition. This is held in the run-up to the annual conference. The inaugural competition coincided with the delivery of a virtual annual conference in response to the pandemic.



Figure 1. *Mother and Child*, bronze sculpture by Malcolm Lucas. "I am fascinated by the expression of human emotions in sculptural form, especially when partially abstracted. This is the first piece I've had cast in solid bronze."

"Art, in its myriad forms, can have enormously positive effects on both those who make it and those who observe it."



Figure 2. *Scenes from the Routeburn Walk 2*, oil painting by Simon Harrison.

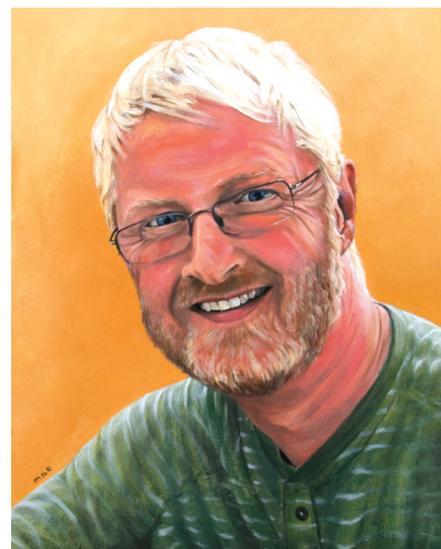


Figure 3. *Bill*, oil painting by Mary Garthwaite. "In the world of portraiture it seems that smiles are often frowned upon, but this may just be because teeth are seen as challenging to paint by a lot of artists. However, if your subject is a naturally jovial person then you must portray them truthfully in order to capture their personality."

The theme chosen was "Seeing it Through." Submissions reflected a personal interpretation of the title, be it the view through the camera lens or how members were coping professionally and personally with the challenges presented both by the pandemic and the modern working life of a urologist. Figure 4 shows one of the highly commended entries. This year's theme was "A New Perspective." Many things have changed over the last 2 years and we have learned a lot about ourselves and all the different communities to which we belong—family, local, workplace, national, and global. Submission images reflected the different views members now saw when looking through their camera. Figures 5 and 6 show the winning entry and the runner

→ Continued on page 24



Figure 4. Highly Commended entry to the BAUS Member's Photographic Competition 2021. *Operating in Full PPE*, by Brendan Berry.

ART WITH A CAPITAL "A"

→ Continued from page 23



Figure 5. Winner of the BAUS Members' Photographic competition 2022. *Green is for Go*, by Tony Browning. "This photo of the village shop at Lephin in Glendale on the Isle of Skye reveals an unusual access system used during the pandemic restrictions. The fact that it is now permanently on green suggests that life is returning to normal."

up. All competition submissions are displayed publicly on the virtual art gallery pages of the BAUS website https://www.baus.org.uk/museum/1380/welcome_to_the_virtual_art_gallery.

Surgery and art have a long and closely linked history. In UK urol-



Figure 6. Runner up of the BAUS Members' Photographic competition 2022. *The Lack of Hospital Beds Paradox*, by Theodora Stasinou. This photograph portrays the paradox of hospital beds lying unused while cases are cancelled due to a lack of beds. "Consider the quintessence of a hospital bed; acknowledge it and treat it with respect."

"Surgery and art have a long and closely linked history."

ogy we can name Sir Charles Bell (1774–1842), Sir Henry Thompson (1820–1904), and Professor John Blandy (1927–2011) as celebrated surgeon artists. From the earliest depictions of disease and surgical intervention in ancient cultures, through the anatomical drawings of Leonardo Da Vinci and Rembrandt's "The Anatomy Lesson of Dr Nicolaes Tulp," to more modern depictions of surgery, such as Barbara Hepworth's "Hospital Drawings" and Jonathan Yeo's "You Are Only Young Twice" and "Skin Deep" exhibitions, art and surgery have walked hand in hand. But you don't have to be a professional artist to get something positive from creating or appreciating art. All art is special. All art is Art with a capital "A." ■

Have You Read?

Craig Niederberger, MD, FACS
College of Medicine and College of Engineering,
University of Illinois at Chicago

Shahinyan GK, Weinberger JM, Shahinyan RH, Yang SC, Mills JN, Eleswarapu SV. Analysis of direct-to-consumer marketing of platelet-rich plasma for erectile dysfunction in the US. *JAMA Netw Open*. 2022;5(5):e2214187.

Special thanks to Drs. Blake Johnson, Samuel Gold, and Tolulope Bakare at the UT Southwestern Medical Center.

Platelet-rich plasma (PRP) has gained attention in popular culture because of use by high-profile figures such as Tiger Woods and the Kardashians after orthopedic injuries and cosmetic procedures. Driven by demand for regenerative treatments for erectile dysfunction and unregulated direct-to-consumer advertising, intracavernosal

PRP injections, the so-called "Priapus" or "P shot," have grown in popularity over the past 5 years despite limited research into their safety and efficacy.

To get a sense of just how popular and lucrative PRP is, these investigators analyzed cost to consumer, injection protocols, and clinician credentials across 109 U.S. clinics offering PRP for erectile dysfunction. The average price per injection was \$1,507. In some clinics, a single injection is offered, while others offer a myriad of treatments without a standardized protocol and no clear way to measure success. By specialty, clinicians offering PRP were 9% urology, 25% family or internal medicine, and 7% ob-gyn, and 22% were nonphysicians.

Despite an absence of clinical trial data demonstrating efficacy, PRP injections for erectile dysfunction

"The authors posit that the growth of PRP for erectile dysfunction is driven by consumerization of sexual health."

are being offered increasingly by nonphysicians and physicians alike, without specific training in male sexual dysfunction and at high cost to the consumer. In fact, the AUA classifies PRP as an investigational therapy that should not be offered for payment.

The authors posit that the growth of PRP for erectile dysfunction is driven by consumerization of sexual health. One need only turn on a television to see evidence of this

trend with the widespread marketing for low testosterone treatments. As cited in this article, testosterone prescriptions tripled between 2001 and 2011. We may see a similar proliferation in sales of PRP for erectile dysfunction in the coming years and need to be prepared for it.

Hudnall M, Goyette B, Ambulkar S, et al. Self-reported race/ethnicity is not associated with abnormal semen parameters after accounting for body mass index and socioeconomic status. *J Urol*. 2022;208:164-170.

Special thanks to Drs. Rabun Jones and Mahmoud Mima at the University of Illinois at Chicago.

Is there a relationship between race or ethnicity and abnormal se-

→ Continued on page 25

HAVE YOU READ?

→ Continued from page 24

“Platelet-rich plasma (PRP) has gained attention in popular culture because of use by high-profile figures such as Tiger Woods and the Kardashians after orthopedic injuries and cosmetic procedures. Driven by demand for regenerative treatments for erectile dysfunction and unregulated direct-to-consumer advertising, intracavernosal PRP injections, the so-called “Priapus” or “P shot,” have grown in popularity over the past 5 years despite limited research into their safety and efficacy”

men parameters? Previous studies suggested there is, but is it real? The authors of this study investigated whether that association would be maintained when controlling for BMI and social determinants of health including insurance status and neighborhood income. They did a retrospective review of 2,750 men who had semen analyses from 2002 to 2021 at an academic center and not only found that Black men had significantly lower median sperm concentration, lower volume, and total motile sperm count, but also that their Black patients were of an older median age, had a higher median BMI, were more likely to have public insurance, and had the lowest median neighborhood income. When controlling for age alone, Black men had significantly higher odds of abnormal sperm concentration and total motile sperm count. However, when BMI, neighborhood income, and insurance status were included in multivariable logistic regression, the association was not statistically significant. These results raise important questions regarding access to fertility care and the way race or ethnicity is factored into both research and clinical decision making. There is always more to the story than a box checked by a patient on an intake form!

Abou Zeinab M, Beksac AT, Corse T, et al. The multi-institutional experience in single-port robotic transvesical simple prostatectomy for benign prostatic hyperplasia management. *J Urol.* 2022;208(2):369-378.

“When controlling for age alone, Black men had significantly higher odds of abnormal sperm concentration and total motile sperm count. However, when BMI, neighborhood income, and insurance status were included in multivariable logistic regression, the association was not statistically significant. These results raise important questions regarding access to fertility care and the way race or ethnicity is factored into both research and clinical decision making”

Special thanks to Drs. Andrew Lai and Omer Acar at the University of Illinois at Chicago.

It is amazing to witness emerging technology that allows us to revisit antiquated surgical approaches to treat the same disease processes. The single-port transvesical robot-assisted simple prostatectomy is a novel modality in our armamentarium that has gained considerable popularity in the management of markedly enlarged prostate glands owing to its technical similarity to open simple adenectomy and its minimally invasive nature. In this study, surgeons at 3 high-volume academic institutions combined their data on single-port transvesical prostate enucleations. On average, patients had brief hospital stays including 42% same-day discharges, shorter catheter indwell times, low peri- and postoperative complication rates, and impressive functional outcomes. Remarkably, most of the patients reported a 9-month median quality of life score of 0, or “delighted.” Circumferential vesicourethral mucosal anastomosis, which minimizes the risk of bleeding and need for continuous bladder irrigation, coupled with an extraperitoneal approach were the technical nuances that facilitated expedited recovery. While currently available only in the hands of highly experienced surgeons and OR teams, this promising option will surely offer patients a valid choice in managing their large prostates. ■

CODING TIPS AND TRICKS

Hospital Visit Evaluation and Management Updates for 2023

Jonathan Rubenstein, MD, FACS
Chair, AUA Coding and Reimbursement Committee

The American Medical Association Current Procedural Terminology (CPT) Editorial Panel released the updated CPT Evalu-

ation and Management (E/M) Office or Other Outpatient Code and Guideline Changes, which became active on January 1, 2021 (<https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>). Highlights of

the new 2021 Guidelines compared to the 1995 and 1997 Guidelines included allowing performance and documentation of a medically appropriate history and exam rather than having to meet specific criteria, revising the way that time

is counted (total time spent on that patient that calendar day rather than face-to-face time), and revising the medical decision-making guidelines. Ultimately, the number

→ Continued on page 26

HOSPITAL VISIT EVALUATION AND MANAGEMENT UPDATES FOR 2023

→ Continued from page 25

of new patient levels was reduced to 4 (99202-99205) while keeping 5 levels of established patient visits (99211-99215). This update was a major step towards reducing provider documentation burden and allowing practitioners to focus on that which was most important to patient care, while also recognizing patient complexity and management considerations in level selection rather than volume of documentation. A limitation of this update is that it was effective only for new and established office or other outpatient services. No other E/M codes were similarly updated. That is changing.

On January 1, 2023, a number of other E/M codes will be similarly updated to mimic that of the updated Office and Other Outpatient codes guidelines, including similar documentation requirements, medical decision-making guidelines, and updated time requirements. Updated codes which are of highest interest to urologists include Consultation codes (CPT codes 99242-99245) for insurers that recognize consultations, and Hospital E/M codes. In addition to these changes, hospital E/M codes will also be consolidated from 2 unique sets of codes (one for inpatient care services and another set for observation care services) to 1 set of codes that can be used for observation or inpatient care services. The results of these 2 changes will greatly improve ease of documentation and ease of coding for hospital services.

For those who are not facile at

Table 1. Hospital Care E/M Codes (pre-2023): Description, Documentation, and Coding Requirements

CPT code	Description	History and exam (each)	Medical decision making	Time (min)
99221	Initial hospital care	Detailed or Comprehensive	Straightforward or Low	30
99222	Initial hospital care	Comprehensive	Moderate	50
99223	Initial hospital care	Comprehensive	High	70
99231	Subsequent hospital care	Problem Focused	Straightforward/Low	15
99232	Subsequent hospital care	Expanded Problem Focused	Moderate	25
99233	Subsequent hospital care	Detailed	High	35
99234	Same day admit/dc inpatient or observation	Detailed or Comprehensive	Straightforward/Low	40
99235	Same day admit/dc inpatient or observation	Comprehensive	Moderate	50
99236	Same day admit/dc inpatient or observation	Comprehensive	High	55
99238	Hospital discharge day management	N/A	N/A	<30
99239	Hospital discharge day management	N/A	N/A	>30

Abbreviations: dc, discharge; N/A, not applicable.

hospital visit coding, currently coding is based upon patient status: Observation of Inpatient services. Observation codes include initial observation care (CPT codes 99218-99220), subsequent observation care (CPT codes 99224-99226), and discharge day services (CPT code 99217), along with same day admission/discharge from inpatient or observation care (99234-99236; Table 1). Inpatient care codes include initial hospital care (99221-99223), subsequent hospital care (99231-99233), and discharge day services (99238-99239), along with CPT 99234-99236 (Table 2). Consultants to patients in observation may use outpatient consultation codes (99241-99245), new patient codes (99201-99205), and established patient codes (99211-99215) depending on the

patient’s insurance (if the insurer recognizes consultations or not), as observation care is considered an outpatient site of service, whereas consultants to inpatients would use hospital consultation services codes (99251-99255) or initial hospital care codes (99221-99223) depending on patient insurance. As documentation and time requirements are actually identical between initial observation care and initial hospital care, and also identical between subsequent observation care and subsequent inpatient care, combining the 2 sets into 1 code set made sense (Table 3). Ultimately, observation codes (99218-99220, 99224-99226, and 99217) were eliminated and merged into the current inpatient care codes.

As an example, the current description of CPT code 99211

is as follows:

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient’s hospital floor unit.

→ Continued on page 27

“Updated codes which are of highest interest to urologists include Consultation codes (CPT codes 99242-99245) for insurers that recognize consultations, and Hospital E/M codes.”

Table 2. Observation Care E/M Codes (pre-2023): Description, Documentation, and Coding Requirements

CPT code	Description	History and exam (each)	Medical decision making	Time (min)
99218	Initial observation care	Detailed or Comprehensive	Straightforward or Low	30
99219	Initial observation care	Comprehensive	Moderate	50
99220	Initial observation care	Comprehensive	High	70
99224	Subsequent observation care	Problem Focused	Straightforward/Low	15
99225	Subsequent observation care	Expanded Problem Focused	Moderate	25
99226	Subsequent observation care	Detailed	High	35
99234	Same day admit/dc inpatient or observation	Detailed or Comprehensive	Straightforward/Low	40
99235	Same day admit/dc inpatient or observation	Comprehensive	Moderate	50
99236	Same day admit/dc inpatient or observation	Comprehensive	High	55
99217	Observation care discharge	N/A	N/A	N/A

Abbreviations: dc, discharge; N/A, not applicable.

HOSPITAL VISIT EVALUATION AND MANAGEMENT UPDATES FOR 2023

→ Continued from page 26

Table 3. Inpatient or Observation care E/M codes (starting January 1, 2023)

CPT code	Description	History and exam (each)	Medical decision making	Time (min)
99221	Initial inpatient or observation care	Appropriate	Straightforward/Low	40
99222	Initial inpatient or observation care	Appropriate	Moderate	55
99223	Initial inpatient or observation care	Appropriate	High	75
99231	Subsequent inpatient or observation care	Appropriate	Straightforward/Low	25
99232	Subsequent inpatient or observation care	Appropriate	Moderate	35
99233	Subsequent inpatient or observation care	Appropriate	High	50
99234	Same day admit/dc inpatient or observation	Appropriate	Straightforward/Low	45
99235	Same day admit/dc inpatient or observation	Appropriate	Moderate	70
99236	Same day admit/dc inpatient or observation	Appropriate	High	85
99238	Discharge from inpatient or observation	N/A	N/A	<30
99239	Discharge from inpatient or observation	N/A	N/A	>30

Abbreviations: dc, discharge; N/A, not applicable.

Note that for inpatient services, all 3 components (history, exam, and medical decision making) are required for the initial visit day while 2 of the 3 components are needed for subsequent care days. Time is a typical time, not a minimum time.

Starting January 1, 2023 the description of CPT code 99211 will be as follows (with the major changes italicized):

Initial hospital inpatient *or observation care*, per day, for the evaluation and management of

a patient, which requires *a medically appropriate history and/or examination* and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, *40 minutes must be met or exceeded*.

A few details to remember about this coding update: in the new guidelines, since history and examination are only that which is medically necessary, medical decision making or time can be used for code selection. As there is

now only 1 set of codes that can be used for inpatient or observation care, the same CPT codes would be chosen no matter the patient status. When using time for code selection, it is no longer “typical” time that should be noted but a minimal time is required. Despite having only 1 set of codes, one must still report the patient status (observation care or inpatient) as that must be submitted with the bill, especially in the case of a status change such as a patient needs to be admitted as an inpatient after

“As there is now only 1 set of codes that can be used for inpatient or observation care, the same CPT codes would be chosen no matter the patient status.”

an observation stay. If billing based upon time, there will be an add-on code that will be able to be used for prolonged time; the details of this code and its use will likely be released in late 2022; as of not it appears that this code will be used for >90 minutes for initial inpatient or observation care, >65 minutes for subsequent inpatient or observation care, and >100 minutes for same-day admission/discharge from inpatient or observation care. Same-day admission and discharge from inpatient or observation care (CPT codes 99234-99235) are basically unchanged for their descriptor but have updated documentation requirements, medical decision-making guidelines, and minimum time requirements. ■

FROM THE AUA PUBLIC POLICY COUNCIL

The House of Medicine of the American Medical Association: A Strategic Imperative for AUA Public Policy around the American Medical Association’s Dinner Table

Eugene Rhee, MD, MBA
Chair, AUA Public Policy Council

Hans Arora, MD, PhD
AMA Lead Delegate, AUA Public Policy Council

The American Medical Association (AMA) House of Delegates (HoD) is the principal policy-making body of the AMA. Voting seats

are apportioned according to the number of AMA members within that society. The AUA currently holds 2 full physician seats within the AMA HoD. The HoD meets twice yearly to discuss and debate issues related to health care. The policies discussed shape the advocacy agenda for the AMA and in-

form the actions of its leadership. The AMA lobbying team is mandated to pursue the issues stated in its policy agenda. The AUA’s involvement in the AMA HoD is one major way in which we advance urology’s legislative and advocacy priorities. Our ability to advance urology-specific issues is directly

related to the number of urologists in the HoD. We need your help to make our voice stronger. Joining or renewing your AMA membership allows urology to take full advantage of the AUA’s participation in the House of Medicine, working

→ Continued on page 28

THE HOUSE OF MEDICINE OF THE AMERICAN MEDICAL ASSOCIATION

→ Continued from page 27

“Our ability to advance urology-specific issues is directly related to the number of urologists in the HoD. We need your help to make our voice stronger.”

collaboratively with physicians from all states and specialties to advance health care for all of our patients.

This past June in Chicago, the AMA HoD convened its first in-person meeting since the start

of the COVID-19 pandemic. Lead delegate Dr. Hans Arora, alongside Drs. Jason Jameson and Ruchika Talwar, reviewed over 300 items of business dealing with issues related to a plethora of issues pertaining to health care in America. Some items of interest to the practice of urology included

- Encouraging shared decision making in the treatment of gender-diverse individuals and promoting informed consent, personal autonomy, and increased access to gender-affirming treatments
- Encouraging the U.S. Food and Drug Administration to improve the development and testing process for drugs in the pediatric age groups in which they are used in order to promote pharmaceutical equity
- Working with TRICARE to cover gamete preservation for active duty and activated reservist military personnel
- Opposing bundling of physician payments with hospital payments unless such an arrangement has been agreed to in advance
- Continuing to push for reform of the Medicare Appropriate Use Criteria Program in order to minimize clinicians' administrative burden and practice expenses while maximizing alignment with the Quality Payment Program
- Supporting coverage of nonclinical ancillary costs by sponsors of clinical trials
- Developing a comprehensive advocacy campaign to achieve enactment of reforms to the Medi-

care Physician Payment System consistent with existing AMA policy

- Improving access to and insurance coverage for fertility preservation and infertility treatment for residents and fellows

At this meeting, the HoD mourned the loss of urologist Dr. William Monnig, and AUA delegates also said goodbye to 2 members of the team: Dr. Terry Grimm, who retired his role as our delegation chair last year, and Kathy Shanley, PhD, Executive Vice President of Public Policy and Advocacy at the AUA, who has been attending these meetings for almost 2 decades. Their leadership, wisdom, and guidance will be missed, but we will forever count them as colleagues and friends. ■