

Incontinence/Pelvic Floor/ Neurourology/BPH

8:00 - 9:45am Tuesday, 2nd November, 2021

Poster Session 4 The Changing Landscape of salvage HoLEP post MIST

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Abstract

Introduction

Minimally invasive surgical treatments (MIST) for BPH are an attractive option for men interested in less invasive options, but come with a higher retreatment rate. Salvage holmium laser enucleation of prostate (s-HoLEP) after prior BPH surgery is common however the landscape of MIST treatments has evolved over time.

Methods

A retrospective database of HoLEP procedures from a single center between 6/2006 and 12/2020 was evaluated for patients who had a s-HoLEP.

Results

Out of 1960 HoLEPs, 223 (11.3%) were s-HoLEP. BPH procedures that proceeded s-HoLEP included TURP (91, 40.8%), TUMT (45, 20.2%), PVP (25, 11.2%), Urolift (24, 10.8%), TUNA (19, 8.5%), HoLAP (6, 2.7%), and Rezum (3, 1.3%). Only 1 (0.4%) had prior HoLEP. Table 1 outlines patient data by procedure. Mean prostate volume at s-HoLEP was 97.8 ± 59.32 cc (range 17-363) and time from index surgery to s-HoLEP was 83.02 ± 76.06 months (0.85-405.95). Urolift had the shortest interval from index surgery to s-HoLEP (23.67 ± 19.62 months) followed by Rezum (39.76 ± 16.53). Operative times were within expected ranges. Catheter duration was 1.9 ± 1.8 days and POD 1 trial of passage successful in 53.8%. Overall postoperative complication rate was 6.3%. The most common index procedure per year was TURP until 2020 where post-Urolift s-HoLEP became more common (10/24, 42%, Figure 1). The proportion of overall HoLEPs done as a s-HoLEP has ranged from 9-15% and has not changed significantly over time.

Conclusion:

S-HoLEP is a common occurrence in a large HoLEP practice with good functional and safety outcomes. Patients presenting for s-HoLEP have large prostates. The relative proportion of each index procedure is changing with more patients presenting with prior Urolift implants. Surgeons should be aware of this shift and the modifications to surgical technique needed to tackle these cases.

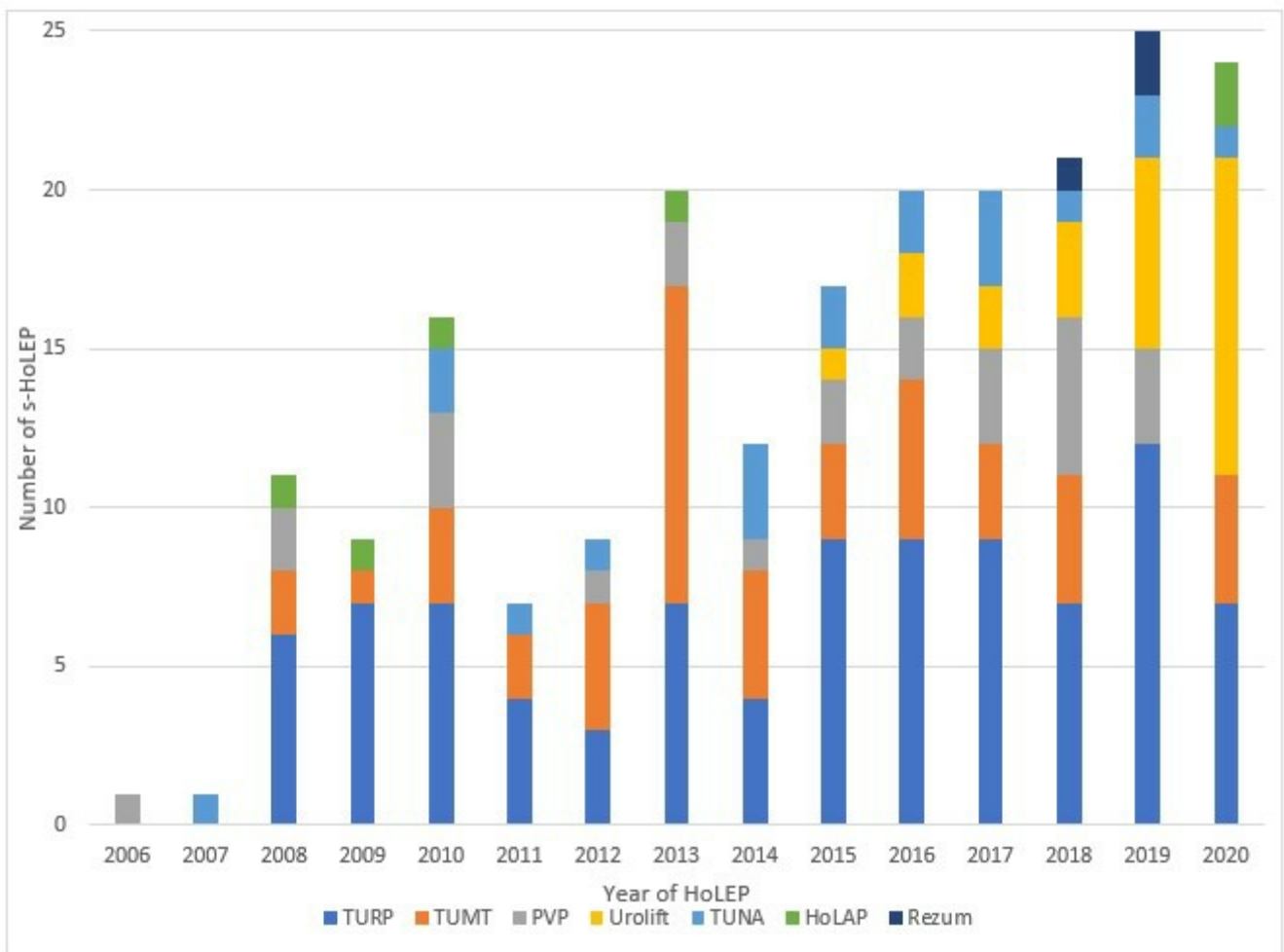


Figure 1 – Proportion of index BPH procedures prior to salvage HoLEP, by year or HoLEP.

Table 1 – Perioperative data for patients undergoing salvage HoLEP (s-HoLEP) by procedure type

Mean ± SD (Range)	Total (n=223)	TURP (n=91)	TUMT (n=45)	PVP (n=25)	Urolift (n=24)	TUNA (19)	HoLAP (n=6)	Rezum (n=3)
Age (y)	70.9±7.4 (43-92.4)	73.04±7.46 (53.9-92.4)	70.63±6.05 (57.3-82.7)	72.12±6.42 (61-89)	66.87±6.42 (54.3-79.9)	70.12±6.54 (59.1-83.1)	69.1±8 (57-76)	68.53±4.99 (62.9-72.4)
BMI	27.8±4.88 (16.6-47)	28.56±5.66 (16.6-47)	27.51±4.22 (20.1-41.9)	26.25±3.93 (20-35)	27.7±5.03 (20.7-36.2)	26.92±3.91 (21.5-35.4)	30.2±3.99 (25-35)	27.53±1.41 (25.9-28.4)
Prostate Volume at HoLEP (cc)	97.8±59.32 (17-363)	110.59±66.56 (17-363)	77.94±41.6 (18.5-195)	88.26±43.75 (27-211)	98.47±58.41 (27-204)	86.57±50.99 (27.7-212)	146.98±127.15 (51-329)	125.83±20.03 (111.66-140)
Pre op Qmax (mL/s)	7.79±5.81 (0-29)	9.16±6.93 (0-29)	7.62±5.87 (0-26)	6.74±4.11 (2-16)	5.92±4.07 (0-16.7)	7.08±4.59 (1-20)	9.27±6.54 (5-17)	6.03±5.32 (0-10.1)
Pre op PVR (mL)	251.7±240.2 (0-1100)	254.4±222.3 (0-925)	291.2±311.4 (0-1100)	260.6±241.8 (15-800)	223.5±218.0 (13-826)	191.8±190.7 (5-610)	269±226.01 (90-600)	289.7±208.2 (123-523)
Pre op AUASS	19.5±8.56 (0-35)	18.64±8.94 (5-33)	20.54±9.56 (0-35)	23.33±8.73 (16-33)	25±5.56 (20-31)	17.66±4.41 (12-24)	10.5±3.53 (8-13)	N/A
Time from index surgery to HoLEP (months)	83.02±76.06 (0.85-405.95)	94.23±86.29 (0.85-369.38)	85.84±59.28 (3.52-300.4)	94.85±70.35 (4.37-246.97)	23.67±19.62 (2.43-83.06)	101.03±58.13 (17.12-247.2)	96.02±153.1 (3.91-406.0)	39.76±16.53 (25.56-57.92)
Total Operative Time (min)	107.63±52.11 (20-293)	112.58±56.89 (21-293)	95.25±38.42 (20-173)	109.83±47.56 (61-268)	120.66±66.7 (30-276)	96.94±40.75 (37-167)	91.5±44.47 (43-161)	187±24.75 (168-215)
Enucleation Time (min)	62.14±50.91 (5-604)	65.79±68.39 (15.42-604)	52.77±26.31 (8.43-119)	57.45±31.77 (20-145)	70.28±41.15 (5-136)	65.19±28.92 (30-125)	44.32±23.85 (22-80)	115.33±16.25 (97-128)
Enucleation efficiency (g/min)	2.04±1.11 (0.6-6.9)	2.18±1.11 (0.6-6.9)	1.99±1.12 (0.6-5.6)	1.86±1.21 (1-5)	1.65±0.63 (0.9-3)	1.7±0.61 (0.9-2.9)	2.98±1.62 (1-5)	1.15±0.07 (1.1-1.2)
Morcellation time (min)	18.91±18.08 (0.51-111)	22.99±21.12 (2.33-109)	16.08±12.13 (0.51-44)	17.05±12.04 (2-46)	19.55±24.89 (1.37-111)	15.24±14.35 (3-61.2)	6.21±6.57 (1-17)	13.73±4.94 (9.2-19)
Laser energy (kJ)	114.02±55.85 (2-339.37)	117.47±55.46 (13.7-275.57)	111.82±51.9 (33.1-237.1)	102.28±38.61 (56-197)	124.07±74.86 (15.8-339.37)	117.03±53.75 (2-219)	78.02±53.92 (44-173)	157.05±83.94 (102.3-253.7)
Post op Qmax (mL/s)	17.04±14.33 (0-66)	15.05±13.27 (0-58)	20.09±16.21 (0-66)	21.13±17.78 (0-63.3)	13.63±10.03 (0-30)	70.12±6.54 (59.1-83.1)	20.7±10.7 (4-33)	29.33±12.66 (15-39)
Post op PVR (mL)	41.38±65.06 (0-391)	43.97±73.23 (0-386)	37.91±64.8 (0-391)	25.35±29.22 (0-101)	34.93±32.67 (0-116)	43.41±76.08 (0-274)	77±80.52 (7-207)	46.66±65.07 (0-121)
Post op AUASS	9.26±5.8 (0-24)	6.21±5.36 (0-18)	10.68±5.81 (1-23)	7.66±3.78 (5-12)	12.66±4.04 (9-17)	10.5±3.98 (6-17)	6±1.41 (5-7)	N/A

134 Real-World Study of the Prostatic Urethral Lift (PUL) Reveals Office-Based Procedures May Lead to a Better Patient Experience

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Abstract

Within the US, PUL is commonly performed in an office setting under local anesthesia, which may pose advantages for an aging male BPH population. Utilizing the large, real-world retrospective (RWR) study of PUL, we assessed outcomes in subjects treated in the clinic office setting with local anesthesia (office+local) compared with other sites of service and anesthesia (i.e., hospital, ambulatory surgery center, clinic office with twilight sedation).

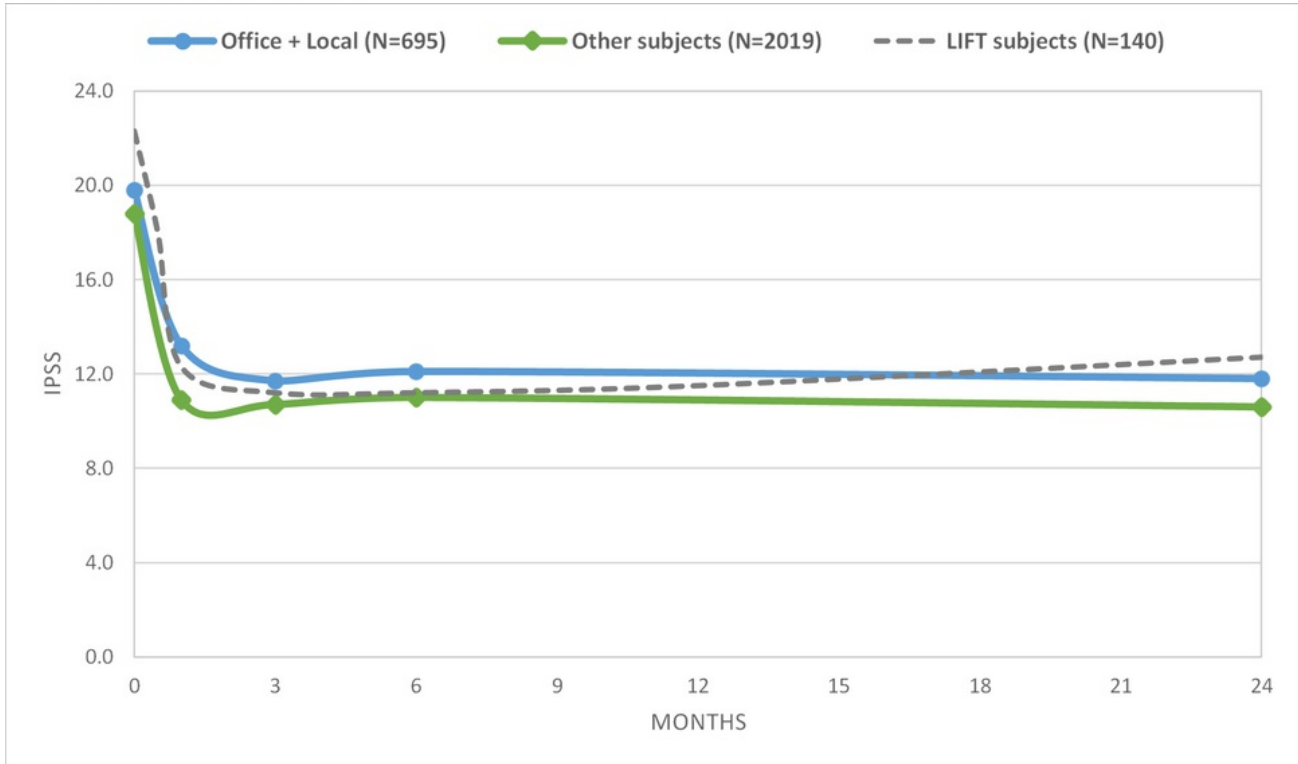
The international RWR database of PUL included 2714 non-retention patients at baseline. Eligible subjects had at least one IPSS score pre- and post-PUL. Baseline demographics, symptom outcomes (IPSS, QoL, Qmax, PVR), adverse events (AEs) and catheterization rates were compared between office+local and all other subjects.

695 patients were treated in the office under local anesthesia, all within the US. Mean age was similar between the office+local group vs. others (both: 69yr); prostate volume was smaller for office+local subjects (45 vs 47cc, $p=0.03$). Office+local subjects were more symptomatic at baseline (IPSS 19.4 vs. 18.9, $p<0.001$); baseline measurements were similar for QoL (4.0 vs 3.9), Qmax (both 11.9mL/sec) and PVR (107 vs. 108mL).

Post-PUL, office+local subjects experienced fewer overall AEs (29% vs 39%, $p<0.0001$) including less hematuria (12% vs 19%, $p<0.001$), dysuria (6% vs 8%, $p=0.02$), urgency (2% vs 4%, $p=0.01$) and nocturia (0.3% vs 1%, $p=0.04$). In addition, office+local subjects received fewer standard protocol post-procedural catheters (23% vs 38%, $p<0.001$). Both groups improved significantly in IPSS and QoL throughout follow-up; IPSS improvement was significantly better for office+local subjects vs other subjects (mean IPSS percent change: 42% vs. 26%; $p<0.01$) at 24 months.

Compared to procedures conducted in other settings and with higher forms of anesthesia, clinic office-based PUL with local anesthesia was associated with similar symptom improvements, fewer AEs and less frequent catheterization. These analyses may be particularly pertinent regarding the Covid-19 pandemic, which may have impacted the site of service of minimally invasive BPH surgeries.

Figure 1: IPSS response to PUL for subjects treated in the clinic office setting with local anesthesia vs other sites of service and anesthesia.



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NeoTract/Teleflex

7 Vibegron for the Treatment of Patients With Dry Overactive Bladder: A Subgroup Analysis From the EMPOWUR Trial

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Abstract

Objectives: Overactive bladder (OAB) is characterized by urgency and frequency with (OAB wet) or without (OAB dry) urge urinary incontinence (UUI). These post hoc analyses of the phase 3 EMPOWUR trial assessed efficacy outcomes in patients with OAB wet and dry.

Methods: In EMPOWUR, patients were randomized to vibegron 75 mg, placebo, or active control (tolterodine), respectively, for 12 weeks. OAB wet criteria included an average of ≥ 8 micturitions and ≥ 1 UUI episode per diary day; OAB dry (up to 25% of patients) included an average of ≥ 8 micturitions, ≥ 3 urgency episodes, and < 1 UUI episode per diary day. Change from baseline (CFB) in average daily number of urgency episodes and micturitions was assessed.

Results: Overall, 1127 patients (77%) had OAB wet (vibegron, N=403; placebo, N=405; active control, N=319), and 336 (23%) had OAB dry (vibegron, N=123; placebo, N=115; active control, N=98). At week 12, vibegron was associated with significant reductions vs placebo in least squares (LS) mean CFB in urgency episodes for the wet (-3.0 vs -2.4, respectively) and dry (-2.6 vs -1.6) populations ($P < 0.05$, each) and in micturitions for the wet (-2.1 vs -1.7) and dry (-1.8 vs -1.0) populations ($P < 0.05$, each). Significant reductions were also seen with vibegron vs placebo at week 2 in the wet population for both outcomes and weeks 4 and 8 for both populations and outcomes ($P < 0.05$, each).

Conclusions: Vibegron is associated with significant reductions vs placebo in daily urgency episodes and micturitions in patients with OAB wet and OAB dry, suggesting that vibegron works similarly for these endpoints in both populations.

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Urovant Sciences

81 Validation of a new fMRI protocol for the investigation of visual trigger related OAB and urgency incontinence

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Abstract

I & O: Visual stimuli are recognized to stimulate overactive bladder (OAB) symptoms and can precipitate urgency incontinence. Clinically this spectrum includes 'key in the door' syndrome where approaching the front door of a living space causes precipitous urgency for urination. Current pathophysiology recognizes the importance of cortical control over micturition, but as clinicians lack any methodology to evaluate causal triggers. Objective: we developed and validated an fMRI protocol to observe cerebral connectivity changes in the brain's response to visual triggers in subjects with clinical symptoms of trigger-related incontinence was developed.

M: fMRI was conducted at the 3 Tesla Philips Elition Scanner at the University of British Columbia Brain Research Centre. Structural T1 weighted images were acquired and used to define ~200 brain regions based on a validated brain atlas. Diffusion Tensor Imaging (DTI) and Myelin Water Fraction (MWF) scans were obtained to investigate for myelin abnormalities. Following natural bladder filling fMRI consisting of subject-specific trigger images supplied by each subject, interspersed with neutral images as depicted below (fig 1).

Figure 1

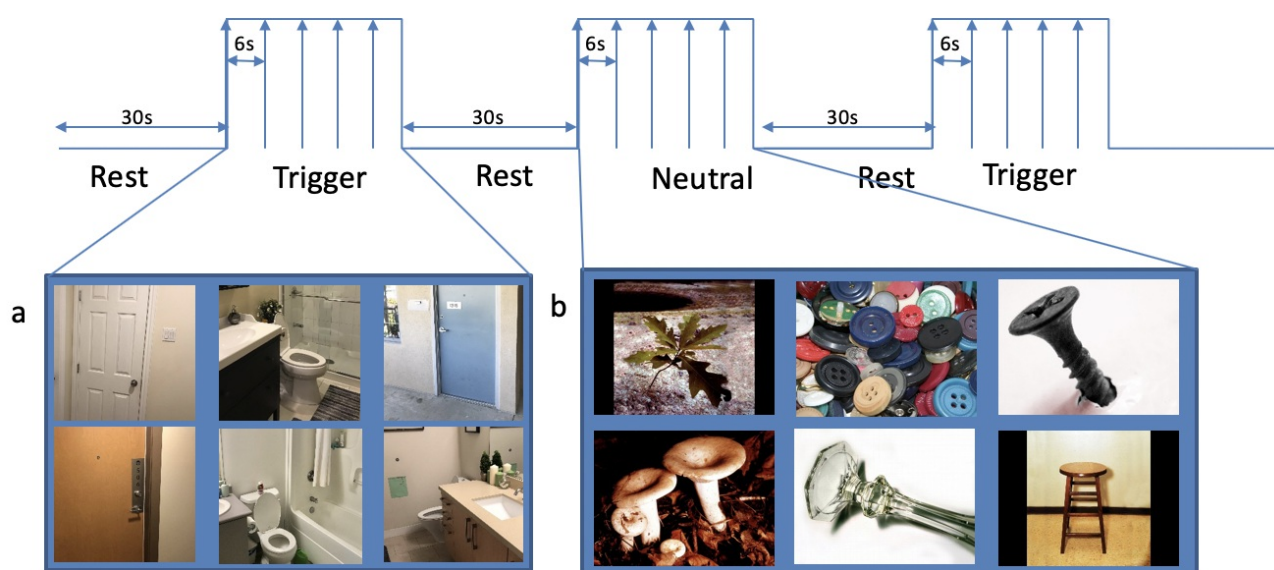


Figure 1 (a): neural images implanted to trigger UUI from front door, bathroom door and bathroom (trigger) (b): neural images implanted to not trigger UUI (neutral). Overall figure depicts sequences of blocks throughout MRI sequence including images that are randomized – both for trigger and neutral responses.

Specifically, trigger images were shown in a predetermined and random order in three 10-minute sequences. Strategies to avoid habituation included showing only a portion of the trigger images and interspersing these with neutral images ensuring no cross over with water, doors, bathrooms or other known reported triggers to UUI. Clinical staging included IPSS, UGDI-6, history and physical exam.

R: N=10 adults (6 asymptomatic controls, 4 with urgency incontinence). Debriefing confirmed that images within the sequence had triggered symptoms of UUI; tractography demonstrated robust structural connectivity between the anterior cingulate cortex and periaqueductal grey matter.

C: Conventional investigation of UUI lacks evaluative methodology for the impact of visual triggers UUI. We describe the feasibility of a novel 1 hour 6 minute fMRI protocol for evaluation and quantification of the cortical mechanisms underlying visual triggers for UUI. Debriefing confirmed images within the sequence had triggered symptoms, scan analysis showed structural connectivity between sensation and voiding control centres in the brain. This protocol is a feasible way to investigate visual triggers for UI.

176 Pivotal Study Effectiveness Data Of A Coin-Sized Tibial Nerve Stimulator For Urgency Urinary Incontinence - Outcomes From A Single Study Center

Alexandra Rogers MD

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Abstract

Objectives: Percutaneous Tibial Nerve Stimulation (PTNS) is an FDA-approved treatment of overactive bladder. PTNS requires weekly office visits, placing a burden on both patients and medical facilities, limiting dosing schedules, and leading to patient drop-off. This study evaluates the safety and efficacy of a subcutaneously implanted tibial nerve stimulator (eCoin[®]) for the treatment of urgency urinary incontinence (UUI), which delivers therapy autonomously. We aim to report on the safety and efficacy after 48-weeks of therapy for Sansum Clinic in Santa Barbara, CA.

Methods: The eCoin-2 trial was a prospective, single-arm study evaluating the safety and efficacy of the eCoin for treating UUI. The Sansum Clinic was one of fifteen centers involved in this study and implanted 26 of 133 subjects. The primary effectiveness objective was the proportion of subjects achieving $\geq 50\%$ improvement in UUI episodes on a 3-day voiding diary after 48 weeks of therapy.

The study included men and women ages 18-80 with at least one daily UUI episode on a 3-day voiding diary who were intolerant of, or had an inadequate response to, currently available therapies.

The leadless, primary battery-powered eCoin has a diameter of 23mm and a thickness of 3.2mm. The study device is implanted in the lower leg during an office procedure under local anesthesia.

Results: All subjects have reached the primary endpoint at 48-weeks post-activation. Mean age is 65.8 (± 8.8) years and all subjects are female. At baseline, subjects had a mean of 4.6 (± 2.7) UUI episodes per day, 10.3 (± 3.5) voids per day. At 48 weeks post-activation, UUI episodes per day decreased by 2.9 (95% CI [-4.0, -1.8]). 77% (95% CI [56, 91]) of subjects improved by at least 50% in their UUI. Additionally, 50% of patients achieved $\geq 75\%$ reduction in UUI, and 23% had complete resolution in UUI (dry). In patient reported outcomes 77% indicated they were at least "Better" after treatment, and 50% indicated they were "Very Much Better" on the PGI-I. There were no related serious adverse events.

Conclusions: The single center results of this study show eCoin as a promising safe and effective option in the treatment of UUI.

If funding provided, type in source company / entity name(s):

Valencia Technologies

44 Trends in Diagnostic Workup and Surgical Management for Recurrent Urinary Tract Infections

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Abstract

Objectives: Recurrent urinary tract infections (rUTI) remain a prevalent urinary complaint. Studies describe variability in the evaluation, treatment, and referral patterns for rUTI. Many are referred for subspecialty care at additional cost to the patient and system. There is little existing literature regarding diagnostic workups and rate of surgical management for patients referred for rUTI. We sought to analyze patterns in workup and surgical management of rUTI at our institution.

Materials and Methods: After IRB approval, rUTI patients referred to urology or urogynecology at Mayo Clinic in Arizona between 2016 and 2019 were retrospectively reviewed. We recorded demographics, provider specialty, and workup, including performance of genitourinary exam, urodynamic evaluation, cystoscopy, and imaging. We recorded whether or not the patient ultimately underwent a surgical procedure and if so, what type. Descriptive statistics were used to describe demographics, diagnostic workups, and rate of surgical management.

Results: A total of 1340 patients were included. Patients were predominantly female (77%). A majority were evaluated by urology (83%) compared with urogynecology (17%). Regarding workup, 68% underwent genitourinary exam, 69% underwent cystoscopy, and 72% received imaging. The most common imaging modality employed was CT (54%) followed by ultrasound (39%). Of the 77% of patients who underwent urodynamics, 20% were evaluated with post-void residual, 28% with uroflow, and 40% with complete urodynamic testing. Urologists pursued urodynamics for 81% of patients compared with 12% among urogynecologists. Urologists more frequently ordered cystoscopies (73% vs. 53%) and imaging (75% vs. 57%) than urogynecologists. A minority of patients underwent a surgical procedure for rUTI (304, 23%). The most common procedure was female sling placement or removal (n=52), followed by cystoscopy biopsy fulguration (n=38), and ureteroscopy with or without laser lithotripsy or stone basketing (n=30). Rate of surgical management was fairly comparable between urologists (22%) and urogynecologists (25%).

Conclusions: Patients who are referred to urology or urogynecology for evaluation of rUTI often undergo a genitourinary exam, cystoscopy, imaging, and urodynamic testing. Despite receiving this extensive workup, the majority of patients with rUTI are ultimately managed medically rather than surgically.

Source of Funding: None

24 Age and Population Adjusted Trends in Inpatient Surgical Management of Vaginal Prolapse, Rectal Prolapse, and Concurrent Vaginal and Rectal Prolapse Surgery in Washington State

Justina Tam MD, Celine Soriano MD, Hannah Koenig MD, Alvaro Lucioni MD, Jennifer Kaplan MD, Kathleen Kobashi MD, Val Simianu MD, Una Lee MD
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Abstract

Objectives: Given the shared pathophysiology, women who undergo surgical repair for rectal prolapse (RP) are more likely to have vaginal prolapse (VP) than the general population. RP and VP surgery is increasingly performed in multidisciplinary settings. Prior work demonstrated the national rate of multidisciplinary repair in women with RP and VP increased from <1% in 2003 to nearly 2% in 2017. The objective of this study is to report age and population adjusted trends in the prevalence of inpatient RP, VP, and concurrent RP/VP surgical procedures in women in Washington State over a contemporary 12-year period.

Materials and Methods: A Washington State administrative inpatient claims database was queried for female patients age 20 or older with a diagnosis of VP and/or RP and associated RP and VP surgical procedures from 2008-2019. Demographic characteristics and rates of concurrent surgical repair were analyzed. Rates were adjusted by age, population, and gender based on WA State Census results 2008-2019.

Results: Seventy-five percent of VP/RP inpatient surgeries were performed in the 7 most populated WA State counties. Between 2008-2019, inpatient admissions for concurrent VP and RP prolapse surgery remained stable, with adjusted rates ranging from 1.42-3.38 per 100,000, with a majority performed in patients <80 years old (Figure 1). The adjusted rate of inpatient RP repairs remained stable, 3.12-5.14 per 100,000. The adjusted rate of inpatient VP repairs decreased, from 81.78 per 100,000 in 2008 to 6.96 per 100,000 in 2019.

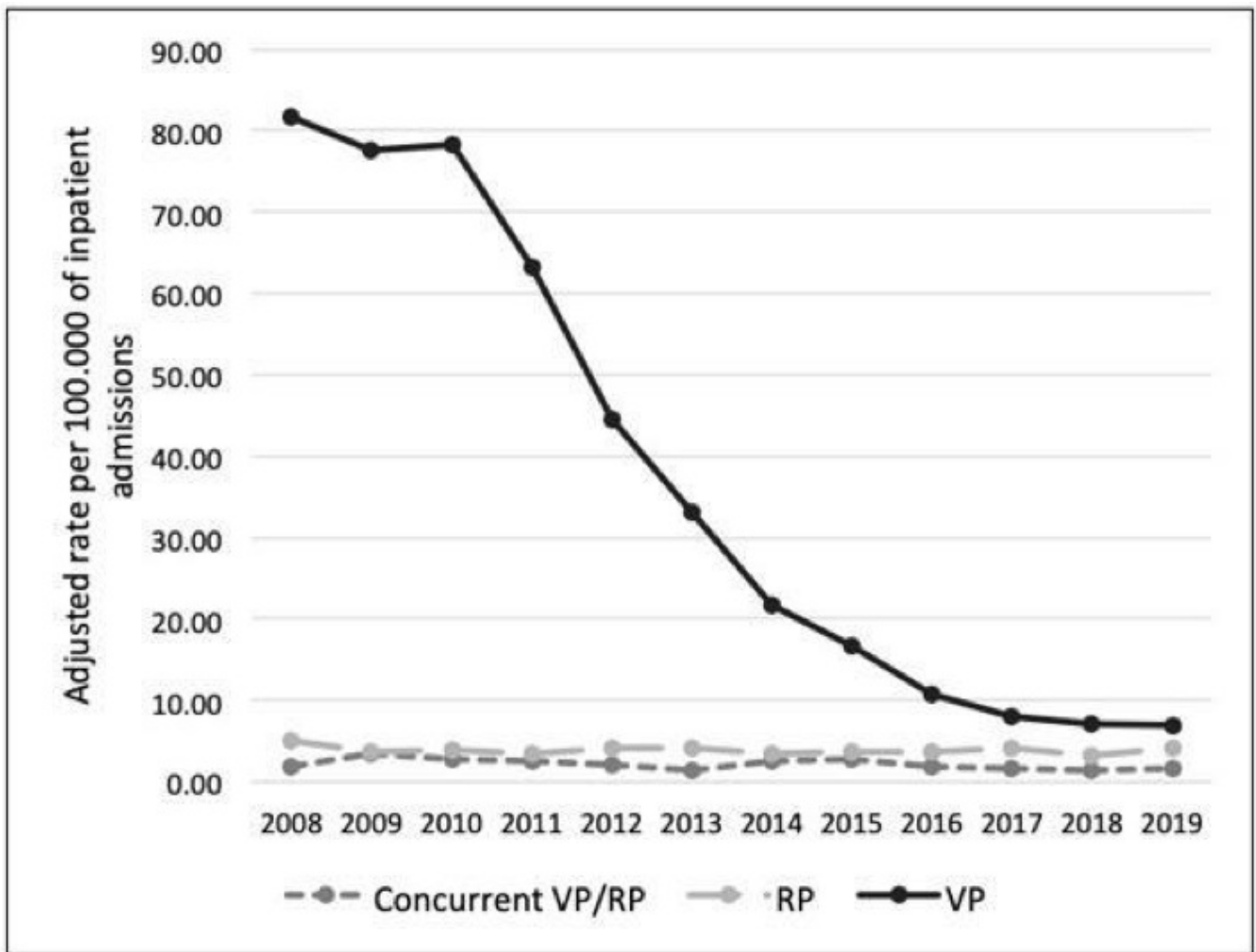


Figure 1. Inpatient admissions for rectal prolapse (RP), vaginal prolapse (VP), and concurrent RP/VP surgery, adjusted rates per 100.000 for WA State, 2008-2019.

Conclusions: In Washington State, the rate of inpatient RP and combined RP/VP surgical procedures between 2008-2009 was low and remained stable, while inpatient VP surgical repairs decreased. WA state trends in multidisciplinary RP/VP surgery do not seem to reflect the same increase as shown nationally, suggesting there is room for improving the utilization of multidisciplinary care.

Source of Funding: None

187 Metoidioplasty with Labia Minora Ring Flap Urethroplasty: Technique and Outcomes

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Abstract

Introduction and objectives

Transmasculine individuals in need of metoidioplasty often desire simultaneous urethroplasty, vaginectomy, scrotoplasty and perineal reconstruction. We describe our technique and surgical outcomes with the labial minora ring flap urethroplasty at time of metoidioplasty.

Methods

We retrospectively reviewed the outcomes of metoidioplasty patients who underwent urethral reconstruction at two centers. All urethral reconstruction utilized the labia minora ring flap technique without use of any vaginal wall flaps nor grafts. The flap is composed mostly of endodermal labia minora tissue and the tissue surrounding the vaginal introitus. The ring flap is transected inferiorly to create two separate flaps that are individually elevated. The ventral chordee of the clitoris is subsequently released and each flap is interposed between the ventral base of the clitoral epithelium and the superior aspect of the urethral meatus, forming the dorsal urethral plate. The flaps are then sewn to the urethral meatus and closed ventrally with dissection of local vascular flaps to cover the native urethral meatus anastomosis. Additional vascular tissue is used to cover the remainder of the urethral suture line.

Results

From Nov 2017 to June 2021, 52 patients underwent metoidioplasty with urethroplasty and concomitant vaginectomy by two surgeons (MC, BF). Mean followup is 22 months. Urethrocutaneous fistulas developed in 7 (13%) patients, 1 of whom had spontaneous closure of the fistula. Urethral strictures occurred in 4 (8%) patients, and two developed a urethral pseudodiverticulum. Fistula repair and/or urethroplasty was required in 8 (15%) patients. Non urethral complications included bacteremia (1 patient) and venous thromboembolism (1 patient).

Conclusions

The labia minora ring flap is safe and reliable for urethral reconstruction in patients desiring metoidioplasty. Fistulas often required revisions. Strictures may be associated with urethral pseudodiverticulum formation.

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GU Recon

114 Mindfulness Based-Stress Reduction Is Associated With Decreased Levels Of Patients' Anxiety After Urodynamics - A Prospective Randomized Controlled Trial

Hillary Wagner MD, Avi Assidon MD, Meghan Baranda MS, Forrest Jellison MD, Andrea Staack MD, PhD
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Abstract

Objective

Urodynamics (UDS) assesses lower urinary tract symptoms (LUTS). UDS is invasive, requiring intravesical, vaginal or rectal catheters. Prior studies show that although well tolerated, some patients have heightened anxiety and pain. The objective was to investigate mindfulness-based stress reduction protocol (MBSR) on patients' anxiety and pain during UDS and the effect of prior UDS.

Methods

A randomized controlled trial was performed of all patients (n=45) who underwent UDS between November 2020-May 2021. Patients were divided into MBSR (n=20) and no intervention groups (n=25). Exclusion criteria were age <18 years, incarceration, pregnancy, non-English speaking or insensate bladders. All patients underwent standardized education about UDS. The MBSR group listened to a mindfulness audio prompt before starting UDS. All patients completed validated questionnaires to assess their LUTS (Urogenital Distress Inventory 6, UDI-6), anxiety (State-Trait Anxiety Inventory 6, STAI-6), and pain (Visual Analog Scale, VAS) levels before and after the intervention. After UDS testing, patients completed a validated UDS - perception questionnaire and whether they had prior UDS. Statistical analysis included paired t-test, independent t-test, and Chi-squared tests. A p-value of ≤ 0.05 was considered statistically significant.

Results

The groups were similar in demographics (MBSR: mean age 64.1, no MSBR: mean age 58.2) and UDI-6 scores (MBSR: 9.0 vs. no MSBR: 10.8). The same number of patients underwent UDS before in each group (MSBR: 7 (35%) vs. no MBSR: 7 (28%)). There was no difference between both groups in terms of anxiety, total pain, or patient satisfaction scores. The MBSR group had decreased post-UDS anxiety subscores of "calmness" and "worried" while the control group had no change. The table illustrates that MBSR patients with no prior history of UDS had an improvement in the STAI-6 scores (p=0.04).

Conclusions

Utilizing a mindfulness-based stress reduction protocol may improve patients' anxiety after UDS, specifically in those with no prior experience of UDS. Future studies are needed for further evaluation.

	STAI-6 pre	STAI-6 post	P-Value
	Mean (SD)	Mean (SD)	
MBSR* no history of prior UDS	11.8 (2.4)	9.8 (3.4)	0.04
MBSR history of prior UDS	8.9 (4.5)	10.1 (3.5)	0.52
P Value	0.45	0.51	
No MBSR no history of prior UDS	13.2 (4.0)	10.7 (3.7)	0.08
No MBSR history of prior UDS	13.9 (4.0)	12.0 (6.4)	0.47
P Value	0.36	0.13	

*Mindfulness-based stress reduction (MBSR)

If funding provided, type in source company / entity name(s):

None

224 Association between stress, discrimination and lower urinary tract symptoms among Latina women in Los Angeles

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Abstract

Introduction:

Stress has been associated with lower urinary tract symptoms (LUTS) but little research has been conducted in this area, especially among Latina women. We evaluated the role of perceived discrimination and perceived stress in LUTS among Latina women in Los Angeles.

Methods:

We conducted analyses using data from a cross-sectional study of Spanish and English-speaking Latina women with and without pelvic floor disorders (PFDs) recruited from Urology and Urogynecology clinics at a large private or public hospital, as well as community sites in Los Angeles through 2019. Study participants completed psychometric measures such as the Everyday Discrimination Scale (EDS), and the Perceived Stress Scale (PSS). We identified women who had urinary symptoms based on the Urogenital Distress Inventory (UDI-6) portion of the Pelvic Floor Disorders Inventory (PFDI-20) questionnaire. We conducted multinomial logistic regression to test the association between PSS and EDS average scores and urinary symptom severity (scale 0-4), adjusting for age, with statistical significance at a p-value ≤ 0.05 .

Results:

We identified a total of 344 women with urinary symptoms (191 from the community, 153 in clinic). Clinic women had higher average scores on social stress metrics than community women ($p < 0.01$). Among community women we observed positive associations for PSS and EDS with frequency (U1), urge incontinence (U2) and urinary pain (U6) ($p < 0.05$), plus urinary leakage with activity (U3) for EDS ($p < 0.05$). Among clinic women we observed positive associations between PSS and all urinary symptoms and for difficulty urinating (U5) for EDS, with a positive trend for the association between urinary symptom severity score and PSS among clinic women ($p < 0.05$).

Conclusions:

In community and clinic populations of Latina women with urinary symptoms, a relationship exists between urinary symptoms and social stress exposures, such as perceived stress and discrimination, which seems stronger for urinary pain in clinic women and for urge incontinence for community women. The divergent psychometric measures highlight the complexity of the biopsychosocial model for LUTS in Latina women.

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