0523: SAVING COST AND SAVING WATER! AN AUDIT ON FLUID WASTAGE DURING ROUTINE FLEXIBLE CYSTOSCOPY LISTS

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Aim: Amount of fluid needed for flexible cystoscopy is minimal. The remaining fluid in the bag would be handled differently in different centres. Our aim was to measure the amount of fluid discarded at Flexible cystoscopy and calculate the costs involved.

Methods: 132 patients attended for flexible cystoscopy between February & April 2014 were included. After every procedure, the fluid left over in the bag was measured. The average fluid wastage per patient was calculated.

Results: It was noted that for 132 patients, the amount of fluid discarded was 112,131 ml and the amount of fluid used was only 19,869 ml. The average fluid wasted per patient was 849.5 ml. When this was calculated in retrospect for the year 2013, for 1737 cases of flexible cystoscopy, it was found that about 1,475,581.5 ml (ie about 1500 litres / 325 gallons) of fluid was discarded.

Conclusion: 1. In time of economical difficulties there is an obligation to save money when safe and possible. 2. In our study we studied this and projected our costs and savings over a year. 3. We identified by changing we would have saved £1,607.6 - £3,844.56 amount of money on Flexible Cystoscopy per year.

0525: TRANSPERITONEAL LAPAROSCOPIC NEPHRECTOMY WITH INTACT SPECIMEN EXTRACTION VIA PFANNENSTIEL NEPHRECTOMY (PFN) VERSUS EXTENDED PORT SITE EXTRACTION (EPS): PRELIMINARY EXPERIENCE IN AN UNSELECTED POPULATION

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Aim: To confirm the hypothesis that intact renal specimen extraction via a Pfannenstiel incision for laparoscopic nephrectomy/nephroureterectomy versus an expanded port site incision causes less pain and therefore reduces inpatient stay.

Methods: The laparoscopic approach for nephrectomy/nephroureterectomy has gained acceptance as the standard treatment for most T1/T2 tumours [1,2]. In the UK most extraction is performed intact but there is a lack of consensus on optimal extraction site [1]. Tisdale and colleagues [1] in their case series of 150 which tested this hypothesis found patients having LRN had a shorter hospital stay (2.84 versus 3.37 days, P < 0.05) and required significantly less morphine (23.7 versus 47.3 mg, P < 0.006).

Results: There were no demographic differences between the groups. IV morphine consumption (P = 0.88), paracetamol consumption (P = 0.41) and duration of inpatient stay (P = 0.43) were shorter for PFN patients versus EPS patients. These figures were not significant.

Conclusion: This study has demonstrated that the use of Pfannenstiel extraction sites may have a role to play in intact specimen extraction during laparoscopic nephrectomy. These authors believe that further work in the shape of a randomised study is indicated to corroborate or refute previous assertions in the literature that the benefits of the Pfannenstiel extraction site extend beyond the cosmetic.

0545: THE EVALUATION OF ROUTINE HISTOLOGICAL SPECIMEN ANALYSIS FOR ADULT CIRCUMCISIONS IN A HIGH OUTPUT UROLOGY DEPARTMENT

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Aim: Our study aims were to determine: (i) the necessity of routine histological analysis by comparing histological results and clinical suspicion of pathology for adult circumcision samples; and (ii) rates of undiagnosed cancer.

Methods: Adult circumcision samples (N = 100) performed at Nottingham City Hospital from 17/09/2013 to 17/09/2013 were analysed retrospectively. The surgical indication and histological result for each sample were documented. Subsequently, the clinical prediction and the pathological result were compared.

Results: CLINICAL INDICATION: When cancer was not suspected (N = 94), the most common indication for surgery was phimosis (N = 80). Cancer was suspected in 6 patients.

HISTOPATHOLOGICAL RESULTS: For non-cancerous histology (N = 98), Balanitis Xerotica Obliterans (N = 58) was the most frequent result and there were no unpredicted cases of cancer. Of patients suspected for cancer (N = 6), two cases were confirmed. Overall, the clinical prediction matched the pathological results in 84% of patients.

Conclusion: When cancer was not suspected (N = 94), the histology result played little role in further management, and there were no unpredicted cancers. When cancer was suspected (N = 6), 4 cases were deemed non-cancerous after histology. Therefore, when cancer is not suspected, it is recommended that circumcision samples are not routinely analysed. When cancer is suspected, however, routine histological analysis remains integral.

0619: RECURRENCE-FREE SURVIVAL IN PATIENTS ON STATINS WITH HIGH-RISK NON-MUSCLE INVASIVE BLADDER CANCER (NMIBC) FOLLOWING INTRAVESICAL BACILLUS CALMETTE-GUERIN (BCG)

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Aim: Controversy exists regarding the impact of statins on the clinical effectiveness of BCG and we aimed to assess the impact of statin use on outcomes of patients with NMIBC following intravesical BCG therapy.

Methods: All patients who received intravesical BCG therapy for NMIBC between December 2001 and April 2010 were included in the study. 97 patients were retrospectively analysed. Patient demographics, bladder cancer pathology, BCG treatment regime, cystoscopic follow-up results, recurrence bladder cancer pathology and medications were recorded. Differences between patient characteristics were analysed using student t-test. Recurrence-free survival was analysed by Kaplan-Meier method.

Results: 30 patients (31%) were on a statin at time of first intravesical BCG. There was no significant difference in demographic characteristics between the group on a statin at time of initial intravesical BCG and those not on a statin (mean p value = 0.41). There was no significant difference in recurrence-free survival between groups (not on statin mean 75.3 months, on statin 50.2 months; log rank p = 0.26).

Conclusion: This single centre retrospective study showed that statins have no impact on bladder cancer recurrence-free or overall survival following intravesical BCG therapy for NMIBC. Based on these results patients should continue taking statins whilst receiving BCG therapy.

0648: TRANSPERITONEAL LAPAROSCOPIC NEPHRECTOMY WITH INTACT SPECIMEN EXTRACTION VIA PFANNENSTIEL NEPHRECTOMY (PFN) VERSUS EXTENDED PORT SITE EXTRACTION (EPS): PRELIMINARY EXPERIENCE IN AN UNSELECTED POPULATION

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Aim: In the UK there is a lack of consensus on optimal extraction site following laparoscopic nephrectomy (LPN)/ nephroureterectomy (LPNU). Multiple studies have suggested reduced analgesia requirements and shorter hospital stay following intact specimen extraction via Pfannenstiel incision. We aimed to confirm the feasibility of this compared to the conventional multiport approach.

Methods: Patients who underwent PFN or EPS extraction for LPN or LPNU were assessed. Outcome measures were duration of inpatient stay and total Morphone and Paracetamol consumption

Results: Seven PFN patients and five EPS patients were analysed. There was no statistically significant difference between study populations with regards to age. Although the Pfannenstiel group consumed less Paracetamol this was not statistically significant (3.9g +/- 2.2 versus 5.5g +/- 3.9). There was no statistically significant difference in equivalent morphine consumption between the study groups (27.3 +/- 13.3 EUP versus 25.4 +/- 29.6 mg). Whilst the mean duration of inpatient stay was less for the Pfannenstiel group this was not statistically significant.

Conclusion: Non-inferiority of PFN was demonstrated in terms of analgesia requirements and duration of inpatient stay. The study however was
limited by its small sample size. Therefore an RCT is planned to further corroborate the benefits of PPN.

**0667: HEXAMINOLEVULINATE FLUORESCENCE CYSTOSCOPY: AN AID TO DIAGNOSIS**

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**Aim:** The aim of this study was to evaluate if Hexaminolevulinate (Hexvix) fluorescence cystoscopy improved bladder tumour identification and management and whether repeated episodes of Hexvix incurred further benefits.

**Methods:** All patients undergoing Hexvix cystoscopy at a District General Hospital between October 2008 and October 2014 were incorporated. Data collected and analysed included reason for Hexvix, repeats of Hexvix, findings at white-light and Hexvix cystoscopies, complications, histology and outcomes.

**Results:** Sixty cases of Hexvix cystoscopies were performed on forty-nine patients. Nine had repeats and two had a further third episode. No complications were reported. Reasons for Hexvix included thirty-eight (63%) for surveillance/abnormal flexible cystoscopy, ten (16.7%) post-BCG treatment and ten (16.7%) persistently abnormal urine cytology. Twenty-two (36.7%) confirmed bladder carcinoma. Twenty-two cases documented white-light and Hexvix findings. Twelve described no abnormalities with white-light which fluoresced using Hexvix. Of these, five confirmed malignancy. Three of nine patients confirmed bladder malignancies after the initial Hexvix. Subsequent repeats detected no abnormalities.

**Conclusion:** Hexvix improved the detection of bladder tumours, particularly in CIS/pT1G3 tumours. It highlighted areas of malignancies not visualised by white-light cystoscopy. No additional benefits were seen from repeating Hexvix cystoscopies.

**0680: META-ANALYSIS OF HOLMIUM LASER ENucleation VERSUS TRANURETHRAL RESECTION OF PROSTATE FOR PATIENTS WITH BENIGN PROSTATIC OBSTRUCTION**

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**Aim:** This meta-analysis aims at comparing Holmium laser enucleation (HoLEP) versus transurethral resection of prostate (TURP) for patients with benign prostatic obstruction.

**Methods:** PubMed was searched for RCTs comparing HoLEP versus TURP using relevant search terms. Data were extracted from eligible studies and were analyzed using RevMan 5.3 for windows. In case of multiple reports for the same patients, we analyzed data from the most recent dataset.

**Results:** Nine RCTs (871 patients) were included in the final analysis. Follow up ranged from 6 to 92 months. For perioperative outcomes, hemoglobin loss (SMD= -0.41, 95% CI=[-0.60, -0.22]) and blood transfusion (RR=0.17, 95% CI=[0.05, 0.65]) were less in HoLEP than TURP. For post-operative outcomes, maximum flow rate (SMD=0.15, 95% CI=[0.00, 0.29]) and post-void residual volume (SMD=-0.27, 95% CI=[-0.46, -0.08]) were better in HoLEP than TURP. There was no difference in terms of IPPS (SMD= -0.01, 95% CI=[-0.20, 0.19]), AUA symptom score (SMD= -0.16, 95% CI=[-0.35, 0.02]) or Qol (SMD= -0.14, 95% CI=[-0.66, 0.33]). The overall relative risk of urethral strictures, incontinence and recatheterization did not favor either of the two modalities.

**Conclusion:** HoLEP achieved better changes in Qmax and PVR than TURP. Hemoglobin loss and perioperative blood transfusion were less in HoLEP than TURP.

**0757: A SERVICE IMPROVEMENT PROJECT FOR EMERGENCY UROLOGICAL ADMISSIONS**

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**Aim:** Increasing A&E attendances have resulted in more emergency urology referrals and subsequent admissions. At our Trust, the surgical senior house officer (SHO) is the gatekeeper for patients with possible urological problems. Our Trust has moved to a consultant-led service with loss of registrar cover out-of-hours. A previous Trust audit concluded 29% of all emergency urological admissions were inappropriate. The registrar timetable was therefore reconfigured to extend their hours from 8pm to 10pm to support the SHO. This re-audit reviewed admissions after these changes.

**Methods:** We retrospectively reviewed the notes of 77 patients who were admitted under the urology team during one month and compared results to the previous audit.

**Results:** Total preventable admissions dropped by 11%. Half of these admissions could be managed at home. 72% of inappropriate admission were admitted out-of-hours. Collectively, these patients stayed in hospital for a total of 46 days. The total cost for these days is estimated to be over £15,000.

**Conclusion:** Improvements in registrar timetabling resulted in a 11% decrease in inappropriate urological admissions, highlighting the importance of senior support and potential financial savings. Further investigation into the causes of inappropriate admissions is required e.g. depth of urological knowledge of admitting SHOs.

**0758: TIMING OF SECOND RESECTION IN HIGH-GRADE NON-MUSCLE-INVASIVE BLADDER CANCER: DOES DELAY ADVERSELY AFFECT OUTCOME?**

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**Aim:** In non-muscle-invasive bladder cancer (NMIBC), there is a risk that residual tumour may be present after initial resection and that the tumour is under-staged. There is still debate regarding the optimum timing of second resection although current guidelines advocate 2–6 weeks. The aim was to determine whether delay to second resection adversely affects disease outcomes in NMIBC.

**Methods:** This was a retrospective analysis of 56 patients with high-grade (G3) NMIBC from 2005–2010 who underwent repeat resection following initial TURBT. Data was collected from online databases.

**Results:** The majority of patients (61%; 34/56) had T1 disease. Out of 56 patients, 50% (28/56) had evidence of residual tumour on repeat resection; 14% (8/56) had been under-staged and 50% (4/8) of these had muscle-invasive disease which altered treatment. During follow-up, 61% (34/56) developed recurrence and 25% (14/56) disease progression. Time to second resection was <6 weeks in 30% (17/56) and >6 weeks in 70% (39/56). There was no significant difference in recurrence (76%/54%, p=0.11) or progression (35%/21%, p=0.24) between these two groups.

**Conclusion:** We find no significant difference on adverse outcomes when repeat resection is delayed beyond 6 weeks. Further research is required to determine the optimum timing for repeat resection.

**0783: ASSESSMENT OF CLINICAL OUTCOMES OF ORTHOTOPIC NEOBLADDER RECONSTRUCTION AFTER RADICAL CYSTECTOMY**

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**Aim:** In reconstructive urology orthotopic neobladder is the diversion of choice. It does not compromise oncological outcome, yields excellent functional results and cost effective compare to incontinent diversions. **Methods:** 128 patients underwent radical cystectomy April 2009 till October 2014. 109 ileal conduit and 19 had orthotopic neobladder reconstruction (ONB). Data collected from hospital notes, electronic records. Patients evaluation on functional outcomes (incontinence, infection, urinary retention, self catheterisation, oncological outcomes (cancer free survival(CSS), overall survival(OSS), cancer recurrence, pathological staging) and surgical complications (Clavien-Dindo).

**Results:** Total n=19 ONB reconstruction (male=16, female=3), age 67 ± 21 years, 67%(n=12) ASA-1, 37%(n=7), duration of surgery 370 ± 110 minutes, blood loss 700 ± 500 ml, Mortality (n=7) secondary to chest infection. CSS 100%(n=18) and OSS 94.7% at a median follow-up of 36 ± 14 months. Local