Newsletter

West Zone Urology Society

July 10th, 2019

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From the desk of President & Secretary

Dr. Ajay Bhandarkar

July 10th, 2019

From the desk of the president

Dr. Hemant Pathak
Honorary President, WZ-USI,
Professor & Head, Department of Urology,
B Y L Nair Hospital, Mumbai

Dear Friends,

After assuming office we have had good academic activities.

In our Department at Nair Hospital, Mumbai the Reconstructive Urology Workshop in May 2019 was well attended. We could showcase good variety of pediatric urology and urethral reconstruction.

The Department of Urology Nair Hospital in collaboration with Mumbai Urology Society and West zone USI resulted in a successful conference. It had good academic deliberations and live surgeries.

The September 2019 Conference to be held in Rajkot will also feature excellent academic program. Looking forward to seeing you in Rajkot.

Thanking you,

Yours sincerely,

Hemant Pathak

From the desk of the secretary

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Dear Esteemed members,

Greetings from the desk of Honorary Secretary, USI West Zone !!

It has been nearly eight months, since I accepted responsibility of Honorary Secretaryship for our zone. We as a governing council, are very pleased to bring out 2nd Newsletter for our zone. As a part of being responsible governing council members, we have taken several steps for the best interests of our USIWZ. While going through this newsletter, I am sure, you will appreciate these changes.

In past few months, our zone has successfully conducted two astounding academic programs at Aurangabad and Mumbai. I wish to congratulate and thank all the people behind these endeavors. Overseas Conference cum Tour organized by our zone is always innovative and fun-filled ones. This time, visit to Balkan countries, Bulgaria and Romania, was very unique and outstanding trip by all means. Very interactive and informative academic session with Dr. Gleavelet Petrisor and his team at Bucharest was like a cherry on the cake.

Preparations for 29th Annual conference, WZUSICON at Rajkot on 26-28 September 2019 are in full swing. Organizing team of WZUSICON 2019 is all geared up to put up a great show. We have designed an interesting Scientific Program keeping Clinical Practicing Urologist in the mind. We intend to keep all sessions as interactive as possible. I request all members to plan and register for our own event and make it the most successful.

This newsletter is intended to keep you informed about the activities of our zone and I humbly request you to go through all-important announcements. Success of any organization or society lies in, sense of involvement and contribution by its members. I request you to come forward with your valuable suggestions. I am just phone call away and available 24x7 for any zone related activities.

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Important Announcements

Dr. Ajay Bhandarkar

Website related matters:

All members are requested to visit our newly constructed website www.usiwz.org

We have made all efforts to make this website more informative and attractive. We have also designed new WZUSI app (for Android and iOS). Members can access all the important information securely by using the "Members Area" sections.

In order to access the Members Area, members have to use their registered mobile number as user id and FIRSTNAMEMOBILENUMBER as password. For example for me, my user ID is 9825300222 (my mobile number) and password is AJAY9825300222.

We are also planning very informative and interesting academic sessions made live in USIWZ Academy sections.

We have plans for online registrations, digital payments etc. for all matters for upcoming conferences. We are also updating Members Data in our directory. Please contact me/Dr. Abhay Mahajan for any queries.

We invite your suggestions and ideas for making best use of website and WZUSI app. We are also working on e-voting for USIWZ elections.

Abstract Submission for WZUSICON 2019:

Last date for Abstract Submissions for upcoming WZUSICON 2019 at Rajkot is 15 July, 2019. You can submit your abstracts only online. Do not send by email to me. But, you can write to me for any help needed.

USIWZ supported academic activities:

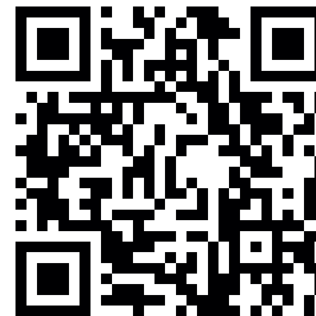
Applications are invited for USIWZ supported academic activities or Midterm CUE from different centers/states for year 2019-20. We can have 2-3 such programs with advance intimation to the governing council.

USIWZ Governing Council Election at WZUSICON 2019, Rajkot:

There will be vacancies for two posts (One post of President Elect and One Post for Executive Council Member) in the Governing Council of USIWZ for the year 2019-20.

Applications are invited from Full members of USIWZ for above posts. Last date for application for the candidature would be 31st July 2019. Withdrawal of application of candidature can be done before 15th August, 2019. Please send your duly filled form to Election officer in time.

Election officer
DR. LALIT SHAH
E-mail : drlalitshahraipur@yahoo.in



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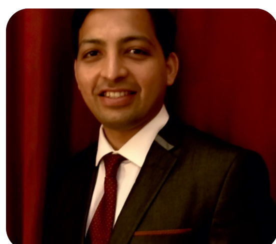
The R Sitharaman memorial essay competition award (2019) goes to….

Dr. Ankur Malpani

July 10th, 2019



Dr. Ankur Malpani is currently working as consultant urologist in Chirayu hospital , Bhopal . He has completed his graduation and post graduation from NSCB medical college, Jabalpur and subsequently c ompleted his urology training from Nadiad in year 2018. He has been awarded R Sitharaman memorial essay award for year 2019 on the topic " role of immunotherapy in bladder cancer".

The Role of Immunotherapy in Bladder Cancer

Introduction

Immunotherapy has found a strong role in bladder cancer treatment. It is now "fifth pillar" after the previous established chemotherapy, radiation, targeted therapy, surgery in the bladder cancer treatment.

The Concept of Immunotherapy

The promise of immunotherapy is for the body to heal itself. Immunotherapy, such as BCG, functions by stimulating the immune system in the same way as native TB. The infection of urothelial and bladder tumor cells by BCG results in internalization of BCG, which increases the expression of antigen-presenting cells. BCG enters bladder cancer cells where it is broken down and the antigenic fragments combine with the MHC complex on the tumor cell surface. This induces cytokine mediated immune response. Th1 cytokines (IL-2, TNF, IL-12, IFN-□) and Th2 cytokines (IL-4, 5,8,10) are involved. This immune cascade induces antitumor activity mediated by cytotoxic T lymphocytes(CD8+), natural killer cells, neutrophils, and macrophages. BCG immunotherapy now have a well established role in superficial bladder cancer (CIS,Ta,T1) for prevention as well as reducing the chances of recurrence. The optimum maintenance schedules varies from 1 year to 3 years.

Checkpoint regulators have prime role in preventing in self destructive immune responses and maintain peripheral self tolerance. Around twenty checkpoint molecule pairs, both co-stimulatory and co-inhibitory have been identified till date. Since these checkpoint molecules are up-regulated in suppressed T-cells, they can also be used as markers of "T-cell exhaustion". The two pairs of inhibitory receptor/ligands which have received the most attention in recent years are cytotoxic T lymphocyte-associated antigen-4 (CTLA-4) receptor with B7 ligand, and programmed cell death protein 1 (PD1) receptor with PD1-L1 ligand(figure 1).

AntiPD-L1 antibodies such as atezolizumab, durvalumab and avelumab block the ligand on the tumor cells and tumor-infiltrating immune cells so that they cannot interact to down-regulate the activated T cells(table 1). AntiPD-1 antibodies such as nivolumab and pembrolizumab block the receptor on the T cell so it cannot interact with the tumor cells or other tumor-infiltrating immune cells.CTLA-4 and PD-1/PD-L1 are nonredundant immune checkpoint pathways that are involved in T-cell activation and act at different stages of the anticancer immune response so that targeting each immune checkpoint provides the potential for additive or synergistic effects.

This review highlights few important trials with ICI in bladder cancer.

Nivolumab

Nivolumab, the first marketed PD-1 inhibitor is fully human monoclonal IgG4 anti PD-1 monoclonal antibody. A nonrandomized Checkmate 032 study (phase II) of nivolumab in around 78 patients with metastatic urothelial cancer showed an ORR of 24% for those with PD-L1 expression P1% on tumor cells (TC) versus 26% for those with PD-L1 expression <1%. Mean survival was 9.7 months . 22% of patients experienced grade 3/4 adverse events. Increased lipase or amylase, fatigue, neutropenia, and dyspnea were the most common.

Atezolizumab

Atezolizumab is human monoclonal anti PD-L1 antibody .In a phase 1 study for patients with metastatic urothelial carcinoma it proved a considerable second line option with a acceptable safety profile. Among 68 patients receiving Atezolizumab, ORR was 43% in the high PD-L1 expression group (more or equal to 5% in tumour / immune cells). Only 4% experienced grade 3 adverse effects.

The IM vigor 210 trial (Phase 2) was a multicentre, two-cohort trial. Cohort 2 included 310 patients with inoperable or locally advanced or metastatic urothelial carcinoma whose disease had progressed after previous platinum-based chemotherapy. Cohort 1 of IMvigor 210 evaluated the use of Atezolizumab in treatment-naive patients with locally advanced or metastatic urothelial cancer who were cisplatin ineligible. In cohort 1, with a median follow-up of 17.2months, the ORR for 119 patients

was 23%, however high PD-L1 expression did not correlate with higher ORR. The median OS was 15.9 months. 16 % observed adverse events grade 3 or above. Atezolizumab has been accepted as a first-line option for cisplatin ineligible patients with metastatic bladder cancer.

Pembrolizumab

KEYNOTE-045 (phase 3) a randomized trial of pembrolizumab versus chemotherapy in 542 patients with metastatic urothelial cancer, demonstrated additional OS benefit of 2.9 months versus chemotherapy as second line therapy .The ORR was also significantly improved by 10% with pembrolizumab .except pruritis , rest adverse effects were almost comparable.

Durvalumab

Durvalumab, a monoclonal antibody against PD-L1, was tested in phase 1/2 study of durvalumab in patients with metastatic urothelial bladder cancer .The ORR was 31% in the overall population of 61 patients and 46% in the patients with high PD-L1 expression .Grade 3 adverse events occurred in 5% of patients. The combination of durvalumab plus Tremelimumab(CTLA-4 inhibitor) versus standard-of-care chemotherapy in patients with advanced urothelial bladder cancer is ongoing.

Avelumab

JAVELIN is a multicentre open label dose escalation trial which is evaluating the response of Avelumab in advanced solid tumors. Interim analysis from this trial which is expected to complete soon, ORR of 17% , median OS 6.3 months and acceptable adverse event rate of 8%. JAVELIN BLADDER 100 is another trial evaluating response of avelumab versus best supportive care in patient who previously received chemotherapy.

DANUBE, a phase 3 trial of Durvalumab monotherapy versus combination Durvalumab and Tremelimumab (anti-CTLA4), versus standard of care chemotherapy in patients with stage IV unresectable urothelial cancer may answer the question of poor response rates with immunotherapy. Similarly KEYNOTE 698 a phase 3 randomized study of Pembrolizumab and Epacadostat (an IDO inhibitor) versus Pembrolizumab and placebo in the second line may answer question of synergy of ICI with other oncology drugs. IMvigor 130 and KEYNOTE-361 (both phase 3 trials) are investigating whether combination immunotherapy-chemotherapy will be more effective than immunotherapy alone .

Conclusion

Cisplatin based combination chemotherapy, the standard of care in cisplatin eligible patients, is associated with an OS of 14 to 15 months and a 5-year survival of 13% to 15%. In cisplatin ineligible patients other chemotherapy options are associated with an OS of 8 to 9 months. The facts tell us that the need for development for effective treatment for advanced bladder cancer is of utmost importance. Sincere efforts are being put in field of immune-oncology to provide a solution to poor results with second line chemotherapy drugs in these cases. This review brings light upon the relevant clinical trials which are evaluating the role of ICI in locally advanced or metastatic bladder cancer in second-line setting or as first line setting in cisplatin ineligible cases.

An improved understanding of the immunology and tumor biology has led to major advances in targeted immunotherapy. There are still some questions which require answers before ICI can prove themselves to be the fifth pillar of oncology. With better research methodologies, use of biomarkers and inculcation of gene information in clinical trials, immunotherapy may justify itself to be pivotal in bladder cancer management.

Recent important trials in Immunotherapy

	NUMBER OF PATIENTS	ORR	MEDIAN SURVIVAL
NIVOLUMAB Checkmate -032 Checkmate -275	78 275	24% 20%	9.7 months 8.9 months
PEMBROLIZUMAB Keynote -012 Keynote-045	27 542	13% 25%	13 months 10.3 months
ATEZOLIZUMAB Imvigor210	310	16%	7.9 months
AVELUMAB javelin study	161	17%	6.5 months
DURVALUMAB Study 1108	191	18%	18 months

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"PROSTASURG-CON 2019" & Mock Exam at Rajkot

Dr Abhay Mahajan, Organising Secretary and Council Member WZ-USI

July 10th, 2019

Operative workshop on various modalities of prostate surgery "PROSTASURG-CON 2091" was held on 3rd March 2019 at United Ciigma Hospital Aurangabad in association with Aurangabad Urology Association and under the auspices of West Zone Urological Society of India. Dr. Abhay Mahajan was the organizing secretary and Dr. Arun Chinchole was the Co-Organizing Secretary. Various modalities of prostate surgery techniques were demonstrated by expert faculties. For the first time HOLEP was performed by Pankaj Maheshwari on a 140 W Holmium laser with in-built morcellator Ketan Vartak demonstrated a very difficult THULEP and Dr. Ajay Bhandarkar showed his single lobe technique of HOLEP and one bipolar enucleation. Dr. Madhu Agrawal beautifully performed bipolar Vapo enucleation for a large prostate. Dr. Rajesh Kukreja performed a bipolar resection of prostate. Conventional monopolar TURP was also demonstrated by Dr. Deepak Kirpekar for the benefit of delegates and especially residents. Interspersed with the operative program were informative lectures delivered by Dr. Hemant Pathak, Dr. Mukund Andankar, and Dr. Sharad Somani. Around 70 Urologist attended the operative workshop.

Mock examination

Mock examination for 3rd year M.Ch. / D.N.B. residents was held at B.T. Savani Kidney Hospital, Rajkot on 9th & 10th March 2019 under the aegis of B.O.E. – I.S.I., 102 residents across the country participated enthusiastically. On 9th March, total 16 cases were discussed, in the manner of examination. Selection of cases covered wide spectrum of urological discusses and were nicely worked up cases. On 10th March lectures on "Radionuclides in urology" and "MRI in urology" were found very useful. Meet the professor session followed by X-rays, pathology specimens and instruments by Dr. Sabnis kept resident glued their seats. Arrangement in 3 lecture halls and auditorium were excellent. Dr. Vivek Joshi (Host) along with Dr. Aneesh Shreevastavav, Dr. Hemant Pathak, Dr. Rajeev T.P., Dr. Sabnis, Dr. Sujata Patwardhan, Dr. Shrenik Shah and Dr. Jitendra Amlani provided their services as faculty.

URORECON 2019

The Department of Urology at BYL Nair Ch Hospital & TNMC, Mumbai under the aegis of Mumbai Urological Society (MUS) & West Zone USI conducted a live operative workshop on Reconstructive Urology "URO RECON 2019" in the Urology Modular OT Complex at Nair Hospital with Live Streaming at the TNMC auditorium on 18th & 19th May 2019.

The conference took place under the able leadership of Dr. Hemant Pathak as the Organizing Chairman, Dr. Mukund Andankar as Organizing Secretary, Dr. Shivaji Nabar as President of the MUS & Dr. Ganesh Bakshi as Honorary Secretary, MUS.

The Workshop was attended by over 200 delegates from all over the country with more than 25 esteemed faculty in the field of Reconstructive Urology. Renowned faculty like Dr. Ganesh Gopalakrishnan, Dr. Amilal Bhat, Dr. Jiten Kulkarni, Dr. Shailesh Shah, Dr. Abhay Mahajan, Dr. Sanjay Kulkarni, Dr. Takwani, Dr. Shivaji Mane and Dr. Pankaj Joshi attended the conference and enriched the learning experience for the delegates.

27 cases were operated in the live operative workshop including complex urethroplasties, primary & complicated hypospadias repair, re do VVF, Retroperitoneal fibrosis. This provided a great opportunity for the attending delegates to sharpen their skills and update their knowledge in this field. We thank everyone involved for their support and co-operation in making the event a grand success.

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West Zone USI "Overseas Conference Tour: "Beauteous Balkans" 5-15 June, 2019

Dr. Rajendra Lahoti , Indore.

Balkan countries are a group of countries in southeast Europe, with rich history suppressed by Ottoman Empire for centuries and then by communist. Recently liberated. We went to Bulgaria and Romania although not a popular destination for Indians but rich in geography and culture and bordering Black Sea.

Day 1: Arrived in Sophia, capital city of Bulgaria (pop 70 million)

Day 2: City tour of Sophia Alexander Nevsky cathedral dedicated to Russian Saint who helped Bulgaria to get free from Turkey. Then saw Russian church, compare the architecture. Afternoon time was to climb Vitosha Mountain for Panoramic view of Sofia city.

Day 3: **Rila Monastery**-2 hr drive from Sophia. Biggest Orthodox Church of Bulgaria since 8th century, survived Ottoman Empire now UNESCO heritage.

Day 4: **Plovdiv :** UNESCO heritage. Declared 2019 Cultural city of Europe. Plovdiv is an ancient city built around 7 hills, in southern Bulgaria. The Regional Archaeological Museum chronicles the city's history, with exhibits including mosaic panels, clay lamps and early coins. The Roman-era Ancient Theatre of Philippopolis, which once seated around 6,000 now hosts opera and concerts

Day 5: **Sunny Beach:** on way to Sunny Beach Black Sea saw Rose farming for rose oil. Bulgaria produces 70% of world rose oil. Surprised to know oil producing Roses are different and only bloom once in a year. Reached Sunny beach in evening. A very popular holiday destination. Popular because of sand quality, mountain in background and warmer water of sea.

Day 6: Enjoyed boating, fishing and bathing in Black Sea. Later in the day went to see Nessebar island Many ruins of old churches. Starting point of Christianity in Bulgaria.

Day 7: Left for Bucharest via Varna. Here biggest gold treasure was found in grave digging. After crossing border in late evening we reached Bucharest, capital of Romania.

Day 8: Did local sightseeing in Bucharest Parliament building is one of the biggest. More than 1000 rooms and looks beautiful in night and musical colour fountains added attraction.

In the afternoon we had very interactive and informative academic session at **Department of Urology, Saint John Emergency Hospital, Bucharest.** There were presentations by Dr. Ajay Bhandarkar on Single Lobe Enucleation of Prostate, by Dr. Shirish Yande on Evolution of SUI surgery & by Dr Gaurang Shah on Robotic Partial Nephrectomy. Their Department Associate Professors presented their work in Bladder cancer, RIRS and Uretero-Renoscopy. All appreciated it very well.

Day 9: Visit Bran Castle. Surrounded by an aura of mystery and legend and perched high atop a 200-foot-high rock, Bran Castle owes its fame to its imposing towers and turrets as well as to the myth created around Bram Stocker's Dracula. Arrive Brasov & start walking tour in the old town of Brasov and a visit the famous Black Church.

Day 10: on way back to Bucharest enroute we visited Sinaia. Visit the famous and very beautiful Peles Castle, one of the best preserved royal palaces in Europe. It served as summer residence for several Romanian monarchs including King Carol I.

Last day evening, everyone enjoyed farewell Gala Dinner in traditional Indian dress at Local Indian Hotel Taj.

Day11: Everyone departed for their journey back home from Bucharest with plenty of lifelong sweet memories, like visiting world heritage sites, fiercely fought Antakshari in the Bus, evening of talent show at Sunny Beach Hotel, fishing/swimming in the Black Sea followed by Drink and Dance on the boat... and many more.

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Nephron Sparing Surgery - When to do and when not to do ?

Dr Arvind P Ganpule & Dr Abhijit Patil
MPUH, Nadiad, Gujarat, India

July 10th, 2019

Introduction :

Traditionally, 30–40% of patients with RCC have died due to the disease as compared to 20% mortality rates associated with prostate and urinary bladder cancers. In India, the estimated incidence of RCC among males is about 2/100,000 population and among females is about 1/100,000 population. Stage at presentation is also different in India as that from those in West. Around 40% of patients presented with metastatic disease and only 22% in stage I in Joshi et al3 series while only 20% of patients presented at stage I and 42.6% of patients presented at stage III in Ray et al series. Most common stage in operated patients was T3 (25%) in Joshi et al series. SEER data suggest that 60–70% of their patients present at stage I.

With the development of ultrasound and computed tomography(CT), there was increase in incidence of small incidentally detected renal mass- small renal mass(SRM). The traditional radical nephrectomy would be overtreatment in such patients. With development of renal cooling, reno-protective techniques and renorrhaphy, partial nephrectomy gained momentum.

Licht and Novick (1993) reported their experience of 241 cases the median tumour size was 3.5 cm, and they demonstrated only two local recurrences with a 95% survival at 3 years. This paved the pathway for new surgical technique – Nephron Sparing Surgery.

The need for Nephron Sparing Surgery(NSS)

The following factors dictate the need for NSS:

- **Tumour biology:**

Even though modern imaging like contrast CT was useful for diagnosing renal malignancy without the need for renal biopsy, it had its own limitations. Nearly 20% of small renal mass are found to be benign on histopathology with diagnoses including oncocytoma, angiomyolipoma, metanephric adenoma or hemorrhagic cyst. At the same time Nguyen and Gill have shown that up to 5% of small renal mass can metastasize. Hence, NSS can cure the disease with the benefit of preserving maximum renal tissue.

- **Preservation of renal tissue:**

Chronic kidney disease, defined as a GFR <60 ml/min/m2, is a growing health problem all over the world. CKD has been shown to be an independent risk factor for cardiovascular disease, and studies have shown an increased mortality and hospitalization risk as GFR declines.

Campbell, Lane and colleagues proposed CKD categories in patients undergoing renal surgery based on CKD etiology. Patients with CKD due to medical causes who do not have renal cancer are identified as CKD-Medical (CKD-M). Patients with CKD before PN or RN and then undergo resection are classified as CKD-medical/surgical (CKD-M/S). Meanwhile, patients with normal baseline renal function who have eGFR <60 ml/min/1.73 m2 only after surgical resection are classified as CKD surgical(CKD-S).Consistent with data from EORTC30904, renal function in patients with CKD-S appears to largely remain stable following an initial drop after renal resection, while CKD-M/S and CKD-M cohorts experience progressive GFR decline.

Huang et al. showed in a series of 662 patients with a normal serum creatinine and RCC who underwent PN or RN, RN was an independent risk factor for the postoperative development of CKD on multivariate analysis. Thompson et al. described that in patients younger than 65 years at the time of surgery, RN was associated with an increased risk of death, even after controlling for common comorbid illnesses and tumour histology. Lau et al from Mayo clinic described that patients undergoing radical nephrectomy were more likely to have serum creatinine >2 mg% and proteinuria postoperatively. Thus, NSS for small renal mass preserves maximum available renal tissue, thereby preventing CKD progression and cardiovascular morbidity in future.

- **Oncological outcomes:**

The initial concern for NSS was tumour recurrence at margins, positive surgical margins and undiagnosed multifocal renal malignancy. Many studies have since demonstrated that gross resection of all tumour, as assessed intraoperatively by the surgeon, with microscopically negative margins, allows

Nephron Sparing Surgery - When to do and when not to do ?

West Zone Urology Society

Dr Arvind P Ganpule & Dr Abhijit Patil
MPUH, Nadiad, Gujarat, India

excellent local control without increased risk of recurrence, even without the need for a 1-cm margin of normal renal parenchyma. Routine frozen section of the resection bed is also no longer recommended. This finding also allowed surgeons to offer NSS to patients with perihilar, sinus or endophytic tumours in whom the 1-cm margin was previously a barrier. Investigators from Mayo Clinic and MSKCC reported that a positive surgical margin (5.5% in a series of 1344 patients) had no association with an increased risk of tumour recurrence or metastatic disease.

- **Factors deciding the indications of NSS :**

Though partial nephrectomy seems to have benefit over radical nephrectomy, it has its own limitations. If stretched for extended indications, it may be counter-productive.The feasibility of partial nephrectomy in any renal mass depends upon: tumor size, location, complexity, presence of adherent peri-nephric fat and previous renal surgery.We would discuss the various factors affecting the outcomes and complications of partial nephrectomy in renal carcinoma, thereby affecting the decision making.

1. Tumor size:2. Tumor location
3. Complex tumors
4. Presence of adherent peri-nephric fat
5. Previous renal surgery

Tumor size:

- **T1a tumours:**

"Physicians should prioritize PN for the management of the cT1a renal mass when intervention is indicated. In this setting, PN minimizes risk of CKD or CKD progression and is associated with favourable oncologic outcomes, including excellent local control. (AUA guidelines:Moderate Recommendation; Evidence Level:Grade B)".

The European randomized trial suggests that PN provides similar oncologic outcomes when compared to RN for clinically localized small (<5 cm) renal masses. 28 The AHRQ systematic review also reaffirms this for properly selected patients.

Thus the role of partial nephrectomy in T1a (<4cm) renal mass is quite proven and can have good overall survival with preservation of renal function.

- **T1b tumours and T2 tumours:**

Zhang et al reported the largest series analysis (about 1400 cases for each group) comparing PN to RN for larger (T1b and T2) renal masses. They inferred that PN had no different overall survival than RN for these T1b-2N0M0 patients. However, PN benefitted older (>65 years age), male patients with single kidney, clear cell pathology.

Recent studies suggest PN for T1b tumors can be safe, with similar oncologic outcomes and no increased risk of complications, even with laparoscopic approach. RN is utilized for many cT1b tumors and is the recommended treatment for T2a (7 to <10 cm) and greater tumors. Weight et al identified PN as an independent favor predictor of OS among a cohort composed of 212 PN and 298 RN patients with T1b non-metastatic RCC. On contrary, others did not find significant impact on OS and CSS of RCC patients between PN and RN approach.

Two single institutional studies demonstrated that PN for T2 or greater renal cell carcinoma preserves renal function and did not have any significant influence on OS and CSS. But a multiinstitutional study of 925 patients who underwent nephrectomy treatment for >7cm RCC revealed that PN for tumors> 7 cm was associated with higher mortality than RN with same cancer control as RN.

- **Locally advanced tumors:**

The role of PN in advanced renal tumours is controversial. The Mayo Clinic's experience of PN for T2, T3a, and T3b lesions was assessed by matching to a reference RN cohort by stage, tumor size, baseline renal function, age, and gender. PN as compared to RN was not associated with an increased risk of death from all causes or RCC-specific mortality. At median follow-up of 3.2 years, 15 PN patients (22%) and 69 RN patients (33%) had metastatic disease. Long et al reported outcomes of PN on masses ≥7 cm (including 41% >10 cm). In this series of 46 patients, the 5- and 10-year overall and RCC-specific survival rates were 94.5% and 70.9%, respectively.

These studies being single institutional and with limited number of patients, the role of PN in locally advanced tumours

Nephron Sparing Surgery - When to do and when not to do ?

Dr Arvind P Ganpule & Dr Abhijit Patil
MPUH, Nadiad, Gujarat, India

July 10th, 2019

should be taken with a pinch of salt.

- **Metastatic tumours:**

  There is a scarcity of data in the literature regarding the role of NSS in the setting of metastatic disease. Marberger et al. were the first to report the feasibility of NSS in three patients in 1981. Mohammed Shahait et al described a review article describing five articles reporting the use of NSS in the setting of mRCC have been published between 1996 and 2013. This was tried after the introduction of targeted therapy to the treatment algorithm for mRCC. A total of 192 patients have been described by all authors, with a follow-up range between 0 and 212 months. Patients most likely to benefit from a nephron-sparing approach are those for whom RN is not feasible due to preexisting renal impairment and patients with limited metastatic disease expected to enjoy prolonged survival with a combination surgical intervention and systemic therapy.

- **Complex tumours:**

  Patients who undergo complex NSS for large and/or anatomically complex masses may be exposed to perioperative and potential oncologic risks that would be avoided if RN were performed. Tumor excision and reconstruction are challenging for larger, endophytic, central, and hilar tumors when compared to smaller, peripheral, polar lesions. PN is not without complications which include bleeding, ischemia times, urine leaks, renal artery aneurysm/ arteriovenous malformation.

  Simhan et al demonstrated that tumors with high anatomic complexity (RENAL nephrometry score 10–12) were associated with higher estimated blood loss and a threefold greater incidence of major complications when compared to tumors of low complexity (RENAL score 4–6). Patients with more complex renal tumors, such as a completely endophytic tumor abutting the collecting system or a tumor in a kidney with an intrarenal pelvis, have a higher risk of post-PN urine leaks.

  Bruner et al in a Mayo clinic series reported that each nephrometry score point correlated with a 35% increase in the likelihood of urine leakage following PN with T1 renal tumors. Tanagho et al in muti-institutional, retrospective cohort study showed higher rates of perioperative and postoperative complications following PN for higher complexity renal masses, although most complications were minor (grade I or II).

- **Adhesive perinephric fat:**

  The quantity and the quality of the perinephric fat can influence the technical difficulty of a PN. The adherent perinephric fat rather than truncal fat affects the duration and difficulty of dissection for partial nephrectomy. Davidiuk et al. introduced an image-based scoring system, the Mayo Adhesive Probability (MAP), to predict intraoperative adherent perinephric fat, based on posterior perinephric fat thickness and stranding. The anticipation of "sticky" fat would allow surgeons to counsel patients on predicted anatomical challenges during PN and the possibility of conversion to RN.

  Lee et al in a review article consisting of eight series studying adherent perinephric fat (APF), concluded that APF is associated with increased operative time and estimated blood loss. However, there is no documented increase in warm ischaemia time or perioperative complications in patients with APF.

- **Previous renal surgery:**

  Ablative procedures such as radiofrequency ablation and cryotherapy are increasingly utilized in the management of SRMs, particularly in non-surgical candidates.

  The NSS following ablative surgery with recurrence is really challenging. A series from the National Cancer Institute reported more successful outcomes for PN after radiofrequency ablation. Most of these patients had severe fibrosis, but PN was completed in all patients (n=16) and required a prolonged operative time together with a greater risk of transfusion. The series had increase in the risk of complications such as prolonged urine leak and the need for re-operation.40 Though feasible in expert hands, NSS in such cases would still require more data to establish the role. This would also come with complication rate.

- **Verdict :**

  NSS definitely has role in management of renal malignancy. In properly selected cases, it preserves maximum renal tissue without affecting oncological outcomes. This prolongs the CKD onset and thereby decreasing cardiovascular morbidity in such patients. At the same time, the stretching limits and indications of NSS to advanced and complex tumours, should be done at high volume centres. It definitely has learning curve to prevent complications and have good oncological outcomes.

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Job Negotiation by Young Urologist

Dr Gaurang R. Shah, M.S.,M.Ch
(Genito-Urinary Surgery), LL.B.

India's corporate hospitals are set to gain on rapid growth in health care industry in India. Healthcare has become one of the largest sectors in terms of employment and revenue generation in India comprising hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance and medical equipment.

In ETHealthWorld | May 24, 2016 there was an article.

Doctors' life in corporate hospitals or individual practice? Which is better?

According to an ASSOCHAM-RNCOS report, India's health care market is expected to rise 3 fold to $372 bn in 2022 from $110 bn in 2016 at a compounded annual growth rate (CAGR) of 22%.

The factors supportive of growth are growing incidence of lifestyle diseases, more medical awareness, technological advancements and increasing investments by public and private sector.

They concluded that corporate hospitals are inevitable.

There was an article published in Scroll in 2018. **Is the corporate hospital killing small hospitals and exploiting patients?**

Technology like mobile devices is continuing to make communication more robust, strengthening the bonds between individual and corporate practitioners

According to a study conducted by staffing firm Robert Half, just 39% of workers negotiated their salary during their last job offer. It was surveyed that 46% male and 34% female negotiated their salaries. Age also played a factor in determining a worker's likelihood of entering salary negotiations. About 45% of workers between the ages of 18 and 34, 40% of those between the ages of 25 and 54 and just 30% of those over 55 negotiated.

In India only 20 to 25 percent doctors negotiate, and male to female ratio is 2:1. Age wise it is opposite of workers where older group had more percentage in negotiation.

Choosing not to negotiate can also hurt you in the long run says Paul McDonald, senior executive director at Robert Half. "Failing to negotiate can damage earning potential over the long term since raises and bonuses are often a percentage of base salary," he tells CNBC .

About 5% of the Indian government's annual expenditure goes towards healthcare. According to WHO, most of the healthcare expenditure in India - which averages $75 per capita - comes from the private spending of households.

The standards of India's public healthcare system contrast starkly with its private counterpart, which generates billions of dollars annually from medical tourism.

For local Indians, the cost of private healthcare is about 4 times greater than the country's public healthcare. About 72% of residents of rural areas and 79% of residents of urban areas use private healthcare services.

A young urologist can become maverick in a corporate hospital. To become iconoclast he has to be professional and proficient. His ability to colloquy with the organisation will decide his faith in future.

Once you are clear about your own goals and desires, begin to look for a suitable opportunity for your next employment. In the present scenario of rapidly changing dynamics of health industry, choosing a right hospital job at a right time is very crucial. Young doctors often lack experience searching jobs and negotiating contracts. Unfortunately, these aspects are not covered in their speciality training programs. Hastily made decisions may lead to frequent change of jobs, financial losses, and utter frustration. It is therefore advisable to the new consultants to make their initial selection with care. The candidates can make the process easier by avoiding seven common mistakes.

1. **Not launching a broad search.** First-time-job-seeking doctors should launch a broad search to have a better chance of finding an appropriate position. A constant and reliable source of information is your own colleagues. The NSI annual conference is an excellent venue for casual but directed conversations with doctors currently practicing in the settings you are considering. A closely bounded group like the Private Practitioner's Forum by Neurological Society of India (NSI) can help the new consultants by providing more informations and guidance on job prospects. A physical tour of the institute(s) of your interest with direct negotiations is also very useful. Electronic media based information systems like websites, whatsapp groups, facebook, etc. are extremely helpful to identify job opportunities. Employing physician recruiters or search agencies who can set up meetings with others.

Job Negotiation by Young Urologist

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July 10th, 2019

2. **Rushing to find a position.** The job search should be started early. If you wait too long, confusion and panic can set in, which may force you to accept an offer out of necessity rather than choice. It has been suggested to start the process atleast 12 months prior to the end of training to avoid having to make a rushed decision.
3. **Focussing only on large cities.** There is no shortage of job openings for new doctors if you are willing to work outside the large city limits. Many applicants feel difficulties to find positions because they gravitate toward large metropolitan areas. Better job opportunities and packages may be possible in smaller cities or on the outskirts of larger ones.
4. **Being too drawn toward employed positions.** New graduates are often attracted to employed positions with large health systems because those organizations mirror the environment where they received their training. While such jobs have advantages, new doctors should also be mindful of potential drawbacks, such as less autonomy and reduced income potential.
5. **Relying too much on a recruiter.** Many applicants work with a recruiter to find positions, and they can be helpful in securing offers. However, too much reliance on them should be avoided.
6. **Accepting the first reasonable offer.** A lot of young doctors jump at a job without doing much due diligence. Before accepting an offer, applicants must carefully scrutinize their contract, make sure the organization is a good culture fit, and consider waiting for another potential offers.
7. **Negotiating poorly.** Negotiations before signing the contract is extremely important because it heavily influences one's future career and prospects. One should not allow his/her pay-cheque to compromise the overall package. The new doctors should be careful not to indicate they are comfortable with a certain salary level only because it makes latter negotiations difficult. If you negotiate, there are 80% chances that you will get more. It might be worth considering the following points at the time of signing contract :

1. **Salary.** As you think appropriate. Insist on a well-defined and transparent structure for salary and other revenues.

   üThere are different modus vivendi which can be implemented during negotiation of salary.

   First, if fixed amount is standard practice then

   A. There should be increment of 25 % of your value and 10 % inflation rate . So one must get 35 % increment every year.

   B. Or take average of three years and ask for fixed salary.

   Second operandi is that you get fixed amount and 70% of the revenues you earn for institute. This basic amount should be enough for you to survive in that place .

   Third method is that you take 90% of the revenues and institute gets 10% of your earnings.And there is no basic salary.
2. **Family -** Accommodation should be provided by institute.
3. **Position -** As long as possible don't work under any one. You should have independent practice.
4. **Working hours -** Well defined. If you work more, you must have more benefits
5. **Leave -** As per the hospital schedule. Additional time off for research, education, conferences, and other academic activities
6. **Promotion -** Transparent. Scope for periodic promotions
7. **Equipments -** Hospital should provide the necessary equipment for regular functioning and special technology that you are specialized in.
8. **Research -** If you are interested ask for a research budget.
9. **Facilities -** For research, teaching, and learning
10. **Medicolegal coverage -** Should be complete and unconditional
11. **Health and medical treatment facilities -** Employer's responsibility
12. **Period.** Contract should be for a period of minimum 3-5 years
13. **Job security.** Termination or withdrawal of services should be completely based on the ethical committee's recommendation, and not the management's decision

How to Calculate Salaries ?

Today the value of M.Ch degree in private hospitals is about 1.5 Cr. Means if you take loan of 1.5 Cr. for 15 years you will land up paying 3 Cr. ruppes. That means one will be paying 1.6 acs per month. Above that your minimum expenditure of 70,000 Rs ie it amounts to 2.25 lacs minimum per month. All new comers up to 5 years in practice should unite and be on whats up group and keep on discussing your demands and your facilities so other can bargain in your favour

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29th ANNUAL CONFERENCE

UROLOGICAL SOCIETY OF INDIA - WEST ZONE

WZUSICON - 2019

" Tell me and I forget, teach me and I may remember, involve me and I learn "

- Benjamin Franklin

Dear Colleague,

The organising committee of **WZUSICON 2019** is glad to announce **" Pre-conference live operative workshop "** on 26th Sept. 2019. The theme selected holds the most common interest of Urologist that is **Endourological management of Stone & Benign Prostate diseases**. Come & join us in the process of learn, unlearn & relearn.

Tentatively planned surgeries:

RIRS | ULTRA-MINI-PERC | MINI-PERC | MICRO-PERC | BIPOLAR ENUCLEATION OF PROSTATE | HoLEP | ThuLAP

FACULTY LIST

INTERNATIONAL FACULTY

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Secretary,
American Urological Association

NATIONAL FACULTIES

Dr. Janak Desai

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26th to 28th September - 2019

VENUE : REGENCY LAGOON RESORT-RAJKOT

Web : www.wzusicon2019.in | Email : wzusicon2019@gmail.com

Scientific Program
29'th WZUSICON 2019, Rajkot, 26-28 September 2019

July 10th, 2019

Thursday, 26th September 2019

- **8:30 AM - 9:00 AM** : Breakfast and Registration
- **9:00 AM - 3:00 PM** : **Live Operative Workshop** (no formal lunch Break)
- "This Live Surgical Demonstration aims at showcasing Perspectives in Newer Techniques in the **surgical management of BPH and Calculus Disease.** Renowned International and national experts will operate, debate, discuss and share tips and tricks of the trade which can be useful for General Urologist in his routine clinical practice."
- **3: 00 PM - 3: 15 PM** : Tea / Coffee Break
- **3:15 PM - 5:30 PM** : **Semi Live (Video based Learning)** Session (20 minutes video + 10 minutes discussion). In this section of Semi-Live demonstration, experts shall show unedited videos of surgical procedures. Videos can be paused or fast-forwarded, as per requirement to make/explain the point. All steps of surgeries shall be explained with important landmarks and interactive discussion with moderators/audience will be encouraged.
  - **Moderator: Welcome & Opening Remarks**
  - **Laparoscopic Partial Nephrectomy**
  - **Hypospadias Repair**
  - **Robotic Radical Prostatectomy**
  - **Lotus Flap Perineal Urethrostomy**
  - **Take home messages and Concluding Remarks**
- **6:00 PM-7:00 PM** : **Inauguration of WZUSICON 2019**
- **7:00 PM-8-00 PM** : **Key Note Address**
- **8:00 PM onwards** : Entertainment Program followed by Inaugural Dinner

Friday, 27th September 2019

- **8:30 AM-10 AM** :
  - Hall A : **Podium Session 1**
  - Hall B : **Video Session 1**
  - Hall C : **Moderated Poster Session 1**
- **10:00 AM-12:00 Noon** : **Plenary Sessions;** Hall A
- **10: 00 AM-10:30 AM** : **V. V. Desai Oration**
- **10:30 AM-11:00 AM** : **A.G. Phadke Oration**
- **11:00 AM-11:30 AM** : **Invited Guest Lecture**
- **11:30 AM-11:45 AM** : Tea Break
- **11:45 AM-12: 30 PM** : **Coach on the Couch: "How difficult it was to Learn and Teach PCNLs?"**
- This section aims to have lively interaction by moderators with experts, Dr. Mahesh Desai/Dr. Janak Desai. In this witty and formal/informal chat, nuances of Percutaneous Stone Removal learning and teaching shall be discussed.
- **12: 30 PM to 1:30 PM** : **What went wrong ? : Handling Pediatric Urological Complications...**
- Anything can go wrong during surgical treatments. Do complications differ in Pediatric Urological procedures? This Video based interactive discussion by experts in the field of Pediatric Urology will be a great learning for all interested delegates.
- **1: 30 PM – 2: 00 PM** : Lunch Break
- **2:00 PM – 3: 00 PM** :
  - Hall A: **Podium Session 2**
  - Hall B : **Video Session 2**
  - Hall C : **Moderated Poster Session 2**

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- **3:00 PM-4:00 PM** : **Balloon Debate**
- There will be a very interesting Debate for a very common Urological Case, with four different options of management. Each expert in given time frame shall argue for the procedure. Exclusion of option/debater shall depend on audience poll. Moderator's decision shall be final. This unique interaction hopes to bring out best possible points of scientific evidence in every procedure.
- **"Surgical Treatment for 90 gram Obstructive BPH in 70 years old with well controlled DM, HTN"**

  1. Bipolar TURP/Enucleation 2. HolEP

  3. ThulEP 4. Robotic Simple Prostatectomy
- **4:00 PM-5:00 PM** : **Update on Urological Armamentarium**
- Industry is introducing many new Technologies, equipment and accessories to be used in EndoUrology and Laparoscopy. This section is dedicated for informative lectures and interaction by experts about options available and their usefulness for endourological procedures.

  a. Essential accessory instruments in Laparoscopic Urology **b.** New Lasers in Urology

  c. Debate in Flexible Uretero-renoscopy:
- "Disposable Single Use Ureteroscope is a game changer for RIRS "

  1. I, Agree 2.I don't think so.
- **5:00 PM-6:00 PM** : **Annual General Meeting**
- **7:30 PM onwards** : Banquet and Dinner

Saturday, 28th September, 2019

- **8:30-9:30 AM** : • Hall A: **Podium Session 3** • Hall B: **Video Session 3** •Hall C: **Moderated Poster Session 3**
- **9:45-10: 30 AM** : **"Let's talk about Residual Stones"**
- Miniaturization of endourolocial equipments has certainly reduced morbidity of surgical interventions in Calculus disease. Has it brought back the menace of Residual stone after Minimally Invasive Procedures? This section aims to shed the light on less talked about aspect of Modern stone management.
- **10:30-11:15 AM** : **"Pearls of Wisdom" in Urethroplasty**
- Urethral reconstruction is an art. Our experts have learnt this with lots of dedication and hard work. This session aims at educating delegates about their modifications in technique in Urethroplasties and evidence based knowledge they have gained over the years.
- **11:15-11: 30 AM** : Tea / Coffee Break
- **11: 30 AM-12: 30 PM** : **Karanjawala Symposium**
- Prostate Cancer is the most common urological malignancy treated by General Urologist. In his practice, he faces many dilemmas while adopting/advising correct approach in this subset of patients. Aim of this symposium is to focus on topics, which needs expert Uro-Oncologist/Radiologists' guidance.
- **"Burning Issues related to Diagnosis and Imaging in Cancer Prostate"** • **Interpreting Multi-Parametric MRI**
- **TRUS & Prostate Biopsy:** • **High PSA, negative Biopsy: What Next?** • **PET CT Scan: When & Why**

Veltam Plus

- **12:30-1: 30 PM** : **Urological Practice Management**
- Urological Education and Training are very important in shaping the career of Urologist. But, running a clinical Urological practice is different ball game. This session has topics/issues faced by practicing urologists, along with some discussion on how to ethically sell/popularize your expertise.

  A. Are Government Schemes, a death-knell for Nursing home practice? **B. How to preserve/handle Telescopes, our "Goldeneye"**

  C. Impending Litigation in Clinical Practice: words of advice. **D. Ethical Marketing in Urology**
- **1:30 PM-2:00 PM** : Lunch Break
- **2:00 PM-3:00 PM** : • Hall A: **Podium Session 4** • Hall B: **Video Session 4** •Hall C: **Moderated Poster Session 4**
- **3:00 PM-4:00 PM** : **"Trouble shooting in SUI surgeries: case based discussion"**
- Surgical procedures for Stress Urinary Incontinence may look simple and straightforward to practice. But, things can go wrong anytime. This interactive session with case based discussion is dedicated for common problems encountered during this routine procedure and their solutions.
- **4:00 PM-5:00 PM** : **Chitale Travelling Fellowship Urology Quiz**
- **5:00 PM-6:00 PM** : **"What is the right choice?"**
- There are many drug treatment options available for common urological diseases. Which drug to use? Why? These are important questions. This session aims to discuss advantages of each molecule/approach in given clinical condition.
- In Male LUTS : Alfuzosin or Silodosin
- In Metastatic CaP : Bilateral Orchiectomy + Bicalutamide LHRH or Antagonist + Aberaterone
- In OAB Darifenacin or Mirabegron
- **6:00-6:30 PM** : **Valedictory Function**
- **7: 30 PM onwards** : Dinner & Disperse

Editor's Note

It's a pleasure to come out with the next edition of our newsletter. We had interesting events in the last quarter like the ProstaSurg-Con (Aurangabad), Mock exam (Rajkot) and Urorecon (Mumbai) along with our overseas conference with lot of hard work put in by our members.

Preparations at Rajkot are in full swing for our next annual conference. On behalf of the local organizing team and the WZ-Council, I request you all to register for the same. The scientific program has been outlined in this edition of the newsletter.

If any of you would like to contribute with article/news towards the newsletter, requesting you to mail the same.

Please download our new WZ app. You can scan the QR code on page 3.

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