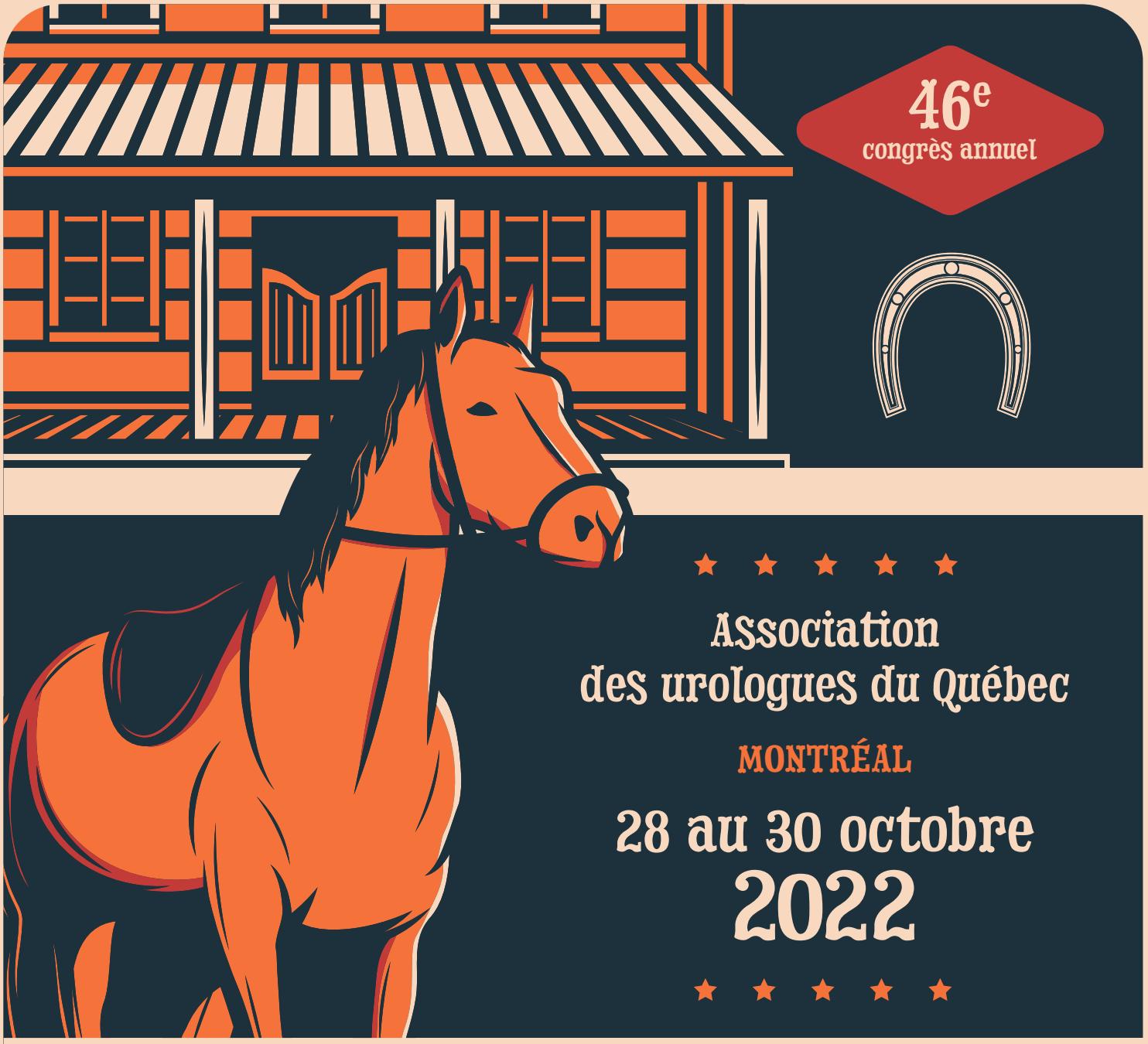

46e congrès annuel

Association des urologues du Québec

MONTRÉAL

28 au 30 octobre 2022

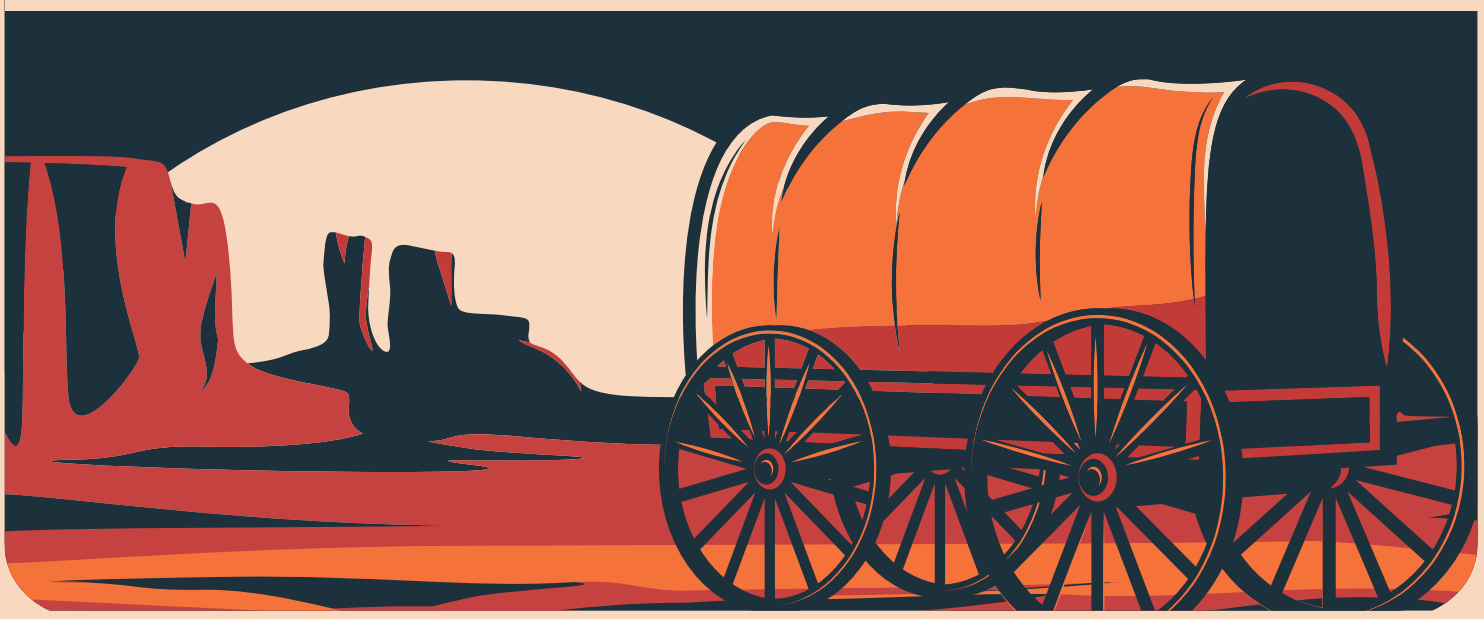

TABLE DES MATIÈRES

CONSEIL D'ADMINISTRATION DE L'A.U.Q.

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Dr Steven P. Lapointe, Président-sortant
Dr Frédéric Soucy, Vice-président
Dr Thierry Lebeau, Secrétaire
Dr Samer Hanna, Trésorier
Dr Gaétan Duchesnay, Conseiller
Dr Nader Fahmy, Conseiller
Dre Le Mai Tu, Présidente Comité DPC et Conseillère

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CONTINUING PROFESSIONAL DEVELOPMENT COMMITTEE

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Dr Mathieu Bettez
Dre Anne-Sophie Blais
Dre Marie-Pier Deschênes Rompré
Dr Nader Fahmy
Dre Nancy Girard
Dr Nawar Hanna
Dr Julien Letendre
Dr Vincent Trudeau
Dr Felix Couture (Résident)
Dre Ioana Fugaru (Résidente)

COMITÉ DE SÉLECTION (PRIX AUX RÉSIDENTS)

AWARD COMMITTEE (RESIDENTS'S AWARDS)

Dr Michel Carmel, président
Dre Mélanie Aubé-Peterkin
Dre Annie-Claude Blouin
Dr Matthieu Gratton

COMITÉ DE MISE EN CANDIDATURE

NOMINATING COMMITTEE

Dr François Bénard
Dr Michel Carmel
Dr Serge Carrier
Dre Marie-Paule Jammal
Dr Steven P. Lapointe

COMITÉ ORGANISATEUR DU 46E CONGRÈS ANNUEL (2022)

ORGANIZATION COMMITTEE OF THE 46th ANNUAL MEETING (2022)

Dre Le Mai Tu, Directrice scientifique
Dr Julien Letendre, Président du congrès

PRÉSIDENT DE L'ASSOCIATION DES UROLOGUES DU QUÉBEC DEPUIS 1966

1966 - 1967	Dr Arthur Bédard
1967 - 1968	Dr Kenneth MacKinnon
1968 -1969	Dr Jean Charbonneau
1969 -1970	Dr Clarence Schneiderman
1970 -1971	Dr Paul Dessureault
1971 -1972	Dr John A. Oliver
1972 -1973	Dr Jules Charron
1973 -1975	Dr Pierre E. Bertrand
1975 - 1976	Dr André Vallières
1976 -1977	Dr Ivan Laberge
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1983 -1985	Dr Gilles Béland
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1991 -1993	Dr Jean Simard
1993 -1995	Dr Luc Valiquette
1995 -1997	Dr Claude Trudel
1997 -1999	Dr Bruno Laroche
1999 - 2001	Dr Michael McCormack
2001 - 2003	Dr Fred Saad
2003 - 2005	Dr Réjean Roy
2005 - 2007	Dr Denis Allard
2007 - 2009	Dr Lorne Aaron
2009 - 2011	Dre Marie Paule Jammal
2011 - 2013	Dr François Bénard
2013 - 2015	Dr Serge Carrier
2015 - 2017	Dr Michel Carmel
2017 - 2020	Dr Steven P. Lapointe
Président actuel	Dr Alain Maillette

PRÉSIDENT DU COMITÉ D'ÉDUCATION MÉDICALE DEPUIS 1978

1978 - 1980	Dr Yves Homsy
1980 - 1982	Dr Erik Schick
1982 -1984	Dr Normand Sullivan
1984 - 1986	Dr Bruno Laroche
1986 - 1988	Dr Georges Assaf
1988 - 1991	Dr Luc Valiquette
1991 - 1995	Dr Claude Trudel
1995 - 2001	Dr Fred Saad
2001 - 2004	Dr Simon Tanguay
2004 - 2007	Dre Marie-Paule Jammal
2007 - 2010	Dr Paul Perrotte
2010 - 2013	Dr Steven P. Lapointe
2013 - 2016	Dre Martine Jolivet
2016 - 2019	Dr Samer Hanna
Présidente actuelle	Dre Le Mai Tu

PRIX JEAN CHARBONNEAU

Ce prix est accordé à un urologue ayant marqué de façon significative l'urologie au Québec, soit par son action au niveau de l'éducation, des soins aux patients, de la recherche ou par ses activités au sein de l'Association.

Récipiendaire 1995	Dr Paul Dessureault
Récipiendaire 1998	Dr Roméo Charrois
Récipiendaire 1999	Dr Pierre E. Bertrand
Récipiendaire 2000	Dr Normand Sullivan
Récipiendaire 2001	Dr Mostafa M. Elhilali
Récipiendaire 2002	Dr Jean-Paul Perreault
Récipiendaire 2004	Dr Claude Trudel
Récipiendaire 2007	Dr Yves Fradet
Récipiendaire 2010	Dr Luc Valiquette
Récipiendaire 2012	Dr Jean-Guy Vézina
Récipiendaire 2014	Dr Yosh Taguchi
Récipiendaire 2016	Dr Bruno Laroche
Récipiendaire 2018	Dr Fred Saad
Récipiendaire 2021	Dr Michel Carmel

CONSEIL D'ADMINISTRATION DE LA FONDATION DE L'AUQ

EXECUTIVE COMMITTEE OF THE QUA FONDATION

Dre Marie-Paule Jammal, Présidente

Dr François Bénard, Représentant
le président de l'AUQ

Dr Robert Sabbagh, Président Comité scientifique

Dre Johanne Drouin, Représentant
milieu non-universitaire

Dr Louis Lacombe, Représentant universitaire

Dr Samer Hanna, Trésorier / Secrétaire

La Fondation fut créée officiellement lors de l'assemblée générale annuelle de 1999. La Fondation a été par la suite accréditée à titre d'organisation à but non lucratif à la fin de l'année 2000.

Les objectifs de la Fondation sont les suivants :

- Promouvoir la qualité de l'urologie au Québec en octroyant des bourses d'études et de perfectionnement aux résidents et aux urologues et des subventions pour stimuler la recherche clinique et fondamentale.

The Foundation was created officially during the 1999 QUA Annual Meeting. At the end of year 2000, the Foundation received full accreditation as a non-profit organization.

The objectives of the Foundation are as follows:

- Promote the quality of Urology in Quebec by giving scholarships for post-graduate studies, and grants to stimulate clinical and fundamental research.

LES PRINCIPAUX COMMANDITAIRES DE LA FONDATION SONT ACTUELLEMENT :

L'ASSOCIATION DES UROLOGUES DU QUÉBEC	415 000 $
LA SOCIÉTÉ INTERNATIONALE D'UROLOGIE, SECTION CANADIENNE	300 000 $

Les compagnies pharmaceutiques suivantes ont promis un montant total de 200 000 $

ABBOTT LABORATORIES LTD.	200 000 $

Les compagnies pharmaceutiques suivantes ont dépassé l'objectif de 100 000 $

BAYER INC.	105 000 $
BOEHRINGER INGELHEIM (CANADA) LTD.	110 000 $
PFIZER CANADA	150 000 $
SANOFI-AVANTIS CANADA INC.	155 000 $

Les compagnies pharmaceutiques suivantes ont promis et contribué un montant de 100 000 $

ASTRAZENECA INC	100 000 $
ELI LILLY CANADA INC.	100 000 $
JANSSEN-ORTHO	100 000 $

Les compagnies pharmaceutiques suivantes ont aussi souscrit généreusement à la Fondation :

ASTELLAS PHARMA	50 000 $
BOSTON SCIENTIFIC LTD.	2 500 $
GLAXOSMITHKLINE INC	60 000 $
MERCK FROSST CANADA LTD.	75 000 $
NOVARTIS CANADA INC.	45 000 $

LA FONDATION DE L'ASSOCIATION DES UROLOGUES DU QUÉBEC A REMIS CETTE ANNÉE UNE BOURSE D'ÉTUDE AUX PERSONNES SUIVANTES :

LAURÉATS 2021

Dre Sara Jeanne Cyr

Urologie fonctionnelle et reconstructive

St-François d'Assise au Centre Hospitalier Universitaire de Québec,

Directeur de recherche : Dre Geneviève Nadeau

Dre Cora Fogaing

Fellowship en urologie reconstructive

Kulkarni Reconstructive Urology Center

Pune, India.

Directeur de recherche : Dr Sanjay Kulkarni

Dre Joanie Pelletier

Formation complémentaire en douleur pelvienne chronique et urologie fonctionnelle

Université de Sherbrooke, urologie

Directeur de recherche : Dre Le Mai Tu

Dre Élyse Potvin

Urologie pédiatrique et greffe rénale

CHUL de Québec et Hôtel-Dieu de Québec

Directeur de recherche : Dr Stéphane Bolduc

Marie Pier St-Laurent

Uro-Oncology Clinical Fellowship

Prostate Vancouver Center

Vancouver General Hospital et UBC Hospital

Directeur de recherche : Dr Alan So

LAURÉATS 2020

Dre Anne-Sophie Valiquette

Projet 1 : Validation externe du rôle du ratio neutrophiles-lymphocytes comme biomarqueur prédicteur de la réponse à l'abiratérone chez les patients CRPC métastatiques.

Projet 2 : Évaluer le rôle de la microscopie confocale pour les biopsies rénales ciblées, dans le diagnostic du carcinome rénal.

Centre hospitalier IVO (Instituto Valenciano de Oncologia),

Département de chirurgie, service d'urologie.

Valence, Espagne

Directeur de recherche : Dr José Rubio Briones

LAURÉATS 2019

Dre Mélanie Aubé-Peterkin

The impact of competence-based design (CBD) residency model on urology resident performance and confidence.

School of Health Professions Education (SHE)

Faculty of Health, Medicine and Life Sciences

Maastricht University, Maastricht, the Netherlands

Directeur de recherche: Dr. Danielle Verstegen, MHPE Programme Director

LAURÉATS 2018

Dre Anne-Sophie Blais

Assessing Semen Quality in Men Undergoing Checkpoint Inhibitor Therapy for Melanoma

Hospital for Sick Children

Toronto, Ontario

Directeur de recherche: Dr Armando Lorenzo

Dr Malek Meskawi

Identification of Novel High Quality Methylated DNA Markers in Renal Tumors: Whole Methylome Discovery, Tissue Validation, and Feasibility Testing in Blood and Urine

Mayo Clinic

Rochester, Minnesota

Directeur de recherché: Prof. Matthew Gettman

Dre Sophie Ramsay

L'urétroplastie ventral avec greffe de muqueuse buccale sans incision vaginale: une étude prospective à court terme

Austin Health

Victoria, Australia

Directeur de recherché: Dr Johan Gani

Dre Alice Yu

Impact of Multiparametric prostate MRI and Targeted Biopsy on the Cost and Clinical Outcomes of Active Surveillance.

Massachusetts General Hospital

Boston, Ma

Directeur de recherché: Dr Adam S. Feldman

LAURÉATS 2017

Dr Mounsif Azizi

Assessment of PD-L1 expression in invasive penile squamous cell carcinoma and its clinical correlates as prognostic factor and potential immunotherapeutic target

Dr Pierre-Alain Hueber

Identification of the molecular players of macula densa-derived stem cells in nephron repair

Dr Hugo Lavigueur-Blouin

Évaluation de la méthode optimale de décompression urgente du système collecteur pour le traitement de la pyonéphrose

LAURÉATS 2016

Dr Nawar Hanna

Regional Variation in Prostate Cancer Screening, Incidence and Mortality

Dr Salima Ismail

L'expression de Foxp3 et d'IDO dans le cancer de la vessie associé à shistosomiase vésicale

LAURÉATS 2015

Dr Nawar Hanna

Comparaison of Prostate Cancer Care across the USA, Canada, UK and Germany

Dr Salima Ismail

La Toxine Botulinique intravésicale durant le choc spinal

Dr Evan Kovac

A Prospective Study of MRI, PCA-3 and Genomic Testing in Predicting Future Important Prostate Cancer Diagnosis after an Initial Biopsy Showing ASAP or Low-risk Prostate Cancer

Dr Faysal Yafi

Efficacy of Mirabegron in the Prevention and Treatment of Erectile Dysfunction in a Rat Model

RENSEIGNEMENTS GÉNÉRAUX

L'horaire de cette année est modifié afin de tenir compte des mesures sanitaires.

Vendredi 28 o ctobre:

- Les inscriptions auront lieu au **Foyer Salle de Bal**, le vendredi 28 octobre 2022 à compter de 7 h 00.

  Registration will be held in **Foyer Salle de Bal** Friday October 28, 2022, from 7:00 A.M.

- Les réunions scientifiques ont lieu dans la **Salle de Bal Ouest** de 8 h 00 à 18 h 00

  Scientific meetings take place in the **Ballroom Ouest** from 8:00 a.m. to 6:00 p.m.

- Le petit déjeuner sera servi dans la **Salle de Bal Centre Est** de 7 h 00 à 9 h 00.

  Breakfast will be served in the **Ballroom Centre Est** from 7:00 to 9:00 a.m.

- Un déjeuner sera servi de 12 h 20 à 13 h 20 à la **Salle de Bal Centre Est**.

  A lunch will be served from 12:20 to 13:20 on in **Salle de Bal Centre Est**.

- Pause-santé » dans la **Salle de Bal Centre Est** qui a lieu de 15 h 36 à 16 h 35.

  pause-santé" in the **Ballroom Centre Est** which takes place from 3:36 am to 4:35 p.m.

- Cocktail offert par l'Association des urologues du Québec à la **Salle de Bal Centre Est** de 18 h 00 à 19 h 30

  Cocktail by the Association des urologues du Québec in **Salle de Bal Centre Est** from 6:00 p.m. to 7:30 p.m.

Samedi 29 octobre:

- Un petit déjeuner sera servi de 7 h 00 à 10 h 00 a.m. à la **Salle Drummond**.

  Breakfast will be served from 7:00 to 10:00 a.m. in the **Salle Drummond**

- Les réunions scientifiques ont lieu dans la **Salle de Bal Ouest** de 8 h 00 à 18 h 55

  Scientific meetings take place in the **Salle de Bal Ouest** from 8:00 a.m. to 6:55 p.m.

- Pause-santé » dans la Salle de **Bal Centre Est** qui a lieu de 9 h 30 à 10 h 15.

  "health break" in the **Ballroom Centre Est** which takes place from 9:30 a.m. to 10:15 a.m.

- Un déjeuner sera servi de 11 h 50 à 12 h 50 dans la **Salle Drummond**.

  A lunch will be served from 11:50 to 12:50 in the **Salle Drummond**

- Le Banquet du Président aura lieu à 19 h 30 à la **Salle Drummond**. Assurez-vous d'avoir vos billets.

  the President's Ball will be at 7:30 P.M. in the **Salle Drummond**. Be sure to have your tickets.

Dimanche 30 octobre:

- Un petit déjeuner sera servi de 8 h 00 à 9 h 00 a.m. à la **Salle Drummond**.

  Breakfast will be served from 8:00 to 9:00 a.m. in the **Salle Drummond**.

- Les réunions scientifiques ont lieu dans la **Salle de Bal Ouest** de 9 h 00 à 12 h 00

  Scientific meetings take place in the **Ballroom Ouest** from 9:00 a.m. to 12:00 p.m.

Les frais d'inscription au congrès et de banquet pour les urologues en règle de l'Association des Urologues du Québec sont de 550 $. Ces frais sont inclus et prélevés à même la cotisation annuelle. Les frais d'inscription pour les urologues non-membres de l'Association sont de 950 $.

Pour les résidents inscrits dans les programmes universitaires du Québec, il n'y a pas de frais d'inscription.

The conference registration and banquet fee for the members of the Quebec Urological Association is $550. This fee is included and taken from the annual membership fee. Registration fee for non-member urologists is $950.

For the Quebec residents, there is no registration fee.

Le Banquet du Président est inclus dans la cotisation annuelle pour les membres de l'association inscrits au congrès mais ils doivent réserver leur billet. Un billet gratuit sera donné à tous les résidents qui présentent un résumé scientifique lors du congrès mais ils doivent le réserver. Toute autre personne désirant participer au Banquet du Président peut se procurer un billet au secrétariat au coût de 150 $ par personne (514) 350-5131.

The President's Banquet is included in the annual membership fee for the members of the association registered for the congress, but they must reserve their ticket. A free ticket will be given to all residents who present a scientific abstract at the conference, but they must book it. Any other person wishing to attend the President's Banquet may purchase a ticket from the Secretariat at a cost of $150 per person (514) 350-5131.

OBJECTIFS ÉDUCATIFS

L'objectif général du congrès annuel de l'Association est le maintien de la compétence et la mise à jour des connaissances de ses membres. Les objectifs spécifiques du programme incluent la mise à jour des connaissances de certaines conditions urologiques, une revue des nouveaux développements en urologie clinique et en recherche fondamentale :

AVEC LA CONTRIBUTION DES CONFÉRENCIERS INVITÉS

Dr Martin Plaisance
Néphrologue
Professeur agrégé
Faculté de médecine et des Sciences de la Santé
Université de Sherbrooke
CIUSSS Estrie – CHUS
Sherbrooke

Dre Maude Carmel
Associate Professor
Fellowship Program Director in Female Pelvic Medicine and Reconstructive Surgery
Department of Urology
University of Texas Southwestern Medical Center

Dre Christine Dionne
Interniste-Gériatre
CHU de Québec
Centre intégré universitaire de santé et de services sociaux (CIUSSS) de la Capitale-Nationale

Dre Catherine Pound
Physician Advisor, Safe Medical Care - Learning
Médecin conseil, Soins médicaux sécuritaires Apprentissage
ACPM

Dre Katherine Larivière
Médecin conseil, Soins médicaux sécuritaires Éducation
ACPM

CONFÉRENCIERS LOCAUX / TABLE RONDE

Dre Mélanie Aubé-Peterkin
Dr Mounsif Azizi
Dre Anne-Sophie Blais
Dr Thierry Dujardin
Dr Wassim Kassouf
Dre Andrea Kokorovic
Dre Geneviève Nadeau
Dr Paul Perrotte
Dr Frédéric Pouliot
Dr Patrick Richard
Dre Le Mai Tu
Dr Vincent Trudeau

DÉBAT DES RÉSIDENTS

Dr Samuel Tremblay
Dre Laurianne Garabed

De plus, les présentations cliniques libres et les comptes rendus de recherche stimuleront l'acquisition de connaissances nouvelles et informeront les membres des activités scientifiques de leurs collègues.

PROGRAMME GÉNÉRAL

VENDREDI 28 OCTOBRE 2022

07 h 00 - 15 h 00 Inscription
FOYER SALLE DE BAL

07 h 15 - 8 h 15 Petit déjeuner
SALLE DE BAL CENTRE EST

08 h 15 - 10 h 02 Sessions scientifiques
SALLE DE BAL OUEST

10 h 02 - 10 h 50 Pause santé
Visites des exposants
SALLE DE BAL CENTRE EST

10 h 50 - 12 h 20 Sessions scientifiques
SALLE DE BAL OUEST

12 h 20 - 13 h 20 Déjeuner
SALLE DE BAL CENTRE EST

13 h 20 - 15 h 36 Sessions scientifiques
SALLE DE BAL OUEST

15 h 36 - 16 h 35 Pause santé
Visites des exposants
SALLE DE BAL CENTRE EST

16 h 35 - 18 h 00 Sessions scientifiques
SALLE DE BAL OUEST

18 h 00 - 19 h 30 COCKTAIL AUQ/EXPOSANTS
SALLE DE BAL CENTRE-EST

SAMEDI 29 OCTOBRE 2022

07 h 00 - 10 h 00 Petit déjeuner
DUMMOND

08 h 00 - 09 h 30 Sessions scientifiques
SALLE DE BAL OUEST

09 h 30 - 10 h 15 Pause santé
Visite des exposants
SALLE DE BAL CENTRE EST

10 h 15 - 11 h 35 Sessions scientifiques
SALLE DE BAL OUEST

11 h 50 - 12 h 50 Déjeuner
DRUMMOND

12 h 50 - 15 h 50 Sessions scientifiques
SALLE DE BAL OUEST

15 h 55 - 18 h 25 ASSEMBLÉE GÉNÉRALE
ASSOCIATION DES UROLOGUES DU QUÉBEC
SALLE DE BAL OUEST

18 h 25 - 18 h 55 ASSEMBLÉE GÉNÉRALE
FONDATION DE L'ASSOCIATION DES UROLOGUES DU QUÉBEC
SALLE DE BAL OUEST

19 h - 19 h 30 Cocktail

19 h 30 - 00 h 00 Banquet du Président
SALLE DRUMMOND

DIMANCHE 30 OCTOBRE 2022

08 h 00 - 09 h 00 Petit déjeuner
DUMMOND

09 h 00 - 12 h 00 Sessions scientifiques
SALLE DE BAL OUEST

12 h 00 - 12 h 10 MOT DE LA FIN
Clôture du congrès

LA TENUE DE CETTE ACTIVITÉ A ÉTÉ RENDUE POSSIBLE GRÂCE À UNE SUBVENTION À VISÉE ÉDUCATIVE

PARTENAIRES PLATINUM (25,000$ ET PLUS)

ELITE SPONSORS ($25,000 AND MORE)

ASTELLAS PHARMA CANADA

BAYER CANADA

TOLMAR PHARMACEUTIQUES CANADA

PARTENAIRES OR (20,000 $ ET PLUS)

GOLD SPONSORS ($20,000 AND MORE)

JANSSEN INC.

MERCK CANADA

PARTENAIRES ARGENT (15,000 $ ET PLUS)

SILVER SPONSORS ($15,000 AND MORE)

ABBVIE CANADA

AMGEN CANADA

KNIGHT THERAPEUTICS INC.

MERCK CANADA/ASTRAZENECA

TERSERA CANADA

COLLABORATION SPÉCIALE

EXPOSANTS

Les compagnies suivantes ont contribué au succès de ce congrès en louant un espace d'exposition. Ces exposants pourront vous recevoir, vendredi de 8 h 00 à 18 h 30, samedi de 8 h 00 à 13 h 00 particulièrement pendant les pauses santé et les buffets du midi. Nous vous encourageons à leur rendre visite.

EXHIBITORS

The following exhibitors have contributed to the success of this meeting by reserving an exhibit area. You can visit their exhibits Friday from 8:00 A.M. to 6:30 P.M. and Saturday from 8:00 A.M. to 1:00 P.M. particularly during coffee and lunch breaks. We encourage you to visit all the displays.

ABBVIE

ADVANCED ACCELERATOR APPLICATIONS/NOVARTIS

AMGEN CANADA

ASTELLAS PHARMA CANADA

BAYER CANADA

BK MEDICAL

BLT MEDICAL TECHNOLOGIES INC.

BOSTON SCIENTIFIC LTD.

CLARION MEDICAL TECHNOLOGIES

COLOPLAST CANADA CORPORATION

COOK CANADA INC.

EMD SERONO/PFIZER

FERRING PHARMACEUTICAL CANADA

JANSSEN INC.

KARL STORZ ENDOSCOPY CANADA LTD.

KNIGHT THERAPEUTICS INC.

LABORIE MEDICAL TECHNOLOGIES INC.

MERCK / ASTRAZENECA

MERCK CANADA

OLYMPUS CANADA INC.

PENDOPHARM, DIVISION DE PHARMASCIENCE INC.

PHOTOCURE CANADA INC.

SEARCHLIGHT PHARMA INC.

TERSERA CANADA

TOLMAR PHARMACEUTIQUES CANADA

La présente activité est une activité de formation collective agréée (section 1) et d'un programme d'autoévaluation (PAE) agréé (section 3) au sens que lui donne le programme de Maintien du certificat (MDC) du Collège royal des médecins et chirurgiens du Canada ainsi qu'une activité de développement professionnel (catégorie A) et d'évaluation de l'exercice reconnue (catégorie B) au sens que lui donne le Collège des médecins du Québec. Cette activité a été approuvée par la direction de Développement professionnel continu (DDPC) de la Fédération des médecins spécialistes du Québec.

La DDPC reconnaît 15 heures pour l'activité globale. Vous pouvez déclarer un maximum de 14 heures en section 1 / activité de développement professionnel reconnue (catégorie A) et un maximum de 1 heure en section 3 / activité d'évaluation de l'exercice (catégorie B). Les participants doivent réclamer un nombre d'heures conforme à la durée de leur participation.

ACTIVITÉS 2023 - 2024

RÉUNION SEMI-ANNUELLE

17 au 19 février 2023

Espace 4 Saisons

Orford

CONGRÈS ANNUEL 2023

20 au 22 octobre 2023

Le Centre Sheraton Montréal

Montréal

CONGRÈS ANNUEL 2024

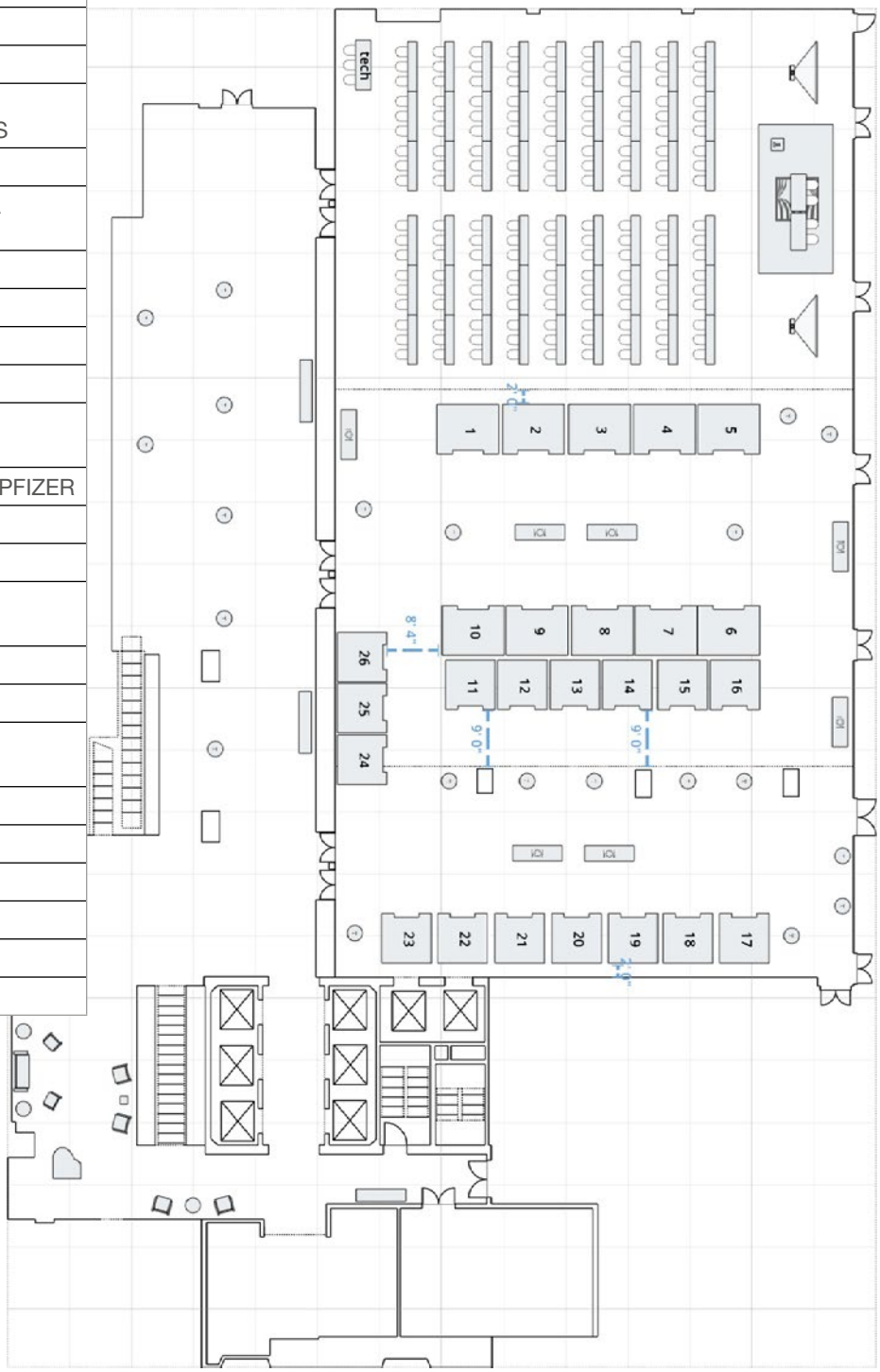
8 au 10 novembre 2024

Hilton Québec

Québec

PLAN DES EXPOSANTS

EXPOSANTS	KIOSQUE	KIOSQUE	EXPOSANTS
PAR NOM D'EXPOSANTS		PAR NUMÉRO DE KIOSQUE	
AAA CANADA	18	1	TOLMAR
ABBVIE	6	2	JANSSEN
AMGEN	3	3	AMGEN
ASTELLAS	9	4	TERSERA
BAYER	10	5	KNIGHT THERAPEUTICS
BK MEDICAL	24	6	ABBVIE
BTL MEDICAL	23	7	MERCK/ASTRA ZENECA
BOSTON	19	8	MERCK
CLARION	22	9	ASTELLAS
COLOPLAST	11	10	BAYER
COOK	16	11	COLOPLAST
EMD SERONO/ PFIZER	13	12	FERRING
FERRING	12	13	EMD SERONO/PFIZER
JANSSEN	2	14	PHOTOCURE
KARL STORZ	21	15	SEARCHLIGHT
KNIGHT THERAPEUTICS	5	16	COOK
LABORIE	25	17	OLYMPUS
MERCK	8	18	AAA CANADA
MERCK/ASTRA ZENECA	7	19	BOSTON
OLYMPUS	17	20	PENDOPHARM
PENDOPHARM	20	21	KARL STORZ
PHOTOCURE	14	22	CLARION
SEARCHLIGHT	15	23	BTL MEDICAL
TERSERA	4	24	BK MEDICAL
TOLMAR	1	25	LABORIE



SESSION I

VENDREDI 28 OCTOBRE 2022

CONCOURS ET PRÉSENTATIONS DES RÉSIDENTS ET FELLOWS

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure d'actualiser leurs connaissances sur les projets de recherche récents de la communauté universitaire québécoise en urologie et aussi des projets des jeunes urologues en fellowship.

Modérateurs : Dr Nawar Hanna et Dr Mohamed El-Sherbiny

08:15 - 08:24 Mot de bienvenue : Dre Le Mai Tu et Dr Julien Letendre

08:24 - 08:31 PERFORMING UROLOGICAL INPATIENT PROCEDURES AS SAME-DAY PROCEDURES DURING THE COVID PANDEMIC - A RESTROSPECTIVE FEASABILITY STUDY

Siron Nicolas[1, 2], Anis Assad[1, 2], Kevin Zorn[1, 2], Jean-Baptiste Lattouf[1, 2], Malek Meskawi[1, 2], Naeem Bhojani[1, 2]

[1]Université de Montréal, [2]CHUM

08:31 - 08:38 SECONDARY MALIGNANCIES AFTER RADIOTHERAPY FOR PROSTATE CANCER : A POPULATION-BASED STUDY

Patricia Quintana Barcena[1, 2], Armen Aprikian[1, 3], Alice Dragomir[1, 2]

[1]Urology, Department of Surgery, McGill University, [2]Research Institute of the McGill University Health Centre, [3]McGill University Health Centre; and ||Department of Oncology, Division of Radiation Oncology, McGill University, Montreal, QC

08:38 - 08:45 THE ASSOCIATION OF CORTICAL TRANSIT TIME (CTT) WITH DIURETIC DRAINAGE

Ioana Fugaru[1], Richard Liu[2], Alexa Ehlebracht[3], Sophie Turpin[2], Roman Jednak[1], Mohammed El-Sherbiny[1], John-Paul Capolicchio[1]

[1]Division of Urology, Departments of Pediatric Surgery and Surgery, Montreal Children's Hospital, McGill University, Montreal, Quebec, Canada, [2]Division of Nuclear Medicine, Department of Radiology, Montreal Children's Hospital, McGill University, Montreal, Quebec, Canada, [3]McGill Faculty of Medicine, Montreal, Quebec, Canada.

08:45 - 08:52 SWIPE RIGHT ON MALE INFERTILITY : EFFECT OF CELL PHONE

Francis Petrella[1], Kevin Y Chu[2], Kajal Khodamoradi[2], Alexandra Dullea[2], Ruben Blachman-Braun[2], John Zizzo[2], Ranjith Ramasamy[2]

[1]McGill University, [2]University of Miami

08:52 - 08:59 ABSENCE OF RECURRENCE AND ANDROGEN DEPRIVATION THERAPY IN HALF OF PATIENTS TREATED FOR HIGH-GRADE PROSTATE CANCERS AFTER RADICAL PROSTATECTOMY : A CASE FOR TREATMENT DESINTENSIFICATION

Daphnée Bédard-Tremblay[1], Nawar Touma[1], Bertrand Neveu[1], Hélene Hovington[1], Thierry Dujardin[1], Vincent Fradet[1], Yves Fradet[1], Michele Lodde[1], Rabi Tiguert[1], Louis Lacombe[1], Paul Toren[1], Frédéric Pouliot1

[1]Université Laval - CHU de Québec

08:59 - 09:06 ANALYSE DE LA QUALITÉ DE VIE CHEZ LES HOMMES À RISQUE DE DÉVELOPPER UN CANCER DE LA PROSTATE : RÉSULTATS DE LA COHORTE BIOMARQUEURS ET CANCER DE LA PROSTATE, PRÉVENTION ET ENVIRONNEMENT (BIOCAPPE)

Roxane Tourigny[1, 2], Hanane Moussa[1, 2], Karine Robitaille[1, 2], Vanessa Bussières[1], Fred Saad[3], Michel Carmel[4], Armen Aprikian[5], Yves Fradet[1], BIOCaPPE-GRePEC Network[1, 3, 4, 5], Vincent Fradet[1, 2]

[1]Centre de recherche du CHU de Québec-Université Laval, Québec, Qc, [2]Institut sur la nutrition et aliments fonctionnels (INAF) et centre NUTRISS, Université Laval, Québec, Qc, Canada, [3]Centre de recherche du CHUM, Montréal, Qc, [4]Centre de recherche du CHUS, Sherbrooke, Qc, [5]Institut de recherche du CUSM, Montréal, Qc

09:06 - 09:13 SEPTICÉMIE POST BIOPSIE DE PROSTATE : EXPÉRIENCE DE TROIS-RIVIÈRES

Catherine Morin[1], Mazen Jundi[1], Ariane Smith[1], Vincent Fournier-Cloutier[1], Julie Morisset[1], Alain Maillette[1], Sylvain Lapierre[1], Gaetan Duchesnay[1], Luc Marchand[1], Vincent Trudeau[1]

[1]Centre hospitalier affilié universitaire régional (CHAUR) - CIUSSS MCQ

09:13 - 09:20 IMPACT OF FRAILTY ON POSTOPERATIVE COMPLICATIONS AMONG ELDERLY PATIENTS UNDERGOING MAJOR UROLOGICAL PROCEDURES

Jessy Gatete[1], Jason Hu[1], Dr. Alice Dragomir[2], Dr. Wassim Kassouf[2]

[1]Experimental Surgery, McGill University, [2]Department of Surgery, Faculty of Medicine and Health Sciences, McGill University

09:20 - 09:27 ASSOCIATION BETWEEN TESTICULAR MICROLITHIASIS AND TUMORS IN PEDIATRICS : WOULD PRACTICE CHANGES AFFECT OUTCOME ? A 20 YEAR RETROSPECTIVE EXPERIENCE IN A LARGE TERTIARY CARE CENTER

Elyse Potvin[1], Julie Franc Guimond[1], Diego Barrieras[1], Valérie Hogues[1]

[1]Centre Hospitalier Universitaire Sainte-Justine, Division d'Urologie Pédiatrique, Université de Montréal

09:27 - 09:34 POSTOPERATIVE LEAVE IN UROLOGY : SURVEY TO UROLOGISTS OF CANADA

Karen Farag[1], Le Mai Tu[1], Salima Ismail1

[1]Université de Sherbrooke (CHUS)

09:34 - 09:41 PARTIAL GLAND ABLATION WITH HIGH INTENSITY FOCAL ULTRASOUND IMPACT ON GENITO-URINARY FUNCTION AND QUALITY OF LIFE : A SINGLE CENTER PILOT EXPERIENCE

Ioana Fugaru[1], Gautier Marcq[2], Alexis Rompré-Brodeur[1], Joseph Moryousef[3], Andrew Meng[3], Oleg Loutochin[1], George Loutochin[1], Maurice Anidjar[1], Frank Bladou[4], Raphael Sanchez-Salas[1]

[1]Division of Urology, Department of Surgery, McGill University, Montreal, QC, Canada, [2]Department of Urology, Claude Huriez Hospital, CHU Lille, Lille, France, [3]Faculty of Medicine, McGill University, Montreal, QC, Canada, [4]Department of Urology, Pellegrin University Hospital, Bordeaux, France

09:41 - 09:48 L'AMLEXANOX, UN INHIBITEUR DE IKK EPSILON, FAVORISE LA SENSIBILITE A L'OLAPARIB VIA LA REGULATION DE LA TRANSCRIPTION DE RAD51 DANS LE CANCER DE LA PROSTATE RESISTANT A LA CASTRATION.

Fayrouz Annab[1, 2], Sophie Gilbert[1, 2], Benjamin Péant [1, 2], Anne-Marie Mes-Masson[1, 2, 3], Fred Saad[1, 2, 3]

[1]Centre de recherche du Centre hospitalier de l'Université de Montréal (CRCHUM), Montreal, QC, Canada, [2]Institut du cancer de Montréal, Montreal, QC, Canada, [3]Department of Surgery, Université de Montréal, Montreal, QC, Canada

09:48 – 09:55 URETHROPLASTY SURGICAL WAIT-TIMES DURING COVID-19 : "FROM BAD TO WORSE"

Laurianne Rita Garabed[1], David-Dan Nguyen[2], Daniel Liberman[1]

[1]Centre Hospitalier de l'Université de Montréal, [2]University of Toronto

09:55- 10 :02 UTILIZATION TRENDS OF NOVEL HORMONAL AGENTS IN METASTATIC CASTRATION-RESISTANT PROSTATE CANCER IN QUEBEC

Jason Hu[1], Armen Aprikian[1], Ramy Saleh[2], Alice Dragomir1

[1]Division of Urology, McGill University, [2]Division of Medical Oncology, McGill University

10:02 - 10:50 PAUSE-SANTÉ

Visite des exposants

SESSION II

VENDREDI 28 OCTOBRE 2022

PRÉSENTATION DES ANCIENS LAURÉATS/TES DE LA FONDATION DE L'ASSOCIATION

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de :

- Discuter des controverses et nouveautés de la chirurgie préservant l'organe et de la lymphadénectomie inguinale
- Intégrer les nouveaux paradigmes de traitements dans la prise en charge des cancers du pénis localement avancé et métastatique.

Modératrice : Dre Marie-Paule Jammal

10:50 - 11:25 STRATÉGIES ET RÉSULTATS DES TRAITEMENTS POUR LE CANCER DU PÉNIS : OÙ EN SOMMES-NOUS EN 2022?

Conférencier : Dr Mounsif Azizi
Urologue
Hôpital du Sacré-Cœur de Montréal

11:25 - 11:35 PÉRIODE DE QUESTIONS

SESSION III

VENDREDI 28 OCTOBRE 2022

PRÉSENTATION DES ANCIENS LAURÉATS/TES DE LA FONDATION DE L'ASSOCIATION

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de :

- D'évaluer adéquatement le nouveau-né ou l'enfant présentant une hydronéphrose
- Établir un plan de prise en charge adapté de l'hydronéphrose chez le nouveau-né et l'enfant

Modératrice : Dre Marie-Paule Jammal

11:35 – 12 :10 L'HYDRONÉPHROSE PÉDIATRIQUE : UN SIMPLE PROBLÈME DE PLOMBERIE

Conférencière : Dre Anne-Sophie Blais
Urologue
CHU - CHUL

12:10 - 12:20 PÉRIODE DE QUESTIONS

12:20 - 13:20 DÉJEUNER

SESSION IV

VENDREDI 28 OCTOBRE 2022

CONCOURS ET PRÉSENTATION DES RÉSIDENTS ET FELLOWS

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure d'actualiser leurs connaissances sur les projets de recherche récents de la communauté universitaire québécoise en urologie et aussi des projets des jeunes urologues en fellowship.

Modérateurs : Dre Marie-Pier Deschênes-Rompré et Dr Samuel Lagabrielle

13:20 - 13:27 IMPACT OF URETHRAL CATHETERIZATION ON VOIDING EFFICIENCY IN CHILDREN

Ioana Fugaru[1], Marika Edvi[1], Lina di Re[1], Roman Jednak[1], Mohammed El-Sherbiny[1], Lysanne Campeau[2], John-Paul Capolicchio[1]

[1]Division of Pediatric Urology, Department of Pediatric Surgery, Montreal Children's Hospital, McGill University, Montreal, Quebec, Canada, [2]Division of Urology, Department of Surgery, Jewish General Hospital, McGill University, Montreal, Quebec, Canada.

13:27 - 13:34 THE ANTI-TUMOR ACTIVITY OF PREBIOTICS IN BLADDER CANCER

Jalal Laaraj[1, 2, 3], Gabriel Lachance[1, 3], Amenan Prisca Nadège Kone[1, 3], Yves Fradet[1, 2], Alain Bergeron[1, 2], Karine Robitaille[1, 3], Vincent Fradet[1, 2, 3]

[1]Laboratoire d'Uro-Oncologie Expérimentale, Oncology Axis, Centre de recherche du CHU de Québec-Université Laval and Centre de Recherche sur le Cancer de l'Université Laval, Québec, QC, Canada., [2]Faculty of Medicine, Laval University, QC, Canada., [3]Institut sur la nutrition et aliments fonctionnels (INAF) et centre NUTRISS, Université Laval, Québec, QC, Canada.

13:34 - 13:41 FIABILITÉ ET VALIDITÉ DE LA VERSION FRANCO-CANADIENNE DU SCORE DES SYMPTÔMES DE LA VESSIE NEUROGÈNE (SSVN)

Jonathan Fadel[1], Mahukpe Narcisse Ulrich Singbo[1], Marie-Pier Deschênes-Rompré[1], Michel Bureau[1], Geneviève Nadeau[1]

[1]CHU de Québec - Université Laval

13:41 - 13:48

ANALYZING OUTCOMES OF THE ADJUSTABLE TRANSOBTURATOR MALE SYSTEM (ATOMS) FOR POST-PROSTATECTOMY INCONTINENCE AND ITS RELATIONSHIP WITH OVERACTIVE BLADDERS AND RADIOTHERAPY WITH THE HELP OF URODYNAMICS

Samuel Farag[1], Joanie Pelletier[1], Salima Ismail[1], Le Mai Tu1

[1]CHUS Fleurimont- Université de Sherbrooke

13:48 - 13:55

COMPARAISON ENTRE LA NÉPHRECTOMIE PARTIELLE ROBOTIQUE TRANSPÉRITONÉALE ET RÉTROPÉRITONÉALE : NOTRE EXPÉRIENCE INITIALE DANS LE CIUSSS DE L'EST-DE-L'ÎLE-DE-MONTRÉAL

Massine Fellouah[1], Thierry Lebeau[1], Julien Letendre[1], Nawar Hanna1

[1]Département d'Urologie, CIUSSS de l'Est-de-l'île-de-Montréal, Université de Montréal

13:55 - 14:02

TRANSPERINEAL PROSTATE BIOPSY : REVIEW OF TECHNIQUE AND PRELIMINARY PATHOLOGICAL RESULTS AT OUR INSTITUTION

Elie Antebi[1], Christian Diab[1], Émilie Baillargeon[1], Daniel Jonathan Lewinshtein[1], Mahmoud Nachabé[1], Tal Benzvi[1], Philippe Arjane[1]

[1]Hôpital Charles Lemoyne

14:02 – 14 09

PREVALENCE OF QTC PROLONGATION IN PROSTATE CANCER PATIENTS UNDERGOING BRACHYTHERAPY

Daniel Taussky[1, 2], Simon Saad[1], Carole Lambert[1, 2], Maroie Barkati[1, 2], Charles Darianne[3, 4], Mikhael Laskine[2, 5], Guila Delouya[1, 2]

[1]Department of Radiation Oncology, University of Montreal Health Center, Montreal, Canada., [2]CRCHUM-Centre de Recherche du Centre Hospitalier, de l'Université de Montréal, Montreal, Canada., [3]Department of Urology, University of Montreal Health Center, Montreal, Canada., [4]Department of Urology, Hôpital européen Georges-Pompidou, Paris University, Paris, France., [5]Department of Medicine, Université de Montréal, Montreal, Quebec, Canada.

14:09 - 14:16

IMPACT DE LA DIÈTE RICHE EN GRAS ET DE L'ACTIVITÉ PHYSIQUE SUR LA PROGRESSION DU CANCER DE LA PROSTATE ET DE LA RÉPONSE AU TRAITEMENT À L'ENZALUTAMIDE

Patricia Langlois[1, 2], Amine Lounis[1, 2], Benjamin Péant[1, 2], Kim Leclerc-Desaulniers[1, 2], Anne-Marie Mes-Masson[1, 2, 3], Fred Saad[1, 2, 3]

[1]Centre de recherche du Centre hospitalier de l'Université de Montréal (CRCHUM), Montreal, QC, Canada., [2]Institut du cancer de Montréal, Montreal, QC, Canada., [3]Department of Surgery, Université de Montréal, Montreal, QC, Canada

14:16 - 14:23

COMBINATION IMMUNOTHERAPIES AND ANTI-ANDROGENS TO IMPROVE RESPONSE TO BLADDER CANCER IMMUNOTHERAPY

Typhaine Gris[1], Marjorie Besançon[1], France-Hélène Joncas[1], Valérie Picard[1], Alain Bergeron[1], Yves Fradet[1], Paul Toren1

[1]chu de Québec - Université Laval

14:23 -14:30

THE IMPACT OF BILATERAL STONE DISEASE ON PATIENTS' DISEASE PROGRESSION AND QUALITY OF LIFE

Brendan Raizenne[1], Claudia Deyirmendjian[2], Maimouna Balde[3], Seth Bechis[4], Roger Sur[4], Stephen Nakada[5], Jodi Antonelli[6], Necole Streeper[7], Sri Sivalingam[8], Davis Viprakasit[9], Timothy Averch[10], Jaime Landman[11], Thomas Chi[12], Vernon Pais Jr.[13], Ben Chew[14], Vincent Bird[15], Sero Andonian[16], Noah Canvasser[17], Jonathan Harper[18], Kristina Penniston[19], Naeem Bhojani[20]

[1]Division of Urology, Centre Hospitalier de l'Université de Montréal, Montréal, QC, Canada., [2]Faculty of Medicine, Université de Montréal, Montréal, QC, Canada., [3]Faculty of Sciences and Technologies, Gaston Berger University, Saint Louis, Senegal, [4]Department of Urology, University of California San Diego, San Diego, CA, USA, [5]Department of Urology, University of Wisconsin School of Medicine and Public Health, Madison, WI, USA., [6]Department of Urology, University of Texas Southwestern Medical Center, Dallas, TX, USA., [7]Division of Urology, Pennsylvania State University College of Medicine, Hershey, PA, USA., [8]Glickman Urological and Kidney Institute, Cleveland Clinic, Cleveland, OH, USA, [9]Department of Urology, University of North Carolina School of Medicine, Chapel Hill, NC, USA., [10]Department of Urology, Palmetto Health USC Medical Group, Columbia, SC, USA., [11]University of California Irvine School of Medicine, Orange, CA, USA., [12]Department of Urology, University of California San Francisco, San Francisco, CA, USA, [13]Urology Section, Dartmouth Hitchcock Medical Center, Lebanon, NH, USA., [14]Department of Urologic Sciences, University of British Columbia, Vancouver, BC, Canada., [15]Department of Urology, University of Florida College of Medicine, Gainesville, FL, USA., [16]Division of Urology, McGill University Health Center, Montreal, QC, Canada, [17]Department of Urology, University of California Davis, Sacramento, CA, USA, [18]Department of Urology, University of Washington, Seattle, WA, USA, [19]Department of Urology, University of Wisconsin School of Medicine and Public Health, Madison, WI, USA, [20]Division of Urology, Centre Hospitalier de l'Université de Montréal, Montréal, QC, Canada

14:30 - 14:37

PROJET BIOCaPPE_GRePEC : ANALYSES DES LIENS ENTRE DE POTENTIELS BIOMARQUEURS ET LE RISQUE DU CANCER DE LA PROSTATE

Lamoussa DIABATE[1, 2], Vanessa Bussières[3], Karine Robitaille[1, 2], Hélène Hovington[1], Afshin Jamshidi[1, 2], Pierre Julien[1], Fred Saad[4], Michel Carmel[5], Armen Aprikian[6], BIOCaPPE Network[1, 2, 4, 5, 6], Yves Fradet[1], Vincent Fradet[1, 2]

[1]Centre de recherche du CHU de Québec-Université Laval, Québec, Qc, [2]Institut sur la nutrition et aliments fonctionnels (INAF) et centre NUTRISS, Université Laval, Québec, Qc, [3]Centre de recherche du CHU de Québec-Université Laval, [4]Centre de Recherche du CHUM, Montréal, Qc; , [5]Centre de Recherche du CHUS, Sherbrooke, Qc, [6]Institut de Recherche du CUSM, Montréal, Qc.

14:37 - 14:44

BONE MINERAL DENSITY TESTING AND THE RISK OF FRACTURES IN MEN INITIATING ANDROGEN DEPRIVATION THERAPY : POPULATION-BASED STUDY

Jason Hu[1], Armen Aprikian[1], Alice Dragomir[1]

[1]Division of Urology, McGill University

14:44 - 14:51

CLINICAL OUTCOMES OF PATIENTS WITH METASTATIC RENAL CELL CARCINOMA (mRCC) WITH OR WITHOUT SARCOMATOID DIFFERENTIATION TREATED WITH SYSTEMIC THERAPY IN REAL-WORLD CANADIAN SETTING

Ghady Bou-Nehme Sawaya[1], Alice Dragomir[1], Christian Kollmannsberger[2], Naveen S. Basappa[3], Anil Kapoor[4], Denis Soulières[5], Antonio Finelli[6], Daniel Heng[7], Lori Wood[8], Vincent Castonguay[9], Christina Canil[10], Eric Winquist[11], Jeffrey Graham[12], Georg Bjarnason[13], Bimal Bhindi[7], Aly-Khan Lalani[4], Frédéric Pouliot[9], Rodney H. Breau[10], Simon Tanguay[14]

[1]Faculty of Medicine, McGill University; [2]BC Cancer Care Vancouver; [3]Alberta Health Services Edmonton; [4]Juravinski Hospital and Saint-Joseph's Healthcare Hamilton; [5]Centre Hospitalier de l'Université de Montréal; [6]University Health Network Toronto; [7]Alberta Health Services Calgary; [8]Capital Health Queen Elizabeth II Hospital Halifax; [9]Centre Hospitalier Universitaire de Québec; [10]The Ottawa Hospital; [11]Western University London; [12]Manitoba Cancer Care Winnipeg; [13]Sunnybrook Hospital Toronto; [14]McGill University Health Centre and Jewish General Hospital.

SESSION V

VENDRDI 28 OCTOBRE 2022

Objectifs éducatifs

À la fin de cette présentation, les participants seront en mesure de :

- Interpréter un bilan métabolique d'un patient lithiasique et d'identifier des désordres métaboliques et diététiques courants
- Initier un traitement préventif adapté chez un patient lithiasique

Modérateur : Dr Nader Fahmy

14:51 - 15:26 LITHIASES ET BILAN MÉTABOLIQUE

Conférencier :
Dr Martin Plaisance
Néphrologue
Professeur agrégé
Faculté de médecine et des Sciences de la Santé
Université de Sherbrooke
CIUSSS Estrie – CHUS
Sherbrooke

15:26 - 15:36 PÉRIODE DE QUESTIONS

15:36 - 16:35 PAUSE-SANTÉ

Salon des exposants

SESSION VI

VENDREDI 28 OCTOBRE 2022

Objectifs éducatifs

À la fin de cette présentation, les participants seront en mesure de :

- Discuter des avantages et désavantages de la biopsie de masses rénales
- Considérer les situations où la biopsie joue un rôle dans la prise en charge des masses rénales

Modérateur : Dr Mathieu Bettez

16:35 - 16:53 DÉBAT DES RÉSIDENTS : MASSE RÉNALE DE 3,5 CM – BIOPSIE : OUI OU NON ?
(2 min intro, 5 min chaque résident, 2 min contre-argument chaque, 2 min conclusion)

Dr Samuel Tremblay
Université Laval

Dre Laurianne Garabed
Université de Montréal

16:53 - 17:00 PÉRIODE DE QUESTIONS

18:00 - 20:00 AUQ / RENCONTRE : Cocktail avec les exposants

Salon des exposants

SESSION VII

SAMEDI 29 OCTOBRE 2022

Objectifs éducatifs

À la fin de cette présentation, les participants seront en mesure de :

- Adapter la prise en charge des patients porteurs d'un corps étranger présentant une infection génito-urinaire
- Déployer des stratégies de préventions des infections génito-urinaires chez les patients porteurs d'un corps étranger

Modératrice : Dre Anne-Sophie Blais

08:00 - 08:35 INFECTIONS GÉNITO-URINAIRES IMPLIQUANT DES CORPS ÉTRANGERS

Conférencière :
Dre Geneviève Nadeau
Urologue
CHUS-Hôpital de l'Enfant-Jésus

08:35 - 08:45 PÉRIODE DE QUESTIONS

SESSION VIII

SAMEDI 29 OCTOBRE 2022

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de :

- Reconnaitre les situations où la prise en charge endoscopique est envisageable
- Optimiser la prise en charge endoscopique des sténoses urétrales
- Choisir une approche endoscopique appropriée pour le patient

Modératrice : Dre Elizabeth Naud

08:45 - 09:20 TRAITEMENT ENDOSCOPIQUE DES STÉNOSES DE L'URÈTRE : QUI, QUAND ET COMMENT ?

Conférencière :
Dre Mélanie Aubé-Peterkin
Urologue
CUSM

09:20 - 09:30 PÉRIODE DE QUESTIONS

09:30 - 10:15 PAUSE SANTÉ

Salon des exposants

SESSION IX

SAMEDI 29 OCTOBRE 2022

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de :

- Discuter des enjeux québécois de l'urétropexie par bandelette chez les patientes avec incontinence urinaire d'effort
- Intégrer les lignes directrices récentes dans la pratique actuelle (SUFU/AUA ; SUFU/AUGS)
- Proposer une prise en charge adaptée aux différentes situations d'IUE (jeune vs âgé, ISI, obésité, après 1 ou plusieurs bandelettes)

Modératrice : Dre Martine Jolivet Tremblay

10:15 - 11:25 PANEL : INCONTINENCE URINAIRE D'EFFORT

Conférencières :
Dre Maude Carmel
Associate Professor
Fellowship Program Director in Female Pelvic Medicine and Reconstructive Surgery
Department of Urology
University of Texas Southwestern Medical Center

Dre Le Mai Tu
Professeur Titulaire
Service d'Urologie
CIUSSS de l'Estrie - CHUS
Faculté de Médecine
Université de Sherbrooke

11:25 - 11:35 PÉRIODE DE QUESTIONS

11:50 - 12:50 DÉJEUNER

SESSION X

SAMEDI 29 OCTOBRE 2022

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de :

- Se servir des outils permettant de procéder à une évaluation gériatrique des patients atteints d'un cancer urologique
- Discuter de stratégies de traitement uro-oncologique adaptées au patient gériatrique

Modérateur : Dr Nawar Hanna

12:50 - 13:25 CANCERS UROLOGIQUES CHEZ LE PATIENT ÂGÉ

Conférencière : Christine Dionne, M.D. FRCPC
Interniste-Gériatre
CHU de Québec
Centre intégré universitaire de santé et de services sociaux (CIUSSS) de la Capitale-Nationale

13:25 - 13:35 PÉRIODE DE QUESTIONS

SESSION XI

SAMEDI 29 OCTOBRE 2022

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de :

- Utiliser les outils diagnostics et les meilleurs traitements disponibles afin d'optimiser l'évaluation des cancers de prostate localisés, la surveillance active et le traitement des cancers localement avancés
- Élaborer une prise en charge des cancers de prostate récidivant après radiothérapie

Modérateur : Dr Vincent Trudeau

13:35 - 14:55 PANEL : LES DÉFIS DU CANCER DE PROSTATE LOCALISÉ

Conférenciers :
Dr Thierry Dujardin (Surv. active)
CHU-CHUL

Dr Paul Perrotte
Urologue
CHUM

Dr Frédéric Pouliot (local. avancé)
Urologue
CHU-Hôtel-Dieu de Québec

14:55 -15:05 PÉRIODE DE QUESTIONS

SESSION XII

SAMEDI 29 OCTOBRE 2022

Objectifs éducatifs

À la fin de cette conférence, les participants seront en mesure de :

- Évaluer adéquatement les patients présentant un syndrome de la vessie douloureuse/cystite interstitielle
- Proposer une prise en charge adaptée aux patients présentant un syndrome de la vessie douloureuse/ cystite interstitielle/dysfonction du plancher pelvien
- Appliquer les recommandations de la ligne directive récente de AUA dans notre pratique

Modératrice : Dre Le Mai Tu

15:05 - 15:40 MISE À JOUR SUR LE SYNDROME DE VESSIE DOULOUREUSE / CYSTITE INTERSTITIELLE / DYSFONCTION DU PLANCHER PELVIEN

Conférencière :
Dre Maude Carmel
Associate Professor
Fellowship Program Director in Female Pelvic Medicine and Reconstructive Surgery
Department of Urology
University of Texas Southwestern Medical Center

15:40 -15:50 PÉRIODE DE QUESTIONS

15:55 - 18:25 ASSEMBLÉE GÉNÉRALE ANNUELLE (2h30 heures)

ASSOCIATION DES UROLOGUES DU QUÉBEC

18 :25 - 18:55 ASSEMBLÉE GÉNÉRALE ANNUELLE DE LA FONDATION DE L'AUQ (30min)

FONDATION DE L'ASSOCIATION DES UROLOGUES DU QUÉBEC

19:00 - 19:30 Cocktail

19:30 - 00:00 Banquet du président

SESSION XIII

DIMANCHE 30 OCTOBRE 2022

Objectifs éducatifs

À la fin de cette présentation, les participants seront en mesure de:

- Optimiser la prise en charge de ces cas complexes
- Décrire le bilan initial de certains cas complexes d'uro-oncologie
- Utiliser l'approche multidisciplinaire devant des cas complexes d'uro-oncologie

Modérateurs : Dre Nancy Girard et Dr Alexandre Larouche

09:00 – 10 :00 PANEL : CAS COMPLEXES URO-ONCOLOGIQUES

Conférenciers :
Dre Andrea Kokorovic
Urologue
CHUM

Dr Patrick Richard
Urologue
CIUSSS de l'Estrie- CHUS

Dr Wassim Kassouf
Urologue
CUSM

10:00 – 10:15 PÉRIODE DE QUESTIONS

SESSION XIV

DIMANCHE 30 OCTOBRE 2022

Objectifs éducatifs

À la fin de cette présentation, les participants seront en mesure de :

- Discuter des problèmes médico-légaux les plus courants rencontrés par les urologues
- Identifier 3 stratégies pour réduire les risques médico-légaux les plus courants
- Démontrer comment favoriser la résilience dans le contexte des soins de santé actuel

Modératrice : Dre Martine Jolivet Tremblay

10:15 – 10 :50 SURMONTER LES DIFFICULTÉS MÉDICO-LÉGALES : REDONNER DU TRANCHANT À SON SCALPEL

Conférencières :
Catherine Pound, MSc, MPH, MD, FRCPC
Physician Advisor, Safe Medical Care - Learning
Médecin conseil, Soins médicaux sécuritaires – Apprentissage
ACPM

Dre Katherine Larivière
Médecin conseil, Soins médicaux sécuritaires – Éducation
ACPM

10:50 – 11:00 PÉRIODE DE QUESTIONS

SESSION XV

DIMANCHE 30 OCTOBRE 2022

Objectifs éducatifs

A la fin de cette session, les participants seront en mesure de:

- Vérifier l'état de leurs connaissances acquises lors du congrès en répondant à des questions à choix multiples sur des sujets précis en urologie
- Comparer leurs réponses à celles de leurs collègues
- Intégrer les connaissances acquises des différents sujets traités lors du congrès dans la pratique clinique

11:00 - 12:00 EPC Catégorie 3

QU'AVEZ-VOUS RETENU DES FAITS SAILLANTS DU CONGRÈS 2022 ?

Conférenciers :
Dre Anne-Sophie Blais
Urologue
CHU - CHUL

Dr Vincent Trudeau
Urologue
CHRTR-Pavillon Ste-Marie

12:00 - 12:05 CLÔTURE

Dre Le Mai Tu

ANNEXE 1

ABRÉGÉS SESSION I

PERFORMING UROLOGICAL INPATIENT PROCEDURES AS SAME-DAY PROCEDURES DURING THE COVID PANDEMIC - A RESTROSPECTIVE FEASABILITY STUDY

Siron Nicolas[1, 2], Anis Assad[1, 2], Kevin Zorn[1, 2], Jean-Baptiste Lattouf[1, 2], Malek Meskawi[1, 2], Naeem Bhojani[1, 2]

[1]Université de Montréal, [2]CHUM

INTRODUCTION AND OBJECTIVE:

In line with Canadian provincial directives due to the COVID-19 pandemic, certain urological procedures that are normally performed as inpatient procedures were performed as same-day procedures to reduce the usage of healthcare resources. At our centre, during the pandemic, we began performing laser enucleation of the prostate (LEP), robotic assisted radical prostatectomy (RARP) and percutaneous nephrolithotomy (PCNL) as outpatient surgeries. Recent literature has suggested that these procedures are safe and feasible as same day surgeries. Our goal was to determine if there was a difference in patient outcomes in LEP, RARP, and PCNL patients operated as same day surgery vs inpatient.

METHODS:

Patients operated for LEP, RARP or PCNL were studied between May 2020 to March 2022. Amongst LEP patients, 104 were identified as planned same-day procedures (PSD-LEP) and 65 were planned inpatient procedures (PIP-LEP). Amongst RARP patients, 46 were identified as planned same-day procedures (PSD-RARP) and 148 were planned inpatient procedures (PIP-RARP). Amongst PCNL patients, 38 were identified as planned same-day procedures (PSD-PCNL) and 12 were planned inpatient procedures (PIP-PCNL). PSD patients were compared to PIP patients for all patient groups with primary outcomes being SD failure, 30-day complications, and readmission rates.

Performing urological inpatient procedures as same-day procedures during the COVID pandemic– a retrospective feasibility study

RESULTS:

General patient characteristics such as age, American Society of Anesthesiologist classification, and Revised Cardiac Risk Index (RCRI) were similar between PSD and PIP in both patient populations (table 1). Of the PSD-LEP patients, 77.9 % [NB1] [NS2] were successfully discharged the day of the surgery. The overall post-operative complication, 30-day ED visits and readmission rates were 8.7 %, 3.8 %, and 1.0 % for PSD-LEP patients versus 23 % (p=0.017), 9.2 % (p=0.27), 4.6 % (p=0.32) for PIP-LEP patients, respectively (table 2). Of the PSD-RARP patients, 73.9 % were successfully discharged the day of the surgery. The overall post-operative complication, 30-day ED visits and readmission rates were 15.2 %, 17.4 %, and 4.3 % for PSD-RARP patients versus 6.1 % (p =0.097), 4.1 % (p <0.05), 1.4 % (p =0.51) for PIP-RARP patients, respectively. Of the PSD-PCNL patients, 71.1 % were successfully discharged the day of the surgery. The overall post-operative complication, 30-day ED visits and readmission rates were 21.1 %, 7.9 %, and 2.6 % for PSD-PCNL patients versus 16.7 % (p =1.0), 8.3 % (p =1.0), 8.3 % (p =1.0) for PIP-PCNL patients, respectively.

CONCLUSION:

Same-day discharge for LEP, RARP, and PCNL is safe and feasible in select patients with an acceptable and comparable complication rate.

SECONDARY MALIGNANCIES AFTER RADIOTHERAPY FOR PROSTATE CANCER : A POPULATION-BASED STUDY

Patricia Quintana Barcena[1, 2] Armen Aprikian[1, 3] Alice Dragomir[1, 2]

[1]Urology, Department of Surgery, McGill University, [2]Research Institute of the McGill University Health Centre, [3]McGill University Health Centre ; and ||Department of Oncology, Division of Radiation Oncology, McGill University, Montreal, QC.

BACKGROUND:

Survival of prostate cancer (PCa) patients has improved over time thanks to improvement of surgical and radiation therapy (RT) technics. Recent evidence has shown that receiving RT may predispose to secondary malignancies. This study aimed to assess the risk of secondary malignancies in men treated with RT and radical prostatectomy (RP).with an evidence of BCa or CRCa prior to PCa diagnosis were excluded. Inverse probability of treatment weighti

METHODS:

A cohort study was constructed using Quebec administrative databases (Med-Echo and RAMQ). This included men being diagnosed and treated with RP or RT for PCa patients between 2000-2016. The outcomes of interest were the incidence of bladder cancer (BCa) and colorectal cancer (CRCa). Follow-up ended at the earliest of the following : incidence of BCa or of CRCa, death, or Dec 31, 2016. Patients ng (IPTW) based on a propensity score was used to control for potential confounding. IPTW-Cox proportional hazards models were used to evaluate the associations between the initial PCa treatment (RT or RP) and the incidence of BCa, and CRCa, respectively.

RESULTS:

The cohort consisted of 15,544 and 27,838 patients, treated with external beam radiation therapy (EBRT) and RP, respectively, without androgen deprivation therapy. Among these, 118 and 95 patients presented evidence of BCa and CRCa, respectively, and were excluded for the analyses. Mean age was 70 years old in the RT group and 64 years old in the RP group. In the weighted cohorts, patients treated with RT exhibited a significant increased risk of CRCa (HR : 1.27, 95 %CI : 1.13 to 1.43), and of BCa, respectively (HR : 1.78, 95 %IC 1.54 to 2.07), compared to men treated with RP.

CONCLUSION :

Our study confirmed that men undergoing RT for prostate cancer had an increased risk of secondary bladder and colorectal cancer compared to patients undergoing RP.

THE ASSOCIATION OF CORTICAL TRANSIT TIME (CTT) WITH DIURETIC DRAINAGE TIME PARAMETERS IN ANTENATAL HYDRONEPHROSIS

Ioana Fugaru[1], Richard Liu[2], Alexa Ehlebracht[3], Sophie Turpin[2], Roman Jednak[1], Mohammed El-Sherbiny[1], John-Paul Capolicchio[1]

[1]Division of Urology, Departments of Pediatric Surgery and Surgery, Montreal Children's Hospital, McGill University, Montreal, Quebec, Canada, [2]Division of Nuclear Medicine, Department of Radiology, Montreal Children's Hospital, McGill University, Montreal, Quebec, Canada, [3]McGill Faculty of Medicine, Montreal, Quebec, Canada.

BACKGROUND:

There are no clear criteria that define obstruction in the context of AHN. Diuretic renogram determines the differential renal function (DRF), T1/2 and global washout (GWO) and can assist the clinician in their assessment. Cortical transit time (CTT) is another parameter that can aid in decision-making in AHN. Our primary objective is to determine the association of various CTT cut-offs, alone or in combination with T1/2 and GWO, with patient management.

METHODS:

We retrospectively reviewed 296 charts. We included 64 consecutive pyeloplasties (treatment group), who presented from 2010 to 2021, and 44 conservatively managed AHN with diuretic renogram (conservative group), from 2010 to 2016. Excluded were 55 patients >12 months old and 133 patients with other urinary abnormalities/ incomplete data. Initial ultrasounds and MAG-3 diuretic renograms were reviewed. Δ CTT between the affected and normal kidney was calculated. Chi-square/ Fisher and t-tests were used for categorical and continuous data. We performed ROC curves in order to evaluate the correlation of different CTT cut-offs with T1/2 and GWO. P-value was significant if <0.05.

RESULTS:

The pyeloplasty group consisted of 64 patients and the conservative group of 44 patients. Initial median DRF in the pyeloplasty group was 46 % and 51 % in the conservative group. Patients with T1/2 <5 min had a median CTT=3 min, those with T1/2 5-75min had CTT=5 min and those with T1/2 >75 min had CTT = 6 min. A cut-off of >3 min for CTT had the highest sensitivity to pyeloplasty (79.7 %) but poor specificity (54.6 %) (p=0.0004). CTT > 5 min had the best specificity (95.5 % ; p=0.0135). A cut-off for Δ CTT of ≥ 3 min had the highest specificity to pyeloplasty (97.7 %). For T1/2, the cut-off with the highest area under the curve (AUC) on the ROC curves was CTT> 5 min (AUC =0.84 ; p=0.0001) and Δ CTT ≥3 min (AUC=0.91 ; p=0.0001). For GWO, the best cut-offs were the same : CTT > 5 min (AUC=0.87 ; p<0.0001) and Δ CTT ≥ 3 min (AUC=0.91 ; p<0.0001).

CONCLUSIONS :

The previously suggested cut-off of CTT > 3 min is sensitive but not specific. We identify that initial CTT > 5 min and the presence of a Δ CTT ≥ 3 min may represent indicators of severity for children presenting with AHN. These cut-offs may be useful for tailoring the frequency and severity of follow-up imaging and may be of benefit in counselling families.

SWIPE RIGHT ON MALE INFERTILITY : EFFECT OF CELL PHONE RADIATION ON SPERM MOTILITY

Francis Petrella[1], Kevin Y Chu[2], Kajal Khodamoradi[2], Alexandra Dullea[2], Ruben Blachman-Braun[2], John Zizzo[2], Ranjith Ramasamy[2]

[1]McGill University, [2]University of Miami

INTRODUCTION:

Over the past decade, the relationship between humans and their smartphones have been marked with stark symbiosis. The advent of technology has prolonged the amount of time the cell phone resides in the pockets of men. This places the smartphone and its respective radiofrequency - electromagnetic radiation (RF- EMR) near the testicles. RF-EMR has been postulated to increase oxidative stress and induce free radical formation. We hypothesized that RF-EMR from cell phones has deleterious effects on sperm parameters, though these effects can be mitigated with solid mediums or distance.

METHODS:

We evaluated the impact of current generation smartphone, in talk mode, as the RF-EMR source. We certified the exposure to the specimen using calibrated RF-EMR meter. Initially, we studied the impact of RF-EMR on sperm motility and viability from fertile, normozoospermic men, between the ages of 25-35 years old by exposing their semen in an in vitro study over an 8-hour duration. We then determined whether using a cell phone case and increasing distance from semen sample would make a difference in outcomes.

RESULTS:

At 6 hours after exposure, we identified a decrease in sperm motility and viability in samples exposed to RF-EMR as compared to those samples that were not from fertile controls. With the addition of the case, we noted a smaller impact on total sperm motility and viability ($p = 0.01$, $p = 0.01$) as compared to direct RF-EMR exposure. In fact, moving the cell phone away by 3 inches represented the best mitigation strategy to deleterious effects on sperm motility and viability. Interestingly, when the phones were turned on in the talk-mode, most detrimental effects on sperm motility were identified.

CONCLUSIONS:

In this pilot study, we observe that the sperm parameters of motility and vitality are impacted with RF-EMR exposure from cell phones. Precautionary measures such as physical shields and increased distance from the scrotum dampened the effects of RF-EMR. Further in vivo research on the true impact of cell phone radiation on male fertility potential is warranted.

ABSENCE OF RECURRENCE AND ANDROGEN DEPRIVATION THERAPY IN HALF OF PATIENTS TREATED FOR HIGH-GRADE PROSTATE CANCERS AFTER RADICAL PROSTATECTOMY : A CASE FOR TREATMENT DESINTENSIFICATION

Daphnée Bédard-Tremblay[1], Nawar Touma[1], Bertrand Neveu[1], Hélene Hovington[1], Thierry Dujardin[1], Vincent Fradet[1], Yves Fradet[1], Michele Lodde[1], Rabi Tiguert[1], Louis Lacombe[1], Paul Toren[1], Frédéric Pouliot[1]

[1]Université Laval - CHU de Québec

INTRODUCTION:

Delaying androgen deprivation therapy (ADT) is considered a valid objective of prostate cancer (PCa) directed therapies due to its associated side effects. For high grade (HG) PCa, both radiotherapy (RT) plus ADT or radical prostatectomy (RP) are treatment options. Unfortunately, very few descriptive data focusing on HG PCa outcomes following RP have been published. The objective of this study was to evaluate the baseline characteristics and the oncological outcomes (including avoidance of ADT) of patients undergoing RP for HG PCa.

METHODS:

This is a retrospective study on 486 patients treated by RP for non-metastatic HG PCa at biopsy between 2007 and 2021 at CHU de Québec. Patients were excluded if they had a salvage RP following RT, a non-prostate active cancer, less than two postoperative PSA or PSA not available at diagnosis. Biochemical recurrence (BCR) was defined as two consecutive PSA ≥0,2 ng/mL or one PSA ≥0,2 ng/mL and treatment of recurrence. Castration resistant PCa (CRPC) was defined as two subsequent increases in PSA with a castrate testosterone value (<1.7 nmol/L).

RESULTS:

In the 453 patients included, median age at diagnosis was 67 (48 to 85), and median PSA was 7.5 ng/mL (0.6 to 155). At biopsy, 61.4 % had ISUP grade 4 and 38.6 % had ISUP grade 5. After RP, 51.1 % patients were downgraded to ISUP 3 or less while 9.1 % were upgraded to ISUP 5. Positive margins were found in 53.2 % patients, 65.7 % patients had ≥pT3 and 30.7 % patients were N1. At a median follow-up of 49.6 months, 48.3 % of patients were free of BCR without receiving ADT nor RT. Fifty-eight (12.8 %) patients developed metastasis (median time to metastasis = 21.9 months) and 38 (8.4 %) became CRPC (median time from RP = 33.0 months). At last follow-up, overall survival was 92.5 %.

CONCLUSION :

Half of the patients remain free of recurrence without treatment intensification after RP. Therefore, RP should be systematically offered in fit patients and those who want to avoid ADT.

ANALYSE DE LA QUALITÉ DE VIE CHEZ LES HOMMES À RISQUE DE DÉVELOPPER UN CANCER DE LA PROSTATE : RÉSULTATS DE LA COHORTE BIOMARQUEURS ET CANCER DE LA PROSTATE, PRÉVENTION ET ENVIRONNEMENT (BIOCAPPE)

Roxane Tourigny[1, 2], Hanane Moussa[1, 2], Karine Robitaille[1, 2], Vanessa Bussières[1], Fred Saad[3], Michel Carmel[4], Armen Aprikian5, Yves Fradet[1], BIOCaPPE-GRePEC Network[1, 3, 4, 5], Vincent Fradet[1, 2]

[1]Centre de recherche du CHU de Québec-Université Laval, Québec, Qc, [2]Institut sur la nutrition et aliments fonctionnels (INAF) et centre NUTRISS, Université Laval, Québec, Qc, Canada, [3]Centre de recherche du CHUM, Montréal, Qc, [4]Centre de recherche du CHUS, Sherbrooke, Qc, [5]Institut de recherche du CUSM, Montréal, Qc

INTRODUCTION:

Le cancer de la prostate (CaP) est le cancer le plus fréquent chez les hommes au Canada et affecte la qualité de vie (QdV) de façon importante. Peu d'études se sont intéressées à la QdV des hommes à risque de CaP et aucune n'a été réalisée au Canada. Notre objectif visait à faire une analyse descriptive complète de la QdV dans une cohorte canadienne d'hommes à haut risque de développer un CaP, et à évaluer l'impact des problèmes urinaires et érectiles sur la QdV générale.

MÉTHODE :

La QdV a été récoltée chez 2053 hommes à risque de CaP participant à l'étude observationnelle prospective multicentrique BIOCaPPE, qui vise à évaluer l'impact de certains biomarqueurs liés aux habitudes de vie sur l'incidence du CaP. Les participants ont rempli plusieurs questionnaires validés afin d'évaluer leur QdV générale (Échelle d'anxiété et de dépression [HADS] et 36-item Medical Outcomes Study Short Form Health Survey [SF-36]), et celle spécifique au CaP (Score international des symptômes de la prostate [IPSS] et Inventaire de la santé sexuelle pour hommes [SHIM]).

RÉSULTATS:

Parmi tous les participants, 6,1 % sont des cas définitifs d'anxiété et 2,0 % sont des cas définitifs de dépression ; 53,9 % ont des symptômes urinaires modérés à sévères et 15,0 % ont des symptômes de dysfonction érectile modérés à sévères. Plus les symptômes urinaires et de dysfonction érectile sont sévères, moins bonne est la QdV générale. La majorité des participants ont une QdV similaire à celle des hommes de la population générale.

CONCLUSIONS :

Nos résultats suggèrent que la majorité des participants perçoivent leur QdV comme étant satisfaisante, bien que la majorité présentent des symptômes urinaires modérés à sévères. Les symptômes anxieux, dépressifs et érectiles sont moins fréquents. Les symptômes urinaires et de dysfonction érectile ont un impact négatif sur la QdV générale. Il s'agit de la première analyse de la QdV d'une cohorte canadienne d'hommes à haut risque de CaP.

SEPTICÉMIE POST BIOPSIE DE PROSTATE : EXPÉRIENCE DE TROIS-RIVIÈRES

Catherine Morin[1], Mazen Jundi[1], Ariane Smith[1], Vincent Fournier-Cloutier[1], Julie Morisset[1], Alain Maillette[1], Sylvain Lapierre[1], Gaetan Duchesnay[1], Luc Marchand[1], Vincent Trudeau[1]

[1]Centre hospitalier affilié universitaire régional (CHAUR) - CIUSSS MCQ

INTRODUCTION :

La septicémie post biopsie de la prostate apporte une morbidité supplémentaire dans la trajectoire des patients. Le fonctionnement particulier de la clinique d'urologie du CHAUR de Trois-Rivières permet fréquemment d'effectuer des biopsies de la prostate sans planification préalable. La prophylaxie antibiotique utilisée (ciprofloxacine) est alors administrée po souvent 30 minutes avant la procédure. Lors de biopsies projetées, de la ciprofloxacine seule ou en association avec la fosfomycine est prescrite d'avance aux patients qui l'ingèrent avant la séance de biopsies. Nous avons voulu évaluer l'impact de ces différents régimes thérapeutiques sur l'incidence de la survenue d'état septique suite aux biopsies prostatiques.

MÉTHODES :

Cette étude rétrospective inclut les patients ayant subi une biopsie de la prostate à la clinique externe d'urologie du CHAUR-CIUSSS MCQ de janvier 2019 jusqu'à mai 2021. Avec la révision du dossier numérisé du patient, nous avons aussi pu analyser plusieurs variables pouvant influencer le risque de septicémie, sa survenue et analyser sa morbidité. Nous avons analysé tout le dossier numérique du patient et toutes les visites de celui-ci à travers tout le CIUSSS-MCQ dans la semaine suivant la biopsie.

RÉSULTATS :

Dans la période étudiée, nous avons effectué 798 biopsies de la prostate à la clinique externe du CHAUR. Nous avons enregistré 23 cas de septicémie post biopsie pour un taux de survenue de 2,88 %. La vaste majorité de la prophylaxie s'est donnée per os le jour même (83 %), per os en avance (16 %) ou IV (1 %). Il n'y avait pas de différence significative dans le taux de septicémie pour la préparation per os si elle était donnée le jour même (3 %) ou avant (2.4 %). La majorité de la prophylaxie per os était à base de ciprofloxacine (91 %) ou de ciprofloxacine + fosfomycine (6 %). Quoique le nombre de biopsies soit petit dans ce groupe (48), nous n'avons pas enregistré de sepsis avec la prophylaxie à base de ciprofloxacine + fosfomycine. Sur les 23 cas de septicémie, la durée moyenne d'hospitalisation était de deux jours et nous avons pu identifier un germe chez 12 patients. Ces germes étaient majoritairement des E Coli et étaient résistants au ciprofloxacine dans la moitié des cas.

CONCLUSION :

Notre étude semble démontrer l'efficacité et la sécurité de la prophylaxie po avec la ciprofloxacine le jour même de la biopsie. Malgré la taille limitée de l'échantillon, la combinaison ciprofloxacine et fosfomycine semble être associée à une tendance à la baisse des états septiques suite aux biopsies. La supériorité potentielle de cette combinaison mériterait d'être évaluée chez une plus large population de sujets en l'offrant possiblement le jour même de la procédure

IMPACT OF FRAILTY ON POSTOPERATIVE COMPLICATIONS AMONG ELDERLY PATIENTS UNDERGOING MAJOR UROLOGICAL PROCEDURES

Jessy Gatete[1], Jason Hu[1], Dr. Alice Dragomir[2], Dr. Wassim Kassouf[2]

[1]Experimental Surgery, McGill University, [2]Department of Surgery, Faculty of Medicine and Health Sciences, McGill University

BACKGROUND:

As developed countries' populations age, the number of older individuals undergoing surgery for urological disorders is on the rise. Preoperative frailty evaluation has been linked to worse postoperative outcomes. We sought to assess the impact of frailty on short-term postoperative complications among elderly patients undergoing major urological procedures.

METHODS:

The American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database was used to retrieve patients ≥65 years who underwent either radical cystectomy (RC), nephrectomy (NEP), or radical prostatectomy (RP) between 2014 and 2020. Five-item Frailty Index (FFI), a shortened version of the validated 11-item modified Frailty Index (mFI) was calculated in order to measure frailty. It is consisted of four categories : non-frail, mildly frail, moderately frail and frail (FFI= 0, 1, 2 and ≥3 respectively). We evaluated 30-day postoperative complications and readmissions using multivariate logistic regression.

RESULTS:

Overall, 59,558 cases were identified. Most underwent RP (49.1 %), followed by NEP (34.2 %) and RC (16.7 %). Higher frailty scores were associated with increased overall postoperative complications (mildly frail OR : 1.14 [1.00-1.31] ; moderately frail OR : 1.29 [1.04-1.60] ; frail OR : 1.57 [1.14-2.17]). These findings were most prominent in RC patients aged 70-74 (frail OR : 5.65 [1.34-24.3]). Across all 3 procedures, frail individuals also had higher risk of readmission (mildly frail OR : 1.29 [1.09-1.52] ; moderately frail OR : 1.34 [1.04-1.74] ; frail OR : 1.60 [1.09-2.37]). However, this association was not significant across age groups for RP and NEP patients.

CONCLUSION :

This study suggests that frailty in older patients undergoing major urological surgeries increases the risk of postoperative complications and readmission, particularly for RC patients where the impact of frailty increases with age. This highlights the need for preoperative frailty assessment in this vulnerable patient population to improve quality of care.

ASSOCIATION BETWEEN TESTICULAR MICROLITHIASIS AND TUMORS IN PEDIATRICS : WOULD PRACTICE CHANGES AFFECT OUTCOME ? A 20-YEAR RETROSPECTIVE EXPERIENCE IN A LARGE TERTIARY CARE CENTER

Elyse Potvin[1], Julie Franc Guimond[1], Diego Barrieras[1], Valérie Hogues[1]

[1]Centre Hospitalier Universitaire Sainte-Justine, Division d'Urologie Pédiatrique, Université de Montréal

INTRODUCTION:

Use of high-resolution ultrasounds (US) for scrotal conditions has led to an increased detection of testicular microlithiasis (TM), but their significance remains ill-defined. Active screening has been advocated in many publications. In our center, the management of TM has been a prudent one. We reviewed all patients that required orchiectomy to determine the prevalence of TM and sought to identify whether a prior diagnosis of TM impacted their management.

METHODS:

The records of children who underwent radical orchiectomy since 2000 at our pediatric tertiary care center were retrospectively reviewed. We determined demographic characteristics, presenting symptoms, US/histological findings and long-term to complete a descriptive analysis. Summary statistics were calculated.

RESULTS:

Sixty-one orchiectomies were performed over the study period. The mean age was 7.7 years old. They all presented because of symptoms : testicular mass (49), scrotal swelling (4), pain (3) or others (5). Malignant testicular tumors, paratesticular tumors, benign lesions, inflammatory processes and streak gonads accounted for 18, 8, 26, 7 and 2 cases.

Malignant tumors were diagnosed as non-seminomatous germ cell tumor (NSGCT) (15), gonadoblastoma (1), leukemia (1) and secondary metastasis (1).

Newly diagnosed TM were observed in 7/61(11.7 %) and 6/7 had a malignant tumor. None of these patients had risk factor for testicular cancer. Sixty percent of NSGCT were stage 1 vs. 80 % for the subgroup with TM. A greater proportion of patients with TM had embryonal carcinoma component.

Overtime, two cancer-related deaths occurred, both of which had no TM. All patients with TM fared well.

CONCLUSIONS :

Following incidentally found TM did not appear to benefit our pediatric population for the last two decades, since no testicular tumor were identified because of a screening protocol. All cases came to our attention because of symptoms and adopting a less prudent approach would not translate into missing testicular tumors.

OSTOPERATICE LEAVE IN UROLOGY : SURVEY TO UROLOGISTS OF CANADA

Karen Farag[1], Le Mai Tu[1], Salima Ismail[1]

[1]Université de Sherbrooke (CHUS)

INTRODUCTION:

Recently, a pilot study amongst urologists in Quebec suggested that there is a large discrepancy regarding prescribed postoperative sick leave. The primary objective of our study is to assess the duration of postoperative sick leave prescribed by urologists in Canada. The secondary objective is to identify factors that may impact the length of sick leave prescribed.

METHODS:

An online survey was sent to Canadian urologists via email. Respondents' demographics prescribed postoperative sick leave after six common surgeries and related factors were assessed.

RESULTS:

The survey was sent to 662 urologists, and there were 123 (18.6 %) respondents. The group had an average of 14 years of practice and most respondents were men (79.7 %). 74 % of respondents agree that the most important factor when prescribing sick leave, regardless of the type of surgery or patient, is if there were complications during the procedure. Most respondents prescribed 2 weeks of sick leave for light-working patients after a scrotal surgery. This was the only statistically significant consensus after any of the six surgeries studied. More experienced surgeons tend to prescribe shorter sick leave after a ureteroscopy (p=0.010), laparoscopic/ robotic renal surgery (p=0.040) and scrotal surgery (p=0.003), and longer sick leave after a TURP (p=0.003). Urologists with a lower surgical volume prescribe longer sick leave after a prostatectomy (p=0.008), regardless of the surgical approach.

CONCLUSION :

There is no0 evident consensus on how much sick leave is to be prescribed after urological surgeries by Canadian urologists. Surgeons' years of practice seem to influence the length of sick leave. We hope with these results, urologists will reflect on their tendencies when prescribing sick leave. Although the appropriate length of sick leave may be difficult to standardize, recommendations by a consensus panel would be greatly valuable.

PARTIAL GLAND ABLATION WITH HIGH INTENSITY FOCAL ULTRASOUND IMPACT ON GENITO-URINARY FUNCTION AND QUALITY OF LIFE : A SINGLE CENTER PILOT EXPERIENCE

Ioana Fugaru[1], Gautier Marcq[2], Alexis Rompré-Brodeur[1], Joseph Moryousef[3], Andrew Meng[3], Oleg Loutochin[1], George Loutochin[1], Maurice Anidjar[1], Frank Bladou[4], Raphael Sanchez-Salas[1]

[1]Division of Urology, Department of Surgery, McGill University, Montreal, QC, Canada, [2]Department of Urology, Claude Huriez Hospital, CHU Lille, Lille, France, [3]Faculty of Medicine, McGill University, Montreal, QC, Canada, [4]Department of Urology, Pellegrin University Hospital, Bordeaux, France

INTRODUCTION:

Partial gland ablation (PGA) using High Intensity Focal Ultrasound (HIFU) is an emerging option for localized prostate cancer (PCa). This pilot study assessed quality of life (QoL) outcomes during the implementation of PGA-HIFU at a single institution.

METHODS:

We prospectively enrolled 25 men with a diagnosis of localized low/intermediate risk PCa who elected to undergo PGA-HIFU in a pilot study at our institution between 2013 and 2016. Patients underwent pre-treatment multiparametric MRI and transrectal ultrasound-guided biopsies. The primary endpoints were impact on QoL, erectile and urinary function, assessed at 1-, 3-, 6- and 12-months following PGA.

RESULTS:

The median age was 64 years old (IQR 59.5-67). Baseline median International Index of Erectile Function-15 (IIEF-15) score was 50, which decreased to 18 at 1 month ($p<0.001$), returned to baseline by 3 months and thereafter. International Prostate Symptom Score (IPSS) median at baseline was 8, which worsened to 12 at 1 month ($p<0.05$), and subsequently improved thereafter. On the UCLA-Expanded Prostate Cancer Index Composite urinary function, there was a decrease in median score from 92.7 at baseline to 76.0 at 1 month ($p <0.0001$), which improved to or above baseline afterwards. QoL remained similar to baseline at each follow-up period as assessed via the EQ-5D questionnaire, its visual analogue scale and the Functional Cancer Therapy-Prostate scores. At systemic control biopsies 6 months after treatment, 12/25 (48 %) of patients still had clinically significant cancer (GGG≥2).

CONCLUSIONS :

This is the first cohort of men who underwent PGA-HIFU at our institution. Patients demonstrated a slight, but transient, deterioration in urinary and erectile function at 1 month. QoL metrics were not impacted during follow-up over one year. Although the QoL profile of PGA is favourable, oncologic control remains to be improved, given the high rates of persistent GGG≥2.

L'AMLEXANOX, UN INHIBITEUR DE IKK EPSILON, FAVORISE LA SENSIBILITE A L'OLAPARIB VIA LA REGULATION DE LA TRANSCRIPTION DE RAD51 DANS LE CANCER DE LA PROSTATE RESISTANT A LA CASTRATION.

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INTRODUCTION :

Chez un patient sur quatre, le cancer de la prostate (PC) va finir par développer une résistance à la castration (CRPC). Les patients souffrant de CRPC sont traités par hormonothérapie ou chimiothérapie. Cependant, ces médicaments ne sont efficaces qu'un temps, et la découverte de nouvelles approches thérapeutiques est primordiale pour améliorer la survie des patients. Nous avons récemment montré que l'inhibition de l'activité de la kinase IKKe, par déplétion ou via les inhibiteurs BX795 et Amlexanox, diminue la prolifération cellulaire in vivo et in vitro de lignées CRPC. Les inhibiteurs d'IKKe induisent également un phénotype de sénescence accompagné d'une forte augmentation des dommages à l'ADN et d'une instabilité génomique dans les cellules CRPC.

MÉTHODES ET RÉSULTATS :

Nous avons découvert un nouveau rôle pour IKKe dans le fonctionnement des voies de réparations des dommages à l'ADN dans le CRPC. Nous avons par conséquent examiné le potentiel thérapeutique de l'Amlexanox combiné à l'Olaparib, un inhibiteur de PARP. L'association de l'Amlexanox avec l'Olaparib diminue la prolifération des cellules CRPC et augmente les dommages à l'ADN. L'Olaparib inhibe le recrutement et l'expression de Rad51 dans les cellules CRPC ainsi que dans la lignée PC-3 déplétée d'IKKe. Nous avons démontré que l'activité du promoteur de Rad51, mesurée par essai luciférase, était diminuée par l'Amlexanox ou par la déplétion d'IKKe, et que le traitement à l'Amlexanox diminuait la fixation de C/EBP-βsur ce promoteur. Notre modèle de souris a également montré que l'Amlexanox combiné à l'Olaparib inhibait la croissance tumorale des xénogreffes de CRPC.

CONCLUSION :

Notre étude a mis en évidence un nouveau rôle potentiel pour IKKe dans la réparation des dommages à l'ADN par la régulation de la transcription de Rad51 et justifie l'association potentielle de l'Amlexanox avec l'Olaparib dans le traitement des patients atteints de CRPC.

URETHROPLASTY SURGICAL WAIT-TIMES DURING COVID-19 : “FROM BAD TO WORSE”

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BACKGROUND:

Wait times for urethral reconstruction for strictures are significant, and the COVID-19 pandemic significantly affected operating room prioritization. However, there are no published studies on the specific impact of the pandemic on reconstructive urethral surgery wait times and outcomes.

OBJECTIVE :

To compare surgical wait times before and during the COVID-19 period, as well as to compare characteristics and surgical outcomes of patients.

DESIGN AND INTERVENTION :

In this retrospective study, 147 male patients with a urethral stricture treated with a urethroplasty or perineal urethrostomy (PU) between September 2016 and April 2021 were included. Patients were divided based on their surgery date (before/after Quebec lockdown on March 13th, 2020). Median patient follow-up was 426 days.

OUTCOME MEASUREMENTS :

Baseline and surgical characteristics, and post-operative outcomes and surgical wait times were compared between the two groups, using the t-test, the Pearson chi-square test, and the Wilcoxon rank-sum.

Results and Limitations : Median surgical wait times during the COVID-19 period were significantly prolonged to (577 vs 332 days, $p<0.001$). There was no differences in baseline characteristics between the 2 groups. There was a greater proportion of PUs performed after March 13th, 2020 ($p=0.003$). The stricture recurrence rate at 3 months post-operatively was lower during the COVID-19 period (20.4 % vs 2.3 %, $p<0.001$). The one-center study is limited because of its shorter follow-up period for patients who had their surgery in the COVID-19 period.

CONCLUSION :

Our results show longer surgical wait times and better success rates during the COVID-19 period, with no significant differences in baseline characteristics between the patient groups.

PATIENT SUMMARY :

In this study, we compared surgery wait times, types, and outcomes, as well as characteristics of patients who had a reconstructive surgery for urethral strictures before and after the COVID-19 Quebec lockdown. We conclude that wait times did increase with the COVID-19 pandemic, with different types of reconstructive surgeries performed and improved stricture recurrence rates.

TILIZATION TRENDS OF NOVEL HORMONAL AGENTS IN METASTATIC CASTRATION-RESISTANT PROSTATE CANCER IN QUEBEC

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INTRODUCTION:

The introduction of novel hormonal agents (NHAs) such as abiraterone acetate (ABI) and enzalutamide (ENZ) for metastatic castration-resistant prostate cancer (mCRPC) was an important milestone given their survival benefits, their tolerability and ease of administration relative to taxane chemotherapies. This descriptive study sought to examine the utilization trends of these NHAs in patients with mCRPC in the early years after approval in the province of Quebec in Canada.

METHODS:

A retrospective population-based cohort was extracted from Quebec public healthcare administrative databases. The cohort included first-time users of NHAs (ABI or ENZ) from 2011-2016. The primary analysis aims to describe the overall temporal trends (2011-2016) of NHA use by chemotherapy status (chemotherapy-naïve versus post-chemotherapy), and prescribing specialty (medical oncology versus urology versus others). In secondary analyses, we described the trends in the years when both ABI and ENZ were available from 2014-2016 (ENZ-era) stratified by NHA type, chemotherapy status and prescribing specialty.

RESULTS:

The cohort comprises 2,183 patients, with 1,562 (72 %) in the chemotherapy-naïve group and 621 (28 %) in the post-chemotherapy group. While the majority of patients were post-chemotherapy NHA users in 2012, this proportion decreased over time and accounted for only 13 % of NHA users by the end of 2016. Medical oncologists were the most frequent prescribers of NHAs (upwards of 60 %) throughout 2012 but fell to 45 % by the end of 2016. Conversely, the proportion of prescriptions by urologists increased from 22 % in 2012 to 42 % in 2016. Adjusted analyses show that urologists were more likely to prescribe ENZ over ABI, relative to medical oncologists.

CONCLUSION :

Over time, there was an increasing proportion of patients who (1) initiated NHAs without prior chemotherapy treatment, (2) NHA prescribing by urologists, and (3) of ENZ users. Further research examining how exactly the introduction of NHAs has impacted disease management and referral patterns in advanced PCa may be of interest to clinicians and policy-makers.

ANNEXE 2

ABRÉGÉS SESSION IV

IMPACT OF URETHRAL CATHETERIZATION ON VOIDING EFFICIENCY IN CHILDREN

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INTRODUCTION:

In adults, the presence of a urethral catheter during the voiding phase decreases the maximal urine flow (Qmax) compared to the free flow produced during uroflowmetry (UF). Little is known about the effect of catheterization during PFS on the Qmax in children, whose urethra is smaller than that of adults. The objective of this study was to determine the effect of urethral catheterization on Qmax and other voiding parameters during PFS compared to the free flow produced during UF.

METHODS:

We retrospectively reviewed the charts of 63 consecutive children who underwent UF and PFS at our center in the same setting between 2019 and 2022. The patients first undergo a UF with full bladder, then PFS after insertion of a 6, 7 or 9 Fr urethral catheter. We excluded patients who were known or investigated for urethral pathologies, who were on clean intermittent catheterization and those with major comorbidities. Data was collected from the UF and the PFS and compared using paired t-test.

RESULTS:

Median age at the time of the study was 7 (IQR 5-11). Twenty-one (39.6 %) patients were male and 32 (60.4 %) patients were female. Of the 53 patients, three boys and four girls (n=7 ;13.2 %) were unable to void with the catheter during PFS but able to void after its removal. The Qmax during PFS was 5 mL/s slower than the Qmax recorded on the UF without catheter, representing a decrease of 29 % (12.3 vs 17.3 mL/s ; $p<0.0001$). The impact of urethral catheter during PFS was more significant in males vs females (Qmax decreased by 7.7 vs 3.3 mL/s, or 45 vs 19 %). There was no statistically significant difference between the residual volumes when comparing PFS to UF (30 vs 25 mL, $p=0.5774$). When using age and gender-specific nomograms for Qmax versus volume voided, we noted that 16/36 (35 %), fell from > 10th percentile in UF values to < 5th percentile with the PFS values.

CONCLUSION :

We conclude that Qmax is reduced by 29 % in children due to the presence of a urethral catheter. Males, with an anatomically longer urethra, were particularly affected, with a mean decrease of 7.7 mL/s. Moreover, 13 % of children undergoing PFS could not void at all secondary to the presence of the catheter. When using PFS parameters alone, a clinician may attribute abnormally low flow values to 35 % of children assessed, thus abnormally low flow parameters on PFS should be interpreted cautiously.

THE ANTI-TUMOR ACTIVITY OF PREBIOTICS IN BLADDER CANCER

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INTRODUCTION:

Recent evidence showed that gut microbiota plays a crucial role in the response to immune checkpoint blockade (ICB) immunotherapy in various cancers. Multiple approaches are under investigation to modulate the gut microbiota and improve the systemic anti-tumor activity of ICB in cancer. Here, our objectives were to first assess the anti-tumor effect of promising prebiotics and their modulatory potential on gut microbiota in bladder cancer (BCa), and test the effects of prebiotics on the systemic anti-tumor efficacy of ICB therapy.

METHODS:

C3H syngeneic mice were injected subcutaneously with MBT-2 mouse bladder tumor cells. Prebiotics and control water were daily gavaged until the end of experiment. Following tumor implantation, mice were treated with four injections of anti-PD1 monoclonal antibody or isotype control intraperitoneally. Tumor growth was monitored twice a week. Fecal samples were collected at many time-points during tumor growth for the profiling of gut microbiota. End point tumors were dissociated for flow cytometry analysis of tumor infiltrating lymphocyte composition.

RESULTS:

The treatment with prebiotics induced an enrichment of Akkermansia and Bifidobacterium bacteria previously associated with response to ICB therapy. Independently of immunotherapy, two prebiotics induced a strong anti-tumor activity compared to control group, and improved the overall survival of mice. Interestingly, one prebiotic combined with anti-PD1 immunotherapy also enhanced the systemic antitumor effect of ICB. Underlying mechanisms linking prebiotics treatment with tumor reduction will be deciphered by the flow cytometry analysis and tumor RNA sequencing.

CONCLUSIONS :

Overall, our findings support that promising prebiotics can induce an anti-tumor effect at steady state, and in combination with anti-PD-1 treatment, in BCa mouse model. These data will have a significant impact to enhance the clinical response to ICB treatment for BCa patients.

FIABILITÉ ET VALIDITÉ DE LA VERSION FRANCO-CANADIENNE DU SCORE DES SYMPTÔMES DE LA VESSIE NEUROGÈNE (SSVN)

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INTRODUCTION :

Le Score des Symptômes de la Vessie Neurogène (SSVN) est un questionnaire validé, qui mesure les symptômes vésicaux selon 3 domaines : l'incontinence, le remplissage et la miction, les conséquences et une question sur la qualité de vie urinaire. Nous visons à valider une version franco-canadienne du SSVN pour les patients atteints de sclérose en plaques (SEP) ou de lésions de la moelle épinière (LME).

MÉTHODOLOGIE :

Dans cette étude prospective, 107 patients atteints de SEP et de LME ont été recrutés de novembre 2019 à janvier 2022. Les participants ont rempli le SSVN et d'autres questionnaires (SF-12, ICIQ, SCI-QOL) à l'évaluation initiale et au suivi à 3 mois et 6 mois. La cohérence interne est évaluée avec le coefficient βde Cronbach et la fiabilité test-retest à l'aide du coefficient de corrélation intraclasse (CCI). Des corrélations positives ont été supposées. Une valeur βde 0.70 est considérée acceptable tandis que >0.8 est considérée comme bonne. La validité a été évaluée en comparant la question qualité de vie avec le questionnaire SF-12.

RÉSULTATS :

Parmi les 107 participants avec SEP (27) ou LME (80), les méthodes de gestion vésicale sont la sonde à demeure (29), le cathétérisme intermittent (43), la miction spontanée (24), le condom urinaire (4) et mixte (7).

À l'évaluation initiale, le score global médian du SSVN était de 24/78 (EIQ 15-32.5), similaire à 6 mois (24/78 (EIQ 14-31)). La cohérence interne et la fiabilité test-retest du score global et chaque sous-domaine à 3 mois est de 0.66 (0.54-0.76), 0,58 pour l'incontinence, 0.73 pour les symptômes de remplissage et 0.58 pour les conséquences. À 6 mois, le résultat global est 0.80 (0.72-0.86) et pour chaque sous-domaine 0.82 (incontinence), 0.82 (remplissage) et 0.66 (conséquences). La validité démontre une corrélation statistiquement non significative ($p>0.05$) à l'évaluation initiale ($p=0.217$, $r=-0.12$) et 3 mois ($p=0.065$, $r=-0.12$).

CONCLUSION :

La version franco-canadienne du SSVN démontre une bonne fiabilité ainsi qu'une validité cliniquement significative. Ce questionnaire permet d'évaluer un score global et évaluer chaque sous-domaine des symptômes vésicaux à 3 et 6 mois chez les patients avec SEP et LME. Nous recommandons son utilisation pour appréciation de la qualité de vie et des symptômes vésicaux dans une cohorte de patients avec vessie neurogène.

ANALYZING OUTCOMES OF THE ADJUSTABLE TRANSOBTURATOR MALE SYSTEM (ATOMS) FOR POST-PROSTATECTOMY INCONTINENCE AND ITS RELATIONSHIP WITH OVERACTIVE BLADDERS AND RADIOTHERAPY WITH THE HELP OF URODYNAMICS

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INTRODUCTION:

ATOMS has been a treatment option for post-prostatectomy incontinence (PPI) in Canada since 2014. It has recently gained popularity touting advantages such as surgical simplicity and post-operative adjustability. We report our single center's device effectiveness and security. We also explore effects of prior radiotherapy and of overactive bladder (OAB) on these outcomes.

METHODS:

A retrospective study was done on 91 patients who had ATOMS installed between February 2016 and March 2021 at our center. Preoperative incontinence severity was defined as <2 pads per day (PPD), 2-4 PPD, and >4 PPD with regards to 24-h pad-count or/and <200g, 200-400g and >400g regarding 24-h pad-test (24h-PT) to classify mild, moderate, and severe, respectively. Dryness was defined as requiring 0 or 1 PPD postoperatively. Patients considered "improved" or "very much improved" were defined as having a PPD diminution of ≥ 50 % or ≥ 75 %, respectively. Significant patient satisfaction was defined by "Much better", and "Very much better" PGI-I results.

RESULTS:

Sixty-five patients were included among 91 (26 excluded due to follow-up <12 mo). Mean patient age was 71yr and mean follow-up was 29.9mo (SE 1.8 ; [12-67]). Median preoperative PPD and 24h-PT were 4 (IQR 6-3 ; [1-10]) and 358g (IQR 607-256 ; [34-1592]) respectively. Median PPD at final follow-up was 1(IQR 2-0 ; [0-5] ; p<0.001). 56 (86.2 %) patients noted overall improvement, with 43 (76.7 %) being "very much improved" and 42 (75.0 %) being "dry". 87.7 % (n=57) of patients were satisfied. 59 (90.7 %) patients required adjustment postoperatively, with a mean of 2.4 adjustments (SE 0.2498) and a mean total instilled volume of 14.8mL (SE 0.7641 ; range 6-31). 8 (12.3 %) patients experienced complications of any Clavien-Dindo grade, of which 4 were grade III (1 migration (1.5 %), 3 leakages (4.6 %)). Patients having received prior radiotherapy (n=22, 33.8 %) had lower improvement (73 % vs 93 % ; p=0.03) and "dry" (45.5 % vs 74.4 % ; p=0.02) rates but required more adjustments (MED 3.5 vs 2 ; p=0.01) and total instilled volume (MED 18.3mL vs 13mL ; p=0.01). No other statistically significant difference was found in this subgroup or in that of patients with OAB.

CONCLUSION :

This study vouches ATOMS as safe and effective for PPI. Also, radiotherapy seems to impact its effectiveness, whereas OABs do not.

COMPARAISON ENTRE LA NÉPHRECTOMIE PARTIELLE ROBOTIQUE TRANSPÉRITONÉALE ET RÉTROPÉRITONÉALE : NOTRE EXPÉRIENCE INITIALE DANS LE CIUSSS DE L'EST-DE-L'ÎLE-DE-MONTRÉAL

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INTRODUCTION :

La néphrectomie partielle laparoscopique est le traitement chirurgical de choix pour les petites masses rénales. Cette chirurgie peut se faire soit par approche transpéritonéale ou rétropéritonéale. L'objectif de l'étude est de comparer les résultats peropératoires et postopératoires de l'approche robot-assistée rétropéritonéale et transpéritonéale.

MÉTHODES :

Une analyse rétrospective de tous les cas de néphrectomies partielles robotique a été réalisée entre janvier 2019 et septembre 2021. Les résultats peropératoires et postopératoires suivant ont été compilés : la durée opératoire, les pertes sanguines, le temps de clampage, la durée d'hospitalisation ainsi que les taux de complications. Les résultats ont été comparés entre l'approche transpéritonéale et rétropéritonéale.

RÉSULTATS :

Sur les 74 cas, 17 (23 %) étaient par approche rétropéritonéale et 57 (77 %) par approche transpéritonéale. La taille moyenne des masses rénales était de 2,6 cm. Les résultats peropératoires incluant le durée opératoire (149 min vs. 157 min), et le temps de clampage (23min vs. 24min) étaient similaires entre les deux approches. Les pertes sanguines étaient plus élevées pour l'approche transpéritonéale (165cc vs. 86cc). Pour ce qui est des résultats postopératoires, la durée d'hospitalisation était plus courte pour l'approche rétropéritonéale (1,8j vs. 2,6j).

CONCLUSIONS :

L'approche rétropéritonéale offre une alternative équivalente à l'approche transpéritonéale pour les masses postérieures avec une durée de séjour hospitalier et de pertes sanguines moindres que l'approche transpéritonéale.

TRANSPERINEAL PROSTATE BIOPSY : REVIEW OF TECHNIQUE AND PRELIMINARY PATHOLOGICAL RESULTS AT OUR INSTITUTION.

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INTRODUCTION :

Prostate cancer is the most common cancer in men. Diagnosis is usually made with an image guided biopsy of the prostate. The most common technique is a transrectal (TR) ultrasound guided biopsy. Complications from this procedure include rectal bleeding and risk of bacterial prostatitis and sepsis. A more recent technique has emerged using the transperineal (TP) route which has the advantage of not puncturing the rectum to get biopsies. This alleviates the risks of rectal bleeding, prostatitis and urosepsis. Our objective is to evaluate the efficacy of the TP biopsy technique in terms of cancer detection and positive cores.

MATERIALS AND METHODS :

We report data on our first 50 patients who underwent TP prostate biopsy. TP biopsy was performed under local anesthesia in office setting. 12 core biopsies were taken using an automatic biopsy device and were evaluated by the same pathology department. Some samples were sent for a second opinion at the McGill pathology department to be examined by a uropathologist. Patients received one dose of cephalosporin antibiotic one hour before the procedure. We then tabulated pathology data and positive core results.

RESULTS :

50 patients were included in the analysis. All patients underwent TP biopsy. Median age was 66 years and median PSA was 7.2 ng/ml. 65 % of the biopsies were positive for adenocarcinoma of the prostate. We had an average of 4.29 positive cores in patients in whom cancer was detected. 8 patients had a pirads 4 or more lesion on mp prostate MRI before biopsy of which 7 patients had adenocarcinoma detected. We had two cases of urinary retention in the first 48 hours. There were no cases of prostatitis or urinary sepsis or infection. 31 % of patients experienced hematuria.

CONCLUSION :

Our results corroborate literature findings of cancer detection and complications for the TP prostate biopsy technique. This technique is associated with less rectal bleeding and urosepsis in our cohort.

PREVALENCE OF QTC PROLONGATION IN PROSTATE CANCER PATIENTS UNDERGOING BRACHYTHERAPY

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INTRODUCTION:

QTc has been associated with a higher risk of Torsade de Pointes, sudden cardiac arrest and general cardiac mortality. We examined the prevalence of prolonged QTc in prostate cancer patients undergoing brachytherapy, in patients with aggressive cancers and in patients who underwent prostatectomy.

METHODS:

We randomly selected 1094 patients receiving low-dose or high-dose rate brachytherapy between August 2010 and February 2022. All patients had a preoperative ECG and QTc was automatically calculated with the Bazett formula. Patients with left or complete bundle branch block, ventricular extrasystoles, atrial fibrillation, pacemaker or QRS ≥ 120 ms were excluded. As primary outcome, a QTc ≥450ms was considered abnormal. Chi-square or Fisher's exact test were used to compare groups. Correlations between QTc and clinical values were evaluated with Pearson correlation coefficient and binary multivariable regression analysis.

RESULTS:

6.2 % (n=68) had a QTc ≥450ms. Patients with a Cancer of the Prostate Risk Assessment (CAPRA) high risk disease (score 6-10) were significantly more likely to have a QTc ≥450ms than patients with low-or intermediate risk (9.7 % vs. 5.5 %, p=0.039). QTc as a continuous variable correlated weakly with the neutrophil count (r=0.13, p<0.001), age (r=0.08, p= 0.009) and inversely with testosterone (r=-0.17, p=0.002). On binary multivariable regression analysis including neutrophils, testosterone and age, only testosterone [nmol/L] was predictive of a QTc ≥450ms, OR 0.9, 95 % CI 0.82-0.98, p=0.02. We then compared patients treated with brachytherapy to 178 patients who had a prostatectomy. The latter had a non-significantly smaller portion of patient with a QTc ≥450ms : 4.5 % vs. 6.2 %, p=0.5.

CONCLUSION :

Our data show that about 10 % of patients with high-risk prostate cancer have a prolonged QTc. Physicians should be aware of this and monitor the QTc to possibly decrease cardiac mortality in patients who require androgen deprivation therapy.

IMPACT DE LA DIÈTE RICHE EN GRAS ET DE L'ACTIVITÉ PHYSIQUE SUR LA PROGRESSION DU CANCER DE LA PROSTATE ET DE LA RÉPONSE AU TRAITEMENT À L'ENZALUTAMIDE

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INTRODUCTION :

Des études épidémiologiques ont rapporté que la consommation de graisses saturées et l'obésité sont associées à une augmentation de la progression du cancer de la prostate (CP) et de la mortalité. De nombreuses évidences supportent l'idée que l'activité physique (AP) réduit le risque de cancer en général. Cependant, il existe peu de preuves d'une association entre l'augmentation de l'AP et la diminution du risque de CP. Nous émettons l'hypothèse que l'AP affecte le développement et la progression du CP et améliore la réponse aux thérapies.

MÉTHODES :

Pour étudier le rôle potentiel de l'alimentation et l'AP sur le développement, la progression et la réponse médicamenteuse du CP, nous avons lancé une étude avec des xénogreffes dans quatre groupes de souris nourries avec une diète normale ou riche en graisses (HFD) et avec ou sans AP volontaire. Lorsque le volume tumoral a atteint une moyenne de 700 mm3, les souris ont subi une castration, puis ont été traitées par des injections intrapéritonéales quotidiennes d'enzalutamide (20 mg/kg) pendant 35 jours.

RÉSULTATS :

Nous avons observé moins de progression et de développement de tumeurs dans les groupes de souris avec AP volontaire par rapport aux groupes sans AP. À 54 jours après l'injection des cellules, les volumes tumoraux étaient 50 % plus petits chez les souris avec AP que ceux des souris sans AP, et ce, quel que soit le régime alimentaire. Aucune différence n'a été observée dans la croissance tumorale entre les groupes « régime normal » et « HFD ». Aussi, nous avons observé que l'AP améliore la réponse à l'enzalutamide avec une diminution des volumes tumoraux dans les groupes avec AP volontaire par rapport aux groupes sans AP, en particulier pour les groupes HFD.

CONCLUSIONS :

L'activité physique semble être en mesure d'annihiler les effets négatifs introduits par une alimentation riche en graisses sur la progression et la réponse aux traitements du cancer de la prostate.

COMBINATION IMMUNOTHERAPIES AND ANTI-ANDROGENS TO IMPROVE RESPONSE TO BLADDER CANCER IMMUNOTHERAPY

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BACKGROUND:

Men are 3-4 times more likely to be diagnosed with bladder cancer (BCa) than women, who often have more aggressive tumors. Intravesical BCG for non-muscle invasive BCa (NMIBC) is one of the first immunotherapies, with use of immune checkpoint inhibitors for BCa immunotherapy expanding. Nonetheless, around 35 % of patients fail to respond to BCG, with response rates to checkpoint immunotherapy much lower. Based on prior work suggesting the importance of the androgen receptor (AR) in BCa, we investigated the MBT-2 murine BCa model to evaluate AR-targeting as a novel strategy to improve the response to BCa immunotherapy.

METHODS:

Human NMIBC tumors were freshly collected following transurethral resection. In vivo studies used the subcutaneous MBT-2 BCa model in male and female C3H mice. Enzalutamide was given alone or in combination with anti-PD-1 or intra-tumoral BCG treatments. Flow cytometry and RNA sequencing characterized the immune cells present in murine and human tumors.

RESULTS:

We first observed that the immune composition of tumors from the MBT-2 murine models resembled human BCa and also reproduced gender differences observed in BCa patients. In male mice with MBT-2 tumors, enzalutamide in combination with either anti-PD-1 or BCG treatments synergized to improve complete response rates and decrease tumor growth. Immune memory was demonstrated in cured mice. Notably, the proportion of complete responses in male mice treated with the combination treatment resembles that observed in female mice with either immunotherapy alone. Relatively minor differential gene expression changes were observed between treated and control MBT-2 tumors, with more pronounced differences in the proportion of infiltrating immune cells.

CONCLUSION :

Enzalutamide synergizes with BCG or anti-PD-1 immunotherapy in the MBT-2 BCa model to improve response rates. Further, our results support the relevance of the MBT-2 murine model to investigate immunologic BCa sex differences. To further evaluated anti-androgens as a treatment for male patients, a Phase II trial of bicalutamide in combination with BCG is underway.

THE IMPACT OF BILATERAL STONE DISEASE ON PATIENTS' DISEASE PROGRESSION AND QUALITY OF LIFE

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INTRODUCTION:

Kidney stone disease is associated with significant morbidity and functional impairment. Few studies have examined the impact of bilateral kidney stones on disease progression. We sought to determine the impact of bilateral stone disease on age of onset, number of stone events and individual patient Health Related Quality of Life (HRQOL) by querying the validated and prospectively collected Wisconsin Stone Quality of Life (WISQOL) database.

MATERIAL AND METHODS:

Cross-sectional data was obtained from 2,906 kidney stone formers from 14 institutions in North America who completed the WISQOL questionnaire from 2014 to 2019. The 28-question survey has a 1-5 point scale for each item (total score range 0-140). Kidney stone formers were further stratified according to presence of bilateral or unilateral kidney stones. Categorical variables were reported and compared using a Chi-square test. A multivariable linear regression model assessed the impact of bilateral kidney stone disease on HRQOL.

RESULTS:

Of 2,906 kidney stone formers, 1,340 had unilateral kidney stones and 1,566 had bilateral kidney stones. Bilateral kidney stone formers had a younger mean (SD) age of kidney stone onset (37.2±15.8 vs 46.4±15.9 years of age, $p<0.001$). Bilateral kidney stone formers had a higher number of stone events than unilateral kidney stone formers ($p<0.001$). Bilateral kidney stone formers had a higher mean (SD) number of comorbidities (2.02±1.82 vs 1.87±1.77, $p<0.05$). Among those comorbidities, bilateral kidney stone disease was associated with an increased number of depression/anxiety symptoms (350(22.4 %) vs 247(18.4 %), $p<0.05$). Bilateral and unilateral kidney stone formers did not differ for calcium oxalate, calcium phosphate, uric acid and mixed stone composition ($p>0.05$). On multivariable analysis, bilateral kidney stone disease was an independent predictor of worse HRQOL (β=-11.2 (CI:-19.5 - -3.0) points, $p<0.05$).

CONCLUSION :

Bilateral kidney stone formers had a younger age of kidney stone onset and a higher number of stone events than unilateral kidney stone formers. Presence of bilateral kidney stones negatively impacted HRQOL. Therefore, clinicians should pay closer attention to bilateral kidney stone patients on clinical presentation and their risk for disease progression.

PROJET BIOCAPPE_GREPEC : ANALYSES DES LIENS ENTRE DE POTENTIELS BIOMARQUEURS ET LE RISQUE DU CANCER DE LA PROSTATE

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INTRODUCTION :

Le développement du cancer de la prostate (CaP) pourrait être impacté par certaines habitudes de vie. Bien que mal connu, ce lien impliquerait la modulation de certains biomarqueurs tels que l'adiponectine, l'insulin-like growth factor-1 (IGF-1) et les lipoprotéines de basse densité oxydées (LDL-ox). Ces biomarqueurs pourraient potentiellement être utilisés pour stratifier le risque de CaP. Nous avons évalué le lien entre la concentration des biomarqueurs en circulation et le risque de CaP dans une cohorte d'hommes à risque élevé de CaP participant à l'étude prospective observationnelle multicentrique BIOCaPPE_GRePEC.

MÉTHODES :

La concentration des biomarqueurs sériques a été mesurée à l'entrée dans l'étude chez 1500 hommes à risque de CaP par la méthode ELISA. L'incidence du CaP a été déterminée par biopsie prostatique sur un suivi entre 2 et 7 ans. Le lien entre le CaP et les biomarqueurs a été évalué à l'aide d'un modèle de poisson robuste.

RÉSULTATS :

L'âge moyen des participants est de 63 ans (±7), dont 162 ont développé un CaP au cours de leur suivi (10,8 %). Le taux moyen d'IGF-1, de LDL-ox et d'adiponectine est de 110ng/mL (±32), 69.14U/L (±19.9) et 8.24µg/mL (±3), respectivement. Une concentration plus élevée d'adiponectine serait protectrice contre le CaP (RRAdiponectine = 0.63, IC95 % [0.40 ;0,98], p=0.04) alors qu'une concentration plus élevée de LDL-ox serait délétère (RRLDL-ox = 1.43, IC95 %. [0.95 ;2,15], p=0.08).

CONCLUSION :

L'adiponectine aurait un rôle protecteur contre le CaP tandis que LDL-ox favoriserait le CaP chez les hommes à risque élevé de CaP. Nos résultats suggèrent que LDL-ox et adiponectine seraient des biomarqueurs potentiels pour la stratification du risque du CaP. Plus d'études sont justifiées.

BONE MINERAL DENSITY TESTING AND THE RISK OF FRACTURES IN MEN INITIATING ANDROGEN DEPRIVATION THERAPY : POPULATION-BASED STUDY

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INTRODUCTION:

Androgen deprivation therapy (ADT) is a staple of advanced prostate cancer (PCa) treatment ; however several side-effects are associated with its long-term use. Notably, loss of bone mineral density (BMD) is accelerated which increases fracture risk. Although guidelines recommend BMD testing when initiating ADT to properly assess baseline fracture risk, there is limited data to support this recommendation in the PCa patient population. The objective was to examine the association between baseline BMD testing (bBMDT) and the risk of fractures in men initiating ADT for PCa.

METHODS:

A retrospective observational cohort study using data from Quebec public healthcare insurance administrative databases was conducted. The cohort included PCa patients who initiated ADT from 2004-2015 and who received at least one year of ADT treatment. Baseline BMD testing was defined as a BMD test performed from 6 months prior to ADT initiation and up to 3 months after. Patients were categorized as either having received bBMDT or not received bBMDT when initiating ADT. The primary study outcomes were incidence of any fracture and incidence of fractures resulting in hospitalization. Inverse probability of treatment weighting was used to adjust for measured baseline characteristics which included patient demographic variables, comorbidities, risk factors for fractures, and use of other medications affecting bone density.

RESULTS:

We identified 13,532 patients who initiated ADT, of which 2,070 (15.3 %) underwent bBMDT. The unadjusted 5-year incidence of any fracture was 15.1 % for patients not receiving bBMDT and 14.0 % for patients receiving bBMDT. In adjusted analyses, bBMDT (hazard ratio [HR] 0.92, 95 % confidence interval [CI] 0.76-1.12) was not associated with the risk of any fracture. For fractures requiring hospitalization, bBMDT was associated with a lower risk (HR 0.71, 95 %CI 0.52-0.98). Furthermore, bBMDT was associated with increased odds of bisphosphonate use within 1 year of ADT initiation among patients who were bisphosphonate-naïve at baseline (odds ratio [OR] 2.03, 95 %CI 1.74-2.36).

CONCLUSION :

In our study population, bBMDT was associated with a lower risk of fractures resulting in hospitalization. Given the low uptake of bBMDT, additional efforts emphasizing the importance of BMD testing in guidelines may be needed.

CLINICAL OUTCOMES OF PATIENTS WITH METASTATIC RENAL CELL CARCINOMA (MRCC) WITH OR WITHOUT SARCOMATOID DIFFERENTIATION TREATED WITH SYSTEMIC THERAPY IN REAL-WORLD CANADIAN SETTING

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BACKGROUND:

The objective of this study was to evaluate the impact of first-line systemic therapies on survival of metastatic renal cell carcinoma (mRCC) patients (pts) with or without sarcomatoid differentiation (SD) using real-world data.

METHODS:

The Canadian Kidney Cancer information system was used to identify mRCC pts diagnosed from Jan 2011 to April 2022. Only pts with synchronous primary and metastatic disease, treated within 12 months from initial diagnosis, IMDC intermediate/high risk, and a confirmed histology of RCC with documentation of presence/absence of SD were included. Pts were classified in two groups according to initial treatment received for mRCC : (1) targeted treatment (TT) or (2) immunotherapy-based treatment (IO). Within each of these groups, pts were subclassified by presence or absence of SD based on their nephrectomy specimen. Inverse probability of treatment weighting using propensity scores was used to balance the groups for sex, age, Charlson comorbidity score, clear cell histology, nephrectomy (before or after TT/IO), IMDC risk, sites and number of organs with metastasis. Cox proportional hazards models were used to assess the impact of initial TT vs IO on overall survival (OS) and by SD status.

RESULTS:

A total of 650 pts were included in the study cohort : 484 pts were treated with TT and 166 pts were treated with IO. Median age was 62 years, 75 % were male and the majority had a nephrectomy before TT/IO (86 %). In weighted analysis of the SD pts (113 TT and 50 IO patients), treatment with IO was associated with an increase in OS compared to TT (median of 48 versus 18 months, hazard ratio [HR] 0.43, 95 % confidence interval [CI] 0.25-0.74). In the non-SD pts (371 TT and 116 IO patients), mRCC patients treated with IO had an improved survival compared to patients treated with TT (median of 84 versus 48 months, HR 0.64, 95 % CI 0.44-0.92). A sarcomatoid involvement above the median (10 %) was associated with an increased risk of death (HR 1.71, 95 % CI 1.11-2.64).

CONCLUSION :

In conclusion, mRCC patients with or without SD have an improved survival when treated with IO-based first-line systemic therapies compared to TT-based first-line treatments.

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