AUA 2026
Washington, DC
MAY 15-18

047IC - Contemporary Techniques in TURBT

Sunday, May 17

Faculty

Max Kates, MD

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Contemporary Techniques in TURBT

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- Please refer to AUA website for all speaker disclosures

Course Outline

7:30-7:35: Introduction to the Course	Dr Max Kates
7:35-7:55: TURBT best practices	Dr Jen Jane Liu
7:55-8:10: Case Discussion	Dr Kates & Panel
8:10-8:15 Q&A	
8:15-8:35: TURBT in the guidelines and peculiar situations	Dr Paolo Gontero
8:35-8:50: Case Discussion	Dr Kates & Panel
8:50-8:55 Q&A	
9:55-9:15: En bloc TURBT: from basic to advanced techniques	Dr Jeremy Teoh
9:15-9:25 Case Discussion	Dr Kates & Panel
9:25-9:30: Q&A and Closing comments	

Dr Max Kates

Brady Urologic Institute, Johns Hopkins Medicine

- Director of Bladder Cancer
- Director, Division of Urologic Oncology

Dr Jeremy Teoh

- Assistant Dean (External Affairs), Associate professor, The Chinese University of Hong Kong

- Director of the Urology Centre, CUHK

- Chairperson of the Younger Fellows Chapter of the College of Surgeons of Hong Kong (2019-2021)

- Chair of the Young Fellows Chapter, Hong Kong Academy of Medicine (2021-2022)

Dr Paolo Gontero

- Chairmen of the Division of Urology at San Giovanni Battista Hospital (Molinette)
- Associate Professor of urology at the University of Studies of Torino in Italy.

Dr Jen Liu

Oregon Health Science University

- Associate Professor
- Director of Urologic Oncology

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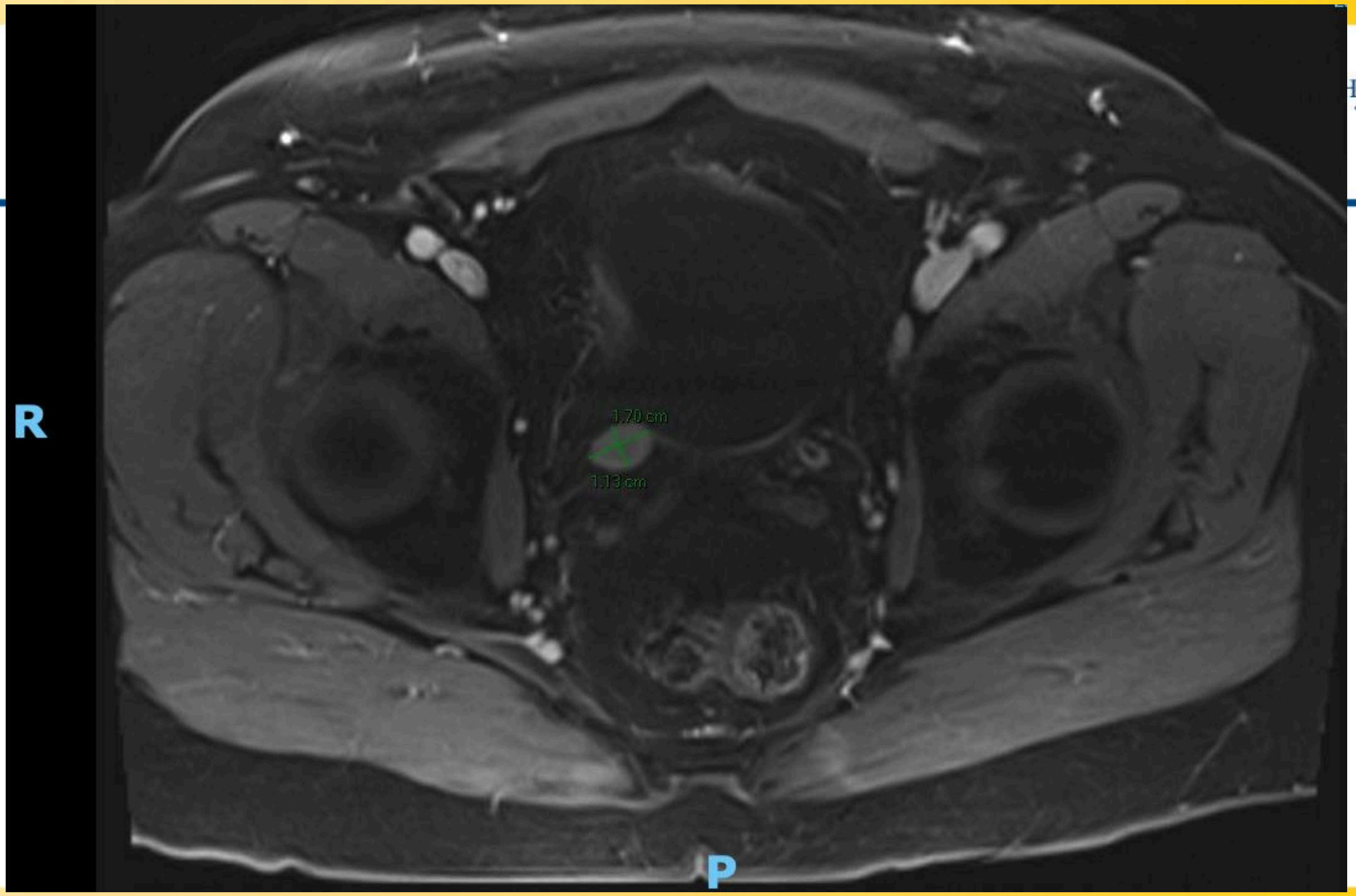
Case #1

59 yo M

- **July 2021: Right Nephroureterectomy**
- **Jan 2023: HgT1 s/p BCG**
- **June 2023: HgTa, s/p GemDoce**
- **September 2023: HG cytology, normal cystoscopy**
- **Undergoes MR abdomen/pelvis**


R
1.70 cm
1.13 cm
P

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59 yo M

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- **September 2023: HG cytology, normal cystoscopy**
- **Undergoes MR abdomen/pelvis**
  - **Demonstrates 2cm perivesical mass**
  - **Next Steps? Technique?**

Case #1

59 yo M

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- **Jan 2023: HgT1 s/p BCG**
- **June 2023: HgTa, s/p GemDoce**
- **September 2023: HG cytology, normal cystoscopy**
- **Undergoes MR abdomen/pelvis**
  - **Demonstrates 2cm perivesical mass**
- **TURBT- muscle invasive bladder cancer**
- **Management: Radical Cystoprostatectomy (cis-ineligible)**
  - **Final Pathology: pT3N1**

Case #2

85 yo M, CKD, CHF (EF 40), CAD on Plavix

- **Gross hematuria causing clot obstruction**
- **Transferred from another hospital to you.**
- **You take him for a clot evacuation and TURBT**

Panel Questions

1) How are you approaching this TURBT?

Case #2

85 yo M, CKD, CHF (EF 40), CAD on Plavix

- **Gross hematuria causing clot obstruction**
- **CT reveals pelvic lymphadenopathy and a bladder wall thickening with large clot burden**
- **Transferred from another hospital to you.**
- **You take him for a clot evacuation and TURBT**

- **TURBT: muscle invasive bladder cancer. Discharged POD 1.**
- **Patient currently on EV Pembro with stable disease and no further episodes of clot hematuria.**

Case #3

- 65 yo gentleman referred with newly diagnosed HGT1 w CIS
- Brought to the OR for a restaging TURBT

Panel Questions

1) Are you routinely doing restaging TURBTs in a case like this? Are you re-resecting with loop electrocautery?

2) Are you using enhanced cystoscopic techniques?

AUA NMIBC Guidelines

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Enhanced Cystoscopy

30.In a patient with NMIBC, a clinician should offer blue light cystoscopy at the time of TURBT, if available, to increase detection and decrease recurrence. (Moderate Recommendation; Evidence Strength: Grade B)

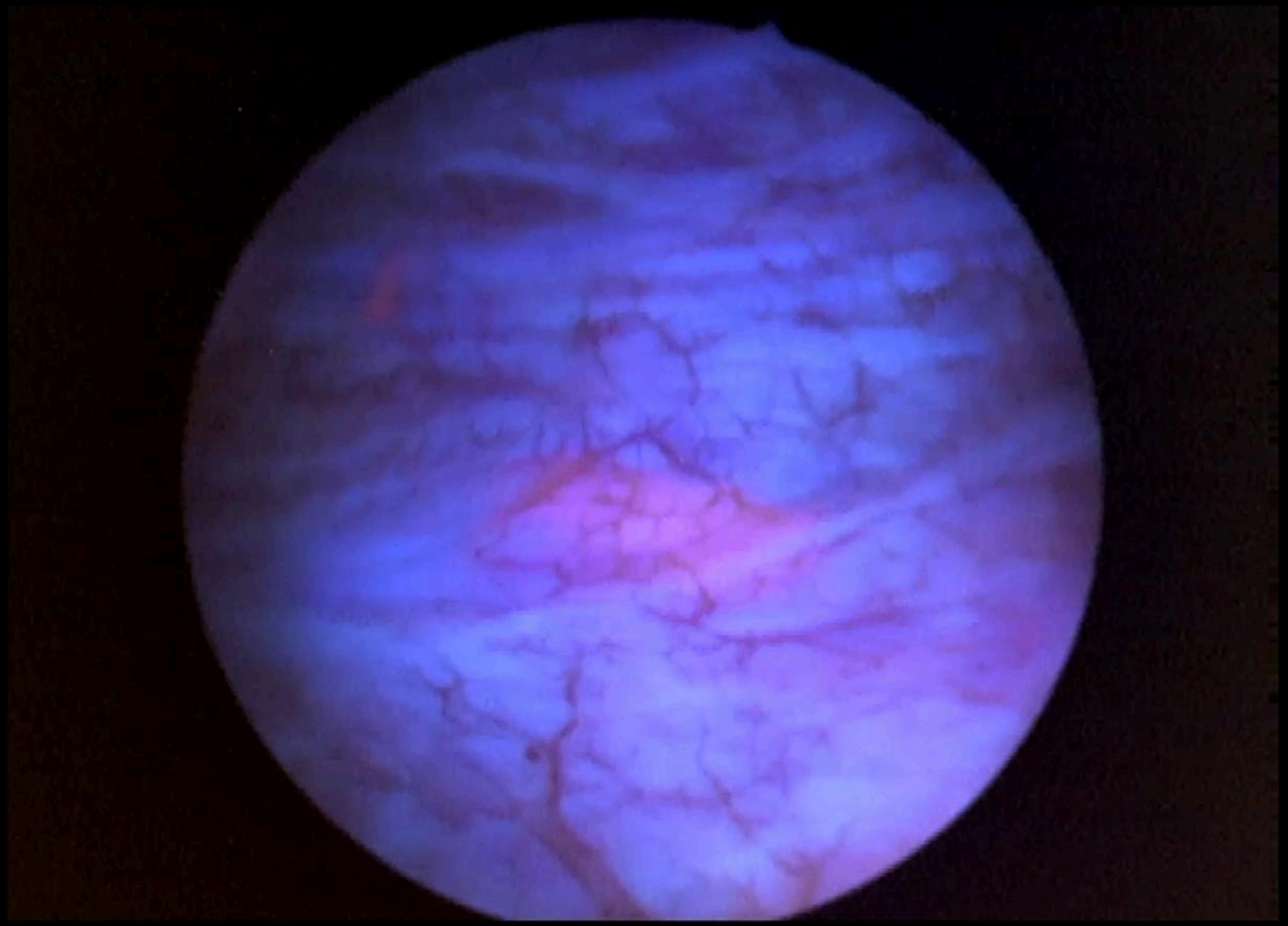
31. In a patient with NMIBC, a clinician may consider use of NBI to increase detection and decrease recurrence. (Conditional Recommendation; Evidence Strength: Grade C)

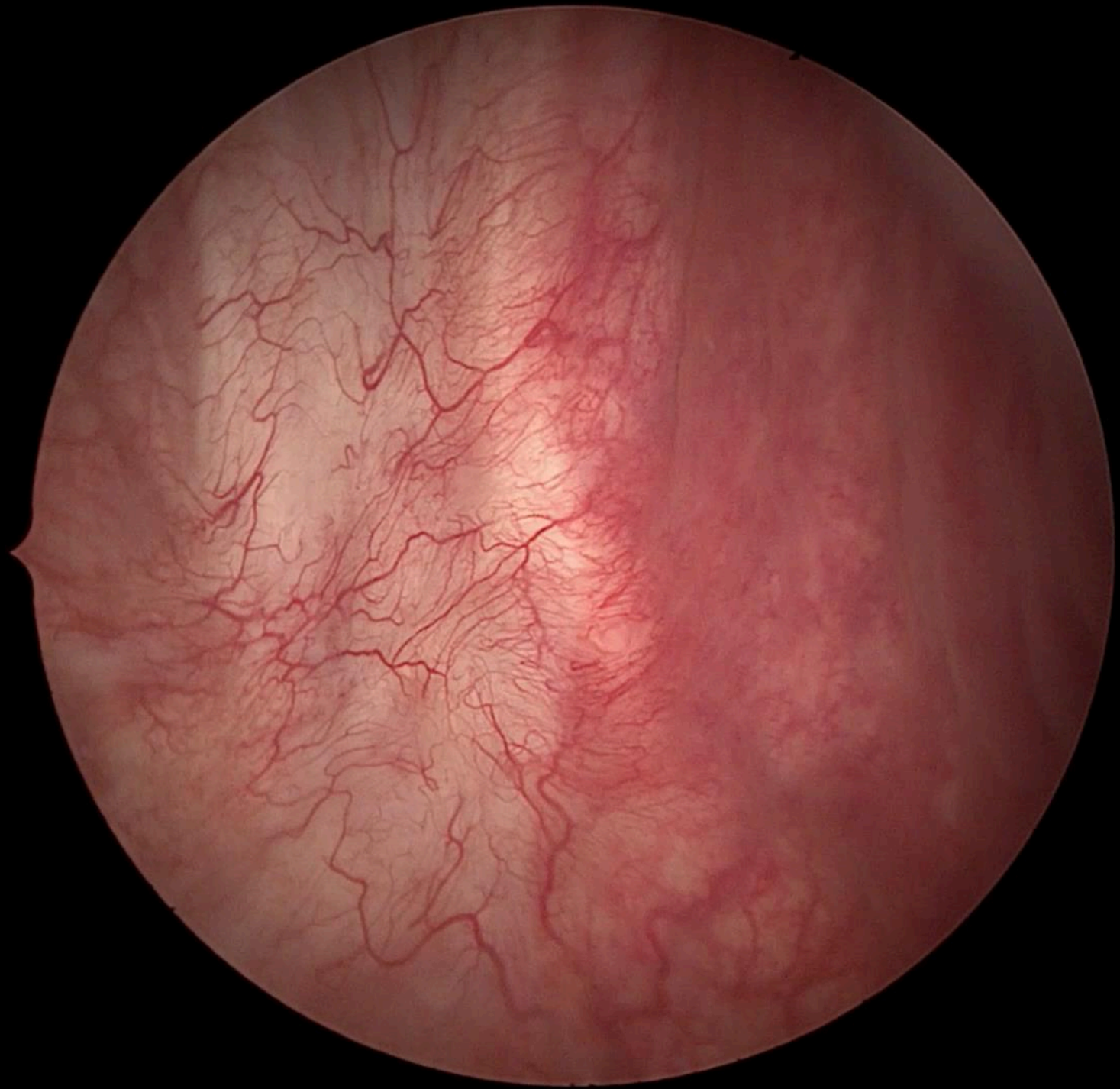
Chang, Boorjian S et al. AUA NMIBC Guidelines 2020

Bladder Cancer Detection by Stage

Number of lesions	Detected by Both WL & BL	Detected by WL Only	Detected by BL Only
CIS* (n = 66)	33	6	27 **41%**
Ta (n = 580)	472	52	56 **12%**
T1 (n = 95)	76	10	9 **9%**
T2 – T4 (n = 47)	38	8	1 **3%**

Stenzl A et al. J Urol 2010; 184: 1907-1914.





Case #3a VARIATION

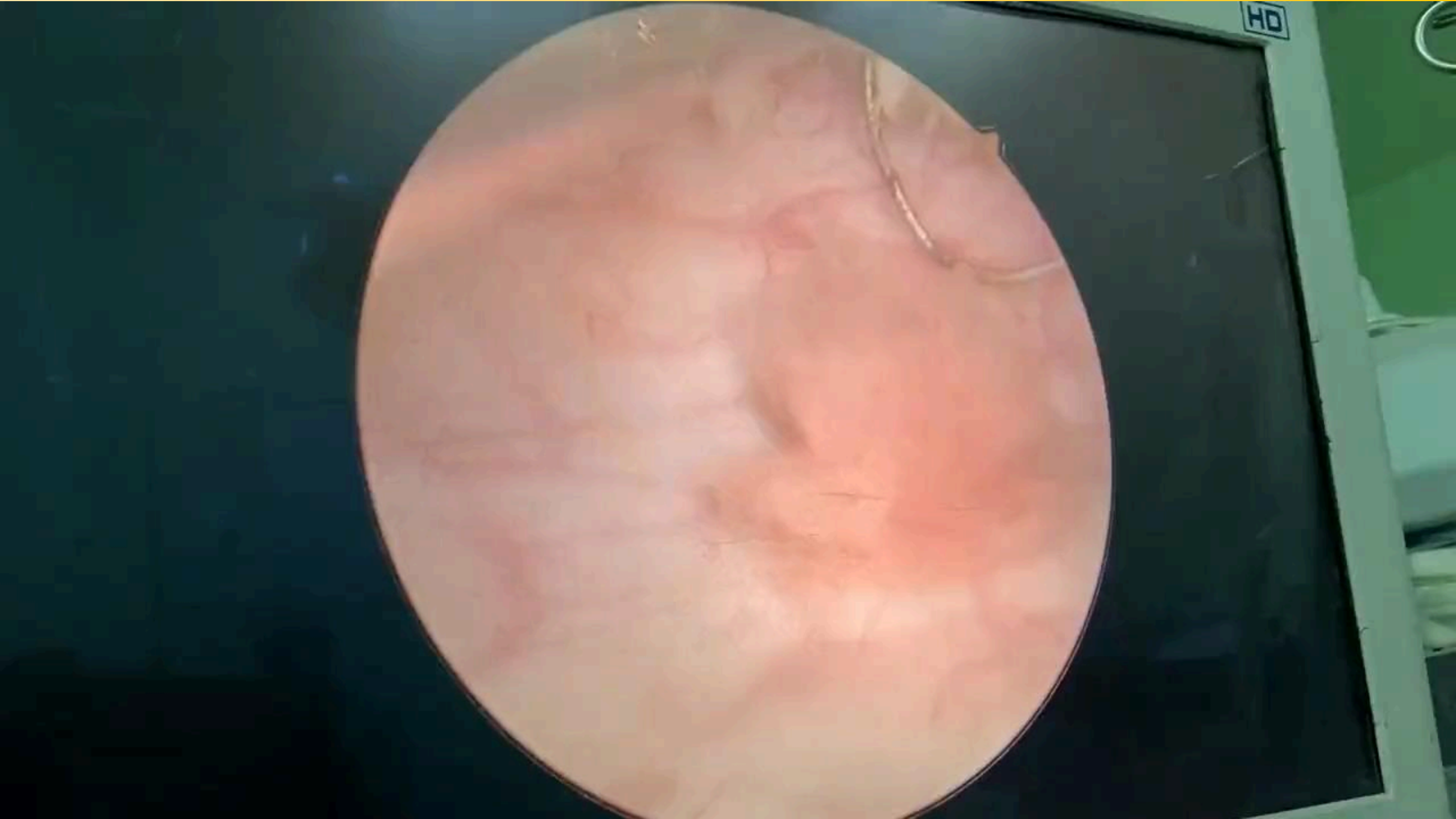
- Final Pathology CIS

- Panel Questions

  1). After BCG, how will you do his first surveillance? Flexible cystoscopy? Enhanced cystoscopy? Will you always biopsy?

Case #3a VARIATION

- During resection the following occurs…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Case #3a VARIATION

- Panel Questions
  1). What are you doing next?

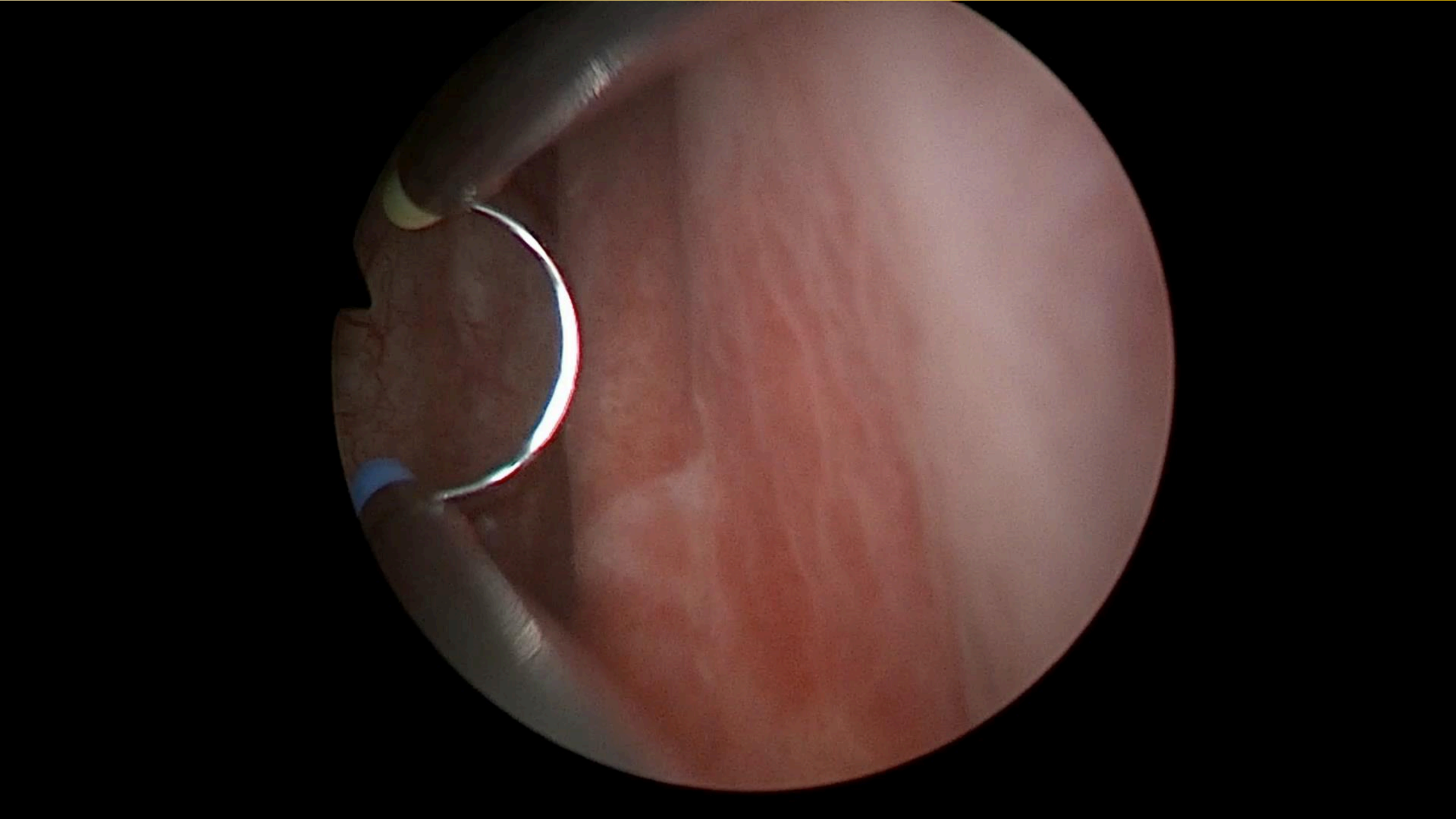
Case #3a VARIATION

- Panel Questions
  1). How can this be prevented in the future?

Resecting CIS/Small lesions and avoiding Obturator Reflex

- Bladder Underdistention (Increases Distance from Bladder to Obturator nerve) Most Important
- Staccato TURBT technique
- Bipolar >>> Monopolar (Controversial)
- Paralysis (rarely if ever done)

Venkatramani, J Urol, 2014



	Intent to Treat			Per Protocol		
	Monopolar	Bipolar	p Value	Monopolar	Bipolar	p Value
No. pts	75	72	—	69	68	—
No. obturator jerk (%)	29 (49.2)	33 (60)	0.27	28 (50.9)	30 (57.7)	0.56
No. bladder perforation (%)	12 (16)	12 (16.7)	1	12 (17.4)	12 (17.6)	0.97
Mean ± SD decrease:						
% Packed cell vol	3.07 ± 3.17	3.11 ± 3.83	0.95	3.18 ± 3.16	3.11 ± 3.83	0.92
Sodium (mmol/L)	1.97 ± 4.65	1.17 ± 3.08	0.25	1.95 ± 4.73	1.15 ± 3.1	0.26
No. transfusion (%)	1 (1.3)	4 (5.6)	0.2	1 (1.5)	4 (5.9)	0.17
No. recoagulation/clot retention (%)	3 (4)	4 (5.6)	0.72	3 (4.4)	4 (5.9)	0.68
No. TUR syndrome (%)	2 (2.7)	0	0.49	2 (2.9)	0	0.49
Mean ± SD resection time (mins)	49 ± 32.5	41.6 ± 23.1	0.11	48.8 ± 32.5	41.9 ± 23.4	0.16
No. deep muscle (%)	71 (94.7)	69 (95.8)	1	65 (94.2)	66 (97.1)	0.41
No. severe cautery artifact (%)	35 (46.7)	18 (25)	0.0096	33 (47.8)	15 (23.5)	0.0042

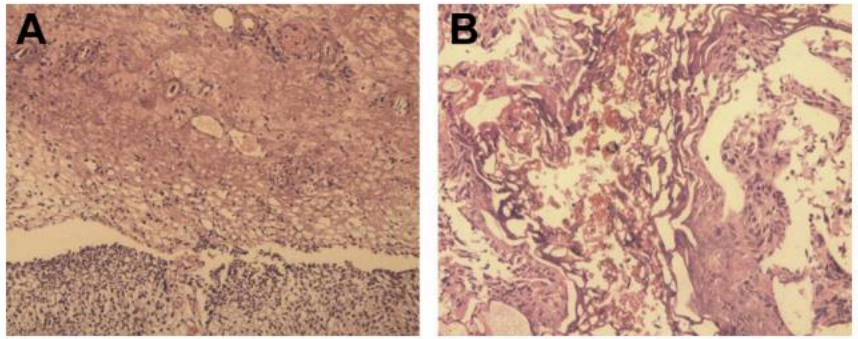


Figure 2. *A*, mild cautery artifact with preserved tissue architecture. *B*, severe cautery artifact with extensive vacuolation and necrosis. H&E, reduced from ×200.

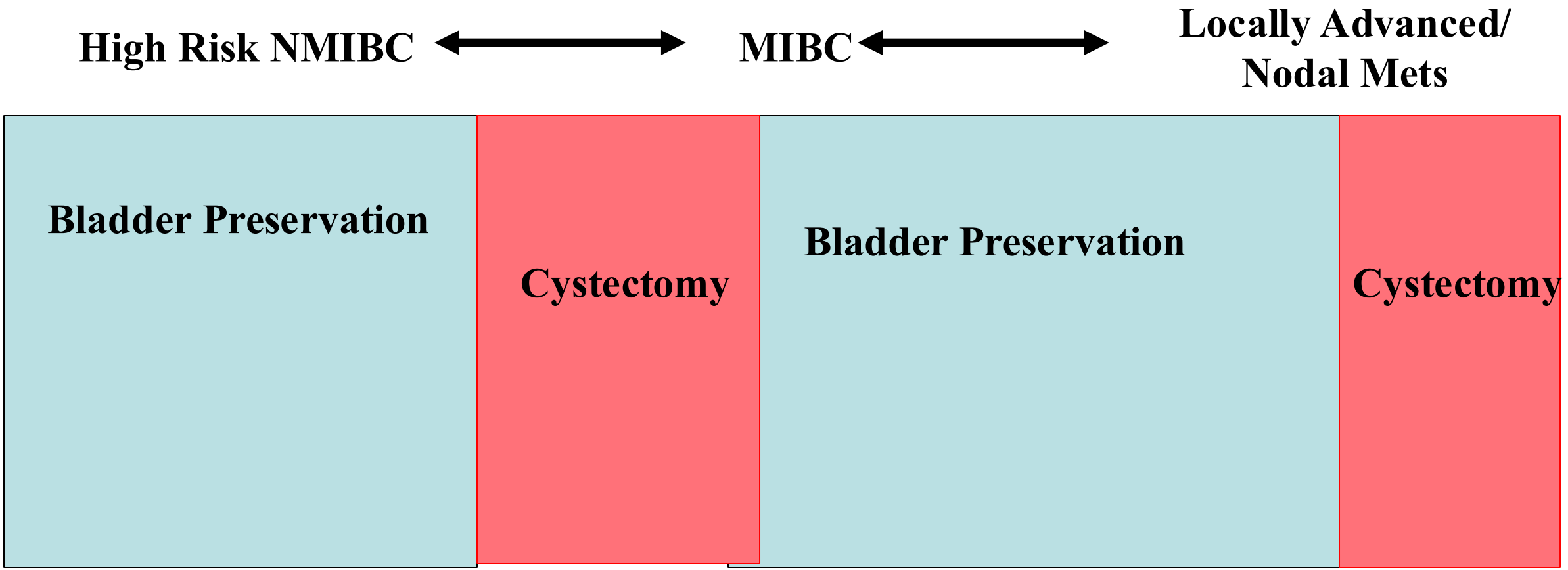
Venkatramani, J Urol, 2014

Case #4

84 yo F

- **10+ episodes of recurrent multifocal LgTa Bladder Cancer. Multiple rounds of Intraveiscal BCG, MMC, Gem/Doce with near constant recurrences. Multiple current small tumors near the UO.**
- **What to do?**

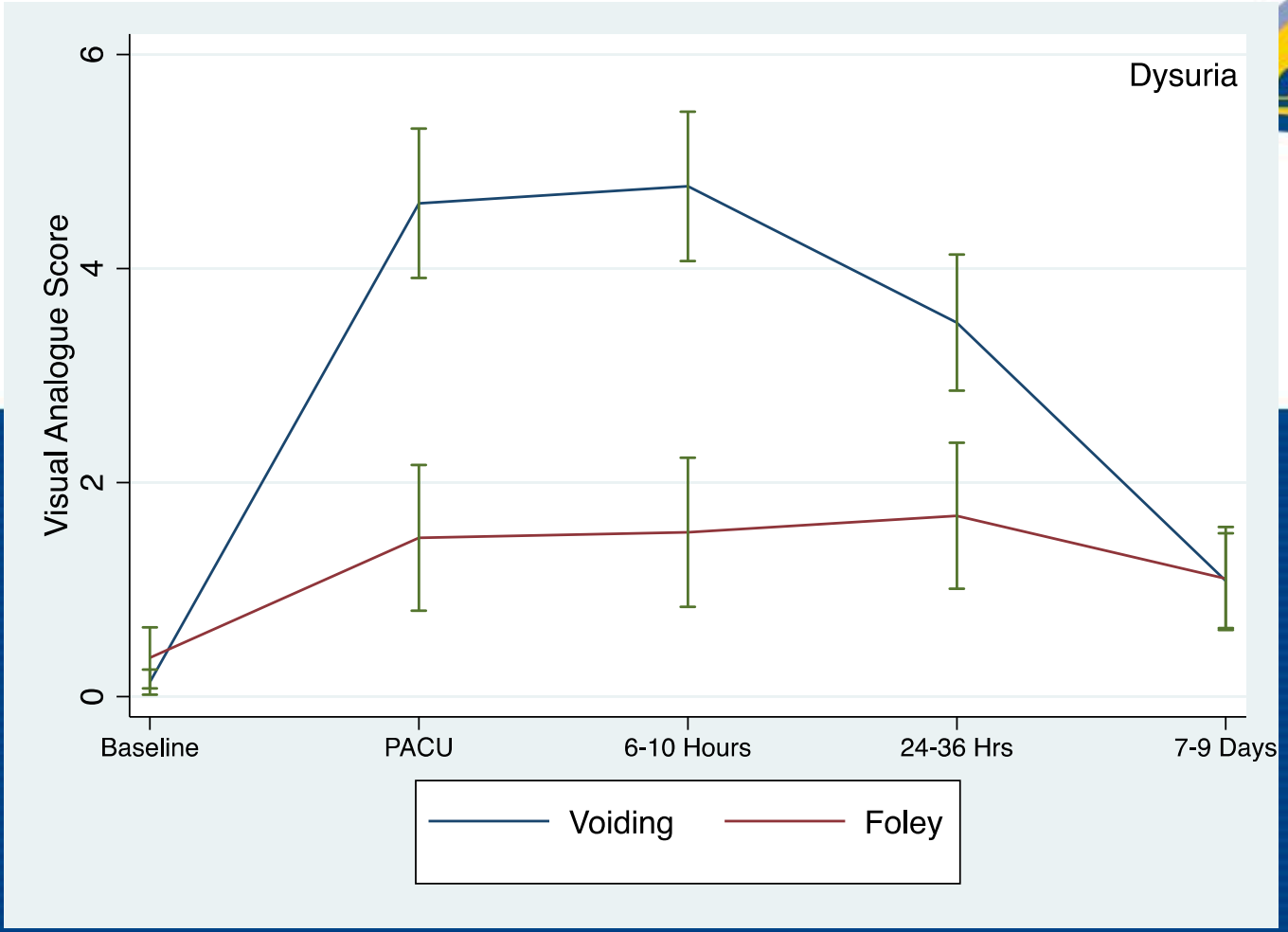
How do we safely de-escalate Surgical Care for our bladder cancer patients?

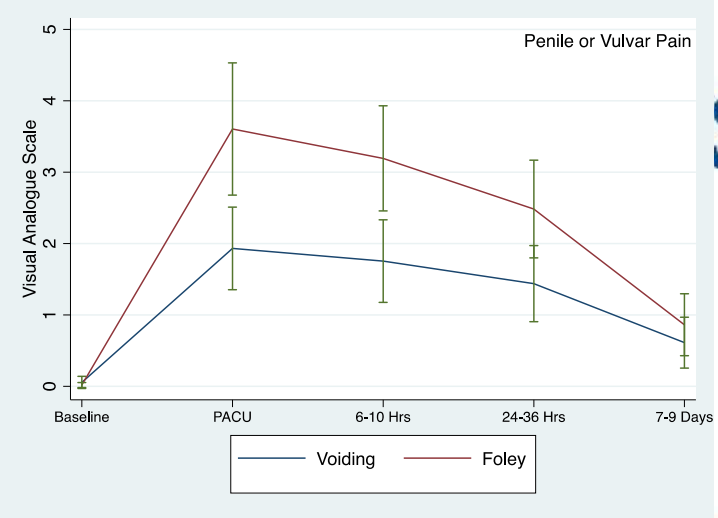


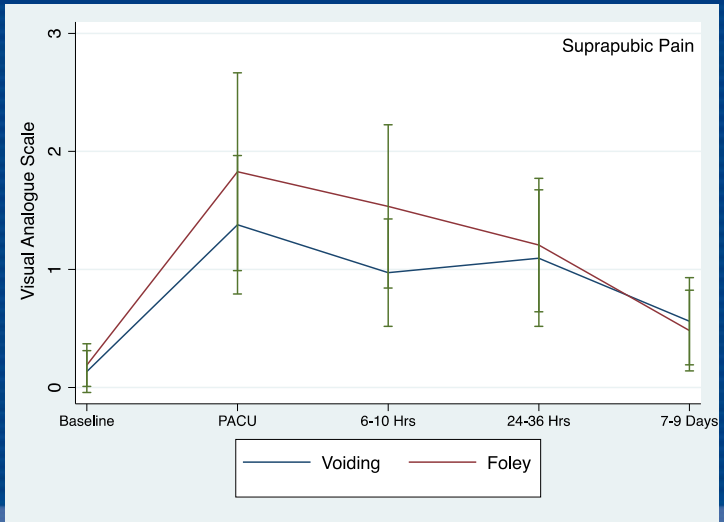
Characterizing Recovery & Defining Toxicity after TURBT- A Needs assessment

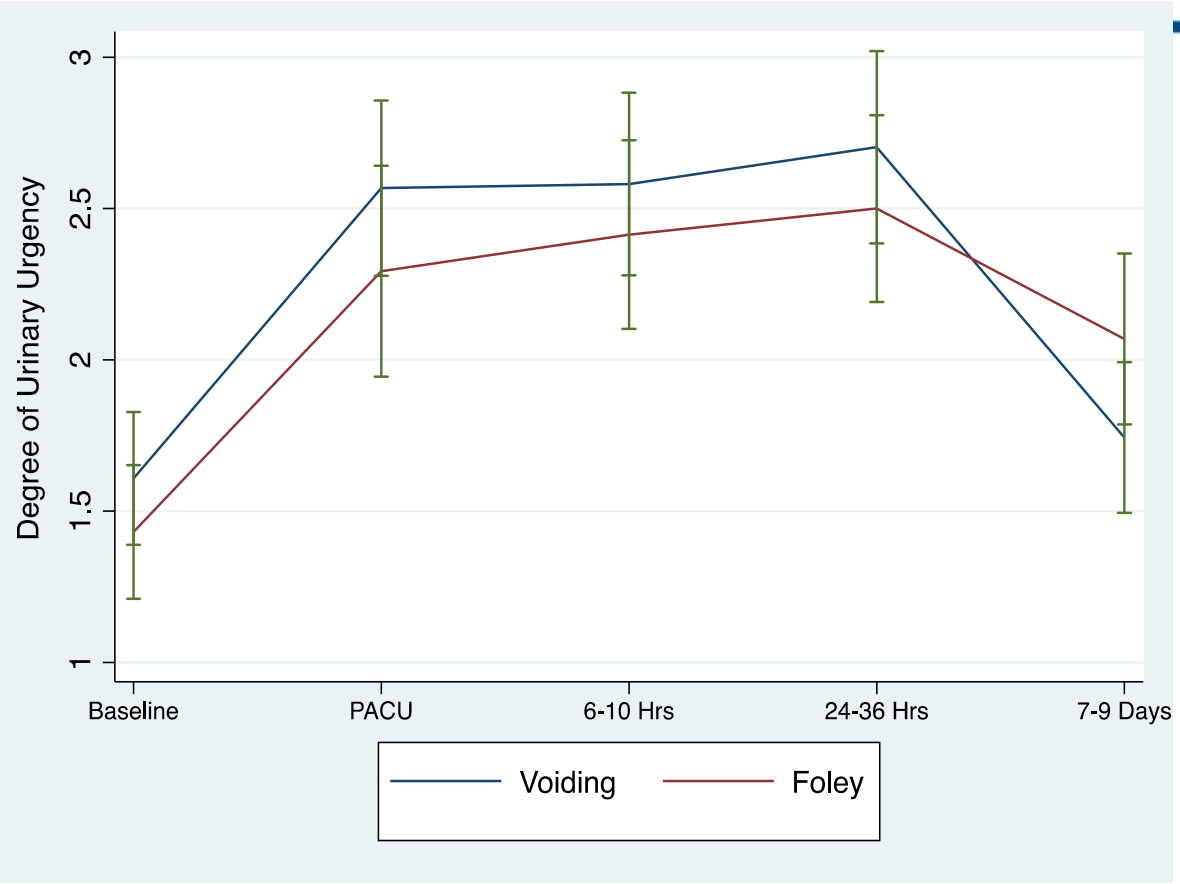
Dr Michael Rezzae

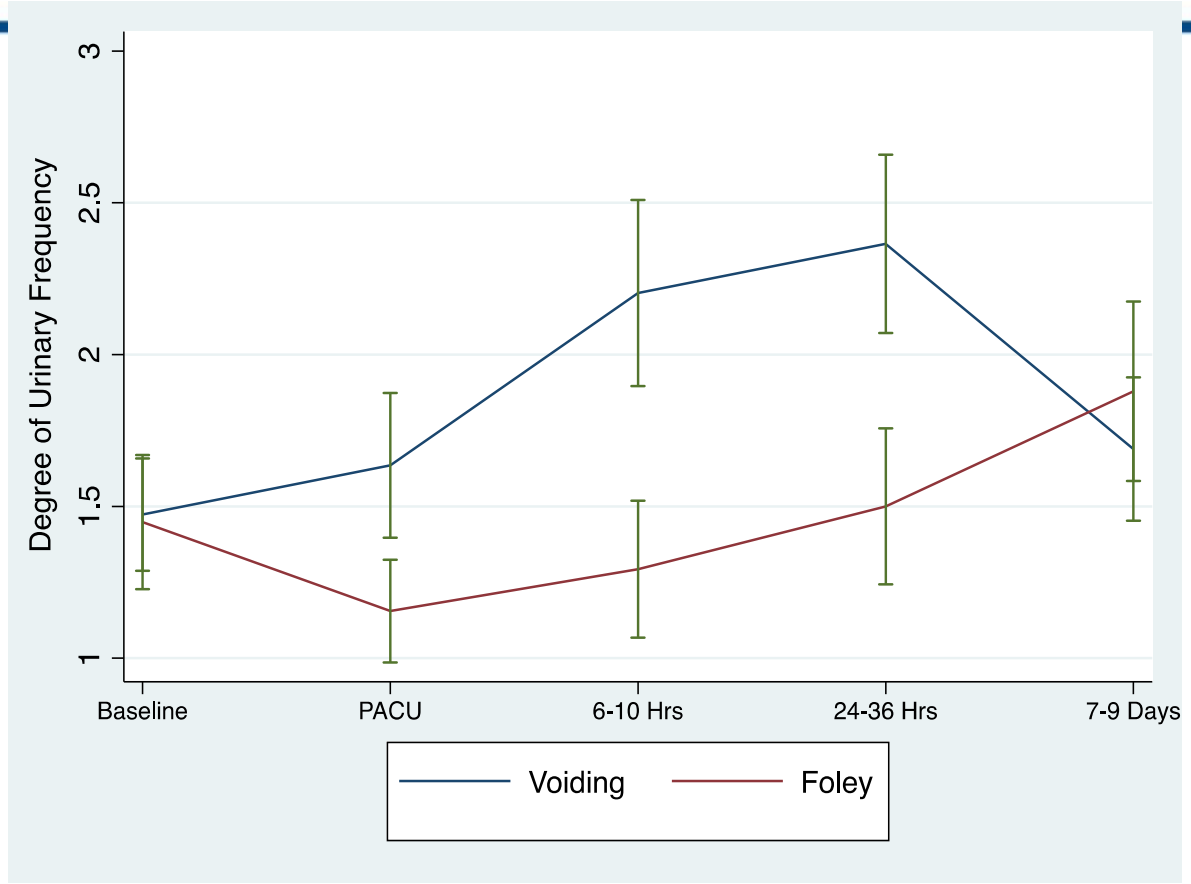
- Multicenter prospective cohort of patients with bladder cancer undergoing ambulatory TURBT
  - Johns Hopkins
  - Dartmouth
- 132 patients enrolled to-date (Jan-June 2023)
- In-person and telephone-based assessments:
  - Dysuria, suprapubic pain, penile/vulvar pain (visual analogue scale)
  - UTI-SIQ-8 for LUTS assessments
- Time Points
  - Baseline
  - PACU prior to discharge
  - 6-10 Hours
  - 24-36 Hours
  - 7-9 Days


Dysuria
Visual Analogue Score
0
2
4
6
Baseline
PACU
6-10 Hours
24-36 Hrs
7-9 Days
Voiding
Foley

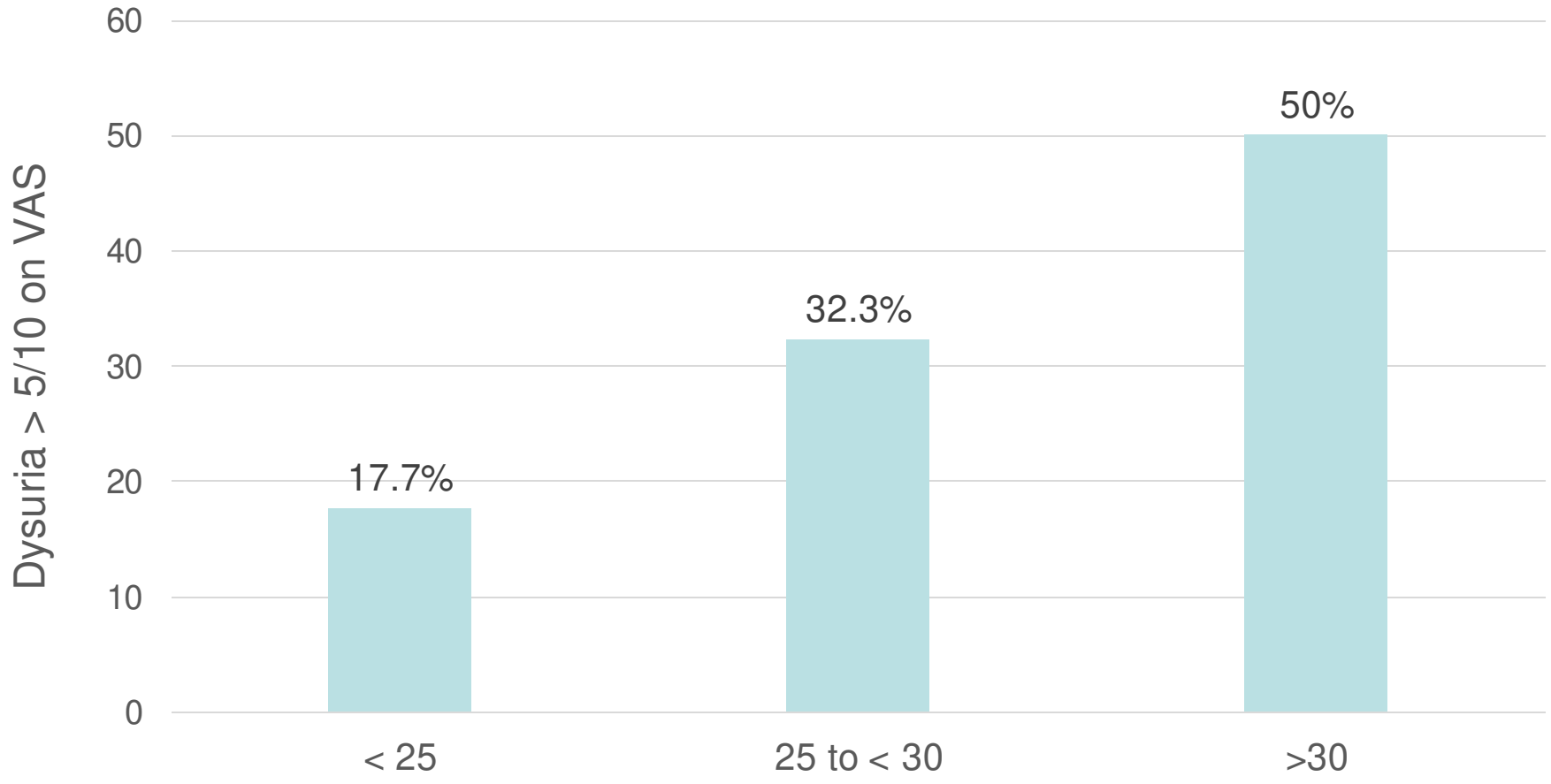

Penile or Vulvar Pain
Visual Analogue Scale
0
1
2
3
4
5
Baseline
PACU
6-10 Hrs
24-36 Hrs
7-9 Days
Voiding
Foley


Suprapubic Pain
Visual Analogue Scale
0
1
2
3
Baseline
PACU
6-10 Hrs
24-36 Hrs
7-9 Days
Voiding
Foley

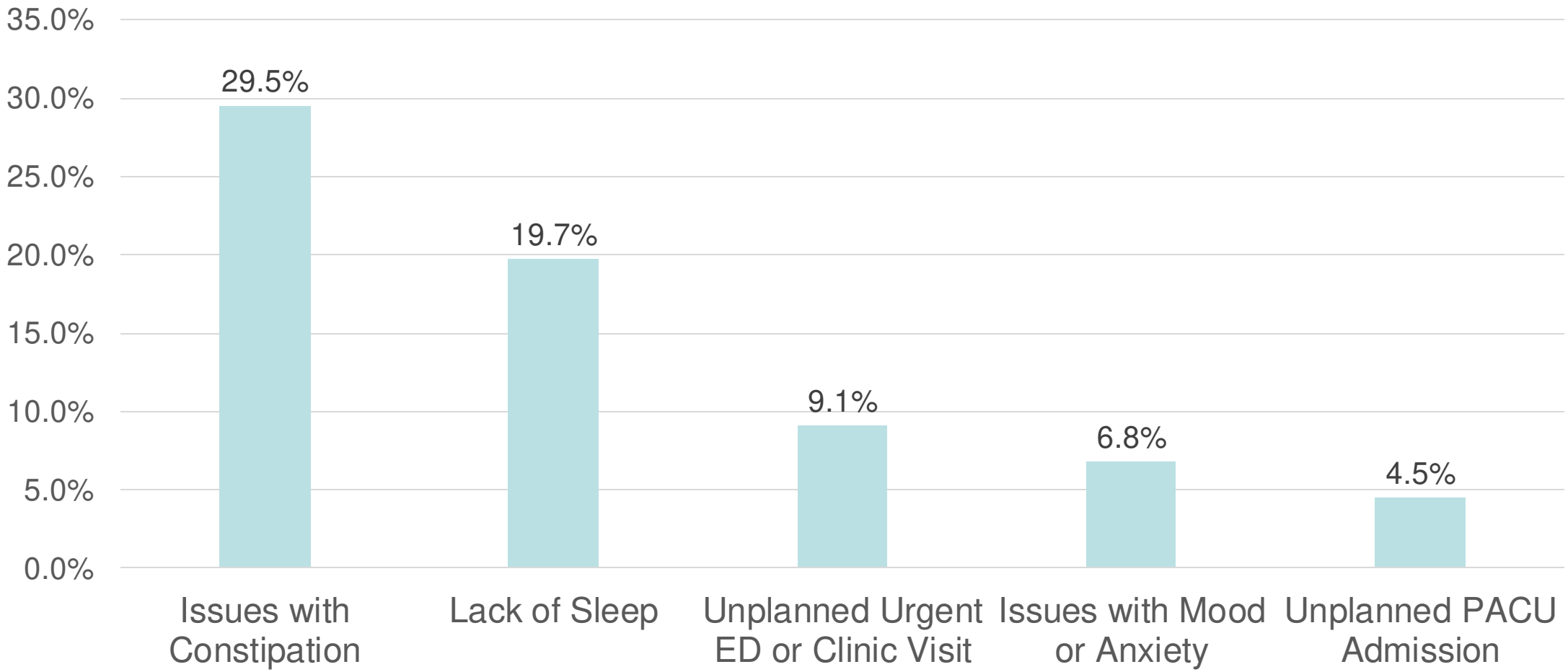

Degree of Urinary Urgency
1
1.5
2
2.5
3
Baseline
PACU
6-10 Hrs
24-36 Hrs
7-9 Days
Voiding
Foley


Degree of Urinary Frequency
1
1.5
2
2.5
3
Baseline
PACU
6-10 Hrs
24-36 Hrs
7-9 Days
Voiding
Foley

BMI as a driver of dysuria?



Self-reported outcomes



Takeaways

- We underappreciate what patients with bladder cancer experience after TURBT
- Symptomatology and toxicity needs to be better defined and understood
- We need to move towards a model of survivorship and optimizing experience of care, especially among those with high-risk disease who are likely to have multiple recurrences requiring numerous TURBTs over time

ERAS for Ambulatory TURBT: Enhancing Bladder Cancer Care (EMBRACE) Randomized Controlled Trial

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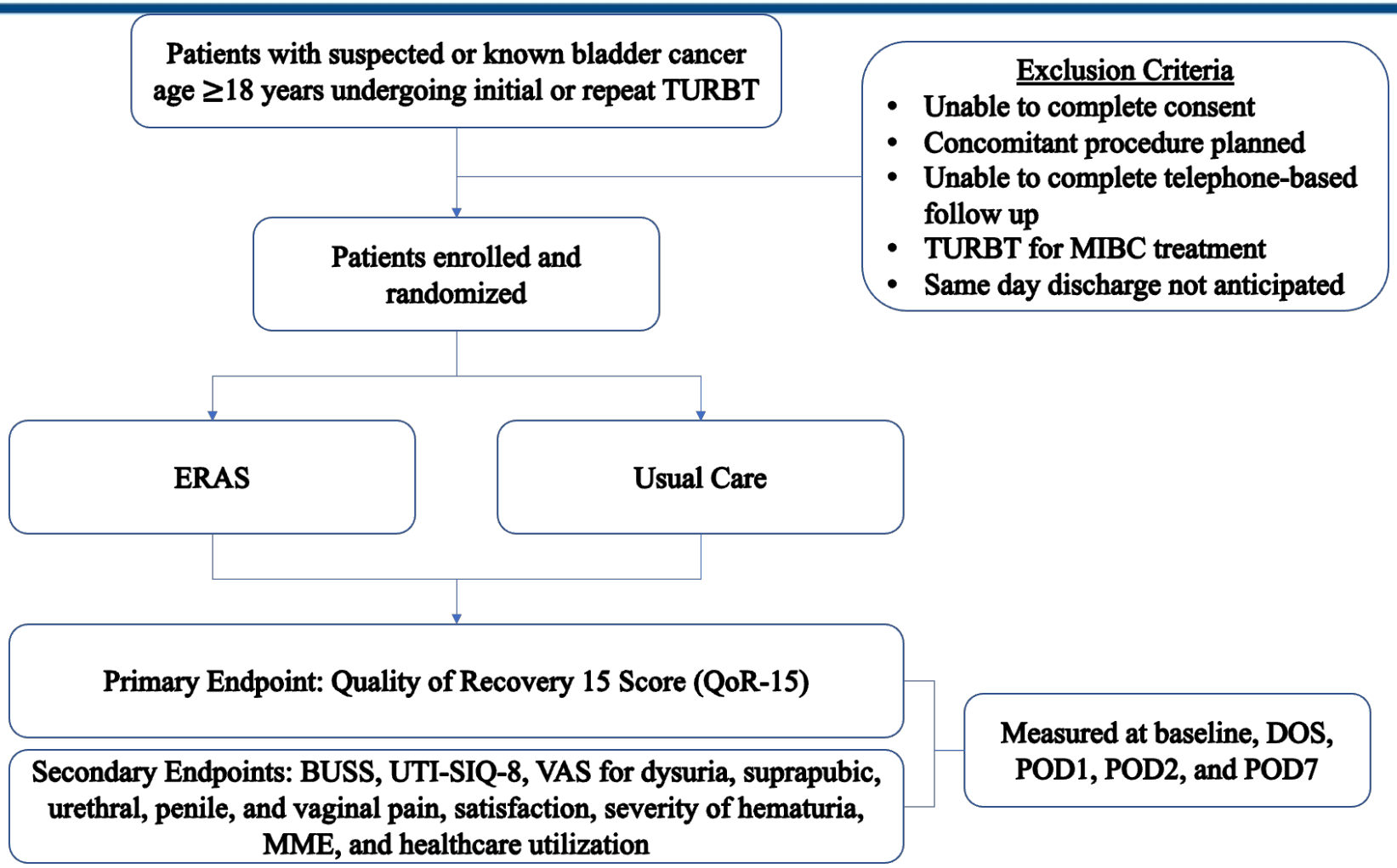
- The EMBRACE trial is the first of its kind to assess the impact of an ERAS protocol for ambulatory TURBT in patients with bladder cancer
  - Randomized-controlled trial of ERAS versus usual care, producing the highest level of evidence possible
  - Developed by patients and providers and prioritizes the use of patient-reported outcomes, including the QoR-15 score, BUSS, UTI SIQ8 and visual analogue pain scale.
  - Single center design of the study may limit the generalizability of the results, but the ERAS protocol is customizable to any setting

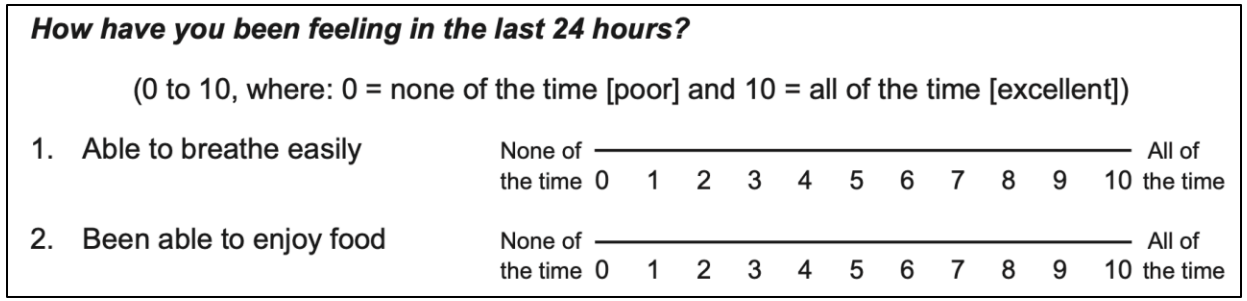
Study Schema



Hypothesize that ERAS will improve overall mean QoR-15 score by 6 points.
Assume SD of 12 based on literature review. 2 sided test alpha 0.05. With 50 pts in each group, 87% power to detect 6 point difference
N=100

Quality of Recovery - 15

- Validated 15-item questionnaire that assesses quality of recovery in five dimensions:
  - Pain
  - Physical Comfort
  - Functional Autonomy
  - Emotions
  - Psychological Support



How have you been feeling in the last 24 hours?

(0 to 10, where: 0 = none of the time [poor] and 10 = all of the time [excellent])

1. Able to breathe easily

None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

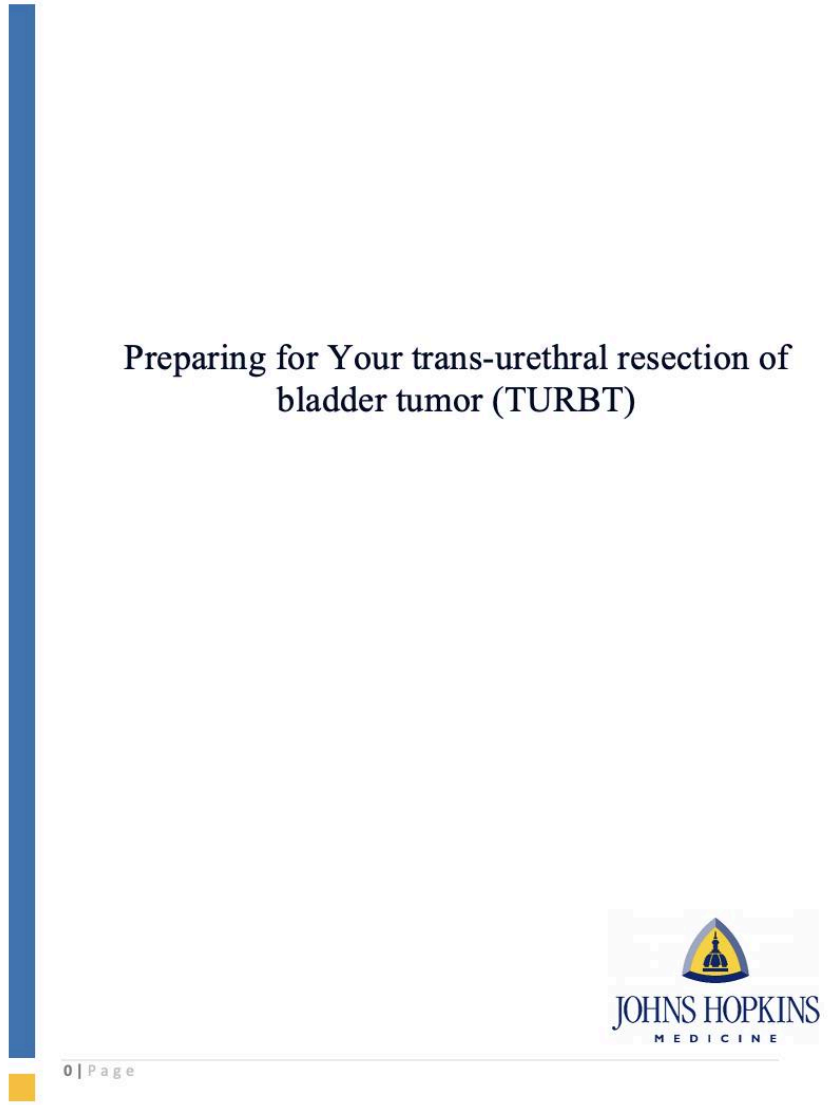
2. Been able to enjoy food

None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

- Patient-reported outcome measure extensively used to evaluate ERAS protocols for inpatient and ambulatory surgeries.

ERAS Interventions

- Preoperative
  - Procedure and Foley catheter education
  - Constipation Prevention
- Intraoperative
  - Anesthetic standardization
  - Toradol utilization
- Postoperative
  - Discharge instruction standardization
  - Foley catheter assessment at discharge (need for piston syringe)


Preparing for Your trans-urethral resection of bladder tumor (TURBT)

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0 | Page

Data Collection Schedule

	DOS-5	DOS	POD1	POD2	POD7
Patient Enrollment, Consent, and Randomization	x				
QoR-15 score	x	x	x	x	x
VAS for dysuria, suprapubic, urethral, penile, or vaginal pain	x		x	x	x
UTI-SIQ-8 questionnaire	x		x	x	x
BUSS questionnaire	x		x	x	x
Rating of satisfaction with TURBT experience			x	x	x
Hematuria scale	x		x	x	x
Incontinence assessment (pads per day)	x		x	x	x
MME utilization			x	x	x
Number of outpatient visits, patient phone calls, and electronic messages			x	x	x
Unplanned admissions from PACU		x			
Pathology results					
Clavien-Dindo complications					
Readmission to the Hospital after Discharge					

Needs Assessment Domains

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Pain and Discomfort	Lower Urinary Tract Symptoms	Medication Use
Suprapubic Pain Dysuria Penile or Vulvar Pain Metric: Visual Analogue Scale (1-10) Bladder Spasms Metric: Self-Reported	Urgency Frequency Dysuria Lower Abdominal Pain Metric: Urinary Tract Infection – Symptoms and Impairment Questionnaire (UTI-SQ-8) Hematuria Incontinence Metric: Self-Reported	Morphine Milligram Equivalents Tylenol NSAIDS Pyridium Oxybutynin Metric: Self-Reported **Open Ended Patient Feedback**

UTI-SIQ-8

- A reliable and validated questionnaire of voiding symptom severity and bother in women with a urinary tract infection

- Patient-reported outcome measure
  - Urinary Urgency
  - Urinary Frequency
  - Lower Abdominal Pain
  - Dysuria

How severe are your symptoms today?	not at all	Mild	moderate	strong	very strong
	0	1	2	3	4
1. Urgency of urination	☐	☐	☐	☐	☐
2. Pain or burning when passing urine	☐	☐	☐	☐	☐
3. Frequency of urination	☐	☐	☐	☐	☐
4. Pain in the lower abdomen	☐	☐	☐	☐	☐

How much impairing are the symptoms for you today?	not at all	Little	moderate	severe	very severe
	0	1	2	3	4
5. Impaired activities due to urgency	☐	☐	☐	☐	☐
6. Impaired activities due to pain while passing urine	☐	☐	☐	☐	☐
7. Impaired activities due to frequency of urination	☐	☐	☐	☐	☐
8. Impaired activities due to pain in the lower abdomen	☐	☐	☐	☐	☐

Patient Voices

Pain (pelvic, dysuria) → delayed for some until Foley catheter removal; better controlled in PACU and then spikes at home; pain at tip of penis from catheter

No sleep night of POD0 – "Hell night"

Anxiety with trial of void in PACU

Foley or catheter secure device malposition by RN

Prescription pickup issues (no in stock or pharmacy closed by the time they get home)

What number to call for emergencies?

Discharge around catheter

How much should I drink?

Voiding symptoms (urgency, frequency, incontinence, pad use, urinal reliance) – "Recovery is worse than my heart surgery"; Urgency most pronounced when getting up from sitting to standing position

Constipation requiring manual decompaction

Path results/next steps

Activities I can safely do after surgery (lifting, sex)?

Jeans/slacks/belts/suspenders slow down ability to void. Best clothing is loose-fitting or sweatpants

Local ED or Urologist visits for issues

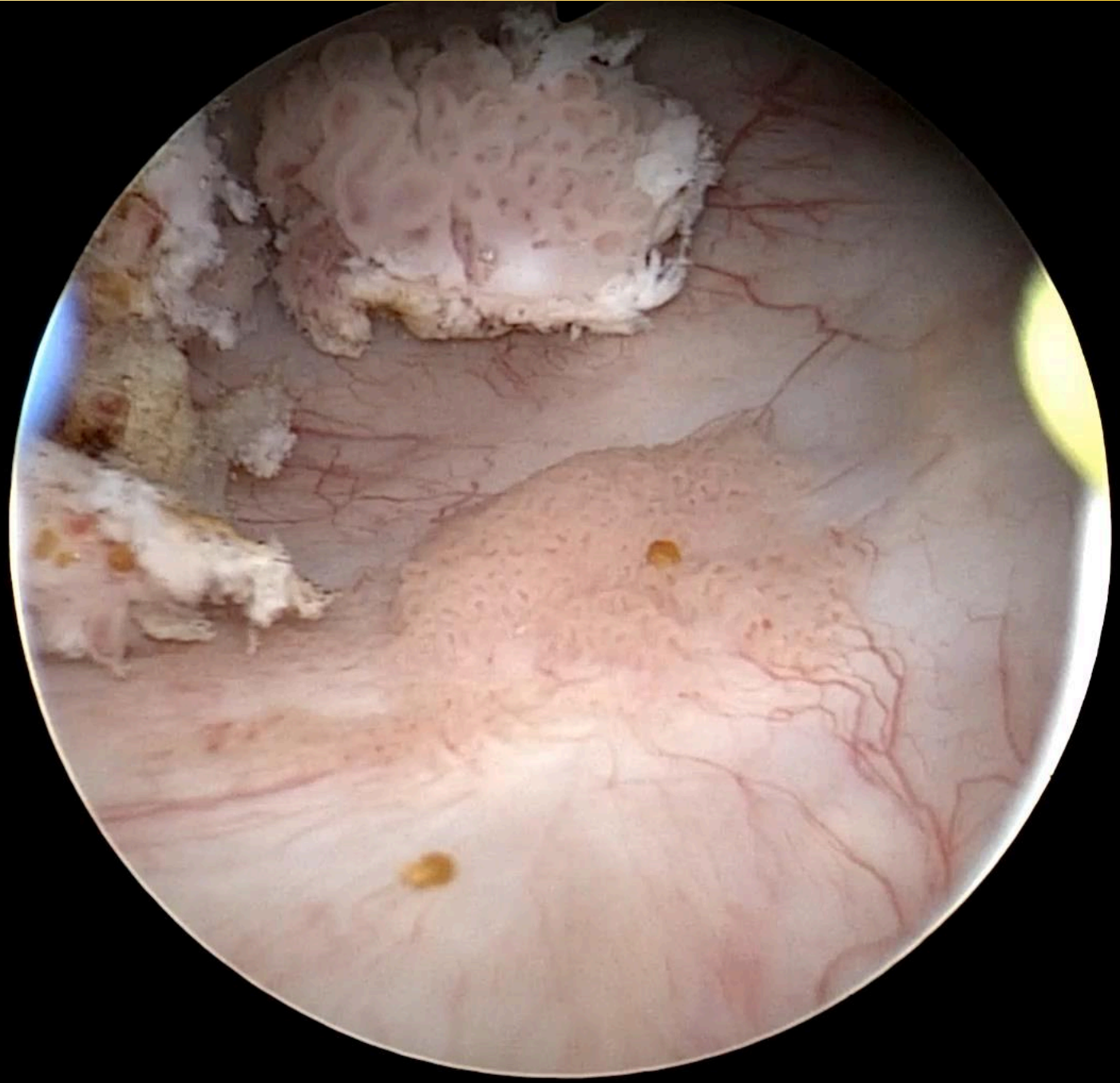
Debris coming through catheter

TURBT is a procedure and not a diagnostic test

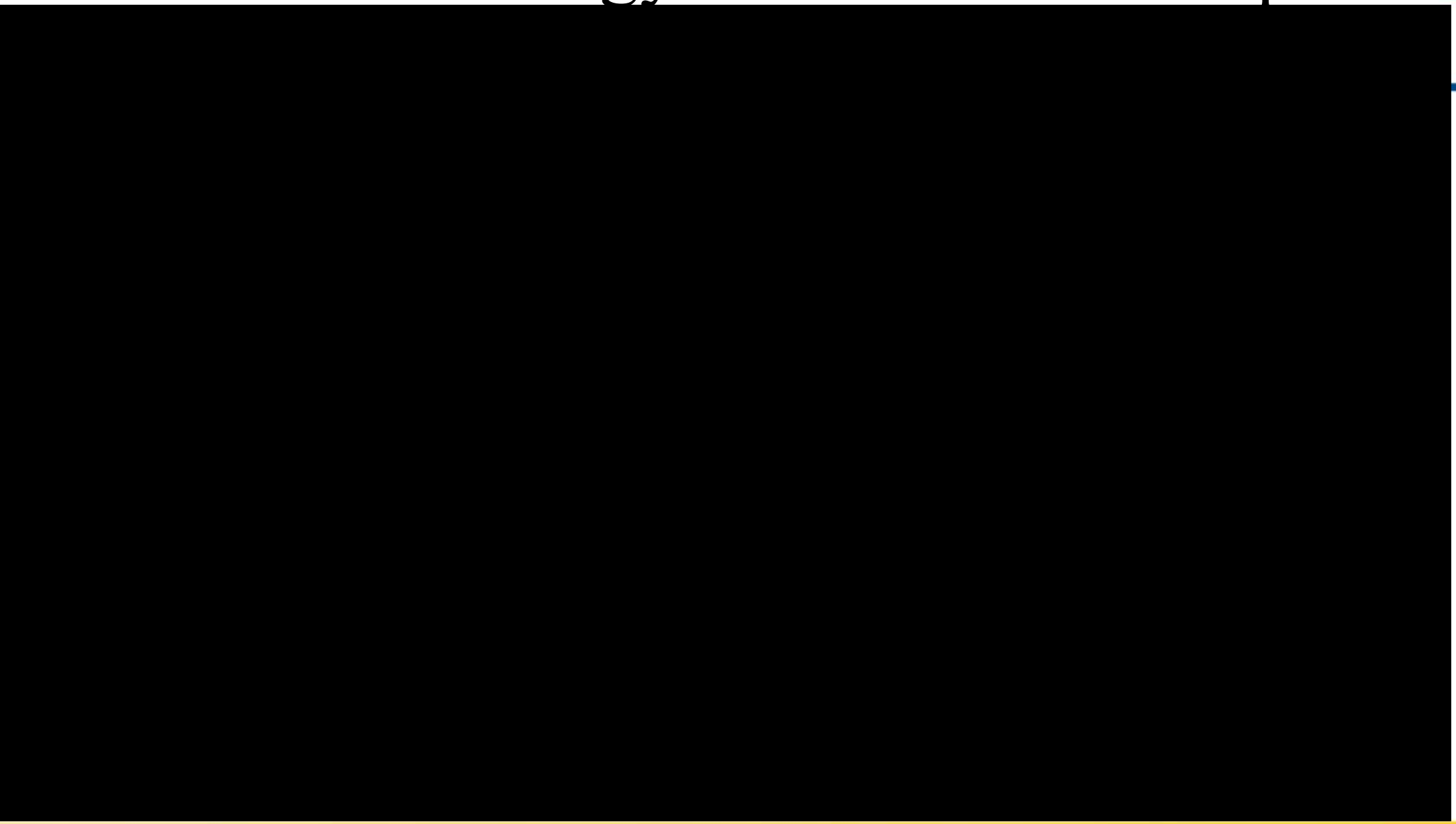
Case #4- Bipolar Ablation: “Popcorning”

84 yo F

- **10+ episodes of recurrent multifocal LgTa Bladder Cancer. Multiple rounds of Intraveiscal BCG, MMC, Gem/Doce with near constant recurrences. Multiple current small tumors near the UO.**
- **What to do?**
- **Tumor Ablation using the ”Bipolar Popcorn technique”**



Case #3- “No energy resection” technique:



Case #5

36 yo F

- **New Tumor close to but not involving the UO on a stalk.**

Case #5- Bipolar En Bloc Resection

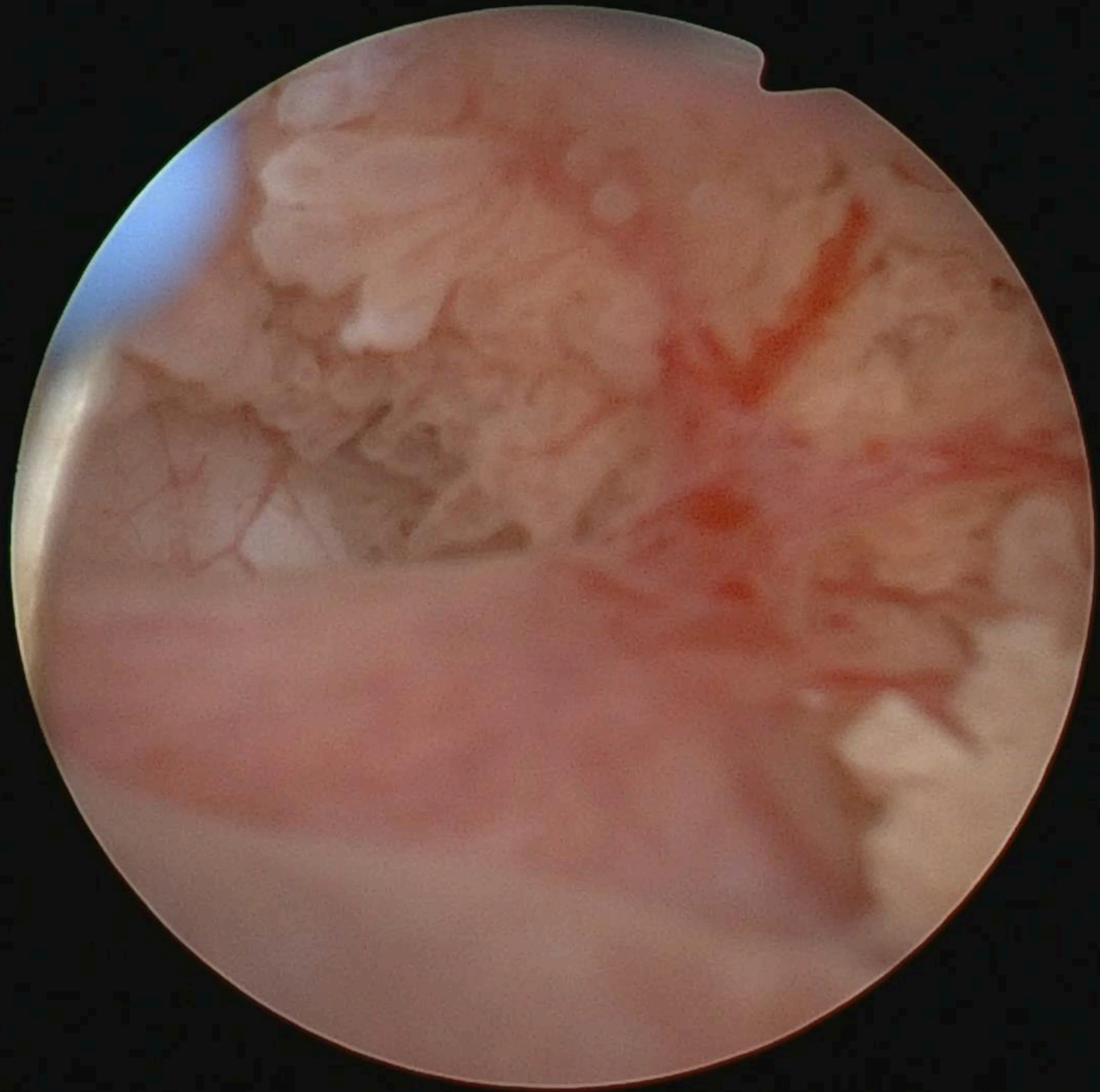
https://www.urotoday.com/conference-highlights/esou18/esou18-bladder-cancer/101592-esou18-new-techniques-for-bladder-tumor-resection.html

Case #5

36 yo F

- **New Tumor close to but not involving the UO on a stalk.**

- **Great Case for those just starting with en bloc concepts**



Case #5

36 yo F

- **New Tumor close to but not involving the UO on a stalk.**
- **Final pathology LgTa, No muscle in specimen**
- **Panel:**
  - **Do you need muscle in specimen? What if its was HgTa?**

Case #6

70 yo F with infiltrative tumor involving the right UO

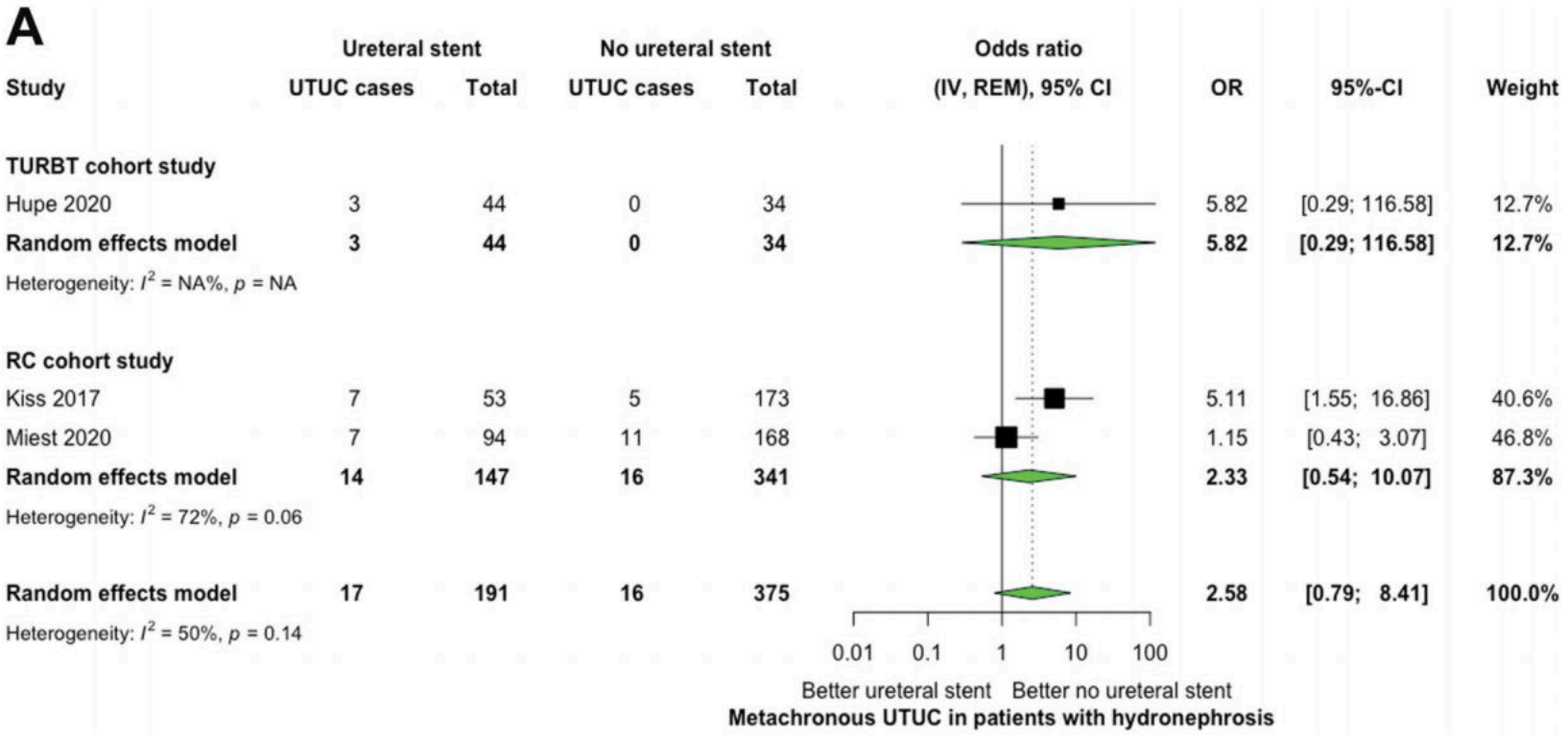
- **How to manage tumor involving a UO**

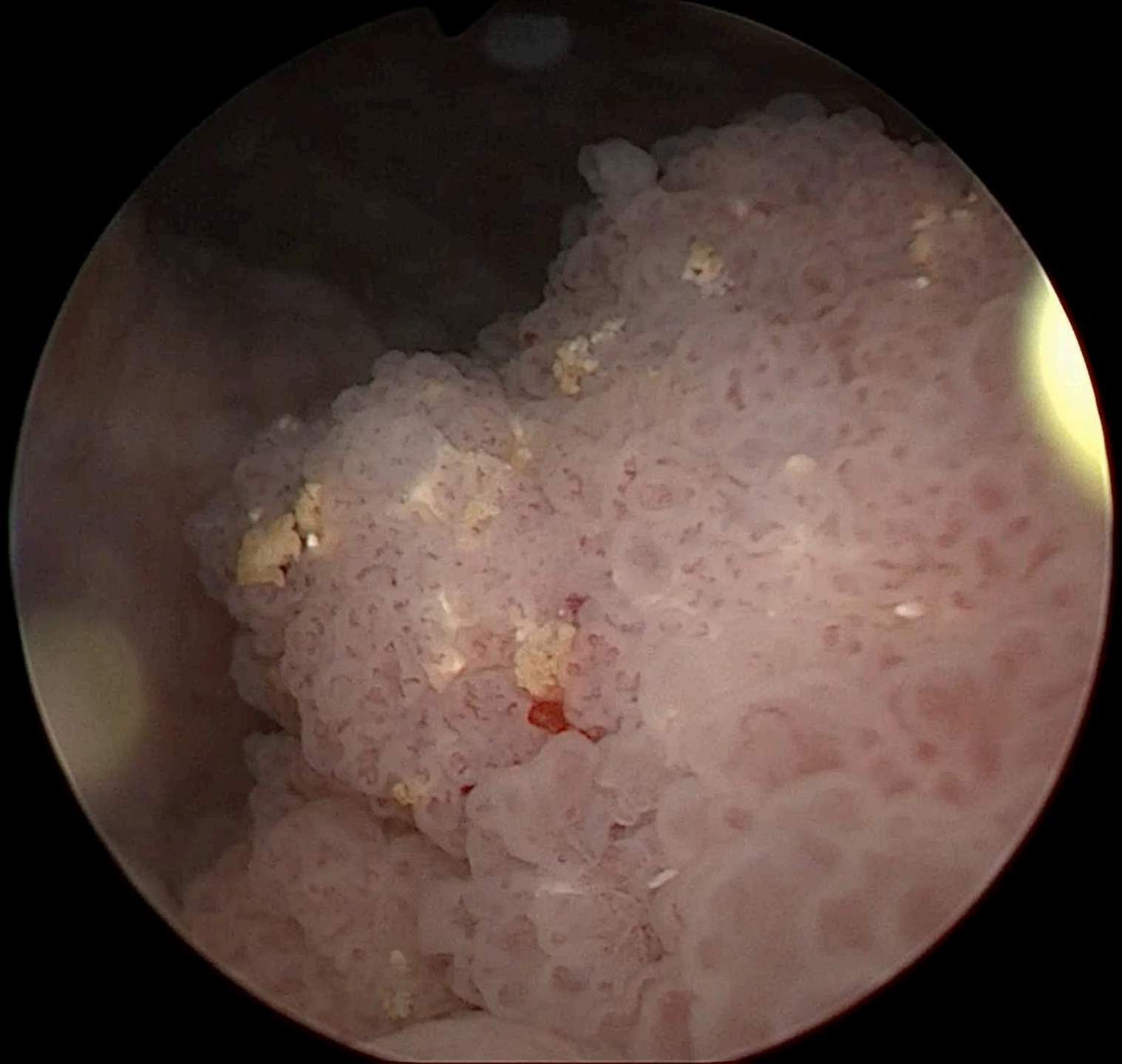
Case #6-Resecting the UO

Does Ureteral Stenting Increase the Risk of Metachronous Upper Tract Urothelial Carcinoma in Patients with Bladder Tumors? A Systematic Review and Meta-analysis

Petros Sountoulides,* Nikolaos Pyrgidis, Sabine Brookman-May, Ioannis Mykoniatis, Theofilos Karasavvidis and Dimitrios Hatzichristou

Conclusions: Stenting as a preventive measure after resection of tumors involving the orifice should be avoided, when possible, as it increases the risk of metachronous upper tract urothelial carcinoma. In cases of hydronephrosis, drainage with either nephrostomy or stent is recommended depending on indi-





Case #6

Author	pT stage (ERBT/cTURBT)	RFS (ERBT/cTURBT)	RR (ERBT/cTURBT)	PSM rate (ERBT/cTURBT)	Residual tumor rate	DM rate (ERBT/cTURBT)	MM rate (ERBT/cTURBT)
Abotaleb	Ta 30.4%, T1 54.3%, T2 15.2%	NR	15.2% (12M)	NR	13.0% (ERT)	NR	NR
Balan	Ta 53.3%/51.1%, T1 46.7%/48.9%	NR	17.1%/27.5% (12M)	NR	NR	NR	NR
Cheng	Ta 41.8%/43.33%, T1 47.06%/50.00%, T2 11.76%/6.67%	NR	8.82%/33.33% (12M)	NR	NR	97.06%/80%	NR
Cheng	Ta 54.7%/55.1%, T1 45.3%/44.9%	94.7%/78.4% (33M)	NR	1.1%/5.2%	NR	NR	NR
Hayashida	Ta 48.7%/51.6%, T1 46.2%/45.2%, T2 5.1%/3.2%	NR	15.4%/19.4%(12M)	NR	NR	100% (ERT)	NR
Hurle	Ta 21.79%, T173.08%, Tis 5.13%	NR	3.85% (3M),14.1%(overall)	1.3% (ERBT)	6.41% (ERT)	100% (ERT)	NR
Li	NR	31.79M/27.86M	NR	NR	NR	95.6%/83.3%	NR
Liang	Ta 33.0%/47.1%, T1 67.0%/52.9%,	NR	NR	NR	NR	NR	30.7%/11.4%
Xu	Ta 38.5%/56.8%, T1 46.2%/36.4%	NR	15.4%/27.3%(overall)	NR	NR	NR	NR
Zhang	Ta 37.5%/54%, T1 62.5%/46%	NR	20%/24%(overall)	NR	0%/5% (ERBT/cTURBT)	100%/54%	NR
Zhang	Ta 31.7%, T1 62.2%, T2 6.1%	NR	20.8% (18M)	NR	1.22% (ERT)	100% (ERT)	NR

cTURBT, conventional transurethral resection of bladder tumor; DM, detrusor muscle; EBRT, en bloc resection of bladder tumor; MM, muscularis mucosae; PSM, positive surgical margin; RFS, recurrence-free survival; RR, recurrence rate.

Vieweg, Current Opinion in Urology January 2020, Volume 30 (1), p 41–47

Role of TURBT in Chemoradiation (TMT) for Muscle Invasive Disease

Outcomes	All patients	TURBT visibly complete	TURBT not visibly complete	*p* value
All patients, no.	343*	227	116	–
CR rate	72%	79%	57%	<0.001**
OS:				0.003***
At 5 yr, % (range)	52 (46–57)	57 (50–63)	43 (33–51)	
At 10 yr, % (range)	35 (30–41)	39 (32–46)	29 (21–38)	
DSS				0.03***
At 5 yr, % (range)	64 (58–70)	68 (61–75)	56 (46–66)	
At 10 yr, % (range)	59 (53–65)	63 (55–70)	51 (40–61)	
% undergoing cystectomy				
TOTAL	29%	22%	42%	<0.001**
Immediate (non-CR), %	17	11	29	
Salvage, %	12	11	13	

Efstathiou, *European Urology*, 2012

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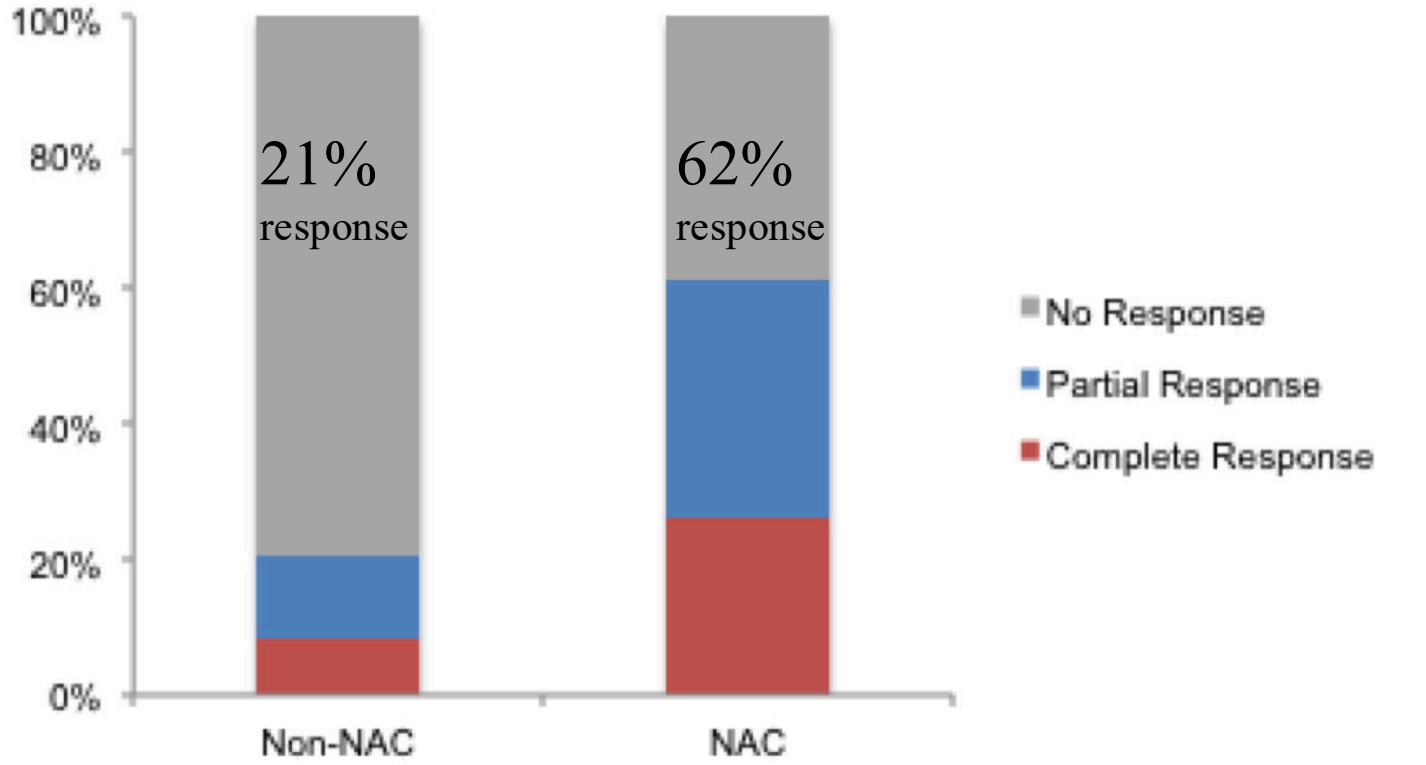
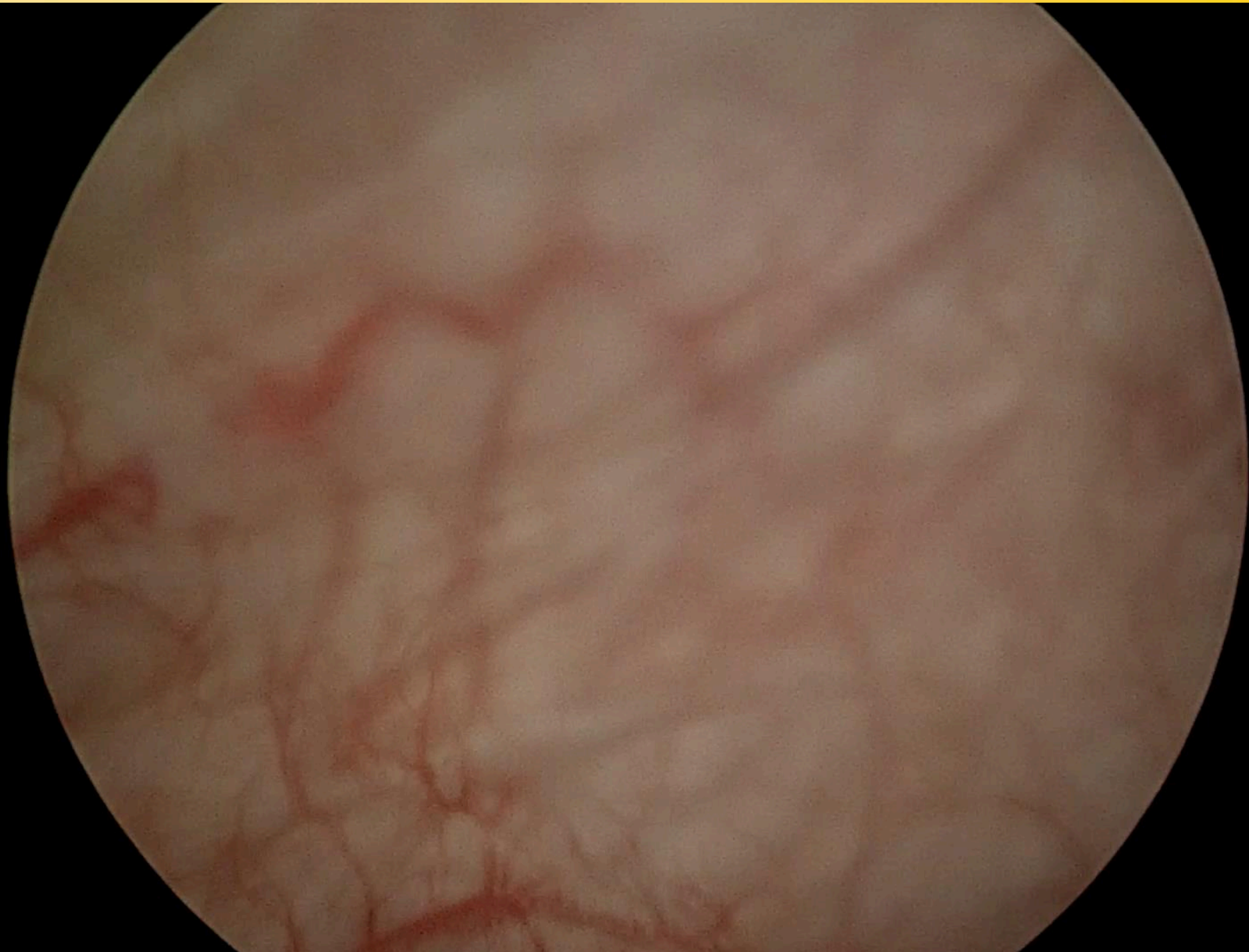
Efstathiou, *European Urology*, 2012

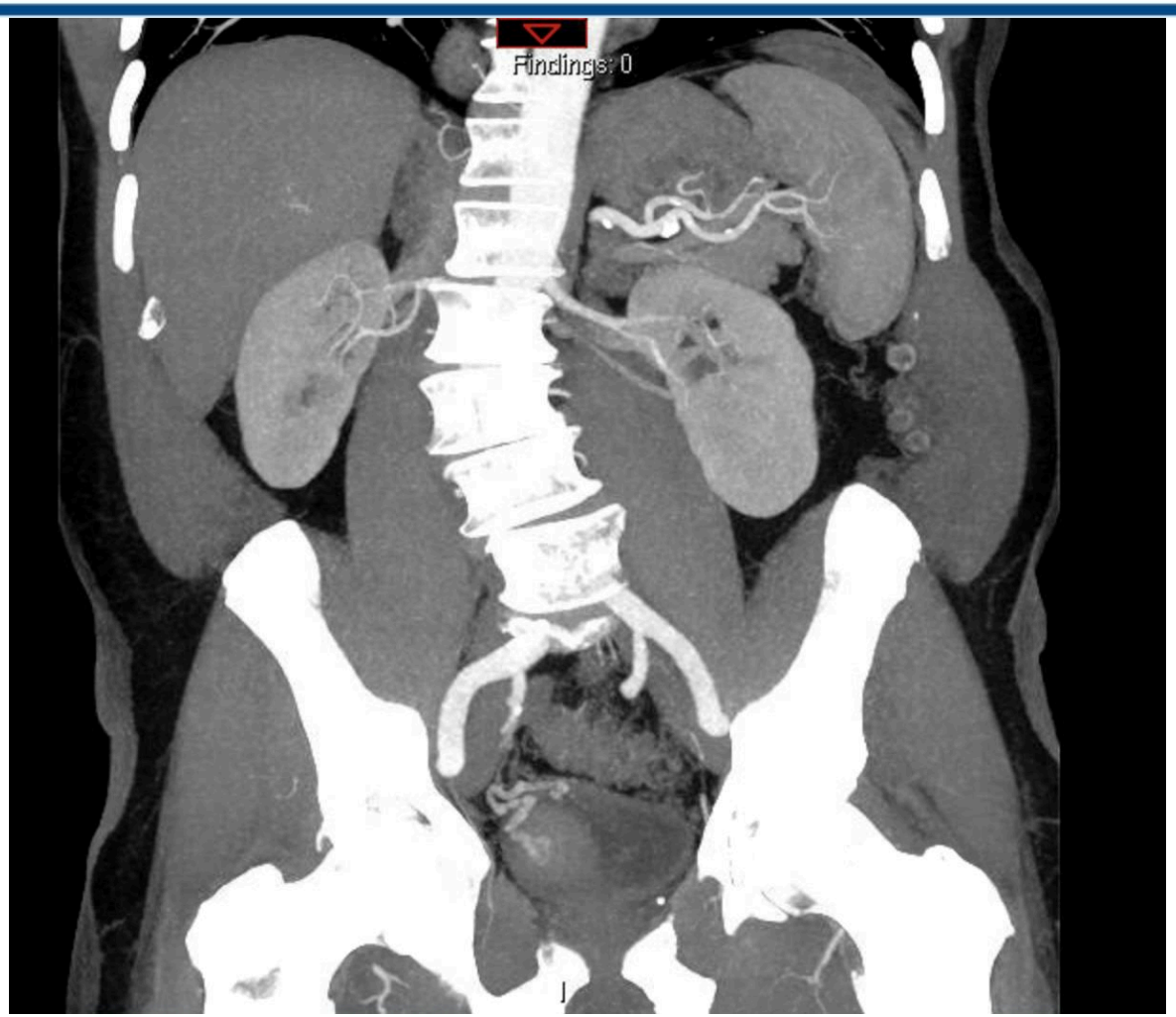
How Much of the Therapeutic Effect of NAC is due to TURBT?



- Unadjusted relative risk = 0.34
- Multivariate adjusted relative risk =0.4
- **40% of therapeutic response attributed to TURBT**

Brant, *Urologic Oncology*, 2017




Findings: 0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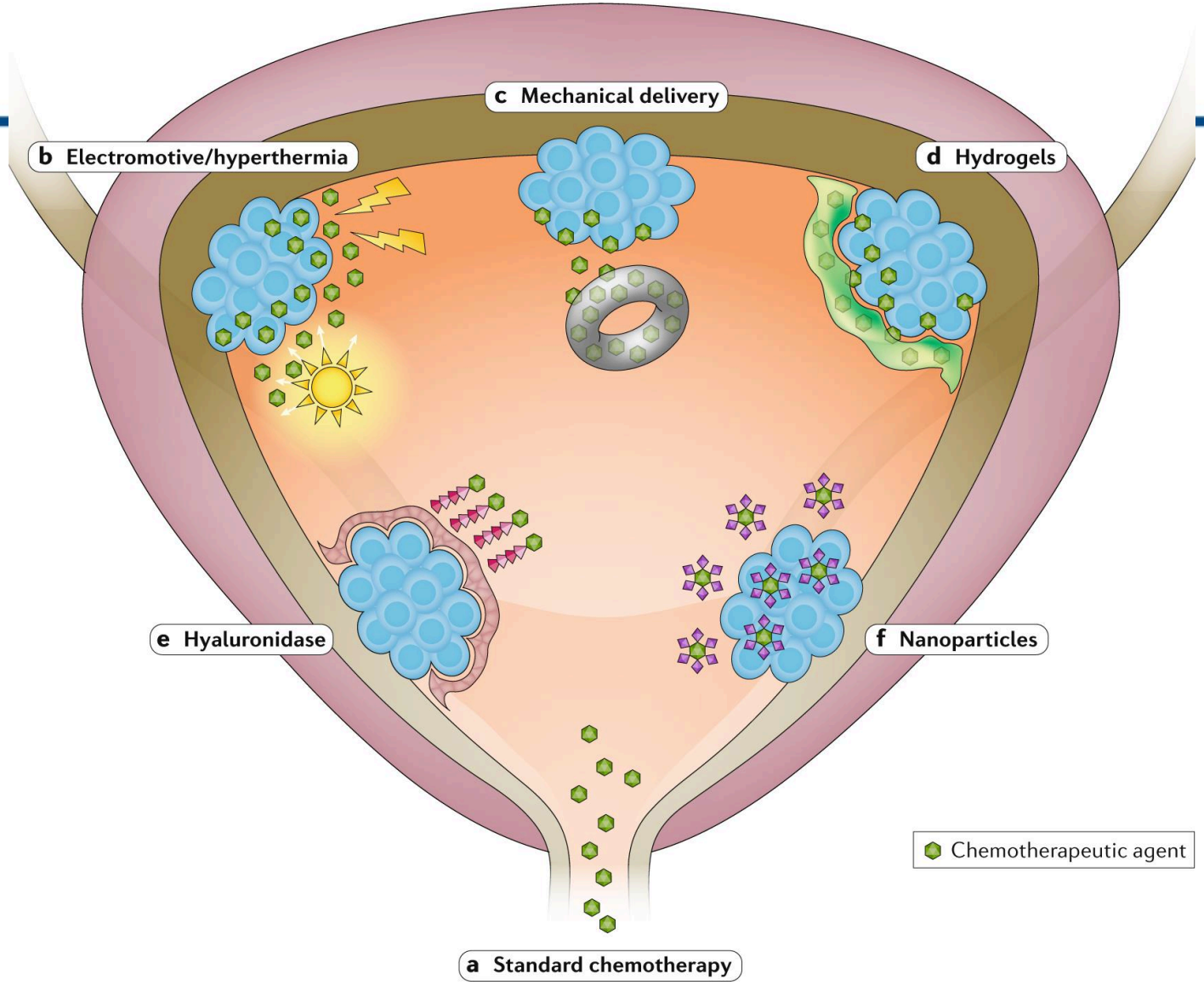
Methods to Improve Chemo Delivery



Joice, Kates, *Nature Reviews Urology, 2019*

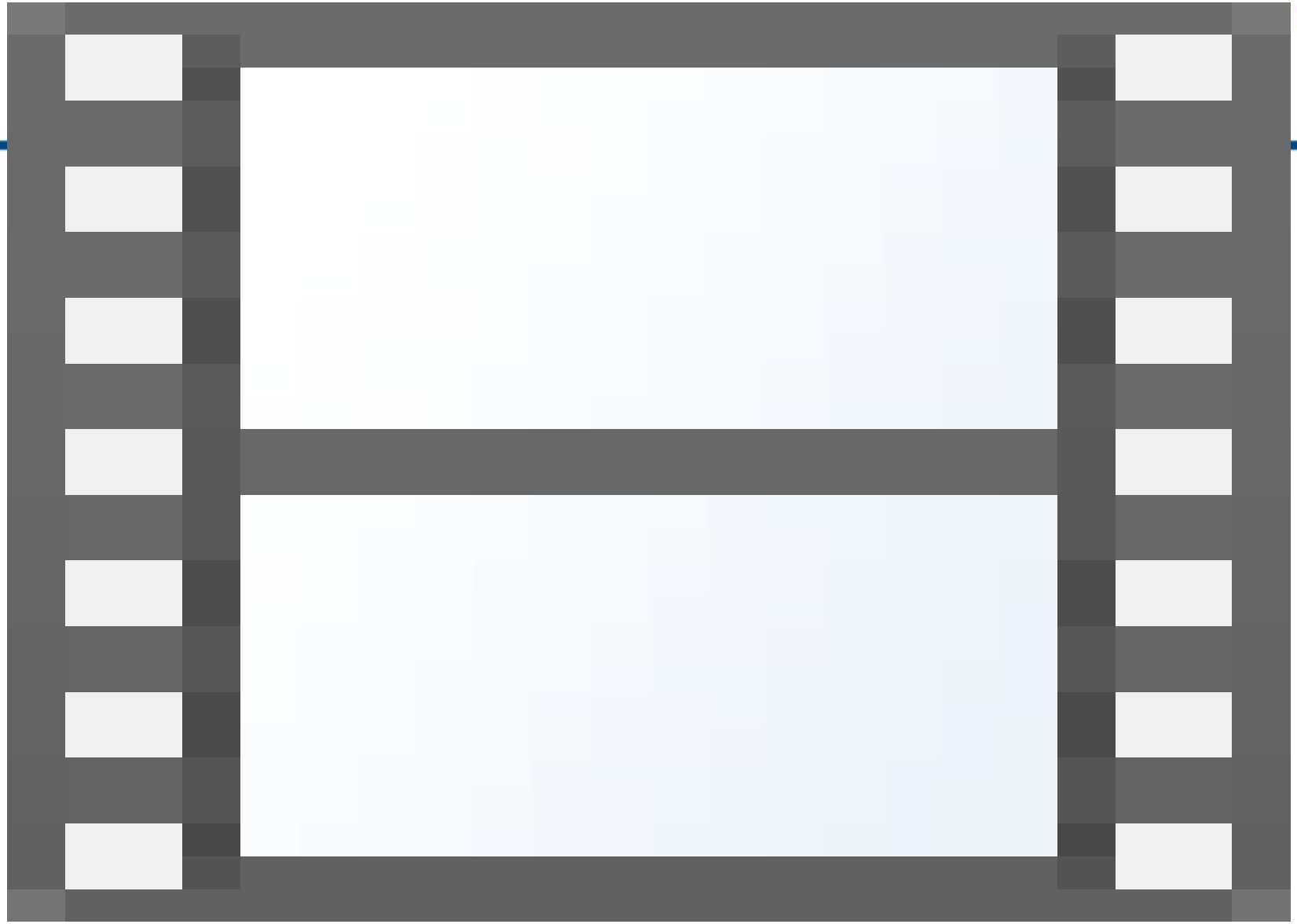
Phase 1/2 Trial of LSAM-DTX for hrNMIBC (NCT03636256)

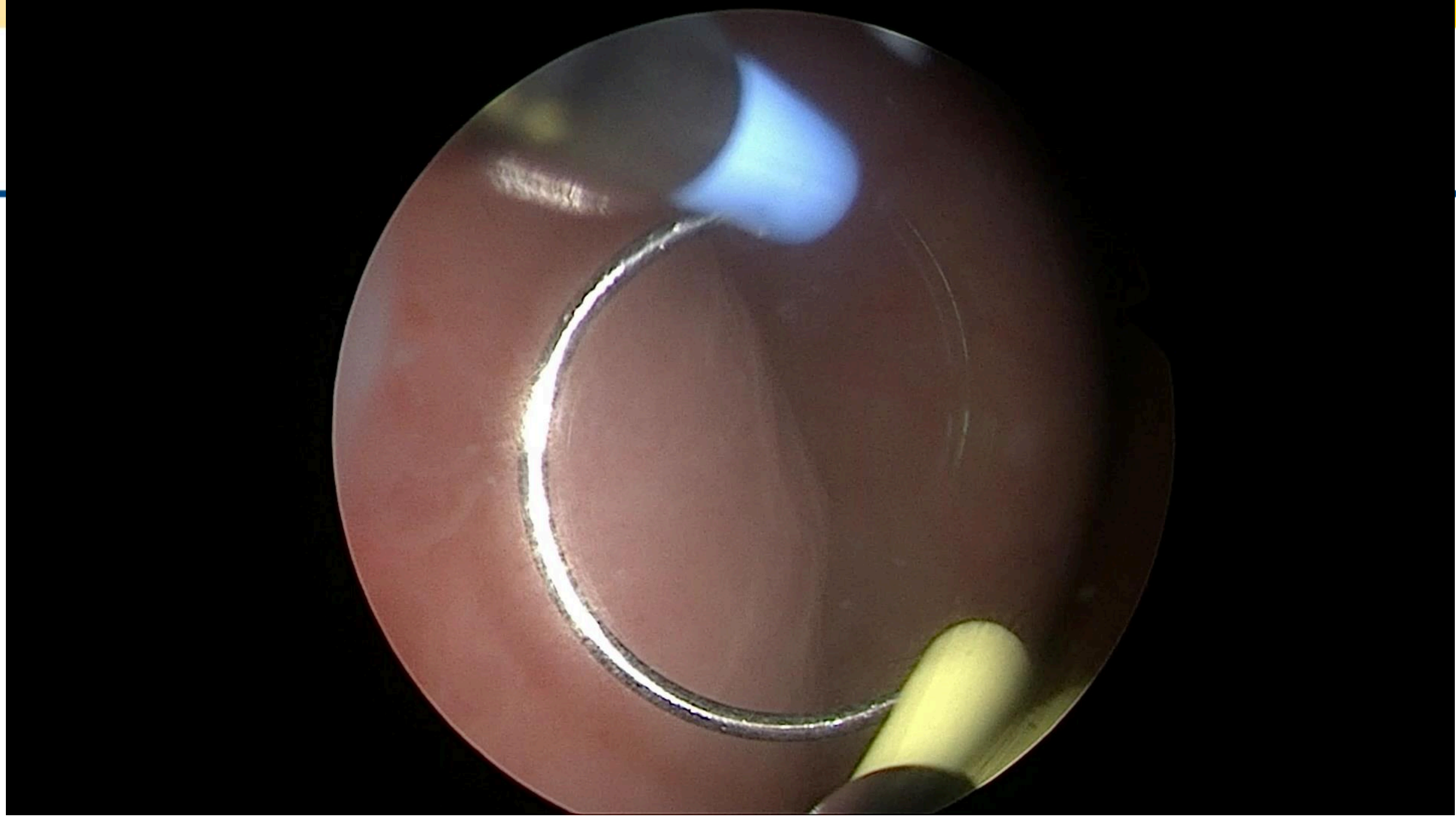
Treatment Timelines

- Treatment Timelines
  - 3+3 dose-escalating design of direct intramural injection (IMI) of 4 concentrations of LSAM-DTX in suspension (3-15 mg) cystoscopically into and around the resection bed after TURBT followed by intravesical instillations (IVT) LSAM-DTX (50-75mg in 25 ml)

	Screening	Treatment		Induction						Maintenance			EOT (End of Treatment)	Survival Follow-up
Procedure		Day 1	Day 15	Day 1 Week 1 (≥ 4 W)	Day 8 Week 2	Day 15 Week 3	Day 21 Week 4	Day 28 Week 4	Day 35 Week 6	Day 85 Week 13	Day 92 Week 14	Day 99 Week 15	Day 180	Months 9 & 12
LSAM-DTX Direct Intramural Injection (IMI)		X												
LSAM-DTX Intravesical Instillation (IVT)		x		X	X	X	X	X	X	X	X	X		

NCT03636256





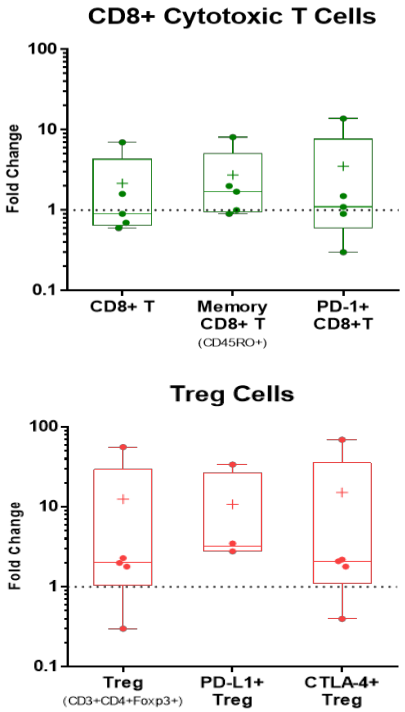
Immunomodulation Following LSAM-DTX Treatment

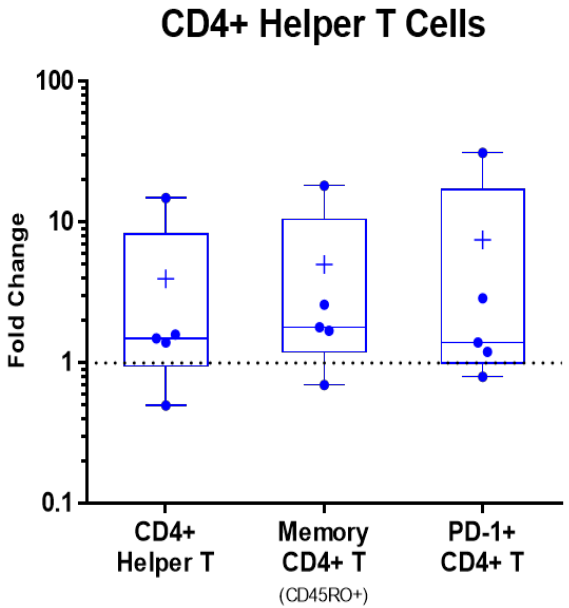
Changes in Immune Cell Densities in TME

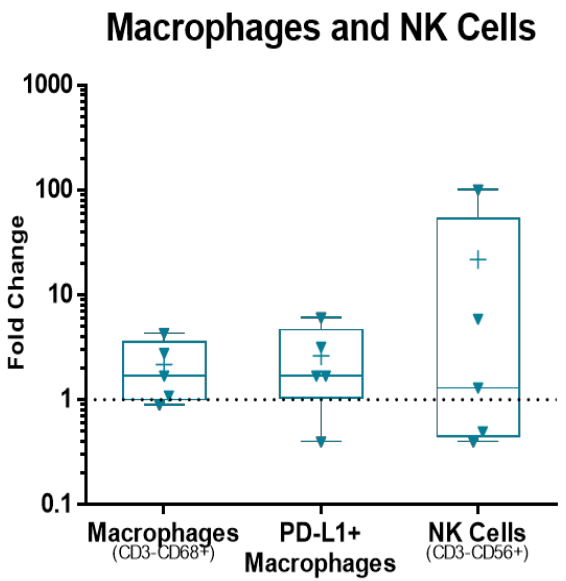
- Across 5 NMIBC subjects:
  - Increased density of T Cells Pre to Post LSAM-DTX treatment
  - All subjects show increased density of macrophages (including PD-L1+)
  - 3/5 subjects show increase in NK Cell density
  - Variable changes in densities of Myeloid and MDSC cells

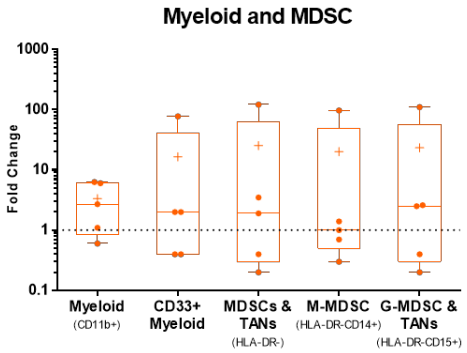
Pre to Post LSAM-DTX Treatment

Change in Cell Density (Cells/mm²); Line = Median; + = Mean









NCT03077685; FDA IND#132692; NanoDoce-2017-02

Final Thoughts

JOHNS HOPKINS MEDICINE

In every clinical scenario in bladder cancer, TURBT remains the most important diagnostic and therapeutic step. Technology and technique will continue to improve TURBT and expand its use particularly as we continue seeking to spare more bladders in the future.

Thank You