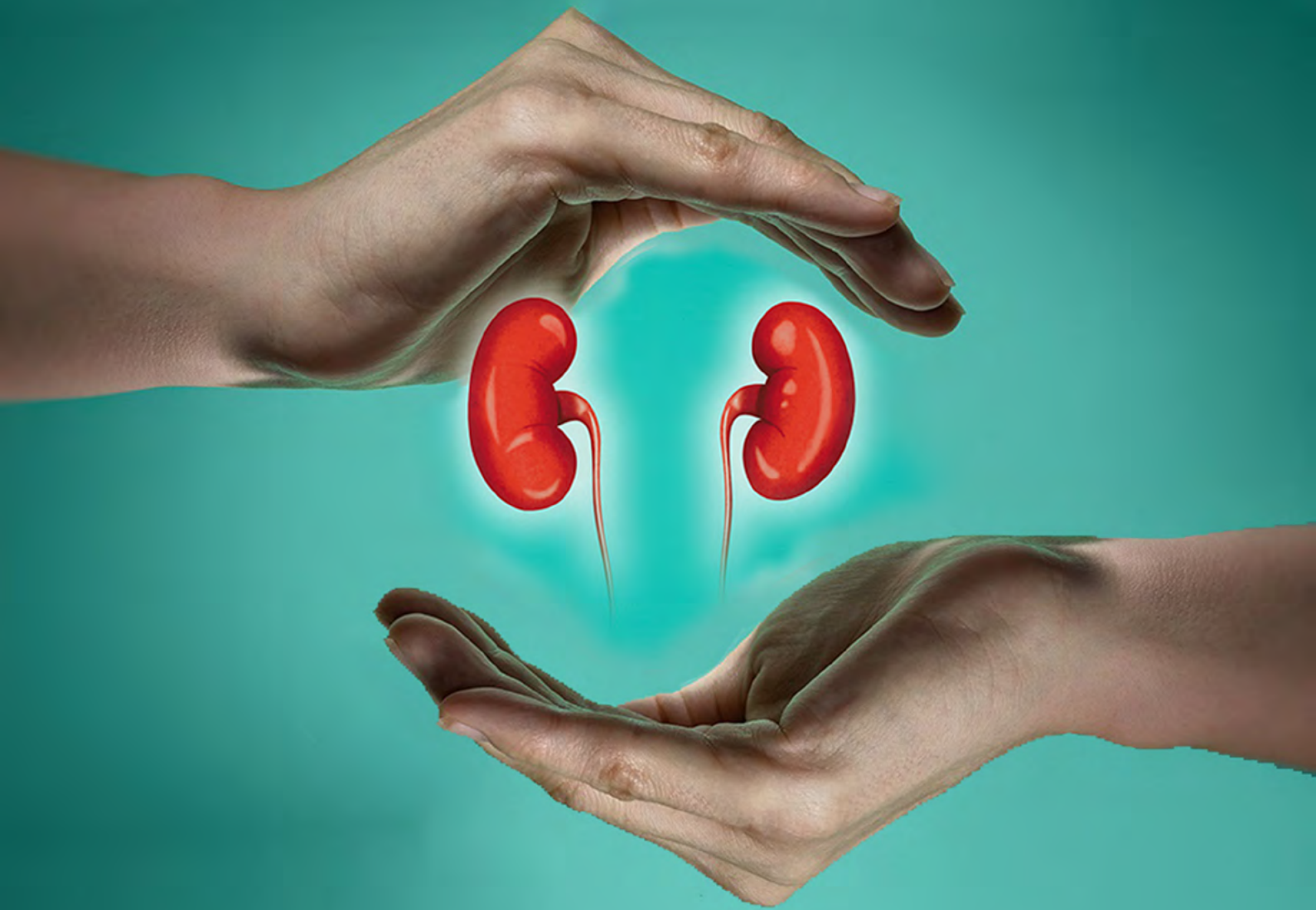
UROLOGICAL ASSOCIATION OF KERALA

NEWS LETTER

FEBRUARY
2024



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President Message



Dr Dineshan K M
President

Greetings from Kozhikode!

Dear UAK Members,

By this time this News Letter reaches you the USICON 2024 will be over and many of you have participated in the scientific deliberations and entertainments at Patna.

Recently we had two academic programmes under the auspices of South Zone USI at Aluva and Kottayam. H. S. Bhat Mid-term Workshop on Adolescent Urology at Rajagiri Hospital, Aluva on 26 November 2023 and South Zone Council members programme on Bladder Cancer updates at Caritas Hospital, Kottayam on 7th January 2024. Both these meeting were well attended and deliberations were highly informative to the trainees as well as for practicing Urologists.

Our forthcoming major event is going to UAK Mid-term conference at Ernakulam. This is being planned for one and half day programme provisionally planned in last week of April 2024, details of the programmes will reach you soon.

The UAK online clinical discussion planned to help the post graduates will start by February 2024. I want all the post graduates of the state to utilize this opportunity and also request all the faculty members in teaching institutions to support this programme.

The other area which is disturbing is the lack of quality research work among our institutions. We will have to address this issue seriously and all the institutions including the non-teaching institutions need to schedule some short-term and long-term research projects.

We have enough and more clinical materials and only thing we have to channelize it to structure some research projects. I request the teaching hospitals to take the lead and we can also form a research committee under UAK who can coordinate the research programmes. Once we have good research work going on the quality of papers presented during the conference will also improve. Looking forward to meet you all at Ernakulam for the Mid-term conference in April 2024.

With warm regards

Dr Dineshan K M
President UAK

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Message from Hon. Secretary



Dr. Balagopal Nair T
Hon. Secretary

Dear Members;

Wish you all a Happy New Year!

At the outset I would like to express my heartfelt condolences to our departed member and beloved secretary Dr GG Laxman Prabhu. UAK had conducted a digital zoom condolence meeting in the memory of Dr Augustine Komaranchath and Dr GG Laxman Prabhu attended my members meeting ho shared there memories about the two stalwarts
I would like to inform the members that the UAK executive council have been busy in new activities of UAK.

The UAK WEBSITE is being revamped and talks are ongoing with various vendors and are on the verge of fixing one. The website would be user friendly with various features.

A teaching program is going to start this month for all the post graduate students studying in various institutions in our state with faculty from both within and outside the state.

I would like to inform members that the Midterm UAK conference is being planned in April 2024 at Amrita institute of medical sciences. Kochi. We plan to have it as a 1 and 1/2 day program with half day for presentations by the members and also a general body meeting of our association

Our members conducted 2 successful meetings first one hosted at Amrita under the leadership of Dr Ginil kumar was on prostate biopsy and robotic surgery in prostate. It was well attended with delegates having a hands on experience on various methods of prostate biopsy including fusion biopsy and robotic platform's

The second was hosted by the urology department at RAJAGIRI Hospital ALUVA as part of the ASU HS Bhat midterm work shop. The topic was Adolescent urology with leading faculty from ASU deliberating on the various adolescent urological issues.

I would request members to contribute more articles to the newsletter that want to enrich.

Thanks

Dr. Balagopal Nair T
Secretary Urological association of Kerala

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Dr. Joju Varghese Akkara
Editorial Secretary

Message from Editorial Secretary

From the Editors Desk

Dear UAK Members,

Greetings from Thrissur!

A very happy new year to all of you, In this Newsletter I have incorporated three very good articles and an excellent case report, Identifying Financial value in Clinical Practice by Dr Vinod K V, Position of prostatic artery embolization in treating BPO - where we stand in 2023 By Dr.Rama Prasad, Changing paradigm of High-Risk NMIBC management : What's New? Dr Nishant P. This issue also come with an excellent case report from Aster MIMS Calicut by Dr Surdas Radhakrishnan, it also comes with othersfeatures like URO Quiz and Safety tips for Common Urological Procedures. Once again requesting all members to extend support by sending articles or case reports, or any other interesting Urology scenarios.

We are in the process of revamping the UAK Website, all members are requested to update the details through the google form provided in the WhatsApp group. Please ask other members who are not in the group to do it through the link provided or mail to jojueditsecretary@gmail.com

Regards

Dr. Joju Varghese Akkara
Editorial Secretary – UAK

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Congratulations to our UAK Members Elected to USI



Dr Rajeev T P
President Elect USI



Dr Vinod K V
Treasurer Elect USI

URO Quiz

1. Name the people credited with Invention of Modern cystoscope
2. Name the person who is credited with the design and construction of First Rigid Ureteroscope

H S BHAT WORKSHOP







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Identifying Financial value in Clinical Practice



Dr Vinod K V MCh (Uro)
CURE Urology Centre
Thiruvananthapuram

Industrialization of Healthcare : A Reality

The healthcare sector has evolved into a vital industry characterized by substantial capital investments and intricate integration with ancillary sectors such as pharmaceuticals, diagnostics, equipment manufacturing, and the associated financial apparatus. The substantial influx of human resources essential for the smooth operation of medical departments, coupled with the necessity for proficient professional management, further cements its industrial nature, moving away from a mere altruistic pursuit.

In the realm of governance, the healthcare sector teeters on the brink of commercial equivalence, evident in taxation structures, certifications, registrations, and the intricate legal framework enveloping its operations.

The discerning public is drawn to corporate entities boasting cutting-edge facilities and an air of opulence, contingent on financial capacities. A proclivity for establishments radiating a luxurious ambiance prevails among those with the means. Conversely, the narrative within the healthcare industry, government circles, and public discourse exhibits notable disparities. Despite the industry's acknowledgment of commercial realities, there exists a reluctance among some to fully embrace this shift, rooted in the longstanding perception of healthcare as a charitable endeavour. Acknowledging this truth is crucial; denying it hinders progress, and true advancement is only possible when we confront the prevailing reality.

Within the realm of industry, every facet is subject to the meticulous assessment of financial worth, governed by the unyielding principles of pure mathematics. Emotions and sentiments, no matter how passionately expressed, prove inconsequential in the face of these mathematical certainties. Despite the fervency with which we may implore, the sum of one and two remains unwaveringly fixed at three, resolute in its refusal to yield to our emotional pleas.

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In the intricate machinery of healthcare industry, where different other industries weave their delicate patterns, doctors who stand as the central wheel, a linchpin in the relentless motion of the apparatus also need to valued.

Determinants of Financial Value of Doctors:

The doctor's educational profile is a pivotal determinant in shaping their financial valuation. Specializations enhance their market value, expanding the range of medical services they can provide within a hospital setting. The prestige of the institutions granting their qualifications significantly influences this valuation.

Clinical experience, quantifiable in terms of years and the diversity of institutions served, becomes a tangible asset in the financial assessment. The temporal investment in the field, coupled with the esteemed institutions associated with the doctor's career, contributes to the valuation.

The nature of services offered, whether encompassing intricate treatments or complex surgeries, especially within specialized domains, elevates the doctor's financial significance. Patient outcomes and feedback, if quantifiable, form integral components that attest to the doctor's effectiveness and contribute to the overall valuation.

Geographic considerations play a significant role in the valuation process. The demand for specific medical services may vary by region, influenced by a hospital's historical standing or brand recognition. The cost of living and healthcare demands in a given geographic area directly impact the doctor's financial worth. Urban settings or regions facing a shortage of medical professionals may experience an escalation in doctor compensation, reflecting the supply and demand dynamics. In the Indian context, rural regions with fewer physicians witness higher remuneration compared to their urban counterparts.

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Problems of Assessment of Financial Value

Negotiations regarding financial valuation transpire between the doctor and hospital management, each rooted in their respective financial viewpoints. Disparities may arise as the physician advocates for remuneration aligned with perceived value, while the hospital seeks a balance that aligns with its fiscal estimations. In the negotiation process, compromises are brokered, leading to the formulation of a memorandum of understanding that reconciles the disparate financial outlooks.

As the contractual arrangement commences, both parties initiate a re-evaluation of their financial viability, a juncture that often ushers in challenges. The fiscal soundness of a healthcare professional is conventionally quantified by assessing the patient volume and the resultant revenue generated. The ensuing gross income becomes the benchmark against which the remuneration extended to the doctor is juxtaposed. Unfortunately, meticulous financial assessments are seldom conducted by most healthcare managements, with subjective evaluations predominantly guiding their decisions.
If the management determines through financial assessments that a program is not yielding the expected profitability, it initiates a course of action that applies pressure on the doctor. This situation often leads to heightened stress for the doctor.

On the contrary, in instances where the doctor's workload experiences an escalation without a corresponding adjustment in perceived compensation, the doctor tends to voice concerns and advocates for a renegotiation of the terms. Such scenarios are ubiquitously observed across various hospitals.

Even when adhering to the established determinants of financial value in remuneration calculations, there is a recurrent failure to achieve accuracy, indicating the omission of crucial considerations.

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Doctors often perceive their substantial contribution to hospital revenue through consultation fees, investigations, and procedure charges. Some may even deduce this income from hospital statistics to substantiate their claims. However, managements may frequently reject such assertions. Are there crucial aspects being overlooked in this evaluation?

The doctor's role in patient treatment can be broadly construed as the evaluation of patients and recommending necessary treatments. In cases requiring procedures or surgeries, the doctor is tasked with their execution. Additionally, doctors are required to oversee the treatment process, even if they are not directly administering it, such as in nursing, drug administration, and monitoring. This demands a significant commitment and expertise, a fact acknowledged by all.

A doctor's impact on the hospital extends beyond direct involvement in patient treatment. They serve as a supportive figure for colleagues in various specialties and within their own department. Possessing goodwill among numerous patients, some may specifically choose the hospital due to the doctor's presence. Engaging in cross-referrals, the doctor aids other specialties within the hospital. Their role extends to supporting the emergency care team, a vital component of the hospital's credibility. Despite having limited working hours, the doctor is consistently available on call to provide assistance when needed.

Simultaneously, it's imperative not to overlook the system that expends considerable effort to bring a patient to the consultation room, ensuring that the doctor has access to all necessary facilities, equipment, and support systems for safe treatment. This extends to providing mental and physical comfort to the already stressed patient. This comprehensive effort includes maintaining well-equipped operation theatres and procedure rooms with state-of-the-art facilities, efficient nursing management and support systems, intensive care units, and other vital departments staffed by expert healthcare professionals. A robust management and administration team is crucial for the seamless functioning of these systems.

This multifaceted activity necessitates substantial investments in infrastructure, human resources, and finances.

Both the doctor's role and the supportive healthcare system are complementary and equally vital components of the overall patient care framework. Determining the percentage of income share for each party in financial terms requires an evaluation of the overhead expenses of each institution. Overhead expenses are often directly proportional to the amenities provided to patients, investments in infrastructure and equipment, and promotional expenses. In smaller clinics, a larger portion of the income may be allocated to the doctor, given lower overhead expenses. Conversely, in larger hospitals, the financial stake of doctors may be comparatively lower, considering the higher overhead costs associated with maintaining extensive facilities. Unfortunately, these critical nuances are frequently overlooked in financial considerations.

The central question at hand is whether we can accurately ascertain the true financial value of a doctor. This task proves exceedingly challenging unless the doctor operates a solo practice independent of any hospital affiliation. Even a hospital attachment, particularly for inpatient or surgical treatment, may introduce a minor bias. The undeniable reality is that patients seeking treatment are typically influenced not solely by the doctor's expertise or reputation but also by various other factors inherent in the dynamics of patient choice. These factors are often predominantly managed by the hospital.

The scientific separation of these interdependent and influential factors poses a significant challenge, often escaping thorough evaluation by both the medical community and the healthcare industry. The question then arises: how can we navigate this complex puzzle? In response to this challenge, hospital managements have devised various payment strategies as a means to overcome these intricacies.

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Financial Models of Compensation

The conventional approach of paying a monthly salary is a widespread method, akin to practices in other sectors. Under this arrangement, the doctor adheres to a fixed working schedule and receives a predetermined salary each month, regardless of the volume of work performed. While this method provides stability, it does pose the risk of diminishing incentives, potentially leading the professional to operate within the confines of a standard salaried structure. In such situations, the management's push for increased productivity can be a cause for concern. Insufficient productivity may even result in removal from the job.

Another system involves a combination of a monthly salary and additional professional income derived from the generated revenue. The percentage share may be granted in entirety or when it surpasses the basic salary. The proportion of the revenue share fluctuates based on the baseline salary and other specified conditions. In all these scenarios, working conditions may differ, and there exists an incentive for the doctors to increase their workload as it directly impacts their overall remuneration. Challenges emerge when the doctor fails to render services adequate to cover even the basic salary. To address this, some managements may opt to set the salary at a minimal level, a decision that may not be grounded in any specific calculations.

Certain consultants operate solely on professional charges, which constitute a share of the revenue generated without any additional payments. In this arrangement, the consultant may experience stress, as their income is contingent upon a variable share that can fluctuate over time, rendering it unstable. The management, on the other hand, benefits from a secure position, as they are not obligated to make extra payments. Consultants, in this scenario, do not face pressure from management for underper formance since there is no loss to the management at any point. Managements may vary in the percentage of revenue shared with the consultant and in what is considered as the revenue.

For Beginners : A salary system may work well, providing a stable income when goodwill is limited. However, there may be pressure from management to increase workload

For Middle-Level Consultants : A salary plus revenue-share model could be considered ideal. This approach reduces management pressure and offers incentives to work more

For Senior-Level Consultants : The revenue-share system might be preferable, as it grants more freedom and independence, freeing senior consultants from management pressure.

Ultimately, the consultant's choice should align with their individual preferences, experience, and professional standing in the field.

Challenges emerge when doctors opt for high salaries but deliver less output, leading to dissatisfaction. Similarly, if consultants receive only a small percentage of the revenue share, discontent may arise. Achieving a clear understanding of these dynamics is crucial for both management and consultants. A practical and scientific approach grounded in financial analysis can bring transparency to these matters. However, the discussions often revolve around the bargaining power of each party, adhering to the market dynamics that have already ensnared us.

Valuation of Clinical Practice

A thought-provoking scenario presents itself for examination. Let us delve into the circumstances of a singular practitioner contemplating retirement and the subsequent sale of his/her practice, a familiar transaction within the western paradigm. The procedural roadmap for such an event begins with the fundamental question: How does one conduct a financial valuation of the practice?

The primary undertaking in this process involves a rigorous assessment of the practice's intrinsic value. Extracting the unadulterated annual income and removing any subjective biases, we arrive at a precise financial metric. The computation of the capital required to generate his annual income, factored with a standard return of 10%, dictates the initial evaluation. Assuming an annual income of 12 lakhs, the calculated value of the practice stands at a commendable 1.2 crores.

However, the financial calculus introduces an additional layer of complexity through the consideration of depreciation. Employing a conservative approach, a fifty percent reduction is applied, accounting for the potential decline in the practice's value over time. In the illustrative example, this adjustment leads to at refined valuation of 60 lakhs. Hence, Six lakhs are earmarked as immediate returns, while the remaining six lakhs are strategically earmarked for inclusion in a corpus. Over a decade, this corpus matures into a substantial 60 lakhs, accruing interest along the way. Finally, we may conclude that the valuation oscillates between a floor of 60 lakhs and a ceiling of 1.2 crores, contingent upon the intricacies inherent to each unique scenario. Tangible assets, inherently distinct, warrant a parallel and separate financial consideration within this methodical analysis.

Conclusion

In the evolving landscape of healthcare as an indispensable industry, the financial valuation of doctors hinges on multifaceted determinants, including education, specializations, clinical experience, geographic nuances and patient dynamics. Challenges persist in accurately assessing their value, exacerbated by the complex interplay of patient volume, revenue, and remuneration. Payment structures, encompassing fixed salaries, revenue shares, or professional charges, introduce additional complexities based on consultants' standing. Achieving a true understanding necessitates a nuanced blend of practicality, financial analysis, and acknowledgment of evolving industry dynamics, balancing contributions, infrastructure, and market forces shaping doctors' financial worth.

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POSITION OF PROSTATIC ARTERY EMBOLISATION IN TREATING BPO- WHERE WE STAND IN 2023



Dr Ramaprasad M K
Senior Consultant Urologist
Aster Medicity, Kochi

Prostatic artery embolization is being publicized as a non-surgical modality to treat Benign Prostatic Hyperplasia. It is included in various guidelines as an option to treat BPO

In our region, PAE has been used as a treatment option for BPH by practitioners from specialties other than interventional radiology and Urology. This is a synopsis of the current evidence on PAE and its position as a modality to treat LUTS due to BPO

The current standard of care of BPO:

Treatment of BPO is the part of a larger clinical pathway to treat LUTS in men. This pathway includes various conditions like urethral stricture disease and neurogenic bladder. The evaluation and correct diagnosis of these conditions depends on the experience of the clinician. This is the reason why, LUTS is managed by Urologist around the globe. Even the NICE guidelines stipulate that the patient should undergo a specialist evaluation before any form of intervention. The current standard of care for BPO is medical therapy followed by TURP or HoLEP. Experts have observed that being a common clinical syndrome with a significant sham effect, extreme caution should be exercised while considering any new interventional care for LUTS due to BOO. Hence TURP remains the standard of care for LUTS due to BPO till decades-long large-scale prospective multiregional trials bring us more evidence.

Position of various guidelines on PAE:

NICE and AUA guidelines have indeed included PAE as an option in their clinical pathway for the management of LUTS. According to NICE guidelines, the initial evaluation should be meticulous and should be done by a specialist. The healthcare system in UK is heavily audited and reviewed. In such a system, it is permissible for a newer modality to be tried with informed consent and adequate care. AUA has included PAE as a conditional recommendation(Grade C). EAU has observed weak evidence to recommend PAE as a treatment modality for BPO.

Scientific evidence on PAE:

Most of the studies on PAE are short-term and underpowered. All of the trials show that the PAE is less effective than TURP as far as most of the clinical endpoints are concerned. There is less improvement in symptom score and the residual prostate is more after PAE. There is some advantage for PAE since it has less retrograde ejaculation, post-procedural bleeding, and stricture rates. However, PAE may lead to non-targeted embolization, vascular injury, and radiation hazard. There have been adverse incidences like penile gangrene, embolization of Carcinoma of the Prostate, and embolization done for patients with stricture in the last five years. These are often not reported due to the uncontrolled nature of the clinical practice.

Conclusion:

The introduction of PAE into clinical practice should be done with caution. A Urologist should evaluate the patient before any intervention for LUTS due to BPO. The clinical pathways put forward by various Urology societies have to be followed while making a decision. The evidence on PAE will have to evolve with adequately powered and well-designed studies over the next decade. Till then, it cannot be considered as a standard of care for LUTS due to BPO. In our region, Urologists must lead the path by being active in clinical decision-making and monitoring the outcomes of patients undergoing PAE. The medical community should be made aware of the facts regarding the treatment of BPO through academic programs and publications.

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Changing paradigm of High-Risk NMIBC management: What's New?



Dr. Nisanth Puliyath
Senior Resident
Govt. Medical College, kozhikode

Bladder cancer is a significant global health concern, ranking as the tenth most common cancer worldwide with nearly half a million new cases annually. Non-muscle invasive bladder cancer (NMIBC) accounts for 75% of these cases, primarily urothelial carcinoma. NMIBC encompasses a spectrum of disease stages, including Ta, T1, and carcinoma in situ (CIS), and is typically managed with transurethral resection followed by immunotherapy with Bacillus Calmette-Guerin (BCG) and surveillance.

High-risk NMIBC, particularly high-grade T1 tumors, presents challenges due to its high recurrence rate (approximately 50%) and potential for progression to muscle invasion within two years of diagnosis. To address these complexities, risk stratification systems have been established to categorize NMIBC into low, intermediate, and high-risk groups based on various factors, including stage, grade, size, presence of CIS, and response to treatment. This article enumerates the recent developments under diagnosis and management subheadings with short descriptions.

Recent advancements in the diagnosis of high-risk NMIBC have focused on enhancing visualization techniques beyond standard white light cystoscopy and transurethral resection. Emerging technologies include:

1. Photo-dynamic Diagnosis (PDD): This technique uses violet light after instilling 5-aminolaevulinic acid (ALA) or hexaminolaevulinic acid (HAL) to improve the sensitivity of detecting malignant tumors, especially CIS.

2. Narrow-band Imaging (NBI): NBI enhances the contrast between normal urothelium and cancer tissue, improving tumor detection

3. Confocal Laser Micro-endoscopy: Offers high-resolution, real-time histological grading but requires further validation.

4. IMAGE1 S System: An image enhancement system that uses different light spectra modalities to potentially improve diagnostic accuracy.

5. Optical Coherence Tomography (OCT): Offers the capability to provide real-time bladder cancer staging by imaging below the mucosal surface.

Recent developments in the treatment of high-risk NMIBC include:

1. Optimal timing of Re-TURBT? : Recommended by guidelines for eligible cases within six weeks of the initial transurethral resection.

2. Transurethral Laser Resection of Bladder Tumour: Perioperative complications like obturator nerve reflex are less in laser resection with Holmium (HOLRBT) group compared to the TURBT

3. Radical Cystectomy: Immediate radical cystectomy is suggested for very high-risk NMIBC (New risk class from EAU guidelines) cases to prevent disease progression.

4. Management of BCG Failure: Various scenarios where BCG treatment is unsuccessful require different approaches, including radical cystectomy.

5. Intravesical Chemotherapy: Strategies involve the use of gemcitabine, docetaxel, and multidrug platinum-based regimens for BCG-unresponsive disease.

6. Device-Assisted Intravesical Chemotherapy: TAR-200 is an intravesical drug delivery system that releases gemcitabine in a controlled continuous manner.

7. Conductive Chemohyperthermia: This technique combines hyperthermia with chemotherapy to enhance drug penetration and immune activation.

8. Electromotive Drug Administration (EMDA): Uses electrical current to improve the penetration of chemotherapeutic agents into the bladder wall.

Immunotherapy is also emerging as a promising treatment for high-risk NMIBC, particularly the use of immune checkpoint inhibitors like PD-1/PD-L1 inhibitors. Pembrolizumab (following KEYNOTE 057trial) has received FDA approval for BCG-unresponsive NMIBC with CIS. To address the ongoing global shortages of intravesical BCG, strategies including expanding the use of chemotherapy and combination approaches with BCG has been suggested. Nadofaragene Firadenovec is a FDA spproved option in BCG unresponsive NMIBC.

Additionally, genomic markers and urinary biomarkers are being investigated for their potential in diagnosing and surveilling high-risk NMIBC. Several tests, such as CXbladder, Xpert Monitor, and UroMonitor, have shown promise in detecting recurrence and progression with high sensitivity and specificity.

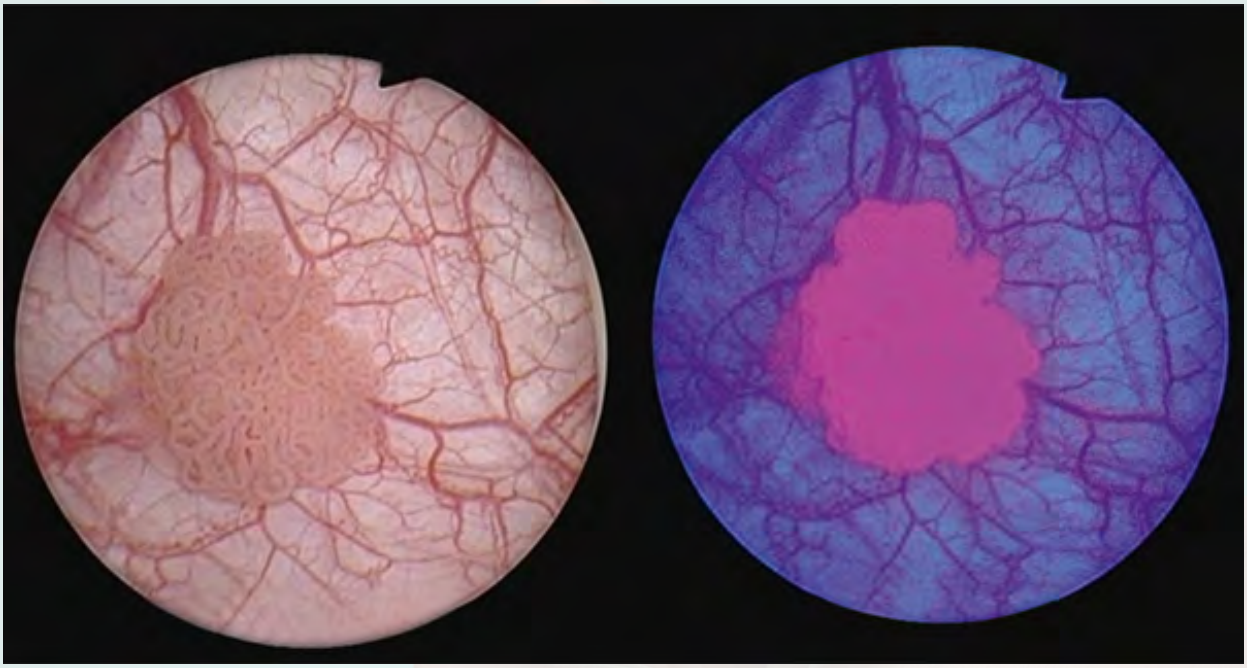
Artificial intelligence (AI) is playing an increasing role in predicting disease recurrence and progression. AI-based models using radiomics, histopathological markers, and genomic markers have shown superior accuracy compared to traditional statistical methods.

In conclusion, the management of high-risk NMIBC is evolving with the introduction of new diagnostic techniques, treatment options, and surveillance methods.

Intravesical therapies, immunotherapy, and AI-based tools are expanding the armamentarium for clinicians managing this challenging disease. As clinical trials continue to explore these options, the landscape of NMIBC management is likely to undergo further transformation, potentially reducing the need for radical cystectomy in high-risk cases.

Images:

1. Photodynamic diagnosis



TAR 200 device:



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URO Quiz Answers

1. Name the people credited with Invention of Modern cystoscope

Ans. Maximilian Carl-Friedrich Nitze

(German Urologist, 1879 and Joseph Leiter (Viennise Electrophysician)



2. Name the person who is credited with the design and construction of First Rigid Ureteroscope

Ans. Richard Wolf 1979

Common Urology Procedures, HOLEP



Safety tips for Enucleation of median lobe

1. Elevate bottom edge of median lobe with beak of the scope, keep it under tension to lase against.
2. Free the lateral corners of the lobe while advancing the scope
3. At bladder neck incise horizontally from left to right when detaching the lobe
4. Do not lase upon to the Trigone – Only do it horizontally

(Editorial Team)

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TOTAL 3D LAPAROSCOPIC RADICAL NEPHRECTOMY AND LEVEL 3 INFERIOR VENACAVA THROMBECTOMY WITH SUPRAHEPATIC IVC CONTROL - Aster MIMS Calicut

Dr Surdas Radhakrishnan, Dr Ravikumar Karunakaran, Dr Abhay Anand, Dr Alphons Philip

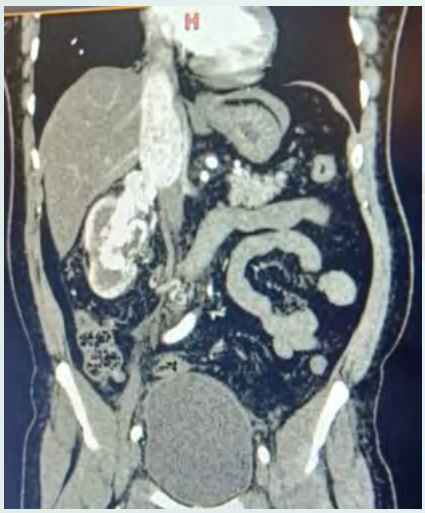


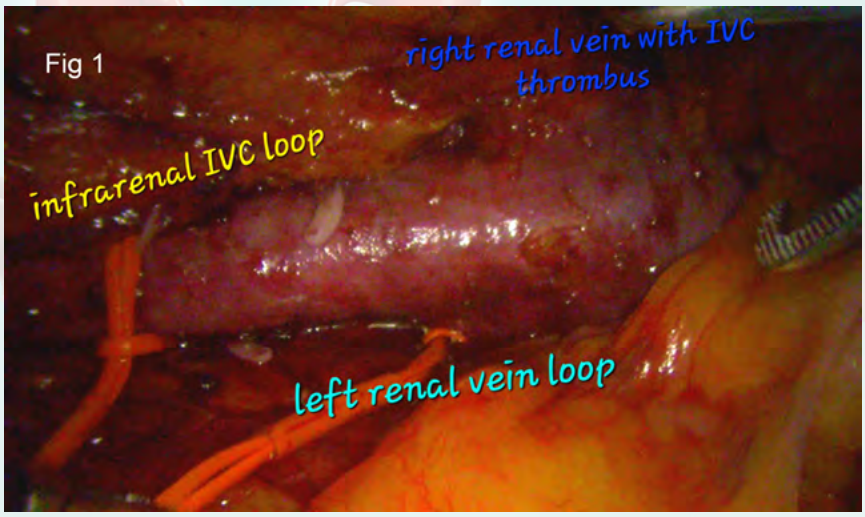
Dr Surdas Radhakrishnan
Department of Urology
Aster MIMS Calicut

Introduction

Renal cell carcinoma with level 3 IVC thrombus usually managed by open surgery. Recently robot assisted radical nephrectomy and IVC thrombectomy with suprahepatic ivc clamping has been reported from china and India. To the best of our knowledge total laparoscopic management of RCC with level 3 IVC thrombectomy has never been reported.

A 57 year old male came to ED with complaints of hematuria with clots. On evaluation he was found to have right renal mass with IVC thrombus upto level of diaphragm(level 3) for a length of 9 cm(fig 1)



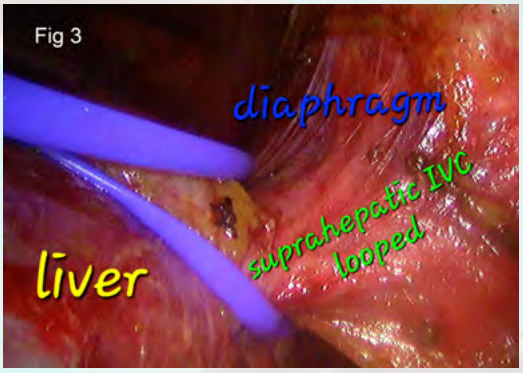


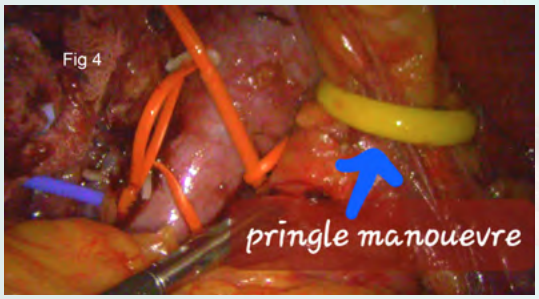
Inferiorly thrombus was reaching upto level of right renal vein. It was a highly vascular tumor with multiple intratumoral arteriovenous malformations and FDG PET revealed a localized tumor (cT3bNoMo).After adequate pre-op optimization and anticoagulation as per protocol surgery was planned.

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Owing to extensive vascularity and tumor thrombus preoperative angio embolization was done on the day of surgery. In left lateral decubitus position, renal hilum and IVC dissected and looping of infrarenal IVC and left renal vein done (fig 2) In the same position retrohepatic IVC was mobilized after taking down right adrenal vein and short hepatic vein(fig 3). Right lobe of liver mobilised after dividing triangular ligament followed by complete mobilization of kidney.Patient position turned supine, suprahepatic IVC mobilized and looped (fig 4)Pringle manouvre(fig 5) followed by sequential clamping of Infrarenal IVC, left renal vein (fig 6) and Suprahepatic IVC done. Venotomy followed by removal of tumor thrombus en toto from IVC done (fig 7).

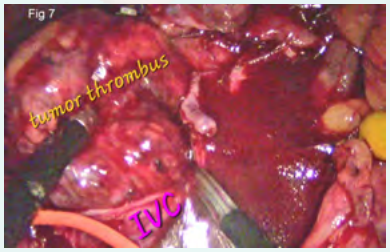


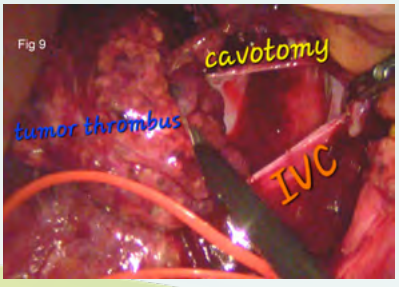


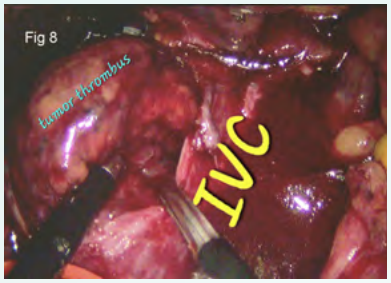












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Right nephrectomy with IVC thrombus mass excised en bloc and specimen retrieved in endobag and taken out through previously placed mini pfannensteil incision. Cavotomy closed with 5-0 prolene. Clamps taken down sequentially(clamp time 13min).Hemostasis ensured. Post op period uneventful and was discharged on POD 4.



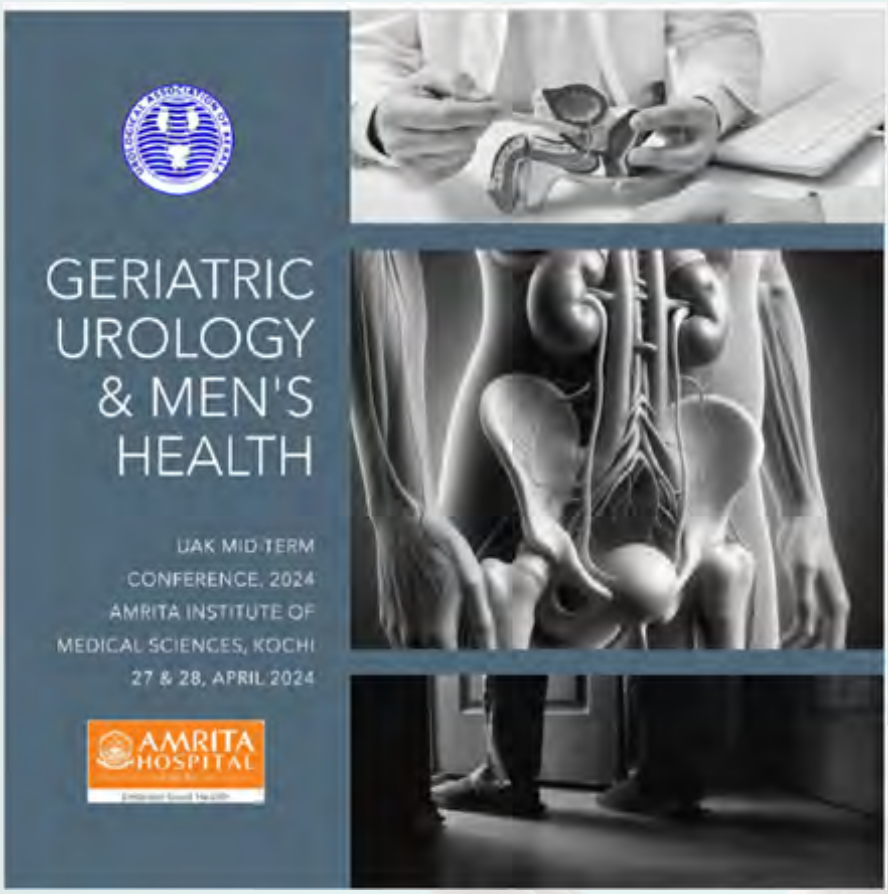




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Forthcoming Events







UROLOGICAL ASSOCIATION OF KERALA
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Obituary



Dr O S Thampan
(1947-2024)

Eminent Senior Urologist Dr O S Thampan left for heavenly abode on 28 Jan 2024.

He did is M.B.B.S and M.S from Banaras Hindu University, did his M.Ch Urology from Government Medical College, Calicut, (4th Batch) passed out in 1987. After leaving Banaras in 1975, worked as general surgeon in Women and Children Hospital Alleppey Kerala. As assistant surgoen for 2 years, and moved to Samaritan Hospital.

After completing M.Ch he Joined at M.B.M.M Hosptial Kothamanagalm as a urologist. In 1989 moved to Little Flower Hosptial Angamaly, in 2000 he moved to P.V.S Hospital, Kaloor, Kerala. In August 2015 he decided to take retirement.

A very friendly and joyful person. All Co-urologists have a very good memory of him. He is survived by his wife Dr Ramani Paulose, HOD & Consultant Gynaecologist, M.B.M.M Hospital, Kothamangalam, son Dr. Sam Thampan Aster hospital, Dubai, Daughter-in-law – Dr Selin Abraham, Physician, Lifeline hospital, Adoor, Grandchild- Thomas Sam, 10th Std, Daughter – Donna Liza Thampan, Health Data Analyst, Amala Institute of Medical Sciences, Thrissur.

May his soul rest in peace

Heartfelt condolences and payers

UROLOGICAL ASSOCIATION OF KERALA
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Obituary



Dr G. G. Laxman Prabhu
(1963-2023)

Remembering Laxman.....
(16-10-1963 to 17-11-23)

It is with profound sadness that we pay homage to Laxman, our cherished friend, who has departed to the heavenly abode. Laxman's life was a testament to the art of cultivating friendships, for he was known to harbor no adversaries, only kindred spirits. His infectious enthusiasm radiated ceaselessly, creating an atmosphere of joy in every interaction. Laxman's articulate nature ensured that he was never without a thoughtful remark, making his presence felt in every situation.

Born on October 16, 1963, in Mangalore, Dr. Laxman Prabhu pursued his medical education at Kasturba Medical College (KMC), Mangalore, where he completed his MBBS in 1984 and MS General Surgery in 1989. He did his MCh (Urology) from KMC Manipal (1990-92) under (Late) Prof. P Venugopal, his Guru for whole life.

His illustrious career was shaped mostly in KMC Mangalore where he joined as an Associate Professor and continued to serve an uninterrupted span of twenty-seven years until the final curtain of his demise. He was steering the department as HOD for an impressive eleven years. Amidst these years, his compassionate hands bestowed solace upon a myriad of patients, while his mentorship nurtured a generation of brilliant urologists.

He was known to us an active member of Urological Association of Kerala. His adept organizational prowess left an ineffaceable impression during his tenure as the Secretary of the Association of Southern Urologists (ASU) from 2016 to 2018. As we observed his leadership unfold, it became evident that he was not only admired but deeply respected and loved in his role as the Secretary of our esteemed national association, the Urological Society of India, from 2022 to 2023.

A maestro of oratory, he seamlessly blended his profound understanding of Sanskrit literature with his expertise in Urology. Renowned for his wit, every discourse of his was adorned with Sanskrit quotes, sprinkled with moments of laughter and contemplation. His mastery extended beyond mere words; he skilfully drove his ideas to the depths of the listener's heart, leaving an enduring impact.

Fate was cruel to us. Laxman had a cardiac event on 09.11.23 right in front of the cardiac department of his hospital. He came back normally but destiny stole him away from form our midst on 17.11.23 The best of our medical expertise could hold him back. Laxman, who meticulously followed the footsteps of his Guru- PVG, followed him to heaven.

I had lot of personal moments with Laxman to cherish. Our travels to various conferences became more than just journeys; they were immersive experiences with him discussing about everything under the sun. Through his words, I could vividly picture not only a compassionate humanitarian with a grand vision but also a dedicated member of professional organizations he belonged to – ASU and USI.

His loss is irreparable. He is felt more in his absence. For every instance in the associational activities, we tend to say, Laxman would have made this comment now. We could see him walking around the venue chatting with friends..... even in his absence from this material world. This is Laxman taking rebirth in our hearts

Dear all I wish to tell you this. I am a falling leaf. But let me assure you of this. I shall fall at the foot of the tree called USI to nourish it from inside as manure when I decay"
GGLP 02.11.23

UROLOGICAL ASSOCIATION OF KERALA
NEWS LETTER 2024 FEBRUARY

Obituary



Dr. Sunil K Rahulan
(1966 -2024)

Dr. Sunil K Rahulan, a distinguished urologist known for his dedication and expertise, sadly passed away following an acute cardiac event on the night of February 11, 2024, in Abu Dhabi. His untimely departure has left a void in the medical community and among his loved ones.

Dr. Rahulan served at LLH Hospital Musaffah, bringing comfort and healing to his patients. He was a respected alumnus of MCH, Thrissur, where he completed his MBBS. Further, he obtained his MS from Medical College, Calicut, and MCh in Urology from MCH, Kottayam. Prior to his latest role, he contributed his skills and compassion at PVS Hospital, Kozhikode. His professional affiliations included active memberships in the Urological Society of India (USI), the Association of Southern Urologists(ASU), and the Urological Association of Kerala (UAK), where he was esteemed for his contributions and camaraderie.

Dr. Rahulan's legacy is not only in his professional achievements but also in the warmth and integrity he brought to every aspect of his life. He is mourned by his wife, Dr. Deepa, a consultant anaesthesiologist, and his two daughters, who reside in Australia and the USA. His influence and memories will forever live in the hearts of those he touched.

May his soul rest in peace

Heartfelt condolences and prayers