UAK
NEWSLETTER



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Presidential Message



Dr Vinod K V
President – UAK

Dear UAK Members,

As we stand at the crossroads of rapid scientific advancement and an ever-evolving medical landscape, it is imperative to reflect on the true purpose of our professional organizations. The Urological Association of Kerala has long been a pillar of knowledge exchange, collaboration, and professional growth. However, in an era where information is readily accessible at our fingertips, we must redefine our role to remain relevant and impactful. Beyond organizing conferences, we must become enablers of research, mentors to the next generation, and advocates for ethical and scientific urological practice.

Professional organizations were originally established to bring together experts in a specific field, fostering discussions on emerging advancements, complex cases, and surgical techniques. At that time, these organizations were the primary means for professionals to exchange knowledge. Even after years of significant change in the world, professional organizations continue to prioritize organizing conferences, in the traditional format.

Today, the sheer volume of medical literature has expanded from a handful of journals to hundreds, all serving the same purpose—disseminating research and innovations. Online platforms now facilitate real-time scientific discussions. Video demonstrations, case discussions, and educational content are widely accessible. Conferences are no longer limited to professional organizations alone—numerous private, governmental, and academic institutions organize them frequently, leading to an overwhelming number of such events. In this changing landscape, we must reassess the relevance of our traditional approaches and redefine our role in the medical community.

The purpose of professional organizations must extend beyond merely organizing conferences. We should create platforms where research projects and preliminary data can be discussed before formal publication. Such discussions foster constructive debate, enabling researchers to refine their work and improve its quality. Additionally, we must provide a space for sharing practical experiences that may not reach publication but hold immense clinical value.
Published data represents only the “tip of the iceberg.” Many professionals possess valuable insights but, due to various constraints—lack of mentorship, writing skills, or structured data—these remain undocumented. Organizations should bridge this gap by encouraging knowledge exchange beyond traditional research publications.

Despite the availability of online surgical videos, live and semi-live demonstrations still have a unique advantage. They allow real-time interaction with experts, enabling participants to ask questions and clarify doubts—something that online materials cannot replicate. Similarly, case discussions tailored to regional contexts are more relevant than generic online resources. Hands-on training and simulation sessions remain invaluable for skill development. Beyond knowledge transfer, these gatherings also foster essential networking opportunities, strengthening professional ties within the urological community.

However, our responsibilities extend far beyond knowledge dissemination. Professional organizations must actively contribute to shaping clinical practice and healthcare policies. They should take the lead in developing guidelines and practice recommendations, a challenging yet vital task. They should facilitate collaborative research programs and help members engage in studies that align with their regional healthcare needs. Furthermore, they must create structured training opportunities for young professionals while ensuring that all consultants stay updated on the latest advancements. Establishing ethical and scientific frameworks for medical practice is another critical function. Importantly, professional organizations must serve as a platform for discussions on enhancing and updating undergraduate and postgraduate medical training, enabling them to effectively advise the relevant authorities on these matters.

If professional organizations fail to evolve, they risk becoming obsolete. Recognizing and embracing these newer roles is essential. Conferences must be restructured to maximize their impact, ensuring that professional organizations remain relevant and continue to serve their true purpose—advancing knowledge, fostering collaboration, and shaping the future of healthcare.

Secretary's Message



Dr Balagopal Nair M
Secretary

Greetings to Everyone !

Dear members,

As we begin our sojourn through 2025 I would like to share with you all the activities of our association. A lot has happened in last few months with our members and post graduates bringing laurels. At the recently concluded USICON 2025 our members have excelled in both organisational and scientific aspects. Our honorary president has stepped into the role of Treasurer of USI and Prof. Dr Ginil Kumar has been entrusted with the Charge of USI's collaborative research. Our members Dr Kishore T A and his team and the post graduates from Kozhikode medical college (Dr Nishanth P and Dr Sanjula) won USI awards and fellowships.

It has been our endeavour as mentioned by our honourable president in his address to promote our members on both organisational and scientific aspect. We had conducted a leadership meeting in 2024 for the same reasons.
It brings me great pleasure in informing that our members have been elected to the various organisational posts in the subspeciality sections (Dr Vijay Radhakrishnan, secretary renal transplant section, Dr Renu Thomas council member renal transplant section, Dr Sanel Varghese council member Andrology section)

UAK's midterm conference is planned on 6 th April 2025 at Caritas with an enlightening topic on "Diagnostic dilemmas in prostate cancer". Hope that we will have a good participation from our members. KTCON 2025 is also at our doorstep in May 9-11 at Crowne Plaza kochi an academic feats with live operative sessions on all 3 days has been planned and the preparations are going in full swing under the leader ship of Dr Vijay Radhakrishnan

Our annual conference planned in 9-10 October 2025 at Kannur. As part of the preparation's council members conducted a site visit. We were hosted by the newly formed Kannur Urology club. We had fruitful discussions with the organising team who are doing a wonderful job to make the annual conference a great success. I would like to inform the members that it would be a great event in all aspects (Venue, scientific content and the hospitality).

Our teaching program has restarted in full swing under the guidance of Dr Manikandan with fortnightly classes by zoom with very good attendance. We are also planning for another session of leadership meeting in august 2025. As part of communication with our members the Annual general body minutes held at Kollam in Oct 2025 has been circulated by mail. We have also set up a Whats app group of all local urology clubs in Kerala and plan to have periodic zoom sessions starting from last week of March 2025 informing them about UAK's activities and through them to all our members.

I would like to inform members that ASU conference in 2027 is to be hosted by Kerala on rotational members. I would like members interested in hosting the event to send a mail to UAK office so that it could be put up in the Annual general body meeting at Kannur and the decision would then be intimated to the ASU. Similarly, I would like members interested in hosting UAKON 2026 to apply the same through mail to UAK office.

As mentioned by our president that a lot of scientific material is available now to all of us through various forum. It has been our endeavour to develop the scientific thinking and research and mentor youngsters in publishing it. As part of this we had a very good session on best papers with original research. We had plans of getting them published by mentoring them but unfortunately not much progress has been made. It will be my endeavour to kick start this.

Editorial Secretary's Message



Dr Joju Varghese Akkara
Editorial Secretary

Dear UAK Members,

Greeting from Thrissur.

Apart from usual reports, this newsletter comes with excellent case reports from Medical College, Trivandrum, Review article by Dr. Vishnu Prakash, Medical College, Kozhikode, Urology Quiz, Common Urological Procedures.

All our newsletters are available in UAK website. I humbly request all our members to contribute to newsletter, either in the form of case reports or interesting articles or anything related to urology.

Please enrol for all subsections, as our USI subsection memberships of our members is very less.

Once again, thanking you all for the support extended.

Dr Joju Varghese Akkara
Editorial Secretary UAK



Review Aricle

Dr Vishnu Praksah R
Senior Resident,
Department of Urology,
GMC,Calicut



IMMUNE CHECK POINT INHIBITORS IN UROLOGY

Vishnu Prakash R, Venugopalan A V, Rajeevan A T,Shanmughadas S, Manikandan M,Farzana T C, Subeesh P Govt medical college Calicut

ABSTRACT

Immune check point inhibitors represent the next leap in the management of urological malignancy. In urology immune check point inhibitors are already in used extensive in Renal cell carcinoma and up to extent in carcinoma bladder and carcinoma prostate.in this review article we will be looking in to immune check point inhibitors use in various urological malignancy, latest trials and protocol.

INTRODUCTION

In 2018, James Allison and Tasuku Honjo won the Nobel Prize in Physiology or Medicine for their work leading to the development of immune checkpoint inhibitors, a type of cancer drug that blocks certain proteins made by some types of immune cells.1 Immune checkpoint inhibitors (ICIs) have shown efficacy in the treatment of a variety of solid tumours, including advanced urological cancers. Over the past 20 yr, standard first-line treatment for advanced and metastatic UCC has been cisplatin-based chemotherapy. The past decade has seen significant improvement in our understanding of tumour biological features, which has led to use of anti-programmed-death 1 (PD-1) and anti-PD-ligand-1 (PD-L1) agents and cytotoxic T lymphocytes antigen 4 (CTLA-4) inhibitors in a multitude of cancers.

Mechanism of action of immune check point inhibitors.

The CTLA-4 check point protein prevents dendritic cells from Priming T cells to recognize tumours. Inhibitor drug block the check point. The PD-1 check point protein prevents T cells from attacking cancer cells. Inhibitor Drug allows T cells to act. Programmed death ligand-1 (PD-L1) is an essential immune checkpoint expressed on the surface of tumor cells, which corresponds to the receptor of PD-1 of this ligand expressed on T cells. T cells bind to PD-L1 on the surface of tumor cells through programmed death-1 (PD-1), and the combination of the two will make T cells to deem the cell as a normal cell and thus give up killing tumor cells.

Methodology

This review is focused on publications reporting immune check point inhibitors with special emphasis on urological malignancy. A literature review of the Medline database via PubMed and google scholar was conducted in August 2024 by the author using appropriate MeSH terms and combined them with the Boolean operators to identify research materials with a high level of evidence, preferably systematic reviews, and meta-analysis. The search was restrictted to recent articles, published within the last 10 years and only articles in English or those where the data are extractable in English were included. The selected articles were then categorized according to the different subject domains in urology, tabulated, and then analyzed.

Results and discussion

A. RENAL CELL CARCINOMA (RCC)

The use of immunotherapy for RCC has changed dramatically over the last decade. Cytokine-based, high-dose interleukin-2 (IL-2) was initially used in some patients and showed a complete response (CR) [3]. Inhibition of the VEGF pathway with a tyrosine kinase inhibitor (VEGF-TKI) or the anti-VEGF antibody bevacizumab subsequently emerged, demonstrating well-documented effects on T-cell infiltration into tumours [4,5]
Nivolumab was the first checkpoint inhibitor approved in kidney cancer. The CheckMate 025 phase III trial compared nivolumab to everolimus in 821 patients with locally advanced or mRCC who had progressed on other therapy (6).
CHECKMATE 214 trial tested the combination of ipililumab (CTLA-4 inhibitor) with nivolumab over sunitinib in previously untreated mRCC. At a median follow-up of 25.2 months, the immunotherapy combination showed an 18-month survival of 75% versus 60% in the sunitinib arm in intermediate- to poor-risk patients (7)
Atezolizumab plus bevacizumab versus sunitinib in patients with previously untreated metastatic renal cell carcinoma (IMmotion151). In the PD-L1 positive population, the median progression-free survival was 11·2 months in the atezolizumab plus bevacizumab group versus 7·7 months in the sunitinib group (hazard ratio [HR] 0·74 [95% CI 0·57–0·96]; p=0·0217).
The KEYNOTE-426 trial assessed pembrolizumab (anti-PD-1) plus axitinib versus sunitinib.(8,9) With a median follow-up of 16.6 months for survival, OS and PFS were significantly longer in the combination arm versus the sunitinib arm [HR 0.59 (P = 0.0001) and HR 0.69 (P < 0.0001), respectively] (9). The ORR was 59.3% in the combination arm and 35.7% in the sunitinib arm (P < 0.001; median follow-up of 12.8 months (8)
JAVELIN Renal 101 trial (NCT02684006) demonstrated significantly improved progression-free survival (PFS) with first-line avelumab plus axitinib versus sunitinib in advanced renal cell carcinoma (aRCC).

IMDC risk group	PFS, median (95% CI), months			OS, median (95% CI), months			ORR (95% CI), %	
	Avelumab plus axitinib (*N*= 442)	Sunitinib (*N*= 444)	HR (95% CI)	Avelumab plus axitinib (*N*= 442)	Sunitinib (*N*= 444)	HR (95% CI)	Avelumab plus axitinib (*N*= 442)	Sunitin (*N*= 44
Favorable	24.0 (20.7–NE)	16.7 (12.6–NE)	0.626 (0.397–0.986)	NE (NE)	NE (NE)	0.812 (0.336–1.960)	67.0 (56.56–76.38)	39.6 (29.75–50.08)
Intermediate	11.6 (8.4–15.2)	8.3 (6.9–11.0)	0.756 (0.603–0.948)	30.0 (30.0–NE)	28.6 (27.4–NE)	0.860 (0.615–1.202)	53.1 (47.00–59.20)	26.8 (21.68–32.45)
Poor	6.0 (3.0–9.0)	2.9 (2.7–5.6)	0.514 (0.342–0.774)	21.2 (14.7–26.3)	11.0 (7.8–16.5)	0.570 (0.363–0.895)	31.9 (21.44–43.99)	12.7 (5.96–22.70)

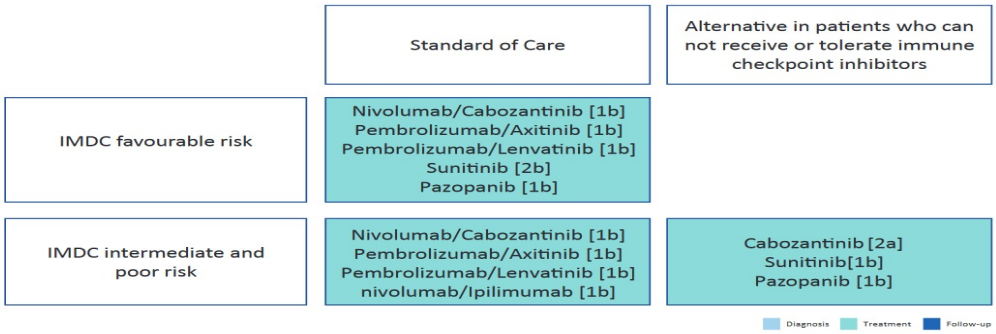
CI, confidence interval; HR, hazard ratio; IMDC, International Metastatic Renal Cell Carcinoma Database Consortium; NE, not estimable; ORR, objective response rate; OS, overall survival; PFS, progression-free survival.

- KEYNOTE-426 (pembrolizumab + axitinib), KEYNOTE 581 (pembrolizumab + Lenvatinib), and finally, CheckMate 9ER study (nivolumab + cabozantinib) further supported the superiority of the new drug combinations

ADJUVANT IN RCC

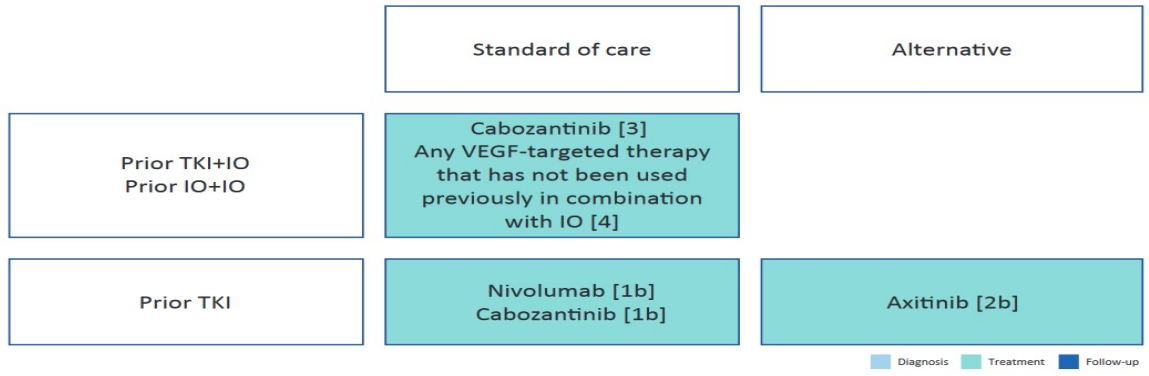
- Pembrolizumab has been the first ICI to be approved by FDA and EMA as adjuvant therapy for intermediate/high-risk RCC based on the significant DFS advantage demonstrated in the KEYNOYE-564 study [15]. But at the same time IMmotion010 trial failed in demonstrating that adjuvant treatment with atezolizumab compared to placebo prolonged DFS and OS in patients with resected RCC at high risk of relapse.the PROSPER trial (NCT03055013) evaluated the efficacy of perioperative nivolumab (an antiPD-1 monoclonal antibody) failed show any advantage.

Figure 7.1: Updated EAU Guidelines recommendations for the first-line treatment of cc-mRCC



IMDC = The International Metastatic Renal Cell Carcinoma Database Consortium.
**pazopanib for intermediate-risk disease only.*
[1b] = based on one randomised controlled phase III trial.
[2a] = based on a well-designed study without randomisation, or a subgroup analysis of a randomised controlled trial.

Figure 7.2: EAU Guidelines recommendations for later-line therapy



IO = immunotherapy; TKI = tyrosine kinase inhibitors; VEGF = vascular endothelial growth factor.
[1b] = based on one randomised controlled phase III trial.
[2b] = subgroup analysis of a randomised controlled phase III trial.
[4] = expert opinion.

B. UROTHELIAL CARCINOMA

Carcinoma Bladder-In muscle-invasive urothelial cancer, the standard of care is radical cystectomy with previously applied neoadjuvant cisplatinum-based chemotherapy (19). Treatment of locally advanced metastatic cancers of the urinary bladder is also based on cisplatinum-based chemotherapy. The median OS of patients treated with gemcitabine and cisplatinum is about 14 months. (19)(20).
However, 30%–50% of these patients are unfit for cisplatin treatment, making gemcitabine and carboplatin the optimal therapeutic option with a 9-month median OS(21).In this contest the need for new treatment modalities in muscle invasive and metastaic carcinoma bladder arised.

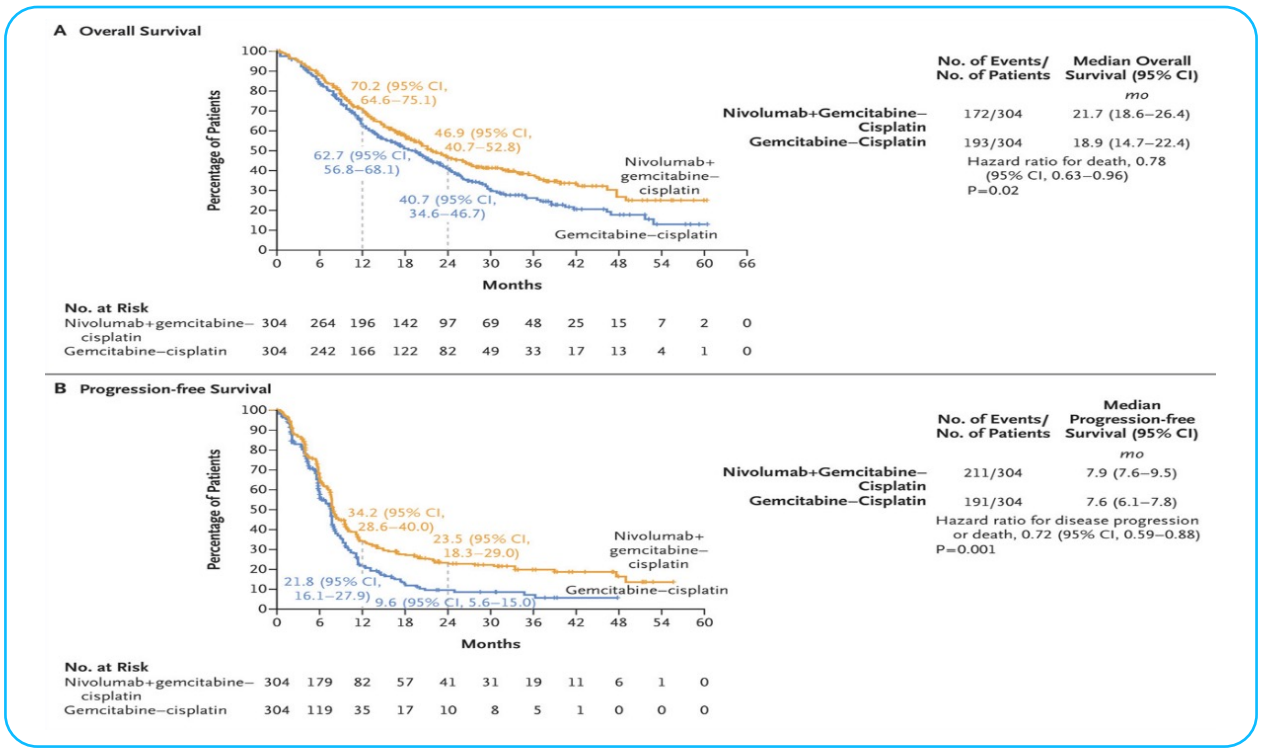
As adjuvant therapy-The FDA has approved nivolumab for adjuvant treatment of patients with UC who are at high risk of recurrence after undergoing surgery whereas the EMA has approved adjuvant nivolumab for the treatment of adults with muscle-invasive UC (MIUC) with tumour cell PD-L1 expression ≥ 1%, who are at high risk of recurrence after undergoing radical resection of MIUC

For metastatic bladder cancer-Atezolizumab was the first checkpoint inhibitor approved by the FDA(IMvigor 211) for metastatic UC based on the results of phase I and II trials, however, the indication has subsequently been withdrawn two ground breaking randomised clinical trials (RCTs) demonstrating an overall survival benefit in the first line setting against platinum-based chemotherapy (EV-302/KEYNOTE A39 and Checkmate 901) [31,32]. These updated guidelines reflect the results of these two trials and the impact for first and later lines management of patients with metastatic bladder cancer.

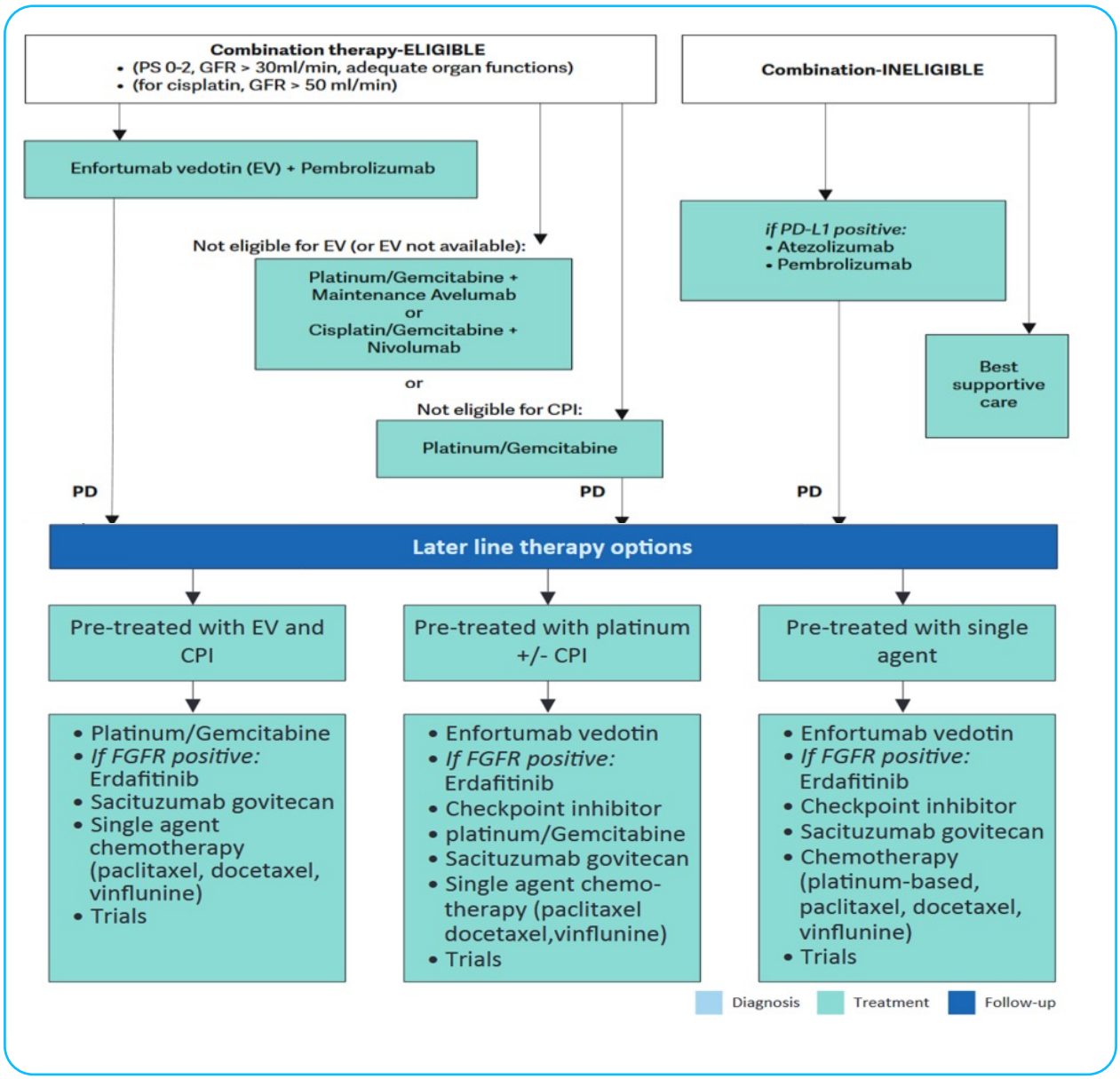
The confirmed overall response was higher in the enfortumab vedotin–pembrolizumab group than in the chemotherapy group (67.7% [95% CI, 63.1 to 72.1] vs. 44.4% [95% CI, 39.7 to 49.2]; P<0.001) . A complete response was observed in 29.1% (127 of 437) of the patients in the enfortumab vedotin–pembrolizumab group and in 12.5% (55 of 441) of those in the chemotherapy group. The results of the analysis of overall response were consistent between the intention-to-treat population and all the prespecified subgroups.

The median duration of response was not reached in the enfortumab vedotin–pembrolizumab group and was 7.0 months in the chemotherapy group. The percentages of patients who were still in remission at 12 months and 18 months were 67.3% and 59.6%, respectively, in the enfortumab vedotin–pembrolizumab group and 35.2% and 19.3% in the chemotherapy group (31). the below table show the OS and the survival different sub group in EV-302 study.

Checkmate 901 Clinica lTrials compared patients with previously untreated unresectable or metastatic urothelial carcinoma either to receive intravenous nivolumab (at a dose of 360 mg) plus gemcitabine-cisplatin (nivolumab combination) every 3 weeks for up to six cycles, followed by nivolumab (at a dose of 480 mg) every 4 weeks for a maximum of 2 years, or to receive gemcitabine-cisplatin alone every 3 weeks for up to six cycles



Based on this the treatment for both metastatic urothelial carcinoma bladder and upper tract.



Carcinoma Prostate

KEYNOTE-028, a phase Ib study has reported an objective response rate (ORR) of 17.4% (95% CI: 5.0–38.8%) with pembrolizumab in a cohort of 23 heavily pretreated mCRPC patients with measurable disease and ≥1% PD-L1 expression in tumour or stromal cells. The response was a partial response (PR) in 4 patients and 3/4 experienced parallel biochemical response (defined as >50% PSA decline from baseline).
At present only FDA approved is Pembrolizumab. In May 2017 the FDA approved the use of the anti–PD-1 antibody, pembrolizumab, for treatment of patients with "unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair-deficient (dMMR) solid tumors who have progressed on prior treatments and who have no satisfactory alternative treatment options.

But lot of studies are on going with combination of Imnnue check point inhibitors in combination with other drugs in carcinoma prostate.

Carcinoma Testis

Various targeted agents have generally failed in refractory disease, including immune checkpoint inhibitors . Trials combining PD1/PDL-1 and CTLA4 inhibitors are ongoing, however, even for those combinations early results are not encouraging

Carcinoma Penis

One study done The GSRGT assembled an international cohort of pts with advanced PeCa treated with ICI to evaluate toxicity and clinical outcomes showed The median OS and 24-month OS and median PFS and 24-month PFS were 9.4 (95%CI: 6.8, 12.8) months and 19.3% (95%CI: 9.2, 32.1) and 2.8. Another study by yale school of medicine showed In this study conducted between 2015 and 2022, researchers assessed the efficacy of ICIs by focusing on an international cohort of 92 patients with locally advanced or metastatic penile cancer. The most common ICIs administered were pembrolizumab, nivolumab, and cemiplimab, but some patients received combination treatment with nivolumab and ipilimumab. Researchers found that 13% of all patients, and 35% of patients with metastases limited to lymph nodes, responded to ICIs.

Adreno cortical Carcinoma

In 2017, the FDA approved the use of pembrolizumab for the treatment of microsatellite-instability-high (MSI-H) solid malignancies (35). Raj et al. found that out of the six patients treated with pembrolizumab, two patients achieved PR and another two achieved SD [36]. Currently, we are waiting for the results of several early-phase clinical trials using ICI and WNT/β-catenin inhibitor combinations in advanced solid tumors (NCT03447470, NCT02675946, NCT04166721).

Conclusion

- Immune check point inhibitor has definite role in the management of urological malignancy which only going to expand in the future. Metastatic RCC immune check point inhibitors alone or in combination are the already the main stay of treatment.
- And in case of Metastatic urothelial carcinoma, it is rare Ray of light bringing new option after so many years. As for carcinoma prostate, carcinoma Testis and carcinoma Penis it does present a scope for future option at present there not much role for immune check point inhibitors.
- One more factor we have to consider is the cost Factor of ICI.
- And also we have to look further to see the side effect ICI may have on fertility and sexual functions.

Dr Rituraj
Senior Resident,
Department of Urology,
GMC,Trivandrum



A COMPARATIVE STUDY OF PAIN SCORE BETWEEN TRANSDERMAL BUPRENORPHINE PATCH AND CONVENTIONAL ANALGESICS IN POST PERCUTANEOUS NEPHROLITHOTRIPSY

Ritu Raj,Aquil Faris S J ,Lingesh Sairam C,Harikrishnan A B,Naiji S James,Haris C H
Senior resident, Department of Urology, Government medical college, Trivandrum Assistant Professor, Department of Anaesthesia, Government medical college,Trivandrum Professor, Department of Urology, Government medical college,Trivandrum

ABSTRACT

Introduction : Postoperative pain management after percutaneous nephrolithotomy (PCNL) is crucial for patient comfort and recovery. The study aimed to compare the efficacy and safety of transdermal buprenorphine (TDB) patches to conventional analgesics (paracetamol and tramadol) for postoperative pain management in patients undergoing PCNL.

Methods : This prospective cohort study included 60 patients undergoing PCNL who were sorted sequentially into two groups of 30. Group A received TDB patches, while Group B received conventional analgesics. The primary outcome was pain intensity, assessed by Visual analogue Scale (VAS). Secondary outcomes included the need for rescue analgesia and adverse events.

Results : A total of 60 patients were sorted into groups A and B (30 each) based on the analgesics they received. Both groups had similar preoperative characteristics. Mean VAS pain scores assessed at different times in the postoperative period were significantly lower in the TDB group ($p < 0.05$). Fewer patients in the TDB group required rescue analgesia compared to conventional analgesic group ($p < 0.05$). Side effects like nausea, vomiting, and constipation were significantly lower in the TDB group. Respiratory depression was not observed in either of the group.

Conclusion : Transdermal buprenorphine patches provided superior postoperative pain relief with fewer side effects compared to conventional analgesics in patients undergoing PCNL. TDB patches may be a valuable alternative for postoperative pain management in this patient population.

Key-words

Percutaneous Nephrolithotomy, Transdermal Patch, Buprenorphine, Visual Analogue Scale

INTRODUCTION

Percutaneous nephrolithotomy (PCNL) is a minimally invasive surgical procedure for the treatment of renal stones. Despite its minimally invasive nature, PCNL is associated with significant postoperative pain, the management of which remains a critical aspect of patient care, significantly impacting recovery and overall well-being. The current standard of care for postoperative pain management in PCNL patients involves the use of oral or parenteral opioids, which, whil e effective, carry the risk of significant side effects, including respiratory depression, nausea, vomiting and constipation. The quest for safer and more effective alternatives has led to the exploration of novel drug delivery systems and analgesic agents.

Transdermal buprenorphine (TDB) has emerged as a promising option for postoperative pain management due to its unique pharmacological properties and favourable safety profile. Buprenorphine, a partial mu-opioid receptor agonist and kappa-opioid receptor antagonist, exhibits a ceiling effect for respiratory depression, making it a potentially safer alternative to traditional opioids. The transdermal delivery system offers several advantages, including sustained drug release, improved patient compliance, and reduced side effects associated with oral or parenteral administration.

This study aims to compare the safety and efficacy of TDB patches to conventional analgesics (e.g., paracetamol and tramadol) for postoperative pain management in patients undergoing PCNL. This is an observational study, with patients who receive TDB patches and conventional analgesics sorted into two separate groups. The primary outcome will be pain intensity, as assessed by the Visual analogue scale (VAS). Secondary outcomes include the need for rescue analgesia and adverse events in both groups.

The findings of this study provide valuable insights into thepotential benefits and limitations of TDB patches for postoperative pain management in PCNL patients. If TDB patches prove to be effective and safe, they could offer a valuable alternative to conventional analgesics, leading to improved patient outcomes and reduced healthcare costs. The study will also contribute to the growing body of evidence on the use of TDB patches for various surgical procedures, further establishing its role in modern pain management strategies.

METHODS

The study was conducted after approval from institutional ethics committee. All patients who underwent prone PCNL over a period of 6 months (January 2023 to June 2023) who fit the inclusion criteria were included in this prospective observational study. Patients were excluded if supine PCNL was performed or there was a history of previous PCNL or they were already on opioids. All consecutive cases meeting the inclusion criteria, who received TBD patch were recruited to group A and who received conventional analgesics to group B till the required sample size was met. In group A, patients received 5mcg/hr TDB patch applied 12 hours before surgery and continued till discharge, whereas in group B patients received conventional analgesics in the form of IV paracetamol 1 gm TID and IV tramadol 50 mg BID for first 24 hours followed by oral formulation of acetaminophen 500 mg + tramadol 50mg thrice daily until discharge. Objective of the study is comparison of demographic, pre-operative and postoperative characteristics, mean pain score, number of patients requiring rescue analgesics and adverse reactions of both groups. During the pre-operative visit, all patients were familiarized with visual analogue scale (VAS) based pain assessment and details of demographic and baseline characteristics such as age, ASA grade, laterality and pre-operative baseline VAS score were collected using a structured questionnaire cum data collection form. All the patients in the study underwent prone PCNL under general anaesthesia and were operated by the same surgical team from the department of urology. Intra operative findings including procedure duration, stone size, tract size, number of punctures and percutaneous nephrostomy (PCN) tube or DJ stent insertion were noted. Post operative pain was assessed with VAS serially at 6-hour intervals on postoperative day (POD) one, at 12-hour intervals on POD two and three and one time on POD four. Rescue analgesics in the form of IV tramadol 50 mg or IV paracetamol 1 gm was given when VAS score was ≥ 6 and a secondary rescue with an additional dose of oral analgesics was given when VAS score was ≥4. Additional data on the number of patients requiring rescue analgesics, adverse reactions associated with medications in each group were noted during this period. Statistical analysis to determine baseline differences between the groups was performed in statistical software, SPSS version 27 using independent t-test for quantitative variables and chi squared test for qualitative variables. $P < 0.05$ was considered statistically significant.

RESULTS

Demographic and pre-operative characteristics
A total of 60 patients were included in the study, with 30 patients in each group. There were no statistically significant differences between the two groups in terms of age (Group A: 46.77±11.30 years, Group B: 52.7±11.56 years, p=0.1276) and the presence of comorbidities. The ASA grading was also comparable, with 18 patients in Group A and 16 patients in Group B classified as ASA I, and the remaining patients classified as ASA II (p=0.6023). The mean pre-operative baseline VAS scores were similar in both groups, with 6.2±1.9 in Group A and 5.8±2.1 in Group B (p=0.620). Laterality of the procedure was also evenly distributed between the groups (p=0.4321).

INTRA-OPERATIVE CHARACTERISTICS

The intraoperative characteristics, including the duration of surgery (Group A: 60.27±10.96 minutes, Group B: 53.6±14.12 minutes, p=0.0665), stone size (Group A: 2.33±0.75 cm, Group B: 2.58±0.90 cm, p=0.1790), number of punctures (Group A: 1.17±0.38, Group B: 1.20±0.41, p=0.745), and tract size (Group A: 23.93±0.83 mm, Group B: 24.78±0.87 mm, p=0.078), were also similar between the two groups, with no statistically significant differences observed [Table 1]. The rates of PCN insertion (Group A: 11, Group B: 18, p=0.0705) and DJ stent insertion (Group A: 17, Group B: 22, p=0.176) were also comparable between the groups [Table 1].

POST-OPERATIVE CHARACTERISTICS, PAIN SCORES AND ANALGESIC REQUIREMENTS

The mean duration of hospital stay was similar in both groups (Group A: 5.63±0.76 days, Group B: 6±1.05 days, p=0.1966) [Table 1]. Mean VAS pain scores, both at rest and during movement, were consistently lower in Group A (transdermal buprenorphine patch) compared to Group B (conventional analgesics) at all postoperative time points (p<0.0001 for all time points except 0 hours and 60 hours) [Table 2,3] [supplemental figure 1,2]. The number of patients requiring rescue analgesia was also significantly lower in Group A (15 patients) compared to Group B (29 patients) (p<0.0001) [Table 4].

Adverse Reactions

The incidence of adverse reactions, specifically nausea and vomiting (Group A: 2 patients, Group B: 10 patients, p=0.0 083) and constipation (Group A: 3 patients, Group B: 14 patients, p=0.0018), was significantly lower in Group A compared to Group B [Table 4]. No instances of respiratory depression were observed in either group.

DISCUSSION

Our study corroborates the growing body of evidence supporting the use of transdermal buprenorphine (TDB) patches for postoperative pain management. The significant reduction in pain scores and the decreased need for rescue analgesia in the TDB group compared to the conventional analgesics group aligns with previous research demonstrating the efficacy of TDB patches in various surgical settings. 4,5,6,7 Furthermore, the lower incidence of adverse effects, particularly nausea and vomiting and constipation highlights the favourable safety profile of TDB patches, which is consistent with the findings from the studies of Dahan et al. (2005, 2006) regarding buprenorphine's ceiling effect on respiratory depression.2, 3

The advantages of TDB patches extend beyond their efficacy and safety. The transdermal delivery system offers sustained drug release, ensuring consistent analgesia and potentially improving patient compliance compared to oral or parenteral opioids that require frequent dosing. This aligns with the observations of Prausnitz and Langer (2008), who emphasized the potential of transdermal drug delivery systems to enhance patient adherence and minimize side effects.

Moreover, the non-invasive nature of TDB patches may contribute to improved patient satisfaction and reduced healthcare costs by minimizing the need for intravenous access and associated complications.While our study provides valuable insights into the use of TDB patches for postoperative pain management in PCNL patients, it is not without limitations. The single-centre design and relatively small sample size which introduce selection bias, may limit the generalizability of our findings. Additionally, the observational nature of the study precludes definitive conclusions regarding causality. Further research with larger, multicentre randomized controlled trials is warranted to validate our results and establish the optimal dosage and duration of TDB patch therapy for PCNL patients. Future studies should also explore the potential benefits of TDB patches in combination with other analgesic modalities as part of a multimodal pain management approach.Despite these limitations, our study contributes to the growing body of evidence supporting the use of TDB patches as a safe and effective alternative to conventional opioids for postoperative pain management. The findings highlight the potential of TDB patches to improve patient outcomes, enhance patient satisfaction, and reduce healthcare costs associated with postoperative pain management. As the field of pain management continues to evolve, TDB patches represent a promising avenue for further exploration and innovation.

CONCLUSION

This study demonstrates that transdermal buprenorphine (TDB) patches offer superior postoperative pain control compared to conventional analgesics in patients undergoing PCNL. The significant reduction in pain scores, decreased need for rescue analgesia, and lower incidence of adverse effects highlight the potential of TDB patches as a valuable alternative for postoperative pain management in this patient population. These findings align with previous research demonstrating the efficacy and safety of TDB patches in various surgical settings. While this study provides valuable insights, further research with larger sample sizes and diverse patient populations is warranted to establish the optimal use of TDB patches in postoperative pain management and to explore its potential benefits in other clinical scenarios.

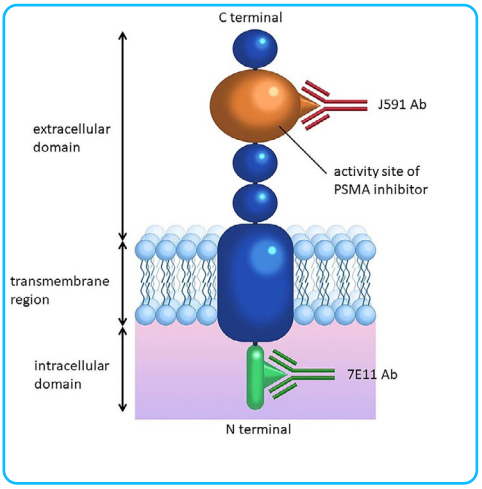
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Uro Quiz

Question : Who first described PSMA?

Prostate-Specific Membrane Antigen



Case Report

Dr Manu Jose Chirayath
Senior Resident,
Department of Urology,
GMC,Trivandrum



COMPLETE EVERSION OF URINARY BLADDER THROUGH VESICOVAGINAL FISTULA

Manu jose chirayath, Aquil faris, Haris C H
[1,2]Senior resident, Department of Urology, Government medical college, Trivandrum
[3]Professor, Department of Urology, Government medical college , Trivandrum

ABSTRACT

Complete bladder eversion through vesicovaginal fistula (VVF) is an extremely rare condition that occurs as a sequalae of uncorrected vesicovaginal fistula alongside ligament laxity caused by multiparity. A 65year old female presented with total urinary incontinence and mass per vagina of 40- and 10-years duration respectively. Pelvic examination coupled with MR urogram revealed a complete eversion of urinary bladder through vesicovaginal fistula. Exploratory laparotomy, hysterectomy, bilateral DJ stenting, manual reduction, closure of defect and a psoas hitch were performed. At three monthly follow-up DJ stents were removed and patient is currently on monthly SPC change

Key-words

Eversion, Urinary bladder, urinary bladder prolapse, Urinary incontinence, Vesicovaginal Fistula

Introduction

Complete bladder eversion through external urethral meatus is a condition reported sparsely in literature. Even more uncommon is the type that occurs through a VVF which poses significant diagnostic and therapeutic challenges. In this report, we detail the clinical presentation, diagnostic evaluation, and management of this rare condition, aiming to enhance its understanding among clinical practitioners.

Case History

A 65year old female patient of tribal origin presented with complaints of mass per vagina of ten-year duration which was irreducible from the past one week. She has history of associated total urinary incontinence for more than 40 years. She also complains of decreased urine output, facial puffiness and bilateral pedal edema of two weeks duration. She is a known hypertensive with history of three pregnancies in the past. She developed total urinary incontinence following the first delivery which was forceps assisted. Physical examination revealed single pear-shaped mass seen protruding through the vagina which was irreducible. Urethral orifice visualized but urine was leaking from the completely everted bladder via vesicovaginal fistula. Per-urethral catheterization (PUC) and manual reduction of prolapse was attempted under anaesthesia but failed.



Fig 1 - MR Urogram T2 weighted sagittal images showing bladder eversion

Vaginal examination revealed a cicatricial area in the anterior vaginal wall posterior to the prolapsed mass. Biochemical evaluation showed deranged renal function with serum creatinine at 4.1 mg/dL. Sonography of abdomen revealed bilateral moderate hydroureteronephrosis (Right more than left)with non-visualization of bladder. Further imaging with MR urogram revealed severe prolapse of anterior pelvic compartment with descent of bladder, both lower ureters and peri-vesical fat into the vagina extending upto introitus [Figure 1]. Bilateral obstruction of VUJ with moderate hydroureteronephrosis also noted. In view of serial raise in creatinine, right percutaneous nephrostomy was done on the side which showed marked dilatation in imaging studies. Serum creatinine level dropped to 1.5mg/dL following PCN insertion.

An exploratory laparotomy through a low midline incision was performed [Figure 2]. On initial survey, urinary bladder was absent in anterior pelvic compartment. Bilateral ureters were safeguarded and found to be dilated.
Careful inspection of the prolapsed mass showed urine leak from ureteric orifices on the posterior surface of the mass. Subsequently ureteric orifices were cannulated and double J stents were placed. Hysterectomy with vault closure was done to avail space for bladder reduction. Part of anterior bladder wall was excised for ease of reduction. At this point, manual reduction of everted bladder

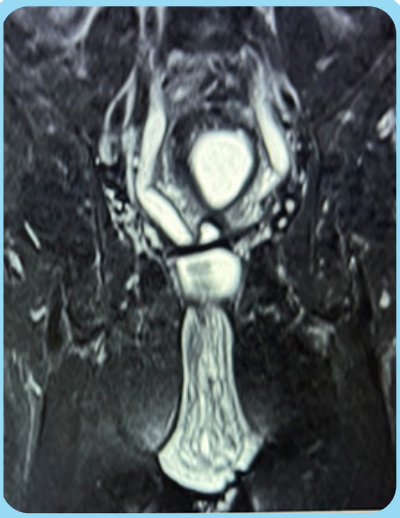


Fig 2 - MR Urogram T2 FS coronal images showing bladder eversion with Bilateral dilated ureters

into anterior pelvic compartment was done. VVF of size 3cm involving infra-trigonal area, bladder neck and mid-urethra was visualized. In view of edematous and ischemic mucosa at fistula site, suspicion of malignancy and intra-op hemodynamic instability, plan for primary repair of fistula was abandoned and proceeded with closure of defect along with bladder neck in single layer. A psoas hitch in a standard fashion was done to prevent recurrence of bladder descent. Suprapubic catheter, drain tube placed and abdomen closed.

Postoperatively there was no urine leak per vagina and patient was taken off ionotropic supports on postoperative day 1. Patient was discharged on postoperative day 8 with a serum creatinine of 0.77mg/dL after removing drain and right PCN tube, keeping only the suprapubic cystostomy (SPC) catheter insitu. At 3months follow-up bilateral DJ stents were removed through the SPC site. Currently she is on monthly replacement of SPC cathetert.

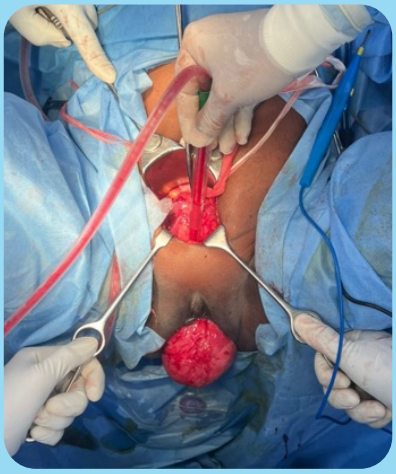


Fig 3 - Intra operative image showing bladder eversion through the vesicovaginal fistula



Fig 4 -
Post B/L DJS insertion



Fig 5 - Dome of bladder opened(Foley inserted per abdomen which was felt inside prolapsed inverted bladder can be seen)

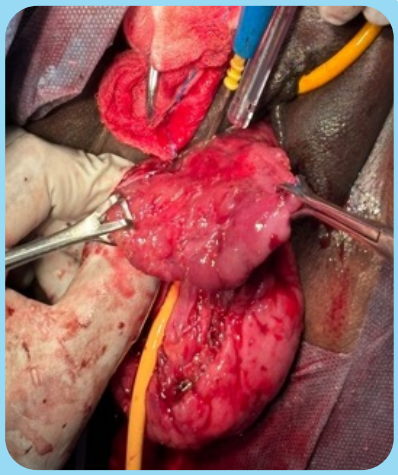


Fig 5 - Dome of bladder opened(-Foley inserted per abdomen which felt inside was prolapsed inverted bladder can be seen)

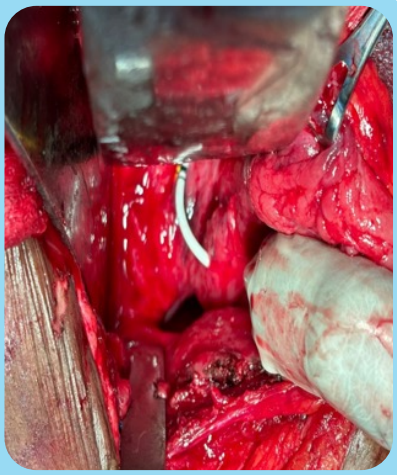


Fig 6 - Part of anterior bladder wall excised to avail ease of reduction

Discussion

Complete bladder eversion through VVF is a rare condition. The exact mechanism behind bladder eversion is unclear. Some of the predisposing factors that can lead to bladder eversion includes large uncorrected VVF, multiparity resulting in pelvic muscle and ligament laxity.1

Some of the reported cases in literature relevant to our case are summarized hereafter. Recently in 2019 Mae delara et al. reported a case of elderly woman with history of bladder eversion through VVF caused by anterior vaginal wall erosion which was surgically managed by manual reduction and closure of vaginal wall and bladder defect.2
Kalorin CM et al. in 2009 reported a case of bladder eversion through an eroded urethral meatus as a result of chronic indwelling urinary catheter, which occurred following a Le Fort partial colpocleisis done for moderate pelvic organ prolapse. It was managed by exploratory laparotomy and manual reduction of the mass along with cystopexy and a cadaveric dermis sub-trigonal sling to prevent recurrence.
They also describe a management algorithm for bladder eversion which recommend attempting external trans-urethral reduction, and if unsuccessful, suprapubic reduction with suprapubic catheter placement, cystopexy to psoas or anterior abdominal wall, urethral support procedure and surgical treatment of any associated organ prolapse.3

Overall, the management of a complete bladder eversion can be detailed sequentially as follows.

1. Initial attempt at manual reduction, trans-urethrally or through the defect it occurred, and trans-vaginal repair of the defect under anaesthesia
2. Exploratory laparotomy and a re-attempt at manual reduction by manipulation from both sides when initial attempt has failed
3. Closure of defect in two layers with a barrier such as omentum in between (In case of VVF)
4. Psoas hitch or cystopexy to abdominal wall to prevent recurrence.
5. Urethral buttressing (mid-urethral sling) or sub-trigonal sling for additional support.

Conclusion

Urogenital fistulas with bladder eversion are a very rare and challenging condition and have a high impact on the patients' mental and physical health, social status, family life and sexual health. The present case reports our personal surgical experience on a patient with complete bladder eversion though a vesico-vaginal fistula and kidney insufficiency. Surgical details and meticulous technique are crucial to obtain success at the first attempt in this extreme situation.

Moreover, reporting rare and complex cases like the present one, can help in the challenging task of developing guidelines in such rare conditions which can be shared between surgeon worldwide. The ERN eUROGEN (European Reference Network for Rare and Complex Urological Conditions, please add citation: Oomen et al.
Eur Urol, 81:204-212;2022) is currently working on developing guidelines on treatment of vesico-vaginal fistulas. It is the Authors hope and intention to give a contribution to such a difficult task through the publication of this rare and extremely clinically significant case report.

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Financial Support: None
Conflicts of interest: None

Case Report

Dr Suman De
Senior resident
Department of Urology
GMC, Trivandrum



BILATERAL RENAL LYMPHANGIECTASIA- AN UNUSUAL CASE OF PAGE KIDNEY

Suman De[1] , Haris C H[2] , Govind S[3], Manu jose chirayath[4], Amal mohan[5][1,3,4,5}Senior resident, Department of Urology, Government medical college, Trivandrum
[2]Professor, Department of Urology, Government medical college, Trivandrum

Abstract

Renal lymphangiectasia is a rare benign condition characterized by the failure of renal lymphatics to connect with larger retroperitoneal lymphatics, accounting for approximately 1% of diagnosed lymphomas. This case report describes a 36-year-old female who presented with bilateral flank pain, pedal oedema, and secondary hypertension due to “page kidney,”. Initial examination revealed elevated blood pressure (180/90 mmHg) and elevated creatinine levels (2.4 mg/dL). Imaging studies, including ultrasound and CT urogram, confirmed large bilateral fluid collections around the kidneys without active connection to the pelvicalyceal system. USG-guided aspiration yielded chylous fluid, leading to temporary relief of symptoms. However, reaccumulation of fluid and worsening renal function necessitated surgical intervention. Bilateral deroofing of the cysts allowed drainage into the peritoneum, resulting in normalization of blood pressure and renal function post-operatively. Follow-up imaging showed complete resolution of fluid collections, and the patient remained asymptomatic with normal renal parameters over one year. This case underscores the importance of accurate diagnosis of rare conditions like renal lymphangiectasia, which can have significant clinical implications when misdiagnosed.

Key words

Renal lymphangiectasia, Page Kidney, Bilateral lymphangiectasia

Introduction

Renal lymphangiectasia is a rare benign condition that happen due to the failure of the renal lymphatics to join with the larger retroperitoneal lymphatics(1). Renal lymphangiectasia contributes to up to 1 % of all diagnosed lymphoma. It can present across all age groups and both sexes and could be unilateral or bilateral. Owing to its rarity it is quite usual for this condition to be misdiagnosed. Here we present the case of a 36 years old female who presented with secondary hypertension – page kidney and bilateral renal lymphangiectasia who was treated with full recovery of renal function and resolution of hypertension. This case underlines the importance of aptly diagnosing such rare conditions that can completely turn the tide in the life of patients.

Case history

A 36 years old female presented to the Emergency room with complaints of bilateral flank pain and pedal oedema for 5 days duration. On examination she was found to have blood pressure of 180/90 mmHg. Abdominal examination revealed bilateral flank swellings –10 * 8 cm mass on the right side and 8*6 cm mass on the left side. Both lumps were firm in consistency moving with respiration and were not crossing midline. They were bimanually palpable and ballotable. No evidence of renal bruits bilaterally. Her bloodwork revealed a raised creatinine of 2.4 mg/dL. She underwent Ultrasound scanning of the abdomen which revealed bilateral large fluid collection surrounding the kidneys. For further characterisation of these, she underwent a CT Urogram which revealed bilateral cystic collections around both the kidneys which showed no contrast extravasation on the urogram phase. Thus, an active connection to the Pelvicalyceal system was ruled out. A USG guided aspiration of the collection was planned in order to further analyse the nature of the fluid and to give a therapeutic trial. She underwent aspiration of bilateral collections. 860 ml of straw-coloured fluid was aspirated from the left side and 740 ml of fluid was aspirated from the right side. The fluid was sent for analysis which was showing high levels of chylomicrons and triglycerides. 3 days after the aspiration, her abdominal pain subsided, Serum creatinine level fell to 1.3 mg/dL and pedal oedema subsided. 9 days after aspiration, she underwent a repeat ultrasound examination which was showing reaccumulation of the fluid. This was associated with an increase in the blood pressure to 164/86 mm Hg and Serum creatinine worsened to 1.9 mg/dL. During this time her plasma renin activity increased to 39.1 ng/ml/hr. Hence, she was taken up for surgery. Prior to surgery, she underwent an RGP which demonstrated no dye extravasation to the collection, the pelvicalyceal system appeared to be compressed extrinsically. She underwent bilateral deroofing of the cysts. A 2*2 cm widow was created on both the cysts in order to drain into peritoneum.

Post operatively she improved, abdominal pain subsided, blood pressure normalised and serum creatinine dropped to 0.9 mg/dL. She was discharged on POD 4. She was kept under constant follow-up . Post operative CT imaging was obtained which showed complete resolution of the collection. She underwent monthly outpatient follow-up for 1 year . During all these visits, her blood pressure remained normal, pedal oedema subsided, S. creatinine within normal limits and is completely asymptomatic

Discussion

Lymphatics are abundant near the cortex of the kidneys but they remain elusive in most of the anatomic discussions(2). They originate in the substance of the renal lobules as blind ended capillaries and can either follow the arteries and veins towards the hilum or penetrate the capsule to join the capsular lymphatics. There are no valves in the interlobular lymphatics which allow the lymph to flow in either direction(2). Renal lymphangiectasia is a rare condition characterised by abnormal proliferation of the renal lymph vessels which can lead to the formation of lymphatic collection surrounding the kidneys. Albeit a rare diagnosis the prompt identification plays a crucial role in the proper treatment of the patient. Renal lymphangiectasia has very rarely been reported after renal transplant also (3).

This usually presents as fluid collections around the transplanted kidney. Cystic diseases pf the kidneys are the close and far common differential diagnosis of renal lymphangiectasis (4). It would need a very keen eye from the part of the radiologist to diagnose a case of renal lymphangiectasia from the common cystic diseases of the kidneys and to guide the clinician towards proper diagnosis. Renal lymphangiectasia presenting with page kidney and renal failure are extremely rare events with no literature available so far. In our case the subcapsular location of the large masses of lymphangiectasia led to the compression of renal parenchyma, activation of renin angiotensin aldosterone system causing secondary hypertension and renal failure(5). However, when the compression of the parenchyma was relieved, the renal function and blood pressure quickly touched the baseline and has remained there since. This case reckons the relevance of keeping an eye open to the rare aetiologies that can present with common presentations. Prompt diagnosis and early initiation of treatment helped in making the patient symptom free.

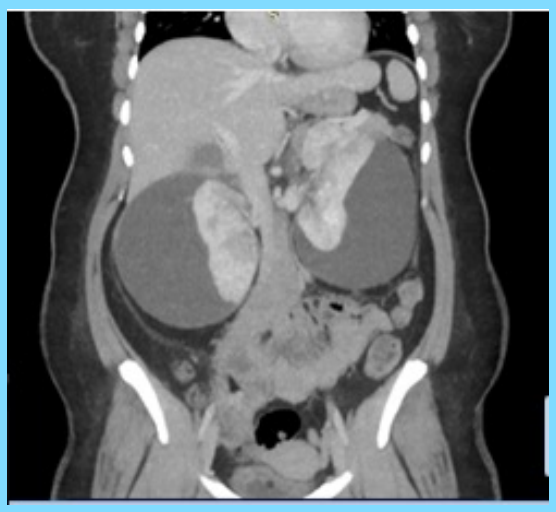


FIGURE 1
Pre operative CT scan showing the lymphatic collection surrounding both kidneys

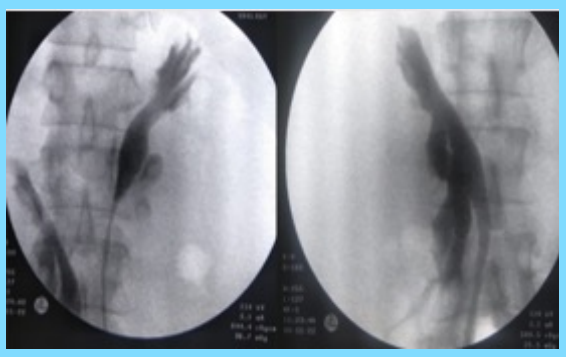


FIGURE 2
RGP image showing no contrast leak

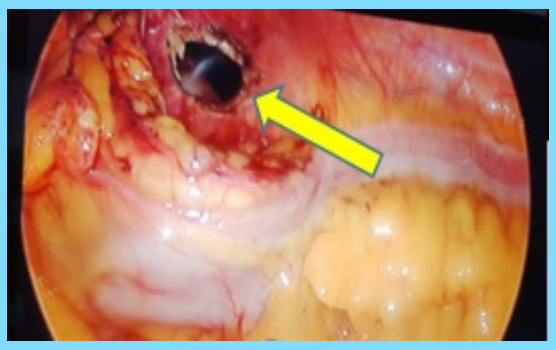


FIGURE 3
Creation of a 2 x 2 cm window on the wall of the collection



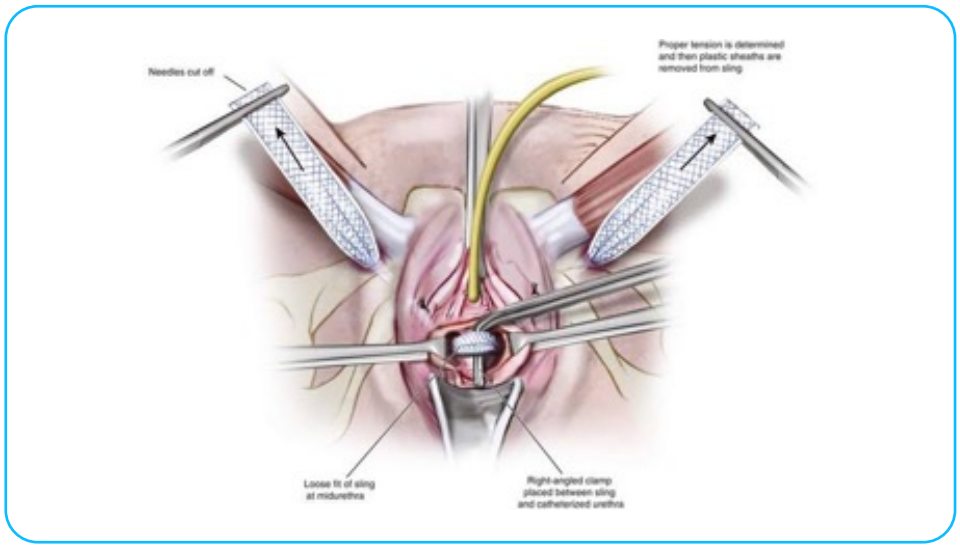
FIGURE 4
Post operative CT scan showing resolution of collection

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Common Urology Procedures

Transobturator Synthetic Midurethral sling Placement (Outside-In Approach)



- Dorsal lithotomy position with legs supported in Allen or candy cane stirrups
- Surgical draping to allow access to the vagina and inner groin
- Penetration site of trocar marked in inner groin just below adductor longus tendon lateral to the clitoris
- Localize the site with index finger in the vaginal fornix and thumb in the inner groin
- Distal anterior vaginal wall incision mobilize distal anterior vaginal wall completely of posterior urethra
- Incision should be large enough to allow placement of surgeon's index finger to the level of inferior pubic ramus.
- With thumb on curve of the needle, push needle tip through skin incision until obturator membrane is perforated.
- Continue needle behind ischiopubic ramus, rotate needle towards vaginal tunnel.
- Do a cysto-urethroscopy
- Mesh is attached to the trocar and needles are withdrawn, passing the sling through the groin incision.
- Proper tension is determined. loose fit of sling at mid-urethra.
- Right angled clamp placed between sling and catheterized urethra.

URO Quiz

Answer :
S. Horoszewicz and Associates (1987)



Upcoming Events

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KTCON 2025
KERALA

4th ANNUAL CONFERENCE OF USI RENAL TRANSPLANT SUBSPECIALITY SECTION
Date: 9th,10th &11th May 2025 | Venue: Hotel Crowne Plaza Kochi Kerala

Catergory (Please Tick): FULL MEMBER ☐ TRAINEE MEMBER ☐ ACCOMPANYING PERSON ☐

USI MEMBERSHIP NO : .....

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Age: .....Sex: .....

Address: .....

City: .....State: .....Pin: .....

Phone/Mobile: .....Email: .....

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Ph- 9895583363
Email- ktcon2025@gmail.com

Obituary

Dr. George P. Abraham



A Beloved Urologist, mentor, and cherished member of the community, passed away on 2/3/2025 at the age of 74. With a deep commitment to healthcare and a passion for improving the lives of others, Dr. George P sir dedicated his life to serving his patients and advancing medical practice.

Dr. George P Abraham was born on 3/10/1950 in Brahmapuram, Ernakulum. He earned his medical degree from Govt Medical College, Kozhikode. He went on to get his MS General surgery from Govt Medical College, Thiruvananthapuram. He returned to Kozhikode to get his MCh Urology degree under Dr Roy Chally. His distinguished career spanned for more than 4 decades, starting from Lissie hospital in Ernakulum, to Medical Trust hospital, PVS memorial hospital and VPS Lakeshore hospital, during which he made a lasting impact in the fields of Endourolgy, laparoscopic Urology and Renal Transplantation. Known for his compassionate bedside manner, Dr. George P Abraham was a trusted doctor who went above and beyond to ensure the well-being of those under his care.

He introduced laparoscopic urology in kerala and has many firsts in the state such as the first cadaver transplant, PCNL, Lap Donor Nephrectomy, 3D laparoscopy. He is credited as the third surgeon in the world to perform live related laparoscopic renal transplant. Dr GPA has performed more than 10000 laparoscopic urological procedures, he has completed more than 3500 renal transplants. He has been bestowed with various honours such as American Urological Association Best video Award 2012, the Bharat Chikitsak Ratan award, Bharath Vikas Ratan award, Life time health achievement award for his excellence in field of urology.

Outside of his medical practice, Dr. George P Abraham was a devoted family member, friend, and colleague. He leaves behind a legacy of kindness, generosity, and professionalism that touched the lives of everyone who knew him. He was also a dedicated mentor to many young Urologists inspiring them with his knowledge, humility, and unwavering dedication to his craft.

Sir is survived by his wife Mrs Daisy George, Son Dr Datson George, daughter in law Riya Datson and granddaughters Ritvika and Ishita. His family, friends, colleagues, and patients will forever remember him for his warm heart, wisdom, and unwavering commitment to making the world a better place.
His legacy will live on in the hearts of all who were fortunate enough to know him.

Dr Vijay Radhakrishnan