

SLAUS
2025
10 - 15 NOVEMBER



ANNUAL CONGRESS 2025

SRI LANKA ASSOCIATION OF UROLOGICAL SURGEONS

"EQUITY THROUGH COLLABORATION"

14TH - 15TH NOVEMBER @ GRAND KANDYAN HOTEL, KANDY

PROGRAMME AND BOOK OF ABSTRACTS



The ROYAL
SOCIETY of
MEDICINE



GENERAL INFORMATION

Event Venues

10th November

Live Surgery – Lap Nephrectomy & ECIRS
Kings Hospital – Colombo

11th November

Hands-On Workshop (Nurses)
CSSL – Colombo

12th November

Cadaveric Course in Urological Surgery
UCFM Tower – Colombo

13th November

Live Surgery for Male Incontinence
Asiri Hospital – Kandy

Ultrasound for Urologists
Asiri Hospital – Kandy

14th November

Sri Lanka Association of Urological Surgeons Annual Congress 2025 – Day 1
Grand Kandyan Hotel, Kandy

Inauguration ceremony – Sri Lanka Association of Urological Surgeons Annual Congress 2025
Grand Kandyan Hotel, Kandy

15th November

Sri Lanka Association of Urological Surgeons Annual Congress 2025 – Day 2
Grand Kandyan Hotel, Kandy

Accommodation (Kandy)

Grand Kandyan Hotel – Kandy
Devon Hotel – Kandy
Topaz Hotel – Kandy
Cinnamon Mist – Kandy

Registration Desk

Venue:

The desk will be situated in the registration foyer at *Grand Kandyan Hotel – Main Lobby and Ground Floor (Royal Peacock Ballroom)*. It will be opened at the following times

14th November: 7:00 AM – 5:00 PM

15th November: 7:00 AM – 5:00 PM

WIFI

Complementary Wi-Fi is available.
Log in credentials available at the registration desk.

Electronic Poster Display

All the selected e-posters will be displayed at exhibit area.

Science and Technology Area

Situated at the *Golden Eagle Hall, Ground floor, Grand Kandiyani.*
Delegates who are registered for the conference could visit the exhibitors on conference days

Certificates of Attendance

Certificates will be emailed to delegates from 14th & 15th November 2025.
Resource persons will receive printed certificates at the conclusion of each sessions.

Transport

Kandy City Tour and other tours for accompanying persons could be arranged via the travel partner.
Contact person - Wageesha
+94 74 351 7114
slaus.concierge@gmail.com | slaus.secretary@gmail.com

Contact

Event coordinator

Dr Aruna Rajapaksha
+94 71 341 2674

Mr Dilip Weeraman
+94 77 111 0200

Congress Secretariat

Dr Munipriya Willaraarachchi
+94 77 200 4240

Dr Hilary Fernando
+94 76 058 8852

SRI LANKA ASSOCIATION OF UROLOGICAL SURGEONS (SLAUS)

THE COUNCIL 2025

President

Prof. Srinath Chandrasekera

slaus.president@gmail.com

urology.sju@gmail.com

Immediate Past President

Dr. Manjula Wijewardena

gamagemk@gmail.com

President Elect

Dr. Balasubramaniam Sathesan

bsathesan@gmail.com

Treasurer

Dr. Ranga E Wickramarachchi

slaus.treasurer@gmail.com

reshwi@yahoo.com

Joint Secretaries

Dr Hilary Fernando

Dr. Munipriya Willaraarachchi

slaus.secretary@gmail.com

Editors

Dr Thaha M Musthafa

Dr. Meganathan Sivashankar

slous.editors@gmail.com

Council Members

Prof. Neville D Perera

Dr. Anuruddha Abeygunasekara

Dr. Kumaradasan Umashankar

Dr. Kalana Parana Palliya Guruge

Prof. Balasingam Balagobi

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M Musthafa



Dr. Meganathan
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Abeygunasekera



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MESSAGE FROM THE PRESIDENT OF SRI LANKA ASSOCIATION OF UROLOGICAL SURGEONS (SLAUS)



Dear Friends,

It is with great pride and pleasure that I welcome you to the 20th Annual International Conference of the Sri Lanka Association of Urological Surgeons (SLAUS), to be held in the historic city of Kandy at the Grand Kandyan Hotel.

Looking beyond our Silver Jubilee, this year's theme, "Equity through Collaboration", underscores our mission to promote equitable access to urological care through shared knowledge, inclusive dialogue, and cross-border partnerships.

We are honoured to present this year's congress as a joint academic event, co-hosted with the British Association of Urological Surgeons (BAUS), the Urology Section of the Royal Society of Medicine (RSM), and the South Asian Association of Urological Surgeons (SAUS). Together, we have curated a rich scientific programme featuring a world-class faculty of distinguished academics and specialists in urology.

In today's interconnected world, meaningful collaboration is no longer optional—it is essential. By fostering partnerships across disciplines, institutions, and nations, we strive to bridge gaps in healthcare delivery and drive innovations that benefit all communities everywhere.

A special focus of this year's event is the empowerment of the next generation. We are committed to creating opportunities for young urologists, trainees, and researchers to learn, contribute, and confidently step into leadership roles.

Beyond the academic programme, I warmly encourage you to enjoy the cultural heritage and hospitality of Kandy, through the unique social and leisure activities prepared for our participants.

I look forward to welcoming you to SLAUS 2025 in Kandy for an inspiring academic and cultural experience.

With warm regards,

Professor Srinath Chandrasekera
MBBS, MS, FRCS, FEBU, Hon. FRCS Glasg
President – Sri Lanka Association of Urological Surgeons (SLAUS)

MESSAGE FROM THE PRESIDENT OF SAARC ASSOCIATION OF UROLOGICAL SURGEONS (SAUS)



Congratulations to the SLAUS for another exciting conference planned for November 2025. The two-day meeting in Kandy will include a comprehensive review of the exciting cutting-edge research and developments in urology.

The SLAUS 2025 is being held in active collaboration with BAUS, RSM and SAUS. The conference will not only showcase developments and progress in South Asia but will also explore cutting-edge, paradigm-shifting, and practice-changing clinical trials in the field of urology.

The meeting in Kandy is preceded by a bold initiative of the SAUS school of urology to hold a 2-day cadaveric / animal model hands-on training workshop in Colombo. The first such workshop was held recently at the same venue in the summer, and now the SAUS School of Urology is hosting the second HOT workshop on 12th and 13th November.

I wish the organisers and the leadership of SLAUS success in their endeavours.

Professor Hammad Ather
MBBS, FCPS (Urol), FEBU, FRCS
President - SAARC Association of Urological Surgeons (SAUS)

MESSAGE FROM THE PRESIDENT (ELECT) OF BRITISH ASSOCIATION OF UROLOGICAL SURGEONS (BAUS)



It is a privilege to extend my warmest greetings on behalf of the British Association of Urological Surgeons to the Sri Lanka Association of Urological Surgeons on the occasion of your 20th International Congress. The historic city of Kandy provides a fitting backdrop for a gathering dedicated to advancing knowledge, sharing expertise, and strengthening friendships.

The chosen theme — Equity through Collaboration — resonates deeply with our shared mission to ensure that excellence in urological care is accessible to all, wherever they live. As colleagues across continents, we are united by the belief that collaboration not only enhances clinical standards but also builds the equitable future our patients deserve.

I look forward to joining you in celebrating the achievements of Sri Lankan urology, learning from one another's experiences, and fostering enduring partnerships between our associations.

With warm regards,

Professor Joe Philip
MBBS, MRCS, MD, FRCS(Urol.)
Consultant Urological Surgeon
President (Elect), British Association of Urological Surgeons (BAUS)

MESSAGE FROM THE PRESIDENT OF RSM UROLOGY SECTION



It gives me great pleasure that the Urology Section of the Royal Society of Medicine is once again involved with the Annual Meeting of the Sri Lankan Association of Urological Surgeons. This continues a long-standing tradition of collaboration between our two societies. We greatly value these international partnerships and are proud to send a delegation of RSM urologists to take part in this year's meeting.

While the healthcare challenges in our two countries may differ in many respects, there is much we can learn from one another by sharing knowledge and experience.

Education and collaboration are core values of the RSM, and by working with SLAUS we are delighted to further these aims in support of your mission.

Although I am personally disappointed not to be able to join you this year, I wish you all a most successful and rewarding meeting.

Mr Matthew Bultitude
MD, FRCS, FRCS (Urol)
President RSM Urology Section 2025-6

MESSAGE FROM THE SECETRY OF SRI LANKA ASSOCIATION OF UROLOGICAL SURGEONS (SLAUS)



It is with immense pleasure that we welcome you all to SLAUS 2025, held at the Grand Kandyan Hotel in the historic city of Kandy. Our theme for this year, “Equity Through Collaboration,” reflects our commitment to providing the best services and state-of-the-art care to our patients through teamwork, partnerships, and shared learning.

Our efforts to uplift urological services across the country—reaching every corner and ensuring equitable access regardless of locality—are reflected in this year’s diverse line-up of pre-congress workshops and the main congress.

A notable addition to SLAUS 2025 is the introduction of “Urology for Primary Care,” conducted in collaboration with the College of General Practitioners of Sri Lanka and the Lanka College of Specialist Family Physicians. This initiative aims to enhance continued education in urology among primary care physicians, bridging knowledge gaps to support early diagnosis and prevent complications. The pre-congress workshops similarly focus on addressing training deficiencies and service disparities—ultimately translating into improved care for our patients, who remain at the heart of everything we do.

Urology is advancing rapidly, with developments in endourology, minimally invasive surgery, and robotics linked to AI algorithms. The expanding use of ultrasonography and other emerging technologies continues to refine service delivery for the greater benefit of our patients. SLAUS 2025 proudly brings together our international collaborators—both regional and global leaders in urology—to Kandy, Sri Lanka, for an enriching academic experience that bridges the fast-moving world of urology with Sri Lanka’s unique realities.

We wish you a week filled with meaningful learning, collaboration, and inspiration—one that leads to lasting benefits in urological service delivery to our communities and patients across the country.

Dr. Hilary M. Fernando
MBBS,MD,FRCS (Glasgow), CST (Urol) CSSL
Consultant Urological Surgeon
Secetry – Sri Lanka Association of Urological Surgeons (SLAUS)

Dr. Munipriya Willaraarachchi
MBBS, MD(Surgery), MRCS(Edin), CST(Urology) CSSL, FRCS(Glasgow)
Consultant Urological Surgeon
Secetry – Sri Lanka Association of Urological Surgeons (SLAUS)

MESSAGE FROM JOINT EDITORS OF SRI LANKA ASSOCIATION OF UROLOGICAL SURGEONS (SLAUS)



We are delighted to extend a warm welcome to all participants to the Annual Meeting of the Sri Lanka Association of Urological Surgeons. This year's theme, "Equity Through Collaboration," reflects our shared commitment ensuring that every patient benefits from the collective expertise, innovation, and compassion within our urological community.

As we gather this November in the historic city of Kandy to share knowledge, experiences, and new research, we are privileged to be joined by many foreign delegates and we should utilize this opportunity to engage, exchange ideas, and build new professional relationships across borders and disciplines to promote the urological care delivered to patients.

We are also proud to publish Volume 16 of the Sri Lanka Journal of Urology (SLJU) during this session week, marking another milestone in our ongoing effort to promote academic excellence and scholarly exchange. We extend our gratitude to all those who made this possible.

We wish all participants a productive, engaging, and memorable conference.

Thaha M. Musthafa & M. Sivashankar
Joint Editors
Sri Lanka Journal of Urology

MARVELS OF SRI LANKA

KANDY LAKE AND CITYSCAPE



At the center of Kandy lies a serene body of water known as Kandy Lake or Kiri Muhuda, meaning “Sea of Milk.” It was built in 1807 by King Sri Wickrama Rajasinghe as part of the royal palace complex and remains one of the city’s most picturesque landmarks. A small island in the middle of the lake adds to its charm, while the surrounding pathway shaded by trees invites visitors to take leisurely walks and enjoy the peaceful scenery.



The lake reflects both the Temple of the Tooth and the surrounding hills, creating a postcard-perfect view that captures the essence of Kandy. Around it, the city preserves its unique blend of colonial heritage and local culture. The streets are filled with bustling markets, traditional crafts, and historic buildings that tell stories of the past. Kandy is recognized as a UNESCO World Heritage City because it preserves the traditions, rituals, and artistry that define Sri Lanka’s national identity.



DAY 01 14TH NOVEMBER 2025

8.00 am - 8.30 am	Registration		
8.30 am - 8.45 am	Open Remarks		
8.45 am - 9.00 am	Plenary 1	Role of metastasectomy in the treatment of Renal Cell Carcinoma	Mr Zeeshan Aslam - UK
9.00 am - 9.15 am	Plenary 2	HolEP - The gold standard bladder outflow procedure	Ms Tharani Nitkunan - UK
9.15 am - 9.30 am	USANZ lecture	Reconstructive urology - an algorithm for decision making	Dr Ashani Couchman - Aus
9.30 am - 9.45 am	Plenary 4	Imaging in andrological emergencies	Dr Miles Walkden - UK
9.45 am - 10.00 am	AUA lecture	South Asian Urology : training south asian urologist for a global tomorrow	Dr Jaspreet S Sandhu - USA
10.00 am - 10.15 am	Plenary 6	Essential male fertility care in lower middle income countries: the neglected crisis	Prof Balasingam Balagobi - SL
10.15 am - 10.45 am	Tea Time		
10.45 am - 11.30 am	Prostate cancer symposium	Evolving role of PSMA-PET in prostate cancer	Dr Vinod KV - India
		Current trends in the management of advanced prostate cancer	Dr Nuradh Joseph - SL
		RSM lecture - Assessment and management of post prostate cancer treatment related urinary incontinence	Mr Roland Morley - UK
11.30 am - 11.45 am	Plenary 7	Treatment options for ED following priapism	Dr S Sasikumar - SL
11.45 am - 12.45 pm	SAUS Symposium South Asian Urology : training south asian urologist for a global tomorrow	BAUS lecture - Global training initiative: equity through collaboration in urology education and training	Mr Joe Philip - UK
		Access to specialist post-graduate training in urology in the UK	Mr Roland Morley - UK
		AUSTEG and its role in training urologists in Asia	Mr Roland Morley - UK
		Pathways for fellowship training in Australia	Dr Ashani Couchman - Aus
		Role of SAUS in bridging gaps in south asian specialist training	Prof Hamad Ather - Pakistan
12.45 pm - 1.45 pm	Lunch Time		
1.45 pm - 2.00 pm	Plenary 7	Peyronies disease: evaluation and surgical management	Miss Pippa Sangster - UK
2.00 pm - 2.15 pm	BJUI lecture	Non-Technical Skills in Emergency Reconstructive Urology: A Case-Based Approach	Dr Sarah Itam - UK
2.15 pm - 2.30 pm	Plenary 10	Therapeutic options during BCG scarcity	Dr M Sivashankar - SL
2.30 pm - 2.45 pm	Plenary 11	Upper tract TCC : impact of surgical approaches on the oncological outcomes of radical nephroureterectomy	Mr Zeeshan Aslam - UK
2.45 pm - 3.00 pm	Plenary 12	Correction of urethrocutaneous fistulae	Mr Peter Malone - UK
3.00 pm - 3.15 pm	NAUS lecture	From vision to reality: Nepal's journey in robotic urology	Dr Parash Mani Shrestha - Nepal
3.15 pm - 3.30 pm	BanAUS lecture	Laparoscopic radical cystectomy for MIBC: experience and outcome at NIKDU	Dr Md Mashiur Arefin - Bangladesh
6.30 pm Onwards	INAUGURATION - FRIDAY, 18:30 ONWARDS AT ROYAL PEACOCK BALLROOM		

15TH NOVEMBER 2025

8.00 am – 9.00 am	Free paper session		
9.00 am – 9.15 am	Plenary 15	Female urethral reconstruction (Urethroplasty)	Mr Jeremy Ockrims – UK
9.15 am – 9.30 am	PAUS lecture	CT and MR-based radiomics in the diagnosis of RCC subtypes	Prof Hammad Ather – Pakistan
9.30 am – 9.45 am	Plenary 17	Application of AI in urology	Prof Ananda Kumar – UK
9.45 am – 10.00 am	Plenary 18	Pelvic fractures and their effects on the urological system	Mr Julian Shah – UK
10.00 am – 10.15 am	Plenary 19	Organ and function preservation in urological surgery	Prof Gang Zhu – China
10.15 am – 10.30 am	Plenary 20	Bladder pain syndrome: "Hedge your bets"	Dr Amita Jain – India
10.30 am – 11.00 am	Tea Time		
11.00 am – 11.10 am	Symposium 3 Game changing clinical trials in urology (2015–2025)	Male LUTS	Mr Ananda Kumar Dhanasekaran – UK
11.10 am – 11.20 am		Urolithiasis	Prof Joe Philip – UK
11.20 am – 11.40 am		Uro-oncology	Prof Hammad Ather – Pakistan
11.40 am – 11.45 am		Q&A	
11.45 am – 12.15 pm	Symposium 3	Sustainability in Urology	Ms Tharani Nitkunan – UK Dr Ashani Couchman – Aus Dr Hilary Fernando – SL
12.15 pm – 12.30 pm	USI lecture	Ergonomics and surgeon wellbeing in the era of robotics	Dr Suriyaprakash Vadi – India
12.30 pm – 12.45 pm	Plenary 22	Surgical management of male genital lichen sclerosis (MGLSc)	Mr Peter Malone – UK
12.45 pm – 1.00 pm	Plenary 23	Legacy of stone surgery: lithotomy to precision surgery	Mr Julian Shah – UK
1.00 pm – 2.00 pm	Lunch Time		
2.00 pm – 3.00 pm	Symposium 4 Urolithiasis	Challenging endourology cases	Mr Joe Philip – UK
		Shaping the future of stone surgery: robotic flexible ureteroscopy	Prof. Anthony Ng – HK
		Long-term management strategies for high-risk stone formers	Prof Hammad Ather – Pakistan
		Navigating complex renal anatomy in stone disease	Dr Ulhas Sathaye – India
3.00 pm – 4.00 pm	Uro-oncology MDT		
4.00 pm	Raffle draw & Closing remarks		

Plenary 1

Role of metastasectomy in the treatment of Renal Cell Carcinoma

Mr Zeeshan M Aslam

Metastasectomy plays a significant role in the management of renal cell carcinoma (RCC). It can improve survival, alleviate symptoms, and potentially enhance the effectiveness of systemic therapies.

The decision to perform metastasectomy depends on patient factors, metastasis location, and overall disease burden, making it a valuable component of a multidisciplinary approach in selected RCC cases.

Plenary 2

HoLEP – the gold standard bladder outflow procedure

Miss Tharani Nitkunan

The gold standard procedure can be defined as the best available procedure for a condition. Transurethral resection of the prostate (TURP) has been previously accepted as the gold standard for bladder outflow obstruction. This needs to be challenged. Holmium Laser Enucleation of the Prostate (HoLEP) should now be considered as the gold standard for bladder outflow obstruction.

Efficacy evidenced by improvement in post-operative Qmax, reduction in symptoms scores, lower rates of redo procedures demonstrate significant better outcomes with HoLEP. HoLEP patients benefit from significantly shortened catheterization times, decreased length of hospital stay (LOS), and fewer serious post-operative complications. Day-case HoLEP surgery with catheter removed on the day of surgery is being performed in various departments. HoLEP is also a prostate size independent procedure, can be used after previous prostate procedures and is particularly safe in patients who are anti-coagulated. All these factors above contribute to the statement that HoLEP is indeed the gold standard bladder outflow procedure.

USANZ lecture

Reconstructive urology – an algorithm for decision making

Dr Ashani Couchman

Reconstructive urology encompasses a wide range of complex surgical challenges requiring nuanced clinical judgement and inter-disciplinary coordination. This presentation outlines a structured, algorithmic approach to decision making in reconstructive urology—integrating patient factors, anatomical considerations, functional outcomes, and long-term quality of life. By synthesising evidence-based practice with real-world surgical experience, the framework can provide clinicians with a pathway from assessment to intervention. The algorithm emphasises the importance of individualized care, shared decision making, and adaptability to local resource contexts, aligning with sustainable and equitable surgical care.

Plenary 4

Imaging in andrological emergencies

Dr Miles Walkden

Andrological emergencies represent a small but critical subset of urological conditions in which timely imaging assessment and intervention are vital to preserving function and fertility. This talk, delivered by a specialist urologist, will explore the pivotal role of imaging in the diagnosis and management of acute scrotal and penile emergencies.

Key topics will include testicular torsion, trauma, infection, priapism and penile fracture. The session will review the strengths and limitations of ultrasound, CT, and MRI in different clinical scenarios. Illustrative case studies will demonstrate both classic and atypical presentations, alongside pitfalls that can delay diagnosis. Attendees will gain an updated, practice-focused understanding of how radiology directly contributes to improved outcomes in andrological emergencies.

Plenary 6

Essential male fertility care in low-and middle-income countries: the neglected crisis

Prof Balasingam Balagobi

This presentation outlines the urgent need to address male subfertility—a neglected crisis contributing to nearly 50% of infertility cases globally, particularly acute in Low- and Middle-Income Countries (LMICs) like Sri Lanka. Infertility affects up to 15% of couples, leading to severe social stigma, marital distress, and economic hardship in these settings. The core challenge lies in shifting focus from solely female partners to a comprehensive, couple-centred approach. Essential care must prioritize cost-effective diagnostics, starting with standardized Semen Analysis (SA), advocating for strict quality control in local laboratories. Further investigation must be rational and targeted, avoiding unnecessary, expensive testing.

Management should emphasize high-impact, low-cost interventions: promoting lifestyle modification, aggressively treating prevalent causes like varicocele repair (surgical procedure with high returns), and controlling infectious causes (STIs, Mumps). For assisted reproduction, IUI (Intrauterine Insemination) is positioned as the most fiscally responsible first-line ART option.

Crucially, the presentation calls for policy integration and task-shifting, empowering General Practitioners (GPs) for initial screening and counselling. The ultimate goal is to champion equitable, accessible male fertility care, ensuring it is recognized as a vital component of public health in Sri Lanka and across LMICs.

Plenary 7

Treatment options for ED following priapism

Dr S Sasikumar

Erectile dysfunction (ED) is a common and often devastating sequela following ischemic priapism, resulting from irreversible corporal smooth muscle necrosis and fibrosis. Management requires a structured approach based on the duration of priapism, residual erectile function, and patient expectations. Early recognition and timely detumescence are crucial to minimize tissue damage. However, most patients with prolonged ischemia experience severe, irreversible ED, necessitating surgical intervention. Penile prosthesis implantation—either early or delayed—remains the definitive treatment. Early implantation, performed within weeks of the priapism episode, offers advantages including preservation of penile length, easier dissection due to less fibrosis, and improved patient satisfaction, though it carries risks of infection and mechanical complications. Delayed implantation, while technically more challenging, may be appropriate in selected cases once fibrosis stabilizes. Individualized patient counselling, psychological support, and multidisciplinary follow-up are essential to achieving optimal functional and cosmetic outcomes. Advancements in prosthesis design and surgical techniques continue to improve results for this challenging patient group.

SAUS Symposium

South Asian Urology : training south asian urologist for a global tomorrow

AUSTEG and its role in training urologists in Asia

Professor Anthony C.F. Ng

The rapid growth in population, especially the ageing population, in Asia has increased the demand for urological care for the public. Many urological issues require surgical procedures, from simple diagnostic cystoscopy to BPH-related endoscopic surgery, stone removal, and laparoscopic kidney or pelvic surgeries. Unfortunately, training opportunities and facilities may not be easily accessible in many Asian countries, particularly those in developing areas. Therefore, there is an urgent need to provide surgical training, especially practical and hands-on skill development. The Asian Urological Training and Education Group (AUSTEG) is a non-governmental, non-profit organisation that aims to offer affordable courses for young urologists across Asia to enhance their surgical skills. Since its founding in 2015, we have held over 50 courses and workshops across various fields, covering both basic and advanced endo-laparoscopic surgical training. We hope our efforts will help raise surgical standards in Asia and benefit more patients in the region.

Pathways for Fellowship Training in Australia

Dr Ashani Couchman

Australia's surgical training system is internationally recognised for its structured governance, competency-based assessment, and emphasis on professionalism and patient safety. This is echoed in the NZ structure, and the regulations are comparable but also very different.

The pathways available for overseas medical graduates and local trainees seeking fellowship training in urology within the Australian system is clearly defined. There are key relationships between RACS, USANZ, AHPRA (Aus) and NZMC (NZ) that support delivery of these structured processes.

Eligibility requirements, application processes, training structures, and the integration of clinical, academic, and leadership competencies within fellowship programs are defined. International collaboration and fellowship will remain a cornerstone in the collegial relationships and support.

Plenary 8

Peyronies disease: evaluation and surgical management

Miss Pippa Sangster

The talk will run through the pathogenesis, epidemiology and history of this incredibly common disease. Miss Sangster will discuss how to investigate and manage these men in the early acute phase. Most of the talk will concentrate on the important issues of patient selection for surgical management. She will run through the Peyronie's disease (PD) surgical algorithm. Deciding whether a man is appropriate for plication or grafting techniques does not just depend on the level of curvature and these factors will be discussed before moving on to the potential of a penile implant. This is a difficult disease to manage correctly, ensuring men are happy with their surgical choices and understanding the consequences of not only the disease but treatment outcomes.

BJUI lecture

Non-Technical Skills in Emergency Reconstructive Urology: A Case-Based Approach

Miss Sarah Itam

Non-Technical Skills for Surgeons (NOTSS)—such as situational awareness, decision-making, leadership, communication, and teamwork—are fundamental to safe and effective surgical practice. While technical proficiency is vital for achieving successful reconstructive outcomes, non-technical skills are equally essential for ensuring patient safety and promoting cohesive team performance. Their importance is particularly pronounced in emergency reconstructive urology, where complex procedures are not uncommon and multidisciplinary collaboration is necessary. This presentation adopts a case-based approach to demonstrate how strong non-technical performance can improve outcomes, strengthen team dynamics, and optimise patient care.

Plenary 10

Therapeutic options for NMIBC during BCG scarcity

Dr M Sivashankar

The global shortage of *Bacillus Calmette–Guérin* (BCG) poses a significant challenge in managing non-muscle invasive bladder cancer (NMIBC), where intravesical BCG remains the gold-standard adjuvant therapy. This presentation explores evidence-based alternatives and adaptive strategies to optimize patient outcomes during periods of BCG scarcity. Key approaches include dose reduction and fractionation protocols, sequential or combination intravesical chemotherapy using agents such as mitomycin-C, gemcitabine, and epirubicin, and the use of device-assisted instillation techniques. The talk also discusses patient selection, risk stratification, and the role of early radical cystectomy in high-risk cases. Emphasis is placed on balancing oncological safety, treatment accessibility, and cost-effectiveness in resource-limited settings, with insights drawn from current literature and clinical experience in Sri Lanka.

Plenary 11

Upper Tracts TCC: Impact of Surgical approaches and pathways on the oncologic outcomes of radical nephro-ureterectomy

Mr Zeeshan M Aslam

Upper tract transitional cell carcinoma (UTTCC) of the ureters and kidneys poses significant therapeutic challenges. Various studies suggest how different surgical treatment pathways influence oncological outcomes, including recurrence-free, cancer-specific, and overall survival. Findings suggest that prior Ureteroscopy is not necessary in all cases and can result in treatment delays, different lower end surgical techniques do not effect the oncological outcomes, and appropriate case selection and risk stratification is absolutely necessary in these cases.

Plenary 12

Correction of urethrocutaneous fistulae

Mr Peter Malone

Urethrocutaneous fistula is usually seen as a complication of hypospadias repair but can also be found in patients with genital piercings and following gender reassignment surgery. Rarely it can present spontaneously or be traumatic.

Animal studies have shown that fistulae form by early and rapid epithelialisation of suture tracks. In hypospadias surgery the incidence can be minimised by interposition of dartos between the urethra and skin closure. Despite this, and even in the best surgical hands, it is still one of the most common complications of surgical repair.

The standard fistula repair involves dissection of the tract, which is then excised with separate closure of the urethra and skin. As in primary hypospadias repair, dartos is usually interposed, with or without rotational skin flaps, to put distance and substance between the overlapping suture lines.

Using standard techniques, the recurrence rate is high with some patients requiring many operations. Surgery for coronal fistulae seems particularly prone to break down and many surgeons either interpose tunica vaginalis or repeat the hypospadias repair to reduce the recurrence rate.

An alternative strategy is presented, the PATIO repair, where, instead of excising the tract, it is preserved and turned inside out (PATIO) into the urethra. This creates a flap valve which prevents the ingress of urine and allows the fistula to heal. The technique is demonstrated in large coronal fistulae following hypospadias repair and after genital piercings have been removed.

The PATIO repair has been adopted by several centres around the world, and the results of the operation, and the modifications others have made to it in different centres, are discussed and compared to alternative techniques.

NAUS lecture

From vision to reality: Nepal's journey in robotic urology

Dr Parash Mani Shrestha

For decades, Nepal's most complex urological cases presented a sobering reality: patients facing life-altering diagnoses had no choice but to travel thousands of kilometres abroad for advanced surgical intervention. This geographical limitation imposed not only financial hardship on families but also, emotional strain during critical health crises. Nepal's healthcare visionaries recognized this gap as unacceptable.

Advancements in the robotic surgical technology have revolutionized the standard of care for many surgical procedures. The different issues involved in developmental phase of starting a robotic program and to evaluate the important considerations in developing this program at a given healthcare institution.

Although every hospital might desire a robotic program, there are many requirements needed to uphold a successful and self-sustainable program in the current healthcare market.

Patients' interest in robotic-assisted surgery has and continues to grow because of improved outcomes and decreased periods of hospitalization. Resulting market forces have created a solid foundation for the implementation of robotic surgery into surgical practice.

A transformative vision emerged within Nepal's medical leadership—the conviction that world-class surgical care should not be a privilege reserved for those who could afford international travel. This aspiration transcended mere infrastructure; it represented a commitment to national dignity and equitable healthcare access.

Bangladesh Association of Urological Surgeons lecture

Laparoscopic Radical Cystectomy for Bladder Cancer: Experience and Outcome at National Institute of Kidney Diseases and Urology

Dr Md Mashiur Arefin

Introduction:

Urinary bladder cancer is the fourth most common cancer in males with peak incidence in 65 years of age and male: female > 2.7:1. Smoking and occupational exposure are most common etiological factors. Painless haematuria and irritative voiding symptoms are common. Urine analysis and cytology, imaging, cystoscopy and biopsies are main diagnostic tools.

Management depends upon grading and staging of tumour. Non-Muscle-Invasive Bladder Cancer (NMIBC) needs TURBT followed by intravesical therapy (e.g., BCG, Mitomycin) and Regular cystoscopic surveillance. Muscle-Invasive Bladder Cancer (MIBC) treated by Neoadjuvant CT followed by Radical cystectomy with pelvic lymphadenectomy and Consider bladder-preserving strategies in select patients.

Laparoscopic radical cystectomy (LRC) and Robotic surgery is increasingly being adopted as a minimally invasive alternative to open radical cystectomy for muscle-invasive bladder cancer (MIBC). While global experience is growing, data from developing nations remains limited. We present our experience with LRC for MIBC at the National Institute of Kidney Diseases and Urology (NIKDU), focusing on perioperative outcomes, oncological safety, and feasibility.

Purpose:

To evaluate the feasibility, safety, and early oncological outcomes of laparoscopic radical cystectomy (LRC) for muscle-invasive and high-grade non-muscle-invasive bladder cancer at the National Institute of Kidney Diseases and Urology (NIKDU). As Robotic, surgery is expensive and not available in all the centres in third world countries.

Materials and Methods:

From July 2022 to the present, 42 patients (33 males, 9 females; mean age 59 ± 9.63 years) underwent LRC at NIKDU. Inclusion criteria comprised organ-confined MIBC (T2–T3, M0) and high-grade TCC refractory to BCG (Ta–T1), with exclusion of T4, metastatic disease, or ASA grade ≥ 3 patients. All patients received standard pelvic lymphadenectomy and extracorporeal ileal conduit urinary diversion. Perioperative parameters, postoperative complications (graded by Clavien-Dindo), and oncological outcomes were analysed.

Results:

The mean operative time was 210.35 ± 21.28 minutes, with estimated blood loss of 215.32 ± 46.32 ml and average hospital stay of 7.23 ± 2 days. Minor complications occurred in 3 patients (Clavien-Dindo grade I–II), with no major complications. Specific complications included uretero-ileal anastomotic leakage (n=4) and prolonged paralytic ileus (n=5). No DVT or port-site recurrence was observed. Pathologic staging post-LRC revealed 75% T2 disease, with 2 cases (8.3%) having positive urethral margins. During a median follow-up of 21 months (range 6–34), local recurrence occurred in 1 patient and distant metastasis in 3. The overall survival rate was 82%, and cancer-specific survival was 91%.

Conclusions:

Laparoscopic radical cystectomy is a technically demanding but feasible minimally invasive alternative to open radical cystectomy and robotic surgery in selected patients with bladder cancer. Our institutional experience demonstrates encouraging oncological outcomes and acceptable complication rates, supporting its role in contemporary urologic oncology practice.

Plenary 15

Female urethral reconstruction (Urethroplasty)

Mr Jeremy Ockrims

Techniques and outcomes of female urethroplasty after sling erosion will be discussed. The talk will cover the extent and causes of urethral injury from mesh implants, techniques of removal and urethral reconstruction, dealing with post-reconstruction incontinence and the outcomes from a specialist centre.

Plenary 17

Application of AI in urology

Mr Ananda Kumar Dhanasekaran

Artificial intelligence (AI) is rapidly reshaping modern urology, transitioning from a theoretical concept to an integrated clinical reality. This transformation is driven by the confluence of vast, multimodal data streams—including medical imaging, digital pathology, and robotic surgery telemetry—and exponential growth in computational power. AI's primary role is not to replace clinicians but to serve as a powerful form of augmented intelligence, enhancing diagnostic precision, personalizing therapeutics, and optimizing surgical performance.

In urologic oncology, AI has demonstrated profound diagnostic impact. For prostate cancer, deep learning models have surpassed expert radiologists in detecting clinically significant disease on multiparametric MRI and are reducing the inter-observer variability inherent in Gleason grading from digital pathology slides.³ In urothelial carcinoma, AI-enhanced cystoscopy provides real-time analysis to identify subtle lesions like carcinoma-in-situ that are often missed by the human eye. For renal cell carcinoma, AI algorithms non-invasively characterize indeterminate renal masses on CT scans, accurately distinguishing benign from malignant tumours and predicting aggressiveness, thereby preventing unnecessary interventions. AI's utility extends to benign conditions such as urolithiasis and BPH, where it streamlines workflows by predicting stone composition and surgical outcomes.

AI is also revolutionizing treatment delivery. In radiation oncology, it automates the time-consuming process of contouring organs and tumours, generating optimized treatment plans in minutes and enabling advanced adaptive radiotherapy. The synergy between AI and robotic surgery is creating the intelligent operating room; computer vision provides real-time anatomical recognition, augmented reality overlays guide dissection, and analysis of instrument data offers objective surgical skill assessment and predicts postoperative outcomes like continence. Furthermore, AI is accelerating innovation by shortening drug discovery timelines and optimizing clinical trial design. Despite this immense potential, significant challenges remain. The successful integration of AI into routine practice requires navigating a complex landscape of ethical, legal, and regulatory issues. Critical concerns include algorithmic bias stemming from non-diverse training data, the "black box" problem of non-interpretable models, data privacy, and unresolved questions of liability. While regulatory bodies like the FDA have begun authorizing AI tools, establishing robust frameworks for governance and oversight is paramount. The future of urology will involve a deeper partnership between human expertise and machine intelligence, but its realization depends on a collective commitment to rigorous validation and the ethical deployment of these transformative technologies to ensure safe, equitable, and patient-centred care.

Plenary 18

Pelvic fractures and their effects on the urological system

Mr Julian Shah

Background:

Pelvic fractures are complex injuries often associated with significant urogenital morbidity. While early management of bladder trauma is well established, the long-term impact on urinary function and quality of life is less clearly defined.

Objectives:

To evaluate the relationship between fracture type, bladder injury, and long-term urinary outcomes in patients with pelvic trauma.

Methods:

A retrospective analysis was conducted on 103 patients with pelvic fractures. Demographic data, mechanism of injury, fracture classification, bladder involvement, and follow-up urinary outcomes were reviewed. Fracture patterns were classified using the Young–Burgess system. Post-injury urinary symptoms, investigations, and treatments were recorded, with follow-up at ≥ 3 years.

Results:

The mean patient age was 42 years, with most being young to middle-aged adults. High-energy mechanisms—particularly road traffic collisions, falls, and crush injuries—were predominant.

- Fracture patterns: 22 distinct configurations identified; APC2 was most common ($\sim 20\%$).
- Bladder injury: Present in 15% of cases (rupture, avulsion, or laceration).
- Long-term urinary symptoms: Reported by approximately 50% of patients at ≥ 3 years, including urgency, frequency, nocturia, incontinence, and catheter dependence.
- Notably, persistent urinary symptoms were more frequent in patients without initial bladder injury, suggesting secondary neurogenic or functional mechanisms.
- Investigations: Cystoscopy, urethrogram, and urodynamics were used when symptoms persisted.
- Treatment: Most patients were managed conservatively or pharmacologically (e.g., Solifenacin, Mirabegron), while some required surgery or catheterisation.

Conclusions:

Long-term urinary complications are common following pelvic fracture, affecting around half of patients years after injury. Symptoms may occur even without identifiable bladder trauma, indicating that pelvic fracture alone can cause chronic dysfunction. Bladder recovery and urinary outcomes should therefore be integrated into multidisciplinary follow-up, rather than focusing solely on skeletal healing.

Plenary 19

Organ and function preservation in urological surgery

Prof Gang Zhu

The management of genitourinary (GU) cancers has undergone a significant paradigm shift, moving from radical resection toward strategies that prioritize organ and functional preservation without compromising oncological control. The primary goal of this approach is to enhance patient quality of life by minimizing treatment-related morbidities such as urinary incontinence, sexual dysfunction, and infertility.

Key Strategies Across Major GU Cancers:

1. Prostate Cancer:
 - Active Surveillance (AS): A primary strategy for low-risk and selected intermediate-risk patients to defer or avoid curative treatment, thereby preventing functional impairments. Long-term data confirm low prostate cancer mortality but underscore the need for lifelong monitoring due to increasing progression risk over time.
 - Surgical Technique Modifications: In radical prostatectomy, techniques like cold dissection, and holographic imaging for surgical navigation are employed to maximize the preservation of urinary continence and erectile function.
 - Focal Therapy: Minimally invasive treatments (e.g., Irreversible Electroporation - IRE) target the index lesion while sparing surrounding healthy tissue, offering a middle ground between AS and radical therapy.
2. Renal Cell Carcinoma (RCC):
 - Active Surveillance: An appropriate initial management for small renal masses, particularly in older patients or those with comorbidities, showing a low rate of progression to metastatic disease.
 - Nephron-Sparing Surgery (NSS): Partial nephrectomy (PN), especially robot-assisted (RAPN), is the standard for T1-T2 tumours and considered for select T3 tumours. It preserves renal function better than radical nephrectomy, reducing the risk of chronic kidney disease. Holographic imaging aids in precise surgery.
 - Tumour Ablation (TA): Techniques like cryoablation are effective alternatives to surgery for small tumours (<3 cm), though long-term comparative efficacy with PN requires further validation.
3. Muscle-Invasive Bladder Cancer (MIBC):
 - Trimodality Therapy (TMT): TMT provides survival outcomes comparable to RC while offering superior quality of life regarding bowel, sexual function, and body image.
 - Emerging Therapies: Immune Checkpoint Inhibitors (ICIs) like pembrolizumab and Antibody-Drug Conjugates (ADCs) like enfortumab vedotin shows promise for achieving high complete response rates and enabling bladder preservation.
4. Other GU Cancers:
 - Upper Tract Urothelial Carcinoma (UTUC): Kidney-sparing surgeries (endoscopic ablation, distal ureterectomy) are viable for low-risk tumours, reducing morbidity compared to radical nephroureterectomy (RNU).
 - Urethral & Penile Cancer: Partial urethrectomy and penile shaft-sparing techniques are pursued despite higher local recurrence rates, as they preserve urinary/sexual function and do not significantly compromise overall survival compared to more radical resections.
 - Testicular Cancer: Testicular-sparing surgery (TSS) with frozen section analysis is an option for benign tumours or small masses, preserving testicular function and fertility.
 - Adrenal Tumours: Partial adrenalectomy (PA) is most often performed in patients diagnosed with pheochromocytoma, unilateral benign cortisol, androgen, oestrogen, or non-germline mutation driven catecholamine producing tumours to avoid lifelong steroid dependence, demonstrating acceptable recurrence rates while preserving adrenal function.

Conclusion:

The management of GU cancers is increasingly focused on a patient-centric approach that balances oncological efficacy with functional preservation. This is achieved through a combination of surveillance protocols, advancements in minimally invasive and precision surgical techniques, and the integration of novel systemic therapies. Multidisciplinary collaboration is essential for optimal patient selection and treatment planning. Future directions involve further technological innovation (AI, regenerative medicine) and the development of more individualized treatment strategies.

Plenary 20

Bladder pain syndrome: "Hedge your bets"

Dr Amita Jain

Bladder Pain Syndrome (BPS) is a form of chronic pelvic pain. It is defined by persistent pelvic pain, pressure or discomfort perceived to be related to the urinary bladder accompanied by at least one other urinary symptom such as an urgent need to void or urinary frequency. It is diagnosed in the absence of any identifiable pathology which could explain these symptoms. Sometimes a single disorder may be identified as the cause. In other cases, however, pain may be the result of several medical conditions. A systematic approach of evaluation via including relevant investigations should be followed to reach on the correct diagnosis. This can be challenging due to the wide variation in presenting symptoms and lack of clear diagnostic criteria.

Many recent review articles suggest that Hunner lesion phenotype should be excluded from the broad BPS umbrella, as it is characterized by distinct bladder histology, and specific clinical characteristics (older onset age, severe bladder-centric symptoms, reduced bladder capacity, and favorable response to the lesion-targeted therapies). The diagnostic accuracy could be improved by developing an atlas of standardized images of the lesions with the help of pathological correlation. With the same idea, the group the Global Interstitial Cystitis, Bladder Pain Society (GIBS) has worked collectively to systematically review the literature and a consensus on a stepwise technique of diagnostic and therapeutic cystoscopy in cases of BPS has been introduced.

While the presence of bladder beyond symptomatology in Non-Hunner lesion phenotype indicates that it may share the pathogenesis of widely recognized functional somatic syndromes such as chronic fatigue syndrome, irritable bowel syndrome, or fibromyalgia. This finding may have clinical implications to design a successful treatment strategy since Hunner lesion phenotype benefit from specific therapies (fulguration, cyclosporine).

A new phenotyping has been proposed in the same context, by removing the urinary and organ specific domains from UPOINT and adding a Hunner's ulcers (U) domain, yielding 'INPUT': infection, neurologic/systemic, psychosocial, ulcers and tenderness of muscles.

The Multidisciplinary Approach to the Study of Chronic Pelvic Pain (MAPP) Research Network also initiated a Symptom Patterns Study (SPS) to further investigate correlations of Urologic Chronic Pelvic Pain Syndrome (UCPPS) phenotypic characteristics with the response to selected therapies, thus offering important insights for future clinical trial designs.

Symposium 3

The Revolution in Evidence: Game-Changing Clinical Trials in Urology (2015-2025)

Mr Ananda Kumar Dhanasekaran

Prof Joe Philip

Prof Hammad Ather

The past decade, spanning 2015 to 2025, represents arguably the most transformative period in the history of modern urology. This era has been defined by a paradigm shift away from entrenched dogma and toward high-level, practice-changing evidence. In urologic oncology, the advent of immunotherapy and the strategic intensification of systemic therapy have completely rewritten treatment algorithms for prostate, bladder, and kidney cancers, moving from sequential, single-agent therapies to highly effective combination regimens.

Concurrently, the fields of benign urology have seen their own revolution, with a new focus on high-quality, patient-centred data. This includes the rise of minimally invasive surgical therapies for benign prostatic hyperplasia (BPH) that prioritize quality of life and sexual function, as well as critical de-escalation trials in endourology and female urology that challenge long-standing, uncomfortable, and costly practices.

This symposium provides a comprehensive, sub-specialty-based review of the key clinical trials published in this period that have fundamentally altered the standard of care.

Symposium 4

Sustainability in Urology

Miss Tharani Nitkunan

Climate change is a global crisis. Health systems are responsible for 4.4% of global emissions compared with 2.5% from aviation.

The World Health Organisation has formed an Alliance for Transformative Action on Climate and Health (ATACH) with countries committing to build climate resilience and low carbon health systems. UK, Sri Lanka and Australia have all made this commitment. In 2020 the UK's NHS (National Health Service) became the first healthcare system to commit to reaching net zero by 2045. Australia is committed to reach net zero by 2050.

Surgical practice is one of the biggest single causes of health system resource use, accounting for around 27% of NHS England financial spend and an estimated 5.7million tonnes CO₂e per year.

The British Association of Urological Surgeons has committed to supporting its members in embedding sustainable practices at every level of urological care. The BAUS 10-point sustainability plan published in 2025 sets out clear priorities for reducing environmental impact across urological care.

These issues are discussed in this symposium bringing together perspectives from UK, Sri Lanka and Australia.

Dr Ashani Couchman

The healthcare sector in Australia accounts for a significant environmental footprint, with estimates that the system contributes approximately 7 % of the nation's greenhouse-gas emissions and generates large volumes of waste, especially in surgical settings.

Within hospital facilities, operating theatres are a particular hotspot: they may generate at least 20 % of a hospital's waste stream and rely heavily on single-use devices, energy-intensive sterilisation processes, and comprehensive supply chains.

The Royal Australasian College of Surgeons (RACS) has established an Environmental Sustainability in Surgical Practice Working Party and provides resources for surgeons to embed sustainable practice into their work.

At a system level, the Australian Commission on Safety and Quality in Health Care has developed a "Healthcare Sustainability and Resilience" module to guide health-service organisations in integrating environmental sustainability and climate resilience into their safety/quality frameworks.

Despite growing momentum, key barriers persist - entrenched surgical culture prioritising "single-use = sterile", limited staff training on environmental impacts, institutional inertia, and the upfront costs (financial and logistic) of transitioning to circular-economy models.

However, studies suggest that interventions such as improved waste segregation, device re-processing, reusable alternatives, and energy/resource-use audits can deliver both environmental and cost-savings benefits

Looking ahead, we will need to encompass the "triple bottom line of sustainability" -environmentally sustainable, financial sustainable and socially sustainable.

Dr Hilary Fernando

USI lecture

Ergonomics in Robotic Surgery: Safeguarding the Surgeon

Dr Suriyaprakash Vadi

Robotic surgery has revolutionized urological practice, offering superior precision, dexterity, and visualization. However, while patient outcomes have improved, the physical demands on surgeons have evolved in new ways. Prolonged static posture at the console, awkward wrist and neck positioning, and limited movement contribute to musculoskeletal discomfort and fatigue.

Ergonomics, the science of optimizing human performance and safety—plays a critical role in maintaining surgeon health. Proper console adjustment, maintaining neutral spine and wrist alignment, keeping monitors at eye level, and supporting forearms are essential principles. Short “microbreaks” and stretching during lengthy procedures significantly reduce strain and improve concentration.

Studies show that up to two-thirds of robotic surgeons experience some form of musculoskeletal pain, most commonly in the neck, back, and upper limbs. Incorporating ergonomic awareness into training and emphasizing posture optimization can substantially mitigate these risks.

As robotic surgery continues to expand, ensuring surgeon well-being is as important as achieving surgical precision. A focus on ergonomics promotes not only comfort and safety but also sustainability and longevity in surgical careers.

Plenary 22

Surgical management of male genital lichen sclerosis (MGLSc)

Mr Peter Malone

Lichen sclerosis is an inflammatory condition almost exclusively affecting genital skin of both sexes. It is usually managed, initially, by barrier and ultrapotent steroid creams.

It is caused by the trapping of urine between 2 skin layers in susceptible individuals. When medical therapy fails, therefore, the mainstay of surgical management in men is circumcision which prevents occlusion of urine between the glans and foreskin.

Circumcision is within the repertoire of any competent urologist but even the most experienced can run into difficulties when the foreskin becomes welded to the glans by secondary preputial adhesions. Trying to find a plane between the foreskin and glans can be bloody, time consuming and can cause unsightly scarring. Major centres have advocated excision of the fused membrane with glans resurfacing using a split skin graft. Many just perform a partial circumcision excising part of the foreskin down to the point of fusion. A newer alternative is the ROLOCS technique which allows a quick bloodless operation without skin grafting, restoring the coronal sulcus without glans scarring. The technique and the results of surgery are presented.

Urethral involvement can be meatal or extend proximally into the urethra. When the navicular fossa or beyond is involved then a buccal mucosa graft urethroplasty is required. If the narrowing is a purely meatal, however it can be managed more conservatively. Dilatation nearly always fails as does ventral meatoplasty if it is inadequate whereas if the meatotomy is large enough to prevent recurrence, then a hypospadiac meatus is created. A technique of ventral and dorsal meatoplasty is described which minimises the risk of recurrence without the creation of a hypospadiac meatus. The results from 3 European centres are presented.

Lichen sclerosis is premalignant and carcinoma-in-situ a common finding in men with longstanding, uncontrolled LS. The technique of glans resurfacing is described with the split skin graft held in place by a tie over TODGA dressing rather than quilting to allow early mobilisation.

Symposium 5

Urolithiasis

Shaping the future of stone surgery: robotic flexible ureteroscopy

Prof. Anthony Ng

Flexible ureteroscopy has become increasingly common for managing ureteric and renal stones. However, the risk of physical strain and radiation exposure to surgeons during lengthy procedures can be problematic. Additionally, human fatigue and errors may occur during the operation. Therefore, robotic systems have been developed to carry out the procedure, with the aim of improving clinical outcomes and offering better ergonomics for surgeons.

The current data shows that robotic ureteroscopy can achieve outcomes comparable to those of human-performed ureteroscopy. However, cost and economic burden may still pose challenges. The rapid advancement of artificial intelligence may also be integrated into future robotic systems, which could enhance localisation, targeting, and treatment of urinary stones. Hopefully, these semi-automated functions will be useful in further improving surgical outcomes and justifying their clinical value.

Navigating complex renal anatomy in stone disease

Dr Ulhas Sathaye

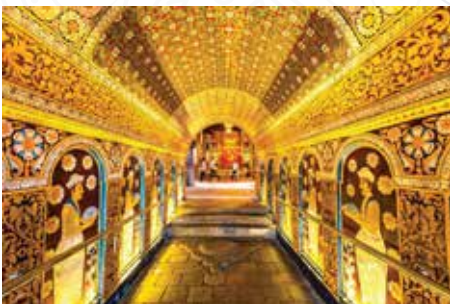
Urolithiasis is a very common occurrence in South Asia. In India there is a stone belt comprising Gujarat, Rajasthan and parts of Maharashtra in the western part of the country.

Stone disease in all forms occurs. Most renal stones which require surgical treatment have a favorable anatomy. However, there are some stones which have a very complex anatomy and test the ingenuity and skill of the treating urologist. Complexities may be of the renal position, renal lie, pelvicalyceal system, vasculature or the cortex.

In this presentation, each complexity is analyzed and techniques to overcome these problems are discussed. Now, with newer armamentarium available, it is possible to navigate these complexities and complete surgery successfully. However, one needs to remember that the surgeon should have a backup plan for any complex renal surgery.

MARVELS OF SRI LANKA

THE TEMPLE OF THE SACRED TOOTH RELIC SRI DALADA MALIGAWA



The Temple of the Sacred Tooth Relic, known locally as Sri Dalada Maligawa, is one of the most sacred and historically significant landmarks in Sri Lanka. Located beside the calm waters of Kandy Lake, it houses the revered tooth relic of Lord Buddha, which has been a symbol of protection and spiritual unity for centuries. The temple's golden roof, carved wooden pillars, and moonstone entrance reflect the finest aspects of Kandyan architecture and craftsmanship. Inside, the rhythmic sounds of chanting monks and the soft fragrance of jasmine flowers create a deeply peaceful atmosphere. Each day, rituals are performed with great devotion, maintaining traditions that have been followed for generations.

During the Esala Perahera festival held annually in July and August, the entire city transforms into a magnificent cultural spectacle. Thousands of dancers, drummers, and beautifully decorated elephants parade through the streets, paying homage to the sacred relic. This temple is not only a place of worship but also a symbol of national heritage and identity, embodying the spiritual heart of the island.

Abstract 1

A preliminary attempt to analyze the gene expression of DNA polymerases in patients with bladder cancer in Sri Lanka

Ramlah Mohamed Kamal, Meran Keshawa Ediriweera, Ajith Peiris Malalasekera, Manjula Wijewardena, Balasubramaniam Sathesan, Tithila Kalum Wethasinghe

Human Genetics Unit, Faculty of Medicine, University of Colombo

Introduction:

Bladder cancer is the eighth most prevalent cancer in Sri Lanka with a high rate of recurrence and morbidity. Bladder cancer is diagnosed using cystoscopy which is an invasive and uncomfortable procedure. The diagnosis is subsequently confirmed by histopathology. During follow-up, patients undergo routine cystoscopy-based examinations to monitor the disease for recurrence. The gene expression of DNA polymerases is known to change during the tumorigenesis of solid tumors however their role in bladder cancer remains unclear. This preliminary study aimed to analyze the gene expression of two DNA polymerases associated with bladder cancer, DNA polymerase beta (POLB) and DNA polymerase delta 1 (POLD1) hoping to validate their use as biomarkers.

Methods:

Midstream urine samples were collected from three healthy volunteers and three patients at the National Hospital, Sri Lanka prior to bladder tumor resection following informed consent. The samples were processed immediately to extract mRNA from the exfoliated urothelial cells. The difference in gene expression of POLB and POLD1 between healthy and cancerous states were analyzed using two-step reverse transcriptase quantitative PCR (qPCR). The fold difference in their expression was calculated against the reference gene glyceraldehyde-3-phosphate dehydrogenase (GAPDH).

Results:

The POLB gene showed an overexpression in patients affected with bladder cancer. The mean fold difference calculated using the $\Delta\Delta C_t$ method was 6.67 in the patient samples compared to the 1.19 of healthy samples. The results were significant at a $p < 0.05$. The data obtained for POLD1 were inconclusive.

Conclusions:

The study demonstrates the overexpression pattern of POLB in the exfoliated urothelial cells in patients with bladder cancer. These findings validate further research into potential of utilizing POLB gene overexpression as a biomarker in the non-invasive diagnosis of bladder cancer. This study is the first of its kind to analyze gene expression of bladder cancer cells in Sri Lanka.

Abstract 2

A Multicenter Experience of Supine Percutaneous Nephrolithotomy (PCNL) in Sri Lanka: Outcomes from Teaching and Peripheral Hospitals

M Sivashankar¹, T Gowribahan²
District General Hospitals of Ampara and Hambantota¹,
Teaching Hospital Jaffna²

Abstract Introduction:

Percutaneous nephrolithotomy (PCNL) remains the standard intervention for large renal calculi. Adoption of the supine approach in Sri Lanka has expanded in recent years, even within peripheral hospitals with limited resources. This multicenter study compares outcomes of supine PCNL performed at Teaching Hospital Jaffna and the District General Hospitals of Ampara and Hambantota over a two-year period, highlighting feasibility, safety, and institutional variations.

Methodology:

A retrospective analysis was conducted on all supine PCNL procedures performed between September 2023 and September 2025. Data included demographics, stone characteristics, operative parameters, tract details, postoperative drainage methods, complications (Clavien-Dindo classification), stone clearance, and hospital stay. All surgeries were performed by two consultant urologists at the three institutions.

Results:

A total of 332 PCNLs were performed—191 in Jaffna and 141 in Ampara/Hambantota. The mean age was 45.3 years (range 2–85) in Jaffna and 49.8 years (range 7–86) in the peripheral centers. Male predominance was noted (61.3% vs 56.0%). Procedures were equally distributed by side in Jaffna (right 50%, left 50%) and slightly right sided in the peripheral group (58.9%). Bilateral procedures accounted for 12.1% in the latter. Average stone size was 2.2 cm in Jaffna and 2.76 cm in Ampara/Hambantota, with staghorn stones comprising 7.9% and 19.9%, respectively. In Jaffna, 24 Fr tracts were used in 92.5% of cases, while peripheral centers showed more variation (30 Fr 42.6%, 26 Fr 23.4%, 24 Fr 30.5%, 22 Fr 3.5%). Most cases were single tract (Jaffna 90.4%, Ampara/Hambantota 91.5%). Mean operative times were comparable (78.8 vs 78 min). Drainage methods differed—DJS used in all Jaffna cases, whereas in Ampara/Hambantota DJS was placed in 84.4%, ureteric catheter only in 8.5%, and 7.1% were tubeless. Stone-free rates were 76.4% in Jaffna and 82.3% in the peripheral group. Complications were mainly minor: Jaffna—Clavien I 81.7%, II 6.3% (blood transfusion 6.3%); Ampara/Hambantota—Clavien I 88.7%, II 7.8% (transfusion 4.3%, UTI 3.5%), III 2.9%, IV 0.7%, V 0%. Mean hospital stay was 4.1 days in Jaffna; in the peripheral centers most patients were discharged on day 2 (86.5%).

Conclusions:

This multicenter analysis demonstrates that supine PCNL can be performed safely and effectively across both tertiary and peripheral hospitals in Sri Lanka. Despite differences in tract size selection and postoperative drainage, complication rates and stone-free outcomes were comparable. Expanding access to minimally invasive endourology in resource-limited hospitals is both feasible and beneficial, provided training and equipment support continue to improve.

Abstract 3

Ovarian Metastasis Masquerading as a Urological Malignancy – An extremely rare presentation.

N A D S Wimalarathne, S.H.M.N.J. Senevirathne, S.H. Somarathne, NJAHD Perera, W.A.M.A. Willaraarachchi

District General Hospital, Kegalle

Metastasis of renal pelvis and ureters are rare, with the most common primary source being breast carcinoma. Ovarian malignancies metastasized into renal pelvis and ureter are extremely uncommon. Ovarian cancers are known to cause external ureteric obstruction through direct invasion or peritoneal spread, however hematogenous metastasis to renal pelvis and ureter is exceptionally rare.

Here we report, a unique case of low-grade serous papillary adenocarcinoma of ovarian origin, metastasizing to the renal pelvis and ureter, mimicking a primary urothelial malignancy. A 58-year-old female was referred with left-sided hydronephroureter, identified during a routine surveillance computed tomography (CT) scan for a previously diagnosed poorly differentiated adenocarcinoma of the right ovary.

Three years before, she had undergone a total abdominal hysterectomy with bilateral salpingo-oophorectomy for a right-sided abdomino-pelvic mass, followed by adjuvant chemotherapy and a subsequent omentectomy with adhesiolysis. Since then, she has been on regular onco-gynaecology follow-up with annual surveillance CT. At the end of two years she underwent left ureteric stenting due to hydronephroureter. At third year follow-up imaging left renal pelvic mass extending into the upper ureter was detected which was suggestive of a primary urothelial carcinoma.

She underwent left-sided ureteroscopy and biopsy was performed from the intraluminal mass. Histopathology revealed a low-grade serous papillary adenocarcinoma, consistent with a metastasis of ovarian origin. Following a multidisciplinary team (MDT) discussion, a left nephroureterectomy with bladder cuff excision was recommended. Unfortunately, our patient declined the surgical option, despite clear explanation of benefit, and opted for a palliative approach to manage disease progression.

In conclusion, we reported exceptionally rare metastases of ovarian malignancy to the renal pelvis and ureter, likely representing hematogenous spread. High index of suspicion and regular surveillance are the key to diagnose such metastasis early and promptly.

Abstract 4

Peripheral Experience in Laparoscopic Urological Surgeries: A Two-Year Review in Resource-Limited Settings

M Sivashankar

District General Hospitals of Ampara and Hambantota

Introduction:

Laparoscopic urological surgery is increasingly becoming standard practice due to its minimally invasive nature and faster recovery. However, its implementation in peripheral hospitals is limited by resource constraints and systemic challenges. This study reports the experience of laparoscopic urological procedures performed by a single surgeon in two peripheral hospitals in Sri Lanka, focusing on case diversity, outcomes, and barriers encountered.

Methodology:

A retrospective review was conducted of all laparoscopic urology cases performed between September 2023 and September 2025 at Ampara and Hambantota hospitals. Data collected included demographics, type of surgery, pathology, tumour or stone characteristics, complication rates (Clavien-Dindo classification), conversion to open surgery, and average hospital stay. Cases were grouped under benign, malignant, stone-related, and reconstructive categories.

Results:

A total of 43 patients underwent laparoscopic urological procedures, including 21 males and 22 females, with a mean age of 49.34 years (range: 19–76 years). Among them, 27 cases (62.79%) were benign, and 16 cases (37.21%) were malignant. Oncological procedures included 10 radical nephrectomies (23.25%) with tumour staging of T1b in 4 cases and T2 in 6 cases, with an average tumour size of 8 cm. Histology showed clear cell RCC in 8 cases and papillary RCC in 2. Additionally, 2 patients underwent partial nephrectomy (4.6%), and 4 patients (9.35%) underwent radical nephroureterectomy for upper tract urothelial carcinoma (2 proximal, 1 mid, 1 lower ureter). Stone surgeries included 2 pyelolithotomies (4.6%)—one involving a 5 cm staghorn calculus and the other a 3cm stone—and 4 ureterolithotomies (9.3%) with an average stone size of 3 cm. Reconstructive procedures included 6 pyeloplasty (13.9%) and 1 vesicovaginal fistula (VVF) repair (2.3%). The average hospital stay was 6 days for malignant cases, 3 days for stone surgeries, and 4 days for reconstructive procedures. In terms of complications, 35 patients experienced Clavien-Dindo Grade I complications (minor, requiring no or minimal intervention), while 7 patients developed Grade II complications requiring pharmacological treatment. Conversion to open surgery was required in 4 cases—2 radical nephrectomies, 1 partial nephrectomy, and 1 pyeloplasty—resulting in a conversion rate of 9.3%.

Conclusions:

Laparoscopic urology is achievable in peripheral hospitals despite several limitations. Major barriers include limited instruments, restricted theatre access, lack of skilled personnel, and pressure to manage backlogged elective cases. With proper planning and training, laparoscopic services can be expanded even in resource-constrained environments.

Abstract 1

Audit on metabolic evaluation in patients with Urolithiasis

A N Chrishan, H. S. U Rathnayake, G T I Gamage, A B U Indrajith, B D M R Chandraguptha , N D Premachandra

Urology unit , Colombo South Teaching Hospital

Background:

Urolithiasis is a common urological condition with significant morbidity. The European Association of Urology (EAU) 2025 guidelines recommend that all stone formers should undergo baseline biochemical assessment and stone analysis, while high-risk stone formers require comprehensive metabolic evaluation, including 24-hour urine studies. This audit is aimed to evaluate adherence to these recommendations among patients managed for urolithiasis at a Urology unit in a tertiary care hospital. Objectives: To assess compliance with EAU 2025 guidelines for biochemical assessment in patients with urolithiasis and identify gaps in current practice.

Methodology:

A retrospective clinical audit was conducted at the Urology unit of Colombo South Teaching Hospital over a period of one month, which included 35 patients with confirmed urolithiasis. Data were collected using a structured questionnaire and analysed using descriptive statistics. Audit standards were derived from EAU 2025 recommendations for baseline and extended metabolic evaluation.

Results:

Majority of patients were males (63%) with a mean age of 55 year. Family history of stone disease was noted in 8.6%. As part of basic biochemical assessment only serum creatinine (88.6%) and urinalysis (94.3%) were assessed in majority of patients. Serum calcium and uric acid each were checked only in 22.9%. Only one patient had stone analysis done. None underwent a 24-hour urine study.. Out of 10 high risk stone formers only 2 had at least completed the baseline biochemical assessment.

Conclusions:

This audit highlights significant gaps between current practice and EAU 2025 guidelines. While renal function and urinalysis were routinely evaluated, metabolic investigations remain under-requested, even in high-risk patients. Non availability of certain tests such as 24 hour urine study and stone analysis in the state sector hospitals is one of the reason behind this. Implementing a standardized stone evaluation checklist, improving clinician awareness, and ensuring access to metabolic testing are essential.

Abstract 6

Laparoscopic dismembered pyeloplasty and pyelolithotomy for a lower moiety pelvi-ureteric junction obstruction in a partial duplex kidney

A B U Indrajith, HSU Ratnayake, SHR Sanjeewa, S Chandrasekera

Colombo South Teaching Hospital

Introduction:

Lower moiety pelvi-ureteric junction obstruction (PUJO) in a duplex collecting system complicated by secondary stone formation is a rare clinical entity.

Case presentation:

A 27-year-old previously healthy male who presented with right loin pain and was found to have a duplex collecting system with PUJO affecting the lower moiety of the right kidney, associated with multiple secondary non-obstructing calculi. The diagnosis of PUJO was confirmed on Tc-99m DTPA renogram. Intraoperative retrograde pyelography demonstrated an incomplete duplex system, with the lower moiety pelvis joining the upper moiety ureter. The patient underwent laparoscopic dismembered pyeloplasty and concurrent pyelolithotomy. Reconstruction was performed as a pelvi-ureterostomy, and the calculi were retrieved using a 16 Fr flexible cystoscope introduced through a 10 mm laparoscopic port. The post-operative course was uneventful.

Conclusion:

Laparoscopic dismembered pyeloplasty with concurrent pyelolithotomy can be offered as a safe and effective minimally invasive procedure for PUJO in incomplete duplex systems. The reconstructive approach should be individualized based on the specific anatomical configuration of the collecting system, to achieve optimal functional and surgical outcomes.

MARVELS OF SRI LANKA

SIGIRIYA – THE ANCIENT ROCK FORTRESS



Rising nearly 200 meters above the central plains, Sigiriya is one of Sri Lanka's most iconic landmarks and a UNESCO World Heritage Site. Known as the "Lion Rock," it was built in the 5th century by King Kashyapa as a royal citadel. The fortress complex is an engineering masterpiece, with moats, ramparts, symmetrical gardens, and intricate frescoes painted on sheer rock walls.



Halfway up the ascent, visitors encounter the famous Lion's Gate — two massive paws carved from the rock, which once guarded a monumental lion structure. At the summit lie the ruins of the king's palace, surrounded by panoramic views of dense forest and farmland stretching to the horizon. The combination of art, architecture, and landscape design makes Sigiriya one of the most extraordinary archaeological marvels in the world. It stands as a testament to Sri Lanka's ancient innovation and aesthetic genius.



Abstract 7

Laparoscopic Partial Cystectomy for Primary Leiomyosarcoma of the Urinary Bladder: A Case Report

H S U Ratnayake, A B U Indrajith, N D Premachandra

Urology unit , Colombo South Teaching Hospital

Introduction:

Non-epithelial tumours of the urinary bladder are rare, with leiomyosarcoma accounting for less than 1% of all bladder malignancies. The diagnosis of mesenchymal bladder tumours is often challenging due to their non-specific clinical presentation.

Case presentation:

A 47-year-old previously healthy male who presented with voiding lower urinary tract symptoms and dysuria for six months. Cystoscopic examination revealed a solid growth at the bladder dome with papillary mucosal projections. Contrast-enhanced CT demonstrated an irregular, enhancing soft-tissue lesion measuring 5.9 × 5.3 cm arising from the superior surface of the bladder, without evidence of extravesical extension or metastasis. Histological evaluation of the transurethral biopsy specimen revealed a spindle cell sarcoma of the bladder. The patient subsequently underwent a laparoscopic partial cystectomy. Histopathological examination of the resected specimen confirmed a high-grade spindle cell sarcoma consistent with leiomyosarcoma of the bladder, with negative surgical resection margins. Follow-up cystoscopy and imaging at six months postoperatively, revealed no evidence of tumour recurrence or metastasis.

Conclusion:

Bladder leiomyosarcoma is a rare entity with non-specific presentation, requiring a high index of suspicion for diagnosis. Laparoscopic partial cystectomy represents a feasible and effective treatment option for tumours located at the bladder dome, enabling oncological control with preservation of native bladder function.

Abstract 8

Brunn's Cyst at the Bladder Neck: A Rare Cause of Bladder Outlet Obstruction

H S U Ratnayake, A B U Indrajith, N D Premachandra

Urology unit , Colombo South Teaching Hospital

Introduction:

Brunn's cysts arise from Brunn's nests which are invaginations of the urothelium into the lamina propria, that become sequestered from the surface epithelium. When located near the bladder neck, these cysts may cause bladder outlet obstruction, although this presentation is rare, with only about ten cases reported in the literature.

Case presentation:

A 43-year-old previously healthy male presented with voiding-predominant lower urinary tract symptoms and a recent episode of acute urinary retention. Transabdominal and transrectal ultrasonography revealed a cystic lesion at the bladder neck, contiguous with the prostate. Flexible cystoscopy demonstrated a cystic lesion at the 12 o'clock position of the bladder neck producing a ball-valve effect. Urodynamic assessment showed a maximum flow rate of 7.6 mL/s with a high post-void residual volume. The patient underwent transurethral deroofting of the cyst, resulting in marked symptomatic improvement. Histopathological evaluation was compatible with a diagnosis of Brunn's cyst.

Conclusion:

Brunn's cysts are an uncommon cause of bladder outlet obstruction, particularly in younger or middle-aged males. Diagnosis can be established with ultrasonography and cystoscopic evaluation. Definitive and curative management involves transurethral deroofting or resection. This entity should be considered in younger or middle-aged males presenting with bladder outlet obstruction, especially with a non-enlarged prostate and a cystic mass at the bladder neck.

Abstract 9

Laparoscopic surgery for Renal Tumours: Experience from a Tertiary Care Hospital in Sri Lanka

H S U Ratnayake, A B U Indrajith, A N Chrishan, B D M R Chandraguptha, N D Premachandra, S Chandrasekera

Colombo South Teaching Hospital

Background:

Minimally invasive surgery is the preferred surgical choice in the management of renal tumours, offering comparable oncological outcomes to open surgeries, with lower morbidity, and cosmetically acceptable surgical scars. Although robotic surgery is gaining worldwide traction, it remains unavailable in Sri Lanka. Specialized urological centres across the country currently offer laparoscopic techniques for renal tumour management. This study reports the experience of laparoscopic renal surgeries performed at a tertiary care hospital in Sri Lanka over an 18-month period.

Methods:

A total of 28 patients, aged 36 – 85 years (mean age 63.8 years; male: female ratio 11:3), underwent laparoscopic renal surgery between April 2024 and October 2025 in Colombo South Teaching Hospital, Sri Lanka. Patient demographics, clinical presentation, tumour characteristics and surgical outcomes were analysed.

Results:

Among the cohort, 55% of tumours were incidentally detected, while haematuria was the most common presentation (75%) among the symptomatic patients. The nephrometric scores were low in 3.5%, intermediate in 42% and high in 53% of cases. Transperitoneal laparoscopic radical nephrectomy was performed in 27 patients, with one case converted to open surgery due to gas insufflator malfunction. One patient with a Bosniak type 3 cyst and a low nephrometric score underwent laparoscopic partial nephrectomy. Tumour sizes ranged from 27 – 110 mm. The mean operative time was 2 hours and 20 minutes and estimated blood loss was less than 100 ml in all except one case. No Clavien-Dindo grade III or higher complications were reported. Four patients developed postoperative lower respiratory tract infections needing antibiotics. The mean post-operative hospital stay was 4.8 days.

Conclusions:

The encouraging outcomes from our clinical experience suggest that Laparoscopic radical and partial nephrectomy can be safely performed for renal tumours of varying complexity in Sri Lankan tertiary care settings and be considered a standard of care, offering favourable perioperative outcomes and short recovery times.

Abstract 10

Young Adult Renal Cell Carcinoma: Experience at a Tertiary Care Hospital in a Developing Country

Saffa Tareen, Hammad Ather, Anika Saeed, Nargis

Aga Khan University Hospital, Pakistan

To assess the radiological and histological features of RCC in patients 18–45 years old who were surgically treated for renal cell carcinoma and to determine the relationship of predefined radiological and histological features to outcomes (survival at 1 year, and documented disease recurrence/progression at 1 year).

Methodology:

This retrospective case series was conducted at a university hospital. All patients aged 18 –45 years who underwent surgical treatment for renal cell carcinoma between January 2006 and January 2023 were included. Patients with incomplete records and those who had undergone outside imaging were excluded. Basic demographics, radiological, and histological features were recorded, and their correlation with the outcome, i.e., recurrence and 1-year survival, was assessed using the Chi-square test or Fisher's exact test.

Results:

A total of 132 young adult RCC patients were included, with clear cell carcinoma being the most common subtype (81%). The one-year overall survival rate was 87%, while 31% of patients experienced recurrence. Well-defined tumor borders, completely exophytic growth, absence of metastasis, and negative surgical margins were significantly associated with one-year survival. High tumor grade, advanced stage, lymphovascular invasion, clear cell histology and intratumoral necrosis were significant predictors of early recurrence.

Conclusion:

Tumor pathology and surgical factors significantly influence early outcomes in young adult RCC. Incorporating key pathological features into a risk-based model may improve prognostication and guide tailored follow-up strategies.

Abstract 11

Treatment of Prostatic Abscess: Case Collection and Comparison of Treatment Methods Single center study

D M D T Disanayaka , EMM Ekanayaka, M K Herath
National Hospital, Kandy

Introduction

Prostatic abscess is an uncommon urologic disease but has a high mortality rate if not treated properly. Diagnosis and proper treatment of prostatic abscesses remains a challenge for physicians. Therefore, we compared data on conservative treatments, transurethral resection of prostatic abscess, and transrectal ultrasound (TRUS)-guided needle aspiration in 21 cases over a 1.5 years period.

Materials and Methods:

The records of 21 patients diagnosed with prostatic abscess by Trans Rectal USS at National Hospital Kandy between November 2023 and April 2025 were retrospectively reviewed. All patients were discharged when the inflammatory markers had normalized and they had been free of fever for 48 hours.

Results:

At the time of diagnosis, the average age of the 21 patients was 59 years (range, 45 to 74 years), the average abscess size was 2.8 cm (range, 2.1 to 5.5 cm). All patients were treated with parenteral antibiotics during their hospital stay with intravenous antibiotics (3rd-generation cephalosporin, fluoroquinolone or Carbapenem monotherapy). Of 21 patients, 15 had diabetes mellitus (71.4%), 8 had hypertension (38%), and 5 (23.8%) had Chronic kidney disease. The most common symptoms were fever 15 (71.4%), perineal discomfort 10 (47.6%), dysuria 18 (85.7%), and urinary retention 3 (14.2%).

Prostatic abscesses were treated by conservative treatment (5 cases), transurethral resection of prostatic abscess (6 cases), and TRUS-guided needle aspiration (10 cases). Pus cultures were positive for E coli in 9 cases (42%) and rest of them had Klebsiella 2 (9%) and Pseudomonas 4 (19%). The average hospitalization stay was 9 days (range, 4 to 14 days). Of the 10 cases who underwent needle aspiration, prostatic abscesses recurred in 5 cases (50%) within 1 month after patient discharge. Patients who underwent TURP did not have recurrence. 3 out of 5 (60%) patients managed with only IV antibiotics recurred within 1 month. No deaths reported during the study.

Conclusions:

Patients with prostatic abscess treated by trans rectal USS guided aspiration and IV antibiotics only had significantly higher risk of recurrence within 1 month.

Abstract 12

A Rare Combination of Congenital Anomalies Presenting with Urinary Stone

V Sanjeev, DMDT Dissanayaka, B. Sathesan
Colombo North Teaching Hospital Ragama

Background:

Ectopic ureteral remnants with cystic dilatation and no renal connection are rare congenital urinary tract anomalies, particularly when associated with a partial duplex system in a solitary pelvic kidney that drains into the contralateral ureter. Calculus formation within such blind-ending ureteric remnants is exceptional and presents both diagnostic and therapeutic challenges.

Case Presentation:

A 45-year-old male presented with intermittent left loin-to-groin pain and episodes of visible hematuria for one year. Urine analysis revealed microscopic hematuria without evidence of infection. Ultrasound demonstrated a solitary pelvic kidney with a dilated left ureter but no hydronephrosis. CT intravenous urography showed a solitary pelvic kidney with a partial duplex system crossing the midline and draining into the contralateral (right) ureter, along with a remnant left ureter that had a blind-ending proximal segment and a distal ectopic insertion into the prostatic urethra with cystic dilatation. A 1 cm floating calculus was identified within the distal pouch of this remnant ureter. Cystoscopy and retrograde contrast studies confirmed the distal ectopic insertion and proximal blind-ending configuration. Endoscopic laser lithotripsy was performed successfully, achieving complete stone clearance without complications.

The patient remained asymptomatic on follow-up. Although definitive surgical excision of the ectopic ureter (open or laparoscopic) was offered to prevent recurrence, the patient declined further surgery.

Conclusion:

This case highlights an extremely rare combination of congenital anomalies—a solitary pelvic kidney with a partial duplex system which drains into the contralateral ureter and a blind-ending ectopic ureteral remnant with cystic dilatation harboring a calculus. Detailed preoperative imaging is essential to delineate the anatomy and guide management. Endoscopic laser lithotripsy provides a safe and effective minimally invasive option for stone clearance in such unusual anatomical variants, while definitive excision of the remnant may help prevent recurrence.

MARVELS OF SRI LANKA

THE DAMBULLA CAVE TEMPLE



The Dambulla Cave Temple, also known as the Golden Temple of Dambulla, is another UNESCO World Heritage Site and one of the most awe-inspiring religious monuments in Sri Lanka. Perched on a massive granite outcrop, it features five interconnected caves filled with over 150 statues and exquisite murals of Lord Buddha and Buddhist deities.



These paintings, some dating back more than two thousand years, cover the ceilings and walls, transforming the interior into a living art gallery of ancient devotion. Each chamber glows with the soft light of oil lamps, highlighting the faces of serene Buddha statues carved directly into the rock. The temple complex offers panoramic views of the surrounding countryside, making it both a spiritual retreat and a historical treasure.

Abstract 13

A Rare Mimicker of Bladder Malignancy: Malakoplakia

V Sanjeev, DMDT Dissanayaka, B. Sathesan

Colombo North Teaching Hospital Ragama

Background:

Malakoplakia is a rare chronic inflammatory condition caused by defective bacterial phagocytosis, leading to the accumulation of Michaelis–Gutmann bodies within macrophages. It often presents with nonspecific urinary symptoms and can closely mimic malignancy clinically, radiologically and endoscopically resulting in frequent misdiagnosis. Greater clinical awareness and exposure to such cases are essential to improve timely diagnosis and appropriate management.

Case Presentation:

A 68-year-old female presented with lower abdominal pain, dysuria, urgency, and frequency for 3 months duration. She was initially treated with antibiotics for a culture-positive urinary tract infection; however, her symptoms persisted despite resolution of the infection. Ultrasound imaging revealed a bladder lesion suspicious for malignancy. Cystoscopy showed a suspicious lesion on the left lateral wall of the bladder. Transurethral resection of the mass was performed, and histopathological examination demonstrated aggregates of macrophages containing Michaelis–Gutmann bodies, confirming the diagnosis of malakoplakia of the bladder. The patient remained asymptomatic at follow-up.

Conclusion:

This case highlights a rare presentation of bladder malakoplakia mimicking malignancy. Careful histopathological evaluation is crucial for accurate diagnosis and to avoid unnecessary radical interventions for this benign condition.

Abstract 14

A Rare Encounter of Fungal Perinephric Abscess Following Percutaneous Nephrolithotomy in a Well-Controlled Diabetic Patient on Empagliflozin

D.M.D.T. Disanayaka, Ekanayake E.M.M., Herath M.K

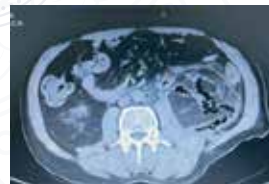
Department of Urology, National Hospital Kandy, Sri Lanka

Introduction

Emphysematous pyelonephritis (EPN) is a life-threatening necrotizing infection of the renal parenchyma and surrounding tissues characterized by gas formation within the kidney or perinephric space. It is most commonly caused by *Escherichia coli* and other bacterial pathogens. Fungal etiology, though rare, has been reported with *Candida albicans*, *Candida tropicalis*, *Candida glabrata*, and *Cryptococcus*. We present a rare case of fungal EPN caused by *Candida albicans* following percutaneous nephrolithotomy (PCNL) in a well-controlled diabetic patient on Empagliflozin.

Case Presentation:

A 51-year-old male with a 10-year history of well-controlled type 2 diabetes mellitus (HbA1c 6.0%) on Metformin and Empagliflozin presented with a left partial staghorn calculus (2.6 × 1.4 cm). He underwent an uneventful prone PCNL, with complete stone clearance. On postoperative day three, he developed fever, flank pain, tachycardia, and hypotension. Laboratory tests revealed neutrophilic leukocytosis and elevated CRP(21,000 & 300). CECT imaging confirmed EPN with perinephric gas and fluid collection. Despite broad-spectrum antibiotics and early surgical drainage, his condition worsened until pus cultures revealed *Candida albicans*. Intravenous Caspofungin was initiated and continued for 14 days, leading to marked clinical improvement. The patient was discharged in stable condition after removal of the ureteric stent after 14 days.



Discussion

EPN is most frequently associated with bacterial infections in diabetic patients; however, fungal causes are increasingly recognized, particularly in those receiving SGLT2 inhibitors like Empagliflozin, which may predispose to genitourinary fungal infections. Prompt imaging, aggressive source control through drainage, and targeted antifungal therapy are critical for recovery. This case highlights the need for heightened vigilance regarding fungal infections in diabetic patients undergoing urological procedures, especially those on SGLT2 inhibitors.

Abstract 15

A single centre analysis of the quality of resection of TURBT and a descriptive analysis of the histological variants in patients investigated for macroscopic hematuria

B Pragalathan, M.Jayasinghe

Colombo North Teaching Hospital, Ragama

Introduction:

Bladder cancer is the tenth most common malignancy worldwide and the most common malignancy involving the urinary system. The most common presenting symptom of bladder cancer is gross haematuria.

Methods:

A sample size of 99 patients who presented with visible haematuria was electively assessed using Trans urethral resection of bladder tumour performed over a period of two year at CNTH Ragama. The histology was then subsequently traced and a descriptive analysis of the histological subtypes was performed. The quality of resection was assessed based on whether detrusor muscle was seen or not and all TURBTs included in our cohort were first look TURBTs, TURBTs for tumour surveillance were excluded.

Results:

Out of the patients investigated 84% were males with a mean age of 65 years in our total sample size. 90% were of urothelial origin, 6% of squamous and 3% adenocarcinoma. 26% revealed muscle invasive bladder cancer while detrusor muscle was seen in 78% of our resection specimens. Redo TURBT done in 6 weeks for patient whose specimen not contain detrusor muscle. 9% was upgraded to muscle invasive in redo TURBT.

Discussion:

TURBT is a diagnostic as well as a therapeutic procedure in Ta/T1 bladder carcinoma. The absence of detrusor muscle in the specimen carries a high risk of early recurrence, residual disease and tumour under staging. The presence of detrusor muscle is seen as an indicator of the quality of bladder resection. A second look TURBT is recommended in select patients after 4-6 weeks as muscle invasion is detected in 25% of initial resections deemed T1.

Abstract 17

Impact of Bladder Removal in Multi-visceral Pelvic Exenteration for Advanced Malignancies of the Pelvis

N Sharma, N Ganesh, J R Vishnoi, D R Poonia

All India Institute of Medical Sciences, Jodhpur (India)

Pelvic exenteration is a radical yet potentially curative surgery for advanced or recurrent pelvic malignancies, often involving bladder removal during anterior and total exenterations. This procedure presents significant functional and reconstructive challenges.

This study retrospectively analyzed 63 patients who underwent pelvic exenteration for various pelvic malignancies in our department between 2019 and 2024. Among them, 25 patients had radical cystectomy as a part of the exenteration. The mean age was approximately 54 years, with a predominance of females.

The main indications included cervical, rectal, ovarian, and bladder cancers. Most surgeries were open, with some minimally invasive techniques employed.

All patients received ileal conduit urinary diversion, with some requiring fecal diversion. The overall postoperative complication rate was nearly 30%, with major complications in 7 patients, primarily wound infection, abdominal collections, flap issues, thromboembolism, and ileal conduit leaks. Mortality was low, with three deaths within 90 days post-surgery.

Despite the high morbidity, pelvic exenteration offers a vital curative option for carefully selected patients with advanced pelvic tumors, requiring thorough perioperative planning and long-term follow-up.

Abstract 19

Rethinking the Role of Restaging TURBT in the Era of HoLERBT: A Comparative Prospective Study

Kalandi Barik, M K Das, S Mandal, M Yadav, S Tripathy, P Nayak
AIIMS, Bhubaneswar Odisha, India

Introduction:

Bladder cancer is one of the most prevalent malignancies worldwide, with non-muscle invasive bladder cancer (NMIBC) constituting nearly 70–75% of cases. The standard of care for NMIBC is transurethral resection of bladder tumor (TURBT). Restaging TURBT, typically performed 2–6 weeks post-primary TURBT for high-risk NMIBC (T1, high-grade), has traditionally served to detect residual tumors and mitigate the risk of under-staging. However, advances in surgical techniques, particularly Holmium Laser En-bloc Resection of Bladder Tumor (HoLERBT), have challenged the necessity of routine restaging TURBT in all patients. This study compares bipolar TURBT and HoLERBT in terms of rates of residual disease, recurrence-free survival (RFS) and evaluates the contemporary necessity of restaging TURBT.

Materials and Methods:

This prospective cohort study was conducted at a tertiary care center between January 2022 and June 2024. A total of 78 patients, diagnosed with primary NMIBC, underwent bipolar TURBT and 39 patients underwent HoLERBT. Baseline demographics, tumor characteristics (size, multiplicity), comorbidities, addiction history, operative details, pathology, and follow-up data were collected from clinical records. The findings of restaging TURBT were extracted from histopathological data. Recurrence was defined by biopsy-confirmed diagnosis of 'recurrent bladder tumor.' RFS was calculated from initial surgery date to recurrence diagnosis. Recurrence data excluded patients with cystitis or unrelated findings. Statistical analysis was performed using Mann-Whitney U test and chi-square tests, with $p < 0.05$ considered statistically significant.

Results:

Of the 117 study patients, 39 underwent HoLERBT and 78 underwent bipolar TURBT. The groups were comparable in terms of patient demographics, comorbidities, and tumor characteristics. The mean tumor size was 23.7 mm in HoLERBT group and 27.9 mm in bipolar TURBT group. Restaging TURBT revealed residual tumor in 4 patients (5.1%) in the bipolar TURBT group and in 1 patient (2.6%) in HoLERBT group. This suggests a trend towards lower residual disease in the HoLERBT group. Recurrence occurred in 7 patients (8.9%) in bipolar TURBT group and 2 patients (5.1%) in HoLERBT group. The median RFS was 9.2 months in bipolar TURBT group and 10.68 months in HoLERBT group. The difference was not statistically significant ($p = 0.889$), but the trend favored HoLERBT arm.

Conclusion:

With growing experience in HoLERBT, routine restaging TURBT may not be universally required, particularly in well-selected NMIBC patients. Our prospective study demonstrates reduced restaging positivity and recurrence with HoLERBT, advocating for its broader adoption and re-evaluation of restaging protocols.

Abstract 20

Comparison of the efficacy of a combination of topical Diltiazem gel, Diclofenac Suppository, and Periprostatic Nerve Block (PPNB) with periprostatic nerve block alone for periprocedural pain control during Transrectal Ultrasonography (TRUS)-guided biopsy of the prostate: a Single-blinded, Double-arm Randomized Controlled Trial

Kalandi Barik, M K Das

AIIMS, Bhubaneswar Odisha, India

Background:

TRUS-guided prostate biopsy is the gold standard for diagnosing prostate cancer.[1] But it is associated with significant procedural pain leading to significant patient anxiety, particularly during probe insertion. A variety of techniques have been described to reduce the pain ranging from application of anaesthetic gels to nerve blocks. [2,3] While PPNB effectively reduces biopsy-related pain, it has limited impact on discomfort from probe insertion.

Objective:

To evaluate whether the combination of topical diltiazem gel and diclofenac suppository with PPNB offers superior periprocedural pain control compared to PPNB alone.

Methods:

This single-blinded, double-arm Randomized Controlled Trial included 48 (24 in each group) consented patients aged ≥ 18 years undergoing TRUS-guided prostate biopsy. Participants were randomized into two groups.

Group-1 (Control):

Non-medicated Gel (30 min prior to biopsy) + PPNB (with 1% lignocaine inj., 5 ml on both sides, by using 22G Chiba needle just before taking biopsy cores with 26 cm long, 18G Semi-automatic Biopsy Gun).

Group-2(Study):

Topical Diltiazem Gel (2%, 2ml) + Diclofenac suppository (100 mg) + PPNB Pain was assessed using Visual Analogue Scale (VAS) during probe insertion and while taking biopsy. Secondary outcomes included procedure duration, bleeding, and infection rates.

Results:

The mean VAS score during probe insertion was significantly lower in Group 2 (3.58 ± 1.018) compared to Group 1 (7.63 ± 1.056), $p < 0.001$. Pain during biopsy showed no significant difference between the groups ($p = 0.136$). No significant differences were found in mean procedure duration, blood loss, or infection rates. No serious adverse effects were observed.

Conclusion:

Adding topical diltiazem and diclofenac suppository to PPNB significantly reduces pain of probe insertion during TRUS-guided prostate biopsy. This combination is safe and effective, and can be recommended for improved patient comfort during the procedure.

MARVELS OF SRI LANKA

THE HANTHANA MOUNTAIN RANGE AND THE CEYLON TEA HERITAGE



Beyond the city limits of Kandy lie the misty peaks of the Hanthana Mountain Range. These hills are famous for their natural beauty and their connection to Sri Lanka's world-renowned tea industry. The slopes are covered with emerald-green tea plantations that date back to the nineteenth century, when Ceylon Tea first became a global symbol of quality.



At the base of the mountains stands the Ceylon Tea Museum, located in a restored colonial-era factory. Inside, visitors can see historical tea-making machinery, photographs, and exhibits that tell the story of the pioneers who shaped the tea trade. The museum also offers the opportunity to taste freshly brewed Ceylon Tea while enjoying views of the lush valleys below. For those who love nature, Hanthana offers scenic hiking trails that lead to lookout points where mist drifts across the hills at sunrise. The experience combines history, agriculture, and natural wonder in a way that perfectly represents the charm of Sri Lanka's hill country.



Abstract 21

Enhancing Precision and Safety in Challenging Upper Pole Punctures for PCNL: A Prospective Analysis of the Valsalva Maneuver.

Z Solangi, J Altaf, I M T Jatoi

Department of Urology(Unit 1), Liaquat University of Medical & Health Sciences, Jamshoro

Introduction:

Percutaneous nephrolithotomy (PCNL) has long been the preferred procedure for treating big kidney stones. However, gaining access to the upper pole calyx during PCNL can be particularly difficult, raising the risk of complications such as pleural injury or hemorrhage while also lengthening the surgery. This study investigates the possibility of using the Valsalva maneuver—a technique routinely used to control intrathoracic pressure—to improve the accuracy and safety of upper pole punctures in these difficult situations.

Methods:

The prospective study comprised 300 patients who had PCNL with upper pole access between 2021 and 2024. These patients were separated into two groups: Group A (150 patients), who employed the Valsalva maneuver during the puncture phase, and Group B (150 patients), who used the usual puncture procedure. We assessed numerous clinical outcomes, including puncture accuracy, access time, total procedure duration, radiation exposure (measured by fluoroscopy time), and any intraoperative or postoperative problems. In addition, we examined hemoglobin levels before and after surgery to determine blood loss, hospital stay length, and stone removal success.

Results:

In Group A, patients who performed the Valsalva maneuver had a greater rate of successful puncture accuracy (92% vs. 78% in Group B). In Group A, the time necessary to get access to the higher pole was reduced by around 25%, making the process faster. There were significantly fewer problems in this group, with pleural injuries occurring in only 3% of cases, as opposed to 12% in Group B. Importantly, patients in Group A were exposed to less radiation since the fluoroscopy duration was shorter, and the entire operational time was lowered. Blood loss, as measured by hemoglobin drop, was lower in Group A, and these patients recovered faster, as demonstrated by shorter hospital stays and fewer postoperative problems like pneumothorax or infections. In terms of stone clearance, both groups had identical success rates, with Group A patients recovering faster and having fewer remaining stones.

Conclusions:

This study suggests that the Valsalva maneuver can significantly enhance both the safety and precision of upper pole punctures in PCNL, particularly in challenging cases. By improving access time, reducing the risk of complications, and promoting faster recovery, this simple yet effective technique may prove to be a valuable addition to standard PCNL procedures. Further studies could explore its broader application across various urological surgeries.

Abstract 22

Predictive Factors for Clinical Outcomes of Povidone-Iodine Sclerotherapy in Filarial Chyluria: A Single-Center Study in an Endemic Region

Vipin Chandra, Naveen Kumar, Kamlesh Gunjan, Nitish Kumar, Saket Singh

Background:

Filarial chyluria is a significant cause of morbidity in regions endemic to lymphatic filariasis (LF). Endoscopic sclerotherapy is the primary treatment for medically refractory cases; however, factors predicting its success remain poorly understood. This study aimed to retrospectively identify predictive factors for the outcomes of endoscopic sclerotherapy using 0.1% povidone-iodine (PI).

Methods:

This retrospective observational study enrolled 142 patients with chyluria who were treated at a single tertiary centre. All patients underwent endoscopic renal pelvic instillation sclerotherapy (RPIS). The primary outcome was treatment success, defined as the resolution of chyluria at the final follow-up visit. The cohort was followed for six months. Demographic, clinical (chyluria grade, efflux laterality, and symptom duration), and procedural variables were analysed. Univariate and multivariate analyses were performed to identify independent predictors of treatment resolution.

Results Of the 142 patients,

118 (83.1%) achieved resolution of chyluria, while 24 (16.9%) did not. Univariate analysis revealed that resolution was significantly associated with a lower clinical grade (Grade I–II), shorter symptom duration (<1 year), history of prior medical/dietary therapy, unilateral chylous efflux, and the need for multiple instillations ($p < 0.05$ for all).

In the multivariate analysis, three factors emerged as significant independent predictors of treatment resolution:

- Grade I–II chyluria (Odds Ratio [OR] 8.5; 95% Confidence Interval [CI] 2.14–33.8; $p < 0.001$)
- Symptom duration <1 year (OR 3.2; 95% CI 1.16–8.8; $p = 0.003$)
- Presence of unilateral efflux (OR 2.8; 95% CI 1.03–7.6; $p = 0.01$)

Conclusion:

This study identified lower clinical grade (I–II), shorter symptom duration (<1 year), and unilateral chylous efflux as strong independent predictors of successful outcomes after povidone-iodine sclerotherapy. These findings provide valuable prognostic information for patient counselling and support a risk-stratified approach to managing filarial chyluria.

Abstract 23

Improving Quality of Transurethral Resection of Bladder Tumor (TURBT) Documentation: A Four-Year Closed-Loop Clinical Audit

Areeba Ahmed, Wajahat Aziz, Zubaid Moazzam Sheikh

Aga Khan University Hospital, Pakistan

Background:

Transurethral resection of bladder tumor (TURBT) is the cornerstone of bladder cancer management, yet its quality often varies. Incomplete resections or poor documentation can lead to inaccurate staging and suboptimal treatment decisions. The European Association of Urology (EAU) guidelines emphasize complete tumor removal, inclusion of detrusor muscle, and thorough operative documentation. This study reports a four-year closed-loop audit evaluating how targeted interventions improved TURBT practice and reporting in a tertiary care center.

Methods:

We reviewed primary TURBT procedures during July–December 2020 (Cycle 1, n=52) and July–December 2024 (Cycle 2, n=55). Following Cycle 1, interventions included structured operative templates, mandatory bladder diagrams, and a histopathology proforma. Compliance with EAU standards was compared across cycles.

Results:

Marked improvements were seen across key parameters. Documentation of tumor size rose from 44% to 76% ($p=0.001$), and bladder diagram use from 92% to 98%. Presence of detrusor muscle in specimens increased from 83% to 95%. Histopathology reporting improved dramatically: tumor stage documentation, lamina propria status and muscle reporting. We also identified areas of further improvement, such as documentation of carcinoma in situ.

Conclusions:

Introducing structured templates and feedback cycles transformed TURBT documentation and reporting, nearly doubling compliance across several critical parameters. This simple, low-cost approach demonstrates how focused audits ensure more accurate staging for bladder cancer patients.

Abstract 24

Primary urothelial carcinoma of an ileal conduit: six decades after childhood bladder exstrophy surgery: a rare and late complication

Areeba Ahmed, Imran Khan Jlabani, Sameen Nasir, Amna Qadri

Aga Khan University Hospital, Pakistan

Urothelial carcinoma is a highly aggressive malignancy, particularly in patients with bladder exstrophy and early urinary diversion. We emphasize the importance of regular surveillance, including periodic endoscopic evaluation of the ileal conduit and urine cytology, to enable early detection and timely intervention. Implementing such measures could significantly improve patient outcomes, even in complex cases like ours, where multidisciplinary management involving urologists, oncologists, and interventional radiologists is essential for optimal care.

Background

Bladder exstrophy is a rare congenital anomaly that requires surgical reconstruction or urinary diversion early in life. While adenocarcinoma is the most commonly associated malignancy, primary urothelial carcinoma arising within an ileal conduit without any evidence of disease in the entire urinary tract is exceedingly rare and has never been reported before.

Case presentation

We report a case of a 64-year-old male with a history of bladder exstrophy managed with an ileal conduit in early childhood. He presented with intermittent bleeding from his urinary stoma, and subsequent evaluation revealed a high-grade invasive urothelial carcinoma arising within the ileal conduit, without involvement of the ureteric orifices or native urinary tract. Metastatic spread to the regional lymph nodes and liver underscored the aggressive disease course. Despite prompt initiation of chemotherapy and later immunotherapy, the disease progressed rapidly, leading to severe complications, including bilateral hydronephrosis requiring percutaneous nephrostomy. The patient was ultimately transitioned to palliative care.

Conclusion:

We report a case of a 64-year-old male with a history of bladder exstrophy managed with an ileal conduit in early childhood. He presented with intermittent bleeding from his urinary stoma, and subsequent evaluation revealed a high-grade invasive urothelial carcinoma arising within the ileal conduit, without involvement of the ureteric orifices or native urinary tract. Metastatic spread to the regional lymph nodes and liver underscored the aggressive disease course. Despite prompt initiation of chemotherapy and later immunotherapy, the disease progressed rapidly, leading to severe complications, including bilateral hydronephrosis requiring percutaneous nephrostomy. The patient was ultimately transitioned to palliative care.

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