Urological Association of Uttar Pradesh

UAU Newsletter

May 2016

Website: www.uauonline.in
Email: office.uau@gmail.com

President's Message

Respected Seniors & Dear friends,

It is a matter of honour and humility for me to write my first message of President of Urological Association of Uttar Pradesh and Uttarakhand. I would like to seek blessings of all seniors and active participation from members so that the flagship of UAU can be carried forward. I wish to salute all past presidents and secretary who have brought our association to National front.

Each year begins with a hope and renewed determination to succeed. We have many activities planned for the year and I would like all of you to volunteer for active participation, to contribute in learning, teaching & developing a strong foundation of Urology in this part of the country with strong bonds of Fellowship.

I would like to thank you all for a overwhelming attendance and active participation in the recently concluded 3rd Annual meet of UAU in Kanpur. It was a nightmare to see advances happening around us & active deliberations from Urologists across the two States. We give credence to Kanpur team who kept the attendees busy till the last event.

In this year we look forward for more active participation from all quarters of the State and request for Local CME's, Workshops, Camps at District level etc; so as to aware the public in general about the Urological diseases and the make them aware about the advantage of getting treated by a Urologist. The UAU will definitely come forward and join hands with the local units in this endeavor. No organization can grow without its members, so it is humbly requested to increase our membership. As the technology and newer gadgets are coming fast, it is difficult to cope up especially for the private sector, hence it has been decided to develop 'Centre of Excellence' for different procedures and subspecialties. All the members & Institutions are requested to volunteer, both to host and participate in learning newer technology so that the benefit can be passed to all. A medico-legal and service cell is also being proposed & very soon we will be announcing the nodal persons. The need to train our Paramedical staff and update them from time to time is also the need of hour. Unlike, Doctors they are not exposed to updates which becomes deterrent in the growth of speciality. There is a need to organise UAU accredited updates for paramedical staff which will be our next priority. The City Chapters should also be developed across the two states.

In the end I would like to offer my unrelenting support to all the members at any time and seek their advice to make our Association more vibrant.

With Best Wishes

Dr. Vinod Kr. Mishra, President UAU
M.B.B.S., M.S.(Surgery), M.Ch.(Urology)
F.I.M.S.A, F.I.C.S.
Kanpur Urology Center
Mobile: 09839068697

Hon. Secretary's Message

This newsletter is an opportunity to address my esteemed colleagues who would by now must have started their professional work after being recharged with a well conducted annual UAU conference at Kanpur.

The previous teams of Dr Anil Elhence, Dr Anil Sanwal & Dr M. S. Ansari have set a great benchmark for this budding organization and the new team must plan to maintain it & take it to better heights.

To start with I would like everybody to participate in increasing the membership of our association so that all urologists in UP & Uttarakhand become active members of the association. This would help in exchange of new ideas and also awareness among people about this superspecialty.

The association would appreciate that members come forward for active participation in academics, discussion and also start taking responsibility in the organization of the association. This would promote smooth future growth of the association.

As the numbers of urologists increase, it is imperative that city chapters are established so that a good organizational framework is developed which can then take up the responsibility of hosting various CMES workshops & annual conferences.

All of us have realized at conferences we attend that many a times the series that is presented is much smaller than our own or a new technique that is publicized is already being done by some of us in some form but never took time to publish it. Publication or presentation is an active form of CME and should be taken up actively to promote the specialty and knowledge. I suggest that our members involve themselves in this activity wholeheartedly.

I look forward to active guidance from our senior colleagues & full participation of younger colleagues to make this young organization perform rapidly to make a mark of its own amongst the urological fraternity of India.

Dr Neeraj K Agrawal
Hon. Secretary UAU
M.S. M.Ch (Urology), MBA (Healthcare Servics)
Neeraj Life Care & Stone Centre
DD Puram, Ektanagar Road
Bareilly 243122
M9837057929

UAU Executive Council

President
Dr V K Mishra, Kanpur
Email: mishravk2k@hotmail.com

President Elect
Dr U S Dwivedi, Varanasi
Email: udaishankarbhu@gmail.com

Imm. Past President
Dr Anil Elhence, Meerut
Email: anil@elhence.com

Hon. Secretary
Dr Neeraj Agarwal, Bareilly
Email: drnkabr2@gmail.com

Hon. Treasurer
Dr Vijay Bora, Agra
Email: vijaybora@gmail.com

Members:
Dr Sanjay Goyal, Dehradun
Email: drsanjayuro@yahoo.com

Dr Sameer Trivedi, Varanasi
Email: drsameertrivedi@gmail.com

Dr Dilip Chaurasia, Allahabad
Email: dilipchaurasia@yahoo.com

Dr S N Sankhwar, Lucknow
Email: sankhwarsn_sn@yahoo.com

Dr Apul Goel, Lucknow
Email: drapul.goel@gmail.com

UAUCON 2017

UAUCON 2017, Bareilly - 25th & 26th March 2017

Minutes for the General Body Meeting of UAU at UAUCON 2016, Kanpur – 9th April 2016

1. Roll Call

Dr A K Sanwal, Hon. Secretary UAU urged all the members to sign the members' attendance register and the meeting then started on a positive note.

2. President: Opening Remarks

Dr. Anil Elhence, President UAU invited all the members to the third general meeting of UAU and to have a positive discussion. He expressed that there were certain things discussed in the council meeting one of which was to identify centres which would volunteer to start training for various sub specialities. He invited all the members of UAU who feel that they or their centre can provide training in sub specialities like RIRS, PCNL or any other speciality to come forward and start the training programs for members and UAU will accredit them for concentrated training in the said sub speciality.

3. Approval of Agenda

The agenda for the General Body Meeting was approved unanimously.

4. Honorary Secretary's Report

Dr. A. K. Sanwal presented his report on the activities of the society during the previous year. He reported that after UAUCON 2015 the society had two mid term meetings, the first being held at Kanpur under the able guidance of the President Elect, Dr. V. K. Mishra which was very well attended and had the workshop on Urethroplasty by Dr. Sanjay Kulkarni which was very well appreciated by the members. The second midterm meeting was held at Dehradun by Dr. Sanjay Goyal and was based on video presentations on various aspects of urology surgery. It was also very well appreciated.

He reported that the society is growing in numbers, though slowly. He opined that there are still many urologists in UP who are members of USI but are not members of UAU. He urged all such members to become members of UAU.

He then expressed that for this conference care was taken as to the scientific content of the program and to include live workshops and to make away with the formal functions of the conference and focus more on the scientific content with lively interactions.

5. Honorary Treasurer's Report

Dr M S Ansari was awaited to present his report but he did not present his report.

6. Approval of new members

Dr Sanwal reported that there were three new membership applications this year. All the applications were checked and approved as members.

7. Report & Finances of the 2nd Annual Conference of UAUCON 2015, Lucknow

Dr Sanwal informed that Dr Ansari is not available to present his report but he had expressed that from UAUCON 2015, Rs 30,000 is being contributed to UAU. The general body appreciated the contribution.

8. Contribution to UAU from UAUCON Meerut

Dr. Anil Elhence apologized for the delay in contribution to UAU from the first UAUCON in Meerut but informed that the Meerut Urological Association has contributed Rs. 2 Lakhs towards UAU from the savings of UAUCON. He then presented the cheque to the society. The general body applauded the contribution.

Dr. V. K. Mishra then announced that he will be presenting a cheque of Rs. 25000/- towards UAU as contribution from the Urethroplasty workshop held earlier at Kanpur. The general body appreciated the contribution.

9. Programs & Workshops for 2016

Dr. Sanwal informed the general body that Banaras, Gorakhpur and Allahabad has tentatively approached UAU to hold workshops this year and the dates and venue for the same will be announced in due course of time. He encouraged the members to hold theme based meetings.

10. Venue of 2017 and 2018

Dr. A. K. Sanwal informed that as already decided in the last meeting, the venue of the next UAUCON will be Bareilly and Dr. Neeraj Agarwal will be the organizing secretary. He will also be then the Hon. Secretary of the UAU. Dr. Anil Elhence then informed that the tentative dates of the conference would be 25th and 26th of March 2017.

Dr. Sanwal then informed that Banaras has proposed to hold the UAUCON 2018. He requested the general body for approval of the same. The General Body approved Banaras as the venue of UAUCON 2018. Dr. Sanwal informed that Dr. Sameer would be the organizing secretary.

11. Letters from Members of the UAU

Dr. A. K. Sanwal informed that there were demands by the members to form a legal cell as well as a service cell and it was discussed in the council meeting and it was decided that one of the member of the council would be given the duty of legal cell and another member would be given the duty of the service cell.

12. Awards and Prizes

Dr Sanwal informed the council that this year it was decided to honour one of the senior urologists from the state Dr V N P Tripathi with the Life time Achievement Award who was to attend the meeting but could not come due to his ailments. He informed that Dr. Tripathi had sent in a message for the same which was then read to the general body. Dr Sanwal then requested Dr. Elhence to hand over the award to Dr. Dwivedi on behalf of Dr. V. N. P. Tripathi.

Dr. Sanwal then invited Dr. V. K. Mishra, President Elect UAU and the election officer to announce the new council to the general body as the present council had finished its term. Dr Sanwal expressed his gratitude and pride to be associated with the society as its founding council members.

Dr. Mishra then announced the new council. He announced that Dr U S Dwivedi has been elected for the post of President Elect unopposed; Dr. Neeraj Agarwal has been elected for the post of Hon. Secretary unopposed; Dr. Vijay Bora has been elected for the post of Hon. Treasurer unopposed; the council members would be Dr Dilip Chaurasia, Dr S N Sankhwar and Dr. Apul Goel. He expressed and hoped that the society will grow to greater heights under the leadership of the new council.

13. Constitutional Amendments

Dr Anil Elhence announced that a constitutional amendment was discussed in the council that the term of the Hon. Secretary and Hon. Treasurer to be for three years instead of the present two year term and to introduce two posts of Secretary Elect and Treasurer Elect. Dr. Elhence informed that the tenure for the present Secretary and Treasurer would be for two years and from next council onwards the tenure would be for three years.

He then asked for the general body approval for the same. The same was approved unanimously.

In end Dr. Sanwal thanked Dr. Aneesh Srivastava, Dr. Madhu Agrawal, the founding members and Dr. Diwaker Dalela, Dr. Elhence and Dr. Ansari for the support and encouragement received during his tenure.

14. Vote of Thanks

Dr. Elhence then thanked all the members for a lively general body meeting and announced the general body meeting closed.

Long Live UAU!!!

Expert's Speak

TITLE: "Modern Management of Vesico-Ureteric Reflux"

Author: Minu Bajpai

Address for correspondence:

Dr. Minu Bajpai, MS, MCh, PhD, FRCS, FACS, FAMS, National Board
Fulbright Scholar (USA), Commonwealth Fellow (UK) & Raja Ramanna Fellow (Science & Technology)
Professor of Paediatric Surgery, All India Institute of Medical Sciences, New Delhi
Email: bajpai2@hotmail.com ; Website: http://www.paediatric-urologyonline.org/;

Primary Vesicoureteric reflux (VUR) is seen in 1% of the general population. It is seen in 37% of children and up to 50% of neonates who present with UTI. The association of the triad of **UTI-VUR-nephropathy** forms the basis of treatment of VUR. However, lack of application of appropriate tools in the studies has led to inconsistencies in management protocols.[1-3] In vesico-ureteral reflux, some urine flows back into the ureters during the act of micturation depending upon the grade of reflux. VUR may resolve spontaneously with increasing age, albeit slowly. At the end of 5 years Grades 1 and 2 reflux persist in 37% of children and at 10 years in 25%. During the corresponding periods, Grades 3 to 5 reflux persist in 48% and 23% respectively.[4] Negative prognostic factors for resolution are recurrent UTIs and bladder dysfunction. Bilateral reflux resolved more slowly than unilateral reflux and it resolved more rapidly in boys than in girls. Antibiotic prophylaxis has been widely employed in the hope of prevention of pyelonephritis.[5] However, pyelonephritis occurs despite antibiotics.

Mainstay of modern management of VUR

- Continuing VUR has the potential to cause long-term renal damage, therefore, early diagnosis and prevention of pyelonephritis are very important.[5]

- UTI may occur even in non-dilating VUR (grade I and II). In a follow up study in children with VUR, who were evaluated using criteria specified in the American Academy of Pediatrics (AAP) guidelines, 17.2% of children with normal ultrasound had renal injury identified on renal scanning, and 62.1% had grade 3 or higher VUR.

- The Sub-committee on UTI of the American Academy of Pediatrics acknowledges, that, it is important to detect urinary tract anomalies, such as VUR, at the outset, once UTI is confirmed. Children with VUR are believed to be at risk for ongoing renal damage with subsequent infections, resulting in hypertension and renal failure. Therefore, identifying urinary abnormalities (by ultrasonography and MCU) may offer the benefit of preventing hypertension and renal failure.

- It has been recognized, that, the diagnosis of UTI in young children is often delayed as the clinical presentation is often with vague general symptoms.

- Any antenatally diagnosed and postnatally confirmed dilated ureter or HN or diagnosis of conditions like duplication anomalies or pelvic kidneys, have a risk of ipsilateral VUR, whereas, multicystic dysplastic kidney and renal agenesis has an increased incidence of contralateral VUR. Therefore, micturating cystourethrogram (MCU)/ Voiding cystourethrogram (VCUG) should be carried out after confirmed UTI even in presence of mild hydronephrosis. Once VUR is confirmed a full workup is carried out which includes DMSA scans and GFR estimation.

- Long-term antibiotic use may increase the severity of otitis media in children. In some studies including the NICE guidelines, prophylactic antibiotics have been found neither to be effective in reducing the risk of recurrent pyelonephritis nor incidence of renal scarring in children less than 30 months of age who have grade II to grade IV vesicoureteric reflux.

- It should be recognized, that, infants often have non-specific symptoms of UTI which may remain unnoticed.[21]

- Renin angiotensin system has been shown to be activated even in the presence of sterile reflux.[2, 3] The upper tracts are, therefore, at risk in presence of VUR even between the episodes of UTI.

- Endoscopic treatment is viewed as preferable to open surgery by 60% of parents even for grade I-II reflux and 80% of those with grade III reflux over long term antibiotic prophylaxis **[Figure 1a & 1B].**

- Presently, the endoscopic treatment of VUR by dextranomer/hyaluronic acid (DXHA) is increasingly viewed as first line therapy for reflux.[7] **[Figure 2a & 2B].**

- Parental preference for choice of therapy is honored and they should be offered information on the 3 OPTIONS of therapy:

  OPTION A= Antibiotic prophylaxis

  Continuous antibiotic prophylaxis (CAP) does not require any procedure, as compared to the other two options. However, **it does not cure reflux and only reduces the incidence of UTI**. Pyelonephritis may continue to occur. It also requires long term treatment, with a low success rate after 1 year (33% in grade II-IV reflux) is a major disadvantage.[8] It has been recognized, that, after 2 years of age chances of spontaneous resolution of VUR are low[21] while prolonged antibiotic use leads to side effects. CAP is still being recommended until more definitive studies suggest otherwise.[6]

OPTION B= Endoscopic injection

Endoscopic injection re-creates the anti-reflux mechanism by injecting an inert material into the bladder wall at the ureteric orifice. While general anaesthesia is required, it is generally a day care procedure. Its success rates range from 70% to 83%. Success for even grades IV and V reflux reaches above 90% after 2 or more injections.[8]

OPTION C= Open surgery

The aim of open surgery is to prevent reflux by re-implantation of ureter and restoring the anti-reflux mechanism. Success rates for open surgery are 98%, with few complications. However, the higher success rates for open surgery necessitate greater expense and the need for in-patient hospitalization.

- Grade V VUR should be offered open/laparoscopic surgery. Depending upon the availability and affordability, endoscopic injection may be offered as an option while explaining the need for 2 or more injections.[8] When treated by surgery, ureteric reimplantation should be performed after 18 months of age. Till this age, continuous antibiotic prophylaxis (CAP) should be given. If recurrent infections continue to occur before this period, either endoscopic injection or surgery may be offered even earlier by creating a pop-off mechanism.[10]

- VUR grades III and IV as well as associated cortical abnormalities delay reflux resolution. Considerations should be given to treat these by intention to cure, such as endoscopic injection (OPTION 2) or open surgery (OPTION 3).

- If CAP is used, reassessment of VUR by cystogram **between 12 and 24 months after the prior cystogram** is recommended to determine when therapy can be stopped.[6]

- Open or endoscopic surgery shall be offered in the **presence of UTI**, **new scars in DMSA scanning**, and **parental preference**. If decision to intervene is postponed even after frequent UTIs, there is a higher risk of continuing postoperative UTIs.[6]

- After open surgery, ultrasonography should be performed to rule out obstruction. Follow up monitoring should be carried out for infections, new scarring and somatic growth through adolescence.

MANAGEMENT OF VUR

Following considerations should be given while outlining choice of therapy:

- Reflux diagnosed in infancy **resolves in about 50% within 24 months**.[6]
- According to NICE guidelines, as well as other studies, prophylactic antibiotics are not effective in reducing the risk of recurrent pyelonephritis or renal scarring in children less than 30 months of age who have grade II to grade IV vesicoureteric

reflux. However, antibiotics seem to be better than placebo in preventing infection if given for short periods, but, have side effects with prolonged use.[11]

- Infants often have non-specific symptoms of UTI which may remain unnoticed. They also have a greater risk of morbidity related to infection.[6]
- Continuing VUR has the potential to cause long-term renal damage, therefore, early diagnosis and prevention of pyelonephritis are very important.
- Renal injury/scars are mediated through the activation of renin angiotensin system:
    - Microalbuminuria indicates, that, renal tubular injury has already begun as this is an early marker of inception of renal damage.[12]
    - Raised Plasma Renin Activity (PRA) indicates, that, activation of renin angiotensin system has already begun[2, 3, 12]
- Renin angiotensin system has been shown to be activated even in the presence of sterile reflux.[2, 3] Therefore, the upper tracts are at risk in presence of VUR even between the episodes of UTI.
- It has been recognized, that, after 2 years of age chances of spontaneous resolution of VUR are low.[6]
- Ureteric reimplantation should be avoided before 18 months of age.

Management of VUR in the child under 2 years of age

Children under 2 years of age should be assessed for renal abnormalites and bladder bowel dysfunction. When present, treatment for the latter is initiated.

- ***Children with grade I, II & III VUR who do not have either, UTI, cortical scarring, raised PRA or microabuminuria, form a special group:*** They should be offered OPTION 1 [Continuous antibiotic prophylaxis (CAP)] for a period of 12 months or till the time any of the above features develop, whichever is earlier. In the absence of UTIs, MCU should be done between 12 & 24 months. If there is persistence of reflux or any of the above features develop they should be offered OPTIONS 2 or 3, as follows.[6] If endoscopic injection could not be offered due to cost or non-availability, a lower ureter 'Santulli' should be offered which would act as a temporary 'pop-off' mechanism and prevent renal injury due to persistent reflux.

- ***Children with any grade of reflux who have either, UTI, cortical defects/scarring, raised PRA or microabuminuria:*** They should be offered OPTION 2(Endoscopic treatment). In the event of non-availability- or, non-affordability due to cost of injection- OPTION 3 should be offered. In the case of decision on the latter case (OPTION 3), antibiotics should be continued till 18 months of age ('waiting period' during which open surgery by ureteric reimplantation is best avoided). During this 'waiting period' if adverse circumstances appear, such as, recurrent UTI, cortical defects, rise in PRA or microalbuminuria, surgical options other than ureteric reimplantation may be

considered. These are temporizing procedures, such as, creating a pop-off mechanism.

Management of VUR in the child over 2 years of age

Children over 2 years of age should be assessed for renal abnormalites and bladder bowel dysfunction. When present, treatment for the latter is initiated.

- ***Children with grade I, II & III VUR over 24 months of age & who do not have either, UTI, cortical scarring, raised PRA or microabuminuria, form a special group:*** They should be offered OPTION 1 for a period of 12 months or till the time any of the above features develop, whichever is earlier. If there is persistence of reflux or any of the above features develop they should be offered OPTIONS 2 or 3.
- ***Children with any grade of reflux who have either, UTI, cortical defects/scarring, raised PRA or microabuminuria***: They, should be offered OPTION 2(Endoscopic treatment). In the event of non-availability- or, non-affordability due to cost of injection- OPTION 3 should be offered.

Additional information:

- Endoscopic treatment can be offered concomitant with management of bladder and bowel dysfunction (BBD). It has been found to be safe and effective in resolving VUR in children with associated Lower Urinary Tract (LUT) dysfunction, even before their LUT condition has fully resolved. However, BBD should definitely be under control before surgical intervention.

- **Reflux in solitary kidney and bilateral reflux:**
  - Any grade of reflux with ***either, UTI, cortical defects/scarring, raised PRA or microabuminuria, should be offered*** endoscopic injection/ Surgery.
  - Grades I and II reflux without ***UTI, cortical defects/scarring, raised PRA or microabuminuria***: Antibiotics for a period of 12 months. If there is persistence of reflux or any of the above features develop they should be offered OPTIONS 2 or 3.

Conclusions:

- While managing VUR, it is important to take into account individual risk factors in each child. These are-age, sex, grade of reflux, bilaterality, bladder dysfunction and bowel function.

- It has been recognized, that, while antibiotics have some role for short periods of time, endoscopic injection and surgery are offered with intention to 'cure' to stop reflux and are more effective in long term renal outcomes.

- Parental preference should be honored and details of the 3 options of management of VUR should be explained to them.

References:

1. Noe HN, Wyatt RJ, Peeden JN Jr et al. The transmission of vesicoureteral reflux from parent to child. J Urol 1992, 148: 1869–71.

2. Bajpai M, Pal K, Bal CS et al. Role of plasma renin activity in the management of primary vesicoureteric reflux: a preliminary report. Kidney Int. 2003 Nov; 64(5):1643-7.

3. Bajpai M, Bal CS, Kalaivani M et al. Plasma renin activity for monitoring vesicoureteric reflux therapy: mid-term observations. J Pediatr Urol. 2008 Feb; 4(1):60-4.

4. Smellie JM, Prescod NP, Shaw PJ et al. Childhood reflux and urinary infection: a follow-up of 10–41 years in 226 adults. Pediatr Nephrol 1998, 12: 727-36.

5. Elder JS, Peters CA, Arant BSJ et al. Pediatric Vesicoureteral Reflux Guidelines Panel summary report on the management of primary vesicoureteral reflux in children. J Urol 1997; 157: 1846–51.

6. Management and screening of primary vesicoureteral reflux in children: AUA guideline(2010). Panel Members: Craig A. Peters, MD, Chair; Steven J. Skoog, MD, Vice-Chair; Billy S. Arant, Jr., MD; et al.

7. Nelson CP, Copp HL, Lai J et al and the Urologic Diseases in America Project. Is Availability of Endoscopy Changing Initial Management of Vesicoureteral Reflux? The Journal of Urology 2009;Vol. 182, 1152-7.

8. Capozza N1, Lais A, Matarazzo E et al. Treatment of vesico-ureteric reflux: a new algorithm based on parental preference. BJU Int. 2003 Aug; 92(3):285-8.

9. Bajpai M, Verma A, Panda SS. Endoscopic treatment of vesico-ureteral reflux: Experience of 99 ureteric moieties. J Indian Assoc Pediatr Surg. 2013 Oct;18(4):133-5. doi: 10.4103/0971-9261.121112.

10. Bajpai M, Mitra A, Bal CS, et al. Journal of Progress in Paediatric Urology:July-September, 2014(in press)].

11. RIVUR Trial Investigators, Hoberman A, Greenfield SP, Mattoo TK et al. Antimicrobial prophylaxis for children with vesicoureteral reflux. N Engl J Med. 2014 Jun 19;370(25):2367-76.

12. Bajpai M, Bal CS, Kumar R, et al. Persistent renin-angiotensin system activation after anti-reflux surgery and its management. J Pediatr Urol. 2011 Dec;7(6):616-22. doi: 10.1016/j.jpurol.2011.06.012. Epub 2011 Jul 31.

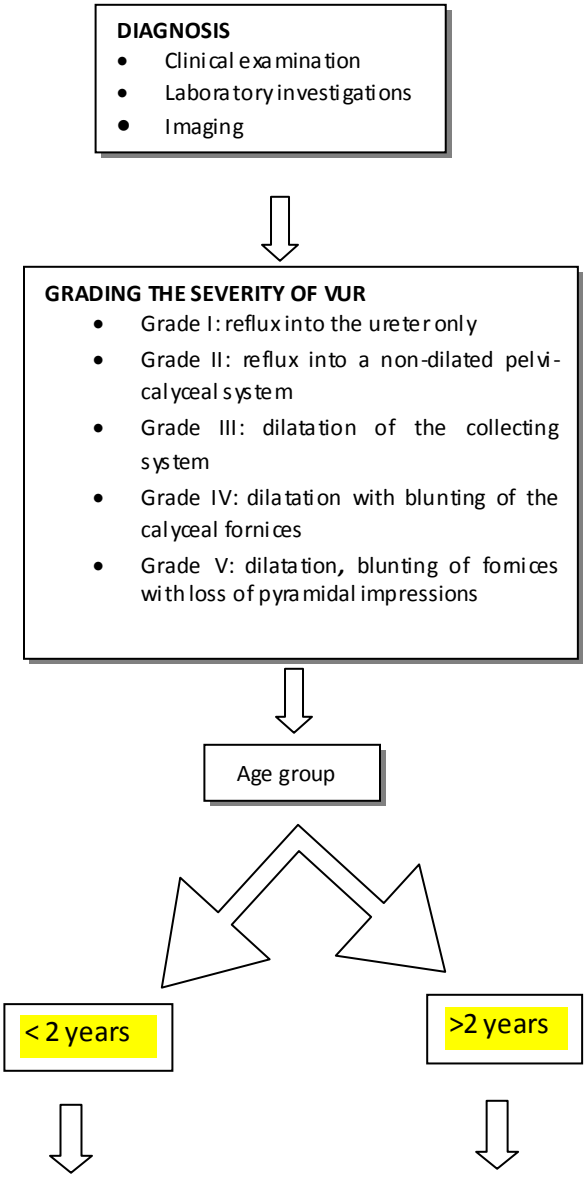
KEY MESSAGES

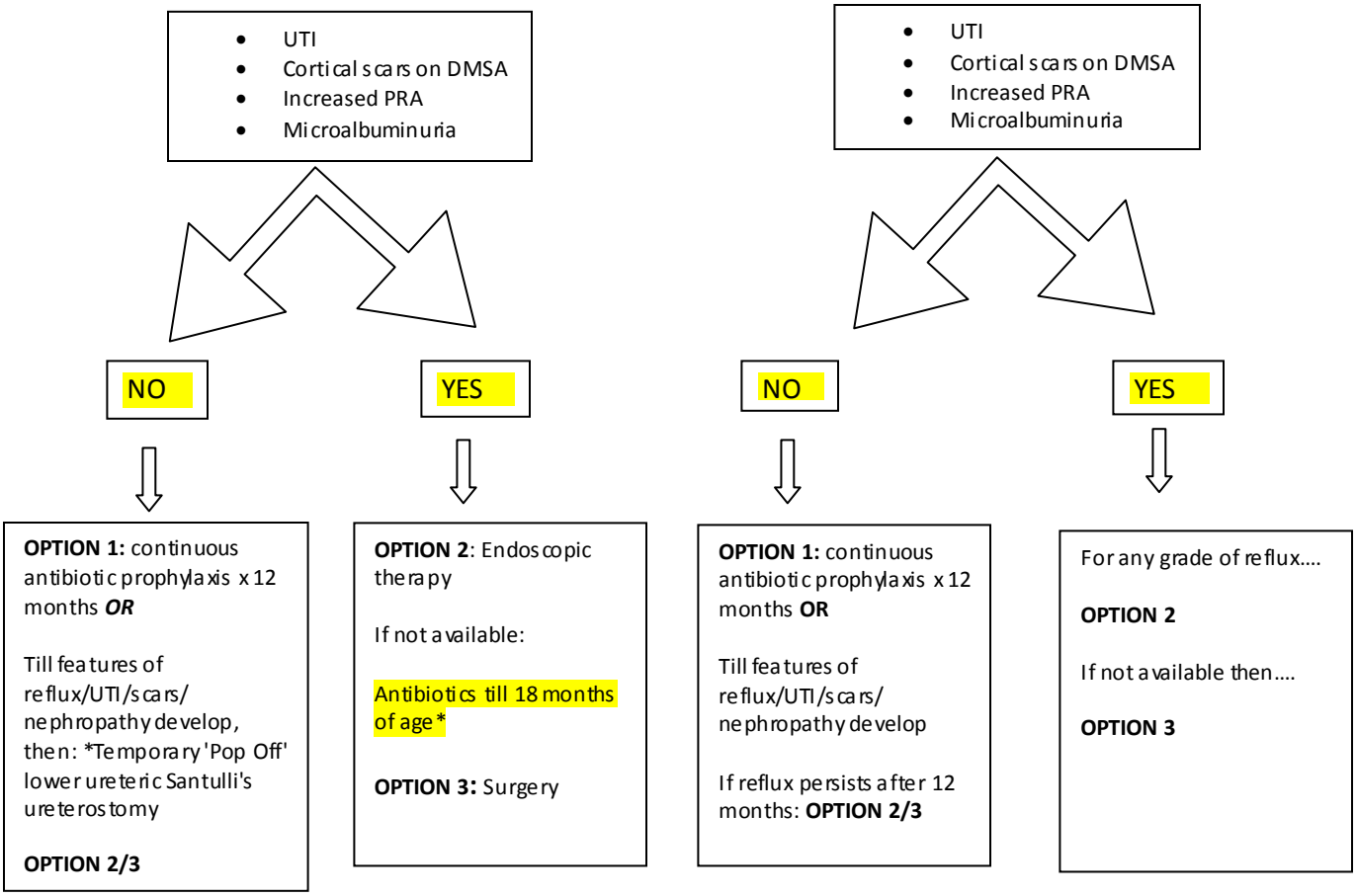
- Children with VUR are believed to be at risk for **ongoing renal damage.**[6]
- UTI may occur **even in non-dilating VUR** (grade I and II).
- Therefore, identifying urinary abnormalities (by ultrasonography and MCU), at the outset-**once UTI is confirmed**[6] may offer the benefit of preventing hypertension and renal failure.
- Micturating cystourethrogram (MCU)/ Voiding cystourethrogram (VCUG) should be carried out after confirmed UTI even in presence of mild hydronephrosis.
- Pyelonephritis occurs **despite** antibiotics.
- Long-term antibiotic use may **increase the severity of otitis media** in children. In some studies including the **NICE guidelines**, *prophylactic antibiotics have been found neither to be effective in reducing the risk of recurrent pyelonephritis nor incidence of renal scarring in children less than 30 months of age who have grade II to grade IV vesicoureteric reflux*.
- Endoscopic treatment is viewed as **preferable to open surgery by 60% of parents** even for grade I-II reflux and 80% of those with grade III reflux over long term antibiotic prophylaxis.
- Presently, the endoscopic treatment of VUR by dextranomer/hyaluronic acid (DXHA) is increasingly viewed as **first line therapy** for reflux.[7]
- Parental preference for choice of therapy is honored and they should be offered information on all the **3 OPTIONS** of therapy: *Continuous antibiotic prophylaxis; endoscopic injection treatment; open/laparoscopic surgery*

CLINICAL PEARLS

- Antibiotics seem to be better than placebo in preventing infection if given for short periods, but, have side effects with prolonged use.
- Infants often have **non-specific symptoms of UTI** which may remain unnoticed. They also have a greater risk of morbidity related to infection.[6]
- Continuing VUR has the potential to cause long-term renal damage, therefore, early diagnosis and prevention of pyelonephritis are very important.
- **Renin angiotensin system** has been shown to be activated even in the presence of **sterile reflux.**[2, 3] Therefore, the upper tracts are at risk in presence of VUR even between the episodes of UTI.
- It has been recognized, that, after **2 years of age** chances of **spontaneous resolution** of VUR are low.[6]
- Ureteric reimplantation should be **avoided before 18 months of age.**[6]

AN ALGORITHM FOR MANAGEMENT OF VUR:





If recurrent UTIs develop during the waiting period, then some other temporizing surgery such as lower ureteric "pop-off mechanism should be offered to the patient

Acknowledgement: This article has been abstracted from the manuscript for Journal of Progress in Paediatric Urology & proceedings of various scientific meetings.

UROLOGICAL ASSOCIATION OF UTTAR PRADESH

APPLICATION FORM FOR MEMBERSHIP

Please paste your recent passport size

USI Membership No. _____ NZ USI No. _____

Category of Membership applied for: Full / Associate / Trainee / Conversion / International

Name

_____

(Use Block Letters) First Name Middle Name Surname

Permanent Address: **Address for Communication:**

_____ _____

_____ _____

_____ _____

_____ _____

Pin Code _____ Pin Code _____

Mobile:

_____

Tel. (Res.): _____ Tel. (Office): _____

Email

_____

Date of Birth:

_____

Qualifications:

Degree/Diploma	Date	Institution/University
_____	_____	_____
_____	_____	_____
_____	_____	_____

Present Appointment & Designation:

_____ _____ _____

Sponsors (Should be Full Members of the Urological Association of Uttar Pradesh)

1. Name: _____
   Address: _____
   _____
   _____

   Signature: _____
   UAU No.: _____

2. Name: _____
   Address: _____
   _____
   _____

   Signature: _____
   UAU No. : _____

I declare that the information given by me as above is correct and if elected, I agree to abide by the constitution of the **Urological Association of Uttar Pradesh**.

Place _____

Date _____ Signature of the applicant

Membership Fee:

Full Membership Fee	**Rs. 4,000/-**
Associate Membership Fee	**Rs. 4,000/-**
Trainee Membership Fee	**Rs. 4,000/-**
International Member	**US$ 100**

For Office Use Only :

UAU membership Approved : Yes / No **Membership No. allotted: _____**

Receipt no. : _____ M**ode of Payment** : Cash / Cheque / DD / Online

Details of Payment :

_____

Signature with Official Stamp

La Renon®

OUR UROLOGY PRODUCT RANGE

UTICHEK™
Nitrofurantoin 100 mg Sustained Release Tablets

TAMGRESS™
Tamsulosin 0.4 mg Modified Release Tablets

TAMGRESS™-D
Tamsulosin 0.4 mg Modified Release &
Dutasteride 0.5 mg Tablets

OCHEK™
Capsules of Oxalobacter, Lactobacillus &
Bifidobacterium with FOS

ALFUGRESS™
Alfuzosin 10 mg Extended Release Tablets

ALFUGRESS™-D
Alfuzosin 10 mg Extended Release &
Dutasteride 0.5 mg Tablets

GUSHOUT™
Potassium Magnesium Citrate Tablets 978 mg
Potassium Citrate,Magnesium Citrate
and Vitamin B6 Oral Solution

Follow us on

Secretary Address:
Dr Neeraj K Agrawal
Hon. Secretary UAU
M.S. M.Ch (Urology), MBA (Healthcare Servics)
Neeraj Life Care & Stone Centre
DD Puram, Ektanagar Road
Bareilly 243122
Mobile: 9837057929
Email: drnkabr2@gmail.com

Disclaimer


UROLOGICAL ASSOCIATION OF UTTAR PRADESH
UAU