UAU Newsletter

Urological Association of Uttar Pradesh

March 2016

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

President's Message

Dear Friends

Greetings

I sincerely wish that 2016 brings Health, Happiness and Contentment to all our members and their loved ones.

The academic activities took off to a brisk start with USICON at Hyderabad from the 7th of January. I am glad that such a large number of our members took active part during the meet. Such large meetings serve both academic and social needs. Apart from the expected academic feast, it is also time to catch up with colleagues both senior as well as junior.

Our own UAUCON is just around the corner and I expect a very enthusiastic participation at Kanpur. I would urge members to come forward with suggestions to make the program exciting and of interest to most and also take up responsibility to shoulder various sessions.

The organizing team at Kanpur shall leave no stone unturned in laying out a grand meeting.

Look forward to meeting you all at Kanpur.

Anil Elhence
President UAU
Cell No.: **+91-9837031323**
Email: **anil@elhence.com**

Hon. Secretary's Message

Dear Friends

Warm greetings to all of you in fag end of winter

Our annual conference UAUCON is being organized by "Kanpur Urology Club" on 9-10 April in "Hotel Landmark". We are in preparation of an interactive academic program for our annual UAU meeting and the organizing committee is working very hard to make this main event of our society a memorable one.

I , on behalf of our society, extend a very warm welcome to all our esteemed members and families and request you to get your arrangements ready to visit Kanpur for a academic and social bonanza. Please do not hesitate to write to me, or ring me, for anything, to facilitate your visit.

Number of academic activities held in our region has seen a great thrust. Thanks to our senior urological faculty for their continuous encouragements and endeavors for teaching and training of latest knowledge and techniques to urological fraternity.

With regards

Dr. A.K. Sanwal
***Hon. Secretary,* UAU**
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E-mail: **uausecretary@gmail.com**

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Expert's Speak

ABO incompatible kidney transplantation—current status and our experience

Aneesh Srivastava, Sanjoy Kumar Sureka

Introduction:

The most effective treatment of end-stage renal disease is kidney transplantation, but a severe donor shortage has significantly limited this treatment especially in our country where deceased donor program is not well established. To overcome this profound donor shortage, immunologic barriers historically considered as absolute contraindications to transplantation are being re-assessed. Through the help of a better understanding of related immunologic mechanisms and availability of effective various regimens for controlling it, ABO-incompatible kidney transplantation (ABOi KT) is being performed with increasing frequency. One such barrier is the ABO blood group incompatibility(Table 1). ABO incompatible kidney transplantations are getting popular all over the world [1–4].

To clarify the current status in this area, the present article focuses on recently reported outcomes of ABOi KT, preconditioning methods before transplantation, post-transplant monitoring and management including our experience regarding the same.

Brief History of ABOi KT

The first attempt at ABOi KT was reported in 1955 by Chung et al. [5]. In their experience, eight of ten ABOi kidney allografts did not work successfully within the first few postoperative days. Further attempts at ABOi KT have been sporadically reported with poor outcomes with graft survival rates of approximately 4% at one year [6-7]. Therefore, ABOi KT was largely discarded for long time.

In 1987, Alexandre et al. introduced an effective desensitization protocol to achieve success in ABOi living donor KT [8]. This protocol included pretransplant repeated plasmapheresis as a strategy not only to reduce the titers of anti-A or -B antibodies, but also to decrease the antilymphocyte globulin-based induction. This plasmapheresis also altered the triple maintenance immunosuppression of cyclosporine, azathioprine, and corticosteroids and concomitant splenectomy . A one-year graft survival of 75% and a recipient survival of 88% were achieved in the 23 recipients [3]. While their results were impressive and became the basis of the next desensitization protocols for ABOi KT, the ABOi KT was still uncommon in the west.

These efforts regarding ABOi KT were significantly expanded in Japan because of the near absence of deceased donors. The largest number of ABOi KT since 1989, more than

1000 cases, have been performed in Japan. The percentage of ABOi KT surgeries reached 14% of all living donor KTs performed in Japan [8]. Following the remarkable results reported in the Japanese center utilizing modern desensitization techniques, together with the development of new immunosuppressive therapies, ABOi KT began receiving new interest in Europe and the USA in the early 2000s [12].

Published Clinical Outcomes of ABOi KT

Short-term results from the protocol described above have been notable. Recipients with a baseline anti-A or -B IgG titer of up to 1 : 128 were successfully transplanted with no episode of acute rejection. Studies have reported one-year patient and graft survivals of 96.-100% at one-year after transplant.(9-10)

Moreover, long-term results of ABOi KT reported by western and Japanese transplant centers also have shown that ABOi KT is equivalent to ABO-compatible KT .Genberg et al concluded that a long-term immunological response against ABO incompatibility has little effect on graft survival with current immunosuppressive protocols and patient monitoring.

ACCOMMODATION

Without adequate anti-A/B antibody reduction and desensitization before KT, an incidence of AMR and irreversible damage cannot be avoided. Successful ABOi-KT requires the reduction of anti-A/B antibody titers against ABO antigens on the graft at the time of KT. However, anti-A/B antibody titer returns to the baseline level within almost 1 wk after KT[, even if optimal desensitization is performed. Therefore, intense monitoring is necessary during critical first two weeks after ABOi-KT[8-11]. Paradoxically, a phenomenon of accommodation is acquired in this term.

Accommodation is defined as a phenomenon whereby graft rejection is avoided despite reemergence of incompatible antibody. The mechanism was originally discovered in the field of xenotransplantation[1], whereby endothelial cell posttransplant humoral injury was avoided, possibly due to changes of antibody specificity, avidity, affinity and alteration of the antigen structure. This phenomenon is allegedly responsible for normal graft function and structure despite reemergence of anti-A/B antibody against incompatible A or B antigen in the graft. However, it is fair to accept that mechanism as well as the very existence of accommodation remains speculative.

CURRENT PROTOCOL OF ABOI-KT

In ABOi-KT, intensified immunosuppressive protocol usually starts before KT in order to deplete anti-A/B antibody. Many centers have modified original successful protocol of ABOi-KT. The splenectomy-free protocols published in the last decade are summarized in Table [1]. RIT has been adopted in the place of splenectomy by majorities of centers. However, the timing and dose of RIT administrated remains variable. RIT or splenectomy-free protocols have successfully, used low dose IVIG after plasmapheresis. The basis of the North Europe protocol is IAs followed by high dose

IVIG. However, postoperative IAs is not performed routinely and its use is determined by antibody titers [12]. Maintenance immunosuppressive agents are mostly triple agents which are CNI, MMF and steroid. Tacrolimus is the CNI of choice in these ABOi-KT protocols. MMF was taken 7-14 d pretransplant in order to inhibit antibody production. Some centers use a protocol without daclizumab, basiliximab or antithymocyte globulin, and report excellent outcomes. Thus it is controversial whether these clonal antibodies should be introduced in ABOi-KT or not. All protocols of ABOi-KT have resulted in satisfactory outcome in the absence of randomized control trials(Table 2). It is impossible to select an ideal protocol fit for all purpose.

Our experience

Over last two years we have performed 29 ABOi renal transplants. Patient survival at 12 months follow-up was 100%, while the graft survival was 100%.Eight episodes of ABMR were seen in six patients. Surgically there were no marked differences from routine transplant except for higher intraoperative bleeding which was noted in initial two patients. It settled with changing plasmapheresis protocol with use of FFP.

CONCLUSION

Since first performed over 50 years ago, ABOi-KT has become an accepted additional tool of KT. Reassuringly, despite lack of controlled trials in ABOi-KT, more than satisfactory outcomes have been observed in adult and pediatric recipients, in many studies equivalent to living ABOc-KT. ABOi-KT also has disadvantages in spite of excellent outcomes . Preconditioning treatment of ABOi-KT, such as antibody reduction and desensitization, is more intensified and complicated than that of ABOc-KT. With current protocols, the occurrence of early graft loss and AMR are not completely abolished and occasional graft losses in the early postoperative period have been reported.. Preconditioning strategy in ABOi-KT has evolved over time. RIT has replaced splenectomy which was once thought a crucial procedure for ABOi-KT,. Overall, ABOi-KT is more expensive than ABOc-KT which may restrict its adoption in resource poor countries. We believe that a live donor ABOi-KT is a suitable alternative to waiting on deceased donor list.

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Table 1 :

Combination of blood type and compatibility

		A	B	O	AB
Recipient	A	-	+	-	+
	B	+	-	-	+
	O	+	+	-	+
	AB	-	-	-	-

+: ABO incompatible transplantation; -: ABO compatible transplantation.

Table 2: Current protocols for ABO incompatible kidney transplantation (13)

Author	Country,year	Rituximab dose	Pretransplant IS	Antibody depletion	IVIG	Target titer at the time of transplantation	Induction IS	Maintenance IS	Posttransplant antibody depletion
Saito et al[53]	Japan, 2006	375 mg/m^2(twice) at -14	MMF/MP at -1 mo	DFPP or PE	-	< 1:16	BAS (20 mg at 0 and 4	CYA/MMF/MP	-

		and -1 d					d)		
Tyden et al[54]	Sweden, 2006	375 mg/m^2(once) at -1 mo	TAC/ MMF/Pred at -13 d	IAs	0.5 g/kg after last IAs	< 1:8	-	TAC/MMF/Pred	IAs, 3 times
Chikaraishie t al[55]	Japan, 2008	100 mg/m^2(twice) at -8 and -1 d	MMF/MP at -14 d, TAC at -3 d	DFPP and PE	-	< 1:8	BAS (20 mg at 0 and 4 d)	TAC/MMF/MP	-
Galliford et al[30]	United Kingdom, 2008	1000 mg (twice) at first day of PE and at the operative day	TAC/MMF at -14 d	PE	0.1 g/kg after each PE	< 1:4	DAC (2 mg/kg at 0 and 14 d)	TAC/MMF/Pred	PE at 1 and 3 d
Genberg et al[31]	Sweden, 2008	375 mg/m^2(once) at -1 mo	TAC/MMF /Pred at -10 d	IAs	0.5 g/kg at -1 d	< 1:8	-	TAC/MMF/ Pred	IAs, 3 times
Oettl et al[32]	Switzerland, 2009	375 mg/m^2(once) at -1 mo	TAC/MMF /Pred at -14 d	IAs	0.5 g/kg after lastI	< 1:8	BAS (20 mg at 0 and 4 d)	TAC/MMF/ Pred	IAs or PE (not routinely)

					As				
Sivakumaran et al[78]	United States, 2009	375 mg/m^2 (once) at -3 wk	MMF at -1 mo	PE	2 g/kg after last PE	NA	ALE (1 mg/kg at 0 and 14 d)	TAC/MMF/Pred	-
Wilpert et al[34]	Germany, 2010	375 mg/m^2 (once) at -1 mo	TAC/MMF or MPS/Pred at -7 d	IAs	0.5 g/kg at -1 to -5 d	< 1:4	BAS (20 mg at 0 and 4 d)	TAC/MMF/Pred	IAs (not routinely)
Fuchinoue et al[36]	Japan, 2011	100-1000 mg, 1-3 times	CYA or TAC/MMF at -2 d	DFPP or PE	-	< 1:16	BAS (20 mg at 0 and 4 d)	CYA or TAC/MMF/steroid	-
Habicht et al[37]	Germany, 2011	375 mg/m^2 (once) at -1 mo	TAC/MMF/Pred at -1 mo	IAs	30 g at -1to -2 d	< 1:8	-	TAC/MMF/MP	IAs (not routinely)
Lipshutz et al[38]	United States, 2011	375 mg/m^2 (once) at -1 mo	TAC/MMF at the first day of PE	PE	10 g after each PE	< 1:8	ATG (1.5 mg/kg for 4 d)	TAC/MMF/Pred	PE (not routinely)

Shirakawa et al [39]	Japan, 2011	500 or 200 mg/m^2 (once), at -5 to -7 d	TAC/MMF/MP at -7 d	DFPP	-	< 1:32	BAS (20 mg at 0 and 4 d)	TAC/MMF/MP	-

Important Information

General Body Meeting 2016

UAUCON 2016 will be held from 9th to 10th April 2016 in Kanpur. During this conference the General body meeting will take place at 6.00 pm on 9th April 2016 in the main hall. All members are requested to attend.

UAU Elections

Elections will be held for the following Posts: a) President Elect: One b) Hon. Secretary: One c) Hon. Treasurer: One d) Council Members: Two.

Elections will be held during UAUCON 2016 and President-Elect, Dr. V K Mishra will be the Returning Officer for the UAU Elections.

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Urological Association of Uttar Pradesh & Uttarakhand

UAUCON-2016

Annual Conference of Urological Association of Uttar Pradesh & Uttarakhand

9th & 10 th April 2016 , Kanpur

Venue : VIJAY INTERCONTINENTAL, Tilak Nagar, Kanpur (U.P.)

Organizing Chairperson :

Dr. Anil K Jain

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HOW TO REACH

By Rail

The rail network of Kanpur is well connected to Delhi, Kolkata, Mumbai and other parts of India. Kanpur Central is the main Railway station in Kanpur that falls on the Grand Chord route. Various Express and Super Fast trains connect Kanpur to the rest of India.

By Road

There are number of public and private buses to and from Kanpur. Uttar Pradesh State Road Transport Corporation runs a fleet of well-maintained buses apart from the luxury coaches offered by private operators.

By Air

Kanpur is well connected with the Lucknow Air Port with the distance of 78 km. by Road.

Places to Visit

About Kanpur

Kanpur is more popularly referred as Manchester of the Country is the biggest city of Uttar Pradesh. This city concentrates on the Commercial, Industrial and Educational fields of Uttar Pradesh. This Metropolitan City has enormous number of Leather & Plastic Industry in the whole of Asia. Kanpur is more into Export of Leather and Leather products. It has a number of Historical important tourist attractions which draws huge crowd to Kanpur.

Kanpur Central

Ganga Bairaj

Green Park Stadium

IIT Kanpur

All Souls Church, Kanpur

Lal Imli

Scientific Program – UAUCON 2016

03rd Annual Conference of UAU, 9th & 10th April

9th April 2016 – Day 1

1030 – 1100	**UAU Executive Meeting**

1100 – 1250	**Masterclass in TUR-BT,11+2minutes** Convener: **Aneesh Shrivastava, Lucknow**
Energy sources for TUR-BT and comparative review - **Pratipal Singh, Lucknow** Prevention of obturator reflex spasm during TURBT - **Aneesh Shrivastava, Lucknow** Techniques of Taking TUR biosies from the bladder - **Rahul Janak Sinha, Lucknow** TURBT of large bladder tumour surgical techique - **Apul Goel, Lucknow** Ebloc dissecation of bladder tumour – **A K Sanwal, Jhansi** Mangement of complication during TURBT - **Alok Shrivastava - Lucknow**	

1250 – 1310	**Guest Lecture:** "Ureteropelvic junction obstruction : diagnosis and management"

1310 – 1330	**CME Lecture:** Obstructed Urinary flow after TURP: Finding Solution to Urologists nightmare

1330 – 1400	**OPD Decisions (rationale behind taking a decision)** **30 min session:7.5 min each** Moderator – **Anil Elhence, Meerut**
Incidental detection of PSA of 6ng in an asymptomatic fit 55 year old Doctor **- Shailendra Goel, Noida** Recurrent Multiple superficial urinary bladder tumours in a 80 year old gentleman **- RPS Bhadauria, Kanpur** Persistent 10mm lower ureteric calculus for 6weeks duration **- Shaleen Sharma, Meerut** Painful erection with >30 degree ventral deviation of 6 month duration in a 35 year old man **- Rajshekhar Gupta, Moradabad** Asymptomatic Rt. Hydronephrotic kidney detected on infertility workup **- Rahul Goel**	

1400 – 1430	**Lunch**

1430 – 1500	**Andrology Session** Convener: **Anil Jain**
Practical approach to patient of male inferlity (Case based discussion) Expert Panel: **Salil Tandon, HS Pahwa**	

1500 – 1530	**OT NIGHTMARES (How to manage a tricky situation)** 30 Min Session :7.5min each Moderator – **AK Sanwal, Jhansi**
Triradiate forceps with calculus within gets impacted during ureteroscopy **- Divaker Dalela, Lucknow** Faecal material seen as soon as nephroscope introduced for a staghorn PNL **- AK Sanwal, Jhansi** Significant persistent oozing from prostatic fossa at end of resection **- VK Mishra, Kanpur** Rectal injury during cystoprostatectomy **– Vishwajeet Singh, Lucknow**	

1530 – 1550	**Thematic Lecture -** Development of Urology in Uttar Pradesh & Uttarakhand, Objectives & Achievements **- Madhusudan Agrawal, Agra**

1550 – 1620	**Expert's View (what needs to be considered and what are the option available)** Moderator – **Apul Goel, Lucknow**
Pain after pyeloplasty-Stenotic PUJ - **B P Singh, Lucknow** Failed Vaginal repair for large urethrotrigonal VVF - **Manoj Kumar, Lucknow** Recurrent tight anterion urethral stricture after Dorsal BMG substitution urethroplasty **- Apul Goel, Lucknow**	

1620 – 1635	**Mini Debates** **(5min.+1min each)**
Urodynamics essential prior to Sling procedures **Shailenda Goel, Ghaziabad vs Sanjay Garg, Ghaziabad** All Alpha blockers are alike **Prajay Shrivastav, Bareilly vs Vijay Bora, Agra**	

1635 – 1700	**World Wide Web** **20 min session: Each topic 10 min.**
How/where to search for information on urological topics – **Subhash Yadav, Meerut** Using Social Media: An Urologist's perspective - **Vikas Giri, Meerut**	

1700 – 1730	**Seminar on Medicolegal Aspects** Convener: **Neeraj Kr. Agrawal**
Protective steps against uncapped compensation – **Sharad Agrawal** Adressing medico legal issues in electronic records – **Subhash Yadav** Legal aspects of violence at workplace – **Neeraj Kr Agrawal**	

1730 – 1830	**Symposium, Vesico ureteric reflux (VUR)** **- M S Ansari, Lucknow**
1730 – 1745	When to evaluate? Do all UTIs need evaluation? **- Virender Sekhon, Lucknow** - Do all UTIs Need evaluation? - Sibling Screening - Circumcision - Bowel bladder dysfunction
1745 – 1800	How to evaluate? - **MS Ansari, Lucknow** - Investigation Protocol - Top down vs bottom up approach
1800 – 1815	When to treat? – **SN Kureel, Lucknow** - Do all grades need treatment? - Do all ages need treatment? [Post pubertal female] - Antibiotic prophylaxis; how long?
1815 – 1830	How to treat? - **Minu Bajpayee, New Delhi** - Medical vs surgical treatment - Long term results of endoscopic management

1830 – 1900	**Uro-Quiz** **- SN Sankhawar, Lucknow**

1900 – 1930	**Annual General Body Meeting**

1930 onwards	**Inauguration, Felicitation & Dinner**

10th April 2016 – Day 2

0800 – 1200	**Operative Live Workshop**
0800 – 0900	Operative Live Workshop on Narrow Band Imaging Bladder - **Madhu Agrawal**
0900 – 1000	Mini PCNL
1000 – 1100	Bipolar TURP, Bipolar Enucleation of Prostate - **Anil Varsney, Anil Jain**
1100 – 1200	HOLEP – **AK Sanwal, Subhash Yadav**

1200 – 1320	**Abstracts Paper Presentation 7+1 (Prize Session)**
Pelvic fracture urethral distraction defect in paediatric patients -Our experience: - **Ved Bhaskar, KGMU Lucknow**	
Holmium laser versus conventional (Cold Knife) direct visual internal urethrotomy for short segment bulbar urethral stricture: Outcome Analysis - **Ved Bhaskar, KGMU Lucknow**	
Role of two stage (johanson) urethroplasty in modern indian prospective and its impact on sexual function in comparison to single stage urethroplasty – a single center experience - **Ashok Kumar Gupta, KGMU Lucknow**	
Giant Hydronephrosis - Still a reality - **Kawaljit Singh, KGMU Lucknow**	
TUIP versus TURP of small sized prostate in Benign Prostatic Hyperplasia: A prospective analysis **- Ruchir Aeron, KGMU Lucknow**	
Holmium laser versus monopolar electrocautery bladder neck incision for prostates less than 30 grams: A prospective randomized trial - **Sunny Goel, KGMU Lucknow**	
Comparison of three endoscopic modalities used in treatment of bladder stones: Transurethral use of cystoscope, nephroscope and percutaneous cystolithotripsy - **Bimalesh Purkait, KGMU Lucknow**	
Association of body mass index with prostate volume and serum PSA in males with LUTS: An observational study from India - **Ashok Kumar Sokhal, KGMU Lucknow**	
Grading of complications of transurethral resection of bladder tumour (TURBT) using clavien-Dindo classification system - **Bimalesh Purkait, KGMU Lucknow**	
Cystitis cystica: a series of 8 consequetive cases with unusual patterns of presentation - **Aditya Kumar Singh, BHU Varanasi**	

1320 – 1400	**LUNCH**

1400 – 1430	**Session on Chronic Renal Diseases** **(3 Presentations of 10 mints each)** Convener: **Anil Jain, Kanpur**
CKD- What a Urologist should know ? - **Jha Nirbhay Kumar / Desraj Gurjarnsi**	
CKD- What precautions to be taken by Urologist before, during and after operation **- Anurag Yadav, Agra**	
CKD - Problems in transplants in our region - **Anil Jain, Kanpur**	

1430 – 1500	**Advances in urology** **(3 Presentations of 10 mints each)**
Advances in management of small renal masses - **Manish Jain, Jhansi**	
Advances in management of overactive bladder **- Vipul Tandon, Allahabad**	
Evolving role of MRI in prostate biopsy - **Sameer Trivedi, Varanasi**	

1500 – 1530	**Poster Presentation 3 minutes**
Morcellation: a novel method for chylous clot removal presenting - **Saini DK, KGMU Lucknow**	
Vascular endothelial growth factor (VEGF) as a novel tumor marker for carcinoma urinary bladder - **Ashok Kumar Gupta, KGMU Lucknow**	
Double contrast urethrogram : Better modality to delineae urethral mucosa - **Kawaljit Singh, KGMU Lucknow**	
Vascular malfrmation of gland penis: a rase case report with review of literature - **Sartaj Wali Khan, IMS BHU, Varanasi**	
A rare case of adenocarcinoma prostate presenting with cutaneous metastasis - **Aditya Kumar Singh, IMS BHU, Varanasi**	
Bilateral single system ectopic ureter with urolithiasis: a rare case entity - **Ved Bhaskar, KGMU Lucknow**	

1500 – 1535	**Video Abstracts Presentation 7+1 (Prize Session)**
Technique of trans-obturator male urethral sling surgery using indigenous sling - **Sartaj Wali Khan, IMS BHU, Varanasi**	
Urethral injury due to glans avaulsion from corpora: a rare case - **Anurag Yadav, Agra**	

1535 onwards	**Valedictory Function**

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

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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: _____**

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Alfuzosin 10 mg Extended Release Tablets

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Potassium Magnesium Citrate Tablets 978 mg
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