ORAL PRESENTATIONS 6C
UROLOGY

O148 LIVE VALIDATION OF AN EXPERIMENTAL EXPERT SIMULATING MODEL IN MANAGING PROSTATE CANCER IN THE COMMUNITY

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Introduction: Artificial intelligence in the form of clinical decision support has demonstrated their positive impact on practitioners performance and patients outcome. In urology, they have wide prevalence in prostate cancer domain where they provide support for diagnosis, staging, image analysis etc. However, they have limited availability in stable prostate cancer (SPC) follow up despite the call for decision support systems in the primary care to facilitate community follow up. We aimed validate an experimental expert simulating tool in managing SPC.

Method: A computer based Clinical Decision Support System (CDSS) was developed from experience of an expert panel (consultant urologists from a UK teaching hospital). The CDSS was then integrated in an existing Clinical Nurse Specialist (CNS) led clinic to collect live data from real patients and synthesise a tailored management plan. The system was then tested for validity against decisions made by the CNS and the agreement was estimated using the kappa statistics. Disagreements were analysed qualitatively and classified according to the severity of the disagreement.

Result: Ninety nine consecutive cases were included in the analysis. The qualitative analysis of the discrepancies only demonstrated minor errors. The cases classified by the CDSS were all correct i.e. did not miss a potential cancer progression or a major complication. The kappa co-efficient indicated substantial agreement between CNS and CDSS $\kappa = 0.8$ ($p<0.0005$).

Conclusion: The CDSS demonstrated high validity and accuracy in its decision making. This tool has potential for safe use in supporting follow up of stable prostate cancer in the community.

Take-home message:
Artificial intelligence based models can enhance and support patients care in the community.

O149 IMPACT OF DONOR TYPE ON THE INCIDENCE OF URETERIC COMPLICATIONS FOLLOWING KIDNEY TRANSPLANTATION

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Introduction: Heightened demand for donor organs has prompted expansion of the deceased donor pool by using increasing number of kidneys from donors after circulatory death (DCD). Our DCD transplant programme is one of the largest in the world and we now perform twice as many DCD as donation after brain death (DBD) kidney transplants. We determined the impact of donor type on the incidence of ureteric complications (UCs; ureteric obstruction, urinary leak) after transplantation.

Method: We studied 1072 consecutive kidney transplants [DCD n=494, live-donor (LD) n=273, DBD n=305] performed from 09/2008 to 12/2014. An ureteroneocystostomy over a double pigtail ureteric stent was performed in all transplants and stents were removed 4–6 weeks post-operatively.

Result: Overall, there was a low incidence of UCs after kidney transplantation (3.5%). Despite a trend towards higher incidence of UCs in DCD (n=22, 4.5%) compared to LD (n=10, 2.6%) and DBD (n=5, 1.6%) kidney transplants, donor type was not a significant risk factor for UCs in multivariate analysis (HR: 2.412, 95% CI: 0.91-6.44; p=0.077). Cold ischaemia time; donor and recipient age; BK virus infection; renal artery multiplicity; urinary tract infection and biopsy-proven acute rejection prior to UC were not significant risk factors for UCs. Management involved surgical intervention in all cases, with re-stenosis in 2.7% requiring re-operation. No grafts were lost secondary to UCs.

Conclusion: Despite a significant increase in the number of DCD kidney transplants, the incidence of ureteric complications remains low. When complications do occur, they can be treated successfully by surgical reconstruction.

Take-home message:
Despite a significant increase in the number of DCD kidney transplants, the incidence of ureteric complications remains low. When complications do occur, they can be treated successfully by surgical reconstruction.

O150 THE USE OF CHAPERONES FOR INTIMATE EXAMINATIONS

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Introduction: The General Medical Council (GMC) outlines clear guidelines for the use of chaperones for intimate examinations. We aim to determine the frequency of chaperone use in a urology outpatient department where intimate physical examinations are performed regularly.

Method: A retrospective audit reviewing clinic letters over a one week period within a busy urology outpatients department. Letters were evaluated for evidence of a chaperone being offered to patients undergoing an intimate examination. We also established if there was a relationship between this and the gender of the patient and clinician performing the examination. GMC guidelines were reviewed in the

departmental meeting and displayed within the urology outpatient departments, we re-audited by reviewing a further week of clinic letters.
Result: 83 patients of 334 reviewed had a form of intimate examination: 77% (34/83) external genitalia and 23% (19/83) digital rectal examination (DRE). Only 1% of patients (1/83) were offered a chaperone. Following implementation of the guidelines within clinic, we saw an improvement of 13% (12/88) of patient's being offered chaperones. In all cases this was when the gender of the patient was female with a male doctor.
Conclusion: Clinical practice concerning the use of chaperones during intimate examinations continues to be discordant with the recommendations of medical associations and medico-legal societies. Chaperone use is higher for examinations of female patients than of male. Highlighting the importance of chaperone use to clinicians as detailed by the GMC can demonstrate an improvement in practice.
Take-home message:
Clinical practice concerning the use of chaperones during intimate examinations continues to be discordant with the recommendations of medical associations and medico-legal societies.

O151 NOT PRESENTING

O152 AN AUDIT OF OUTPATIENT PROCEDURE INCOME

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Introduction: Coded clinical data uses rules and conventions that, when applied accurately result in the provision of high quality statistically meaningful data. Financially, coded clinical data is grouped to meet the reporting structure of 'Payment by Result' to ensure trusts are paid accurately for activity.
Method: A retrospective audit to review the number of outpatient procedures performed over a one week period within a busy urology department. Clinic letters were reviewed for evidence of procedures performed that were previously not specifically coded for. New outcome forms were implemented to include an 'outpatient procedure income table' to be completed by the clinician at the end of the consultation to aid accurate coding. Following new outcome forms, we re-audited a further week of clinic letters to assess the financial implication of the new forms.
Result: On average there were 368 patients reviewed in urology outpatients with 86 procedures performed per week. If all procedures were coded correctly this audit demonstrates an expected weekly income increase of £23,754 per week.
Conclusion: The business intelligence unit at our trust has seen an increase of average weekly income by £14,000 in urology outpatients following new outcome forms. The discrepancy in actual financial gain compared to expected gain likely highlights inaccurate completion of the outcome form.
Take-home message:
Coding data should be a true reflection of hospital activity so establishing a clinical coding system for all procedures financially benefits the department significantly.