



USI-WZ

March 2023

NEWSLETTER

Dedicated to our talented members

INDEX

Page

- 01 USI Council
- 02 Message from President, USIWZ.
- 03 Message from the Hon Secretary, USIWZ.
- 04 Editors note
- 05 Inventions and Innovations in Urology:
A tribute to our innovator members
- 13 Recent advances in Uro-oncology.
- 16 The journey to Ironman: Meet our
President Elect, Dr Ulhas Sathaye.
- 18 Art Gallery
- 24 Art of writing
- 26 Welcome to Indore: 33rd Annual
Conference of the USIWZ

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My dear friends and seniors,
I wish that as you read this post you are in the pink of health. I am indeed grateful to address you as the president of our ever-growing and improving West Zone of the USI, after having started my journey as a council member back in 2002. I have served in the capacity of treasurer and secretary and contribute to our association. I have been blessed to have received your love and support through these years.

We have an exciting few months lined up ahead of us with many activities planned. We also have the West zone camp where many patients receive world-class care at almost no to nominal cost. I encourage you to join us in large numbers for this act of service. There are many academic activities that are planned along the way leading upto the much awaited annual West Zone USICON conference 2023 which will be held in the beautiful city of Indore, a land of great hospitality, good food and wonderful tourist attractions.

The conference will take place from 6th-8th October 2023 and we are honored to host it in a state-of-the-art conference center. The conference will be an academic feast with prominent national and international speakers promising to be in attendance.

Our distinguished speakers are some of the most renowned and respected urologists in the world. They will be sharing their knowledge, insights, and experience in various aspects of urology. We are confident that this conference will provide an excellent opportunity for you to learn, network and engage with other urologists in the field.

Furthermore, the conference will also feature interactive sessions, workshops, and poster presentations. We are proud to offer these activities to ensure a holistic approach to learning and collaboration. In addition, the conference offers a chance for you to reconnect with old colleagues and friends and make new connections in your field.

I encourage all of you to attend the West Zone conference of the Urology Society of India. This is a great opportunity to expand your knowledge and stay up-to-date with the latest developments in the field of urology. We hope to see you there!

Thank you.
Sincerely,
Dr. Kandarp Parikh
President, USIWZ



Dear friends,

Wish you all a Happy Holi and greetings for Holy days of Ramazan.

This 75 th year of independence is a landmark in our life. Let us put our blood and sweat for not just our medical profession but also for pursuing our hobbies or talents.

Like two sides of coin all of us have professional and personal sides. We have sacrificed our hobbies and talents for medical profession. In this newsletter cum magazine we want to showcase the poets, writers and artists of our fraternity.

Post Covid lots of physical workshops and conferences are taking place but there is also definite role of zoom meetings. It is supplementary to it. And we will be holding it quarterly.

We are in process to start our wzusi journal. It will be a milestone for westzone usi.

Friends, without full support of members, no organisation can do well. West zone's success is your success.

Wish you all a colourful year ahead.

Dr Gaurang Shah
Secretary, USIWZ

EDITOR'S NOTE



Dear friends,

I would like to thank all the members of our society to give me an opportunity to be a part of the council and getting an opportunity to serve the society. I ended my term at the recently concluded Delhi USICON and look forward for similar more opportunities.

There's a famous quote:

**Nothing changes
if nothing changes.**

New ideas and positive changes help us to progress. USIWZ is privileged to have innovators who have designed equipments that have helped us all in various urological procedures. Dr Rupin Shah, Dr Ashish Patil, Dr Kaushik Shah, Dr Janak Desai, Dr Arvind Ganpule and Dr Pankaj Joshi are few amongst them. We have briefly summarised their ideas and conceptions in this newsletter as a tribute to their efforts.

This newsletter also compiles the talent in our society whether it may be innovative at work, physical endurance or may it be art in drawing and writing. Do visit the page of art gallery wherein we have beautiful paintings from our members Dr Sujata Patwardhan, Dr R K Lahoti, Dr Sheetal Mistri and Dr Tanvi Davda. We welcome similar contributions from all the members for future editions.

I would also like to invite you all to register and attend this year's annual conference of our society to be held at Indore from the 6th to the 8th October, 2023. The scientific program being planned by the Council USIWZ along with the grandeur of the venue and the taste of Indore food delicacies promise a memorable event.

The Organising committee is also arranging a special evening trip on the 5th October (a day prior to the event) to Mahakal lok, Ujjain to visit the Mahakal temple and see the light show. Please plan your accommodation and travel itinerary accordingly.

Rajesh Kukreja, Indore

A TRIBUTE TO OUR INNOVATIVE MEMBERS

INVENTIONS & INNOVATIONS

IN UROLOGY

A patent, or invention, is any assemblage of technologies or ideas that you can put together that nobody put together that way before. That's how the patent office defines it. That's an invention. An invention has to make sense in the world it finishes in, not in the world it started.

USIWZ is privileged to have great innovators. We have included a few innovations by our own zonal members that have made an impact not only in our zone but also internationally.

NON INFLATABLE SHAH INDIAN PENILE PROSTHESIS

The history of its evolution.

By **Dr Rupin Shah, Mumbai.**

January 26, 2023, marked the 29th anniversary of implantation of the first Indian penile prosthesis. The prototype that was implanted was a pair of simple silicon rods; the patient was a 28-year-old school teacher who had failed to consummate his marriage due to severe erectile dysfunction, and had not benefited from intrapenile injections and venous ligation surgery (this was in 1996– the pre Viagra® era). After the implant surgery, he was able to have successful intercourse, fathered two daughters and was going strong 10 years later. Since then, the Shah Indian penile prosthesis has evolved through many models to reach its present form which is currently the most commonly implanted penile prosthesis in India (3256 implants were sold between January 2013 and December 2022, as per company sales figures).

When I started my andrology practice in 1990 penile prostheses were not available in India. Cost continued to be a major barrier when penile prostheses were finally imported into India and the majority of men whom I advised a penile prosthesis could not afford it. The initial goal was very limited – I was just looking for a plain silicon cylinder that could be implanted in the penis, and I approached



plastic surgeons, silicon importers, and other device manufactures. None could help. Then, I came across the Chhabra Hydrocephalic shunt which was being manufactured in India by a company called Surgiwear in a remote factory in Uttar Pradesh. This was a fairly complex

silicon device and I thought that if they could make this, they should be able to provide me with a silicon rod. I contact their managing director who happened to be a surgeon and an alumnus of King George Medical College, Lucknow. Dr. G. D. Agarwal was interested and promised to work with me on it, but another 2 years passed because their factory was being upgraded. Then, in 1993,

he contacted me and after mutual discussions he provided me with a simple silicon rod [Figure 1a], similar to the small-Carrion implant, but stiffer. This is the device that was implanted in the first 3 patients over a 1 year period while we studied their outcomes.

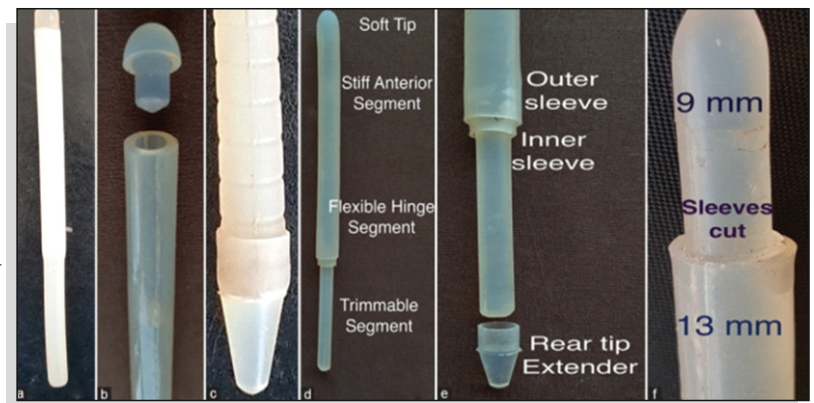
LENGTH ADJUSTMENT OPTIONS: As more patients came up for surgery, we realized that a large inventory would be needed to match different penile lengths. Another version was developed in which the proximal end was made trimmable with grooves every 0.5 cm

and a rear tip cap to round the end after it had been trimmed. The trimmable segment was 8 cm long and thus this single implant could be adjusted to any length.

HAVING THE CAKE AND EATING IT TOO: The hardness of elastomers like silicon is measured using the Shore Durometer test. Soft silicon has a low Shore score while stiff silicon has a high Shore value. Our initial implant was made of moderately stiff, Shore A 50, silicon; this gave adequate stiffness and manageable concealment, but we wondered whether we could increase the stiffness and yet improve the ease of concealment. Thus was born the concept of a differential rigidity implant. We designed a new implant combining silicon of different stiffnesses. There was a tip of very soft silicon (Shore A 10) to reduce risk of perforation, an anterior segment of very stiff silicon (Shore A 70) to provide rigidity to the penile shaft, a central 5 cm zone of soft silicon (Shore A 25) to act as a flexible hinge at the base of the penis for concealment, and a moderately firm (Shore A 50) posterior crural segment that could be trimmed and fitted with rear tip extenders.

ADDITION OF SLEEVES: The initial implants were 11 mm in diameter and seemed to fit most patients well. However, we observed that over time, the corpora relaxed around the implant, and if the implants were loosely fitted to start with, they tended to wobble within the corpora, resulting in instability. Hence, arose the need for implants of different diameters. Making different diameters for all four models would have resulted in a large inventory which would have increased cost and affected availability and we thought of adding a removable sleeve to the implant. The sleeve could be cut and removed to reduce the diameter of the implant by 2 mm. This proved very useful but we found that the best results were obtained when the implant was fit snugly in the corpora, and an even wider range of diameters was needed. Hence, we thought of having two removable sleeves [Figure 1e]. Removing only the outer

sleeve would reduce the diameter by 2 mm, and removing the inner sleeve would reduce the diameter by an additional 2 mm. Thus, a single implant could go from 13 mm to 11 mm to 9mm in diameter. Having two removable sleeves was a new idea that had never been implemented before and we frequently faced the problem of the sleeves sticking together. Numerous modifications were made to try and solve the problem. Finally, in the current model, the problem has been solved by making the sleeves out of different grades of silicon and making the outer sleeve a little looser. Till today, this is the only noninflatable implant in the world that offers the flexibility of two removable sleeves. It is also the only semi-rigid implant available in a 15 mm diameter (for models WH13 and WH15) two removable sleeves. It is also the only semi-rigid implant available in a 15 mm diameter (for models WH13 and WH15).



SPECIAL ADVANTAGES IN DIFFICULT SURGERIES: Since there is no steel core, a suture can be safely placed through the implant. Again, because there is no metal core in the implant it can be cut anywhere. Thus, when dilating very fibrous corpora, if one side can be only partially dilated then one implant can be cut at any level to fit the shorter corpus. Correctly and intelligently used, the Shah Indian penile prosthesis gives very satisfactory results and has helped make implant therapy accessible to many men who otherwise would have remained untreated.

PCNL

SIMULATION

a page from my diary

By : **Dr Ashish Rawandale-Patil**

Chief Urologist: Institute of Urology Dhule.

Chairman & Head: Tejnakh TM Healthcare

At the outset I thank the USIWZ council and appreciate the curiosity to know more about my journey of simulation for PCNL. The same is a story of the last 15 years and is a challenge to pen down the same concisely and precisely in a one pager. Percutaneous lithotripsy is a surgery during which initial puncture has always been a challenge to the learner. After doing successful renal punctures for years, I felt lost when I was called upon to teach PCNL either to my students or at workshops. I would find myself unable to explain how a successful initial puncture is achieved. I and other teachers would be at a dearth of, objective explanatory steps to be followed, in order to achieve the perfect renal puncture.

Necessity is the mother of invention.

Being able to objectively teach the art of puncture to the learner was the necessity.

Unavailability or unaffordability of simulators for various urological procedures, was the factuality. And I was fumbling over various obstacles to achieve my teaching goals, was the reality. I had read no chapters, on how to innovate and so felt like a blind mouse, looking for its mouse hole in the dark.

As I groped around for solutions, I had a couple of eureka thoughts which ended up

in two concrete processes of learning. One was to break down a procedure like PCNL into smaller tasks and create simulators for each task called microsimulators. The other revelation was the need to unwind my own learning process of PCNL puncture in a reverse way, and figure out the pathway to learn along with the trainee. For this I decided to have an open unexposed calyx. Then starting from the surface of the skin figure out how to guide the needle tip to the calyx. Learning this with an exposed target calyx, led to the invention of the logic bench simulator. The simulator developed the thought process and geometry of the renal access.



This helped objectives the steps of renal access. Thus were rediscovered and explicitly documented; the steps of identifying the posterior calyx by moving the fluoroscopy, the bulls eye technique and the

triangulation techniques for renal access.

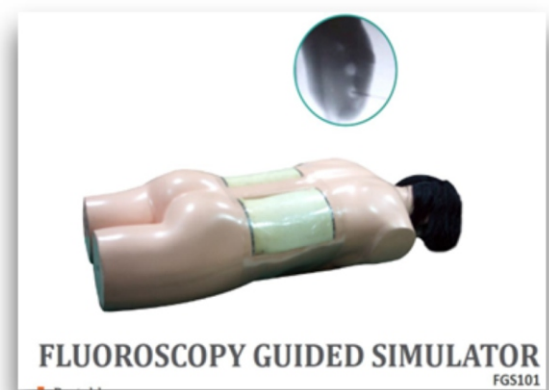
The techniques were thus learnt in an exposed or open calyx model and memorised. Now would the learner find the calyx if it was blocked from his eyesight? Thus emerged the necessity of a simulator which could be opened, closed and allowed puncture learning. Initially fluoroscopy guidance simulator and then fluoro-free PCNL simulators were developed.

Needless to say by that time ultrasound guided punctures were picking up and we developed the ultrasound guided simulator. In order to complete the procedure the Tract dilatation simulator and the Stone pulverisation simulator were also developed.

Trial and errors, application of the learnings, and experimentations, led to a concrete SOP guide book for successful puncture techniques ready to be passed on to the next generation. The same was invited to various textbooks and got printed. The basic objective during all these years of exhaustive research was always aimed at cost effectivity during research and training. Any invention continuously evolves and the same is still going on. We started our journey with one simulator and now have 13 of them. And each is evolving to the next level as time goes by. Newer ideas keep popping up and it is a continuous process of filtering ideas, berry picking the better ones and trying to get them to the surface. To get each idea into existence is always limited and challenged by the available resources and scientific content. To add on to the challenges is the fact that research and development never stops either in the surgical techniques or the surgical simulator modules. So we have two dynamically changing fields at hand at any given point of time. For me it is like riding two horses at the same time. And that is the necessity of the day..

Passion fuels these adventurous experiments and the appreciation by our fellow colleagues and the novice learner generates more passion.....

I hope to keep on doing this because it is close to my heart and is proving to be useful to the young learner of the art... to be continued...



3/5 LAPAROSCOPIC NEEDLE HOLDER

By **Dr Arvind P Ganpule,**
MPUH, Nadiad

Introduction: Any laparoscopic procedure, open or laparoscopic requires two skills to be mastered namely cutting and suturing. The design and functional efficacy of the operating instrument plays a role. Laparoscopic needle driver is a key instrument in accomplishing the task.

Concept of developing the innovation:

The factors which contribute to accurate and dexterous suturing are: -

1) **Shaft Size:** The shaft size of the needle holder should be the same as that of the port to avoid physiological tremors.

2) **Needle holder tip profile:** The knot gets entangled if the needle holder tip is not smooth. This can be achieved by avoiding screws at the tip of the needle holder and holding the shaft with the tip with the help of “weld”

3) **Diameter and Circumference of the port:** The smaller the size of the port the greater the stability.

The Idea (unmet need):

1) The needle holders, although available in a number of shaft sizes, the commonest one available is 5 mm shaft diameter.

2) Shaft diameter and port diameter discrepancies lead to wobbling. (Commonest combination is a 10mm port with a 5 mm shaft). This is called gesture imprecision (Figure 1)

3) Laparoscopic needle drivers work on Type 1 lever principle. (We need to have a shorter length needle holder)

4) In pediatric patients, an excess length of the needle shaft remains outside the body hence the wobble of the needle shaft in the laparoscopic port magnifies the physiological tremors which are further transmitted to the tip of the needle.

5) Hence, the unmet need, is to develop a needle holder with a 5 mm shaft and 3 mm tip and most important the tip is welded to the shaft.

THE INVENTION:

1) The 3/5 laproscopic needle holder comprises of two cannula coaxially joined, wherein the cannula is housing the jaws of the needle holder.(Figure 2)

2) The welding of the two cannulae helps us in avoiding screws at the tip. The positioning of the screws makes the knot throw seamless.(Figure 2 and 3)

3) The 3/5 laparoscopic needle holder has a shorter shaft length.This modification results in shorter length of the shaft remaining outside the abdomen in

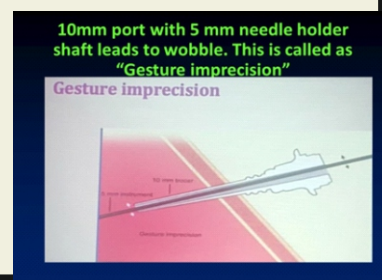
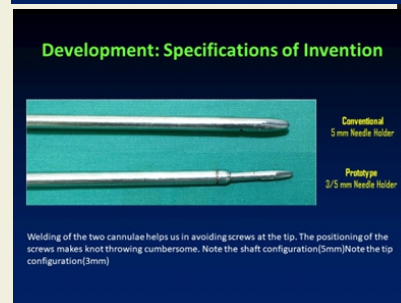
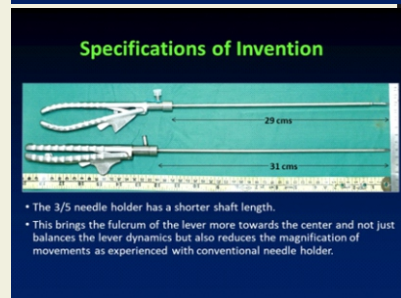
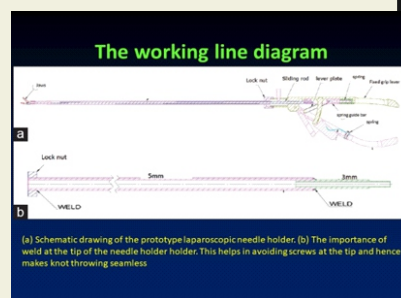
relation to the shaft length remaining inside. This brings the fulcrum of the lever more towards the center and not just balances the lever dynamics but also reduces the magnification of movements as experienced with conventional needle holder has a smaller diameter (3mm) and is welded within the cannula of large diameter (5mm) constituting the rest of the needle holder shaft. (Figure 3 and 4)

Patent filed with the Indian patent office:

Date of filing the application: 11th march 2016

Application

Publication date: 15th September 2017



A Novel Self-retaining Penile Retractor

By Dr Pankaj Joshi, Pune

Effective penile stretch and clear urethral exposure is critical during reconstructive penile surgery. Traditionally, penile stretch is achieved by a glans stich secured in an artery forceps that is held by the surgical assistant. Holding the forceps occupies one of the assistant's hands and causes fatigue.

The majority of surgeons use a tourniquet at base of penis to achieve haemostasis. A variety of penile tourniquets are described, including rubber or latex catheters, a rolled up rubber glove, a rubber band, and a Penrose drain clipped around the base of the penis using artery forceps. In longer operations, they need to be periodically released to prevent ischaemia-reperfusion injuries and local tissue trauma from excessive pressure.

The retractor was devised to address the above surgical problems. The novel retractor is comprised of three components made from surgical-grade stainless steel (Figure 1 A,B). The components are (1) a fixed haemostatic clamp attached to (2) a scale that also houses (3) an artery forceps that move along the scale. The self-retaining design affords stable retraction whilst simultaneously freeing the assistant's hands and providing haemostasis. The retractor has been approved by the Therapeutic Goods Administration for use in Australia (ARTG ID: 297528) Figure 3. In India it is available from Kalelkar surgicals. I dedicate this instrument to my GURU Dr Kulkarni for the tremendous motivation and guidance towards understanding urethra.

ADVANTAGES

Frees the assistant surgeon's hands.



Inexpensive, durable
Non-circumferential, no need to remove the clamp periodically.
Degree of penile traction can be adjusted by moving the forceps along the scale.
The Joshi-Kulkarni retractor can also be used in reconstructive penile surgery for hypospadias and Peyronie's disease.

LIMITATIONS:

It cannot be used for strictures located proximal to the peno-scrotal junction.

REFERENCES

1.Joshi P, Kulkarni S. V1-07 CLAMPO-TRACTOR. A Novel Self Retaining Clamp Retractor for Penile Urethral Reconstruction: Improving Surgeon Ergonomics. J Urol 2017;197(4):e69–e70.

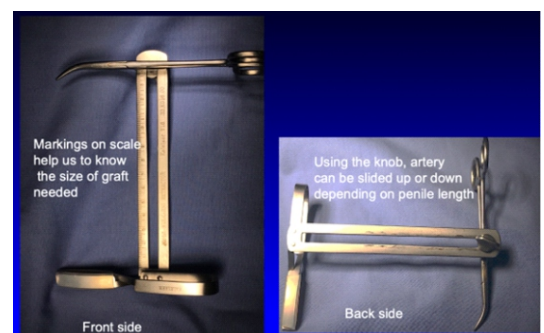


Figure 1:A ,B: Components of Retractor



Figure 2: Retractor in use for Redo Hypospadias

SUPERPERC SHEATH AND THE SUPERNEPHROSCOPE

By Dr Kaushik Shah, Surat.

After attending Segura conference at MPUH and understanding basics of UMP and Micro perc, I duplicated results in a better way with available instruments at my hospital. I presented my work, naming as Superperc, at MPUH after getting encouragement from Prof Mahesh Desai.

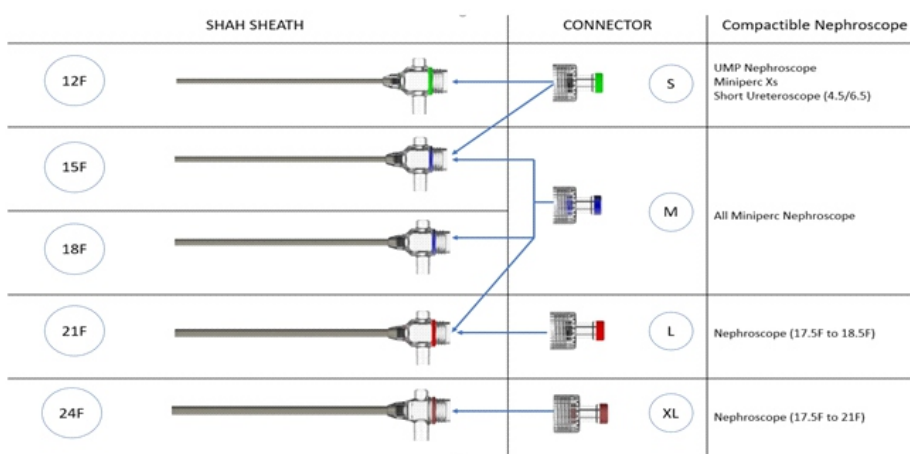
After some brainstorming and observation, I realised that suction needs to be added in some way to remove fragments and dust in miniperc. After exploring, all possibility, suction outside sheath was the only way left out.

I realised the need of reservoir to prevent blockage of suction pathway. Several questions came up while evaluating. How to control suction. Where to keep suction control opening? How big the suction control opening should be? What should be the suction pressure to suck different size of fragments? How to prevent renal mucosal injury when one is withdrawing the nephroscope? What should be the size of sheath? What should be the material to be used? What should be the thickness of sheath? Whether the tip should be round or bevelled? If bevelled, what should be the angle of bevel? How to make the edge non traumatic? How to make reservoir? What should be the material? How to make it light? After reservoir getting blocked, how to know it is blocked? How to make reservoir

transparent once we knew that transparent reservoir is the answer? How to know whether suction is working or not? How to design so that the nephroscope goes straight into the sheath part? How to connect different sizes of connectors to reservoir so that it can be easily disconnected and connected? How to connect reservoir with the main sheath? What should be the diameter of outlet for water? what should the inner and outer diameter of

suction tube? Once we came to know that most suction machine has small diameter inlet and fragments getting blocked at that level, what to do? Many more such questions arose. Each question required several experiments in vitro/ in vivo to find answers by creating different prototypes. It was a big question how to get prototype made as per design. We floated a startup named Usha enterprise & Chinmay Shah, mechanical engineer and M. Tech in computer aided designing and manufacturing was recruited. Finally, we came up with the present design and we are sure that it will stand against the test of time. In order to protect my work, I patented in 2014. Fortunately, it is approved in India, China and USA. Europe is pending. With help & support from urology friends, teachers, seniors and juniors, I could come out victorious from a roller coaster ride. Each feedback positive or negative was taken constructively.

To say few words about specifications of Superperc sheath, sheath diameter & corresponding connector diameters are different. Tract size is determined by sheath size. Connector size from S to XL is decided by nephroscope size.



While we were developing Shah Superperc sheath set, we also focussed our attention to nephroscope. We were aware of the limitations of existing Nephoscopes e.g., cost, durability and no separate channel especially for pneumatic lithotripsy. We realised that chip on tip endoscopes is the future of the endoscopy. We were working on this concept from last few years. Several designs of endoscope were tried. There were problems at one or another place. It is beyond the scope of this article what problems we faced & how they were solved. With the support from Dr Ashish Patil for providing his simulator, we tested in vitro how will it work. We tested for quality of vision, for durability, for life of sensor. We tested for durability while using pneumatic lithotripsy. We started demonstrating at different workshop with the kindness of our friends. Dr Sabnis, as our beloved president of USI, inaugurated. First Super Nephroscope was delivered to Respected Dr Ajay Kumar from Patna. Now we have expertise to make a scope of any length and size. After R & D activity for several years, we came out with an excellent product & applied for patent.

There are three sizes of nephroscope namely 13.5F (M), 16F (L), 19F (XL) available at present. Direction of view is 0 degree & angle of view is 120 degree & 26 cm of working length.

- Same quality of vision irrespective of size of Nephroscope.
- Excellent irrigation flow, no need to increase the height of irrigation bottle/ pressurised irrigation.
- No need to have light source or camera.
- No timer attached / Reusable
- Irrigation flow is not reduced as the instrument channel is separate. Vision is same with/without instrument.
- Different size and length of Nephroscope can be customised as per need of surgical community.
- This can be used as cystoscope for diagnostic cystoscopy, DJ stenting, DJ removal, cystolitholapaxy.
- One can take photo and video from the same unit.
- It is very light weight and can be a boon for roaming urologists.
- Make in Surat, India.



Recent Advances in UROONCOLOGY

(Prostate, Bladder & Renal cancer) 2022

By Dr Abhishek Singh &

Dr Rohan Batra,

MPUH, Nadiad

A lot of research is course-plotting in the field of uro-oncology. Here in this article, we would like to review the recent advances of the year 2022

PROSTATE CANCER:

Role of newer Androgen Receptor Inhibitors (Darolutamide, Apalutamide)

ARASENS trial showed that Darolutamide improves survival in metastatic hormone-sensitive prostate cancer(mHSPC). ARASENS trial is a global phase 3 trial which assesses the role of darolutamide in patients with mHSPC treated with androgen deprivation therapy (ADT) and docetaxel (DOC). Darolutamide is a potent androgen-receptor inhibitor. It is associated with increased overall survival (OS) among patients with non-metastatic castration-resistant prostate cancer (nmCRPC). ARASENS trial showed that the addition of darolutamide to ADT and DOC significantly enhanced OS in all subgroups, reducing the overall risk of death by 32.5%. Darolutamide was also associated with significant improvements in secondary endpoints, including delaying CRPC and pain progression.(1) These findings suggest that darolutamide in combination with ADT and DOC, can become a new standard of care for the treatment of mHSPC.

In the TITAN study, post-hoc analysis of the study evaluated outcomes of patients who had received docetaxel prior to treatment with apalutamide (APA) plus ADT. It has already demonstrated that the addition of APA, an androgen receptor signalling inhibitor, to ADT improves OS and clinical outcomes in patients with metastatic castration-sensitive prostate cancer (mCSPC). In post-hoc analysis, clinical outcomes, including OS, radiographic progression-free survival (rPFS), and time to prostate-specific antigen (PSA) progression did not differ in the APA-treated population regardless of prior DOC treatment status. The



safety profile of APA was not altered by prior DOC treatment status. It also suggests that prior use of DOC in patients with mCSPC does not further improve the clinical benefits of APA plus ADT.(2,3)

With the results of these trials, evidence is mounting in favour of triplet therapy (ADT plus DOC plus androgen signalling inhibitors) to become the new standard of care for the treatment of high-volume mHSPC/mCSPC.

ROLE OF PARP INHIBITORS

Important first-line mCRPC studies, PROpel and MAGNITUDE evaluated the combination of abiraterone and prednisone with a poly ADP-ribose polymerase (PARP) inhibitor.

As median OS in mCRPC patients is low, so improving outcomes in the first-line mCRPC setting is important. The combination of PARP

inhibitors and androgen receptor signalling pathway agents has demonstrated additive anti-tumor effects in preclinical studies. PROpel, a phase 3 trial, evaluated the efficacy and safety of olaparib plus abiraterone in patients with mCRPC undergoing first-line treatment after failure of primary ADT. First-line treatment with olaparib plus abiraterone significantly prolonged rPFS across all subgroups, including patients

with and without HRR mutations. OS data is immature at present. The most common grade ≥ 3 adverse event (AE) reported was anaemia: 15.1% vs. 3.3% for olaparib plus abiraterone vs. placebo plus abiraterone. The results show the benefit of olaparib plus abiraterone without the need for HRR stratification in the first-line treatment of mCRPC.(4)

MAGNITUDE, a phase 3 trial, assessed the addition of niraparib (PARP inhibitor) to abiraterone acetate and prednisone (AAP) as first-line therapy in mCRPC patients with and without HRR mutations. Although no benefit was

observed with NIRA plus AAP in HRR mutation-negative patients, significant improvements in the primary clinical outcome of HRR mutation-positive patients were observed. There was a 47% and 27% improvement in rPFS in patients with BRCA 1/2 alterations and across all HRR biomarker-positive patients, respectively. Niraparib plus AAP had a manageable safety profile. This study highlights the importance of testing for HRR gene alterations in patients with mCRPC to identify those who will benefit from the addition of NIRA to AAP treatment.(5)

Role of 177 Lu-PSMA-617

The FDA has approved the targeted radioligand therapy 177Lu-PSMA-617 (LuPSMA) for the treatment of patients with PSMA-positive metastatic castration-resistant prostate cancer (mCRPC) in the post androgen receptor pathway inhibition, post taxane-based chemotherapy setting.

The approval of LuPSMA, now also known as lutetium Lu 177 vipivotide tetraxetan, is based on findings from the phase 3 VISION trial. In the study, adding LuPSMA to standard of care (SOC) led to a nearly 40% reduction in the risk of death versus SOC alone in patients with progressive PSMA-positive mCRPC.

BLADDER CANCER: The last few years have seen significant advancements in the treatment of patients with metastatic urothelial carcinoma (mUC).

Role of Antibody-Drug Conjugates (ADC)

Sacituzimab govitecan (SG) is an ADC composed of an anti-trophoblast cell-surface antigen 2 (Trop-2) antibody coupled to SN-38 (a topoisomerase-I inhibitor).(6) The combination of SG with pembrolizumab as second-line therapy in immune checkpoint inhibitor (CPI)-naïve patients with mUC who progressed after platinum-based (PB) regimens, in the TROPHY-U-01 study (cohort 3), resulted in an overall response rate (ORR) of 34%, with a clinical benefit rate of 61%. Median PFS was 5.5 months, with a median followup of 5.8 months. The safety profile was manageable with no new safety signals.(7) These data support further evaluation of SG plus CPI in metastatic bladder cancer.

Trastuzumab deruxtecan is another novel ADC

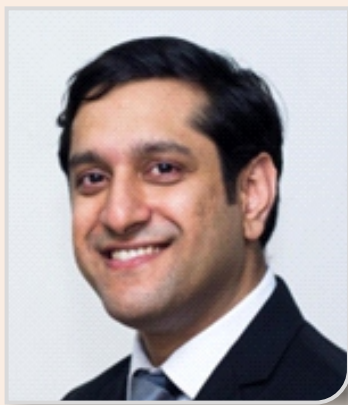
targeting HER2 expressed in certain patients.

Cisplatin-ineligible muscle-invasive bladder cancer (MIBC) patients make up approximately 50% of the disease population and do not currently have effective neoadjuvant chemotherapy (NAC) options prior to undergoing radical cystectomy (RC) and pelvic lymph node dissection (PLND). Enfortumab vedotin (EV), an ADC directed at Nectin-4, which is highly expressed in UC, has demonstrated benefits in UC patients with locally advanced or metastatic cancer in phase 2 and 3 trials. In cohort H of the EV-103 phase 1b/2 trial, patients received neoadjuvant EV prior to RC and PLND. Pathological complete response (pCR) rate was 36.4% and pathological downstaging (pDS), no longer having muscle-invasive disease, took place in 50% of EV-treated patients. Safety data indicated that 18.2% of patients had grade \geq 3 EV treatment-related AEs, which is in line with EV AEs in other clinical settings. Three deaths occurred during the study, which may be higher than expected and requires further examination. This supports the ongoing phase 2/3 programs evaluating EV in MIBC.(8)

Role of PARP inhibitors

Approximately one in four metastatic Urothelial Cancer patients exhibit a DNA repair deficiency (DRD) phenotype. However, to date, no DRD-targeted agents have been approved for mUC treatment. ATLANTIS is a phase 2, randomized trial using maintenance PARP inhibition following chemotherapy for the treatment of mUC in patients with a DRD mutation. Patients with stage 4 UC who had not progressed after PB

were randomized to rucaparib vs. placebo. Rucaparib was well-tolerated, and the median PFS in the rucaparib arm was 35.3 weeks compared to 15.1 weeks in the placebo arm.(9) An unmet need continues to be in patients who are ineligible for PB chemotherapy. There is currently no access to novel therapies in these settings, and some patients will receive best supportive care alone. BAYOU, a phase 2 study, investigated durvalumab plus olaparib vs. durvalumab plus placebo in the first-line treatment of PB-ineligible patients with unresectable, stage 4 UC. Patients were stratified according to their HRR status. Durvalumab plus



olaparib did not improve PFS or OS in HRR-negative patients. However, findings suggested a potential role for PARP inhibition in UC patients harboring HRR mutations. No new safety signals were observed.(10) This study supports further investigation of PARP inhibitors in patients with mUC with HRR mutations.

BCG unresponsive NMIBC

A phase 2/3 clinical trial investigated the IL-15R α Fc superagonist N-803 (anktiva) in bacillus Calmette-Guérin (BCG)-unresponsive non-muscle-invasive bladder cancer (NMIBC). The combination of BCG and N-803 enables the innate immune system to mount a more robust and prolonged response, which was previously demonstrated to induce a CR in NMIBC patients. The study consisted of a single arm with two cohorts; both received N-803 and BCG. In cohort A (carcinoma in situ [CIS]), the CR rate was 71%, with a 62% probability of maintaining CR for ≥ 12 months. For cohort B (papillary), disease-free survival (DFS) was 57% and 48% at 12 and 24 months, respectively. These findings demonstrate a higher response rate than other treatments. The combination of N-803 and BCG was safe and well-tolerated.(11) This combination will provide an alternative option for patients with BCG-

unresponsive disease.

Kidney Cancer: The NeoAvAx study examined the efficacy, safety, and biomarker analysis of neoadjuvant avelumab/axitinib in patients with localized RCC who are at high risk of relapse after nephrectomy. Prior phase 2 trials of neoadjuvant axitinib, a TKI, demonstrated partial primary tumor response rates of 22–46%. NeoAvAx, a phase 2 trial, investigated 12 weeks of combination neoadjuvant avelumab (an immune checkpoint inhibitor [IO])/axitinib (a TKI) prior to nephrectomy in patients with high-risk non-metastatic clear-cell RCC. Thirty percent of patients demonstrated a partial response (PR) of their primary tumor, with a median tumor downsizing of 20%. Of the patients with PR, 83% were disease-free postsurgery. At a median followup of 23.5 months, recurrence occurred in 32.5% of patients, and three died of disease. The secondary endpoint for this trial was surgical morbidity, which is a concern with neoadjuvant immunotherapy and TKI prior to surgery; 53% of surgeries had normal tissue planes, 22% moderately adhesive, and 25% severely desmoplastic. Biomarker analysis indicated that

patients with low CD8+ levels had a higher risk of recurrence.(12)

In a phase 2 study of patients with locally advanced non-metastatic clear-cell RCC, treatment with neoadjuvant cabozantinib, a TKI, resulted in tumor reduction in all participating patients. The median tumor size reduction was 23%. Side effects were as expected, and there were no complications related to cabozantinib treatment.(13) Data on the impact of presurgical neoadjuvant IO therapy on primary tumor size and complexity in correlation with surgical quality and short-term oncological outcomes were also presented. Bifecta, which is a negative surgical margin and no complications for 30 days, was achieved in 78.6% of patients, and tumors were downsized but not as dramatically as demonstrated with TKI treatments. These trials suggest that neoadjuvant TKI may produce a better tumor response than neoadjuvant IO, resulting in more resectable tumors.

CONCLUSION:

The future holds more precise and tailored therapies aided by AI, biomarkers and genetics, along with improved imaging. These factors will impact future direction of novel treatments. These therapeutic approaches will definitely improve overall outcomes, survival, and quality of life for patients with these cancers.

THE JOURNEY TO

IRONMAN 70.3

By Dr Ulhas Sathaye

'Ironman.' A very intimidating word. As a recreational athlete, I used to look with respect at someone who had attempted and completed an Ironman. And it is supposed to be the holy grail for endurance athletes.

PROLOGUE: In January 2019, we (Dr. Prashant Mulawkar and me) had just finished the Mumbai marathon and were returning to the hotel in a taxi. Prashant mentioned that Goa was to hold the first Ironman 70.3 in India and that I should participate in it. The answer at that time was NO.

THE JOURNEY: It was because I had sustained an injury and was having planter fasciitis. My first priority was to recover from it. However, Prashant had sown the seeds for the attempt at that time.

Having recovered from my injury, I started training for an Olympic distance triathlon in Hyderabad in November 2019. Prashant had introduced me to Dr. Amit Samarth from Nagpur and under his tutelage I started preparing in earnest. Not only did I complete that Triathlon, but also got a personal best in the ensuing Mumbai marathon in January 2020.

After this I showed a desire to attempt an Ironman 70.3. He encouraged me to do it and asked me to register for the Ironman 70.3 again to be held in Goa in November 2020. I registered on the 14th

March 2020 for the event scheduled in November 2020. As fate would have it, Covid struck and the country went into a lockdown. And along with it my dream also went up in smoke.

Fast forward March 2022. I received an email from the organizers that the event would take place in 2022. That was the time that the serious targeted preparation started. Only my wife Aarti knew about my preparation at that time. Dr. Amit Samarth used to send me weekly schedules for training, but it was my duty to follow them.

April 2022 onwards, it became a ritual of waking up at 5 am to finish the days training before my professional work starts. Training was progressing slowly but steadily. However, there were hiccups too. In May, during an early morning ride, I had a crash when a stray dog hit my cycle and I fell and injured my right shoulder. But still the training continued and I could feel my endurance increasing. The motto was not to do too much too soon. I was comfortable with swimming and running. but my Achilles tendon was cycling. I stuck to the training plan religiously and steadily my cycling speed increased and I felt confident that I would finish the cycling part within the designated time.

My Mantras to keep me motivated during training were, 'करना है तो करना है' and 'Impossible is an opinion and not a fact'. I would repeat it every



morning to motivate myself. By August, the training load had increased significantly to the tune of 12 to 14 hrs./week and so it was bedtime by 10 pm. No movies and no socializing. A typical day would be: wake up at 5 AM; 5.30 AM to 7.30 AM

Training(1st session); 9 AM to 7 PM Urology work;

7.30 to 9 PM Training(2nd session). 10 PM Bedtime. This was the routine from Tuesday to Sunday. Monday was complete rest. This continued till the 1st week of November. By September I had started telling friends about my attempt at Ironman 70.3(on my wife's advice). The reason being I would not back out of my commitment. Sunday training sessions lasted for 4 to 5 hrs. when 2 activities were done to simulate race day. I also travelled to Porbandar to practice sea swimming and get the hang of open water swimming.

The training load was cut down from 1st November. This is called 'Tapering'. It allows the muscles to be fully rested for the final onslaught. Reached Goa on the 10th November. There is an athlete briefing where the rules are explained. There is a bike check-in on the previous day where we have to surrender the bike to its designated slot. 13th November D Day. Our hotel was occupied with Ironman athletes. We all had a heavy carbohydrate rich breakfast at 4 AM. The plan was to sleep again. But the adrenaline rush kept me wide awake. The swim of 1.9 kms started at 7.30 AM and I finished it in 47 mins. Then the bike part started. 2 loops of 45 kms each were to be completed in 4 hrs. 10 mins. The route was hilly and had 1 km long inclines. The first loop was relatively fast when the climate was still good. But after 10 AM the temperature rose and there was a strong headwind. Conditions were tough, but well, it had to be done. Hydration and fueling were of prime importance during those 4 hours. I could finish the bike part in 3hrs 40 mins, well within the



cutoff time. By the time the run of 21 kms started, the temperature was in the high 30s. (38°C when I finished). Exhaustion set in after only 7 kms of the run and it was an effort just to hang on. At 17 kms I developed severe cramps and had to leave the track for 15 mins to recover. A colleague runner gave me salt tablets and I was ready to restart. It was run walk after that. Around 18 kms my wife Aarti ran by inquiring how I felt. Told me not to exert but if I pace my final 2 km properly, I can get a podium finish. I realized that the runner in front of me would be equally tired. I gave it all in the final leg and was happy to get a podium finish. In spite of the severe heat and humidity, I got goosepimples when I heard the announcement that I was now an IRONMAN. EPILOGUE: Done and dusted. Another ticked off the bucket list. The euphoria of the achievement takes time to sink in. There was an empty feeling for a few days but I had my urology work to keep my mind occupied. I also had as a target the Mumbai full marathon after 2 months. Also, could catch up with family and friends and was back for weekend get to gethers which I avoided for 6 months.

I must acknowledge the support that I got from the family specially my wife Aarti which was phenomenal. She supported me through all the training, motivated me, encouraged and even accompanied me through some tiring training workouts.

So many of my friends asked me. Is it hard? Of course, it's hard. It's supposed to be hard. If it were easy, everyone would do it!

What next? Would I attempt it again? I don't know. Only time will tell.



Art Gallery

Dr Sheetal Mistri

While the world was battling covid, I was blessed with some extra time for myself which I struggled to find during residency. It gave me time to rekindle my lost love for art and painting and also learn some new art form like acrylic pour painting and alcohol ink art. I tried my hand at these new forms after learning the techniques online and then it was fun exploring and trying my hand at these. While there were multiple failures but the end result was rewarding.

1. Deep blue sea- the first of the acrylic pour paintings on canvas. Just like the deep blue ocean, our lives our full of ups and downs..but eventually it's all beautiful.

2. The golden deer- exploring the woods of uncertainty. It's mixed media art- alcohol ink with acrylic paint.



Tanvi Davda

Kalki Avatar.

A painting, sans paint. This piece of art is drawn free hand and brought to life with pastels, alcohol markers and coloured pencils.

R K Lahoti

I started painting 7 years ago. I started painting classes once a week. Initially it used to be sketching followed by use of water colours. Ultimately acrylic painting became my hobby.



The fort of Raghogarh was founded in 1734-1677 A.D. by Hindupat Raja Lal Singhji. Currently Digvijaysinghji ex CM of MP and his son MLA Jaywardhan singh still live in Fort.



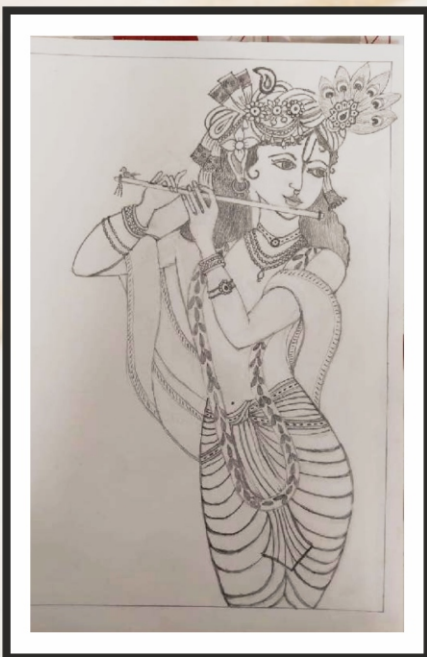
The Alexander Nevsky Cathedral is a cross-domed basilica featuring an emphasized central dome. The cathedral was created in honour to the Russian soldiers who died during the Russo-Turkish War of 1877–1878, as a result of which Bulgaria was liberated from Ottoman rule. We had been to Bulgaria in the trip organised by USIWZ

Sujata Patwardhan

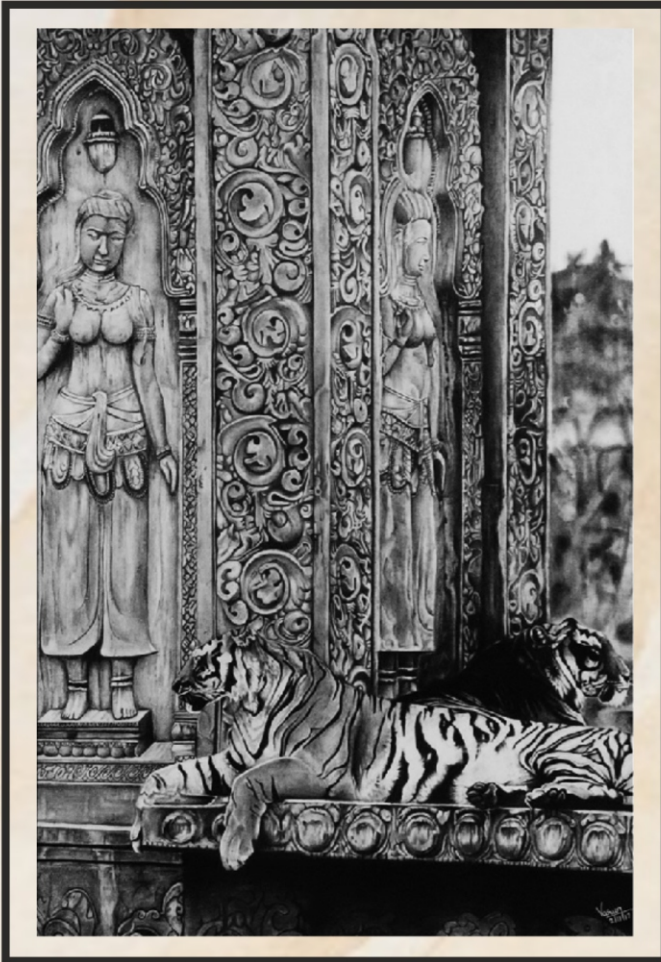
Decoupage or *découpage* (/ˌdeɪkuːˈpɑːʒ/[1] French: [dekupa]) is the art of decorating an object by gluing colored paper cutouts onto it in combination with special paint effects, gold leaf, and other decorative elements. Commonly, an object like a small box or an item of furniture is covered by cutouts from magazines or from purpose-manufactured papers. Each layer is sealed with varnishes (often multiple coats) until the "stuck on" appearance disappears and the result looks like painting or inlay work.



Nayan Sanghvi



I started painting 1st time in my career during the Covid period. I read about life of Krishna and Chaitanya Mahaprabhu and Prabhupada and also read about Bhagwat Gita etc from Iskon library. This stimulated me towards drawing and painting Krishna



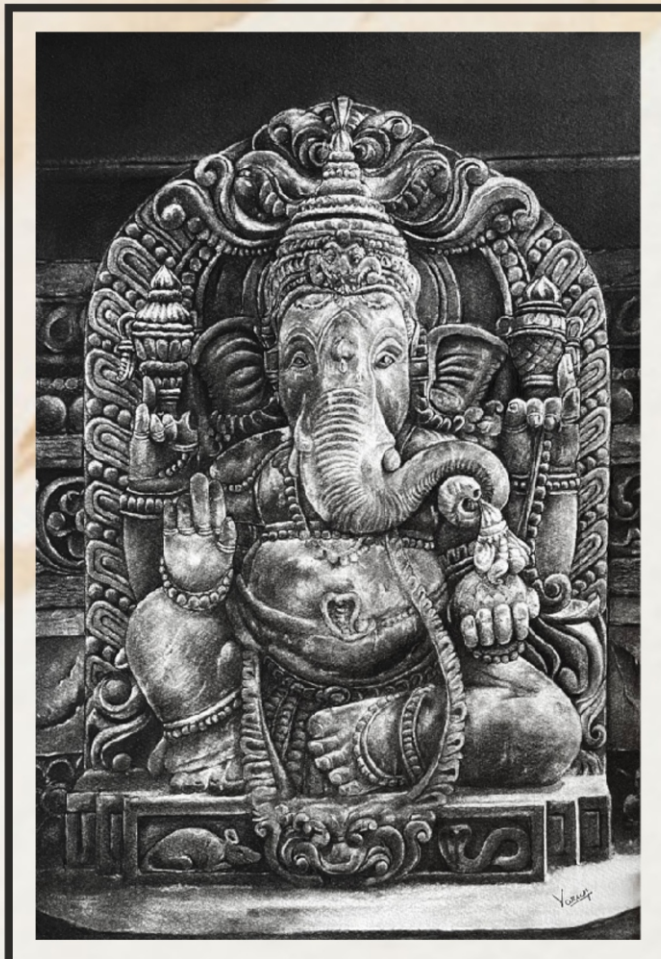
Varun Oswal

I am Varun Oswal (son of Ajay Oswal), a second year student studying Accessory Design at National Institute of Fashion Technology, Mumbai. I began drawing when I was a kindergartener. I do hyper-realistic wildlife and portrait art in the charcoal, water-colour and acrylic mediums

Name - The Tigers of 104

Medium - Charcoal on paper

About - This drawing is very close to my heart. I started it in my 10th grade. With week-long breaks of procrastination and starting multiple drawings simultaneously, I completed it in 104 days at the start of my 10th board examinations. It seemed appropriate that I name it "The tigers of 104"



Name - The Naga Lord

Medium - Charcoal on paper

About - "The naga's forehead was ridiculously broad, his eyes placed on the sides, almost facing different directions. His nose was abnormally long, stretching out like the trunk of an elephant."

Ganesh, also called Ganapati, is the elephant-headed Hindu God of beginnings, traditionally worshipped before any major enterprise and is the patron of intellectuals, bankers, scribes, and authors. He is the son of Lord Shiva. The following is a hyper-realistic Charcoal portrait of the 'Lord of the People'

Dr Gagan Prakash

We urologists work on hand eye coordination .. and of course the brain that lets you do that .. tried my hands on another camera, going beyond endoscopes and laparoscopes .. and more from heart than the brain .. sharing glimpses from an interest that I never knew existed in me until someone gifted me a DSLR .. thank you WZ !



Dr Rashmi Mittal

W/O Dr Sanjay Pandey

"If you can do it for joy you can do it forever"- Stephen King

Being a dermatologist for 25 years I realised about the keen sense of observation that developed within me. The camera which I procured for my clinical pictures of my patients soon shifted to wild life and nature photography. While I was enjoying photography as a hobby we were all forced into a locked down"!!! My focus shifted for the first time into lifting a paint brush. I didn't realise when I started my new passion with water colours, brush and paper. I started following my passions. Passion is energy. I felt the power that came from focusing on what excited me.



Art of writing

By **Dr Ravi Jain,**

Consultant Urologist, Robotic and
Renal Transplantation Surgeon,
Ahmedabad

The art of writing is the art of discovering what you believe.

Write to discover! And: Write to become!

Hey Google

Is Google the answer to all our questions?

Today when we have any queries, questions or concerns, we immediately seek the answers on Google. Which is the best restaurant near me? Hey Google. Who is the best Doctor near me? Hey Google. Where can I find best laptop deals? Hey Google. How do I cook a new recipe? Hey Google. How do I learn my new 4 string Guitar? Hey Google. How do I learn a new surgery? Hey Google.

Google has all the answers. Right from searching an unknown location to finding a soulmate, Google has all the answers. Whether you feel happy or sad, Google or other social platform knows better and earlier than your near and dear ones. People who were not in contact since years together wish you Good morning and Good night daily. We wish Happy Diwali and Merry Christmas to our far ones first and near ones last!

Life has changed. Yes it should of course. With time, if you don't move ahead, you are late and outdated. Why not? Today's generation may not know about Landlines, PCO, telephone booths and the waiting lines for trunk calls. Why should they know about pagers, and the old Nokia mobiles which used to be everyone's envy and a matter of pride for those who had it. Mobile today is not a facility, it is a necessity. And why should we blame the younger generation? The old and elderly retired are more verse to WhatsApp, YouTube and Facebook, Kapil Sharma to Rohit Sharma and what not! Our business is on WhatsApp, our profession runs on Facebook and Instagram, and our entertainment is on YouTube and Netflix.

So does Google give us all the answers? Does it tell watching lot of news gives us more and more negativity and reading books gives us more positivity? Does Google poke you to go outdoors and meet your friends, play some outdoors and have some fun with friends? Does Google point out your mistakes like your teachers do? Does Google anytime say you were wrong Beta when you didn't help out someone? Does Internet all the time give you soothing and satisfaction which sitting under the shade of a tree can give? Can you imagine a life or at least a day or may be even few hours when you don't have electricity, your mobile is discharged and you don't have Internet with you? What you all have is either you and yourself, or you, your friends and family?

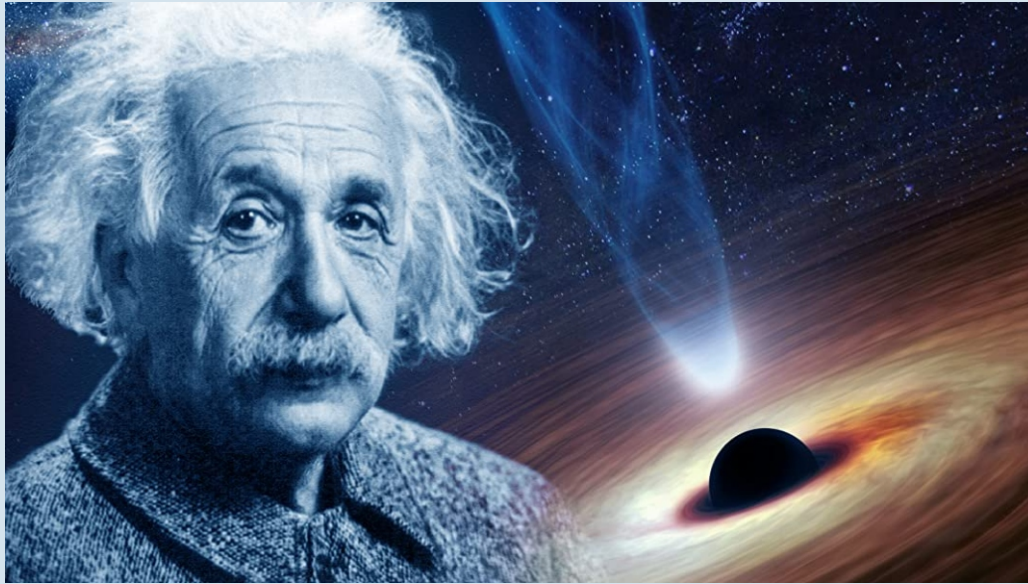
Friends, technology is great! But even greater is the way how you use it! Be smarter than your smart phone and smart TV. Use it judiciously. Just as you always like your independence, let technology be dependable but not dependent!

Just while I was writing this, I remember previously I used to pen it down on a piece of paper, now I just type on it on my cell phone! Being an author, I just hope I don't forget writing actually!

Spreading Positivity
RJ ROCKS.

RELATIVITY

By Dr. Tanvi Davda
DrNB [Urology]



'E=MC²', said Einstein.

Theory of relativity is what he defined.

Little did I know that in my mind,
This would be etched as a philosophy sublime.
They say, 'time doesn't wait for anyone'. It just goes on and on and on.
Or is that just what we feel,
Coz time does stop in moments of zeal.
Sometimes, I think of the worst,
And they call it an anxiety burst.
But where do I draw the line?
Between being a pessimist and an optimist divine.
Sometimes he drives really fast.
They say he's rash and stand aghast. He saved a life and was so responsible, But how do I
break their measly bubble?
Some friends are much more than family, And some from my family maul me verily. Then
who's the saint and who's the fiend? Someday I hope this pandemonium will end.
She earned her living as an upright harlot. Coz she tried her best but lost by ballot.
She had her little munchkins to rear and feed, Shall I dare to call this a noble deed?
The nation feels he displayed exemplary valour. As for him, red was just a regular colour.
The enemies called him a mass murderer.
His allies called him an honourable soldier.
When you try hard to be part of the inner circle, Rather than follow your heart and face
the hurdle. You may die for the cause and seem to few like a hero, But actually you're a
nefarious, empty little zero.
So what holds true for you may not hold true for me.
A matter of sorrow for you, may be to her a source of glee.
'The only thing that is constant is change', said Gandhiji.
Isn't it the same philosophy that Einstein proved mathematically?



33rd Annual Conference of Urological Society of India West Zone (USIWZ)

Sheraton Grand Palace, Indore | 6-8 October 2023
"THE CLEANEST CITY OF INDIA AWAITS YOU"



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REGISTRATION FEES

	1 st Oct 2022 - 15 th April 2023	16 th April 2023 - 15 th Sept. 2023	15 th Sept. 2023 Onwards
Registration fees only (without accommodation)			
Delegates	10500	12500	15000
Accompanying Person	9500	11500	14000
Post Graduates	9000	11000	13000

ACCOMMODATION TARIFF

HOTEL SHERATON GRAND PLACE (VENUE)	Upto 15 th April 2023	16 th April 2023 Onwards
Delegate (2 Nights)	26000	28000
Delegate (3 Nights)	39000	42500

HOTEL RADISSON BLU (6 KMS FROM VENUE)	Upto 15 th April 2023	16 th April 2023 Onwards
Delegate (2 Nights)	20000	24000
Delegate (3 Nights)	30000	36000

All rates are including GST.

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Account Name: USIWZ AC MADHYA PRADESH | Account Number: 50200072454870
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