

Scientific Committee Annual Report 2018

Laurence Stewart – Elected Scientific Chair

Following a very successful Scientific Program Meeting, which took place from May 14th to 16th in Philadelphia, The Committee is pleased to report:

There was a fall in submitted abstracts this year, 833 being received and this is likely to reflect the increased pressure on budgets and leave and reduced industry support.

Having implemented the recommendations of Steinar Hunskaar there was much improved overall scoring and more consistency between scorers. This can be improved further by ensuring a minimum of 3 and maximum of 5 scorers for each abstract. We will also strive to reduce potential distorting effects from wayward individual markers and those seen to be consistent outliers will have all their scored excluded from the pool of scores.

We also recognise that we have no scorers who regard themselves as expert in imaging although some express a major interest and as this area appears to be growing we may need to consider co-opting an imaging expert to mark abstracts. Whilst we recognise the importance of ethics, given the very small number of abstracts received we are unable to give prominence to this field in the presented programme.

We continue to use the editorial board of the NUU as scorers and this increased manpower has been of much benefit over the years but we are aware of the burden of work on these individuals and to try and minimise the workload we will specifically ask which editorial board members wish to score abstract and limit this to abstracts only in their specific field of expertise.

There remains a wide distribution of submitted and accepted abstracts both by geography and speciality, which is encouraging and endorses our commitment to being a global multidisciplinary organisation. To facilitate this we must be able, from time to time, to co-opt an expert onto the committee to represent an unrepresented speciality as has happen in the past.

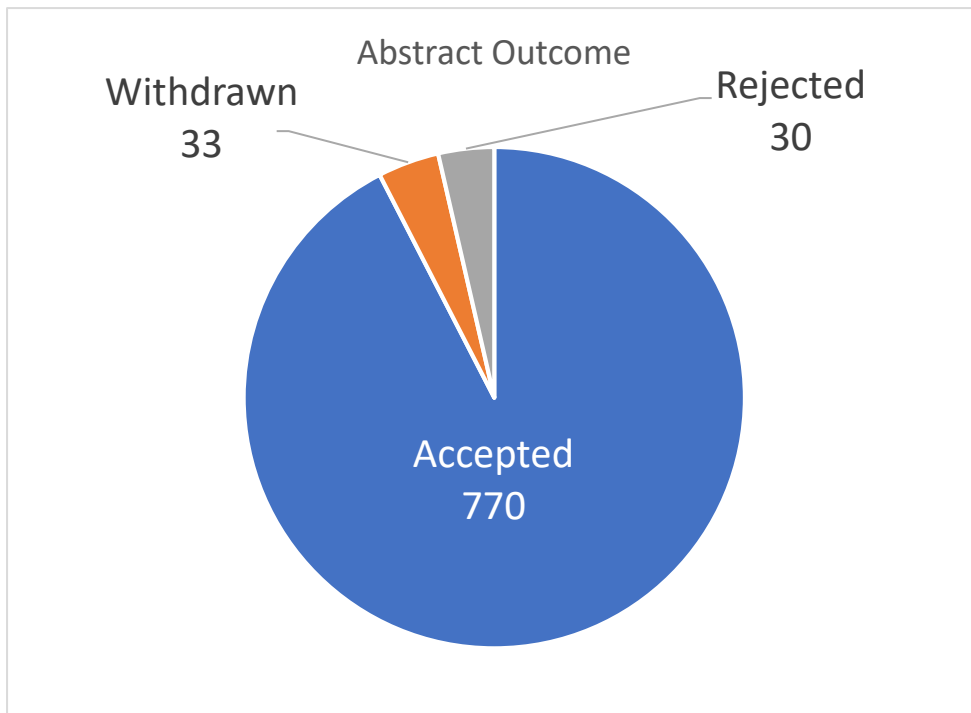
The two day planning meeting remains sufficient to pull the programme together but is only possible with our face to face meeting, facilitated by the expert IT provided by Dom and Ashley. So despite the very significant work performed before hand this remains the cornerstone in constructing a successful meeting.

We continue to refine our programme putting increased volume and quality into the e-poster sessions and with that in mind we aim to make these sessions increasingly robust and educational. They therefore, deserve the same quality of facilities as that afforded to the more formal podium sessions.

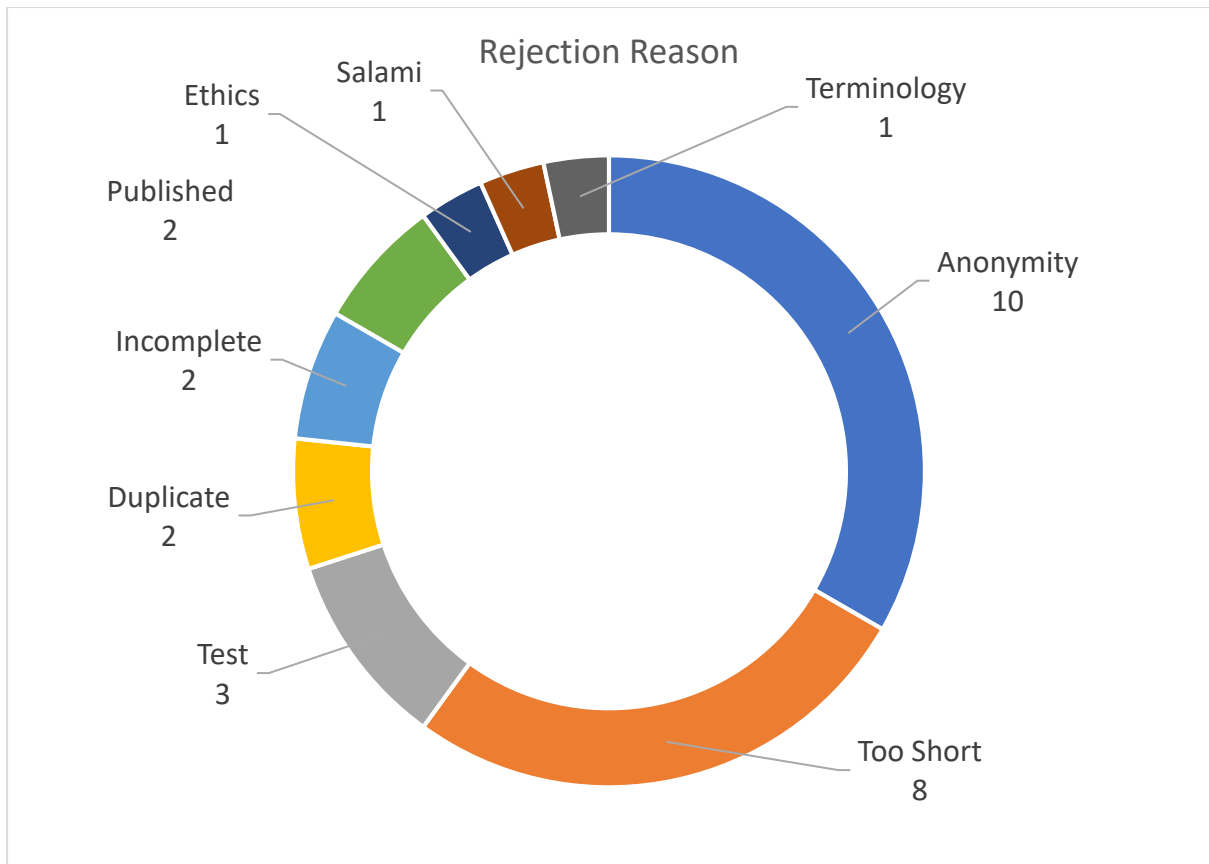
The live surgery session at Florence was discussed. It was technically difficult, poorly attended and controversial. Technically, logistically and legally live surgery would have been difficult in Philadelphia and we have also agreed not to have live surgery for the foreseeable future.

The statistics for this year's meeting are attached.

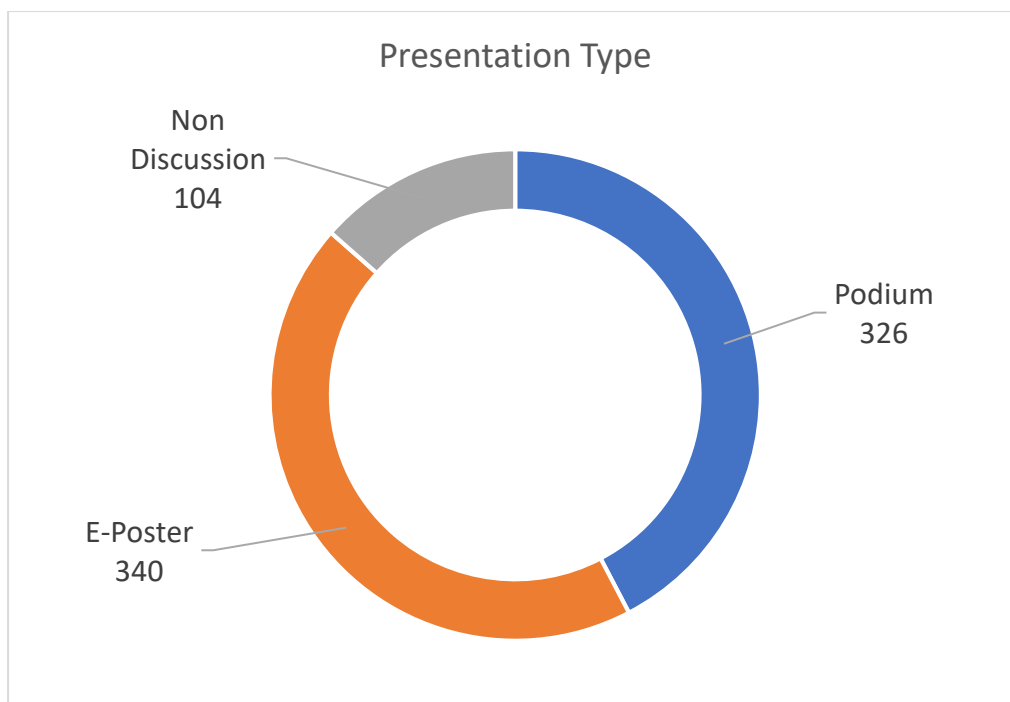
Abstract Outcome	Total	%
Accepted	770	92.4
Withdrawn	33	4.0
Rejected	30	3.6
Total	833	



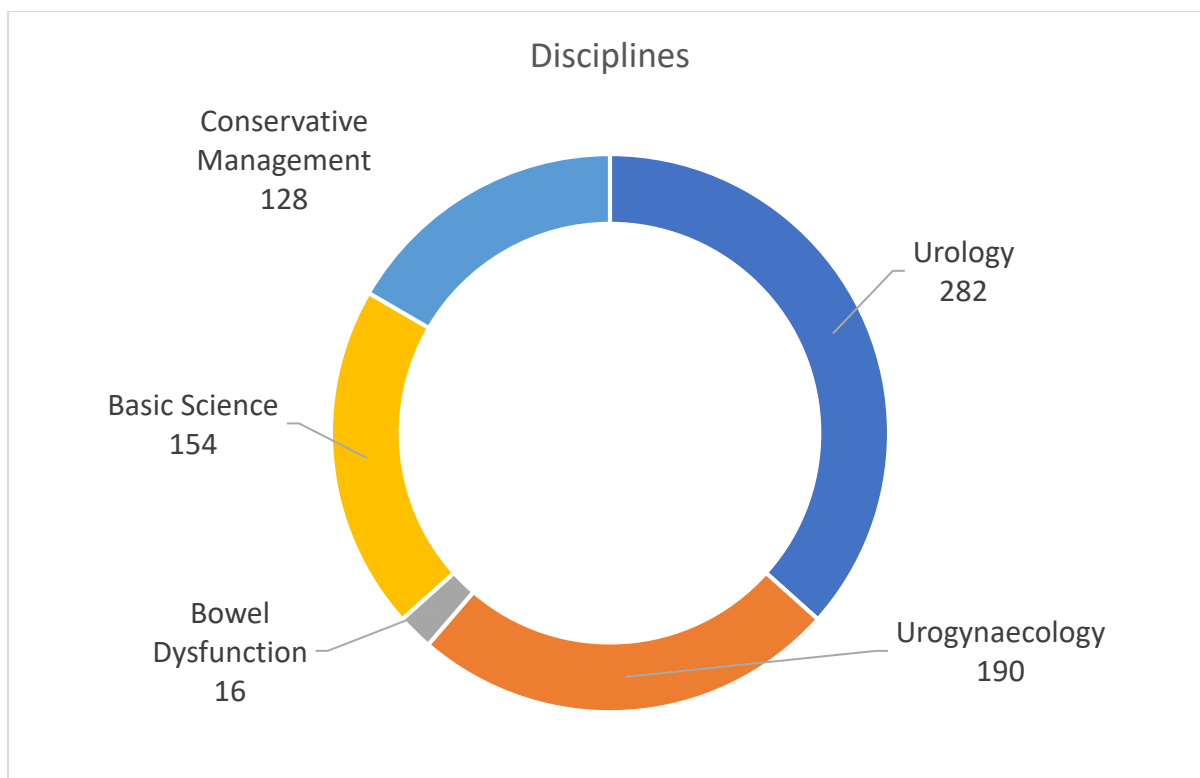
Rejection Reason	Total	%
Anonymity	10	33.3
Too Short	8	26.7
Test	3	10.0
Duplicate	2	6.7
Incomplete	2	6.7
Published	2	6.7
Ethics	1	3.3
Salami	1	3.3
Terminology	1	3.3
Total	30	



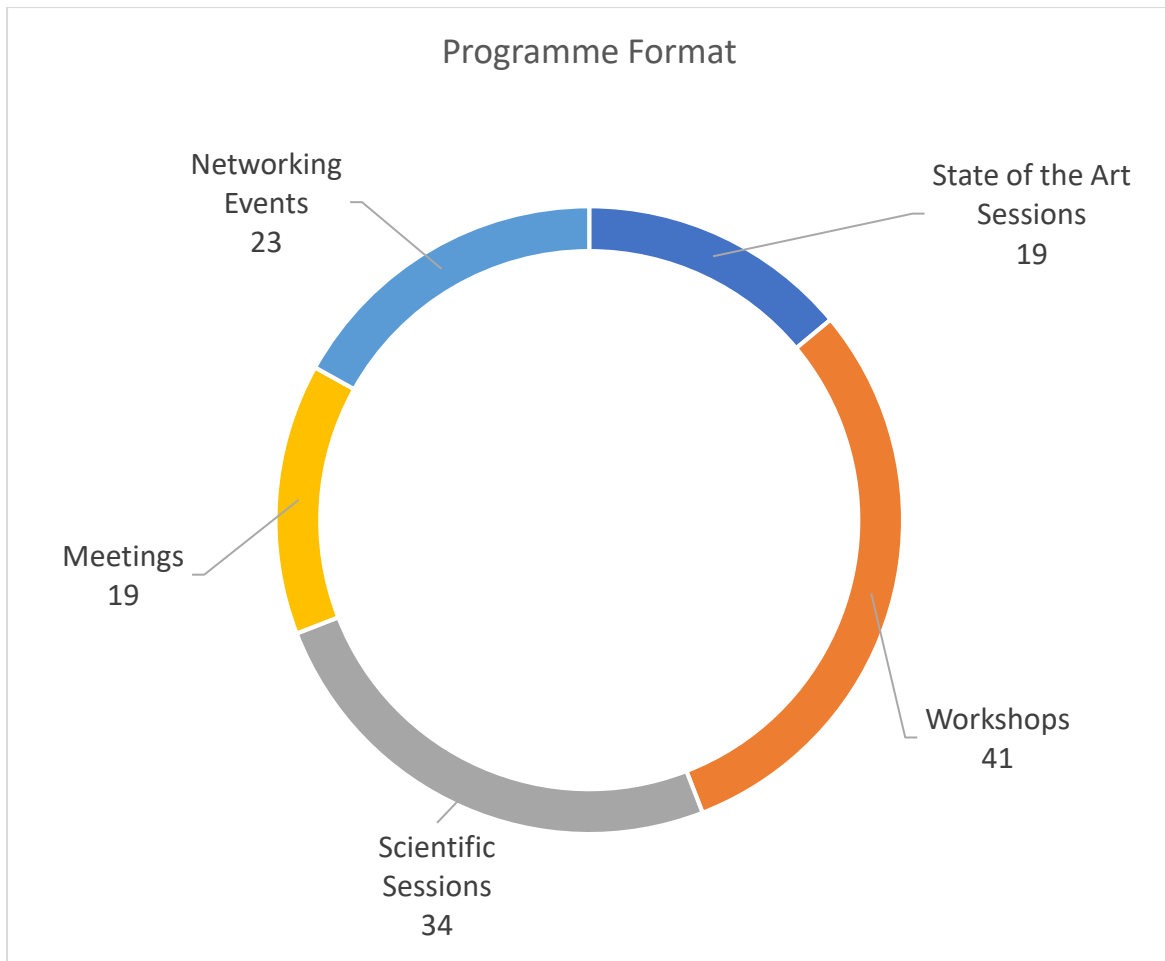
Presentation Type	Total	%	Session Type	Total	%
Podium	326	42.3	Podium	18	2.3
			Podium Short Oral	288	37.4
			Podium Video	20	2.6
E-Poster	340	44.1558	Open Discussion ePoster	340	44.2
Non Discussion	104	13.5	Non Discussion Video	7	0.9
			Non Discussion Abstract	97	12.6
Total	770		Total	770	



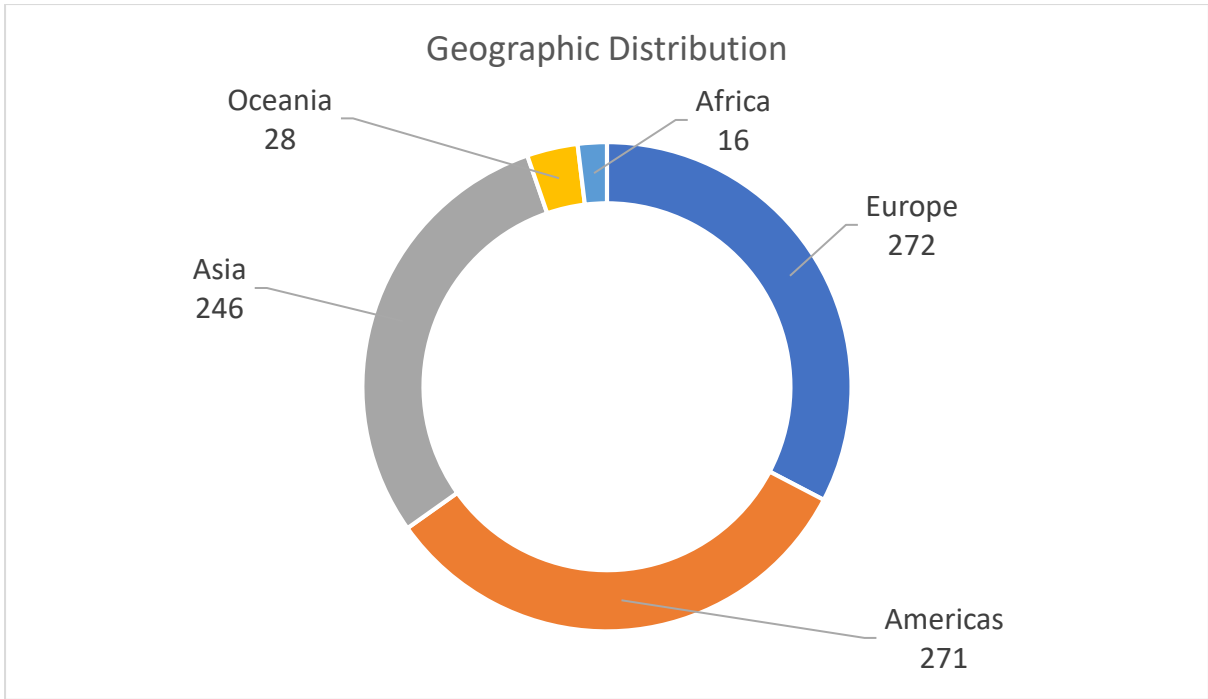
Track	Total	%	Category	Abstracts	%
Urology	282	36.6	Overactive Bladder	87	11.3
			Male Lower Urinary Tract Symptoms (LUTS) / Incontinence	74	9.6
			Urodynamics	46	6.0
			Urethra Male / Female	23	3.0
			Prostate Clinical / Surgical	22	2.9
			Nocturia	21	2.7
			Paediatrics	9	1.2
Urogynaecology	190	24.7	Female Lower Urinary Tract Symptoms (LUTS) / Voiding Dysfunction	71	9.2
			Female Stress Urinary Incontinence (SUI)	63	8.2
			Pelvic Organ Prolapse	35	4.5
			Imaging	21	2.7
Bowel Dysfunction	16	2.1	Anorectal / Bowel Dysfunction	16	2.1
Basic Science	154	20.0	Neurourology	71	9.2
			Pelvic Pain Syndromes / Sexual Dysfunction	40	5.2
			Pharmacology	26	3.4
			Research Methods / Techniques	17	2.2
Conservative Management	128	16.6	Continence Care Products / Devices / Technologies	30	3.9
			Quality of Life / Patient and Caregiver Experiences	27	3.5
			Anatomy / Biomechanics	19	2.5
			Conservative Management	18	2.3
			Prevention and Public Health	15	1.9
			Rehabilitation	8	1.0
			Health Services Delivery	7	0.9
			Geriatrics / Gerontology	3	0.4
Ethics	1	0.1			
Total	770		Total	770	



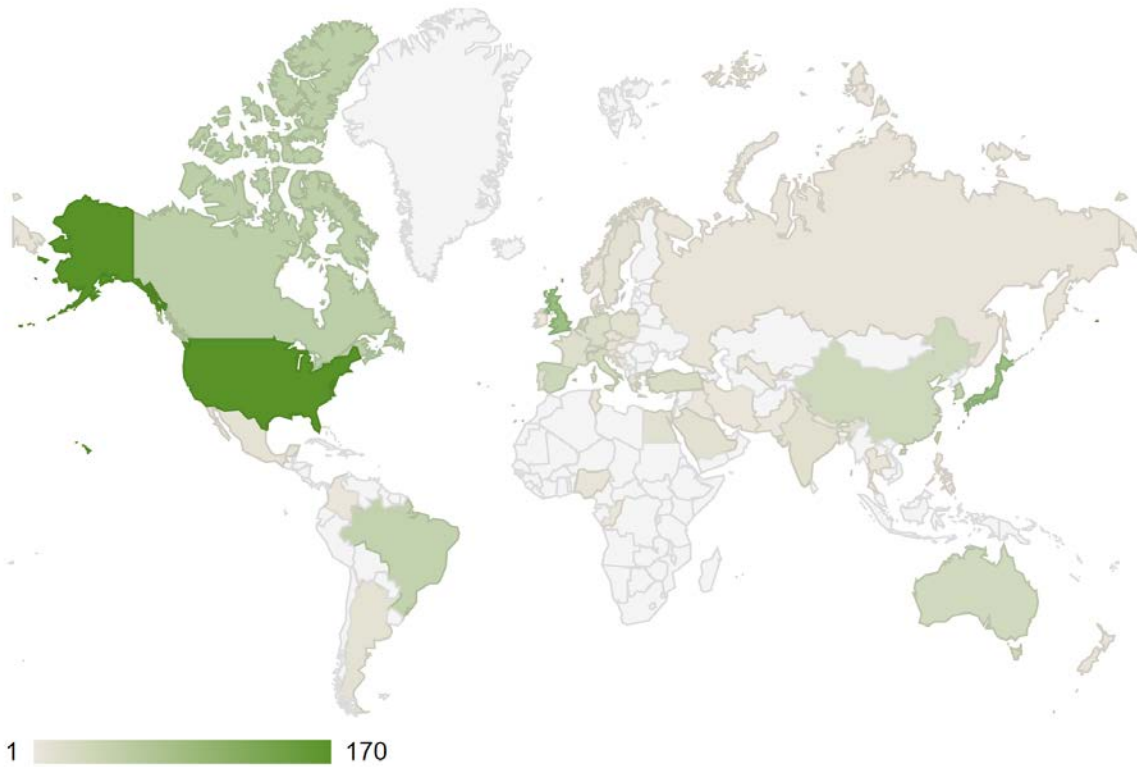
Type	Total	%	Session	Total	%
State of the Art	19	14.0	State of the Art Lecture	3	2.2
			Spotlight On	7	5.1
			Round Table Discussion	9	6.6
Workshop	41	30.1	Workshop	31	22.8
			Committee Activity	8	5.9
			Physical Activity	2	1.5
Scientific	34	25.0	Podium	3	2.2
			Podium Short Oral	26	19.1
			Podium Video	2	1.5
			Open Discussion ePoster	3	2.2
Meeting	19	14.0	Committee Meeting	16	11.8
			Society Meeting	2	1.5
			Business Meeting	1	0.7
Networking	23	16.9	Social Event	6	4.4
			Lunch	4	2.9
			Coffee Break	13	9.6
Total	136		Total	136	



Continent	Total	%
Europe	272	32.7
Americas	271	32.5
Asia	246	29.5
Oceania	28	3.4
Africa	16	1.9
Total	833	



Geographical Submission Location



Abstracts Accepted from 53 countries!

Country	Accepted Abstracts
United States	170
Japan	78
United Kingdom	78
Canada	45
Korea, South	40
Brazil	39
Taiwan	34
Spain	30
China	28
Australia	25
Netherlands	25
Italy	24
Turkey	18
Germany	16
France	13
Switzerland	13
Belgium	11
India	11
Poland	10
Portugal	10
Egypt	9
Saudi Arabia	9
Sweden	9
Argentina	8
Greece	7
Mexico	7
Israel	5
Lebanon	5
Norway	5
Austria	4
Czech Republic	4
Slovenia	4
Denmark	3
Hong Kong	3
New Zealand	3
Nigeria	3
Russia	3
Singapore	3
Tunisia	3
Colombia	2
Iran	2
Slovakia	2
Thailand	2
Bosnia and Herzegovina	1
Congo, Republic of the	1
Croatia	1
Iraq	1
Ireland	1

Malta	1
Nepal	1
Pakistan	1
Philippines	1
Uzbekistan	1
TOTAL	833

New Abstracts Supplement Publishing Format in Neurourology & Urodynamics

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5240
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298 [www.ics.org/doi/10.1093/abct/298](https://doi.org/10.1093/abct/298)

BEST IN CATEGORY PRIZE "URODYNAMICS"

CHANGE OF DETRUSOR CONTRACTILITY IN PATIENTS WITH AND WITHOUT BLADDER OUTLET OBSTRUCTION AFTER OVER TEN-YEAR FOLLOW-UP

Chen S¹, Ong M¹, Lee Y¹, Kuo H¹

¹ Department of Urology, Buddhist Tzu Chi General Hospital and Tzu Chi University, Hualien, Taiwan

HYPOTHESIS / AIMS OF STUDY
Detrusor contractility is believed to decrease with time. However, longitudinal study of the detrusor contractility after long-term follow-up is rare. This study investigated a cohort of male and female patients who had urodynamic study at baseline and more than 10 years later.

STUDY DESIGN, MATERIALS AND METHODS
A total of 166 patients (69 men and 117 women) without bladder outlet obstruction (BOO) and 63 patients (54 men and 9 women) proven to have BOO who had received urodynamic study at baseline and > 10 years later. Patients who had neurogenic voiding dysfunction, previous pelvic surgery, who underwent lower urinary tract surgery or bladder lesions receiving treatment during the follow-up period were excluded. The urodynamic parameters including bladder first sensation of filling (FSF), full sensation (FS), urge sensation (US), cystometric bladder capacity (CBC), compliance, maximum flow rate (Qmax), detrusor pressure at Qmax (Pdet), voided volume, postvoid residual volume (PVR), bladder contractility index (BCI), and BOO index (BOOI) were compared between baseline and >10 years later.

RESULTS
The changes of urodynamic parameters between baseline and >10 years later revealed that Pdet was significantly decreased and PVR was significantly increased in men and women. FS, US, and voided volume were significantly decreased. BCI was also significantly decreased in men and women (Table 1). When we compared the 49 men without BOO and 54 men with BOO, decrease of Pdet, Qmax, voided volume, and BCI were significantly decreased in both groups. PVR was also significantly increased in both groups and was significantly greater in men with BOO after >10 years (p=0.036) (Table 2).

INTERPRETATION OF RESULTS
Detrusor contractility decreases in men and women after > 10 years follow-up. The decrease of detrusor contractility was similar between men with and without BOO. PVR was significantly increased in men with BOO after >10 years, suggesting a greater degree of urethral resistance in men with BOO after >10 years.

CONCLUDING MESSAGE
Detrusor contractility will decrease with time in both men and women. Men with BOO did not have higher rate of decreased contractility, but PVR increased more than men without BOO.

FIGURE 1

Table 1. The changes of urodynamic parameters between baseline and >10 years later

Item	Male (n=49)	Female (n=117)	P value
FSF (ml)	Baseline: 120.91 ± 57.23 >10 years: 120.79 ± 49.25	Baseline: 124.02 ± 47.54 >10 years: 124.82 ± 49.25	0.827
FS (ml)	Baseline: 175.42 ± 86.53 >10 years: 159.69 ± 103.18	Baseline: 207.28 ± 89.68 >10 years: 205.33 ± 103.09	0.024
US (ml)	Baseline: 205.33 ± 103.09 >10 years: 205.33 ± 103.09	Baseline: 205.33 ± 103.09 >10 years: 205.33 ± 103.09	0.524
CBC (ml)	Baseline: 205.33 ± 103.09 >10 years: 205.33 ± 103.09	Baseline: 205.33 ± 103.09 >10 years: 205.33 ± 103.09	0.965
Compliance	Baseline: 41.81 ± 21.46 >10 years: 41.81 ± 21.46	Baseline: 41.81 ± 21.46 >10 years: 41.81 ± 21.46	0.810
Qmax (ml/s)	Baseline: 36.57 ± 15.07 >10 years: 36.57 ± 15.07	Baseline: 37.81 ± 15.11 >10 years: 36.57 ± 15.07	0.256
Pdet (mmHg)	Baseline: 84.7 ± 4.09 >10 years: 84.7 ± 4.09	Baseline: 84.7 ± 4.09 >10 years: 84.7 ± 4.09	0.269
Volume (ml)	Baseline: 205.33 ± 103.09 >10 years: 205.33 ± 103.09	Baseline: 205.33 ± 103.09 >10 years: 205.33 ± 103.09	0.048
PVR (ml)	Baseline: 54.22 ± 24.87 >10 years: 54.22 ± 24.87	Baseline: 54.22 ± 24.87 >10 years: 54.22 ± 24.87	0.042
BOO	Baseline: 105.67 ± 40.74 >10 years: 105.67 ± 40.74	Baseline: 105.67 ± 40.74 >10 years: 105.67 ± 40.74	0.429
BOOI	Baseline: 58.37 ± 37.26 >10 years: 58.37 ± 37.26	Baseline: 58.37 ± 37.26 >10 years: 58.37 ± 37.26	0.235

FIGURE 2

Table 2. The changes of urodynamic parameters between men with and without BOO (>10 years later)

Item	Men (BOO)	Men (non-BOO)	P value
Qmax (ml/s)	Baseline: 33.8 ± 17.4 >10 years: 42.8 ± 22.3	Baseline: 42.8 ± 22.3 >10 years: 42.8 ± 22.3	0.040
Qmax (ml/s)	Baseline: 33.8 ± 17.4 >10 years: 42.8 ± 22.3	Baseline: 42.8 ± 22.3 >10 years: 42.8 ± 22.3	0.040
Volume (ml)	Baseline: 248.4 ± 126.4 >10 years: 237.3 ± 102.3	Baseline: 248.4 ± 126.4 >10 years: 237.3 ± 102.3	0.103
PVR (ml)	Baseline: 43.2 ± 16.03 >10 years: 30.3 ± 18.1	Baseline: 43.2 ± 16.03 >10 years: 30.3 ± 18.1	0.036
BCI	Baseline: 326.9 ± 12.3 >10 years: 326.9 ± 12.3	Baseline: 326.9 ± 12.3 >10 years: 326.9 ± 12.3	0.179
BOOI	Baseline: 53.7 ± 25.5 >10 years: 53.7 ± 25.5	Baseline: 53.7 ± 25.5 >10 years: 53.7 ± 25.5	0.714

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299 [www.ics.org/doi/10.1093/abct/299](https://doi.org/10.1093/abct/299)

DEVELOPMENT OF A DIGITAL PATIENT-REPORTED OUTCOME MEASURE (PROM) FOR REAL-TIME ASSESSMENT OF OVERACTIVE BLADDER SYNDROME.

Hennrichs A¹, Wark L¹, Leue C¹, Krause J¹, van Kesteren G¹, Wilms D¹

¹ Maastricht University Medical Center, Department of Urology, Pevier Care Center, ² Maastricht University Medical Center, Division of Gastroenterology/Hepatology, Department of Internal Medicine, ³ Maastricht University Medical Center, Department of Psychiatry and Medical Psychology

HYPOTHESIS / AIMS OF STUDY
In the current diagnostic process for overactive bladder syndrome (OAB), biased retrospective questionnaires are frequently used. There is a need for a new assessment tool that overcomes the heterogeneity of the OAB complex and overcomes the limitations of retrospective questionnaires, including contextual and recall bias. A momentary assessment tool, the digital Experience Sampling Method (ESM), is promising. ESM captures random repetitive measurements during the day, in the context of daily life, and is capable of measuring potential contextual triggers and psychological aspects. The aim of this study is to develop a new patient-reported outcome measure (PROM) for OAB, a smartphone app named 'Uromate', following the FDA guidelines on PROM development (1).

STUDY DESIGN, MATERIALS AND METHODS
'Uromate' was created based on the ESM literature. The development of an initial draft list of questions, a focus group study, and an expert meeting to evaluate which items should be implemented in an urological ESM tool. The initial draft list consisted of questions regarding different domains: somatic items (urological and otherwise), nutrition and drug use, psychological items, and situation and company. Items concerning social factors, contextual and environmental factors and psychological status following the ESM specific construct, were derived from questions used in previous ESM validation studies in the field of Psychiatry and Gastroenterology (2,3). Urological questions were derived from validated questionnaires (i.e., OAB-q, KIQ-FLUTS, MLUTS, ICQ-OAB, KHQoL, BFLUTS, SF-36) and were rephrased to suit momentary assessment. The possible end-points for all items were ranged by use of an 11 points Numeric Rating Scale (NRS), if applicable. The 11 points NRS was chosen based on FDA recommendations (1). Focus group interviews and an expert meeting were conducted to broadly explore the knowledge and experience from patients and experts for item selection, in agreement with FDA guidelines on PROM development (1). The experts in the meeting were specialists in the field of functional urology or other functional disorders including two urologists, a gynaecologist, a gastroenterologist and a hospital psychiatrist.

RESULTS
Thirteen female subjects were present during the focus group meeting, of whom 9 suffered from OAB and 4 from mixed urinary incontinence (MUI) (Table 1). Saturation of input, the point during the study where no new input was brought in, was reached after two meetings.

The majority of patients experienced urgency as an intensified sensation of the normal urge. One patient experienced no urgency but only pain in the lower abdomen prior to urinary leakage. Another patient experienced leakage without prodromal sensations. Urgency to defecate was also incorporated in 'Uromate', since some patients stated that both urinary and faecal urgency occurred simultaneously.

Patients noted that liquid intake, the amount rather than the nature of the liquid, was a very important item. Most patients adjusted the amount of fluid intake when going outside. Coffee or tea were not mentioned as voiding triggers.

Several somatic complaints were included in the proposed list of questions for 'Uromate', such as palpitations, sweating, shortness of breath, dizziness, muscle pain and painful joints. A few patients reported the whole range of proposed somatic complaints. However, focus group participants could not mention one specific non-urological somatic complaint associated with OAB. Additionally, patients advised to add vaginal pain as a somatic symptom to the list of questions.

Furthermore, patients were asked to point out the least relevant psychological items, leading to a substantially shortened list of items. 'Energetic', 'enthusiastic', 'happy', 'strong', 'worried', 'inspired', 'disappointed', 'insecure' and 'guilty' were removed, because patients found those items not to be associated with OAB.

Situation and company were very important factors, influencing the psyche and severity of complaints. Patients stated that they felt uncomfortable in situations where people did not show understanding of their urological complaints. They felt that people do not take their complaints seriously.

A morning questionnaire was developed to evaluate the symptom pattern during the night. Participants considered the frequency of awakening and whether awakening was due to urological symptoms the most important.

Initially, sexuality questions were not incorporated, because reported assessment was not considered useful. Nevertheless, patients missed questions about sexuality in the list of 'Uromate' items. To them, sexuality was an important item, because their sexual functioning was impaired due to OAB complaints. Hence, integration in the morning questionnaire was proposed.