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144 GENITOURINARY INJURY PRESENTING TO US EMERGENCY DEPARTMENTS ACROSS AGE RANGES

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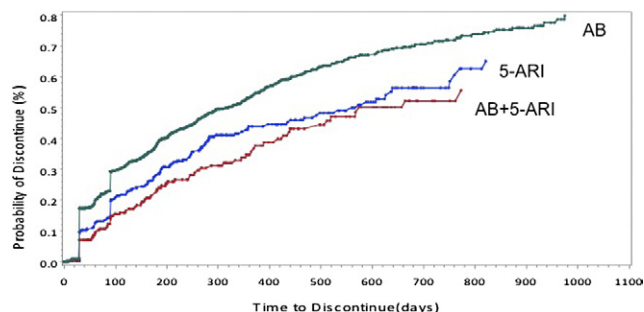
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143

TRENDS AND VARIATION IN MEDICAL MANAGEMENT OF MEN WITH BENIGN PROSTATIC HYPERPLASIA AND LOWER URINARY TRACT SYMPTOMS (1993-2010)

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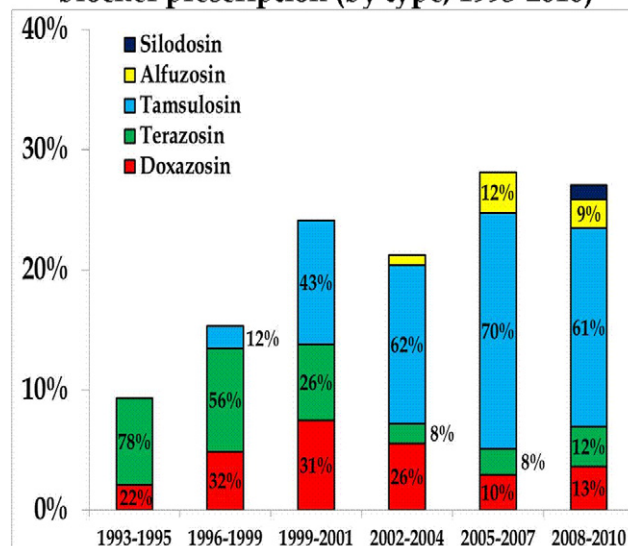
INTRODUCTION AND OBJECTIVES: Management options for men with benign prostatic hyperplasia (BPH) and lower urinary tract symptoms (LUTS) have evolved over the last 15 years. We used a population-based survey to describe historical trends and variation in medical management of men with BPH/LUTS in the United States.

METHODS: We used the National Ambulatory Medical Care Survey (1993-2010) to evaluate outpatient office visits by men with BPH/LUTS. Visits for BPH/LUTS were based on ICD-9 diagnosis codes for BPH and/or patient self-report of LUTS. Prescriptions of interest included α -blockers (AB), 5- α reductase inhibitors (5ARI), and anticholinergics (AC). Standardized survey weights were applied to obtain national estimates. Data from multiple years were occasionally combined to ensure statistical reliability. Linear trends over time were analyzed using χ^2 tests. Factors associated with AB use were evaluated with χ^2 tests and multivariable logistic regression. All tests were performed to the 5% level of significance.

RESULTS: From 1993-2010, there were over 141 million outpatient visits for men with BPH/LUTS. Among these visits, ABs were prescribed most commonly, increasing from 6.4% of visits in 1993 to nearly 30% in 2010 ($p < 0.01$). Use of 5ARIs increased from 3.8% of visits in 1993-1994 to 14.3% of visits in 2009-2010 ($p < 0.01$). Use of ACs also increased, from 2.3% of visits in 1999-2000 to 8.2% of visits in 2009-2010. Use of terazosin decreased from 78% of AB prescriptions from 1993-1995 to 12% from 2008-2010 (Figure). In the modern era, tamsulosin was the most common AB prescribed, representing 61% of prescriptions from 2008-2010 (Figure). Use of AB did not vary by race, region, or insurance status (all $p > 0.05$). Compared to primary care physicians, urologists were no more likely to prescribe ABs prior to the introduction of tamsulosin (OR 0.88, 95% CI 0.57-1.35). However, after tamsulosin was available, urologists were nearly twice as likely to prescribe ABs (OR 1.92, 95% CI 1.41-2.62).

CONCLUSIONS: Over the past 15 years, there has been a steady increase in use of medications to manage men with BPH. Urologists were more likely to prescribe ABs after tamsulosin was available, suggesting that urologists may adopt novel medications more readily than primary care providers.

Figure. Proportion of visits with alpha-blocker prescription (by type, 1993-2010)



Source of Funding: NIH T32 Clinical Training Grant.

144

GENITOURINARY INJURY PRESENTING TO US EMERGENCY DEPARTMENTS ACROSS AGE RANGES

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INTRODUCTION AND OBJECTIVES: The epidemiology of acute genitourinary (GU) injury in the U.S. is poorly characterized, particularly in outpatient populations. We studied the characteristics of patients presenting to US emergency departments (ED) with GU injury stratified across differing age ranges.

METHODS: We used the National Electronic Injury Surveillance System, a dataset validated to provide a probability sample of US ED injury presentations, to analyze patients who sustained product-related GU injuries from 2002-2010.

RESULTS: An estimated 394,536 (95% CI 320,903-468,158) individuals presented to US EDs with GU injury. 64% of patients were children (under age 18), and most injuries involved external genitalia (73%). 93% of children were managed in the ED without inpatient admission. Children 4-7 years old were most frequently injured, with 37% of pediatric GU injuries. These children presented after falls from furniture (20%), use of sporting equipment such as bicycles (20%), or use of playground equipment (16%). One third of injuries in children under 1 year of age occurred in the bathroom: due to trauma with a tub or sink (42%), or from hot water scalds (13%). Most injuries for children over 8 were associated with sporting equipment (40%) or at a playground (12%). Common sources of penile injury in children included crush from a toilet seat (20%) or zipper injury (17%).

The majority of all adults with GU injuries were managed and discharged from the ED (88%), however, 33% of those aged 65+ years required inpatient admission. The highest proportion of adult GU injuries occurred to those 18-28 years of age (38%). These injuries occurred as a result of bicycle and other sporting injuries (33%), genital grooming injuries from razor or scissor use (9%), or falls from furniture (7%). Zipper injuries were the most common source of injury to the penis (33%). As individuals aged, GU injuries resulting from falls in the bathroom (in showers and tubs) and from climbing fixtures (stairs and ladders) steadily increased. Specifically, these injuries represented a quarter of injuries for those aged 65+ years, in comparison to less than 10% of those 18-28 years and 29-45 years of age.

CONCLUSIONS: Our results suggest that GU injuries are a significant health concern resulting in nearly 45,000 ED presentations

each year. We were able to identify specific etiologies of injury across differing age ranges. An understanding of such associations may be helpful in prevention of injury via product and behavior modification. Furthermore, this information may be useful in directing the education of practitioners evaluating and treating GU injuries.

Source of Funding: None

**145
LIMITED USE OF FOLLOW-UP IMAGING AMONG PATIENTS
AFTER PARTIAL OR RADICAL NEPHRECTOMY FOR RENAL
CELL CARCINOMA**

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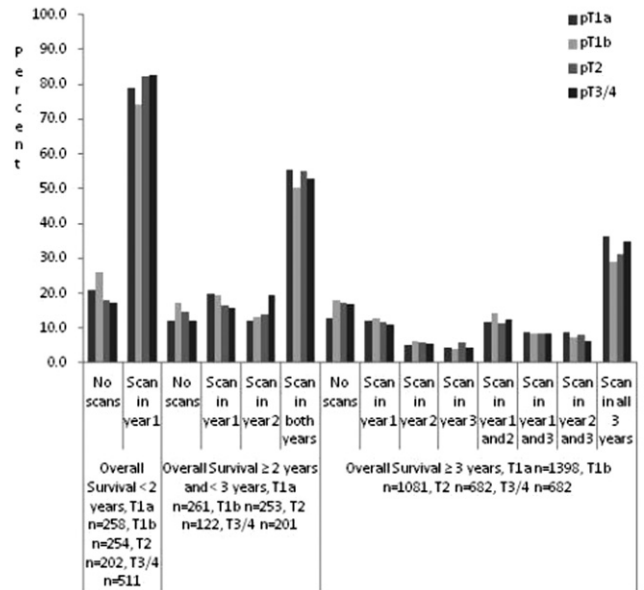
INTRODUCTION AND OBJECTIVES: While many recommended stage-specific and risk-adapted algorithms for postoperative surveillance in renal cell carcinoma (RCC) are available, utilization of these recommendations remains unexplored. We evaluated use of follow-up imaging after partial or radical nephrectomy (P/RNx) in nationally representative data.

METHODS: Using Surveillance, Epidemiology, End Results data linked to Medicare records, we identified patients with RCC treated with P/RNx who were diagnosed from 1997-2007 with follow up through 2009 (N=5905). Patients were stratified by pathologic tumor stage (T1a n=1917, T1b n=1588, T2 n=1006, T3/4 n=1394) and overall survival (< 2 years, 2 to < 3 years and ≥ 3 years). Postoperative abdominal (ultrasound or computed tomography [CT]) and chest (chest roentgenogram or CT) imaging for 3 years following P/RNx was identified for all patients. Imaging was ascertained through the year of cancer recurrence (algorithm based on receipt of secondary therapy for RCC or visits to medical or radiation oncology providers). Intensity of postoperative imaging, stratified by overall survival, was compared between patients with low (T1a) and high risk (T3/4) disease (Chi-square test).

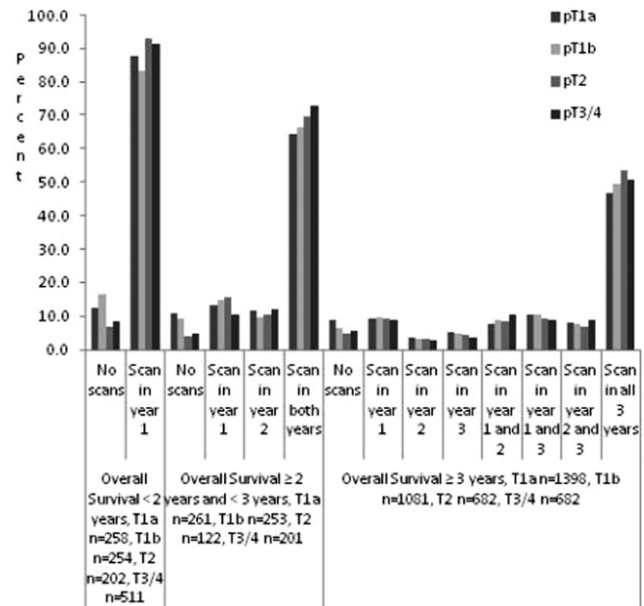
RESULTS: Abdominal and chest imaging stratified by tumor stage and overall survival are shown in figures 1 and 2. Across all survival strata, there were no differences in postoperative abdominal imaging between patients with T1a and T3/4 disease (p > 0.05 for all). Use of postoperative chest imaging was different between patients with T1a and T3/4 disease only for those patients with an overall survival of ≥ 3 years (p=0.01).

CONCLUSIONS: Our analysis reveals that, contrary to suggested algorithms, most patients with RCC have limited use of follow-up imaging after surgery with less than 50% of patients receiving annual abdominal and chest imaging at 3 years. Further, we also found that the risk of disease recurrence was unlikely to affect the intensity of postoperative imaging.

Abdominal imaging (ultrasound or computed tomography) through 3 years following partial or radical nephrectomy stratified by tumor stage and overall survival



Chest imaging (chest x-ray or computed tomography) through 3 years following partial or radical nephrectomy stratified by tumor stage and overall survival



Source of Funding: 1. Clinical and Translational Science Award (CTSA) program of the National Center for Research Resources (NCRR) at the National Institutes of Health (NIH) Grant Numbers UL1 RR024992 and KL2 RR024994. 2. American Cancer Society Institutional Review Grant IRG-58-010-53.

**146
INCREASING USE OF SACRAL NEUROMODULATION
PROCEDURES AMONGST CERTIFYING AMERICAN
UROLOGISTS**

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INTRODUCTION AND OBJECTIVES: Sacral neuromodulation (SNM) alters sacral nerve signals influencing bladder and adjacent pelvic musculature. SNM was first FDA-approved in 1997 for urge urinary incontinence, and subsequently for non-obstructive urinary