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The Hartford HealthCare Tallwood Urology & Kidney Institute was formed as a system-wide entity in 2015 to provide oversight of the complete patient experience through all transitions of care and points of service within the system for individuals being treated for urologic and kidney conditions. Our innovative institute approach is unlike any other in the state and is among the most highly regarded in the nation. Foundational to the institute model are our clinical councils, which are comprised of physicians and caregivers with expertise in specific diseases and conditions. Our clinical councils help ensure best practices are applied throughout the system and that patients receive the same high standard of care no matter where they live or which Hartford HealthCare facility they choose. Clinical councils bring caregivers and leadership together to establish medical guidelines and standards of care designed to reduce variability among providers and facilities, improve quality and outcomes, and enhance the patient experience. The councils also look at gaps in care and explore growth opportunities to better serve our communities.

The Tallwood Urology & Kidney Institute is organized around these five clinical councils:

**Men's Health** Introduced in 2018 under the direction of andrology trained urologist Dr. Jared Bieniek, Tallwood Men's Health provides a new and innovative model of care designed specifically for men. Built around a multidisciplinary and clinically-integrated team of specialists in urology, endocrinology, cardiology, behavioral health, medical and surgical weight loss, sleep medicine, colorectal health and geriatric medicine, and supported by a nurse navigator to help reduce access barriers to care, Tallwood Men's Health provides men with a more holistic approach to managing their health.

**Kidney Stones** Under the leadership of Dr. Joshua Stein, Tallwood urologists and nephrologists partner with such Hartford HealthCare specialists as radiologists, registered dietitians and emergency care providers, to develop clinical guidelines and protocols that improve the way we care for those suffering from kidney stones. Performing procedures such as shock wave and laser lithotripsy, ureteroscopic stone removal and percutaneous nephrostomy, Tallwood Institute experts lead the market by treating more than 2,000 stone transitions of care each year.

**Pelvic Health** Co-led by female pelvic medicine reconstructive surgeons Drs. Richard Kershen, Christine LaSala and Paul Tulikangas, Tallwood’s team of urologists and urogynecologists are recognized as regional and national leaders in their fields. Many have pioneered treatments that have become the gold standard of care nationwide. Extending care to the outpatient setting, Tallwood enlists Hartford HealthCare specialty-trained physical therapists who help our patients better manage pelvic pain and pelvic floor conditions, including female and male incontinence. Our expertise and vast experience means we can help, even when previous treatments or surgeries have been unsuccessful. For this reason, we are a primary referral center for Connecticut and the southern New England region, yielding a volume that has grown more than 24 percent from fiscal year 2017 to fiscal year 2019.
The Tallwood Urology & Kidney Institute is organized around these five clinical councils (continued)

**Genitourinary Oncology** Tallwood’s urology oncology team - also part of the Hartford HealthCare Cancer Institute, which is a charter member of the Memorial Sloan Kettering Cancer Alliance—treats all forms of urologic cancers, including adrenal, bladder, kidney, penile, prostate and testicular cancer. We are able to offer patients with urologic cancers access to state-of-the-art treatment and access to cutting-edge clinical trials closer to home. Under the direction of Dr. Anoop Meraney, Tallwood is the market leader in urologic cancer.

**Chronic Kidney Disease** Our kidney care team, co-led by board-certified nephrologists Drs. Terrence Oder and Jarrod Post, is committed to providing state-of-the-art care for individuals with chronic kidney disease. The team is comprised of experts in urology, nursing, care management, dialysis, hospital medicine, nutrition, radiology and transplant surgery. Focused on getting patients into treatment as early as possible, our goal is optimal outcomes that result in better quality of life and dramatically better survival rates.

Being a leader in urologic health means patients seek us out for care, and system-wide market share continues to increase month over month and year over year.

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**The Hartford HealthCare Tallwood Urology & Kidney Institute is the market leader in Connecticut for:**

- Overall urology and kidney disease
- Overall urologic cancer
- Chronic kidney disease
- General urology
- Men’s health
- Kidney stones
- Kidney cancer
- Pelvic health and incontinence

The experience of our physicians in complex and routine procedures means better outcomes for patients. In addition, research shows that increased patient volume correlates to lower complication and operative mortality rates. The following patient volume represents inpatient and HOPD ambulatory surgery.

- 100,867 arrived visits
  (25 percent of all specialty visits in the Hartford HealthCare Medical Group)
- 12,547 episodes of care
  (in hospital-based settings)
- 8,670 surgeries
Additionally, surgical volume at our hospitals increased year over year by 8 percent.
Effective Communication Puts Patients at Ease

The Hartford HealthCare Tallwood Urology & Kidney Institute team is dedicated to providing patients with exceptional, coordinated care and a single, high standard of service. As a recognized clinical leader with demonstrated respect for our patients, we are also committed to effectively communicating with patients and their families because we know patients who understand and are actively engaged in their care have better outcomes. Our providers and patient navigators are attentive to the physical and emotional needs of patients, engaging in open discussion, offering direction and providing hope in times of frustration and discouragement by solving the most complex cases. When a patient visits a Tallwood office, providers explain the problem/condition, answer questions/concerns, include patients in decisions and communicate in an understandable way. Our communication survey results demonstrate this commitment to patient experience.

<table>
<thead>
<tr>
<th>Provider explanations of prob/condition</th>
<th>Provider concern for questions/worries</th>
<th>Provider efforts to include in decisions</th>
<th>Provider spoke using clear language</th>
</tr>
</thead>
<tbody>
<tr>
<td>84.3%</td>
<td>83.8%</td>
<td>83.5%</td>
<td>86.5%</td>
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Source: Press Ganey
Complication Rates

The Hartford HealthCare Tallwood Urology & Kidney Institute, in conjunction with the Hartford HealthCare Cancer Institute, is a tertiary referral center for Connecticut and New England. Our team of fellowship-trained urologists, nephrologists, medical oncologists and radiation oncologists care for the most complex cancer cases.

The multidisciplinary Urologic Oncology Clinical Council meets regularly to discuss evidence-based medicine. In addition, the team holds case conferences for decisions on patient-specific treatments and planning with experts from across the system and Memorial Sloan Kettering (MSK). Our MSK partnership brings state-of-the-art clinical trials closer to patients’ homes. The focus of establishing clinical standards through the clinical council has resulted in achieving better-than-expected complication rates related to urologic cancer.

### Complication Rate Observed/Expected <1 is Better than Expected

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Observed Rate</th>
</tr>
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<tbody>
<tr>
<td>Bladder Cancer</td>
<td>.93</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>.79</td>
</tr>
<tr>
<td>Robotic Surgery</td>
<td>.96</td>
</tr>
<tr>
<td>Robotic Prostatectomy</td>
<td>.90</td>
</tr>
<tr>
<td>Cystectomy</td>
<td>.91</td>
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Source: Premier
Mortality Rates

Adhering to our core values of excellence and safety, we are keenly focused on reducing mortality rates for patients under our care. Tallwood Urology & Kidney Institute providers exceed expectations when it comes to safety with zero mortalities in FY19.

Zero Mortality Rate for Care by Tallwood Physicians FY19

Source: Premier
Tallwood Men’s Health

According to current national statistics, men are nearly 1.4 times as likely as women to die from almost every chronic medical condition. As a result, men in the United States live an average of five years less than women. In general, men don’t participate in preventative healthcare as often as women and are more likely to engage in risky behaviors such as drinking alcohol, smoking and illicit drug use. There is room for improvement, though.

Tallwood Men’s Health provides the most advanced, clinically integrated care to men in comfortable and accessible settings across Connecticut. Tallwood Men’s Health is focused on treating the whole man. Men’s Health experts at Hartford HealthCare, respected as regional and national leaders in their field, understood the greater implications of the diseases they were treating and recognized a need for better coordination of care. Tallwood has partnered with other Hartford HealthCare specialists and community providers with an understanding of male-specific disease processes. Our comprehensive model of care includes experts in urology, cardiology, surgical and medical weight loss, endocrinology, behavioral health, colorectal health, geriatric medicine and sleep disorders. Our model promotes coordination between specialties, which is demonstrated by the increased case coordination between providers shown below. Our nurse navigators ensure that men are up to date with their preventative health screenings and engage other members of the team to address medical conditions in a timely, efficient manner. Tallwood Men’s Health has surpassed targets for volume, patient experience and national recognition, which demonstrates the demand for men’s healthcare throughout Connecticut.
Men’s Health and Benign Prostatic Hyperplasia

Benign prostatic hyperplasia (BPH) is a common condition addressed by the Tallwood Urology & Kidney Institute. By age 60, about 25 percent of men have troublesome voiding symptoms, percentages that only increase with age. Patients whose symptoms are not well managed by medication may be recommended for transurethral resection of the prostate (TURP), laser ablation (either Greenlight or holmium laser), UroLift, open or robotic simple prostatectomy and other emerging procedures.

Most BPH patients are now treated on an outpatient basis. Those seen in the inpatient setting, therefore, have more complex cases with higher readmission rates and length of stay. The below readmission and length of stay rate represents inpatient results only. Despite the complexity of these cases, our readmission and length of stay is still better than expected.

With a safe decrease in length of stay, patients return to their home and daily activities while connected to care through their physician’s practice.

[Graph showing Benign Prostatic Hyperplasia Observed/Expected <1 is better than expected]

Source: Premier
COVID-19 Response
Keeping patients safe is our priority

Safety is one of our core values. Below are a few examples of ways the Tallwood Urology & Kidney Institute team responded to the outbreak, ensured patient safety and continued to make services available.

- Triaged patients based on emergent, urgent, elective diagnoses/procedures.
- Decongested waiting rooms.
- Instituted contactless registration.
- Extended office hours including early morning, evening and weekend hours.
- Launched virtual health visits—with 4,240 virtual visits in just three months.
Outreach Programs, Events Spread the Word

Educating our community

Our team believes that educated patients get better outcomes. We have provided more than 20 community education events this year based on topics our clinical council members identify as valuable information for patients to know. Some highlights are:

“Breaking the Silence on Men’s Mental Health”
“Cardiac Considerations in Prostate Cancer Treatment”
“Guy Talk: A Urologist’s Perspective”
“Heart Disease in Men: The Pump and the Pipes”
“Men’s Health: Anti-Obesity Medications”
“Men’s Health: Questions You’re Afraid to Ask”
“Options for an Enlarged Prostate (BPH)”
“The Role of Nutrition for Patients with Prostate Cancer”
“Understanding Kidney Stones”
“Understanding Metastatic Prostate Cancer and Research Studies”
“Understanding Prostate Cancer: Imaging”
“Understanding Pelvic Pain in Women”
“Understanding the Impact of Prostate Cancer on Relationships”
“What to Expect After Prostate Cancer”
“Your Kidneys, Your Health”

Supporting the community

This year, the Hartford HealthCare Tallwood Urology & Kidney Institute continued our partnership with ZERO Prostate Cancer, a national not-for-profit organization with a mission of eliminating prostate cancer through awareness, research and education. Our fourth annual ZERO Prostate Cancer Run/Walk awareness event was one of the most successful in the country, raising more than $110,000 to help end prostate cancer.
Provider to Provider Education

At Tallwood, we believe in the importance of continuing education for our providers. This year, we held a variety of educational opportunities including:

“Updates in Men’s Health for the Primary Care Provider”

“Adrenal Etiologies of Hypertension”

Rick Ridlon Visiting Professor Lecture series:

“Lasers in Urology - What You Don’t Know That You Don’t Know (and it’s lot!”

“Review of New BPH Surgical Guidelines and Why You Should Care Childbearing and Women Surgeons”

Resident training at the Hartford HealthCare Center for Education Simulation & Innovation (CESI)

Urologic Oncology and Robotic Surgery Fellowship

Under the direction of Dr. Anoop Meraney, director of urologic oncology at Hartford HealthCare and double fellowship trained at both the Cleveland Clinic and Memorial Sloan Kettering, our fellowship attracts physicians from the most prestigious and competitive residency programs across the county.

The Hartford Hospital Urologic Oncology and Robotic Surgery Fellowship Program is one-year clinical fellowship for urology graduates seeking to improve their surgical skills and knowledge base in urologic oncology and robotic surgery. The fellowship provides an opportunity for new graduates to work closely with physicians who have pioneered cancer and robotic treatments in Connecticut and the United States.

Fellows work in Hartford Hospital operating rooms equipped with four daVinci™ robots. Fellows also have access to CESI, a state-of-the-art surgical simulation center that includes a bio lab, cadaver lab and inanimate laparoscopic training lab that houses robotic, surgical and diagnostic simulators and a daVinci surgical system.

Our fellowship program provides clinical research opportunities as the urology department employs research associates and maintains bladder, kidney and prostate cancer databases.
James Saropoulos

James Saropoulos owned a Greek restaurant in Cambridge, MA, for almost 30 years, so when he needed a specialist for advanced bladder cancer, he turned to Boston for treatment.

He traveled from his home in South Windsor regularly for appointments and tests to prepare him for the surgery he knew was inevitable. But, one day on the long ride home, he had to pull the car over, very sick because he was having trouble urinating. He wound up in a small hospital where a Hartford HealthCare-affiliated urologist just happened to be covering in the emergency department.

It was serendipity—or God’s plan, according to Saropoulos and his wife, Barbara—because the specialist suggested he look to Dr. Anoop Meraney, director of urologic oncology at Hartford Hospital, for help. He called Dr. Meraney’s office on a Monday and was seeing him just four days later, something he was unaccustomed to at the big Boston medical center.

“From there, it was full speed ahead to the operation two weeks later,” the 66-year-old Saropoulos, a native of Greece, says simply. With the help of nurse navigator Susanne Carrier, he was sent to see a pulmonologist, cardiologist and endocrinologist for surgical clearance, and had an MRI, “all within two weeks!” “You don’t have to go find the doctors. The nurse navigator does it all for you! She’d call and say the doctor would be calling with an appointment,” Barbara Saropoulos notes. “It was beyond belief how fast we got in after waiting so long in Boston.”

In an astonishing 12-hour procedure, Dr. Meraney essentially performed three procedures, removing Saropoulos’ bladder, prostate, adrenal gland and 30 lymph nodes because the cancer had spread.

“Jimmy had asked if this would cure him and Dr. Meraney said it wouldn’t be a cure, but he would do his very best to get him as good as he can possibly be. And, he did,” Barbara Saropoulos says of her husband, who was then referred to Dr. Jessica Clement for follow-up immunotherapy.

The surgery was in May 2019, and even with immunotherapy infusions every three weeks and body scans every three months, Saropoulos says he is quite content with his life. He tends a robust garden, cooks treats like spinach pies and pizzas, and relaxes with his cat, Speedy Gonzales.

“I call him my savior, he says quietly, referring to his surgeon. I’m so happy we found these doctors. I have a good team. Without them, I wouldn’t be alive right now. I was that sick.”

The entire experience, his wife adds, has been remarkable, from Dr. Meraney’s manner — “(He) is so humble and calming, and he will answer any questions.” — to the convenience of having infusion treatments in a brand new facility just two miles from their home.”We can’t say enough about Hartford HealthCare. We’ve really and truly had a great experience,” she says.
Deborah Bankowski, a licensed practical nurse for decades, enjoys caring for others, not being the patient. So, when her primary care provider urged her to make an appointment with a specialist to address her prolapsed bladder, she balked at first. When she did make the appointment, it was a few months away and, in that time, her uterus also began to slip from its proper anatomical location. That meant a different kind of specialist, and she waited again for the appointment, nervously thinking about a similar procedure her mother had years before. “It had been botched and she had to have a catheter for the rest of her life,” Bankowski says glumly. Even so, her life with prolapse was an ongoing challenge.

“It felt like having a water balloon right between your legs,” she says. “I couldn’t lift anything.” Her healthcare provider raved about Dr. Elena Tunitsky, a urogynecologist with the Tallwood Urology & Kidney Institute, so she finally decided to make an appointment. They discussed options that were nonsurgical, such as using a pessary, a device inserted into the vagina to hold the organs in place; and others that were surgical. She could choose a procedure to repair the structures holding the organs in place without a hysterectomy or with a hysterectomy, which would involve removing the uterus in addition to a reconstructive procedure.

While Bankowski fretted, she says Dr. Tunitsky patiently explained the potential benefits and limitations of each option. “She helped me feel confident I was making the right decision,” Bankowski says, adding that she chose to have the pelvic reconstructive surgery at Hartford Hospital. “I wanted to get in somewhere and with someone good.” In the holding area waiting to go in for surgery, the mother of two and grandmother of four remembers feeling anxious.

She came to see me before surgery and held my hand. It was so motherly and that’s exactly what I needed right then, Bankowski says of Dr. Tunitsky.

After the surgery, she recalls being able to feel the benefits of the procedure almost immediately. “I felt all fixed—like I had no problem at all and I could do anything!” she exclaims.

Bankowski says she can now lift heavy things and do things around the house that she’d avoided in the past. Recently, she was tugging heavy tarps loaded with weeds and leaves around the yard as she cleaned up the gardens. She also continues to provide in-home nursing services, working for four hours a day as a companion.

“I’m as good as new!” she says.
Jeff Getz

When the need to urinate woke him up three to four times each night, Jeff Getz knew something was wrong.

His primary care provider referred the 63-year-old retired West Hartford police officer to a urologist in the summer of 2019. After several visits, the problem persisted so Getz said he decided to try a new doctor and, with one test, Dr. Abram D’Amato of the Hartford HealthCare Tallwood Urology & Kidney Institute found the problem—a tumor pressing on the bladder. “He determined the problem right away,” Getz remembers.

The test, however, triggered the release of blood clots that blocked urination altogether and sent the New Britain man to The Hospital of Central Connecticut (HOCC) Emergency Department. A catheter relieved the blockage but surgery was needed to remove the bladder cancer. Getz faced a decision—he could move up the surgery already planned with Dr. D’Amato at Hartford Hospital or shift to Dr. Ryan Dorin, another Tallwood urologist based at HOCC. “I decided I was already there, so I went with Dr. Dorin,” Getz says of HOCC.

A pair of procedures followed. First, Dr. Dorin removed part of the tumor to biopsy it. Once the cancer was confirmed, he returned to have a minimally-invasive robotic surgery which removed the bladder, prostate gland and urethra, to which the cancer had spread. A stoma was created so he can void to an outside bag, which he found to be the simplest of three options Dr. Dorin presented.

Because the cancer had spread to his prostate and was determined to be in stage four, Getz also underwent several rounds of chemotherapy to ensure he “shouldn’t have issues going forward.” While it’s been experience no one wants to have, Getz says the Tallwood team helped him adjust and battle every step of the way.

“I thought, ‘Why me?’ but why not me? It’s a fact of life I just have to get used to,” says the father of two and grandfather of four. “I want to get on with my life and maybe my golf game will improve!”

He found Tallwood an efficient “one-stop shop.”

“It was a very smooth pass off to Dr. Dorin. They made everything so nice and easy,” he says.
PATIENT SUCCESS STORIES
Like any good Mainer, Tim Lunt is pragmatic, so when it came time to address a personal health issue, he found what he felt was the best solution, even though it was several hundred miles away in Connecticut.

The former advertising executive, who now works in corporate information technology, had been struggling with erectile dysfunction (ED) for almost a decade, a problem common in men with diabetes, especially Type I like Lunt’s. “The pills were not working for me so I needed to look at other options,” the 49-year-old says from his Bar Harbor home.

His mother’s family is from eastern Connecticut, where she and many relatives still live, so he looked at services available at Hartford HealthCare (HHC). His research, and an appointment with a HHC diabetes specialist, brought him to the office of Dr. Jared Bieniek, a urologist and medical director of Tallwood Men’s Health, part of the system’s Tallwood Urology & Kidney Institute. “I like the way the system operates—everything is clear and straightforward about what I needed to do,” Lunt says, adding that, “Dr. Bieniek and I connected instantly. Usually surgeons are a different breed, but he’s the guy I’d invite over for a barbecue!”

After reviewing options for his ED, Lunt decided the best option for him would be a penile prosthesis. The outpatient procedure was scheduled on June 1, following new protocols due to the COVID-19 pandemic, and he drove himself back to Maine the very next day. The implant has changed Lunt’s life so dramatically that he’s incredulous it took him so long to broach the subject with a healthcare provider.

“Anybody dealing with ED and taking pills is living 15 years ago,” he says. “I was nervous to go in and talk about it, but I realized it’s common. They educated me, and the conversation was as comfortable as can be.” Nerves about anesthesia—he has woken up during procedures in the past—were addressed by the anesthesiologist at Hartford Hospital, and Dr. Bieniek was in the recovery room when he woke up.

“I’m a fan—he’s brilliant but accessible, Lunt said of the doctor. If you’ve got to have a surgery, that’s the way I’d like to go. I wouldn’t change a thing, and I’m not your average patient. I’m picky and careful.”
James Giordano

Even with pandemic restrictions in place, James Giordano managed to spend an average of four days a week this summer on area golf courses. He went with friends, he went with his son—and he enjoyed every minute of it. “I had to make up for lost time!” the 68-year-old Norwalk man says simply.

Time, he explains, was lost in the summer of 2019 when he was unable to swing his clubs as he grappled with hospital visits, relentless infection and wearing a drainage bag connected to a tube into one kidney.

In 2018, an elevated kidney function test prompted imaging studies that revealed a very large left kidney stone in addition to numerous other stones. Initial treatment with medical therapy and extracorporeal shockwave lithotripsy (shock waves) in 2019 was unsuccessful. Giordano’s kidney function tests continued to worsen, which led to placement of a nephrostomy tube into his kidney through his back to facilitate the drainage of urine. Unfortunately, due to the stones and nephrostomy tube, the retired banker and stockbroker had problems with recurrent infections.

The drainage tube then dislodged on Labor Day 2019, sending him back to the hospital where he was diagnosed with sepsis. Massive doses of antibiotics and a PICC line helped clear the infection. His doctor referred him to specialists with Hartford HealthCare’s Tallwood Urology & Kidney Institute. Tallwood Physician-in-Chief Dr. Steven Shichman saw him quickly. After a review of all of the numerous imaging studies, it was determined that he had a congenital blockage where the ureter joins the kidney. This was the underlying reason the kidney stones formed.

During a four and a half-hour robotic procedure in November, Dr. Shichman removed all of the stones, including one measuring four and a half centimeters, and reconstructed the drainage system of the left kidney and ureter.

Giordano went home with a temporary internal tube (stent) in place to help the kidney heal. A few months after the stent was removed, however, he noticed blood in his urine and was referred to Dr. Jared Bieniek, director of Tallwood Men’s Health, for additional care. In a special outpatient procedure in March 2020, Dr. Bieniek cauterized a small bleeding vessel in the kidney to stop the bleeding. That, several transfusions and determination helped Giordano regain his strength by the time the golf courses opened.

“There have been a lot of peaks and valleys, but I feel very fortunate that I called Hartford HealthCare,” he says. “I can’t stress enough what they did for me. Dr. Shichman took a genuine interest in my situation, almost like he took me on as a special project!”

While the pandemic has put his love of regional theatre on temporary hold, Giordano golfed as often as possible over the summer and doesn’t miss his follow-up appointments with Dr. Shichman to ensure no other stones are forming.

“I’ve been fine ever since the second surgery. They really are my heroes,” he says.
Tomas Martinez

When Tomas Martinez relocated from California to Connecticut and began making appointments with new healthcare providers, he immediately noticed a dramatic difference in the health system structure between the two states.

The Avon resident and disabled Vietnam-era veteran said he wasn't used to seeing doctors in different locations and relaying his medical information multiple times from one visit to the next because there was no connection between providers.

Then he saw a television commercial for Tallwood Men’s Health and was elated to find the integrated care he missed. The practice collects specialists from various disciplines—urology, psychology, cardiology, weight loss and more—in one location where care is coordinated by a dedicated nurse navigator and through provider collaboration.

“In California, we’ve been doing this approach to healthcare for years!” he exclaims. “I jumped on Men’s Health because that’s what I’m used to. I believe in this approach to care—the doctors know all of you and all of the doctors work together.”

His first appointment was with Dr. Waseem Chaudhry, a preventive cardiologist with Tallwood Men’s Health, part of the Tallwood Urology & Kidney Institute. In addition to treating his circulatory issues, Dr. Chaudhry referred Martinez to urologist Dr. Jeffrey Morgenstern for additional help.

“The whole concept works. If there’s a concern, they can consult with each other,” Martinez explains.

Retired from Cigna where he worked in information technology, he has had blood pressure issues stemming from the years in the early 1970s he took many salt tablets and water to stay hydrated when he worked as a Marine radar technician in the desert. His heart issues include plaque build-up that prevents enough blood from circulating through the chambers.

“I didn’t want a stent,” he says simply, adding that, “the way Dr. Chaudhry explains everything was enlightening. That’s how medicine should be.”

Married for 40 years and the father of three grown daughters, including one who just retired from the Marines herself, Martinez touts the benefits of the Men’s Health program to friends and neighbors.

“Men are different and we don’t like to go to doctors, he begins. For me, it’s the perfect environment—it’s easier to go to the same place for all of your doctors.”

And, the way they share information is the part I really like.” He credits his connection with the Men’s Health team with improving his overall health, too. Over the past year, he’s lost about 70 pounds and has gotten his diabetes under control. “It’s simple but it really works,” Martinez says of Men’s Health.
Research Highlights

Outcomes obtained from OncotypeDx, Prolaris and Decipher genomic tests differ markedly, present challenges to clinicians and patients

Genomic tests allow clinicians to better classify prostate tumors and their prognosis using the tumor’s own genetic profile. Three unique tests (OncotypeDx, Prolaris and Decipher) have been validated and approved to predict outcomes and guide treatment for patients with clinically localized prostate cancer. OncotypeDx predicts risk of high-grade or non-organ–confined disease and incorporates the patient’s National Comprehensive Cancer Network (NCCN) risk group (very low, low, intermediate, high and very high). Prolaris predicts the 10-year prostate cancer mortality for patients delaying initial curative therapy. Decipher (GenomeDx Biosciences, San Diego, CA) predicts the rates of high-grade disease (Grade Groups 3, 4, 5) at surgery as well as the five-year prostate cancer metastasis rate and 10-year prostate cancer specific mortality rate after surgery. Although these tools were validated individually, little was known about how the results corresponded with each other, leading Dr. Joseph Wagner and his team to investigate how often results of each assay agreed and supported active surveillance based on NCCN risk stratification.

Through a retrospective chart review published in the Canadian Journal of Urology (Can J Urol. 2019 Jun;26(3):9758-9762), Dr. Wagner and his team identified patients at Hartford Hospital who had prostate biopsy or post-prostatectomy specimen evaluations using at least two of three genomic assays (Decipher, Prolaris or OncotypeDx) between 2014 and 2017. Agreement statistics were generated to gauge correspondence between each genomic test and NCCN risk group, with moderate agreement being defined as kappa (k) ≥.6. When Decipher was compared to Prolaris, percentage agreement and k were 67 percent and 0.31 (p = .276), respectively. For Prolaris vs. Oncotype DX, percentage agreement and k were 75 percent and 0.39 (p = .168), respectively with Prolaris tending to favor AS over surgery. For Decipher vs. Oncotype DX, agreement was 50 percent with a very small sample size. NCCN guidelines included AS as an option for 21 out of 22 patients. For Prolaris vs. NCCN, percentage agreement and k were 75 percent and .21, respectively (p = .117; N = 20). For Decipher vs. NCCN, percentage agreement and k were 60 percent and .15, respectively (p = .268; N = 15). For Oncotype DX vs. NCCN (N = 10), agreement was 50 percent, k was incalculable due to small sample size.

Based on this data, it is clear that the prognostic outcomes obtained from OncotypeDx, Prolaris and Decipher differ markedly and that interpreting the results of these genomic tests can present significant challenges to both the clinician and patient. Patients want to take the test that is going to tell them “the right thing to do.” Unfortunately, such a test does not exist. However, further understanding the differences between these tests and their rates of agreement will enable urologists to better counsel patients who are tasked with having to decide upon active surveillance vs. over definitive treatment strategies.

Robotic approach allows men to return to work sooner after radical prostatectomy

The long-term costs to employers due to prostate cancer can be greater than those associated with other cancers. Treatments that allow patients to return to the workforce sooner after radical prostatectomy may significantly lessen the productivity lost due to prostate cancer. The degree to which the robotic approach allows patients to return to work sooner after radical prostatectomy was explored by Dr. Andrew Salner and his team in a study published in the Canadian Journal of Urology. The team analyzed questionnaires from 315 patients who either had radical retro-pubic prostatectomy (RRP) from 1995 to 2004 or robot-assisted laparoscopic prostatectomy (RALP) from 2004 to 2011. They noted that the RALP group returned to work about three weeks after surgery while the RRP group returned about four weeks (p = .016). The percent of subjects who had not returned to work four weeks after surgery was 23.6 percent for RALP and 38.2 percent for RRP (p = .010). In multivariate regression analysis, the surgical approach significantly predicted how soon a patient would return to work independent of other social/clinical variables.

Although the study was not without limitations (including recall bias by participants and non-randomization to treatment groups), these results suggest that the robotic approach may significantly lessen the productivity lost due to prostate cancer and its associated treatment. The project was supported by a grant from the Institute for Health Technology Studies.


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Note: RTWI, return to work interval
Long-acting anesthesia, liposomal bupivacaine, offers no significant benefit in patients undergoing sacrospinous ligament fixation to treat pelvic organ prolapse

Pain control is a key component of postoperative care; however, given the national opioid epidemic, implementing non-narcotic solutions to pain control is crucial. In gynecological surgery, intraoperative use of injected local anesthesia is an important non-narcotic approach to postoperative pain control. Liposomal bupivacaine is a long-acting local anesthetic that has been shown to decrease postoperative pain, opioid use and opioid-related adverse events in some procedures. Seeking to test its effectiveness in gynecologic surgery, Drs. Katie Propst, David O’Sullivan and Adam Steinberg evaluated if use the use of liposomal bupivacaine at the sacrospinous ligament leads to decreased postoperative pain versus short-acting local anesthesia in patients undergoing sacrospinous ligament fixation to treat pelvic organ prolapse.

In this two-arm clinical trial, women were randomly assigned to a lidocaine arm (LA, 17 patients) or a liposomal bupivacaine arm (LBA, 16 patients). Patients in the LA received 30 ml 0.5 percent lidocaine with 1:200,000 epinephrine local injection at the sacrospinous ligament. Patients in the LBA received 20 ml 1.3 percent bupivacaine liposomal mixed with 10 ml 0.5 percent bupivacaine at the sacrospinous ligament. All patients received 50 ml 0.5 percent lidocaine with 1:200,000 epinephrine for anterior and/or posterior colporrhaphy.
No group differences were found for the primary outcome, postoperative buttock pain or global postoperative pain, measured through visual analog scales at 1, 3, 6, 12, 24, 36, 48, 72, 96 and 120 hours after surgery. Patients in the LA had significantly better bladder function at discharge relative to those in the LBA, leading the research team to conclude that use of long-acting local analgesia at the sacrospinous ligament at the time of sacrospinous ligament fixation does not provide any benefit over short-acting local analgesia and may impair bladder function.

This work was support by a grant from the American Association of Gynecologic Laparoscopists.


Simultaneous bilateral adrenal vein sampling performed both pre-ACTHstim and post-ACTHstim maximizes identification of surgically remediable aldosteronism

Bilateral adrenal vein sampling (AVS) is the diagnostic standard for identifying surgically remediable aldosteronism (SRA). It is commonly performed after cosyntropin stimulation (post-ACTHstim). The role of AVS without cosyntropin stimulation (pre-ACTHstim) has not been established. While the selectivity index (SI) is used to confirm AV sampling, the minimally acceptable SI is controversial. A research team including Dr. Steven Shichman sought to determine the role of pre-ACTHstim AVS and the usefulness of a predetermined SI in identifying surgically remediable aldosteronism. Using biochemical cure as the endpoint, they performed a retrospective head-to-head comparison of pre-ACTHstim AVS to post-ACTHstim AVS. They also determined the specificity of a pre-set minimum SI of 1.5 in pre-ACTHstim AVS. The team analyzed 32 patients who had undergone simultaneous
bilateral AVS both pre- and post-ACTHstim and had returned for postadrenalectomy evaluation. All 32 patients achieved a biochemical cure following adrenalectomy. The two AVS protocols were complementary. Seven patients (22 percent) were found to have SRA by a lateralization index (LI) >4 on the pre-ACTHstim AVS, but not on the post-ACTHstim AVS. SI pre-ACTHstim was divided into tertiles and specificity was 100 percent in all. The team concluded that simultaneous bilateral AVS performed both pre- and post-ACTHstim maximizes SRA identification and that a SI of 1.5 pre-ACTHstim does not reduce specificity.


Robotic-assisted radical cystectomy is not associated with increased rates of positive soft tissue surgical margins relative to standard of care

While the safety of robotic-assisted radical cystectomy (RARC) has been well documented, its oncological efficacy relative to the standard of care has not been well established. In order to better understand this issue, an international, multi-site study including Dr. Anoop Meraney and a group of international experts compared the rates of positive soft tissue surgical margins (STSM) between patients treated with RARC or open radical cystectomy (ORC), using a large contemporaneous collaborative database. This is the largest international multi-institutional cohort to assess STSM in RARC vs. ORC.

The study included 2,536 patients with urothelial carcinoma of the bladder treated at 26 institutions. A propensity-score matching 1:1 was performed with three ORC patients matched to one RARC patient. The final cohort included 1,614 patients. Overall, 870 (34 percent) patients underwent RARC and 1,666 (66 percent) ORC. The overall STSM rate was 11 percent; 10 percent in the ORC group and 13 percent in the RARC group. Within the propensity-scorematched cohort, the positive STSM rates were 14 percent and 13 percent in the ORC and RARC group, respectively (p = 0.1). In multivariable analysis, after propensity match, the RARC approach was not associated with the risk of a positive STSM (p = 0.1). These results were confirmed in the subgroup of patients with pathologic non-organ-confined or organ-confined diseases. These data led the team to conclude that while RARC was associated with a higher absolute rate of STSM, the difference did not remain after accounting for other established prognostic factors.

Patients treated with robotic-assisted radical cystectomy and open radical cystectomy have similar survival outcomes

It is generally accepted that robotic-assisted radical cystectomy (RARC) is associated with decreased blood loss, decreased need for transfusion and shorter length of stay compared to open radical cystectomy (ORC). However, the impact of RARC vs. ORC on survival outcomes remains a topic of debate. In an effort to shed light on the issue, an international, multi-site study including Dr. Anoop Meraney retrospectively reviewed records from 9,757 patients with urothelial bladder cancer (BCa). This is the largest international study of bladder cancer patients treated with either ORC or RARC. All patients underwent radical cystectomy with bilateral pelvic lymphadenectomy. To adjust for potential selection bias, propensity score matching 2:1 was performed with two ORC patients matched to one RARC patient. The propensity-matched cohort included 1,374 patients. Multivariable competing risk analyses accounting for death by other causes tested the association between surgical technique, recurrence and cancer-specific mortality (CSM), before and after propensity score matching. The team noted that the three-year recurrence rates and CSM were 37 percent vs. 26 percent and 34 percent vs. 24 percent for ORC vs. RARC (all p values > 0.1), respectively. On multivariable Cox regression analyses, RARC and ORC had similar recurrence and CSM rates before and after matching (all p values > 0.1). These results led the team to conclude that patients treated with RARC and ORC have similar survival outcomes. This information will help guide discussions with patients until further data are available through prospective trials.


Plug-unplug catheter mitigates catheter burden relative to continuous drainage approach

About 25 percent of female patients undergoing pelvic reconstructive surgery require short-term catheter use post-operatively. Traditionally, patients are discharged home with a catheter attached to a bag, allowing for continuous drainage. Alternatively, the catheter can be detached from the bag and plugged; with the plug removed, the patient can intermittently drain the bladder. In a randomized controlled trial, Drs. Sarah Boyd, David O’Sullivan and Elena Tunitsky-Bitton evaluated these two approaches, expecting that the plug-unplug method would allow for better post-operative mobility with higher patient satisfaction and low rates of adverse side effects.

A total of 63 women who had a failed postoperative voiding trial after surgery for prolapse, with or without a concomitant incontinence procedure, were randomized to receive a 16-French transurethral catheter that was either attached to a leg bag (31 patients) or capped with a plastic plug (32 patients).
Women in the second group—the plug-unplug group—were instructed to intermittently drain the bladder by uncapping the catheter when they felt the urge to void, or, in the absence of urge, every four hours. All were scheduled for an outpatient voiding trial five to seven days after discharge. The first 30 study participants who did not require postoperative catheterization were assigned to a “reference,” or control, arm.

While the groups did not differ on postoperative activity, patients with a continuous catheter had more difficulty managing the catheter, and felt that it impeded activities and restricted their choice of clothing. The groups did not differ in adverse side effects, including urinary tract infection rate or pain, and overall patient satisfaction was similarly high. Postoperatively, patients in the plug-unplug arm had significantly higher voiding volumes and almost half of the post-void residual volume relative to the continuous drainage arm. This may suggest that patients using the plug-unplug catheter could have undergone a voiding trial sooner than the typical five to seven days after discharge.

Offering patients options for catheter management is important; the plug-unplug catheter is easier to manage and may decrease the burden that catheterization places on patients in the post-surgical period.


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**Publications**


Presentations and Abstracts


O’Meara A, Boyd SS, O’Sullivan DM, Steinberg AS. Bilateral sacrospinous ligament fixation: Should it be a surgical option? Short oral presentation at the AUGS/IUGA Joint Scientific Meeting 2019; Nashville, TN.


Steinberg AC. “Stress Incontinence: Not a normal part of aging” presented at the ROME conference. Providence, RI. August 9, 2019.


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