AUA 2025
APRIL 26-29 Las Vegas

MONDAY | APRIL 28, 2025

DAILY NEWS

SEE THE DAILY SCHEDULE FOLLOWING PAGE 8

Learning Lab

These important clinical trials are expected to influence practice when they are ultimately reported and/or published.

Clinical Trials in Progress: Bladder Cancer
9-11 a.m.

Clinical Trials in Progress: Prostate & Kidney Cancer
1-3 p.m.
The Square

AUA Robotics Theater

Don't miss today's moderated session with live narration of robotic procedure videos and a panel discussion.
Supported by Intuitive

Kidney and Adrenal
10:30 a.m.-12:30 p.m.
S&T Hall, Booth #355

National Resident Olympic Abstract Competition Awards Ceremony

2-3 p.m.
Residents Pavilion
S&T Hall, Booth #1476

AUA 2025 APRIL 26-29 Las Vegas | DAILY NEWS ONLINE

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Embracing imperfect innovation

Diagnostic technologies are proving their value across the globe, but the U.S. is slow to adopt them.

Technology is about to transform diagnosis and treatment across the practice of medicine, including urology. Automated patient monitoring, advanced at-home care, artificial intelligence and asynchronous care are in daily use from Switzerland to Rwanda but remain experimental in the United States.

"We are in the moment when we can talk about real solutions in health care," said Vin Gupta, MD, MPA, managing director of health care innovation at Manatt, Phelps & Phillips and former CMO of Amazon Pharmacy. "If you pay attention to the news cycle, (you'll see) lots of challenges, lots of problems—and we can get caught up in doom and gloom. But we have real solutions that are working."

Dr. Gupta used the annual Ramon Guiteras Lecture during the Sunday Plenary to explore the expanding frontiers of health care technology. The challenges are clear: an aging population, shrinking health care workforce and combined social-economic-political demands to do more with less. There are no quick fixes, no point solutions, he said, but adopting technological tools and implementing policies designed to foster innovation will make a difference.

Hypertension has been the No. 1 cause of death in the U.S. and globally for decades., Dr. Gupta said, and

KEYNOTE
continued on **page 14**

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What can AI do for you?

Sunday's session explored AI's time-saving advantages for automating clinical documentation and more.

It took 37 years for 50% of the U.S. population to adopt electricity after it was first introduced in 1888. In comparison, after ChatGPT, OpenAI's chatbot, went public in 2022, it was adopted by 50% of the U.S. population in just 10 months—and there's no stopping it.

"Around 75% of workers are using AI today, although many of them are closet ChatGPT users," said Ivan Tarapov, senior director of AI Healthcare and Life Sciences for Microsoft Corporation. To a packed house, Tarapov kicked off Sunday's session: "Practical AI for the Practicing Urologist," with a discussion of AI fundamentals and how its infrastructure of cutting-edge, text-driven frontier large language models is being fine-tuned to support clinician information needs, which is no small task.

"We stand before an immense challenge and opportunity," Tarapov said. "Health data is siloed across many organizations, over 99% of it isn't text and existing large language models don't perform well with non-text health data out of the box. [Plus] building multimodal medical models is resource-intensive, and existing models have limited use in research."

Still, the future is bright. Giovanni E. Cacciamani, MSc, MD, FEBU, associate professor of research urology and radiology and director of Artificial Intelligence at USC Urology, presented a preview of the practical applications of generative AI (GAI) for urologists. GAI uses algorithms, particularly deep learning networks, to identify patterns and structures in data. He described the ways GAI can "bring back the joy of medicine," to support physician in real-time by analyzing patient data, suggesting diagnoses, recommending evidence-based treatment options, streamlining workflows, improving knowledge by continuously synthesizing medical literature and patient data to provide clinicians and patients with the latest insights for informed decisions, and improving communication by generating clear, personalized health information to help patients understand their conditions and treatment options.

"GAI will not replace urologists. But those who use it will replace those who don't," he said.

Outlining the unmet needs AI can address, Jamal Nabhani, MD, a urologist at the Catherine & Joseph Aresty Department of Urology at the University of Southern California, Los Angeles, demonstrated the benefits of AI Physician Co-pilot, which he and his team built, that is a functionality upgrade to AI Scribes. AI Physician Co-pilot creates clinic notes before, during and after a patient consult, so physicians only have confirmatory conversations during the actual patient encounter.

"For physicians, AI Physician Co-pilot eliminates history taking, extraction from prior records, analyzing the data and typing," Dr. Nabhani said. Automating these functions can save seven to 10 minutes per patient, which adds up to more quality time with patients, more revenue and less burnout. "As long as we get to work at the top of our license, we are happy people," he said.

Mahul B. Amin, MD, clinical professor of pathology and lab medicine at the University of Tennessee Health Science Center, discussed the impact of AI in uro-oncology pathology, followed by Vinay Duddalwar, MD, professor of radiology, urology and biomedical engineering at Keck Medicine of USC, who wrapped up the session by highlighting the practical applications of AI for kidney cancer imaging. Overall, it pays to be receptive to how you might incorporate AI into your practice.

"Physicians must robustly explore the potential of AI," Dr. Nabhani said. ●

> "GAI will not replace urologists. But those who use it will replace those who don't."
>
> **–Giovanni E. Cacciamani, MSc, MD, FEBU**

AUA-2025 DAILY NEWS

The AUA Daily News is the official newspaper of AUA2025 and is published by Ascend Media.

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AUA2025 in Action



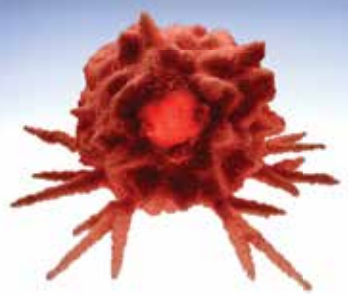

PRODUCT SPOTLIGHT

Scan the QR code to view more of the action in the AUA Annual Meeting Photo Gallery

auadailynews.org/photo-gallery

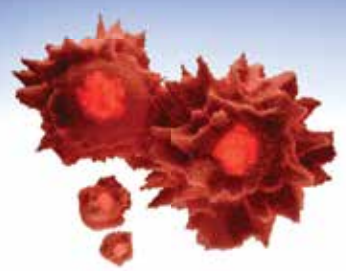
How high are the stakes in high-risk NMIBC?

BCG monotherapy is essential to help protect against recurrence and progression, but many patients do not achieve lasting remission[1-6]



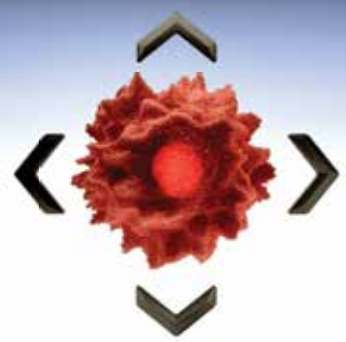
UP TO 50%

of patients with high-risk NMIBC are at risk of recurrence within 1 year of treatment[1,7*]



~20%

of patients with high-risk NMIBC may progress to MIBC within 4 years of diagnosis[5,8†]



~50%

of patients with MIBC may progress to metastatic disease, which has a 5-year survival rate of 9%[6,9,10]

Preventing recurrence and progression is critical in high-risk NMIBC

Scan to visit HighRiskNMIBC.com or visit the Pfizer booth to learn more about the stakes

*Based on a combined analysis of individual patient data from 7 EORTC clinical trials including 2,596 patients. All of the included studies evaluated patients post-TURBT, at which point they received variable treatments.[1]

†Based on a systematic review of 19 clinical trials that included a total of 3,088 patients.[8]

BCG, bacillus Calmette-Guérin; EORTC, European Organisation for Research and Treatment of Cancer; MIBC, muscle-invasive bladder cancer; NMIBC, non-muscle–invasive bladder cancer; TURBT, transurethral resection of bladder tumor.

References: 1. Sylvester RJ, van der Meijden APM, Oosterlinck W, et al. Predicting recurrence and progression in individual patients with stage Ta T1 bladder cancer using EORTC risk tables: a combined analysis of 2596 patients from seven EORTC trials. *Eur Urol*. 2006;49(3):466-477. doi:10.1016/j.eururo.2005.12.031 **2.** National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology. Bladder cancer. Version 5.2024. Published October 28, 2024. **3.** Lamm DL, Morales A. A BCG success story: from prevention of tuberculosis to optimal bladder cancer treatment. *Vaccine*. 2021;39(50):7308-7318. doi:10.1016/j.vaccine.2021.08.026 **4.** Lamm DL, Blumenstein BA, Crawford ED, et al. A randomized trial of intravesical doxorubicin and immunotherapy with bacille Calmette-Guérin for transitional-cell carcinoma of the bladder. *N Engl J Med*. 1991;325(17):1205-1209. doi:10.1056/nejm199110243251703 **5.** Shore ND, Redorta JP, Robert G, et al. Non-muscle-invasive bladder cancer: an overview of potential new treatment options. *Urol Oncol*. 2021;39(10):642-663. doi:10.1016/j.urolonc.2021.05.015 **6.** National Cancer Institute. Cancer stat facts: bladder cancer. Accessed February 19, 2025. https://seer.cancer.gov/statfacts/html/urinb.html **7.** Ritch CR, Velasquez MC, Kwon D, et al. Use and validation of the AUA/SUO risk grouping for nonmuscle invasive bladder cancer in a contemporary cohort. *J Urol*. 2020;203(3):505-511. doi:10.1097/JU.0000000000000593 **8.** van den Bosch S, Alfred Witjes J. Long-term cancer-specific survival in patients with high-risk, non-muscle-invasive bladder cancer and tumour progression: a systematic review. *Eur Urol*. 2011;60(3):493-500. doi:10.1016/j.eururo.2011.05.045 **9.** Patel VG, Oh WK, Galsky MD. Treatment of muscle-invasive and advanced bladder cancer in 2020. *CA Cancer J Clin*. 2020;70(5):404-423. doi:10.3322/caac.21631 **10.** Stein JP, Lieskovsky G, Cote R, et al. Radical cystectomy in the treatment of invasive bladder cancer: long-term results in 1,054 patients. *J Clin Oncol*. 2001;19(3):666-675. doi:10.1200/jco.2001.19.3.666

Pfizer

March 2025 PP-SSN-USA-0087

Renal stone care reimagined


Seth Bechis, MD

A trio of practice-changing, paradigm-shifting (P2) clinical trials is affecting the management of renal stones. Increasing fluid intake does not improve stone-free outcomes, YAG and thulium fiber lasers provide similar results, and patients are happier without stents following uncomplicated ureteroscopy for renal stones.

Results for the three trials were discussed during the Plenary on Sunday morning.

The PUSH (prevention of urinary stones with hydration) trial was the largest stone intervention trial to date, reported Alana Desai, MD, clinical associate professor of urology at the University of Washington. A total of 1,658 participants across six clinical centers in the U.S. were randomized to usual care or behavioral interventions designed to improve fluid intake after stone surgery. Participants were followed for 24 months.

"Increased fluid intake is universally recommended to decrease the risk of recurrent stone disease," Dr. Desai said. "However, the effectiveness of interventions to maintain high fluid intake has not been well studied. Adherence is critical but challenging. How do you change a behavior?"

The trial used financial incentives and structured problem-solving to boost fluid intake, and a wireless smart water bottle to assess fluid intake. Fluid intake target was ≥2.5 L for adults or 30 mL/kg/day for adolescents.

Dr. Desai reported no difference in symptomatic recurrence of urinary stone disease between the two groups. The intervention group had a significant increase in urine output, but neither group achieved average fluid intake at or above guideline volumes.

Ureteroscopy surpassed shockwave lithotripsy as the most common stone surgery in 2017, but there have been few direct comparisons between different laser devices for dusting stones. What may be the first head-to-head clinical trial of high-powered Holmium:YAG and high-powered thulium fiber lasers found similar outcomes.

"We have 107 patients with post-operative data so far, and stone-free rates do not differ between the two groups," reported Margaret Knoedler, MD, associate professor of urology and chief of endourology at the University of Wisconsin School of Medicine and Public Health. "Quality of life postoperatively was similar between the two lasers. Both high-powered lasers are effective and safe at treating renal stones, and the choice of laser system can be left up to the surgeon and the hospital system."

The most recent randomized controlled trial of stenting vs. not stenting following uncomplicated ureteroscopy for renal stones found significantly less pain when stents were omitted. There was no difference in emergency department visits or other unplanned health care utilization, but patient satisfaction was much higher without stenting.

When patients were asked if they would repeat the procedure for another stone, 52% of unstented patients said they would definitely repeat treatment compared to 19% for the stented group.

"We clearly see a preference for avoiding stents," said Seth Bechis, MD, associate professor of urology at the University of California San Diego. "I would urge all of you performing a ureteroscopy for an uncomplicated case to consider not leaving a stent. Your patients will have a better quality of life, and we found no difference in unplanned encounters." ●

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QUESTION OF THE DAY

How do you hope to apply what you learn at AUA2025 to improve patient care or advance your practice?

I am looking forward to using some of the knowledge I have learned at AUA2025 to enhance patient education as I consider using new devices and new techniques. I'll also use what I've learned collaborating with some of our excellent industry partners to find ways to continue to enhance research, innovation and patient care.

Michelle Van Kuiken, MD
San Francisco, California

I am a urologic oncology fellow at UCLA, and I'll be starting my practice at Virginia Commonwealth University in Richmond, Virginia. What I've learned at AUA2025 are different aspects of how to manage an oncology practice, from surgical to therapeutics to the new technology coming. It has been a whirlwind of information, but there are so many exciting things to come to help patients. What I hope to do is to bring to my practice all these different tenets to see how we can advance patient safety, patient care and make their experience better when we're dealing with urologic cancers.

Pratik Kanabur, MD
Los Angeles, California

I am very active with kidney stones and, at the moment, I do not have access to the equipment to aspirate stones after ureteroscopy. I just heard all about that in the Plenary session and I'm about to head into another session about it. I'm going to insist that my hospital and my companies get that equipment to me and my colleagues so we can work with this on our own. That will improve care for patients with kidney stones. I'm also very active with BPH and I'm interested in aquablation, which could help my patients who have that condition.

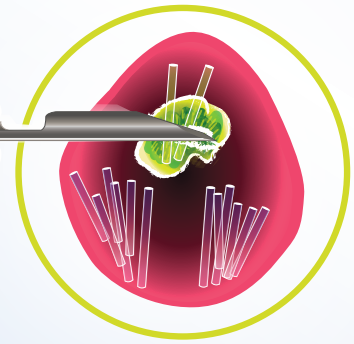
Marc Melser, MD
Port Charlotte, Florida

As a new attending, I am going to be working at the place I trained. I spent this AUA meeting really focused on learning how to teach so that I could bring back state-of-the-art care to apply as I'm teaching. I hope to use this information to effectively shape residents with the skills I learned here to elevate patient care.

Arshia Sandozi, DO, MPH
Brooklyn, New York

Stay on target with bigger, better cores

reduce diagnostic ambiguity



Targeted Biopsy

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Eric Gwynn, M.D.
New River Urology, Hilton Head SC

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Key Takeaways

THOUGHT-PROVOKING DISCUSSIONS WITH THE EXPERTS

Tuesday, April 29 | Venetian D
11 a.m.-1:40 p.m.

Join us Tuesday afternoon as we showcase highlights from the 2025 AUA Annual Meeting. In this innovative format, thought-leaders take the stage for a series of discussions that review the most impactful science from AUA2025.

VOICES & VIEWS

Join the Conversation on Instagram, Facebook and X. **#AUA25**

Marawan El Tayeb, MD
@marawaneltayeb
Great dinner with great friends Egyptian North America Urological Association (ENAUA)
@EUA25470563 #AUA25

Thomas Chi
@thomaschi8
Offering multiple perspectives on one surgical problem is the value of a panel of experts!
@APeterson_Duke moderates @adam_baumgarten, @lindsayahampson, @Kmtheisen1 - a trio of stars in urologic reconstruction featured at **@SocietyGURS for #AUA25**. Dialogue advances surgical care!

Omar M. Khateeb
@OmarMKhateeb
One of my favorite marketing leaders Lindsey Fujita who leads a great commercial team over at **@PROCEPTRobotics** Reunited after 10 years! **#AUA25**

Corinna Hughes
@CorinnaSHughes
Spotted **@kvnkoo** — honored to work alongside a true leader!Selected for the prestigious AUA Leadership Program, picking top applicants across all AUA Sections for a year of elite leadership training. Proud to see excellence in action! **#AUA25 #Urology #Leadership @MayoUrology @NCSAUA @AmerUrological**

Division of Urology, University of Maryland
@MarylandUrology
A lovely reunion w/ our former and current Maryland residents **#AUA25**

Amanda North
@anorth21
Vegas is known for high-end shopping. Like these super fashionable kidney slippers!!! **#AUA25**

Artist rendering; for illustration purposes only.

In RCC, all T3 tumors are characterized by their invasiveness.[1]

These tumors extend into structures within or adjacent to the kidney system, including the perirenal fat, the renal vein, the vena cava, or the pelvicalyceal system.[1,a]

Patients with more invasive tumors are at a higher risk of their cancer returning.[2]

Identify patients in your practice who have T3 tumors so you can take appropriate action following nephrectomy.

How will you manage your next patient with an invasive T3 tumor?

[a]T3 tumors do not extend beyond Gerota's fascia or into the ipsilateral adrenal gland.[1]
RCC = renal cell carcinoma.

References: 1. Edge SB, Greene FL, Byrd DR, et al, eds. Kidney. In: *AJCC Cancer Staging Manual*. 8th ed. Springer International Publishing; 2017:739–748. **2.** Sundaram M, Song Y, Rogerio JW, et al. Clinical and economic burdens of recurrence following nephrectomy for intermediate high- or high-risk renal cell carcinoma: a retrospective analysis of Surveillance, Epidemiology, and End Results-Medicare data. *J Manag Care Spec Pharm*. 2022;28(10):1149–1160. doi:10.18553/jmcp.2022.22133

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SCIENCE & TECHNOLOGY HALL MAP AND EXHIBITOR LIST

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> Nine in 10 people diagnosed with high blood pressure do not like the physical experience of having their arm squeezed. They do not like their brachial artery squeezed, the sensation of feeling that pulse. They are not utilizing the tools we have been trained on to screen and diagnose illness."

KEYNOTE

continued from **page 1**

the U.S. medical community is terrible at early diagnosis and early intervention. The diagnostic tool exists in clinically validated pressure cuffs, but patients hate them.

"Nine in 10 people diagnosed with high blood pressure do not like the physical experience of having their arm squeezed," Dr. Gupta said. "They do not like their brachial artery squeezed, the sensation of feeling that pulse. They are not utilizing the tools we have been trained on to screen and diagnose illness."

The obvious solution is to use different, more acceptable tools. Smartphones, watches, mirrors, refrigerators and even smart toilet seats can all provide blood pressure, heart rate, blood oxygenation and more. All are in clinical use—but not in the U.S.

"We need cheap, scalable solutions that are lovable," he said. "We don't talk about lovability and the patient experience. Why is it that 40% of people between 35 and 54 years of age have never established a primary care physician? How do we bring people to care earlier? That's where the rubber meets the road."

Regulatory approval is a barrier. A smart toilet seat providing 95% specificity and sensitivity for multiple clinical measures is under FDA evaluation. Other devices, including smart mirrors used in multiple countries, provide just 85% specificity and sensitivity, failing FDA standards.

"Wouldn't it be great to give 85 of 100 people with stage 1 hypertension a sense that something might be wrong?" Dr. Gupta asked. "It's not perfect; it's far from perfect. But we cannot keep doing the same things."

Health care services are also in flux. Post-acute inpatient care at home is a reality for some health systems. Dr. Gupta cited at-home-care data for congestive heart failure from Baptist Health showing 0% readmission at 90 days and 2.4% at 180 days. Providing hospital-at-home care can improve health outcomes, improve patient satisfaction and ease pressure on ICU and step-down care inpatient beds.

"What all of us as a profession need to be wrestling with is what is good and why do we let perfect be the enemy of the good," Dr. Gupta said. "There is real data on these tools; we just have to be willing to experiment with what is acceptable risk from a regulatory compliance perspective. Who's going to pay for it and who owns the liability are the things that actually end up crushing innovation." ●

Continued from **previous page**

Think activating the body's natural killer and killer T cells.[1]

Think Anktiva.

ANKTIVA® is the first FDA-approved immunotherapy designed to activate the body's natural immune system, including natural killer and killer T cells, to target and attack BCG-unresponsive non-muscle invasive bladder cancer CIS (NMIBC CIS), while also priming memory T cells to continue to recognize bladder cancer cells over time.[1]

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1. ANKTIVA Package insert. ImmunityBio, Inc.; 2024.

Indication and Important Safety Information

INDICATION AND USAGE ANKTIVA is an interleukin-15 (IL-15) receptor agonist indicated with Bacillus Calmette-Guerin (BCG) for the treatment of adult patients with BCG-unresponsive non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors. **WARNINGS AND PRECAUTIONS** Risk of Metastatic Bladder Cancer with Delayed Cystectomy. Delaying cystectomy can lead to the development of muscle invasive or metastatic bladder cancer, which can be lethal. If patients with CIS do not have a complete response to treatment after a second induction course of ANKTIVA with BCG, reconsider cystectomy. **DOSAGE AND ADMINISTRATION** For Intravesical Use Only. Do not administer by subcutaneous or intravenous routes. Instill intravesically only after dilution. Total time from vial puncture to the completion of the intravesical instillation should not exceed 2 hours. **USE IN SPECIFIC POPULATIONS Pregnancy:** May cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception. **ADVERSE REACTIONS** The most common (≥15%) adverse reactions, including laboratory test abnormalities, are increased creatinine, dysuria, hematuria, urinary frequency, micturition urgency, urinary tract infection, increased potassium, musculoskeletal pain, chills and pyrexia.

For more information about ANKTIVA, please see the Full Prescribing Information at www.anktiva.com.

You are encouraged to report negative side effects of prescription drugs to FDA. Visit www.FDA.gov/medwatch or call 1-800-332-1088.
You may also contact ImmunityBio at 1-877-ANKTIVA (1-877-265-8482)

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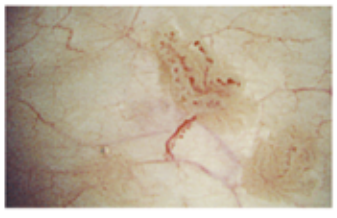
NEW

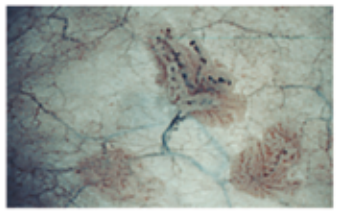
Discover Next Generation, Patient-centered Diagnostic imaging with the VISERA™ S Video System

With a built-in LED light source that is designed for improved color, resolution, and depth of field, the compact VISERA S system provides a clear view of fine vascular structures.*

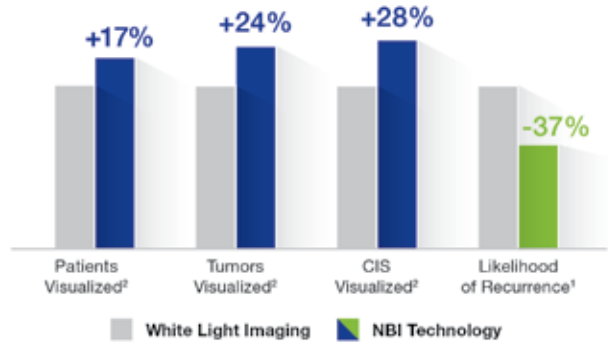
Enhanced cystoscopy is a more powerful way to visualize bladder cancer than using traditional White Light Imaging (WLI) alone. Narrow Band Imaging™ (NBI™) technology is included with all Olympus® video systems and has led to 37%** less likelihood of recurrence over 12-35 months.[1]



Traditional WLI



NBI technology



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For more information, scan the QR code or call 800-401-1086.

The VISERA S video system is a compact, integrated office and ambulatory diagnosis system designed for endoscopic diagnosis, treatment, and video observation. The endoscope connected to this video system center must never be applied directly to the heart because leakage current from the TYPE BF applied part may cause ventricular fibrillation or otherwise seriously affect the cardiac function of the patient.

Based on a weighted average, studies have shown that using NBI technology allows physicians to visualize lesion boundaries. NBI technology is not intended to replace histopathological sampling as a means of diagnosis.

* When compared to CV-170 video system and OTV-S7H-N. Data on file (DC00835040, DC00835041) N=7 Urologists.
** Derived from the hazard ratio in the study. Low certainty of evidence due to risk of bias and imprecision.

1. Lai LY, Tafuri SM, Ginier EC, Herrel LA, Dahm P, Maisch P, Lane GI. Narrow band imaging versus white light cystoscopy alone for transurethral resection of non-muscle invasive bladder cancer. Cochrane Database of Systematic Reviews 2022, Issue 4. Art. No.: CD014887. DOI: 10.1002/14651858.CD014887.pub2.
2. Li, K., Lin, T., Fan, X., Duan, Y., & Huang, J. (2013). Diagnosis of narrow-band imaging in non-muscle-invasive bladder cancer: A systematic review and meta-analysis. International Journal of Urology, 20, 602-609. www.ncbi.nlm.nih.gov/pubmed/23113702