

DAILY NEWS

SEE THE DAILY
SCHEDULE
FOLLOWING PAGE 8

P2s

Practice-Changing, Paradigm-Shifting Clinical Trials in Urology

Exceptional, groundbreaking studies expected to change the day-to-day practice of urology.

11:30-11:40 a.m.
Hall D

Learning Lab

Learning Lab

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

**Clinical Trials in Progress:
Prostate**
1-3 p.m.
Hall B, The Square

AUA Robotics Theater

AUA Robotics Theater

Kidney and Adrenal
9:30 a.m.-11:30 a.m.
S&T Hall, Booth #117

MONDAY

**Key Takeaways:
Thought-provoking
Discussions with the Experts**
11 a.m.-1:40 p.m.

Join us on Monday as we showcase highlights from the 2026 AUA Annual Meeting. In this innovative format, thought leaders take the stage for a series of discussions reviewing the most impactful science from AUA2026. Salon H

AUA Annual Business Meeting
Noon-12:30 p.m.
202B

Updated BPH guidelines focus on patients, not procedures

New recommendations reflect evolving therapies, shared decision-making and changing evidence in BPH management.

New guidelines on benign prostatic hyperplasia (BPH) were published in May and introduced during the afternoon Plenary on Saturday. There are no dramatic changes, but earlier guidelines have been updated to reflect new technologies and new approaches.

“Lower urinary tract symptoms are very common, often attributable to BPH,” said panel moderator Jaspreet S. Sandhu, MD, attending urologist at the Memorial Sloan Kettering Cancer Center in New York City. “Seventy percent of men over the age of 60 have some element of BPH, and treatments, particularly procedural, are evolving quickly and expanding actively.”

Newer, less invasive approaches are gaining attention, especially those with the potential to spare ejaculation. More importantly, the guidelines are patient-focused rather than procedure-focused.

“This is a patient-centered guideline with shared decision

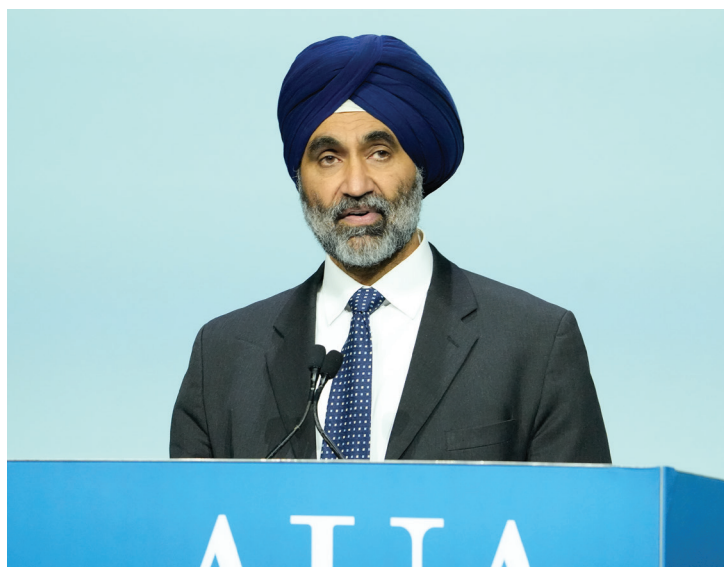
making from the center,” Dr. Sandhu said. “That’s what we focused on as opposed to a procedure-based guideline.”

The initial evaluation and approach to treating BPH remain the same, he continued. Every patient should be counseled as an individual. Urologists should discuss options for intervention, beginning with behavioral and lifestyle modifications.

The new guidelines rely on two distinct grades of evidence. One is the expert opinion of the panel, a consensus based on literature reviews back to 2009 for medical approaches and 2014 for surgical intervention.

The other is a clinical principle, which is an existing, agreed-upon statement that may or may not have clinical evidence. There is little evidence that the use of 5-alpha reductase inhibitors (5ARI) is helpful in managing BPH, for example, but the class is widely used to slow or prevent progression. Trials have shown that the class is not associated with increased mortality.

Lifestyle modification and weight loss are typically



Jaspreet S. Sandhu, MD

the first and least aggressive approaches for many patients. Alpha blockers and 5ARIs are the usual first-line medications. New evidence supports the use of daily low-dose tadalafil with alpha blockers to help preserve ejaculatory function. Earlier guidelines had advised against the combination due to a lack of evidence.

Daily low-dose tadalafil plus finasteride is another new medical approach.

Transurethral resection of the prostate is still the leading surgical intervention. There are two approaches: the familiar monopolar or a newer bipolar. Both are effective, and the choice depends largely on the

surgeon’s experience. Other acceptable procedures are transurethral incision of the prostate and transurethral vaporization of the prostate.

Two more familiar procedures, transurethral microwave therapy and transurethral needle ablation, are now considered legacy technologies and no longer recommended.

Prostate artery embolism (PAE), a technique from interventional radiology, is an acceptable approach but is not recommended. There is evidence of at least a short-term benefit for PAE versus observation in select patients, but insufficient evidence to recommend it. ●

INSIDE

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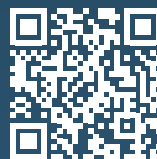
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New stone guidelines sharpen focus on patient-centered care

Revised AUA guidance incorporates quality of life, shared decision-making and evolving surgical technologies for kidney and ureteral stones.

In 2026, the AUA released revised guidelines for the surgical management of kidney and ureteral stones that consider quality of life and patient-centered outcomes.

“The guideline consists of 60 statements that encompass the treatment evaluation of kidney and ureteral stones in both adult and pediatric patients, as well as the treatment of pregnant patients,” said Margaret S. Pearle, MD, PhD, guideline panel co-chair. “Five are classified as strong recommendations, nine are classified as moderate recommendations and 29 are conditional recommendations, in which there’s a balance between the benefit and risk of a particular action.”

Dr. Pearle was the moderator of Saturday’s session, “Case-Based NEW Guidelines Panel Discussion: Surgical Management of Kidney Stones,” and was accompanied by two guideline panel members: Kymora Scotland, MD, PhD, an assistant professor of surgery at UCLA, and Greg Tasian, MD, MSc, MSCE, a professor of surgery and epidemiology at The Children’s Hospital of Philadelphia, as well as Taylor Brewer, an advanced practice provider from Vanderbilt University.

The session reviewed shock wave lithotripsy (SWL), ureteroscopy (URS) and percutaneous nephrolithotomy (PCNL and mini-PCNL). Based on expert opinion, clinicians should not offer SWL as first-line therapy for adult



From left: Kymora Scotland, MD, PhD; Taylor Brewer, MSM, PA; and Greg Tasian, MD, MSc, MSCE.

patients with kidney stones greater than 1 centimeter in the lower pole or greater than 2 centimeters in the non-lower pole.

“We found that for lower pole kidney stones greater than 1 centimeter in size, PCNL has the highest stone-free rate. So, in statement 19, we recommended that clinicians inform patients of this fact. Now that’s a strong recommendation,” Dr. Scotland said.

When comparing standard versus mini-PCNL, one change in these guidelines is that mini-PCNL can be offered for stones up to 3 centimeters, and clinicians may offer either option. However, it’s important that clinicians inform patients that the two have comparable stone-free rates, but that

mini-PCNL is associated with fewer complications.

Regarding preparation prior to surgery, a new statement was added to the guidelines.

“Statement 24 is new to the guidelines. Clinicians may perform PCNL in adult patients without discontinuing daily low-dose aspirin. There were multiple studies that the panel reviewed, and they did not show increased bleeding risk or any issues with the stone-free rate,” Brewer said.

Finally, the panel discussed strategies to enhance the effectiveness and efficiency of URS.

“Statement 47 really brings us into the contemporary era of URS with flexible and navigable suction (FANS)

sheaths. In the literature comparing FANS to standard ureteral access sheaths (UAS), FANS consistently have higher stone-free rates, lower postoperative fever, pain and better quality of life. However, this recommendation remains conditional despite having two trials and six cohort studies because of the risk of bias in these studies,” Dr. Tasian said.

This guideline expands beyond previous ones by emphasizing quality of life and patient-centered outcomes alongside objective measures. It aims to facilitate shared decision-making between the patient and clinician to ensure that treatment choices align with the patient’s objectives and optimize outcomes. ●

AUA 2026 | DAILY NEWS

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American Urological Association

2026 ANNUAL BUSINESS MEETING

HELD AT AUA2026

Monday, May 18, 2026 | Noon

The Walter E. Washington Convention Center
(Room 202B) Washington, DC

Agenda is available at
AUAnet.org/ABM

Everyone is invited to attend the AUA’s Annual Business Meeting. The agenda will include reports of the President, Secretary, Treasurer, Bylaws Committee and Audit Subcommittee.

Antibiotic use clarified in stone removal guidelines

Updated recommendations outline when prophylactic antibiotics are necessary—and when they can safely be avoided.

The question of how to safely administer prophylactic antibiotics to patients for stone removal has been a heavily debated topic among urologists. However, new AUA guidelines on the surgical management of kidney and ureteral stones help bring clarity to the issue.

“The guidelines recommend that for patients undergoing stone surgery, clinicians should obtain a medical history, perform a relevant physical exam and obtain appropriate laboratory studies,” said Kevin Koo, MD, MPH, MPhil, professor and co-director of the Multidisciplinary Stone Clinic at Mayo Clinic College of Medicine and Science.

Obtaining a relevant stone-related history can help to identify patterns of infection, underlying microbial organisms and a patient’s anatomic or clinical susceptibility to infection.

The guidelines also recommend that clinicians obtain a urinalysis and/or urine testing prior to surgery because preoperative urine testing informs timely and appropriate antimicrobial therapy before, during and after surgery.

For patients with a positive urine culture or bacterial growth, clinicians should prescribe culture-directed antimicrobial therapy to sterilize the urine prior to surgery. This should also be considered in asymptomatic patients with known microbial colonization.

The session then moved on to the steps to take if an infection is suspected.

“There are a couple of very important AUA guidelines that

we have that pertain to this. First, positive bacterial and fungal cultures should be treated prior to definitive stone surgery,” said Vincent Bird, MD, professor at the University of Florida College of Medicine. “Some other important aspects of these guidelines include getting labs, complete blood count (CBC), basic metabolic panel (BMP), urinalysis and urine culture. The important factors here are urine culture for identification of infectious organisms and BMP to assess renal function and extent of infection.”

There’s a large body of evidence supporting these guidelines. Systematic reviews and meta-analyses of ureteroscopy (URS) and percutaneous nephrolithotomy (PCNL) demonstrate that positive preoperative urine cultures are a significant risk factor for postoperative infectious complications. Furthermore, studies have shown that examining urine cultures over the 90 days preceding surgery is superior to a single preoperative culture for predicting postoperative infectious sequelae.

The session also explored choosing antibiotic prophylaxis based on the type of surgery.

“Guideline 34 says that clinicians may omit prophylactic antibiotics prior to shockwave lithotripsy. This is because shockwave is non-invasive and has a low rate of postoperative sepsis or urinary tract infections (UTIs). Antibiotics can be harmful and costly,” said Jennifer Robles, MD, MPH, assistant professor at Vanderbilt



Guideline 34 says that clinicians may omit prophylactic antibiotics prior to shockwave lithotripsy. This is because shockwave is non-invasive and has a low rate of postoperative sepsis or urinary tract infections (UTIs). Antibiotics can be harmful and costly.”

—Jennifer Robles, MD, MPH

University Medical Center and chief of urology at Tennessee Valley (VA) Healthcare System.

A systematic review of nine randomized controlled trials found no difference in postoperative fever, positive urine cultures or post-op UTI, regardless of antibiotic use. Similarly, a New Zealand national registry covering

over 10,000 shockwave cases showed no variation in UTI or sepsis rates whether patients received prophylactic antibiotics or not.

On the other hand, guideline 35 says that patients undergoing invasive therapies such as ureteroscopy or percutaneous nephrolithotomy should receive prophylactic antibiotics. ●

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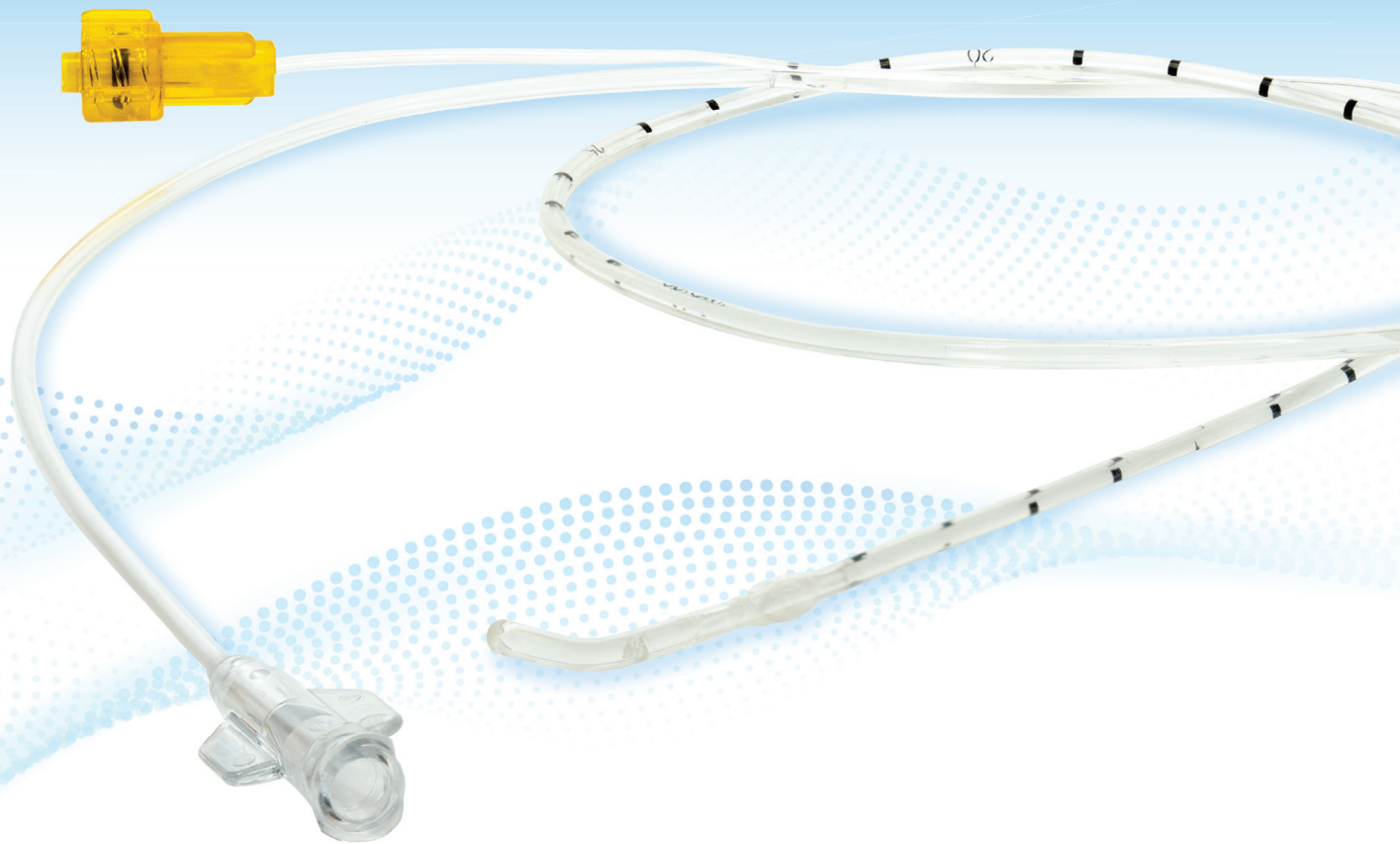
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Key Takeaways: Thought-provoking discussions with the experts

Monday, May 18 | Salon H | 11a.m.-1:40p.m.

Join us Monday afternoon as we present highlights from the Annual Meeting through rapid-fire discussions and clinically significant abstracts. Covering eight topics from prostate oncology to lower urinary tract reconstruction, the series highlights cutting-edge developments from AUA2026.



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QUESTION OF THE DAY

Outside of the education sessions, what has been your favorite part of AUA2026?

My favorite parts of AUA2026 outside of sessions are looking at the new and innovative materials that are available at the Science & Technology Hall exhibits and, of course, connecting with my lifelong colleagues whom I haven't seen in a while and, many times, only get to see at this meeting.



Johanna Figueroa, MD
Roslyn Heights, New York

Outside the sessions, I have really benefited from the mentorship that the AUA meeting has offered. The AUA FUTURE in Urology™ Program organized quite a few mentors to meet with students, and I was one of those students. I've been lucky to receive that mentorship both during this program and outside of the meeting, and I think many more students should be aware of it so that they can receive this mentorship as well.



Brandon Noorvash, MS-3
Los Angeles, California

For me, it's just being able to connect with my old friends and mentors, which is, in many ways, the most important part of the meeting. Plus, this year's meeting is in a fantastic city with a rich history, so I've had a terrific time.



Vikram Narayan, MD, FACS
Atlanta, Georgia

During every session, I think of all these new research ideas, so getting to talk to colleagues about these ideas while I'm here at the meeting during dinner or while I'm walking around is so valuable. Plus, I'm from Michigan, and we have a great alumni event that I always look forward to, so that's probably my favorite part of the meeting outside of the meeting.



Giulia Ippolito, MD, MS
Ann Arbor, Michigan

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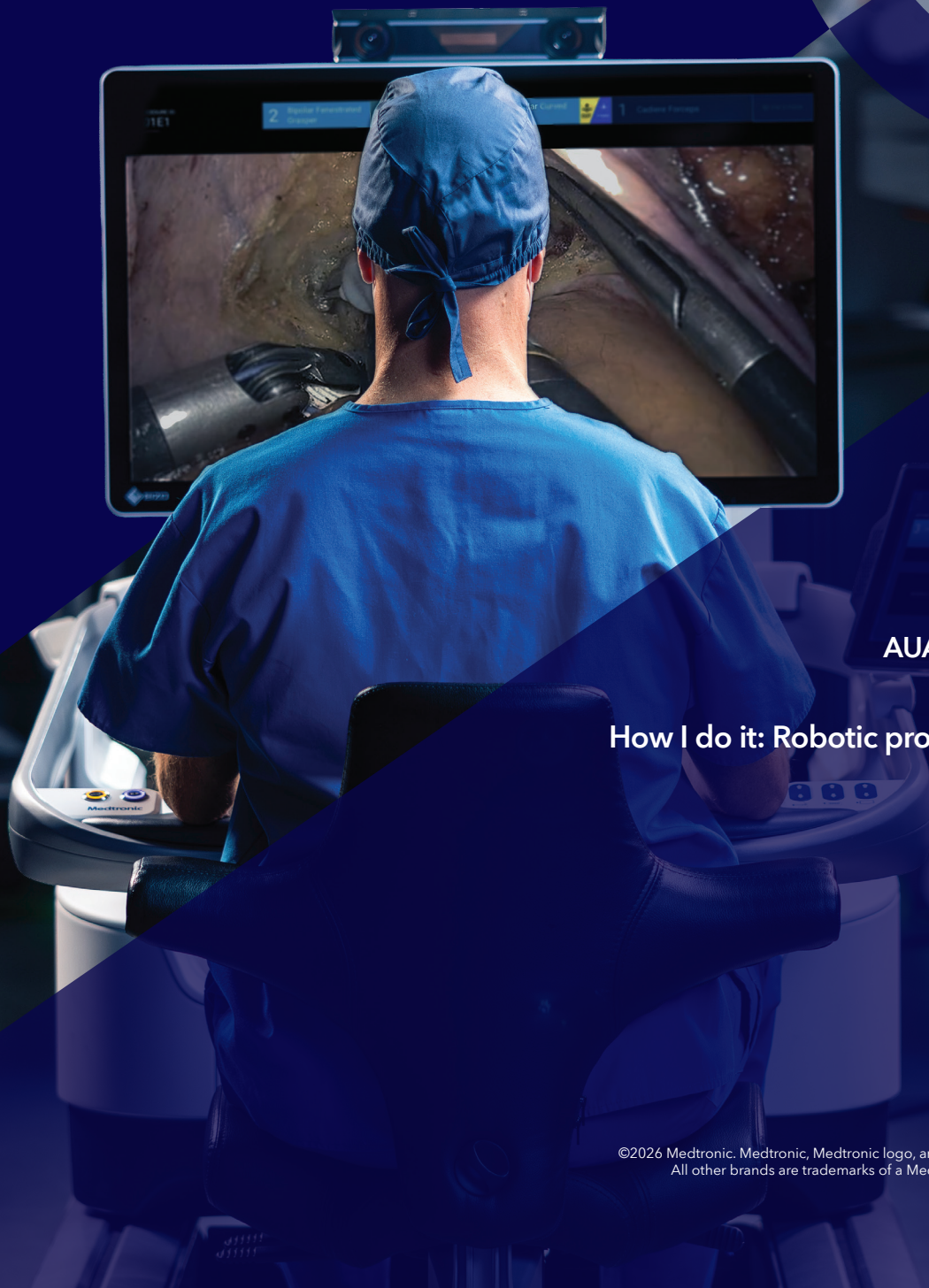
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Presented by Dr. Zack McDowell
Moderated by Dr. James Porter

Friday, May 15
9:30 - 10:15 a.m.

AUA Product Theater | Booth #2701

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How I do it: Robotic prostatectomy video case review

Presented by Dr. Ronney Abaza

Sunday, May 17
11:30 a.m. - 12:30 p.m.
Medtronic Booth #1604

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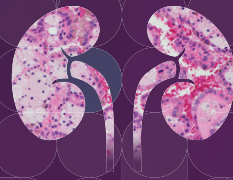


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San Diego MAY 21-24

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WHICH OF YOUR PATIENTS WITH RCC ARE AT HIGHER RISK OF RECURRENCE AFTER SURGERY?

According to a retrospective, observational analysis of EMR data from 439 patients with RCC at higher risk for recurrence post nephrectomy from 2012 to 2021

More than half of patients in this analysis experienced recurrence¹

51%

experienced recurrence

34%

experienced death

- Among patients with a recurrence, 85% had distant metastasis.¹

Analysis Population¹:

- Eligible patients were adults (aged ≥ 18 years) diagnosed with nonmetastatic RCC between January 1, 2012 and December 31, 2017 to allow for the potential of a 3-year follow-up period.
- Patients at higher risk for recurrence included: T2, N0, M0 with grade 4 cells or sarcomatoid histology; T3, N0, M0; T4, N0, M0, or any T stage with N ≥ 1 , M0.
- **Median follow-up duration was 39 months.**

Analysis Limitations¹:

- Data were sourced from principally community oncology practices, representing diverse practice locations in both rural and urban centers, within the US.
- Data from these practices were provided to the ConcertAI Oncology Dataset. Therefore, imaging assessments, procedures, or visits outside this network may not have been captured.

EMR = electronic medical record; M0 = no distant metastasis; N0 = no regional lymph node metastasis; RCC = renal cell carcinoma; T2 = tumor >7 cm in greatest dimension, limited to the kidney; T3 = tumor extends into major veins or perinephric tissues, but not into the ipsilateral adrenal gland and not beyond Gerota's fascia; T4 = tumor invades beyond Gerota's fascia (including contiguous extension into the ipsilateral adrenal gland).

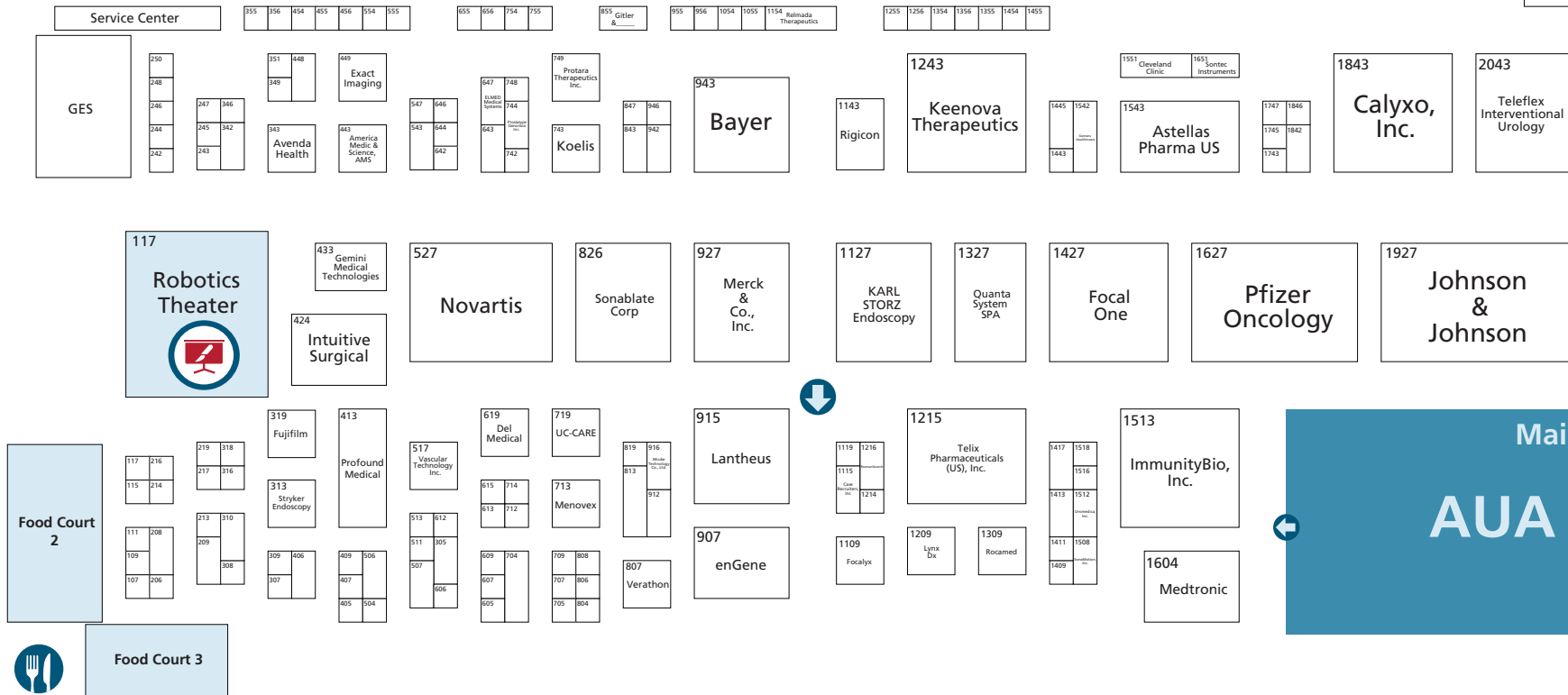
References: 1. Karam JA, Bhattacharya R, Ogbomo A, et al. Real-world study on the characteristics, post-nephrectomy journey, and outcomes of patients with early-stage renal cell carcinoma based on risk groups. *Cancer Med.* 2024;13(11):e7247. doi:10.1002/cam4.7247 2. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Kidney Cancer V.1.2026. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed July 28, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. 3. 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. doi:10.18553/jmcp.2022.22133 4. Sundaram M, Song Y, Rogerio JW, et al. Supplementary Materials for: 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. doi:10.18553/jmcp.2022.22133



Learn more about how patients who have T3 and T4 tumors may be at greater risk of their cancer returning after surgery.²⁻⁴



SCIENCE & TECHNOLOGY HALL MAP AND EXHIBITOR LIST



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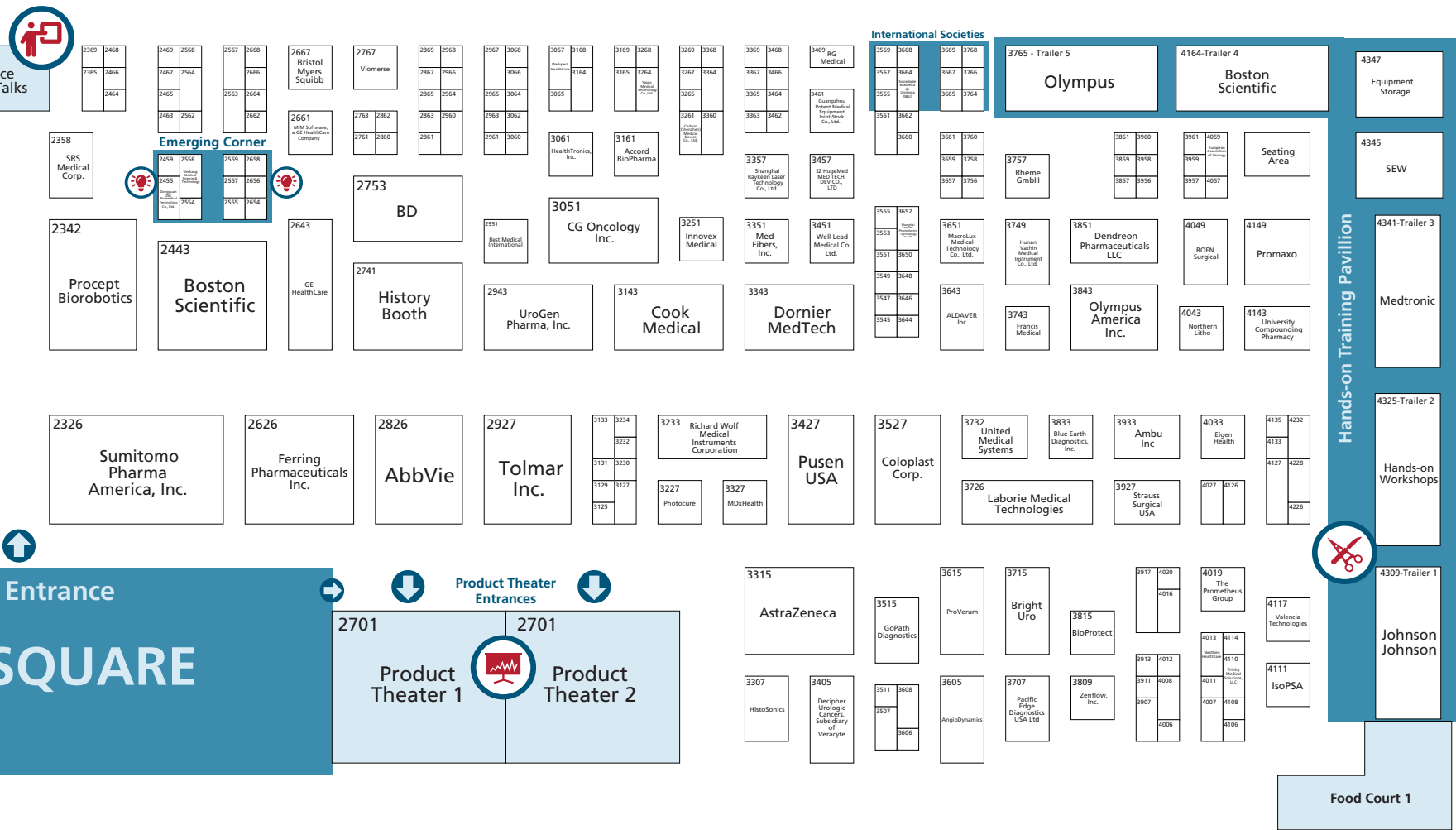
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VOICES & VIEWS

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Tyler Overholt Daniel, MD

@md_overholt

What a great first day at #AUA26!

Special highlights included dinner with my @wakeurology co-chiefs, and @FolawiyoLaditi winning second best podium at the Society of Fetal Urology meeting ★

Excited for Day 2 ✓

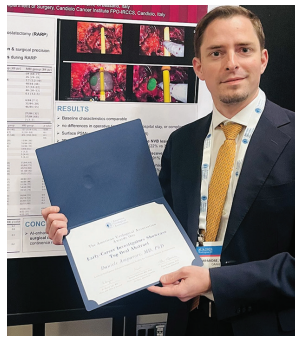
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Daniele Amparore
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Honored to be part of the #AUA26 Early-Career Investigators Showcase (ECIS) and proud to receive the 1st Prize!

A sincere thank you to the @AmerUrological for this incredible opportunity and to all the faculty for the inspiring session!!

@PorpigliaF @EnricoCheccucci



John Leppert

@johnleppert

@liaojoe1 showing the latest in computer vision in endourology at this morning's plenary #AUA26

@StanfordUrology

our patients will benefit from these exciting technologies!



Ben H. Chew, MD, MSc

Break Wave challenges standard lithotripsy approach

Trial finds low-pressure ultrasound cleared 70% of stones without anesthesia or adverse events.

Shock wave lithotripsy has competition. The SOUND trial showed Break Wave lithotripsy is as effective and as safe as shock wave lithotripsy without the need for anesthesia. There were no adverse events in the trial, and 70% of stones were cleared successfully.

"The SOUND trial met its criteria of being noninferior to shock wave lithotripsy," said Ben H. Chew, MD, MSc, associate professor of urology at the University of British Columbia in Vancouver, Canada. "It was well tolerated with no anesthesia, with the majority of cases being done in the clinic. We had patients who biked into the clinic, were treated successfully, and biked themselves home."

Shock wave lithotripsy delivers a sharp shock to fragment stone, which can create pain in the surrounding tissue, Dr. Chew said. The Break Wave device uses ultrasound to create a standing wave that fragments the stone.

He likened the difference to a boxer delivering a single massive blow to a punching bag versus delivering a timed series of less forceful blows to a speed bag to achieve the same effect.

Break Wave forms a lower pressure, high cycle standing wave that creates a grid of high stress points inside the stone that leads to fragmentation. The pressure inside the stone is 10 times higher than in the surrounding tissue, creating little to no pain or discomfort. Both Break Wave and shock wave lithotripsy shatter stones into fragments and dust that can exit via the ureter. The same Break Wave platform can be used with a different delivery device to move stone fragments into the ureter for clearance.

The trial treated 64 patients at 10 centers across North America with stones >4 mm and <10 mm. Patients were followed for 90 days after a one-week treatment period. The median stone size was 7.8 mm, 6.3 mm for renal

stones and 7.3 mm for ureteral stones. Stones had a median hardness of 891 Hounsfield Units, and 29.7% were at the lower pole, with 32.8% at the ureterovesical junction. Most patients (57.8%) had a history of stones.

The median therapy delivery time was 29.7 minutes, with another 14 minutes for discharge. A quarter of patients (27%) required a single retreatment, and none required stents.

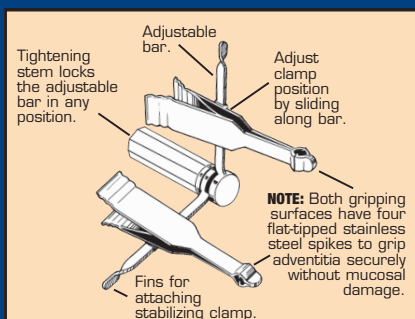
The adverse event rate was 0%, with transient hematuria resolving spontaneously at 1.7 days post treatment. Break Wave had a 70% success rate overall, with 98% of all stones showing evidence of fragmentation. Renal stones had a 52% clearance rate, while 87% of ureteral stones were cleared.

Lower pole stones had the lowest clearance rate at 47%. A follow-up using a smaller, FDA-cleared probe with a larger acoustic window improved lower pole clearance to 71% and 100% for other stones. ●

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Marc Goldstein, MD, DSc (hon), FACS.
Matthew P. Hardy Distinguished Professor of Reproductive Medicine and Urology Senior Scientist, Population Council Surgeon-in-Chief, Male Reproductive Medicine and Surgery Cornell Institute for Reproductive Medicine Weill Cornell Medical College of Cornell University New York Presbyterian Hospital/Weill Cornell Medical Center

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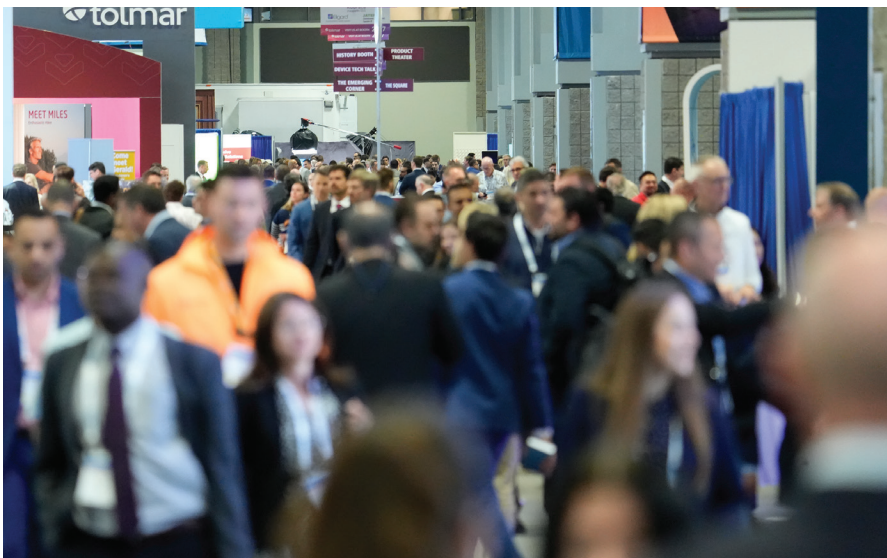
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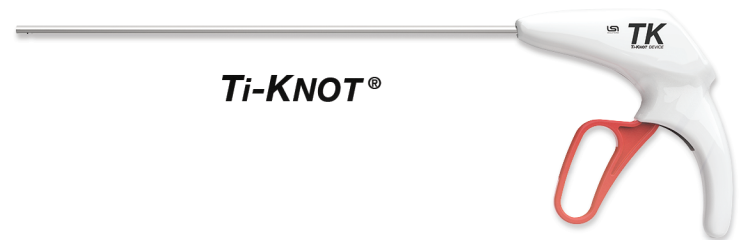
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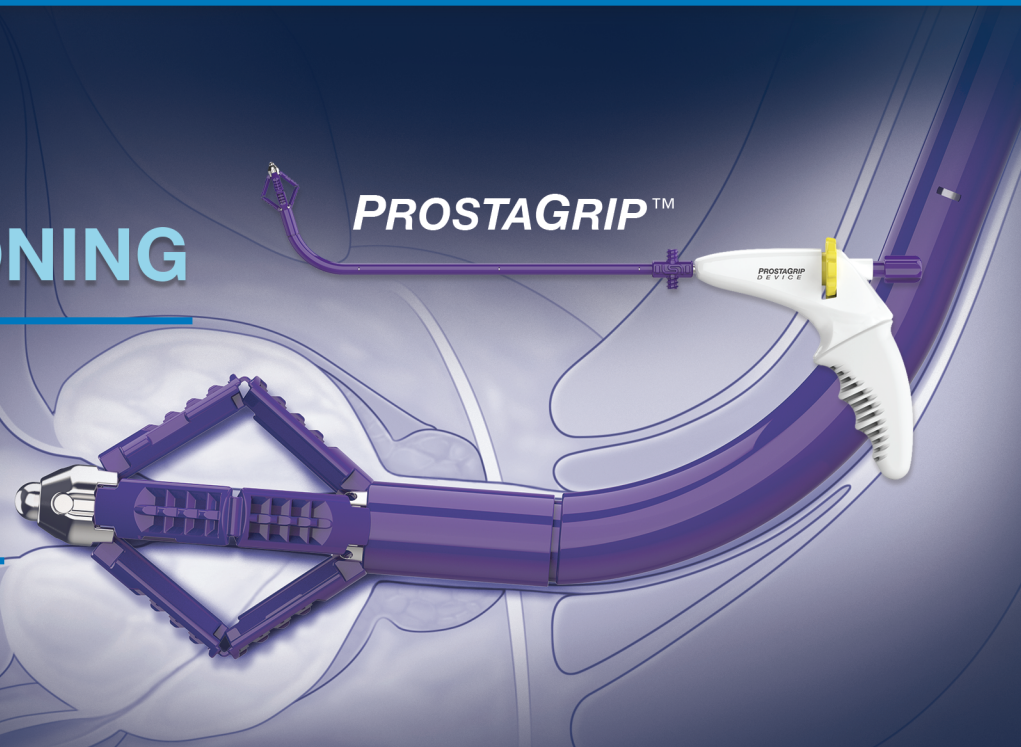
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The use of incompatible/non-validated equipment with the ESG-410 electro-surgical generator can lead to excessive/incorrect HF output. This can result in thermal injuries or death to the patient, and the operator as well as damage to the system.

1. Data on file (PCS-025)
 2. Data on file (PCS-026, PCS-027, PCS-028, PCS-029, PCS-033, PCS-034, PCS-038, PCS-040)
 3. Data on file (PCS-047)