



نقابة الأطباء الأردنية
Jordan Medical Association



SCIENTIFIC BOOK

16th INTERNATIONAL CONGRESS

OF THE JORDANIAN ASSOCIATION
OF UROLOGICAL SURGEONS

Advancing Urological Excellence & Innovation



LANDMARK
AMMAN HOTEL
Amman, Jordan



1-2
OCTOBER
2026

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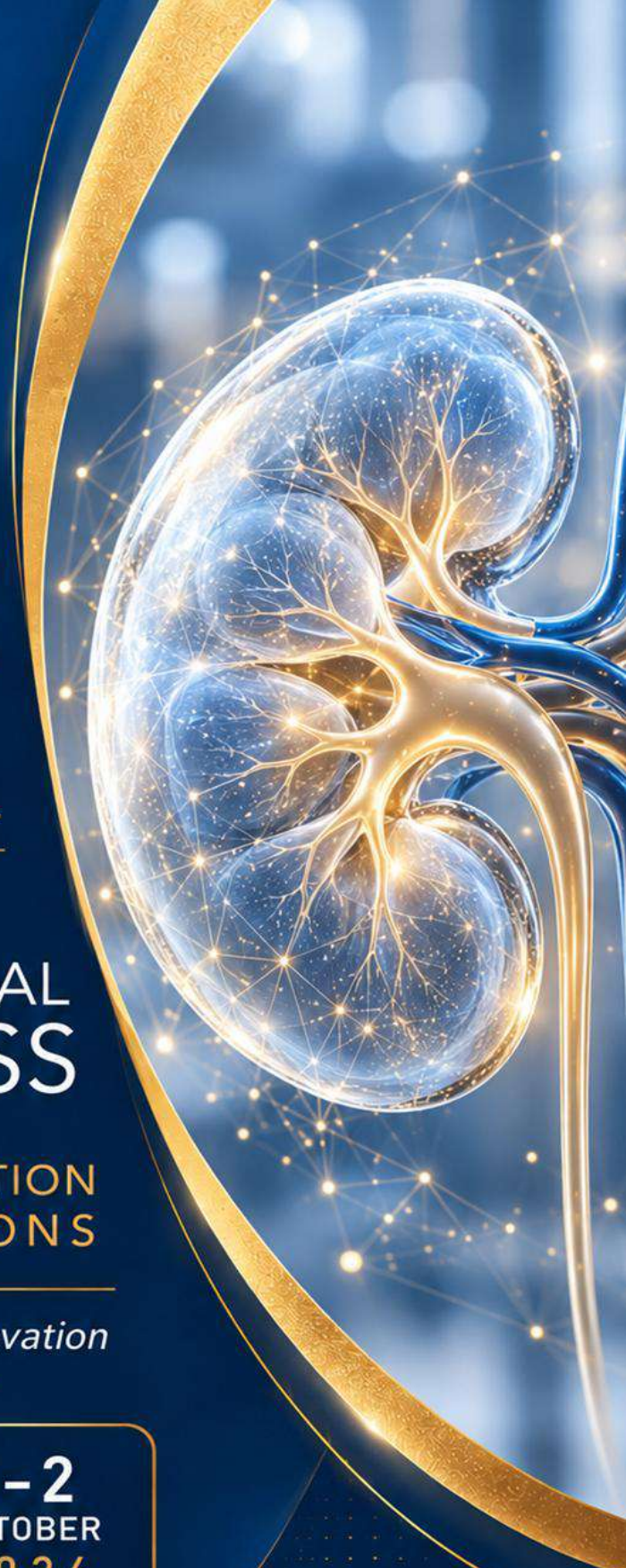
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His Majesty King Abdullah II Ibn Al-Hussein



His Royal Highness Crown Prince Al-Hussein Bin Abdullah II



Welcome Message

WELCOME MESSAGE

Dear Colleagues,

It is with great honor and sincere pleasure that we welcome you to the 16th International Conference of the Jordanian Association of Urological Surgeons (JAUS), to be held in Amman, Jordan, from October 1–2, 2026, at the Landmark Amman Hotel.

This conference brings together leading urologists, clinicians, researchers and healthcare professionals from the region and around the world. Its carefully curated scientific program will feature keynote lectures, panel discussions and interactive sessions highlighting the latest innovations, emerging technologies and evidence-based practices shaping the future of urology.

Beyond its academic value, this gathering is an opportunity to strengthen professional connections, foster meaningful dialogue and build lasting collaborations within our global medical community. We look forward to welcoming you to Amman for an inspiring and rewarding congress experience.



**Ghassan Talahmeh,
MD**

Conference President
President of JAUS



Congress Committees

JAUS EXECUTIVE COMMITTEE



**Dr. Ghassan
Talahmeh**

President



**Dr. Muhannad
Al Naser**

Vice President



Dr. Zeid AbuGhosh

General Secretary



Dr. Husam Obeidat

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Suoub**

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Dr. Feras Sahawneh

Financial Committee



**Dr. Mohammed
Hamdan**

Social Committee

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- Dr. Abd El-Karim Zitawi
- Dr. AbdelNaser Shunaigat
- Dr. Ahmad Abu-Ebeid
- Dr. Bassam Ammari
- Dr. Firas Al-Hammouri
- Prof. Ibrahim Bani Hani
- Prof. Ibrahim Ghalayini
- Dr. Khalaf Al Jader
- Dr. Khaldoun Gharibeh
- Dr. Mamun Ezzibdeh
- Dr. Musbah Surour
- Dr. Nader Younes
- Dr. Omar Sobaih
- Dr. Rami Al-Azab
- Dr. Saeed Al-Ajlouni
- Dr. Wasfi Sha'ban



Congress Committees

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Dr. Mohammad Abd Aldayem

Dr. Muhannad Al Naser

Dr. Muntasir Al-Rawashdeh

Dr. Mohammad Al Hamidi

Dr. Rami Ghanem

Dr. Saleh Abuorouq

Dr. Samer Al-Rawashdah

Dr. Sufian Al-Harabsheh

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Dr. Mutasim Al Smadi

Dr. Tawfiq El-Far



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

SCIENTIFIC

PROGRAM

Eight focused sessions across two days of advanced urology



1-2 OCTOBER 2026



LANDMARK AMMAN HOTEL · AMMAN, JORDAN



16TH INTERNATIONAL CONGRESS

Jordanian Association of Urological Surgeons

A clear guide to every session, speaker and scientific exchange



Congress Topics

Eight core areas shaping the JAUS 2026 scientific agenda

01

Functional and Female Urology

Pelvic floor disorders, urinary incontinence and women-focused urological care.

02

Oncology

Diagnosis, treatment pathways and multidisciplinary cancer care.

03

Novel BPH Surgery

Modern surgical techniques and minimally invasive options for BPH management.

04

Pediatric Urology

Congenital conditions, specialized care and innovations in pediatric treatment.

05

Urolithiasis

Prevention, treatment strategies and procedural updates for urinary stone disease.

06

Robotics and Minimally Invasive Surgery

Emerging technologies and real-world applications in precision surgical care.

07

Men's Health

Andrology, sexual health and quality-of-life-focused care.

08

Reconstructive and Trauma / Miscellaneous

Complex reconstruction, trauma management and evolving areas of urology.



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

DAY 1

THURSDAY · 1 OCTOBER 2026



REGISTRATION 08:30 – ALL DAY · OPENING CEREMONY 09:00 – 09:30

SESSION
1

09:30 – 11:10

Novel BPH



Dr. Saeed Al-Ajlouni, Dr. Eyad Al Safarini
Dr. Samer Al-Rawashdah

SESSION
2

11:30 – 13:10

Urolithiasis: Innovations in Modern Stone Management



Prof. Ibrahim Ghalayini, Dr. Firas Al-Hammouri,
Dr. Mohammad Abd Aldayem

SESSION
3

14:10 – 15:50

Oncology



Dr. Abdul Naser Shunaigat, Dr. Ahmed Qteishat,
Dr. Hassan Al Khatatbeh

SESSION
4

16:10 – 18:10

Urology Beyond Boundaries: Innovation, AI and Global Perspectives



Dr. Rami Al-Azab, Dr. Jordi Guimera,
Dr. Saleh Abuorouq



Coffee breaks: 11:10–11:30 and 15:50–16:10



Lunch: 13:10–14:10



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

THURSDAY 1 OCTOBER 2026

09:30 – 11:10

SESSION 1

Novel BPH



MODERATORS

Dr. Saeed Al-Ajlouni, Dr. Eyad Al Safarini, Dr. Samer Al-Rawashdah

09:30 –
09:45

01 Early Function Recovery after Aquablation for BPH: Symptom Relief and Activity Resumption

Dr. Hashem Darwazeh



09:45 –
10:00

02 Thulium Fiber Laser vs Holmium:YAG in Prostate Enucleation: From Technology to Clinical Outcome

Dr. Samer Al-Geizawi



10:00 –
10:15

03 Laser Enucleation of the Prostate: Current State of the Art and Future Perspectives

Dr. Abdulrahman Alkandari



10:15 –
10:30

04 Anatomy-Driven Endoscopic Enucleation of the Prostate: Surgical Standardization, Continence Preservation and the Omega Sign Technique

Prof. Dr. Lutfi Tunc



10:30 –
10:45

05 Modern Surgical Management of BPH: HoLEP, Mini-HoLEP, Aquablation and Contemporary Laser Technologies

Dr. Jorge Mora Christian



10:45 –
11:00

06 Energy Sources in Prostate Enucleation: Is There an Optimal Laser Platform?

Dr. Abdulrahman Alkandari



11:00 – 11:10



Discussion & Q&A

11:10 – 11:30



Coffee Break



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

THURSDAY 1 OCTOBER 2026



11:30 – 13:10

SESSION 2

Urolithiasis: Innovations in Modern Stone Management



MODERATORS

Prof. Ibrahim Ghalayini, Dr. Firas Al-Hammouri, Dr. Mohammad Abd Aldayem

11:30 –
11:45

01 Robotics in Urolithiasis: What Is New?



Dr. Majed Alharthi



11:45 –
12:05

02 How I Do PCNL: Moroccan Customization



Prof. Mohammed Lezrek



12:05 –
12:20

03 Application of 5G Remote Ultrasound-Guided Holmium Laser Lithotripsy in Complex Renal Calculi Surgery



Prof. Yang Jie



12:20 –
12:35

04 Combined Intra-Renal Pressure and Suction (Integrated FANS): What Should We Know?



Dr. Majed Alharthi



12:35 –
12:50

05 Prevention of Calcium Lithiasis



Dr. Jordi Guimera



12:50 –
13:00

06 Fading Era of Shock Wave Lithotripsy



Dr. Anas Al-Jbarat



13:00 – 13:10



Discussion & Q&A

13:10 – 14:10



Lunch Break



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

THURSDAY 1 OCTOBER 2026

14:10 – 15:50

SESSION 3

Oncology



MODERATORS

Dr. Abdul Naser Shunaigat, Dr. Ahmed Qteishat, Dr. Hassan Al Khatatbeh

14:10 –
14:25

01 Urothelial Carcinoma: Redefining Standards of Care with the Latest Evidence



Dr. Osama Abu Hlalah



14:25 –
14:40

02 Step-by-Step Robot-Assisted Radical Cystectomy with Intracorporeal Studer Orthotopic Neobladder Reconstruction



Prof. Dr. Yaşar Özgök



14:40 –
14:55

03 Bleeding as a Marker of Anatomical Precision: Surgical Standardization and the Future of AI in Robot-Assisted Radical Prostatectomy



Prof. Dr. Lutfi Tunc



14:55 –
15:10

04 Controversies in Testicular Cancer Management: Do They Still Exist?



Dr. Naif Aldhham



15:10 –
15:25

05 Evolution of Radical Cystectomy in the Era of Minimally Invasive Surgery



Dr. Zaid Al-Kailani



15:25 –
15:40

06 VMAT in Prostate Cancer: Precision Radiotherapy in Modern Practice



Dr. Haytham Saraireh



15:40 – 15:50



Discussion & Q&A

15:50 – 16:10



Coffee Break



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

THURSDAY 1 OCTOBER 2026



16:10 – 18:10

SESSION 4

Urology Beyond Boundaries: Innovation, AI and Global Perspectives



MODERATORS

Dr. Rami Al-Azab, Dr. Jordi Guimera, Dr. Saleh Abuorouq

16:10 –
16:25

01

Beyond the Console: The Future of Intelligent Robotic Urologic Oncology



Prof. Maher Moazin



16:25 –
16:40

02

The Genomic Architecture of Urolithiasis: Global Insights and the Middle Eastern Perspective



Dr. Khalid Al Rumaihi



16:40 –
17:00

03

Affordable Innovations in Urology for Lower- and Middle-Income Countries



Prof. Mohammed Lezrek



17:00 –
17:15

04

Artificial Intelligence in Urology: Transforming Clinical Practice, Education and Robotic Surgery



Prof. Maher Moazin



17:15 –
17:30

05

Fluoroscopic Endoscopic Recanalization of Complete UPJ, Ureteral or Ureterovesical Junction Stenosis



Prof. Mohammed Lezrek



17:30 –
17:45

06

Innovations in Medical Robotics and Urological Surgery in China



Prof. Yang Jie



17:45 –
18:00

07

TRUS Prostate Biopsy with Periprostatic Nerve Block in a Different Way



Dr. Rashed Al-Sharqi



18:00 – 18:10



Discussion & Q&A



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

DAY 2

FRIDAY · 2 OCTOBER 2026



FOUR SCIENTIFIC SESSIONS · COFFEE BREAKS · FRIDAY PRAYER & LUNCH

SESSION
5

09:00 – 10:25

Functional and Reconstructive Urology: From Trauma to Neuromodulation



Dr. Awad AlKaabneh, Dr. Fadi Sawaqed,
Dr. Adel Alrabadi

SESSION
6

10:45 – 12:25

Innovations in Minimally Invasive Urologic Surgery



Dr. Adnan Abu-Qamar, Dr. Abedel-Hamid Khairy,
Dr. Yasin AlKhayyat

SESSION
7

14:00 – 15:15

Oncology Session 2



Dr. Wasfi Sha'ban, Dr. Tarek Al-Hammouri,
Dr. Fadi Al Kalailah

SESSION
8

15:35 – 17:45

Andrology



Dr. Maher Zabaneh, Dr. Khalid As'sadiq,
Dr. Yaman Al Tal, Dr. Mohammad Hamdan



Coffee breaks: 10:25–10:45 and 15:15–15:35



Friday Prayer & Lunch: 12:25–14:00

WORKSHOP : 10:00 – 12:00

Urodynamics in Practice: From Basics to Clinical Decision-Making

By Eng. Sara Chemello - Urodynamic trainer



VIP Meeting Room



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

FRIDAY 2 OCTOBER 2026



09:00 – 10:25

SESSION 5

Functional and Reconstructive Urology: From Trauma to Neuromodulation



MODERATORS

Dr. Awad AlKaabneh, Dr. Fadi Sawaged, Dr. Adel Alrabadi

09:00 –
09:15

01

Richard Turner Warwick Bladder Elongation Procedure for the Management of Lower Third Ureteric Injuries



Prof. Bashar W. Nahas



09:15 –
09:30

02

Vesicovaginal Fistula: When to Choose Conservative Management?



Dr. Emad Alwashmi



09:30 –
09:45

03

Functional Urology and Male/Female Incontinence Surgery



Dr. Jorge Mora Christian



09:45 –
10:00

04

Neuromodulation in Voiding Dysfunction: Sacral Neuromodulation versus Percutaneous Tibial Nerve Stimulation (PTNS)



Dr. Emad Alwashmi



10:00 –
10:15

05

Brain-Gut-Bladder Axis: New Insights



Dr. Yaser El Hout



10:15 – 10:25



Discussion & Q&A

10:25 – 10:45



Coffee Break



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

FRIDAY 2 OCTOBER 2026



10:45 – 12:25

SESSION 6

WORKSHOP – 10:00 – 12:00

Innovations in Minimally Invasive Urologic Surgery



MODERATORS

Dr. Adnan Abu-Qamar, Dr. Abedel-Hamid Khairy, Dr. Yasin AlKhayyat

10:45 –
11:00

01 Single-Port Robotic Radical Prostatectomy: Evolution, Outcomes and Surgical Innovation



Prof. Mauro Gacci



11:00 –
11:15

02 National and Single-Institute Experience in Kidney Transplant: Open and Laparoscopic



Dr. Abdelkarim Zitawi



11:15 –
11:30

03 Ultra-Mini-Incision Single-Port Laparoscopic/Single-Port Robotic Resection of Renal Hemangioma Combined with Angioplasty



Prof. Yang Jie



11:30 –
11:45

04 Robotic and Minimally Invasive Approaches in Oncology Surgery: Expanding Boundaries and Refining Surgical Standards



Dr. Tarek Al-Hammouri



11:45 –
12:00

05 Beyond Open Surgery: The Era of Robotic Cystectomy and Intracorporeal Reconstruction



Dr. Malek Gaashan



12:00 –
12:15

06 Robotic Adrenalectomy: Expanding the Boundaries of Minimally Invasive Surgery



Dr. Ibrahim A. Khalil



12:15 – 12:25



Discussion & Q&A

12:25 – 14:00



Friday Prayer & Lunch



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

FRIDAY 2 OCTOBER 2026

14:00 – 15:15

SESSION 7

Oncology Session 2



MODERATORS

Dr. Wasfi Sha'ban, Dr. Tarek Al-Hammouri, Dr. Fadi Al Kalailah

14:00 –
14:20

01 Lu-177 PSMA: Changing the Landscape of Advanced Prostate Cancer (Pluvicto)

 Dr. Rami Ghanem

 NOVARTIS



14:20 –
14:35

02 Real-Time Intraoperative Margin Assessment: Lessons from NeuroSAFE and LaserSAFE Trials

 Dr. Ricardo Almeida Magana



14:35 –
14:50

03 Comprehensive Management of Complex Renal Cell Carcinoma: A Single-Center Case Series

 Dr. Xiao Li



14:50 –
15:05

04 Challenging Cases in Robotic Partial Nephrectomy: Strategies, Pitfalls and Solutions

 Prof. Mauro Gacci



15:05 – 15:15



Discussion & Q&A

15:15 – 15:35



Coffee Break



16TH INTERNATIONAL CONGRESS

JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

FRIDAY 2 OCTOBER 2026



15:35 – 17:45

SESSION 8

Andrology



MODERATORS

Dr. Maher Zabaneh, Dr. Khalid As'sadiq, Dr. Yaman Al Tal, Dr. Mohammad Hamdan

15:35 –
15:50

01 Management of Common IPP Complications

Dr. Christopher Love



15:50 –
16:05

02 Non-Surgical Treatments for Penile Enhancement

Prof. Ege Can Serefoglu



16:05 –
16:20

03 Regenerative Medicine in Erectile Dysfunction: Current Evidence, Clinical Applications and Future Perspectives

Dr. Yaşar Başağa



16:20 –
16:35

04 Unusual Penile Deformation: Case Study

Dr. Anna Bonder-Nowicka



16:35 –
16:50

05 The ED Treatment Spectrum: From Medical Therapy to Penile Implants

Dr. Mohammed Hamdan



16:50 –
17:05

06 Treatment of Non-Obstructive Azoospermia Beyond Micro-TESE: Hormonal Preparation and Predictors of Success

Dr. Mohammad Al-Zubi



17:05 –
17:20

07 Pre-Penile Prosthesis Bladder and Prostate Optimization

Dr. Mathew Fakhoury



17:20 –
17:35

08 Novel and Future Treatments of Premature Ejaculation

Prof. Ege Can Serefoglu



17:35 – 17:45



Discussion & Q&A



Closing



جمعية جراحي الكلى
والمسالك البولية والتناسلية الأردنية
JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

16TH INTERNATIONAL CONGRESS

A GLOBAL EXCHANGE OF EXPERTISE

INTERNATIONAL FACULTY

Distinguished Guest Speakers

Regional and international experts sharing knowledge,
experience and the latest advances in urology.

1–2 OCTOBER 2026

LANDMARK AMMAN HOTEL • AMMAN, JORDAN



International Faculty



Dr. Abdulrahman Alkandari



Consultant urologist and President of the Kuwait Endourology Fellowship Program, with Canadian fellowship training in endourology, robotic and reconstructive surgery.



Dr. Anna Bonder-Nowicka



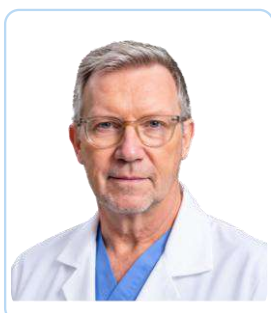
Head of Urology at Praski Hospital in Warsaw and FECSM-certified specialist in sexual medicine, focusing on erectile dysfunction, penile implants, premature ejaculation, and Peyronie's disease.



Prof. Bashar W. Nahas



Professor and consultant urologist at Damascus University, with advanced training in the UK and a fellowship in minimally invasive urology at the University of Edinburgh.



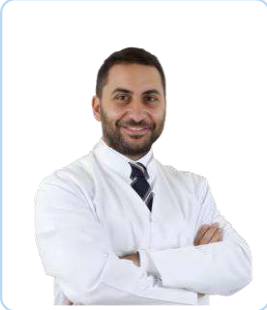
Dr. Christopher Love



Leading prosthetic urologist and male-health specialist; co-director of Melbourne's Andrology Prosthetic and Microsurgical Fellowship program.



International Faculty



Prof. Ege Can Serefoglu



Andrologist, guideline contributor and Editor-in-Chief of the International Journal of Impotence Research; active leader within EAU and ESSM.



Dr. Emad Alwashmi



Female voiding dysfunction and reconstructive urologist; Vice Dean at Qassim University College of Medicine and department head at Qassim University Medical City.



Dr. Ibrahim A. Khalil



Senior Fellow in urological oncology and robotic surgery at Hamad Medical Corporation; author of 40+ peer-reviewed publications.



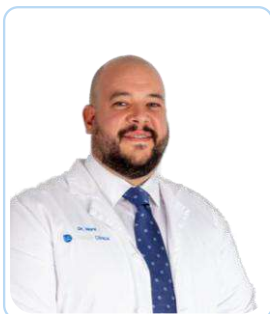
Dr. Jordi Guimera



Consultant urologist at Hospital Universitari Son Espases, FEBU, PhD and scientific author with a special focus on urinary stone disease.



International Faculty



Dr. Jorge Mora Christian



Consultant urologist and Associate Professor at the University of Deusto; expert in endourology, BPH, laser surgery and functional urology.



Dr. Khalid Al Rumaihi



Head of Urology at Hamad Medical Corporation, Urology MDT lead and Chairman of the Urology Tumor Board; Swedish and European board trained.



Prof. Dr. Lutfi Tunc



Professor of Urology with 25+ years in minimally invasive urology; pioneer of anatomy-based laparoscopic, robotic and laser techniques.



Dr. Li Xiao



Dr. Xiao Li is an Associate Professor and urologic surgeon specializing in minimally invasive and robotic surgery for urological tumors. He is a distinguished researcher with over 50 scientific publications and several patents.



International Faculty



Prof. Maher Saleh Moazin



Consultant urological surgeon and robotic-surgery leader; Director of the Simulation Center at King Fahad Medical City and an academic leader in medical education.



Dr. Majed Alharthi



Urology and endourology consultant, advisor to the CEO of King Fahd Hospital Jeddah and board member of the Saudi Urological Association.



Dr. Malek Gaashan



Consultant urological surgeon at University Hospitals of Leicester, specializing in pelvic oncology, robotic cystectomy and intracorporeal diversion.



Prof. Mauro Gacci



Professor at the University of Florence and SIU Academy education chair; author of 600+ indexed publications in LUTS, oncology and robotic surgery.



International Faculty



Dr. Mathew Qudsi Fakhoury



Board-certified urologist and men's-health specialist with expertise in sexual medicine, stone surgery, BPH procedures and incontinence. Fellow of Genitourinary prosthetic Surgeons



Prof. Mohammed Lezrek



Professor of Urology and international endourology educator known for affordable innovation, PCNL techniques, simulation models and hands-on training across Africa.



Dr. Naif Aldhham



Consultant uro-oncology and robotic surgeon at King Fahad Medical City; adjunct assistant professor at Alfaisal University.



Dr. Ricardo Almeida-Magana



Clinical Research Fellow at University College London and prostate-cancer clinical champion, working in imaging, focal therapy and uropathology.



International Faculty



Prof. Yang Jie



Chief Physician and Director of Urology at Jiangsu Cancer Hospital; innovator in remote robotic surgery and single-port urological procedures.



Dr. Yaşar Başaga



Assistant Professor of Urology at Nişantaşı University, FEBU, with clinical and research interests spanning urology and stem-cell sciences.



Prof. Dr. Yaşar Özgök



Professor of Urology, EBU examiner and President of ILRSA; international educator in laparoscopic, robotic and endourological surgery.



Dr. Yaser El Hout



Senior Pediatric Urologist at Sidra Medicine, former AUBMC program director and internationally invited speaker with 45 publications and four book chapters.



جمعية جراحي الكلى
والمسالك البولية والتناسلية الأردنية
JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

16TH INTERNATIONAL CONGRESS

LOCAL FACULTY

Distinguished Local Experts

Leading Jordanian urologists sharing expertise,
experience and the latest advances in urology.



Local Faculty



Dr. Abdelkarim Zitawi



Consultant Urologist and Laparoscopic Surgeon, Fellow of the Royal College of Surgeons, and Head of Urology at Specialty Hospital. His expertise includes male infertility, kidney transplantation, prostate care and minimally invasive surgery.



Dr. Anas Ahmad Al-Jbarat



Urology Specialist at the Jordan Ministry of Health.



Dr. Hashem Azmi Darwazeh



Board-certified urologist and Senior Fellow in Benign Prostate Surgery at Frimley Park Hospital, UK, with a focus on aquablation, minimally invasive prostate interventions and medical education.



Local Faculty



Dr. Haytham Hamed Saraireh



Consultant Radiation Oncologist and former Head of Radiation Oncology at the Royal Jordanian Medical Services. His expertise includes VMAT, IGRT, SBRT, SRS and thoracic oncology.



Dr. Mohammad Al-Zubi



Associate Professor of Urology at Yarmouk University, with advanced training in uro-oncology and endourology at Cork University Hospital, Ireland. He also holds a Postgraduate Certificate in Medical Education from the University of Dundee.



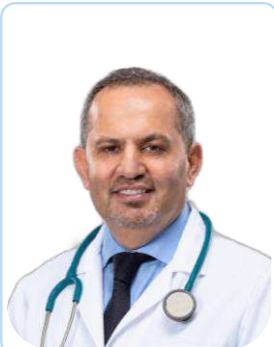
Dr. Mohammed Hamdan



Consultant Urologist and Uro-Andrologist specializing in men's health, erectile dysfunction and advanced penile prosthesis surgery. He is a high-volume implant surgeon and certified trainer.



Local Faculty



Dr. Osama Abu Hlalah



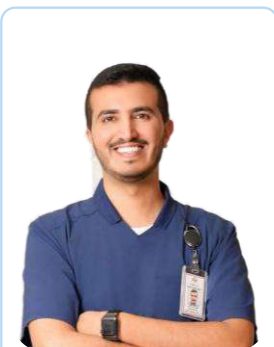
Board-certified Medical Oncologist and Hematologist with more than 20 years of experience in cancer care, stem-cell transplantation, targeted and immune therapies, and clinical research.



Dr. Rami Ghanem



Urologic Oncology Consultant and Head of the Genitourinary Oncology Service and Urology Section at King Hussein Cancer Center. His interests include GU malignancies, robotic and minimally invasive surgery, advanced prostate cancer and emerging therapies.



Dr. Rashed Al-Sharqi



Jordanian and Arab Board-certified Urology Specialist and Head of the Urology Department at Al-Nadeem Hospital, Jordan Ministry of Health.



Local Faculty



Dr. Samer Al-Geizawi



Head of Urology at Saudi Hospital in Amman and former Assistant Professor of Urology at Hashemite University. He completed fellowships in kidney and pancreas transplantation at Wake Forest University and in urology at AUBMC, and holds the European and Jordanian Boards of Urology.



Dr. Tarek Al Hammouri



Consultant in Urology, Uro-Oncology and Robotic Surgery with more than 12 years of experience in London and Amman. A Senior Researcher at UCL London and Prostate Cancer UK Champion, he has contributed to practice-changing randomized trials published in leading journals.



Dr. Zaid Al-Kailani



Consultant Urologist at King Hussein Cancer Center and holder of the Jordanian, German and European Boards of Urology. He specializes in andrology and uro-oncology, with advanced training in robotic surgery and renal transplantation, and has published several studies on prostate cancer.



جمعية جراحى الكلى
والمسالك البولية والتناسلية الأردنية
JORDANIAN ASSOCIATION OF UROLOGICAL SURGEONS

Registration & Accommodation

REGISTRATION FEES

NON JAUS MEMBER

200 USD

JAUS MEMBER

150 USD

RESIDENT / MEDICAL STUDENT

100 USD

YOUR REGISTRATION INCLUDES

Conference bag & badge • Scientific program • Exhibition access
Two lunches and coffee breaks on 1–2 October 2026

ACCOMMODATION



LANDMARK AMMAN HOTEL

5-STAR CONGRESS VENUE

SINGLE ROOM

160 USD

DOUBLE ROOM

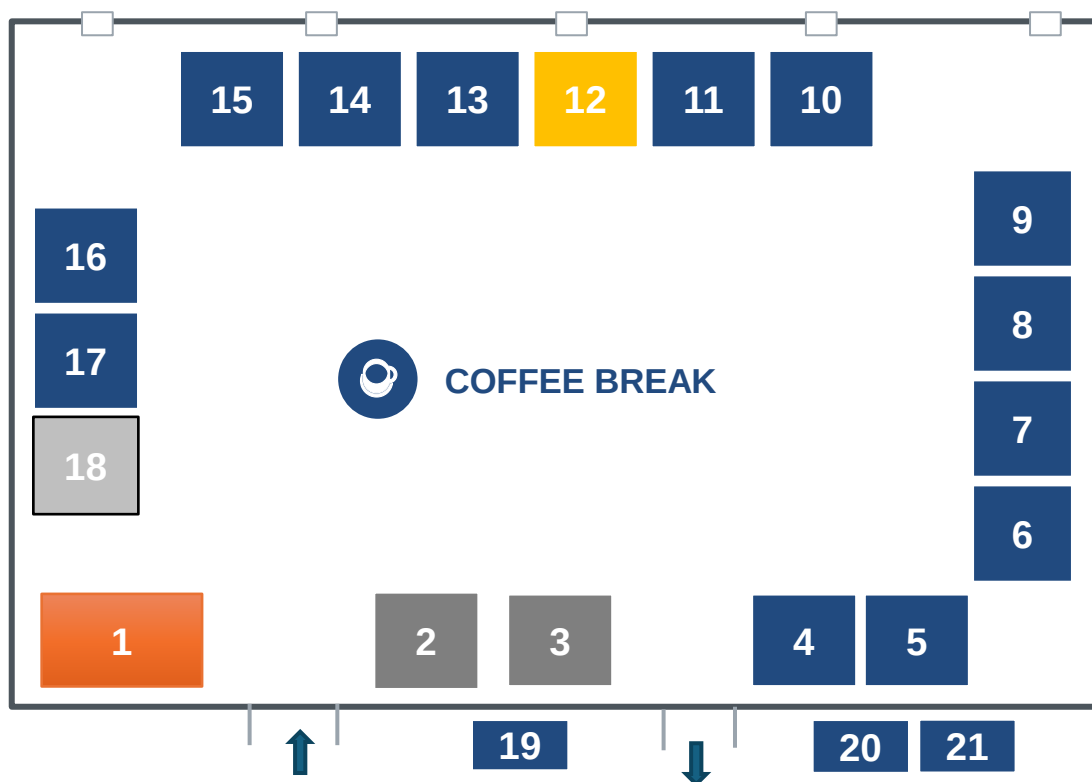
180 USD

Rates are per room, per night and include buffet breakfast,
10% service charge and 16% sales tax.

REGISTER & BOOK ONLINE

www.jausc.com

FLOOR PLAN



Royal Ball Room (1)

EXHIBITOR DIRECTORY

Company Name	Area (m ²)	Booth No.	Category
AlMutanabbe Drug Store	9 sqm	4	Exhibitor
Astellas	18 sqm	1	Bronze Sponsor
Bio Energy Tech	9 sqm	9	Exhibitor
Caviar Medical Center	4 sqm	20	Exhibitor
Coloplast	18 sqm	2+3	Platinum Sponsor
Echo Medical Supplies	9sqm	8	Exhibitor
Green Land Medical	9 sqm	11	Exhibitor
HIKMA	9 sqm	10	Exhibitor
Ipsen Pharma	9 sqm	16	Exhibitor
Jamieson	9 sqm	7	Exhibitor
JOSWE Medical	9 sqm	15	Exhibitor
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ABSTRACTS

16th International Congress of the Jordanian Association of Urological Surgeons

Dr. Anas Ahmad Al-ibarat - Jordan

Fading era of shock wave lithotripsy

Background:

Extracorporeal shock wave lithotripsy (SWL) revolutionized stone treatment and remained a cornerstone of urological practice for decades. However, advances in ureteroscopy (URS), flexible ureterorenoscopy, laser technology, and stone extraction systems have progressively changed the treatment landscape.

Objective:

To examine the declining role of SWL and define its contemporary position in modern stone management.

Discussion:

Across multiple healthcare systems, SWL utilization has progressively declined while URS has become increasingly dominant. This shift reflects the greater predictability of endoscopic stone clearance, particularly with modern flexible ureteroscopes and advanced laser technology. In contrast, SWL outcomes remain strongly influenced by stone size, location, composition, density, skin-to-stone distance, anatomy, and patient habitus. Lower-pole stones remain particularly challenging because successful fragmentation does not always result in effective fragment clearance.

Despite this decline, SWL remains attractive because of its non-invasive nature and relatively low morbidity. Current evidence supports its use in carefully selected patients with favorable stone characteristics and optimized treatment technique.

Conclusion:

The era of "SWL for almost everyone" has faded, but SWL itself has not disappeared. Its role has evolved from a universal first-line treatment to a selective, patient- and stone-specific therapy within modern endourological practice.

Dr. Anna Bonder-Nowicka - Poland

"Unusual penile deformamtion - case study".

This presentation describes the diagnostic and treatment process for a patient with an unusual penile deformity. The patient reported a acquired enlargement of the penis along its entire length, with no history of trauma, pain, or sexual dysfunction. The penis changed in shape and size over a relatively short period of time and caused increasing difficulties with sexual function. Before proceeding, extensive imaging and functional testing were performed, and treatment options were discussed with leading experts in urology and andrology. Ultimately, the patient was offered three treatment options, from which he selected the one most suitable for him. Corporeal plication using single sutures was performed, initially yielding excellent visual and functional results. Over time, the treatment results began to deteriorate, so the patient was referred for a repeat surgery. This time, the plication was performed using a continuous suture. Currently, an optimal treatment outcome has been achieved; however, the underlying condition that caused the deformity remains unresolved, making it difficult to predict the future course of the disease.

Dr. Malek Gaashan - UK

Beyond Open Surgery: The Era of Robotic Cystectomy and Intracorporeal Reconstruction

Radical cystectomy remains one of the most complex procedures in urological oncology and is associated with significant perioperative morbidity. Traditionally, open radical cystectomy has been regarded as the standard surgical approach. However, the rapid evolution of robotic-assisted surgery has transformed the management of muscle-invasive and high-risk bladder cancer, offering the potential benefits of minimally invasive surgery while maintaining the principles of radical oncological resection.

Robotic-assisted radical cystectomy (RARC), particularly when combined with intracorporeal urinary diversion, represents an important evolution in contemporary bladder cancer surgery. The robotic platform provides enhanced three-dimensional visualisation, wristed instrumentation and improved access to the deep pelvis, facilitating precise pelvic lymph node dissection and complex reconstructive procedures. Intracorporeal reconstruction further extends the minimally invasive approach by allowing the entire procedure to be completed within the abdominal cavity.

This lecture will explore the transition “beyond open surgery”, focusing on the practical evolution of robotic cystectomy and intracorporeal urinary reconstruction. It will discuss patient selection, surgical planning, pelvic lymphadenectomy, bowel mobilisation, ureteroenteric anastomosis and the different options for urinary diversion, including ileal conduit and orthotopic neobladder reconstruction.

Particular emphasis will be placed on the learning curve, team preparation, standardisation of surgical technique, operative efficiency and perioperative optimisation. The presentation will also address the challenges associated with intracorporeal reconstruction, including patient selection, bowel-related complications, uretero-enteric strictures and the importance of a multidisciplinary robotic programme.

Drawing on contemporary evidence and practical surgical experience, the lecture will consider where robotic cystectomy currently stands within modern bladder cancer pathways and how the integration of robotic surgery, intracorporeal reconstruction and enhanced recovery principles is changing the perioperative journey for patients undergoing radical cystectomy.

Ultimately, the evolution from open to robotic cystectomy is not simply a change in surgical access; it represents a broader transformation in the way complex pelvic cancer surgery is planned, performed and delivered.

Dr. Jorge Mora Christian - Spain

1. Modern Surgical Management of BPH: HoLEP, Mini-HoLEP, Aquablation and Contemporary Laser Technologies

The surgical management of benign prostatic hyperplasia is undergoing continuous technological evolution, with increasing emphasis on efficacy, safety, and minimally invasive approaches. This lecture will review recent advances in anatomical endoscopic enucleation, focusing on the evolution of laser technologies for HoLEP and their potential impact on surgical performance. Special attention will be given to miniaturization of the endoscopic approach through Mini-HoLEP, aiming to reduce urethral instrumentation while maintaining the principles and efficacy of anatomical enucleation. Finally, the evolution of robotic waterjet therapy will be discussed, with particular focus on the new HYDROS platform and its integration of advanced imaging, treatment planning, and robotic technology. Together, these innovations illustrate the current trend toward more precise, less invasive, and increasingly technology-driven surgical treatment of BPH.

2. Functional Urology and Male/Female Incontinence Surgery

The surgical management of urinary incontinence has evolved toward a more individualized approach, offering different solutions according to severity, sphincter function, previous treatments, and patient characteristics. In male stress urinary incontinence, this lecture will review the contemporary role of the artificial urinary sphincter together with alternative and adjustable options, including the AdvAnce male sling, ATOMS, and the Remeex system, highlighting patient selection and the role of each technique. In female stress urinary incontinence, minimally invasive and adjustable approaches will be discussed, including mini-TOT and Remeex. Particular attention will be given to the artificial urinary sphincter in complex or refractory female incontinence and to the evolution from open surgery toward minimally invasive laparoscopic and robot-assisted implantation. These techniques provide an expanding armamentarium for tailoring continence surgery to the individual patient.

Prof. Ege Can Serefoglu - Turkey

1 — Non-Surgical Treatments for Penile Enhancement

Requests for penile enhancement are increasingly common, yet the majority of men who seek augmentation have penile dimensions within the normal range, making thorough counselling and psychological assessment the essential first step. This lecture reviews the current non-surgical options and the evidence behind them. Temporary and semi-permanent injectable soft-tissue fillers — most commonly hyaluronic acid, as well as autologous fat transfer — are the most widely used approaches for increasing girth, offering the advantages of a minimally invasive, office-based procedure and reversibility in the case of hyaluronic acid. Their reported benefits, durability, and complication profiles (including nodularity, asymmetry, migration, and rare vascular events) will be discussed, alongside the more limited role of vacuum erection devices and penile traction therapy for length. Overall, the current evidence base remains heterogeneous and of modest quality, with a lack of standardised outcome measures and long-term data. Emphasis will be placed on realistic expectation-setting, screening for body dysmorphic disorder and penile dysmorphophobia, appropriate patient selection, informed consent, and the clear distinction between cosmetic augmentation and the management of true functional or reconstructive indications. The

lecture concludes with practical guidance for clinicians and a look at where higher-quality evidence is still needed.

2 — Novel and Future Treatments of Premature Ejaculation

Premature ejaculation (PE) is the most prevalent male sexual dysfunction, yet the therapeutic armamentarium remains limited, with dapoxetine and topical anaesthetics being the only agents specifically developed and approved for the condition. This lecture surveys the current standard of care — on-demand and daily SSRIs, topical lidocaine-prilocaine formulations, tramadol, PDE5 inhibitors in selected patients, and behavioural techniques — before turning to emerging and future directions. Novel pharmacological strategies under investigation include oxytocin-receptor antagonists, modulators of central serotonergic and dopaminergic pathways, and agents aimed at achieving efficacy with a faster onset and fewer systemic side effects than current options. Procedural and device-based approaches will also be reviewed, including glans augmentation with hyaluronic acid fillers, botulinum toxin injection, and dorsal penile nerve neuromodulation, together with the ongoing clinical studies evaluating their safety and durability. The growing role of combination therapy, digital and app-based behavioural interventions, and the need for standardised endpoints such as intravaginal ejaculatory latency time (IELT) and validated patient-reported outcomes will be highlighted. The lecture concludes with a critical appraisal of the evidence, the challenges of trial design in PE, and a realistic outlook on which of these innovations are most likely to reach clinical practice.

Prof. Bashar .W. Nahas – Syria

Turner Warwick Bladder Elongation Procedure for Management Of Lower Third Ureteric Injuries

Purpose: To Evaluate our experience in TWBEP, The Surgical Technique is described and tips and tricks to avoid Surgical Complications. Material and Methods: This is Retrospective study of our experience in TWBEP since 1991-2025, all cases had a minimum follow up 2-3 yrs. The results are discussed and the way we did follow up is shown. Conclusion: TWBEP is an excellent technique which can be used to reconstruct Lower third ureteric injuries; it can be used to repair 15 cm of distal ureter with excellent results.

Dr. Ibrahim A. Khalil - Qatar

Robotic Adrenalectomy: Expanding the Boundaries of Minimally Invasive Surgery

Brief Abstract:

Robotic adrenalectomy provides a minimally invasive platform for managing increasingly complex adrenal pathology. This presentation will review patient selection, operative planning, key technical principles, and strategies for challenging adrenal tumors, integrating contemporary evidence with practical surgical experience.

Objectives:

- Identify appropriate indications and patient selection for robotic adrenalectomy.

- Describe key operative principles and strategies for complex adrenal tumors.
- Evaluate the safety, outcomes, and current limitations of the robotic approach.

Prof. Mauro Gacci - Italy

1-Single-Port Robotic Radical Prostatectomy: Evolution, Outcomes, and Surgical Innovation

Robot-assisted radical prostatectomy (RARP) has become the gold-standard surgical treatment for localized prostate cancer in many institutions worldwide. The introduction of the purpose-built da Vinci Single-Port (SP) platform in 2018 represented a significant technological milestone in the evolution of minimally invasive urologic surgery, offering the possibility of performing radical prostatectomy through a single access point while maintaining instrument articulation, triangulation, and surgical precision. ([PubMed](#))

The development of Single-Port Robotic Radical Prostatectomy (SP-RARP) has expanded the spectrum of available surgical approaches beyond conventional transperitoneal surgery. Contemporary techniques include transperitoneal, extraperitoneal, Retzius-sparing, transperineal, and transvesical approaches, each designed to optimize access to the prostate while minimizing surgical invasiveness and enhancing postoperative recovery. The flexibility of the SP platform has enabled surgeons to explore novel anatomical corridors, particularly in patients with previous abdominal surgery, obesity, hostile abdomens, or other challenging clinical scenarios. ([PubMed](#))

Current evidence demonstrates that SP-RARP is safe, feasible, and reproducible in experienced robotic centers. Comparative studies and meta-analyses suggest that perioperative outcomes are at least equivalent to those achieved with conventional multiport robotic surgery, while potentially offering reduced postoperative pain, shorter hospitalization, lower blood loss, and faster recovery without compromising oncological or functional results. Early continence outcomes appear particularly promising in selected approaches such as transvesical and Retzius-sparing SP-RARP, with some series reporting same-day discharge protocols and opioid-free postoperative pathways. ([PubMed](#))

From an oncological perspective, available data indicate comparable positive surgical margin rates and early cancer control outcomes relative to multiport RARP. Functional results, including urinary continence and erectile function recovery, are encouraging, although longer follow-up and prospective comparative studies remain necessary to define the true clinical advantages of the SP platform. ([PubMed](#))

Beyond the reduction in the number of skin incisions, the SP system should be viewed as an enabling technology that facilitates innovative surgical approaches and personalized treatment strategies. Its ability to operate effectively within confined anatomical spaces has opened new opportunities for organ-preserving and access-modifying techniques that may further improve patient-centered outcomes. ([PubMed](#))

As robotic surgery continues to evolve, Single-Port Radical Prostatectomy represents not merely a cosmetic refinement but a paradigm shift toward less invasive, more tailored, and potentially more efficient surgical care. Future multicenter studies, registry analyses, and long-term functional and oncological data will be essential to define its ultimate role within contemporary prostate cancer surgery.

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2-Challenging Cases in Robotic Partial Nephrectomy: Strategies, Pitfalls and Solutions

Robot-assisted partial nephrectomy (RAPN) has become the preferred surgical approach for the management of localized renal masses whenever technically feasible, offering excellent oncological control while maximizing renal function preservation. As surgeons continue to expand the indications for nephron-sparing surgery, increasingly complex tumors—including completely endophytic lesions, hilar masses, multifocal tumors, solitary kidneys, and lesions in close proximity to the collecting system or major vascular structures—are being approached robotically. These challenging scenarios require meticulous preoperative planning, advanced surgical skills, and the integration of intraoperative imaging technologies.

This presentation will focus on the management of complex renal tumors through a case-based analysis of difficult robotic partial nephrectomies. Particular emphasis will be placed on surgical strategies aimed at optimizing the balance between oncological efficacy, preservation of renal function, and minimization of perioperative complications. Key technical aspects including hilar dissection, selective or super-selective clamping, tumor enucleation, reconstruction techniques, and management of intraoperative bleeding will be discussed through representative clinical cases.

A central theme of this lecture is the critical role of intraoperative robotic ultrasonography. For completely endophytic, poorly visible, or hilar tumors, intraoperative ultrasound has

become an indispensable tool, enabling precise tumor localization, identification of tumor margins, assessment of tumor depth, visualization of intrarenal vascular anatomy, and guidance of resection planes. The integration of real-time ultrasound imaging into the robotic console has significantly enhanced the surgeon's ability to safely perform nephron-sparing surgery in tumors that would otherwise require radical nephrectomy or carry an increased risk of positive surgical margins.

Recent studies have demonstrated that the use of intraoperative ultrasound improves tumor localization accuracy, facilitates enucleative and enucleoresection techniques, reduces unnecessary sacrifice of healthy renal parenchyma, and contributes to favorable functional outcomes, particularly in highly complex renal masses. Moreover, the combination of three-dimensional imaging reconstruction and real-time ultrasound guidance is progressively redefining the concept of precision surgery in renal cancer treatment.

Through the presentation of challenging cases, technical pitfalls, and practical solutions, this lecture aims to provide attendees with a comprehensive overview of contemporary strategies for managing complex renal tumors robotically. The discussion will highlight how advanced imaging guidance, particularly intracorporeal robotic ultrasound, has become a cornerstone of modern nephron-sparing surgery and an essential instrument for safely pushing the boundaries of robotic partial nephrectomy.

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Dr. Rashed Al- Sharqi - Jordan

TRUS prostate biopsy with PeriProstatic nerve block in different way

In this lecture I will show How to do ultrasound for prostate, seminal vesicle, bladder and vas in both sagittal and Axial view then we learn how to do Periprostatic nerve block to

eliminate pain during biopsy in different ways including Modified Bear's technique

Dr. Haytham Hamed Saraireh - Jordan

VMAT in Prostate Cancer: Precision Radiotherapy in Modern Practice

Radiotherapy is a cornerstone in the multidisciplinary management of prostate cancer, offering curative treatment across localized, locally advanced, and selected recurrent disease. This lecture will review modern radiotherapy strategies, including image-guided IMRT/VMAT, hypofractionation, stereotactic body radiotherapy (SBRT), and salvage radiotherapy. Emphasis will be placed on patient selection, target delineation, integration of MRI and PSMA PET/CT, treatment planning, dose and fractionation, and optimization of toxicity while maintaining excellent tumor control. Emerging approaches and the role of radiotherapy in oligometastatic disease will also be discussed.

Dr. Naif Aldhaam - KSA

Background:

Testicular cancer is highly curable, yet several aspects of its management remain controversial. Advances in surgery, systemic therapy, and risk stratification continue to challenge established treatment paradigms.

Objectives:

To highlight contemporary controversies in testicular cancer management and critically evaluate current evidence guiding clinical decision-making.

Content:

Key controversies include surveillance versus adjuvant therapy in stage I disease, the role and timing of retroperitoneal lymph node dissection, management of residual masses after chemotherapy, surgical de-escalation, and the emerging role of minimally invasive and robotic approaches. The balance between maximizing cure and minimizing long-term treatment-related morbidity will also be discussed.

Conclusion:

The modern challenge in testicular cancer is not simply achieving cure, but achieving cure with the least possible treatment burden. Individualized, risk-adapted management should remain at the centre of contemporary care.

Dr. Jordi Guimera - Spain

Prevention of Calcium Lithiasis

The three primary inhibitor agents of calcium lithiasis are phytate, potassium citrate, and magnesium. Each exhibits different mechanisms of action and side effects. Understanding each agent is crucial to achieving adequate inhibition of urinary lithiasis.

Prof. Maher Moazin - KSA

1- Beyond the Console: The Future of Intelligent Robotic Urologic Oncology

Background:

Robotic surgery has transformed urologic oncology by improving visualization, dexterity, precision, and minimally invasive access. However, the next phase of robotic surgery will extend beyond mechanical enhancement of the surgeon. Artificial intelligence (AI), computer vision, augmented reality, advanced imaging, digital pathology, predictive analytics, and autonomous robotic functions are converging to create a new generation of intelligent surgical systems.

Objective:

To explore the emerging transition from conventional surgeon-controlled robotic platforms toward intelligent, data-driven robotic ecosystems in urologic oncology and to examine their potential impact on surgical planning, intraoperative decision-making, oncological precision, training, and patient outcomes.

Current and Emerging Applications:

AI-enabled platforms can integrate preoperative imaging, clinical variables, pathology, and intraoperative data to support personalized surgical planning. Computer vision may enable real-time recognition of anatomical structures, tumor boundaries, critical vascular anatomy, and surgical phases. Image-guided and augmented-reality technologies may further enhance navigation during complex prostate, kidney, and bladder cancer surgery. Beyond navigation, objective analysis of surgical performance could provide automated assessment of technical skills, workflow, and operative risk. Future robotic platforms may progressively incorporate context-aware assistance and task-level automation while maintaining the surgeon as the central clinical decision-maker.

Challenges:

Translation into routine practice requires robust clinical validation, interoperability, high-quality surgical datasets, explainable algorithms, cybersecurity, regulatory oversight, and clear frameworks for accountability. Equally important is ensuring that intelligent robotic technologies augment surgical expertise rather than create inappropriate dependence on automation.

Conclusion:

The future of robotic urologic oncology lies not simply in more sophisticated robotic hardware, but in the development of an intelligent surgical ecosystem that can perceive, interpret, predict, and assist. The evolution from the robotic console toward AI-augmented precision surgery has the potential to improve oncological accuracy, standardize surgical quality, accelerate training, and

personalize treatment. The defining challenge for the next decade will be to combine human surgical judgment with machine intelligence safely, ethically, and effectively.

2- Artificial Intelligence in Urology: Transforming Clinical Practice, Education, and Robotic Surgery

Artificial intelligence is rapidly reshaping urology across clinical practice, education, and robotic surgery. Machine learning, computer vision, and generative AI are enabling earlier diagnosis, personalized risk prediction, improved imaging interpretation, and data-driven clinical decisions. In education, AI offers adaptive learning, simulation, automated assessment, and personalized surgical coaching. Within robotic surgery, intelligent systems can support anatomical recognition, surgical navigation, performance analysis, and increasingly autonomous task execution. These advances may improve precision, efficiency, safety, and standardization of care. Successful adoption, however, requires rigorous validation, ethical governance, data security, and human oversight, positioning AI as an augmentation of urological expertise rather than its replacement.

Dr. Zeid Musa AbuGhosh - Jordan

MBBS. HSU. JBU. FEBU.

CANADIAN FELLOWSHIP IN UROONCOLOGY AND ROBOTICS.

Rezūm start and excel "update in BPH"

REZUM EXPERT

Subject:

Evaluating the real-world clinical efficacy, objective urodynamic improvements, anatomical reduction, and preservation of sexual and ejaculatory function in patients undergoing Rezūm Water Vapor Thermal Therapy for symptomatic benign prostatic hyperplasia (BPH) within the Jordanian clinical setting.

Materials and Methods:

A clinical review was conducted evaluating over 500 consecutive patients treated with Rezūm Water Vapor Thermal Therapy in Jordan. Preoperative assessments included baseline transrectal or transabdominal ultrasound prostate volume measurements, peak urinary flow rate ($Q_{\max}$), post-void residual (PVR) volume, IPSS scores, and validated sexual function questionnaires (IIEF-5 and MSHQ-EjD). Patients received targeted 9-second thermal energy vapor injections into lateral and median lobes as anatomically indicated. Key objective parameters—including prostate volume reduction, $Q_{\max}$ acceleration, PVR clearance, and sexual/ejaculatory outcomes—were monitored throughout postoperative follow-up.

Results:

Analysis of the 500+ case cohort demonstrated marked objective and functional gains:

Anatomical Volume Reduction: Significant decrease in overall prostate volume observed on follow-up imaging.

Uroflowmetry ($Q_{\max}$): Substantial improvement in peak flow rate ($Q_{\max}$), demonstrating effective relief of bladder outlet obstruction.

Post-Void Residual (PVR): Sharp reduction in PVR volumes, signifying improved voiding efficiency and reduced urinary retention risk.

Sexual & Ejaculatory Preservation: High rates of erectile function preservation (IIEF-5) and an exceptionally high rate of preserved antegrade ejaculation (MSHQ-EJD), confirming the therapy's minimal impact on surrounding neuromuscular structures.

Conclusion:

Our clinical experience across 500+ cases in Jordan confirms that Rezūm Water Vapor Thermal Therapy is an exceptionally safe, durable, and highly effective minimally invasive treatment for BPH. It yields meaningful reductions in prostate volume and significant improvements in $Q_{\max}$ and PVR, all while reliably maintaining erectile and ejaculatory function

Prof. Dr. Lutfi Tunc - Turkey

1-Bleeding as a Marker of Anatomical Precision: Surgical Standardization and the Future of AI in Robot-Assisted Radical Prostatectomy

Abstract

Bleeding during robot-assisted radical prostatectomy is more than an intraoperative event; it often reflects the accuracy of anatomical dissection and may influence both functional and oncological outcomes. This presentation will discuss the relationship between meticulous hemostasis, preservation of correct anatomical planes, and postoperative continence, potency, and cancer control. Emphasis will be placed on how anatomy-based surgical standardization can improve procedural reproducibility and reduce variability among surgeons. The lecture will also explore the future role of artificial intelligence in robotic surgery, highlighting how AI-assisted recognition of anatomical planes and real-time intraoperative guidance may facilitate standardized dissection, enhance surgical precision, and contribute to safer and more consistent patient outcomes.

2-Anatomy-Driven Endoscopic Enucleation of the Prostate: Surgical Standardization, Continence Preservation, and the Omega Sign Technique

Abstract

Anatomical enucleation of the prostate is fundamentally based on a thorough understanding of zonal anatomy rather than the choice of laser energy source. This lecture will highlight the importance of identifying and maintaining the correct surgical plane to achieve complete adenoma removal while preserving the continence mechanism. Particular emphasis will be placed on the anatomical relationship between the prostate, bladder, urethra, and the male rhabdosphincter, and how meticulous preservation of these structures contributes to early urinary continence. The principles of energy-independent surgical standardization, its value in improving reproducibility and surgical training, and the key technical aspects of the Omega Sign technique will also be discussed as practical strategies for achieving safe, effective, and anatomically precise endoscopic enucleation.

Dr. Ricardo ALMEIDA MAGANA - UK

Real-Time Intraoperative Margin Assessment: Lessons from NeuroSAFE and LaserSAFE trials

Achieving oncological control while preserving functional outcomes remains a key challenge during radical prostatectomy. Real-time intraoperative margin assessment offers the potential to tailor the nerve-sparing strategy according to the presence of residual tumour at the resection margin.

This lecture will explore the development and clinical evaluation of intraoperative margin assessment through the NeuroSAFE and LaserSAFE trials at UCLH. The NeuroSAFE technique uses intraoperative frozen-section analysis to guide nerve-sparing surgery. Findings from the multicentre NeuroSAFE PROOF randomised controlled trial will illustrate the potential of this strategy to improve functional outcomes while maintaining oncological safety, as well as the practical challenges of integrating intraoperative pathology into surgical workflows.

The lecture will then introduce LaserSAFE, an emerging approach using rapid ex vivo fluorescence confocal microscopy to provide near-real-time assessment of prostate specimens. Experience with the Histolog® system will highlight the importance of specimen handling, image quality, diagnostic performance and multidisciplinary interpretation.

If you would prefer a shorter version,

Achieving oncological control while preserving functional outcomes remains a challenge during radical prostatectomy. Real-time intraoperative margin assessment has the potential to offer nerve-sparing to most patients. This lecture will explore the development and clinical evaluation of intraoperative margin assessment through the NeuroSAFE and LaserSAFE trials experience at UCLH.

Dr. Yaşar BAŞAĞA - Turkey

Regenerative Medicine in Erectile Dysfunction: Current Evidence, Clinical Applications, and Future Perspectives

Abstract:

Erectile dysfunction is a multifactorial condition frequently associated with endothelial dysfunction, impaired penile vascularization, smooth-muscle damage, fibrosis, and neural injury. Although conventional treatments such as phosphodiesterase type 5 inhibitors, intracavernosal injections, vacuum devices, and penile prostheses remain effective, they primarily provide symptomatic improvement and may not reverse the underlying pathophysiological changes.

Regenerative medicine has therefore gained increasing attention as a potential disease-modifying approach. This presentation will review the biological mechanisms, current evidence, and clinical applications of low-intensity extracorporeal shockwave therapy, platelet-rich plasma, stem cell-based treatments, and extracellular vesicles, including exosomes. Their potential roles in promoting angiogenesis, improving endothelial function, supporting neural regeneration, reducing fibrosis, and restoring cavernosal smooth-muscle function will be discussed.

The presentation will also address appropriate patient selection, treatment protocols, possible combination strategies, safety considerations, and the limitations of the available clinical evidence. Particular attention will be given to the gap between encouraging preclinical findings and the need for standardized, high-quality randomized clinical trials. Finally, future perspectives for integrating regenerative therapies into evidence-based andrological practice will be explored.

Prof. Dr. Yasar Ozgok - Turkey

University of Health Sciences, Gülhane Faculty of Medicine, Ankara, Türkiye

Step-by-Step Robot-Assisted Radical Cystectomy with Intracorporeal Studer Orthotopic Neobladder Reconstruction

Abstract

Introduction: Robot-assisted radical cystectomy (RARC) with intracorporeal urinary diversion is an established minimally invasive approach for muscle-invasive and selected high-risk bladder cancer. Intracorporeal Studer orthotopic neobladder reconstruction remains technically demanding, requiring meticulous planning, precise bowel handling, and reliable ureteroileal and urethroileal anastomoses. This video presents a standardized step-by-step approach, emphasizing key anatomical landmarks, surgical principles, and practical technical tips.

Surgical Technique: The video demonstrates patient positioning, port placement, robotic docking, pelvic lymph node dissection, and radical cystectomy. Particular attention is given to ureteral identification and mobilization, preservation of critical anatomical structures, and preparation for intracorporeal urinary diversion. Studer neobladder reconstruction is demonstrated sequentially, including ileal segment selection and isolation, restoration of bowel continuity, detubularization, reservoir configuration, urethroileal anastomosis, and bilateral ureteroileal anastomoses. Key principles for creating a tension-free, well-vascularized, watertight, and low-pressure reservoir are highlighted.

Conclusion: RARC with intracorporeal Studer orthotopic neobladder reconstruction is complex but reproducible when performed using a standardized surgical sequence. A detailed step-by-step video facilitates understanding of operative anatomy, recognition of critical surgical landmarks, and acquisition of practical skills in robotic cystectomy and intracorporeal urinary diversion. This educational approach may help surgeons develop and refine their technique while improving consistency, safety, and confidence during complex urinary reconstruction procedures.

Keywords: Robot-assisted radical cystectomy; Bladder cancer; Intracorporeal urinary diversion; Studer orthotopic neobladder; Robotic surgery; Urinary reconstruction; Urologic oncology.

Dr. Christopher Love - Australia

Management of Common IPP Complications

This presentation will cover how to diagnose and treat intraoperative complications of inflatable penile prosthesis surgery, including cylinder crossover, proximal perforation, glans hypermobility, corporeal dilation difficulties and others

Dr. Hashem Darwazeh - Jordan

Early functional recovery after Aquablation for BPH: A 4-Week snapshot of symptom relief, return to normal activity, and sexual function outcomes

Author list Darwazeh H., Ng K.L, Barber N. Frimley Park Hospital NHS Foundation Trust, Urology, Camberley, United Kingdom

Introduction & Objectives

Aquablation is a minimally invasive, robot-assisted surgical treatment for symptomatic benign prostatic hyperplasia (BPH) using realtime imaging and heat free waterjet to ablate and remove tissue. Although its long-term outcomes are established, limited data describe early postoperative recovery. This study evaluated urinary, functional, and sexual outcomes at four weeks.

Materials & Methods

A retrospective review was performed at The London Clinic on 82 consecutive patients treated between August 2024 and August 2025. Early outcomes were assessed using validated patient-reported questionnaires covering urinary symptoms, quality of life (QoL), pain, recovery time, resumption of daily activities, and sexual function at 4 weeks. Sexual outcomes were analyzed for the 76 sexually active men. Descriptive statistics were applied

Results

At four weeks, mean IPSS was 8.96 ± 4.79 and QoL score 1.78 ± 1.48 , indicating rapid symptom and quality of life improvement. Most patients (83%) reported no or minimal interference of urinary problems with daily activities such as work, exercise, or social engagements, and mean time to full recovery was 21 ± 12 days. Mean postoperative pain score on a 0–10 scale was 0.9 ± 1.2 , suggesting good tolerability. Among sexually active men, ejaculatory function was preserved in 88%, with 9 (12%) reporting anejaculation; ejaculatory strength was unchanged or mildly reduced in most, and 82% had preserved or mildly reduced volume. 86% had determined erectile function sufficient for penetration by 4 weeks, 94% described normal orgasmic function, and sexual desire remained moderate to high in 92%.

Conclusions

Aquablation leads to a rapid improvement in urinary symptoms and return to normal activity with encouraging preservation of sexual function even by 4 weeks. This pattern of functional recovery mimics or exceeds that of the 'Minimally Invasive Surgical Treatments' of PUL (Urolift) - IPSS 10.9 at 4 weeks and WVTT (Rezum) - IPSS 16.2 at 4 weeks, as reported in the CLEAR trial (Presented EAU Annual Congress 2025).

[Dr. Mathew Qudsi Fakhoury DO, FGPS - USA](#)

Fellow of Genitourinary prosthetic Surgeons

Don't Get BPH'ED; Prepping the Pipes: A Practical Guide to Pre-Penile Prosthesis Bladder & Prostate Optimization

Background: Penile prosthesis implantation carries a low but consequential risk of infection and mechanical complication. Postoperative vigilance should extend beyond the device itself to any subsequent manipulation of the prostate or lower urinary tract, as men with a history of BPH remain at risk for urinary retention or progressive LUTS after implantation. Notably, national survey data suggest that only a small fraction of men presenting with ED report a formal BPH diagnosis despite significant urinary symptom burden, indicating that clinically relevant BPH is likely underdiagnosed in this population.

Objective: To highlight the importance of avoiding unnecessary prostatic or urethral instrumentation after penile prosthesis placement, and to propose a framework for minimizing this risk through preoperative optimization and postoperative vigilance.

Discussion: Should retention or LUTS progression occur postoperatively, instrumentation of the prostate or urethra — including catheterization, cystoscopy, or transurethral surgery — introduces direct risk to the adjacent prosthesis. Existing literature is mixed but concerning: catheterization in the setting of an indwelling penile prosthesis has been associated with erosion rates as high as 55% in early series, though more recent data suggest extended catheterization may not uniformly increase complication risk. Even routine or seemingly benign catheter placement can cause urethral trauma, hematuria, clot formation, and catheter-associated infection in close proximity to the implant. Reducing the likelihood that such manipulation becomes necessary begins preoperatively, through optimization of bladder outlet status, but must be paired with sustained postoperative awareness: a low threshold for urologic involvement and implant-aware technique whenever instrumentation is unavoidable.

Conclusion: Vigilance against avoidable prostatic or urethral manipulation after penile prosthesis implantation — and implant-aware management when manipulation is necessary — is essential to protecting device integrity and ensuring long-term surgical success.

Dr. Mohammad Al-Zubi - Jordan

Management Of Non Obstructive Azospermia More Than Micro-TESE, Hormonal Preparation & Factors To Predict Success Rate Pre- Operation

- **Introduction:-** Azoospermia affects around 1% of men.

Approximately 60% of men diagnosed with azoospermia will have non-obstructive azoospermia (NOA).

- **Methodology:-** we will discuss the result of 2 published studies,

First study :- Can We Predict the Outcome of Micro Testicular Sperm Extraction in Non Obstructive Azoospermia From Preoperative Hormonal Profile, Testicular Volume, and Patients Health Factors: A Retrospective Cross-Sectional Study, were A retrospective analysis of 152 patients who underwent a micro-TESE operation for NOA at our center from January 2020 to December 2022 was conducted.

And Second study:- Clomiphene citrate and human chorionic gonadotropin treatment before microdissection testicular sperm extraction in non-obstructive azoospermia: a retrospective non-randomized series were aimed to investigate the effect of preoperative hormonal treatment on sperm retrieval rates (SRRs) during Micro-TESE in NOA patients. Were patients subdivided into two groups first one received hormonal preparation before operation while the second group did not.

Result:- in the first study, Results reveal that free testosterone level, total testosterone level, smoking status and previous TESE operation are significantly related to positive surgical results (p value less than 0.05).

- While in the second study Results revealed no statistically significant differences in most demographic and clinical parameters between the groups, Micro-TESE outcomes were also comparable, with 50% success in the non-hormonal therapy group and 45% in the preoperative hormonal therapy group (p = 0.53).

Dr. Samer Al-Geizawi - Jordan

Thulium Fiber Laser vs Holmium:YAG in Prostate Enucleation: From Technology to Clinical Outcomes

Background: Anatomical endoscopic enucleation of the prostate (AEEP) has become an established surgical approach for benign prostatic obstruction, particularly in men with large prostates. Holmium laser enucleation of the prostate (HoLEP) has the longest clinical track record and a mature evidence base, while thulium fiber laser enucleation (ThuFLEP) has emerged as an alternative platform with distinct laser physics and favorable tissue-interaction characteristics.

Objective: To critically compare ThuFLEP and HoLEP with respect to laser characteristics, perioperative performance, functional outcomes, safety, learning curve, and practical considerations for clinical and institutional adoption.

Evidence Summary: Recent randomized trials and meta-analyses demonstrate that both techniques provide substantial and comparable improvements in International Prostate Symptom Score (IPSS), quality of life, maximum urinary flow rate, and post-void residual volume. Randomized non-inferiority data for ThuFLEP have now extended to 24 months. Overall complication rates, long-term continence, and functional outcomes appear similar. Some studies and pooled analyses suggest potential perioperative advantages for ThuFLEP, including favorable hemostasis, shorter catheterization or hospitalization, and operative efficiency. However, these findings are not consistent across studies, particularly when ThuFLEP is compared with contemporary pulse-modulated Ho:YAG systems. HoLEP retains an important advantage in evidence maturity, long-term durability data, guideline support, and accumulated clinical experience.

Conclusion: Current evidence does not demonstrate universal clinical superiority of either laser platform. The anatomical enucleation technique and surgeon expertise appear more important than wavelength alone. Selection between ThuFLEP and HoLEP should therefore consider patient characteristics, surgeon experience, training, operating-room workflow, infrastructure, platform availability, service support, and total cost of ownership. The optimal decision is to choose the most effective enucleation program—not simply the laser.

Dr. Suleiman Salameh Alhalteh - Jordan

Urologist, MOH Al-Bashir Hospital, Amman, Jordan

Bilateral Renal Angiomyolipoma Presenting with Acute Spontaneous Haemorrhage as the Sentinel Urological Manifestation of Suspected Familial Tuberous Sclerosis Complex: A Case Report

Introduction

Renal angiomyolipoma (AML) associated with tuberous sclerosis complex (TSC) is characteristically multiple and bilateral and carries a significant risk of spontaneous retroperitoneal haemorrhage (Wunderlich syndrome). The cutaneous stigmata of TSC — facial angiofibromas, hypomelanotic macules, and ungual fibromas — are often present for years before a unifying diagnosis is made, particularly in adult women in whom they are frequently misattributed to acne, birthmarks, or nail infection. We present a case in which acute AML haemorrhage was the event that finally prompted recognition of a probable multigenerational familial TSC phenotype.

Case Presentation

A 50-year-old married woman with a decades-long history of an unexplained facial “rash,” nail changes, skin pigmentary lesions, and prior unexplained haematuria presented with acute left loin and abdominal pain. Non-contrast CT of the abdomen demonstrated multiple bilateral fat-attenuation renal masses consistent with angiomyolipoma, with imaging features of recent haemorrhage on the symptomatic left side. Haemoglobin fell acutely from 12 to 8 g/dL before stabilising with supportive management. Examination revealed facial angiofibromas, periungual fibroma-like lesions of the fingers and toes, and a hypopigmented (ash-leaf) macule — collectively raising strong clinical suspicion of TSC. Notably, the patient’s sister, daughter, and a maternal uncle displayed an identical facial and cutaneous phenotype; the uncle had additionally suffered from seizures and died without ever reaching a diagnosis. No family member had previously undergone dermatological, renal, or genetic evaluation for TSC.

Discussion / Conclusion

This case illustrates how an acute urological emergency — haemorrhage from bilateral renal AML — can be the sentinel event that unmasks a longstanding, unrecognised multigenerational TSC phenotype. Applying the 2012 International TSC Consensus diagnostic criteria, the patient meets, or comes close to meeting, a clinical diagnosis on dermatological and renal grounds alone. Management combines nephron-sparing strategies (surveillance or selective embolisation for the acute bleed, with mTOR inhibitors considered for long-term disease control) with a multidisciplinary work-up — dermatology, genetics, neurology, cardiology, and pulmonology — and, critically, cascade clinical and genetic screening of at-risk relatives. Urologists managing apparently sporadic bilateral AML should routinely assess for cutaneous stigmata of TSC and family history, since early recognition allows timely surveillance and may prevent avoidable, and potentially fatal, complications in affected relatives.

Keywords: Angiomyolipoma; Tuberous sclerosis complex; Wunderlich syndrome; Facial angiofibroma; Hereditary renal disease; Cascade screening

Dr. Mohammad Alhioui – Jordan

Urologist and kidney surgeon — MD, ABU, JBU

Non-Surgical Management of Bilateral Emphysematous Pyelonephritis: Our Kidney-Preserving Approach

Background:

Bilateral emphysematous pyelonephritis (EPN) is a rare and life-threatening necrotizing infection associated with significant morbidity and mortality. Historically, nephrectomy was considered the definitive treatment for severe EPN. However, bilateral nephrectomy inevitably results in renal replacement therapy. Advances in imaging, antimicrobial therapy, intensive care, and minimally invasive drainage have shifted management toward renal preservation whenever clinically feasible.

Objective:

To describe a kidney-preserving strategy for the management of bilateral EPN and emphasize the role of conservative treatment in avoiding nephrectomy and subsequent dialysis.

Management Approach:

Our kidney-preserving strategy consists of five fundamental principles:

1. Early diagnosis and CT-based assessment of the extent of renal and perirenal gas and collections.
2. Immediate broad-spectrum intravenous antibiotics, subsequently tailored according to urine/blood cultures and clinical response.
3. Aggressive supportive management, including fluid resuscitation, glycemic control, correction of electrolyte and metabolic abnormalities, and optimization of renal function.
4. Early decompression and drainage when indicated, using percutaneous nephrostomy and/or percutaneous drainage of infected collections, particularly in the presence of obstruction, significant collections, or inadequate response to antibiotics.
5. Close clinical, laboratory, and radiological monitoring, with nephrectomy reserved as a rescue procedure for persistent sepsis, progressive renal destruction, or failure of conservative treatment.

In bilateral EPN, preservation of at least functional renal tissue is prioritized whenever possible. Previous reports demonstrate that even severe bilateral EPN can respond to antibiotics alone or antibiotics combined with percutaneous drainage.

Conclusion:

Bilateral EPN should not automatically be considered an indication for emergency bilateral nephrectomy. A structured kidney-preserving approach combining early antibiotics, meticulous metabolic and supportive care, appropriate urinary decompression, and percutaneous drainage can achieve infection control while preserving renal function. Nephrectomy should be considered a last-

resort rescue procedure when conservative management fails or uncontrolled sepsis and progressive renal destruction persist.

Take-home message:

"In bilateral EPN, save the kidneys whenever possible — control the infection first, drain when necessary, and reserve nephrectomy for treatment failure."

Dr. Wa'el Hussein Abdelmajid Alalami – Jordan

Dr. Wa'el Hussein Abdelmajid Alalami, MD, PhD Urologist, MOH Albasheer Hospital, Amman, Jordan Article type: Narrative Review

Erectile Dysfunction as an Early Marker of Cardiovascular Disease: From Endothelial Dysfunction to Cardiovascular Risk Stratification

Abstract Background: Erectile dysfunction (ED) is a common male sexual disorder that shares important biological and epidemiological links with cardiovascular disease (CVD). Increasing evidence indicates that ED may precede clinically manifest cardiovascular disease, potentially providing an opportunity for earlier cardiovascular risk identification and prevention.

Objective: To review the pathophysiological and epidemiological relationship between ED and CVD and to examine the implications of ED for cardiovascular risk assessment and management in contemporary urological practice.

Evidence acquisition: Current European Association of Urology (EAU) guidance was considered alongside key systematic reviews, meta-analyses and prospective observational studies evaluating the association between ED and cardiovascular outcomes.

Evidence synthesis: ED and CVD share multiple risk factors and mechanisms, including endothelial dysfunction, impaired nitric oxide signalling, oxidative stress, inflammation, arterial stiffness, atherosclerosis, diabetes, hypertension, dyslipidaemia, obesity and smoking. Prospective studies and meta-analyses consistently demonstrate an association between ED and subsequent cardiovascular events, coronary heart disease, stroke and cardiovascular mortality. ED may precede clinically apparent CVD, supporting its role as a potential early marker of systemic vascular disease. Cardiovascular risk assessment should therefore form part of the evaluation of men presenting with ED. Lifestyle modification and optimisation of cardiovascular risk factors are fundamental components of management. Phosphodiesterase type 5 (PDE5) inhibitors are effective first-line treatments and have an established cardiovascular safety profile in appropriately selected patients, although evidence for their use specifically as cardiovascular-preventive agents remains insufficient.

Conclusions: ED should not be considered solely a disorder of sexual function. In selected patients, it may represent an early manifestation of systemic vascular dysfunction and provide an important opportunity for cardiovascular risk assessment. Greater integration between urological and cardiovascular care may improve both sexual and long-term cardiovascular health.

Keywords: erectile dysfunction; cardiovascular disease; endothelial dysfunction; atherosclerosis; cardiovascular risk; PDE5 inhibitors; sexual medicine; urology.

Dr. Sufian Al Harahsheh - Jordan

Department of Urology, Ministry of Health, Al-Zarqa New Hospital, Jordan

Continuous Saline Bladder Irrigation Versus Intravesical Adriamycin After TURBT in Non-Muscle-Invasive Bladder Cancer: A Comparative Study of Recurrence Outcomes

ABSTRACT

Background: Transurethral resection of bladder tumor (TURBT) is the primary intervention for non-muscle-invasive bladder cancer (NMIBC), yet recurrence rates remain substantial. While a single immediate postoperative instillation of intravesical chemotherapy—such as Adriamycin (ADM)—reduces recurrence risk, it is often contraindicated in patients with severe hematuria, extensive resection, or suspected bladder perforation. Continuous saline bladder irrigation (CSBI) may serve as a simple alternative by washing out free-floating tumor cells to prevent mucosa reimplantation.

Objective: To compare the recurrence outcomes and safety profile of post-TURBT single-dose intravesical Adriamycin versus continuous saline bladder irrigation in patients with NMIBC.

Methods: In a comparative study conducted between May 2023 and May 2025 at Al-Zarqa New Hospital, Jordan, 71 NMIBC patients following TURBT were evaluated over a follow-up period ranging from 3 to 24 months. Patients were assigned to receive either immediate intravesical Adriamycin (50 mg in 50 mL saline, dwell time ~1 hour; n = 33) or continuous normal saline bladder irrigation for 24 hours (n = 38). Recurrence was assessed via surveillance cystoscopy and histopathological verification when indicated.

Results: Baseline clinical characteristics were comparable between the ADM and CSBI groups (mean age 63 vs. 66 years; Ta tumors 64.2% vs. 66.7%; T1 tumors 35.8% vs. 33.3%, respectively). Overall tumor recurrence occurred in 28% (20/71) of the total cohort. Recurrence rates were 26% (ADM group) versus 30% (CSBI group), displaying no statistically significant difference between modalities. CSBI was associated with fewer observed treatment-related adverse symptoms, including lower rates of irritative voiding symptoms and post-procedural hematuria.

Conclusion: CSBI demonstrates comparable recurrence outcomes and a favorable feasibility profile relative to single-dose intravesical Adriamycin. In resource-limited settings or clinical scenarios where immediate chemotherapy is contraindicated or unavailable, CSBI offers a practical, low-cost alternative. Larger randomized non-inferiority trials with extended long-term follow-up are warranted to confirm these findings.

Keywords: *Non-Muscle-Invasive Bladder Cancer (NMIBC), TURBT, Continuous Saline Bladder Irrigation (CSBI), Adriamycin, Intravesical Chemotherapy, Tumor Recurrence.*

Dr. Sofian Jibreel Al Hbahbeh - Jordan

Prince Hussein Urology Center, Jordanian Royal Medical Services.

Isolated scrotal inflammatory myofibroblastic tumor of the spermatic cord, a case report

Abstract

Inflammatory myofibroblastic tumors (IMT), are very rare idiopathic lesions, simply composed of myofibroblastic cells mixed with inflammatory cell infiltrative clusters. Such lesions can occur at all ages, most common sites being the lungs and abdominal or retroperitoneal sites. Genitourinary occurrences constitute a small fraction of the already rare incidence rate of those IMTs. The most common genitourinary organ affected is the urinary bladder, the scrotum and spermatic cord are very rare sites with a very few reported cases worldwide. We report a case of an intrascrotal spermatic cord IMT in a 70-year-old male gentleman who presented to urology clinics in Prince Hussein Urology Center (PHUO) / Amman, Jordan, with a slightly tender left-sided scrotal swelling of 3 weeks duration, examination revealed a mildly tender left side scrotal swelling consistent with an intrascrotal collection, and a painless firm irregular right scrotal mass closely related to the right testis. Laboratory investigations and testicular tumor markers were within normal values. Ultrasonography revealed normal testes bilaterally with an irregular lobulated 5*3 cm cystic lesion representing a chronic abscess with surrounding soft tissue and skin edema and another right-sided scrotal lesion 3*2 cm that is suspicious and extratesticular. MRI showed bilaterally normal testes with the same left-sided collection noted on ultrasonography, and a 28*15*15 mm right scrotal suspicious lesion being attached to distal aspect of spermatic cord ipsilaterally and closely related but not invading the right epididymis and the lesion is indenting but not invading the right testis. Intraoperatively the left side collection was accessed via a left inguinal incision and drained and sent for culture and cytology, the right scrotal lesion was also accessed via a right inguinal incision, the lesion was adherent to the right distal spermatic cord and right epididymis, thus radical orchiectomy was performed. Histopathology revealed an inflammatory myofibroblastic tumor which was completely resected.

Keywords: inflammatory myofibroblastic tumor, scrotum, spermatic cord.

Dr. Malek Hasan Sulieman Balaci - Jordan

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Tuberculous Contracted Bladder: Pathophysiology, Diagnosis, and Contemporary Management of an End-Stage Manifestation of Genitourinary Tuberculosis

Background

Genitourinary tuberculosis (GUTB) can affect any part of the urinary and genital tracts. Delayed diagnosis of tuberculous cystitis may allow progression from mucosal inflammation to fibrosis, loss of bladder compliance and capacity, and ultimately a severely contracted bladder — producing debilitating symptoms, vesicoureteral reflux, hydronephrosis, and renal impairment.

Objective

To summarize current understanding of the pathogenesis, diagnosis, and management of the tuberculous contracted bladder, with emphasis on contemporary urological and reconstructive strategies.

Methods

Narrative review of recent literature on bladder tuberculosis, tuberculous cystitis, and contracted bladder, incorporating current UK recommendations, while noting the limited high-quality evidence specific to this entity.

Results

Bladder TB usually arises secondary to renal disease. Diagnosis requires integrating clinical suspicion, mycobacterial urine testing, imaging, and cystoscopy, with a broad differential including malignancy and other fibrotic cystitides. Antituberculous therapy remains essential, but established fibrosis is often irreversible. Patients with a poorly compliant bladder and threatened upper tracts may require augmentation cystoplasty, or urinary diversion/cystectomy in advanced cases.

Conclusion

Tuberculous contracted bladder is a severe, potentially preventable complication of GUTB. Early diagnosis and treatment prevent irreversible damage; in end-stage disease, management must be individualized, with reconstructive surgery offering good outcomes in selected patients requiring long-term surveillance.

Keywords: genitourinary tuberculosis; tuberculous cystitis; contracted bladder; augmentation cystoplasty; urinary diversion

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[Risk of Urethral Stricture Following Monopolar TURP, Bipolar TURP, and Laser Enucleation \(HoLEP/ThuLEP\) for Benign Prostatic Hyperplasia: A Systematic Review and Meta-Analysis](#)

Background

Urethral stricture is a recognised complication of endoscopic prostate surgery for benign prostatic hyperplasia (BPH) and may cause recurrent obstructive symptoms requiring further intervention. Whether stricture risk differs between monopolar TURP, bipolar TURP, and laser enucleation (HoLEP/ThuLEP) remains unclear.

Objective To systematically review and compare the risk of postoperative urethral stricture following monopolar TURP, bipolar TURP, HoLEP, and ThuLEP in men treated surgically for BPH.

Methods

This PRISMA 2020-compliant systematic review and meta-analysis will search PubMed/MEDLINE, Embase, and CENTRAL for randomised and comparative observational studies evaluating at least two of the predefined techniques. The primary outcome is postoperative urethral stricture; secondary outcomes include bladder-neck contracture and reintervention. Risk ratios or odds ratios with 95% confidence intervals will be pooled using a random-effects model where studies are sufficiently homogeneous.

Results

To be completed following the systematic search and data extraction; the final manuscript will report included studies, participant numbers, stricture events, and pooled effect estimates with 95% confidence intervals.

Conclusion

This review will clarify whether postoperative urethral stricture risk differs by endoscopic surgical technique for BPH, informing surgical decision-making and patient counselling.
Keywords: urethral stricture; TURP; bipolar TURP; HoLEP; ThuLEP; benign prostatic hyperplasia; systematic review; meta-analysis

Dr. Hassan Alkhatatbeh - Jordan

Evaluating The Safety of Continuing Antiplatelets Therapy in Patients Who Underwent Transurethral Resection of Bladder Tumor

This study investigates the safety implications of maintaining antiplatelet therapy (APT) in patients undergoing transurethral resection of bladder tumors (TURBT), with a particular focus on tumor size as a determining factor. A retrospective analysis was performed on 295 patients receiving APT, categorized into three groups: those on aspirin monotherapy, those on dual antiplatelet therapy (DAPT), and a control group who discontinued APT prior to surgery. The findings reveal that for tumors under or equal to 3 cm, the continuation of APT had no significant impact on perioperative or postoperative outcomes, including hemoglobin (Hb) reduction, hospital stay duration, or complication rates. However, for tumors more than 3 cm, patients who remained on APT exhibited substantially greater Hb declines, prolonged hospital stays, increased clot retention, and higher re-admission rates.

These results indicate that while it is generally safe to continue APT in cases of smaller tumors, discontinuation is advisable for larger tumors to minimize bleeding risks and optimize surgical outcomes.

Introduction: This study evaluates the safety of continuing APT in patients undergoing TURBT, particularly in relation to tumor size. The lack of consensus among urologists regarding the management of APT in the perioperative setting necessitates this investigation.

Material and Methods: A retrospective analysis was conducted on 295 patients on APT, categorized into three groups: those on aspirin monotherapy, those on DAPT, and a control group who discontinued APT preoperatively. Each group was stratified based on tumor size (≤ 3 cm, or > 3 cm), and intraoperative and postoperative parameters were meticulously documented.

Results: For tumors smaller than or equal to 3 cm, APT continuation did not significantly affect perioperative or postoperative outcomes, including Hb drop, hospital stay, and complication rates. In contrast, for tumors larger than 3 cm, patients continuing APT experienced significantly higher Hb drops, longer hospital stays, increased clot retention, and higher re-admission rates.

Conclusions: The continuation of APT preoperatively in patients undergoing TURBT is safe when tumor size is less than or equal to 3 cm. However, for tumors more than 3 cm, the increased risk of bleeding and associated complications suggests that discontinuation of APT prior to surgery is advisable

Dr. Yazeed I Alghaban - Jordan

The use of fibrin sealant for the prevention of post-transplant lymphatic complications. Clinical efficacy and cost-effectiveness.

Authors:

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Abstract

Objectives:

To assess the effectiveness of intraoperative fibrin sealant instillation in the prevention of post-transplant lymphatic complications and the charges of post-operative care.

Material and method:

This is a retrospective analysis of the prospectively maintained data of all kidney transplantations (KT) between July 2021 and May 2026. Included patients were classified into two groups: group I, in which intraoperative fibrin sealant was installed using a spray technique over the iliac lymphatics and renal hilum; and group II (control), in which no sealant was applied. The measured outcomes were overall lymphatic complications, lymphorrhea incidence, drain volume and duration, length of stay (LOS), lymphocele incidence, and post-transplant care charges. Univariate analysis of factors predicting lymphatic complications was performed using the Mann-Whitney U test, Chi-Square, and Fisher's exact test. Multivariate analysis was performed using binary logistic regression analysis.

Results:

The study included 100 patients (group I; 59, and group II; 41). Group I had significantly lower lymphatic complications [4 (6.8%) vs. 21 (51.2%), $P < 0.001$], lymphorrhea incidence [2 (3.4%) vs. 17 (41.5%), $P < 0.001$], lower drain volume, shorter drain duration [5 (5-7) vs. 9.5 (6-12) days, $P < 0.001$], and LOS ($P < 0.001$). Lymphocele was diagnosed in 2 (3.4%) and 5 (12.2%) patients in groups I and II, respectively ($P = 0.09$). The median (IQR) charge was significantly lower in group I [21000 (18000-22000) vs. 31500 (21000-39000) SR, $P < 0.001$]. In univariate analysis, DM ($P = 0.01$), non-use of fibrin sealant ($P < 0.001$), and DGF ($P = 0.01$) were associated with increased lymphatic complication rate. In multivariate analysis, fibrin sealant was the only independent predictor in preventing post-transplant lymphatic complications [OR=11.9, 95% CI=3.5-40, $P < 0.001$].

Conclusion:

Prophylactic use of fibrin sealant is a cost-effective way to reduce post-transplant lymphatic complications, lymphorrhea, drain volume and duration, and lymphocele formation.

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Microsurgical Denervation of the Spermatic Cord for Chronic Orchialgia: A Contemporary Review of Technique, Patient Selection and Outcomes

Article type: Narrative Review

Submitted to: 16th International Congress of the Jordanian Association of Urological Surgeons

Abstract

Background: Chronic orchialgia, also termed chronic scrotal content pain (CSCP), is defined as constant or intermittent testicular or scrotal pain persisting for three months or longer. It is an underrecognised but clinically significant problem that can substantially impair quality of life, and it remains one of the more difficult diagnoses to manage in andrological practice. When conservative measures fail, testicle-sparing surgical options are limited.

Objective: To review the anatomic basis, patient selection, surgical technique, outcomes and complications of microsurgical denervation of the spermatic cord (MDSC) for chronic orchialgia refractory to conservative management.

Evidence acquisition: The published literature on MDSC was reviewed, including the foundational case series, prospective and multicentre studies, systematic reviews and recent comparative series identified through PubMed/MEDLINE.

Evidence synthesis: Since its original description by Devine and Schellhammer in 1978, MDSC has evolved into a refined microsurgical technique targeting the "trifecta nerve complex" — the ilioinguinal nerve, the genital branch of the genitofemoral nerve, and sympathetic perivascular fibres accompanying the testicular artery and vas deferens — while preserving the testicular artery and lymphatics. Contemporary series report complete or partial pain relief in the majority of appropriately selected patients, with durable long-term outcomes. A positive response to preoperative spermatic cord block is among the strongest predictors of surgical success, while constant (as opposed to intermittent) pain and coexisting pelvic floor dysfunction are associated with higher rates of treatment failure. Reported complication rates are low, and the procedure preserves testicular viability and, in most patients, fertility potential.

Conclusions: MDSC is a safe, effective and testicle-sparing option for men with chronic orchialgia refractory to conservative therapy. Careful patient selection, guided by a diagnostic spermatic cord block and a thorough pain history, is central to achieving optimal outcomes. Because the procedure remains concentrated in a small number of specialised centres, wider familiarity with its indications and technique may improve access to this effective but underutilised operation.

Keywords: chronic orchialgia; chronic scrotal content pain; microsurgical denervation; spermatic cord; testicular pain; andrology.

Dr. Fadi Mousa Al Kalailah - Jordan

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Urodynamics Unlocked: Practical Tips & Tricks

Background

Urodynamics is an important diagnostic tool for evaluating lower urinary tract dysfunction and guiding clinical management. However, meaningful interpretation depends on the technical reliability of the study. Technical errors and artifacts may produce misleading findings and potentially result in inappropriate clinical conclusions.

Objectives

This lecture aims to provide urologists with a practical, step-by-step approach to reviewing urodynamic studies in the clinic, recognizing whether a study is technically trustworthy, identifying errors and artifacts that may compromise interpretation, and systematically interpreting the filling and voiding phases.

Lecture Summary

The presentation will begin with a fundamental clinical question: "Is this UDS technically trustworthy?" Before interpreting the physiology, urologists will learn to assess the technical reliability of the study and recognize errors and artifacts that may compromise its interpretation. Particular emphasis will be placed on recognizing when an abnormal finding represents genuine physiology and when it may be the result of a technical problem or artifact, and on deciding whether the study is sufficiently reliable to proceed with clinical interpretation.

Following technical validation, the lecture will provide a systematic approach to interpreting the filling phase, including bladder sensation, capacity, compliance, detrusor overactivity, and urinary leakage. Practical attention will be given to distinguishing genuine detrusor activity from abdominal or rectal artifacts and to avoiding misleading conclusions from isolated pressure changes or abnormal tracing patterns.

The voiding phase will then be interpreted through the relationship between urinary flow and detrusor pressure. The presentation will address accurate assessment of Q_{max} and P_{det} at Q_{max} , emphasizing that P_{det} at Q_{max} does not necessarily represent the maximum recorded detrusor pressure. The importance of correct pressure-flow timing and recognition of flow-delay misalignment will also be discussed.

A dedicated troubleshooting section will highlight common problems encountered when reviewing completed urodynamic studies, including pressure-line damping, abnormal pressure subtraction, negative rectal pressure, loss of trace activity, sudden pressure shifts, catheter-related problems, and other artifacts. The focus will be on recognizing these

problems and understanding their impact on interpretation, rather than on technical correction of the equipment or recording.

Throughout the presentation, clinicians will be encouraged to review the original urodynamic tracing rather than relying solely on the automated summary table. Computer-generated measurements and events should be critically reviewed and verified before the urologist accepts the findings and proceeds to the final interpretation.

Conclusion

A urologist should not interpret a UDS simply because a report has been generated. Technical validity is the first step in interpretation. By recognizing technical errors and artifacts, determining whether a study is sufficiently reliable, and then applying a structured approach to the filling and voiding phases, urologists can reduce misinterpretation and make more confident clinical decisions in daily practice.

Dr. Tayel Mohammad Abed Aljawad – Jordan

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Successful Transvaginal Repair of a Large Recurrent Vesicovaginal Fistula Involving the Right Ureteric Orifice: A Case Report,

Background: Vesicovaginal fistula (VVF) is an abnormal communication between the urinary bladder and vagina that can result in continuous urinary leakage and significant morbidity. Complex or recurrent fistulas, particularly those involving the ureteric orifice, present a challenging surgical problem.

Case Presentation: A 26-year-old female presented with persistent urinary leakage through the vagina following a previous delivery complicated by cervical suturing, after which she developed a vesicovaginal fistula. She underwent an attempted surgical repair at another hospital in Zarqa; however, the repair failed, and vaginal urine leakage persisted for six months. She subsequently presented to Al-Bashir Hospital for further evaluation and management. Cystoscopic evaluation demonstrated a large vesicovaginal fistula in close relation to the right ureteric orifice. Bilateral double-J ureteral stents were inserted to identify and protect both ureters. A guidewire was successfully passed through the fistulous tract from the bladder into the vagina, facilitating precise identification of the fistula. The patient underwent transvaginal fistulectomy followed by meticulous multilayer, layer-by-layer closure of the bladder and vaginal defects.

Results: The postoperative course was uneventful. The patient demonstrated successful closure of the fistula with complete resolution of vaginal urine leakage. Follow-up revealed no evidence of recurrent fistula.

Conclusion: Recurrent and large vesicovaginal fistulas involving the ureteric orifice require careful anatomical delineation and protection of the ureters. Bilateral ureteric stenting

combined with guidewire identification of the fistulous tract can facilitate safe surgical repair. Transvaginal fistulectomy with meticulous multilayer closure represents an effective approach for complex recurrent VVF, even following failed previous repair.

Keywords: Vesicovaginal fistula; recurrent fistula; ureteric orifice; transvaginal repair; obstetric fistula; double-J stent

Prof. Yang Jie - China

Percutaneous Nephrolithotomy Guided by 5G-powered Robot-assisted Teleultrasound Diagnosis System: First Clinical Experience with a Novel Tele-assistance approach (IDEAL Stage 1)

Abstract:

Background: To demonstrate the technical feasibility of percutaneous nephrolithotomy (PCNL) guided by 5G-powered robot-assisted teleultrasound diagnosis system (RTDS) in a complex kidney-stone (CKS) cohort and present our preliminary outcomes. PCNL is highly skill-required, which hinders its popularization in primary medical units of remote regions. We designed an innovative tele-assistance approach to make PCNL easy to be operated by inexperienced surgeons.

Methods: This was a prospective proof-of-concept study (IDEAL phase 1) on intraoperative tele-assistance provided by online urological experts via a 5G-powered RTDS. Total 265 CKS patients accepted this technology. Online experts manipulated a simulated probe to assist unskilled local operators by driving a patient-side robot-probe to guide and monitor the steps of access establishment and finding residual stones.

Results: Median total delay was 77ms despite one-way network-connecting distance > 5,800 km. No perceptible delay of audio-visual communication, driving robot-arm or dynamic ultrasound images was fed back. Successful tele-assistance was obtained in all cases. The first-puncture access-success rate was 78.6% with a one-session stone-free rate of 71.3% and without complications of grade III-V.

Conclusions: The current technology based on 5G-powered RTDS can provide high-quality intraoperative tele-assistance

Dr. Xiao Li - China

Comprehensive Management of Complex Renal Cell Carcinoma: A Single-Center Case Series

Abstract: This single-center case series presents comprehensive management of complex renal cell carcinoma (RCC). It includes one robot-assisted partial nephrectomy for a highly complex tumor (RENAL score 10), and three cases receiving neoadjuvant or conversion

therapy: RCC with inferior vena cava thrombus, metastatic RCC with lung lesions, and delayed cytoreductive nephrectomy. Treatment integrated targeted therapy, immunotherapy, and robotic surgery, guided by multidisciplinary team discussion. These cases highlight the value of individualized systemic and surgical sequencing, careful perioperative management, and the evolving role of cytoreductive nephrectomy.

Beyond the Semen Analysis: Male Infertility at the Urology-Endocrinology Interface

Dr Duaa Okkeh
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Background: Male infertility represents a major component of reproductive failure. A male factor is solely responsible for approximately 20% of infertile couples and contributes to an additional 30-40%, placing male abnormalities within roughly half of infertility presentations. Male infertility is heterogeneous, encompassing anatomical, testicular, endocrine, genetic, metabolic, and functional disorders. Normal spermatogenesis requires an intact hypothalamic-pituitary-gonadal (HPG) axis, adequate intratesticular testosterone, functional seminiferous tubules, and patent reproductive ducts. This biological interdependence makes male infertility a natural interface between urology and endocrinology.

Objective: To highlight the diagnostic and therapeutic overlap between urology and endocrinology in male infertility and define an integrated approach for identifying structural, endocrine, genetic, and potentially reversible causes.

Clinical Approach: Evaluation should combine reproductive and medical history, genital examination, semen analysis, and targeted endocrine, genetic, and anatomical investigations. The clinical spectrum illustrates the need for multidisciplinary assessment: in a large cohort incorporated into European Association of Urology guidance, varicocele was identified in 14.8% of unselected men evaluated for infertility, while hypogonadism was reported in 10.1%. Among azoospermic patients, hypogonadism was reported in 16.4%. Azoospermia - the most severe manifestation of male infertility - affects approximately 1% of men and 10-15% of infertile men, making accurate differentiation between testicular, endocrine, and obstructive causes particularly important. Hormonal assessment provides the principal diagnostic bridge between the specialties. Serum testosterone and follicle-stimulating hormone (FSH), supplemented by luteinizing hormone (LH), prolactin and additional endocrine testing when indicated, help localize dysfunction. Elevated FSH with impaired spermatogenesis supports primary testicular dysfunction, whereas low testosterone with low or inappropriately normal gonadotropins suggests secondary hypogonadism and warrants investigation for potentially reversible hypothalamic-pituitary disease.

The urologist evaluates varicocele, genital tract obstruction, congenital abnormalities, testicular pathology, and indications for microsurgical reconstruction or sperm retrieval. The endocrinologist evaluates HPG-axis dysfunction, hypogonadotropic hypogonadism, pituitary disease, hyperprolactinemia, thyroid dysfunction, and relevant metabolic disorders. Genetic evaluation further complements this pathway, particularly in azoospermia and severe oligozoospermia.

A critical therapeutic intersection is androgen management. Exogenous testosterone suppresses gonadotropin secretion and intratesticular testosterone and may profoundly suppress spermatogenesis. Consequently, conventional testosterone replacement should be avoided in men actively pursuing fertility. Conversely, selected endocrine causes - particularly hypogonadotropic hypogonadism - may be amenable to fertility-preserving hormonal treatment.

Conclusion: Male infertility extends well beyond an abnormal semen analysis. With male factors contributing to approximately half of infertility presentations, and with structural and endocrine abnormalities frequently encountered in the same clinical population, coordinated urological and endocrine assessment is clinically justified. Integrating semen parameters, anatomical examination, HPG-axis evaluation, and appropriately selected genetic testing can distinguish primary testicular failure, central endocrine dysfunction, obstruction, and potentially reversible disease. Such multidisciplinary care may prevent fertility-compromising therapy and facilitate individualized medical, surgical, and assisted-reproductive management.

Keywords: Male infertility; Urology; Endocrinology; Hypogonadism; Azoospermia; Varicocele; Spermatogenesis; HPG axis.