

system resources. The pandemic scenario could rapidly change due to inadequate social behaviors or in case of a second wave of infection. However, any efforts and suggestions to mitigate the secondary effect of delaying urooncologic treatment should be pursued.

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The Good, the Bad, and the Ugly of the COVID-19 Pandemic in a Urology Residency Program in Singapore



To the Editor:

The COVID-19 pandemic has affected Residency training worldwide in an unprecedented fashion.¹⁻³ Residency Programs have been abruptly asked to respond in innovative and dynamic ways in the face of the pandemic.⁴ We share important lessons and insights about the impact on a Urology Residency Program in an Academic Medical Center in Singapore. We focus our discussion around the Academic, Administrative, Professional, and Personal Developmental aspects of Residency training.

THE “GOOD”

Academically, this crisis has presented a perfect opportunity to revisit fundamentals on disease pathophysiology and

natural history. Due to the need to prioritize resources, residents were challenged to examine the necessity of certain treatment procedures, and the expected natural history if treatment was delayed. Residents even developed guidelines and clinical decision-making tools for prioritizing surgical cases. Residents also dedicated more time “paying-it-forward” by teaching undergraduates who similarly transitioned to virtual-learning, thereby consolidating their own knowledge.

Administratively, Residents participated actively in streamlining departmental protocols for the management of common urological conditions during the pandemic. This was achieved mainly through the expansion of our Tele-consultation services. Interprofessional learning was evident with closer interaction with Primary Care colleagues to streamline management pathways, and stronger linkages with other frontline disciplines to provide patient-centric healthcare.

Professionally, we observed significantly closer mentorship by Faculty as cases were meticulously reviewed. Faculty and Residents demonstrated adaptability while under pressure to defer elective cases. Compared to routine clinics or ward rounds, several-fold more cases were discussed. An interesting observation was that Attendings managed to share clinical pearls and insights for seemingly “routine” and “straightforward” cases, further benefiting Residents in their learning.

THE “BAD”

Academically, patient caseload reduced significantly, for the greater good of resource distribution for COVID-19 patients.⁵ Emergency Urological operations remained constant but elective operations reduced by 70% within 2 months. This had significant impact on Residents’ case-logs, with mandatory training requirements at risk of being unfulfilled. Reduced surgical exposure was partly overcome by simulation and virtual-learning of procedures.

Administratively, cross-hospital clinical rotations were restricted to reduce risks of cross-contamination. Furthermore, incoming residents were at risk of missing the commencement of Residency at our institution. This was circumvented with coordinated Ministry of Health efforts, supported by nationwide sponsoring Programs, to ensure that Residents could fulfil required clinical rotations regardless of the hospitals they were based at.

Professionally, physical team segregation has caused significantly reduced social interaction. Yet, through virtual-means, strong camaraderie remained strong within, and across, teams. Residents also had precious opportunities for longer apprenticeships with Attendings, compared to what normal-length subspecialty rotations would typically allow.

THE “UGLY”

Personally, each healthcare professional faces an “ugly” possibility of contracting COVID-19, and more significantly, have placed our loved-ones at risk of transmission as well. Yet, we are grateful for, and galvanized by, supportive families and the wider society.

Amid challenging circumstances, Residents have grown academically, administratively, professionally, and personally. As Residents, our resolve has never been stronger to overcome this pandemic with the global medical community.

AUTHOR CONTRIBUTIONS

Yi Quan Tan: Conceptualization, Writing - original draft.
Ziting Wang: Conceptualization, Writing - review & editing.
Ho Yee Tiong: Conceptualization, Writing - review & editing.
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Re: Pelvic Hematoma Following UroLift Procedure for BPH, [Urology 2020;137:208]



In “Pelvic Hematoma Following UroLift Procedure for BPH” [Urology 2020; 137:308], Cai et al from Weill Cornell published an important case report regarding an observed adverse event. Their diligent postoperative care led to resolution of this issue and to their patient’s full recovery. Case reports tell us what is possible, and we must then consider the probability of events to decide to what extent we should describe them to our patients. When newly prescribed with tamsulosin, some patients have suffered ischemic

cerebrovascular accidents; and some patients expire after TURP due to cardiac events, or develop Post-Operative Cognitive Dysfunction. The overall probabilities of these adverse events are low, and because of their very low frequency, urologist’s recommendations for these treatments seldom include emphasis on these potential complications.

With regard to pelvic bleeding complications post Prostatic Urethral Lift, we do have one source of information that I feel is worth mentioning. Having advised and acted as investigators for Neotract and Teleflex for years now, we have observed consistent corporate diligence in filing Medical Device Reports to the FDA in accordance with regulation. These reports are publicly available on the FDA MAUDE (Manufacturer and User Facility Device Experience) database at accessdata.fda.gov. Analyzing this database since the commercial introduction of the UroLift device (Fall of 2013), there have been 15 reports of pelvic hematoma requiring intervention. Of these reported cases, all but this case resolved without open surgical intervention. Teleflex recently announced that over 175,000 patients have now been treated with the UroLift system. This equates to a 0.009% estimated occurrence of intervention for pelvic hematoma after PUL and an occurrence of 0.0006% hematoma requiring open surgical intervention. For such a straightforward minimally invasive treatment with few complications of any sort, these numbers appear acceptably low.

With the MAUDE system in place, I encourage all urologists to inform device companies of any serious complication associated with device use. By statute these companies are required to report related serious adverse events to the FDA MAUDE database. The more we do this, the more accurate our estimations will be of infrequent advisor effects of the surgical treatments we offer.

Finally, it may be worth considering potential mechanisms resulting in these hematomas. UroLift implants are delivered through a flexible 19-gauge sharp tipped needle 33 mm in length. It is possible to traverse and potentially tear the dorsal venous complex or perforating arteries (it is generally recommended that deployment should be

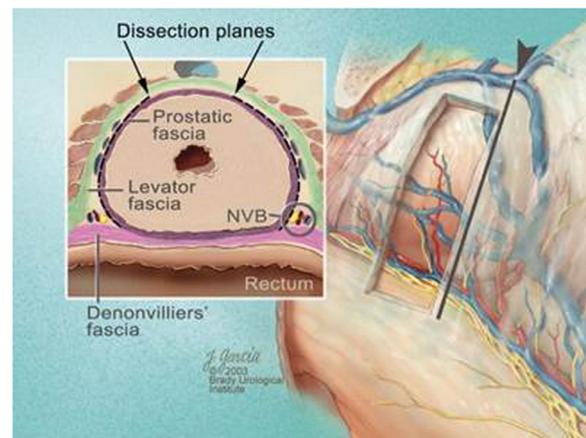


Figure 1. Retrieved from <https://urology.jhu.edu/prostate/fig/Anatomy10.jpg> (Color version available online.)