Preparing for Urology Electives 2024

2024 Panel and Discussion with U of T Residents: Dr. Adree Khondker (PGY2) and Dr. Jethro Kwong (PGY3).

Total number of participants: 20

Introduction

- **Electives are pretty much AUDITIONS to become junior surgical residents.**
- Evaluating attitude, knowledge, teamwork, responsibility, bedside manner. Key traits you must show in elective.

A Day in the Life of a Junior Resident (in Toronto)

0600:	Pre-round on patients (review on-call, make AM list*, print DC summaries*, complete/send CCACs*)
0700:	Round on patients (write notes*, orders, RTL*, calls*)
0800-1600:	Cystoscopy or Clinic, Running Labs*
1600-1800:	See non-urgent consults*
1800-1900:	Ensure tasks for day complete, prepare DC summaries for next day, send staff emails/summaries

How to Make an AM List

- Every hospital and chief resident has different preference for how the list should be prepared. **On first day of elective, coordinate with junior resident to make list.**
    - Brief synopsis about each patient. Do this EVERY morning for every patient.
- After a few days, it should be the MSI4/CC4 doing this. Message the most junior resident the weekend before.
    - Mark of a MSI4/CC4: Can independently and accurately prepare this list.
- Highlight any important abnormalities (fever, tachycardia, bradycardia, hypotension).
- Monitor trends in hemoglobin, creatinine post-op. These are marked in brackets.

Surgical Rounding

- **You must know how to write a SOAP note**. This is very important for rounding.
- Keep it concise and include pertinent positive and negative findings.
- If you prep the AM list well, that info will feed into your SOAP note.
- Some sites will have EPIC templates. You can/should use them if your residents do.

Calls

- After AM rounds, there are usually multiple services to call; volunteer to make these calls to take tasks of junior resident (easy way to help the team and patient).
- If you're calling medical services, it is important to know the patient and their medical history. Try to anticipate things they may ask you to do.
    - Make sure to write down any suggestions.
- Have closed loop communication. If you say you will call ultrasound in the morning, then make sure you follow up afterwards in the group chat.

Running the List

- Residents are often in charge of inpatient lists and day-to-day tasks with staff supervising.
- As a CC4, we expect you to know about what's going on/what's holding up dispo/what patients need.
    - Therefore, you may be put on the spot to run the list with the plans nearing the end of your elective (CC4s often get tested on doing this).

Mid-Day Labs

- Labs are generally released between 8-10 am, sending updates are good to team/resident.
- Put exclamation marks next to values you are concerned about and send to the group chat or show your residents. This shows you are doing inpatient work and taking ownership of your patients.

Discharge Summaries

- When patients are nearing discharge/or you have free time, you should update discharge summaries (especially for long admissions).
    - It is good to anticipate when discharge summaries would be needed and have those completed in advance.
    - Includes admitting and discharge dx, past medical hx, hospital course, follow-up plan, etc.
- Ensure that discharges **planned for the next day** are finished the night prior, so that it must only be printed.
- ***Crucial to be active in the team/advancing from the role from medical student to resident.
    - Strive to function at the level of R1 and emulate the behaviour of your direct senior.

Seeing Consults

- The resident on pager (usually junior) will triage, urgent consults (torsion, septic stone, etc.) will need to be seen quickly.
- Non-urgent consults (asymptomatic hydronephrosis, UTI, hematuria, etc.) are seen after clinical activity.
    - You should volunteer to see these patients (shows you can multi-task).
    - In between seeing clinic patients you can prepare the note, review the patient.
    - In between breaks you can go see the patient and then review with the resident.
        - This is a huge help to junior residents.

Working with Residents

- They are busy, but they do care.
- They want to make the rotation meaningful for you.
- They want you to get your letter(s).
- They are looking for future colleagues, knowledge is good, but not everything.
- Urology is a small community, residents/staff know each other.
    - Attendings message other programs to get a sense of other applicants in other provinces. Make sure to put your best foot forward!
    - Reputation matters.

Red Flags

- Showing up late consistently (*showing up late once isn't the end of the world*).
- Speaking poorly about other applicants/residents/staff.
- Being disengaged from clinical activity (e.g., falling asleep in the OR, refusing to see patients).

Basic Urology Knowledge

<u>Involves catheters</u> Urinary retention **Difficult Foley** Retained catheter **Hematuria**	<u>Stones</u> **Renal colic** Septic stone	**<u>Infections</u>** Epididymo-orchitis Fournier's gangrene Emphysematous Cystitis/pyelonephritis	Testicular torsion
Trauma	**Hydronephrosis**	<u>Penis</u>	

Common Consults

Difficult Foley: An extremely common consult for the clerk/elective student

- Preparation
  - Know what you need equipment wise to perform Foley catheter insertion (residents might ask if you know what to bring)
  - Know the steps of Foley catheter insertion
- When receiving the call
  - **Indication** for Foley?
  - **What has been tried**?
  - **Location of resistance** (ask the nurse who attempted)
  - **Blood at meatus** (false passage)?
  - Are they able to void, uncomfortable?
  - How much are they retaining? How long have they been in retention?
  - Prior uro hx, meds
- Key tips for troubleshooting
  - 2 urojets
  - Make sure Coudé tip is pointing up
  - Ask patient to relax, pretend they're peeing (relax external sphincter)
  - Constant, gentle pressure
  - Male: lots of **penile stretch**, point to the sky
    - Often, you just need good technique (watch videos online!)
- Knowing where the problem is helps
  - Obesity → Buried penis → Assistant to hold back pannus
  - Atrophic vaginitis → retracted, stenosed urethra → Guide 14 Fr Coudé over index finger
  - Phimosis → smaller catheter, dorsal slit
  - Meatal stenosis → urethral sounds, meatotomy
  - Urethral stricture → 12 Fr silastic, ureteric catheter + serial dilation
  - False passage → ureteric catheter + Council tip catheter, bedside cysto
  - BPH → 16-18 Fr Coudé
  - Bladder neck contracture/stenosis (prior TURP/prostatectomy) → 12-14 Fr Coudé, bedside cysto
  - Anatomic variant, congenital condition

Hematuria:

- Often "hematuria" is NOT true hematuria.
- CHECK the catheter drainage tube, not the bag. You need to check what is coming FRESH out of the tube (coming directly from the bladder).
- Hematuria is graded from I to V, good to know different words to describe urine color for these grades and what to do if patient is on CBI for the different grades.

Hydronephrosis:

- General principles of when to intervene in Urology: ***Easy pimp**
  1. Infection
  2. Renal compromise
  3. Symptomatic
- When receiving the call

- Obstruction (stone??, mass)?
- Is this new (check prior imaging)?
- Unilateral vs bilateral?
- Symptomatic (flank pain, fever)?
- Renal function?
- Prior uro hx (transplant, reflux, ureteric stricture/obstruction, UPJO, solitary kidney)

Procedural Expectations

You are expected to know:

- How to insert an "easy" Foley catheter by yourself (with urojets, Coudé, prep/drape yourself)
- Soft skills: Transferring patients, grabbing warm blanket – actively try to help and get things done; try to emulate the behaviour of junior residents.
- How to close skin, basic suturing, hand ties.

You are not expected to know:

- How to operate, how to do cystoscopy

Impressing Staff & Reference Letters

- Key tip: Knowledge is demonstrable.
  - E.g., If you are in prostate cancer clinic tomorrow, and you know prostate cancer guidelines you will look like a rockstar.
- Staff and residents are always talking, and staff often ask residents for their opinion on elective students.
  - If there is a particular staff you are trying to work with, you can tell your chief resident so they can try to facilitate interaction with them for letters.
- Ensure staff are willing to write you a "**strong**" reference letter, aim for one letter per two-week rotation. Pick a staff you vibed well with, one that is willing to make phone calls for you.
- Staff expect you to ask for a letter if you with them, is it not awkward to ask (consider asking early second week for a two-week rotation).

CaRMS Preparation

- Prepare with other applicants and residents, practice interview questions are available online
- Know the university you are applying for (tailor cover letter, interview answers)
  - Don't send the same stuff to every university
- It is normal to lose sleep over CaRMS
- Travel after CaRMS is done ☺ You won't get that amount of free time for a while.

Takeaways

- Be coachable!
- Be adaptable!
- Care about patients, taking ownership and accountability
- Recognize your limitations – if you haven't done something, don't cross your own boundaries as it can be dangerous. Just ask if you have questions!

Q&A Insights

- Urology offers the opportunity to make a tangible difference for patients, often providing life-changing results through relatively short procedures.
- The field is technologically advanced, with ongoing innovation in robotics and surgical tools.
- Research expectations vary by program. Demonstrating involvement—whether through leading a small project, submitting a CUA abstract, or presenting at a local research day—shows initiative and commitment.
- Quality and follow-through in research are valued more than quantity; there is no fixed formula for success.
- Research participation also builds valuable relationships with residents and faculty.
- Personal support systems are essential during residency; proximity to family and friends can strongly affect well-being.
- When considering programs, think about long-term career placement—many staff physicians practice where they trained.
- For early learners, shadowing in both urology and other specialties and engaging in research are the best starting steps.
- Key elective sites include major teaching hospitals such as Toronto General, St. Michael's, Sunnybrook, University Hospital (Western), St. Joseph's (McMaster), Kingston General (Queen's), the Ottawa General, the University of Alberta Hospital, and Vancouver General Hospital.

Panel Contacts

Adree: Adree.Khondker@mail.utoronto.ca
Jethro: Jethro.kwong@mail.utoronto.ca