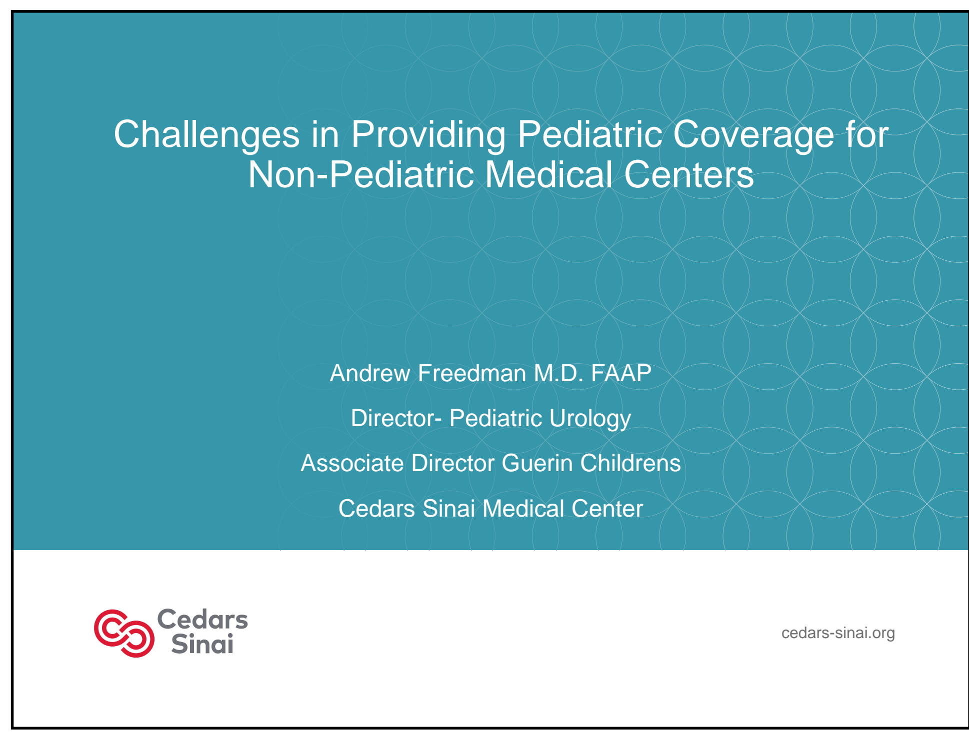

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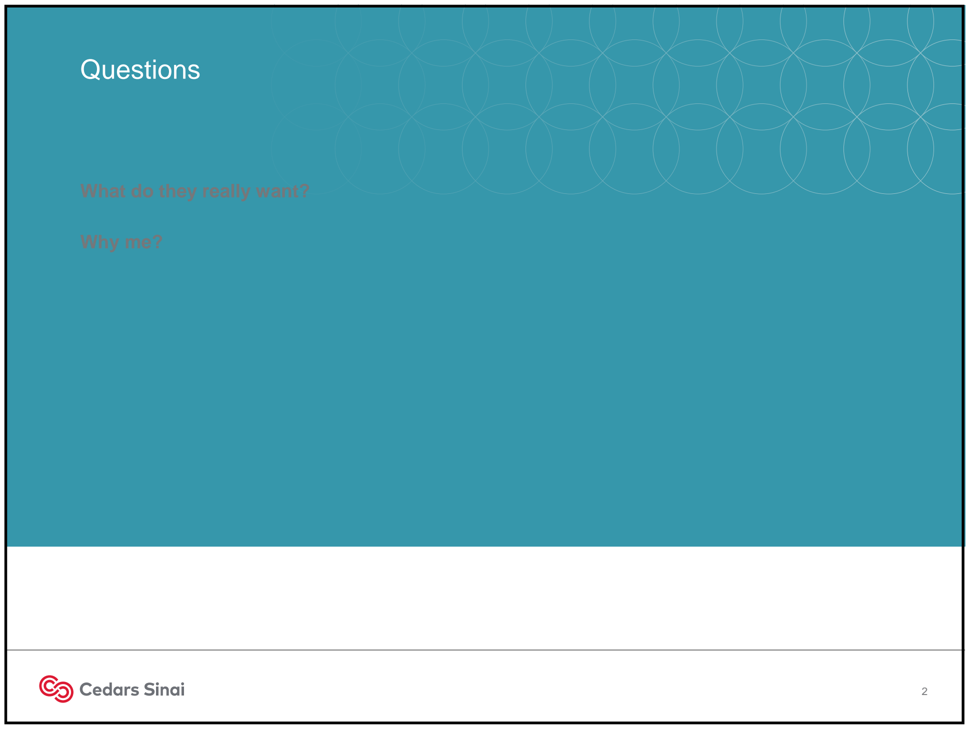

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Discussion Prompt

How do programs provide pediatric coverage when they might have limited pediatric urologists (perhaps only 1).

What do the adult urologists need to do?

What relationships need to be made with other centers that have a pediatric urology program, etc.

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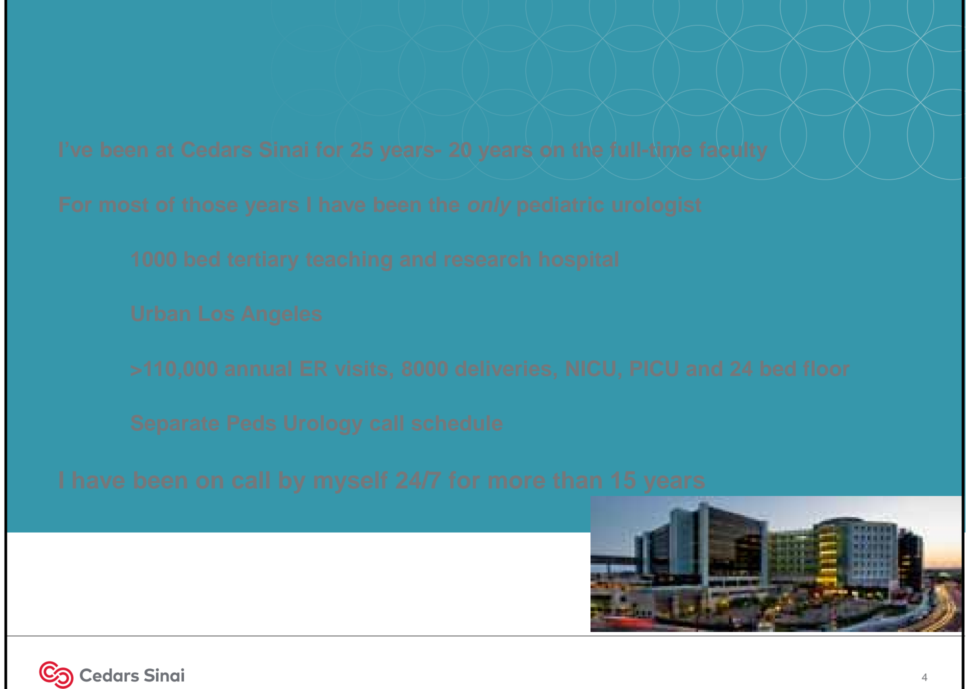

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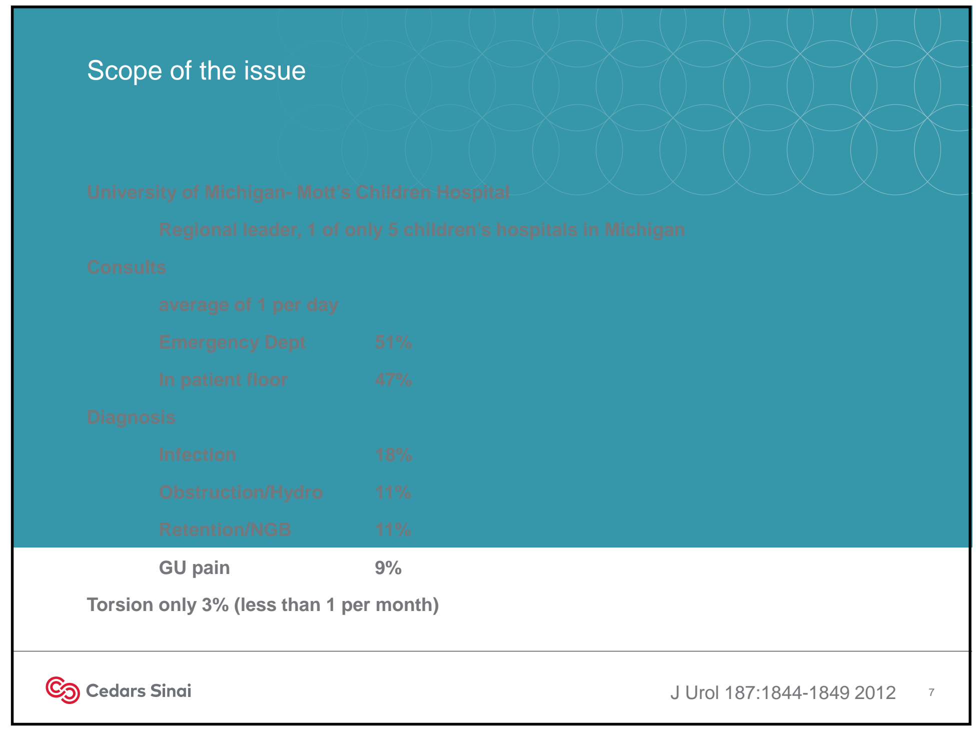

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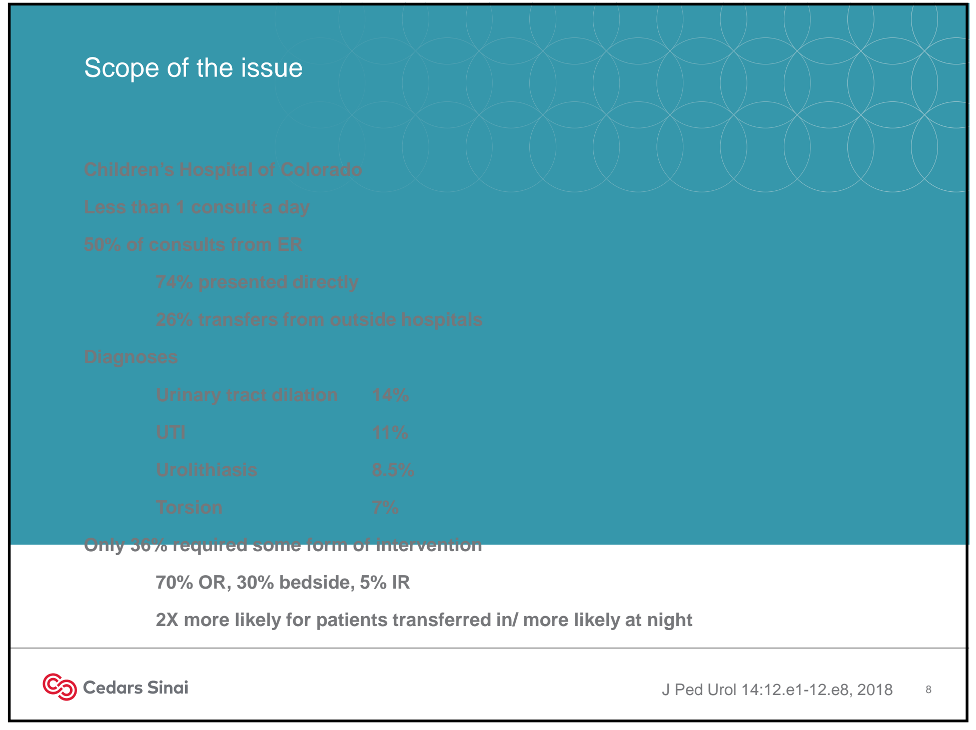

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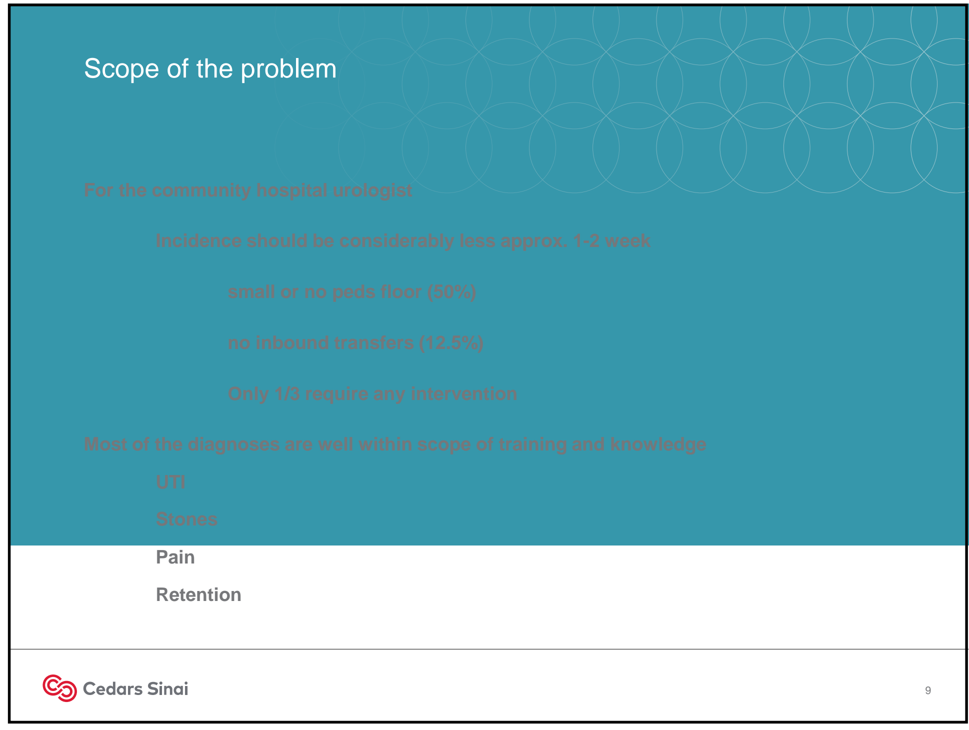

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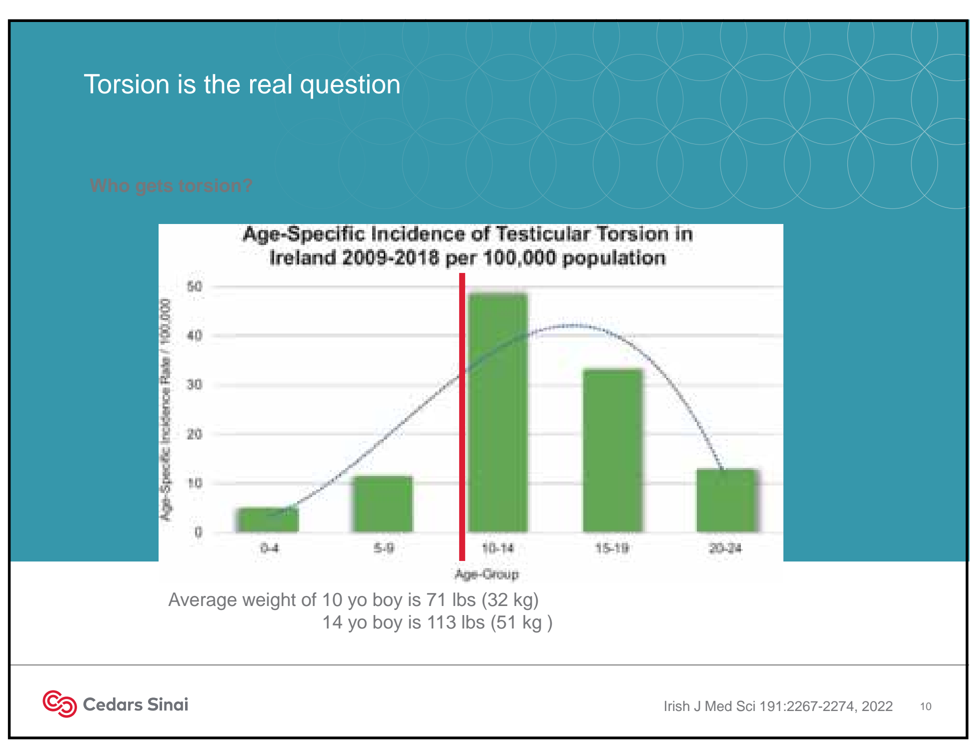

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What are the range of options for pediatric coverage

- Adult urologist on call
- Contract with a pediatric urologist
- Telehealth- Formal
  - Informal
- Pediatric Surgeons
- Transfer out

- Adult urologist on call
- **Contract with a pediatric urologist- just too expensive for too few patients**
- Telehealth- Formal
  - Informal
- Pediatric Surgeons
- Transfer out

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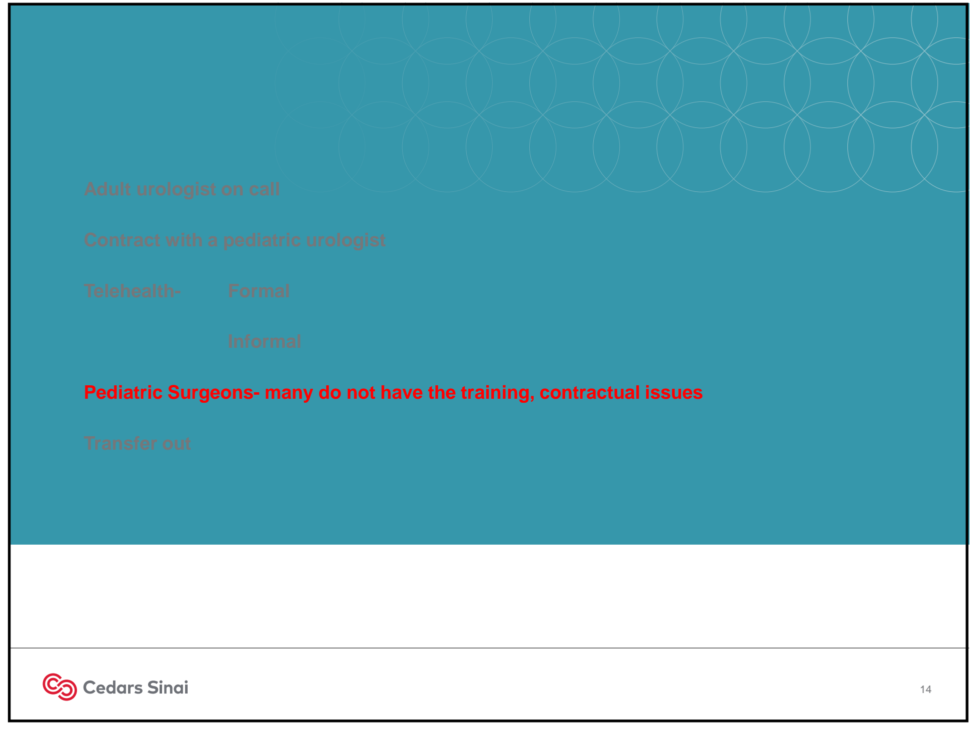

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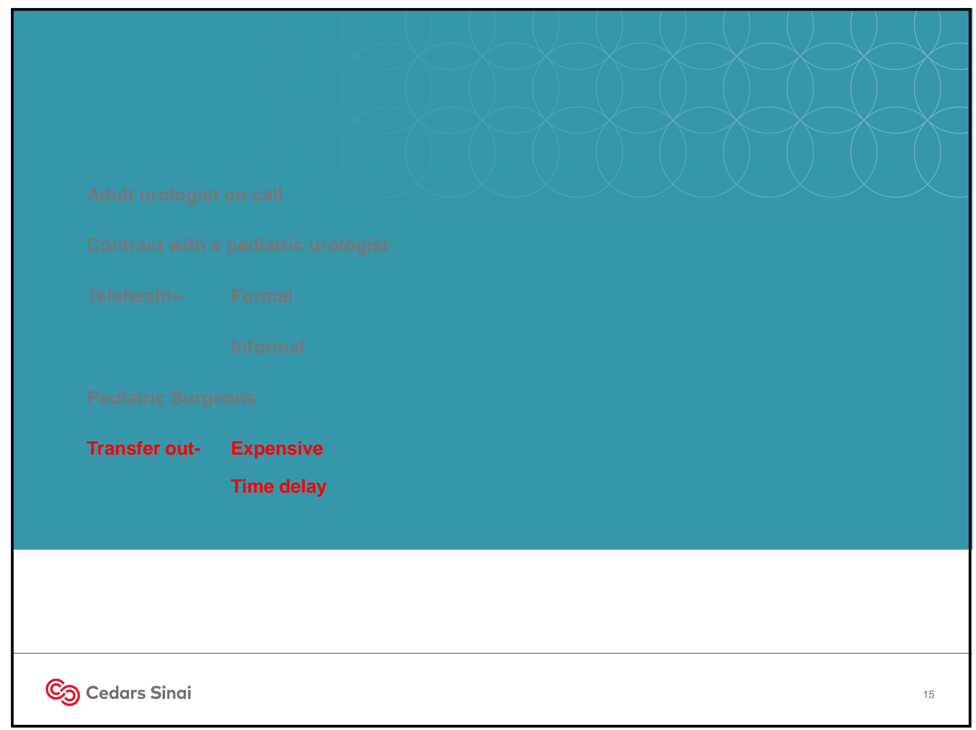

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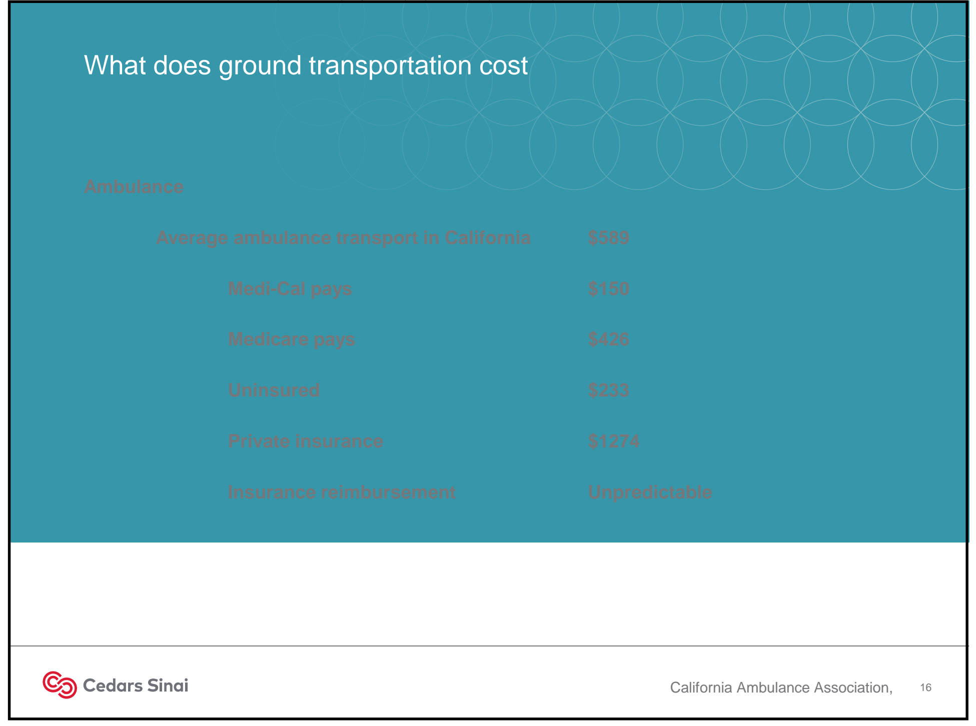

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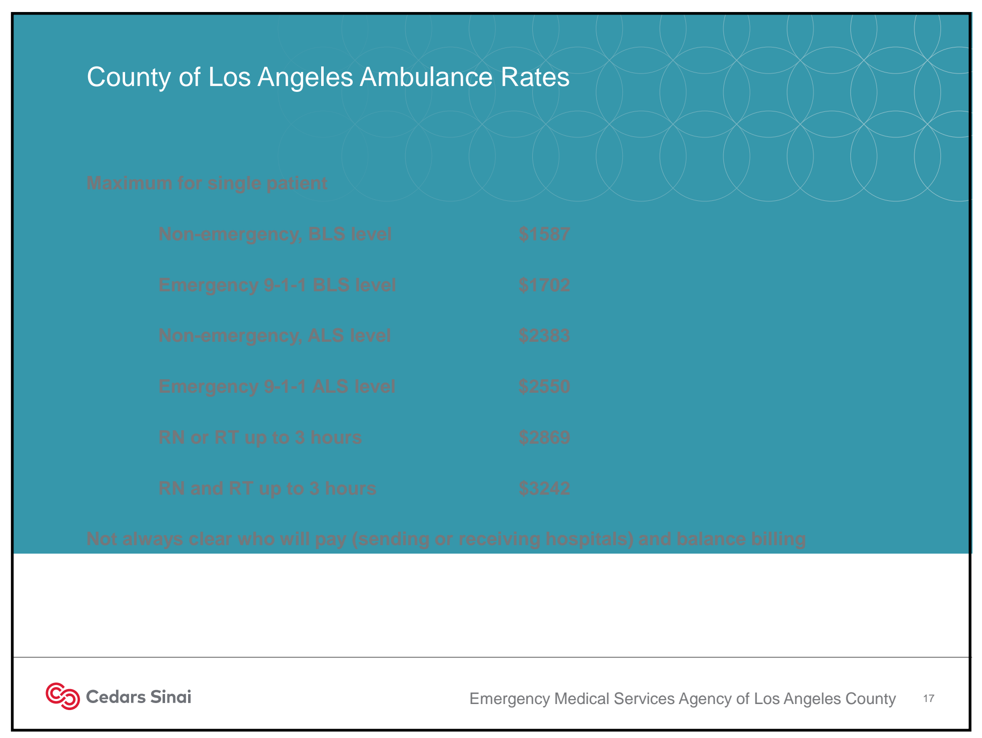

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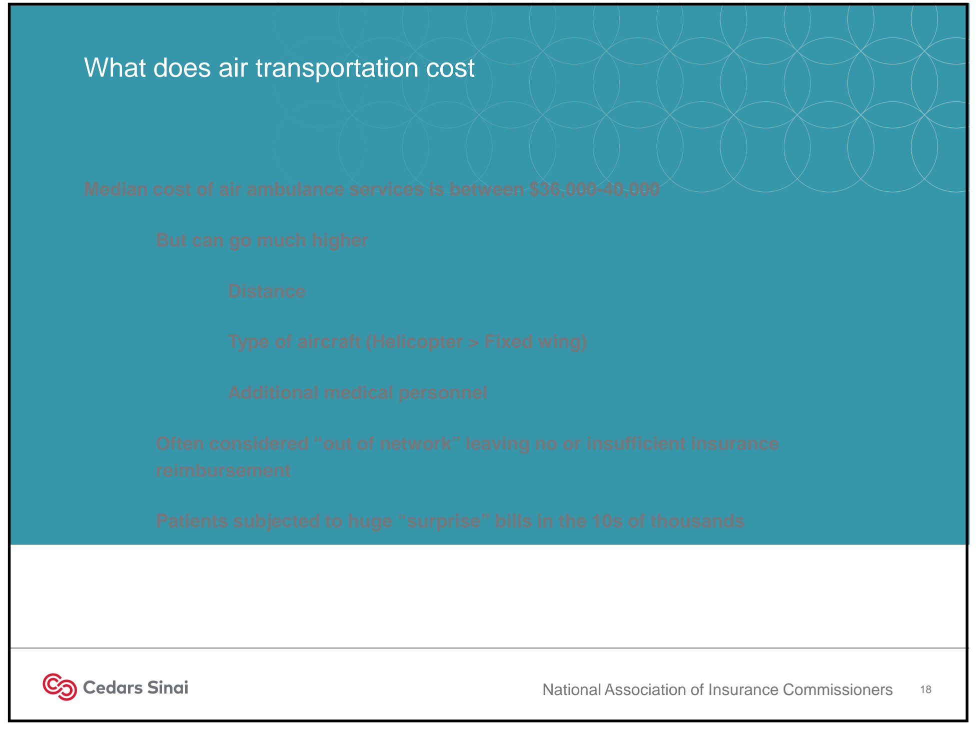

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Time delay for Torsion

Does transfer increase the risk of orchiectomy?

Numerous studies- main takeaways

- Rate of transfers has been increasing
  - Particularly at night and weekends
- 2-3 times increased risk of orchiectomy with transfer in those
  - < 12 yo
  - < 24 hours of symptoms
  - >30 miles in distance

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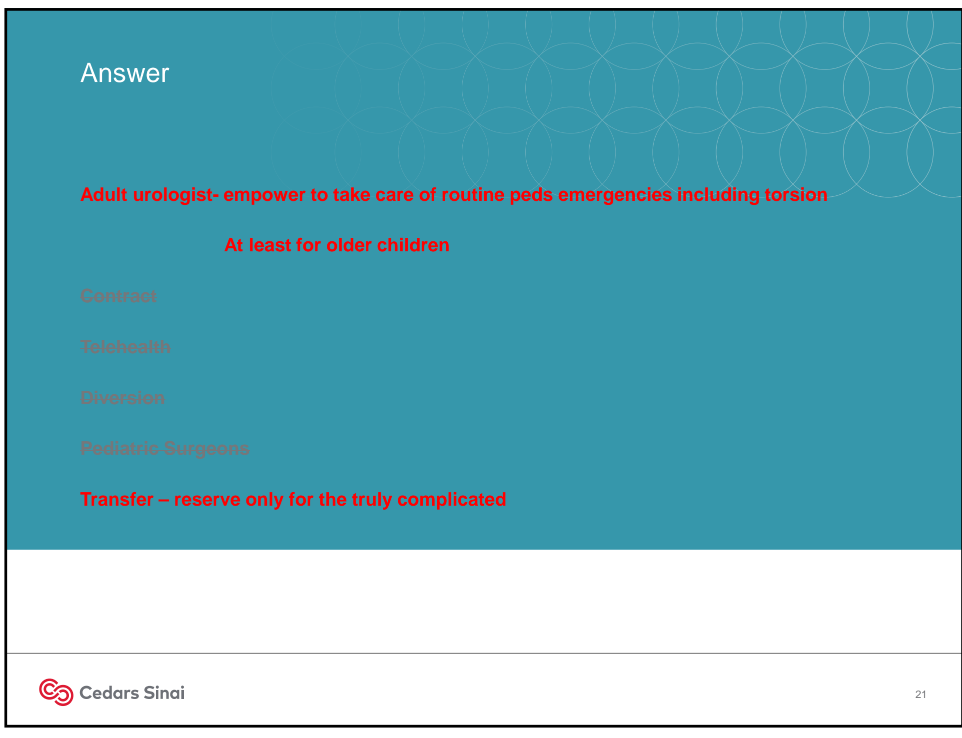

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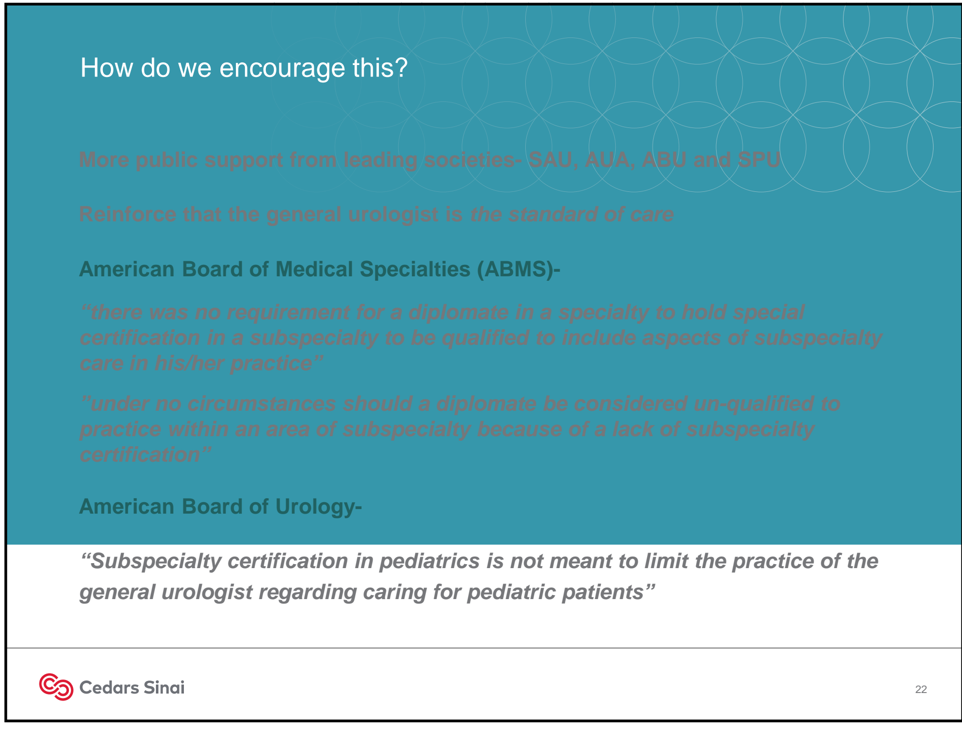

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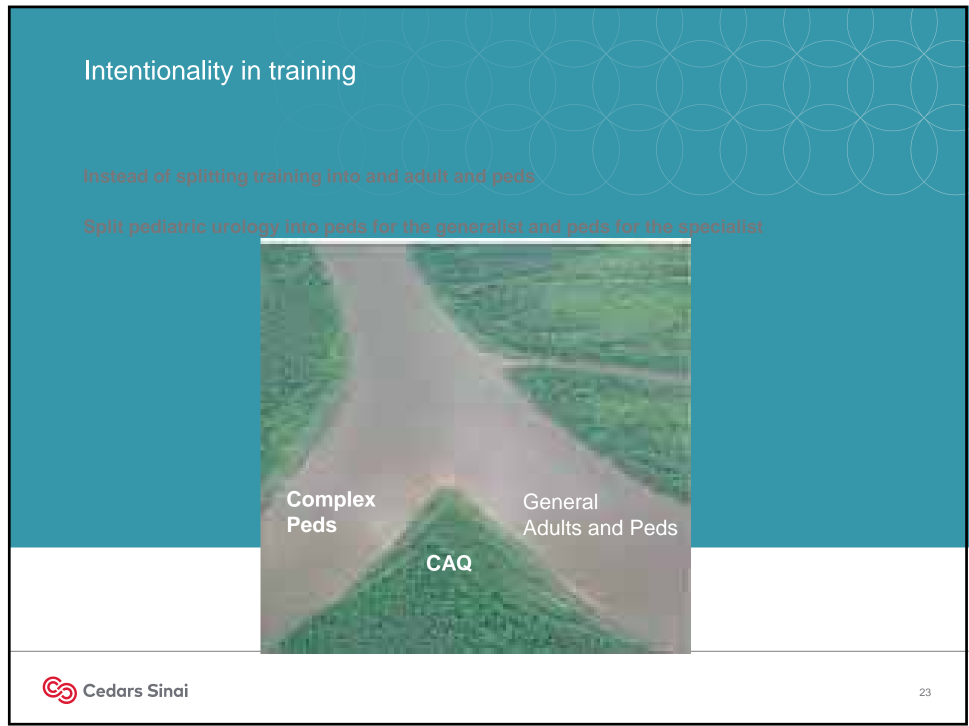

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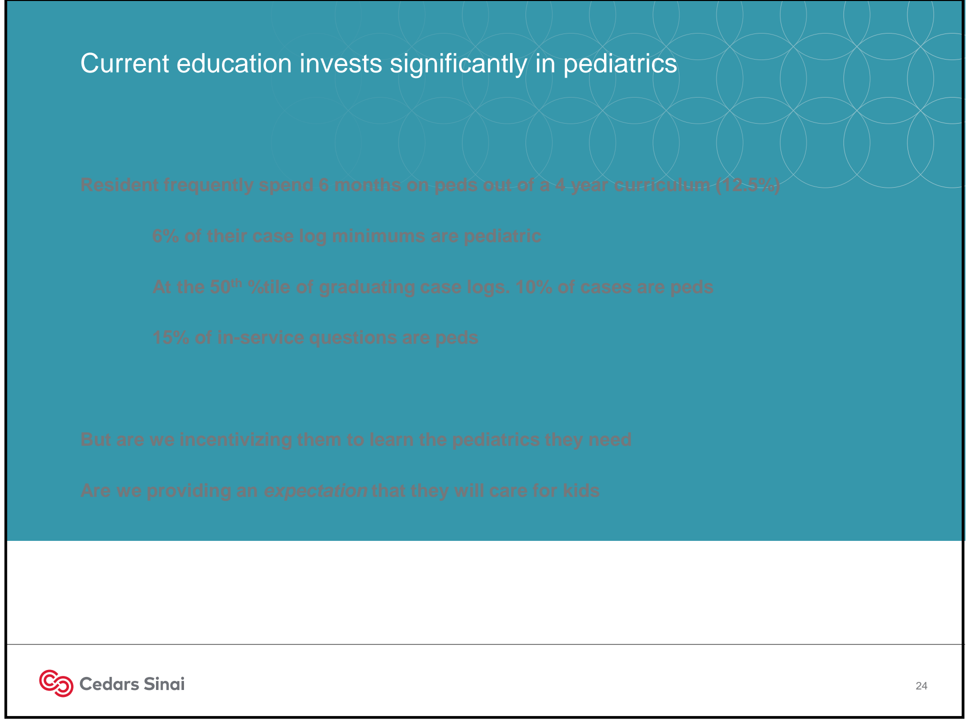

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Are they learning what they need

Hypospadias-

- **Considered an index case**
- **10% of their pediatric cases**
- **Recent survey- 97% pediatric urologist do not feel residents should perform hypospadias after residency without fellowship training**

In service questions on

- **Exstrophy, Posterior Urethral valves, Neurogenic bladder reconstruction**

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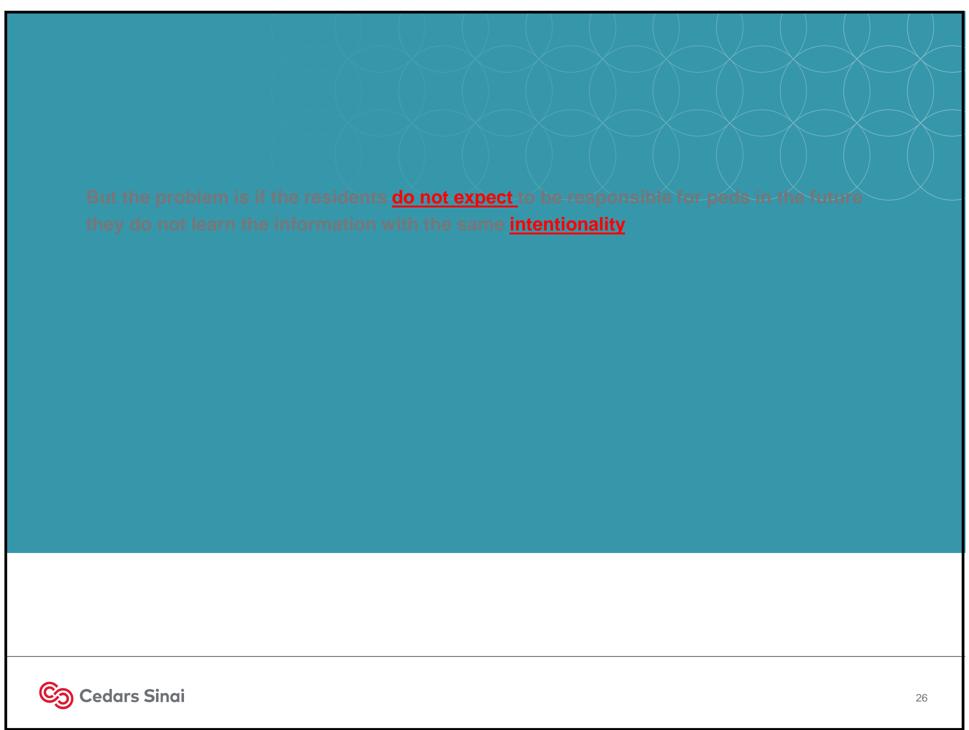

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Need to align the incentives of training to meet the needs of practice

We need to restructure a pediatric curriculum to train the future adult urologist to manage the type of pediatric urology that everyone should know

More time in clinic= evaluation and work up of common pediatric complaints
- infections
- hydronephrosis
- hematuria
- voiding dysfunction
- testis pain

Focus on cases that are common bread and butter
- penile/scrotal/groin cases
- endoscopic cases
- trauma

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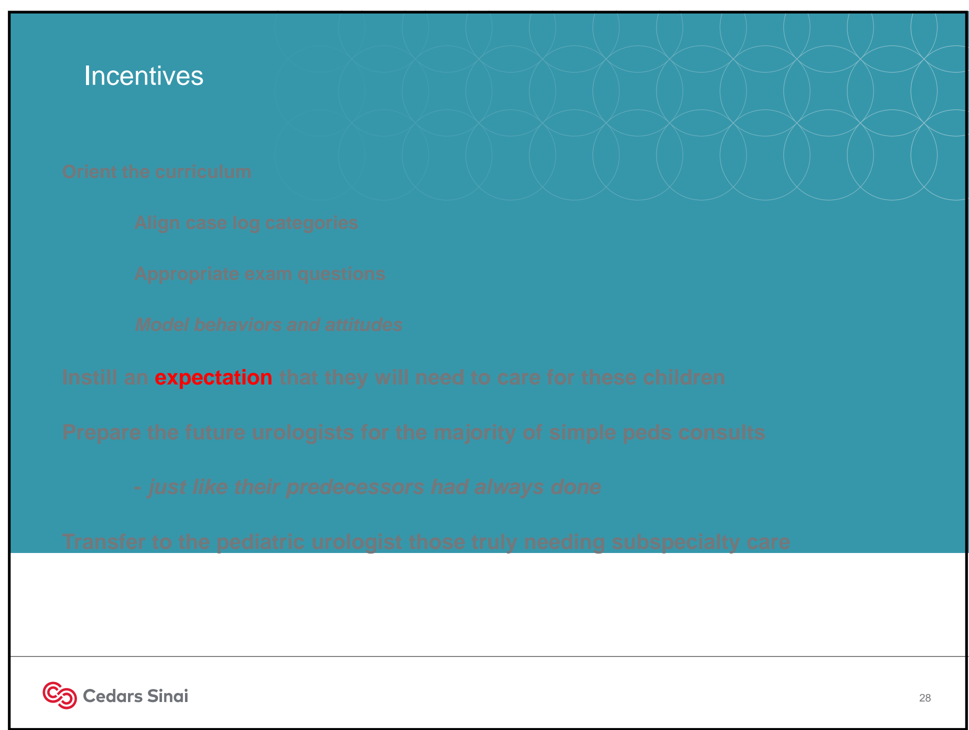

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