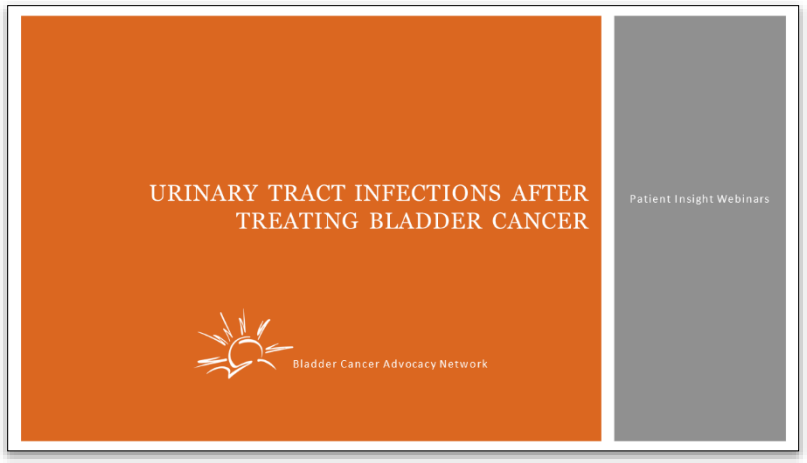

Stephanie Chisolm:

Krisztina, this has been fabulous. I know that everybody is submitting a lot of good questions so I'm going to ask you to stop sharing your screen for a minute, and then we'll just get to have you so that people can see you. We just need to turn off the screen share. There we go. Hang on one second. Let's try to get to as many questions as we can. There was one that came in very early about traveling, and if you're not able to carry everything that you need to like the vinegar and water, can just rinsing out the night bag avoid or reduce the risk of developing a UTI, if you don't have all of the supplies to really clean it well?

Krisztina Emodi:

I think, actually as long as your overnight bag is connected below the waist, it's draining to gravity, nothing should be ascending back into the urinary system. I think white water ... white vinegar and water mixture, that is my go to, and I think rinsing it with just about anything. You can honestly squeeze lemon juice into your water and have some acidic rinse of that tubing, but generally it should not require anything major. It is not a sterile system, and as long as it's rinsed and air dried, and draining below gravity, I think you should not have any issues.

Stephanie Chisolm:

Here's a related question. Does urine backflow from the ostomy bag into a conduit ever, or sometimes? From the ostomy bag back into the ileal conduit itself, and could that lead to problems?

Krisztina Emodi:

Yes. So, it can, because even though it's a low-pressure system by definition from surgery, if you keep emptying your ostomy above the level of the stoma, so we are going continuously above, instead of you emptying your bag half-full or three quarters full, the moment we get above the level of the stoma there's nowhere else to go besides that flow. Once you have that stagnating urine in the conduit, because it's not a continent reservoir like the neobladder, it will a 100% reflux back through the ureters to the kidneys.

Stephanie Chisolm:

Okay, and that does put you then at increased risk for developing infection?

Krisztina Emodi:

Yes. The outflow of your plumbing needs to be very precise, and as ... flow as possible, this is where when I do my preop preparations, I try to present things in what's negotiable and what's non-negotiable. Connecting to your overnight bag is a non-negotiable, because over time you are going to make your renal function worse, you are back-flowing. We potentially put you in a much higher risk for infections, but also, I'm trying to look at in 10 years, how is your renal function going to be when we've had maybe 10 infections that I needed to treat?

Stephanie Chisolm:

Okay. Well, here's a question about prebiotics, probiotics, do you need both? Are you thinking people should take them even if they don't experience UTIs just to reduce their risk?

Krisztina Emodi:

I think so. The benefit of probiotics is not only linked to bladder health. I think there's a lot of studies coming out of immune response, antigen production. I think the healthier you can keep your gut, the better off you are. Now, I think obviously if you have not experienced any infections, and probably your diet is good, and your body is responding in that matter, do you have to take it? I don't know. I don't want to say you have to. Obviously you've been doing well, but that would be certainly the first thing I would be thinking of.

Stephanie Chisolm:

Okay. A few people that were curious about where you can get Visbiome, and they wanted to know do you need a prescription for it?

Krisztina Emodi:

No, so Visbiome needs to come from the company directly, it's visbiome.com. If you go on their site you just click on under products, and you click on capsules. Once you place your order, they ship Monday, Tuesday, and Wednesdays, again, on dry ice with the temperature control. That product does not need prescription. The higher colonic count powder, which is 900 billion instead of 112, that I use for very severe situations, that needs a prescription, but other than that, you do not.

Stephanie Chisolm:

There's somebody on here that uses a condom catheter at night, and is able to sleep through the entire night undisturbed. Are you saying that condom catheters can cause bacterial infections in the neobladder? Or is there something that, from the other elements that you were just talking about, with gravity and other things, that he should be paying attention to?

Krisztina Emodi:

I see, Mr. Pearlman. Condom catheters, it's a slippery slope, let's put it that way. I would challenge to ask a question, if you are leaking urine through the neobladder inter condom catheter, do you empty your neobladder? I think the answer to that is no, because you still have stagnating urine in your neobladder with mucus. Leakage is not empty. Leakage is related to incontinence. The moment you fall asleep, and all those sphincters and all your nice muscles relax in a situation with neobladder, we know that nighttime continence is one of the most challenging parts of long-term survivorship and recovery. I

think condom catheters are fine as long as, let's say, you actually do get up once a night to physically sit on a toilet, and empty that neobladder.

Krisztina Emodi:

Rule of thumb that Dr. Porten and I use at UCSF, you should never go more than six hours without emptying her neobladder. It's okay to get up once a night, if she, let's say, go to bed at nine and you wake up at two, and then you get up at 6:30. Generally speaking, ideally twice a night. So I think condom catheters, with this stagnation mucus, what's coming out is leakage, it's actually not residual urine, is definitely, in my clinical experience, have put patients at a higher risk.

Stephanie Chisolm:

Okay. Is changing a pouch only once a week increasing the chance of the UTI?

Krisztina Emodi:

I wouldn't say that increases the chance if your skin is intact. The important thing is when you take your flange off and you look at the back of that flange, which is hydrocolloid, that hydrocolloid really puffs up from moisture. You can see how far of that hydrocolloid goes to the edge of the tape, if you're very, very close, you're probably really at the end of the wear time of that pouch. Again, in an ideal situation, just for skin health and hygiene, generally it's recommended to change the pouch every three to four days, just because your skin should see water. I encourage my patients to, first thing in the morning, take a shower, take the bag off in your shower, and have your skin deal with normal water situations like your normal skin. But I think in itself, as long as, again, you are not getting above the level of the stoma, it's fine. If you use a two-piece bag, because you get so many supplies, 20 per month, which is a lot, you can also just change the bag in the front if you don't want to change your flange, so that way your bag is actually uncolonized and clean.

Stephanie Chisolm:

Okay. Should a neobladder patient sleep on an incline to minimize reflux?

Krisztina Emodi:

I don't think so. I mean, great question if positioning and whatnot, that helps, I haven't seen any evidence that that would be an issue or helpful. It's really more so emptying on time and catheterizing. If you have residual urine and we don't know about it, self-catheterization is a tool, you need to think of, "I'm in a dark highway and there's no triple A, and I need to change my tire." So that's your catheter, it's a tool, it's a tool to use and make your best friend.

Stephanie Chisolm:

Okay. Here's somebody who's had a UTI every two months, sometimes very bad and became septic. "I take back Bactrim three times a week, probiotics, D-Mannose, cranberry pills, drink three quarts of water a day and eat Activia. What else do you recommend? One doctor wanted to put me on Bactrim every day. They come on very quickly and I become very weak, sometimes I get the chills." Is there something they could be doing prophylactically beyond all the other things that they're doing?

Krisztina Emodi:

I assume that you have been ruled out for any of the structural things I mentioned at the beginning of the talk, and again, a very simple renal ultrasound can do, before jumping into a CT or MRI, or a renogram, or any of these things. My first question is, are you draining properly? Because if there's any mechanical issue, no matter how many times you're treated it's not ... it's a bandaid, you're not addressing the flow problem. So if that hasn't been done, that should be done. If that is addressed, then I think the moment you have a negative culture, I would ask my clinician, or if they're not as well-versed, to potentially get an infectious disease consult from an ID doctor, where they can literally look at all your cultures as susceptibility side to side, see what the common bug was, and oftentimes I find antibiotic suppression helpful, so to kind of get you over that hump. Whether or not, what will I choose will depend on, again, your renal function, allergy profile, what do you tolerate.

I prefer to put people on Keflex or Macrobid versus Septra, because Septra can actually influence and make your creatinine worse. I'm kind of cautious when I use what, I think suppression is definitely ... I would be having a conversation with you about that. Also, I would try to see if this probiotic would be helpful for you, and if there's potentially any backing up in the system. If you have a two-piece urostomy, you could ask for a red rubber catheter, depending on the stoma opening, which would be a smaller one, like a 14 French or 16. If you're able to have a two-piece system, I will ask my patients, "Let's try catheterization. Let's take your bag off three times a day. You insert the catheter and there's a bunch of urine coming out that has been backing up." So those would be my initial suggestions.

Stephanie Chisolm:

So there's a whole bunch of good next steps to follow through to see what's happening.

Krisztina Emodi:

Yeah. I think suppression has a very valid point, but I only start suppression when you are fully treated. We have what we call a test of cure, so then your culture is actually negative, again, from the stoma directly from brand new bag, or your clinician can call you into office, insert the red rubber, collect as clear as possible and clean into a cup. If that comes back negative, then I actually go back on the previous susceptibilities, and look at which antibiotic did not show any resistance that I could suppress with. Again, those three that we talked about, and I would give it a try for three months initially and see how you do. Ciprofloxacin though is not my go to, as I said before, it's a black box warning from the FDA medication. UCSF has taken it off from our clinics for biopsies. It has to be used with a very good reason in your head, "Why am I using Ciprofloxacin?" If there's anything else available, I physically document in my notes why am I taking this over that, when it's a lot more, potentially harmful than ... Even in treatment doses, you don't need to overdose on Ciprofloxacin. In simple doses Ciprofloxacin can be harmful if you have any heart abnormalities, any tendon issues, it can cause tendon ruptures, et cetera. I would not wanting you to be a Ciprofloxacin every six weeks or every other week. That's that's not my ... that would not be my management.

Stephanie Chisolm:

Okay. Well, I think that you've really addressed all of the questions, because the last question was dealing with how dangerous is Cipro every other week, and we are at time, so Krisztina, thank you so much.