NYU Langone Health

Urology

2019 HIGHLIGHTS

Expanding Options for Advanced Bladder Cancer

Urinary tract reconstruction, next-generation tumor sequencing, and targeted adjuvant therapy enhance outcomes for patient with multiple comorbidities

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Advancing Masculinization Surgery

Patient counseling and access to ongoing care proves critical

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Surgery or Surveillance?

A new clinical update provides useful guidance for managing small kidney tumors

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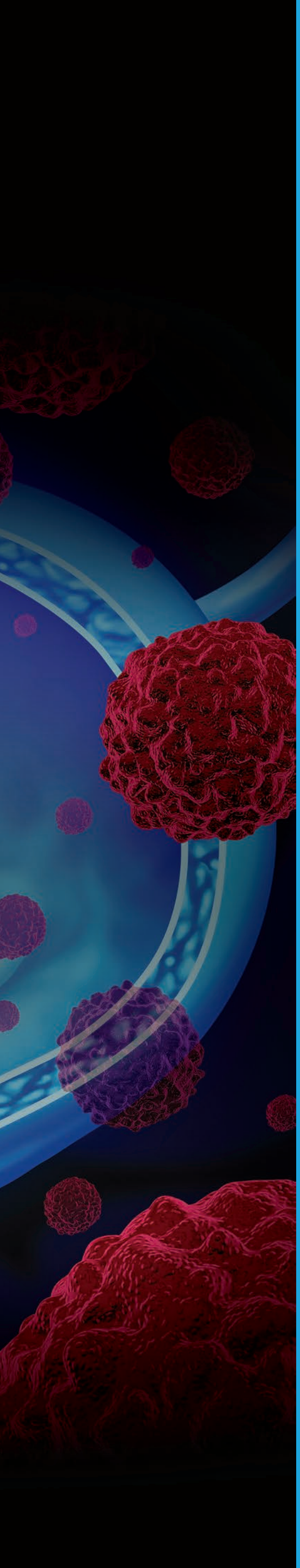
Top 20
In *U.S. News & World Report*

#4
In NIH funding for Urology

1 in 8
Practicing U.S. urologists have attended NYU Langone for postgraduate education



MESSAGE FROM THE CHAIR

HERBERT LEPOR, MD

Professor, Urology and Biochemistry and Molecular Pharmacology
Martin Spatz Chair, Department of Urology
Chief, Urology

Over the past year, our urology faculty have made great strides in understanding the mechanisms underlying urologic diseases and advancing treatments.

Among our many bench-to-bedside advances, our department is at the forefront of exploring new options for the screening, detection, and treatment of prostate cancer.

Our researchers recently found that exposure to e-cigarette smoke caused mice to develop lung cancer and bladder hyperplasia.

Other advances include innovations in reconstructive surgery, new approaches to managing bladder cancer, as well as guidance on the role of active surveillance for some small kidney tumors.

Read on to learn more about our achievements and their potential impact on patient care.

Cover image: Illustration of bladder cancer, showing microscopic cancerous malignant cells spreading in the human body.

RENDERING: GETTY IMAGES

Bladder cancer surgeon Dr. Gary D. Steinberg has extensive experience in creating an orthotopic neobladder following an open radical cystectomy.

PHOTO: NYU LANGONE STAFF

Complex Case: Surgical Expertise & Immunotherapy Expand Options in Advanced Bladder Cancer

A 59-year-old, married white male with a history of obesity, Chronic Obstructive Pulmonary Disease (COPD) related to ongoing tobacco smoking, and hypertension was presented for evaluation and referral to NYU Langone Health.

The patient sought a consultation with Arjun V. Balar, MD, associate professor in the Division of Hematology and Medical Oncology within the Department of Medicine and director of the genitourinary medical oncology program at Perlmutter Cancer Center at NYU Langone.

PATIENT PRESENTS WITH MUSCLE-INVASIVE BLADDER CANCER

The patient had been newly diagnosed with muscle-invasive urothelial cancer of the bladder (MIBC), a highly mutated tumor. The patient's primary risk factor was a long history of smoking. He had no family history of cancer.

Gross hematuria in September of 2018 had prompted an evaluation, at an outside institution. Cystoscopy and CT urogram identified significant right-sided hydroureteronephrosis and possible T3 clinical disease, characterized by extension beyond muscle into the perivesical fat. In early October, the patient underwent transurethral resection of the bladder tumor, the initial step in staging evaluation, which revealed muscle-invasive bladder cancer. The preferred treatment is radical cystectomy with resection of the bladder, regional lymph nodes, and adjacent organs.

Dr. Balar presented an option for a clinical trial evaluating neoadjuvant cisplatin-based chemotherapy with immunotherapy prior to radical cystectomy, which has been shown to improve survival for patients with MIBC.

Lead-in treatment began in mid-November 2018 with initiation of the first of four cycles of gemcitabine/cisplatin/atezolizumab. The patient completed the cycles in early February, 2019, followed in early March by a final dose of the immunotherapeutic agent atezolizumab. Imaging after neoadjuvant therapy revealed prominent hilar lymph nodes, which were anthracotic (carbonaceous) on biopsy.

SURGEON CREATES NEOBLADDER TO ALLOW FOR URINARY DIVERSION

A month after completing neoadjuvant combined therapy, the patient saw Gary D. Steinberg, MD, in consultation for radical cystectomy and orthotopic continent urinary tract reconstruction. A highly experienced bladder cancer surgeon, advocate, and researcher, Dr. Steinberg, professor of urology, director of the Goldstein Urology Bladder Cancer Program, and a member of Perlmutter Cancer Center at NYU Langone, has developed expertise in continent urinary tract

CT imaging results show the patient before chemotherapy and immunotherapy, after chemotherapy and immunotherapy but before surgery, and after surgery, radical cystectomy, and orthotopic neobladder creation.

PHOTOS: DR. GARY D. STEINBERG

reconstruction with creation of a neobladder. The procedure allows the patient to live without an ileal conduit, which collects urine in an external bag through a stoma.

The surgery was uneventful. The surgeons did not discover any tumor outside the bladder, and the lymph nodes appeared unremarkable. Surgeons preserved both of the patient's neurovascular bundles for restoration of erectile function post-surgery.

Postoperative findings were significant for high grade urothelial carcinoma with 3 of 19 nodes positive. Specifically, the cancer was pathologically staged as pT2N2, or tumor invasion into the muscularis propria, with multiple regional lymph node metastasis in the true pelvis. Recovery after surgery was uncomplicated, and the ureteral stents were removed on postoperative day seven, with discharge home.

NEXT-GENERATION TUMOR SEQUENCING EXPANDS OPTIONS

With extensive experience in immunotherapies for bladder cancer, Dr. Steinberg hopes that personalizing treatment will optimize patient care, particularly in cases where the cancer has not responded adequately to initial treatments. In this case, the patient was referred to Dr. Balar for next-generation tumor sequencing and consideration of targeted adjuvant therapy.

On postoperative day 21, the patient's Foley catheter and suprapubic tube were removed, and by 3 months post-op, he was continent day and night and successfully using sildenafil to achieve erection. We are following the patient with surveillance imaging and reviewing his NGS of the surgically resected tumor and lymph nodes.

Generally, checkpoint inhibitor immunotherapy targeting the protein programmed-cell-death-1 or its ligand is recommended for patients who progress after platinum-based chemotherapy. In this patient, the checkpoint inhibitor atezolizumab was initially used in the combination neoadjuvant regimen. New therapies target tumor-specific genetic alterations and include recently approved erdafitinib for patients with advanced fibroblast growth factor receptor (FGFR) mutated urothelial tumors.

In phase II trials there was a response rate of almost 60 percent for chemotherapy plus immunotherapy in patients who had progression of the disease. Other potential targets include deletions in phosphatase and tensin homolog (PTEN), cyclin 1, and mouse double minute 2 homolog; regulators of the G1-S cell cycle progression; aberrant chromatin remodeling genes; and cell adhesion molecule nectin-4.

Researchers at NYU Langone continue to collaborate in developing and evaluating novel agents for targeted personalized therapy. Current bladder cancer options including clinical trials can be found online.

Disclosures: Gary D. Steinberg, MD, is a member of clinical trial protocol committees for Merck, Bristol-Myers Squibb, Janssen, and Cold Genesys. He is a scientific advisor or consultant for Heat Biologics, Cold Genesys, Photocure, Merck, Roche/Genentech, Ciclomed, TARIS Biomedical, MDxHealth, Fidia Farmaceuticals, UroGen Pharma, Ferring Pharmaceuticals, Aduro Biotec, Boston Scientific, Bristol-Myers Squibb, AstraZeneca, Pfizer, Janssen, EpiVax Oncology, Natera, FKD Therapies Oy, EnGene Bio, and Sesen Bio. Dr. Steinberg has equity or stock options in EpiVax Oncology and UroGen Pharma.

Managing Urologic Complications of Masculinization Surgery

Patient demand for gender affirming surgery—including facial, chest, and genital reconstructive surgery—has increased in recent years and become more accessible due to changes in insurance coverage.

However, only a handful of institutions worldwide offer these complex operations. A recent study led by NYU Langone's Lee C. Zhao, MD, assistant professor of urology, suggests that many patients receive the initial surgery far from home and seek follow-up care for short-term complications with other surgeons.

COMPLICATIONS EMERGE SOON AFTER SURGERY

In a retrospective study published online June 20, 2019, in *Urology*, Dr. Zhao, who is also director of male reconstructive surgery and co-director of transgender reconstructive surgery—part of NYU Langone's transgender surgery services—and colleagues report on the cases of 55 patients who experienced urethral complications following masculinizing GRS.

All patients, who ranged in age from 17 to 60, sought care with one of the study's 8 co-authors a median of 4 months following their initial surgery at a different center. Anastomotic stricture was the most common form of urethral complication, occurring in 66 percent of patients. Most patients presented with 2 or more complications, the authors note, and all of those with urethrocutaneous fistula (56 percent) had concurrent urethral stricture.

The findings underscore a scenario that is becoming increasingly common and often challenging for reconstructive urologists—the expectation of managing complications stemming from procedures at other centers. The urologist may lack important details about the original operation, and patients may be surprised or confused about the need for additional interventions.

"Urethral complications after masculinizing genital surgery is very different from urethral strictures occurring in cisgender patients after trauma," Dr. Zhao says. "The tecŸiques needed to revise these strictures are different, and even when the operative reports are available, there is no substitute for the knowledge of the anatomy that the original surgeon had."

Urologist Dr. Lee C. Zhao brings complexities into focus with his new research study highlighting the need for pre-counseling and careful follow-up to increase positive outcomes for masculinizing genital reconstructive surgery.

PHOTO: NYU LANGONE STAFF

Total Healthcare for Individuals Seeking Gender-Affirming Procedures

NYU Langone Health is at the forefront of research and innovation in performing gender-affirming procedures and conducting studies to improve patient outcomes and satisfaction that contribute to the overall wellness of transgender and gender diverse individuals. NYU Langone's multidisciplinary team provides medical services for transgender men, women, and adolescents, including surgery, hormone therapy, reproductive health services, and mental health services. Lee C. Zhao, MD, MS, assistant professor of urology and director of Male Reconstructive Surgery, has pioneered the use of robotic techniques at NYU Langone to make gender-affirming procedures safer, faster, and less invasive. Dr. Zhao often collaborates with Rachel Bluebond-Langner, MD, the Laura and Isaac Perlmutter Associate Professor of Reconstructive Plastic Surgery, at NYU Langone's Hansjörg Wyss Department of Plastic Surgery. Together, they have established one of the country's only dual-surgeon, cross-specialty programs that performs robotic "bottom" genital surgery for vaginoplasty and phalloplasty, which many experts agree presents safer and more effective results. Dr. Zhao and Dr. Bluebond-Langner are part of a growing team of specialists at NYU Langone who care for transgender patients.

PATIENT COUNSELING AND ACCESS TO CARE ARE CRITICAL

Urethral complications are common following masculinizing GRS, with published rates from 25 to 75 percent, says Dr. Zhao. However, due to geographic and cost constraints, many patients may have difficulty following up with their primary surgeons even during the immediate postoperative period.

"It's important to counsel patients that the risk of post-surgical complications is highest in the first few months following surgery." says Dr. Zhao. "Patients should be made aware that they should follow up closely with the surgeon who performed the surgery. While care with a reconstructive urologist is certainly helpful, like for any other complex surgical procedure, there is no substitute for follow up with the surgeon who performed the surgery."

"At NYU Langone, we have a high-volume practice in gender-affirming surgery, with patients traveling from all over the world for care. One thing that we stress before scheduling any surgery is the expectation for the patient to return to New York for postoperative care."

A BROAD RANGE OF COMPLICATIONS

"Masculinizing genital reconstructive surgery, especially phalloplasty, involves a number of separate operations: vaginectomy, perineo-plasty, urethroplasty, scrotoplasty, and radial forearm free flap. Each of these procedures have complications. When all of these procedures are performed simultaneously, it is natural for complications to add up."

The variety of surgical tecŸiques used by the co-authors highlights the broad range of potential urethral complications following masculinization surgery, and the lack of standardized approaches to address them.

For example, patients who received multiple prior skin grafts for urethral repairs had fewer options for reconstruction. In addition, almost half of the patients presented with vaginal remnant, said Dr. Zhao. This can occur after the primary vaginectomy if the mucosa is incompletely resected, leaving remnants in the urinary tract. Patients may experience symptoms including difficulty voiding, leakage, pain, and recurrent urinary tract infections.

"Treatment of vaginal remnants typically requires complete excision and closure of associated tracts," says Dr. Zhao. "At NYU Langone, we remove the vaginal remnant via a robotic approach. Since the patients previously had a perineal reconstruction, we are able to avoid making an incision into the perineum to completely remove the vaginal remnant."

A PROGRAM BUILT ON CONTINUOUS QUALITY IMPROVEMENT

"Due to the complexity of the operation and the unacceptably high rate of complications, it makes sense to have a constant process of quality improvement. At NYU Langone, we perform both revision surgery and primary gender affirming surgery. Taking care of complications from other centers has really informed how we perform the primary operation. We've found that complications often lead to other complications, such as urethral strictures causing urethral fistula or wound breakdown. Thus, we perform phalloplasty in stages to prevent one complication from causing others."

The authors caution that the study is limited by its small size and incomplete details from institutions where the primary surgeries were performed. However, the findings highlight the importance of alerting patients to the signs and symptoms of complications and of having access to long-term follow-up care.

"In addition to reconstructive urologists who are prepared to evaluate and treat patients with complex surgical needs, this study highlights the need for thorough preoperative counseling and long-term local follow-up of transgender patients who undergo masculinizing GRS," concludes Dr. Zhao.

Equality in Healthcare

NYU Langone Health has been recognized by the Human Rights Campaign Foundation Healthcare Equality Index (HEI) Report, a certification that acknowledges the work of medical facilities that are providing equal healthcare access to LGBTQ+ Americans. We also follow the standards of care guidelines set forth by the World Professional Association for Transgender Health (WPATH).

> *"Masculinizing genital reconstructive surgery, especially phalloplasty, involves a number of separate operations: vaginectomy, perineoplasty, urethro-plasty, scrotoplasty, and radial forearm free flap. Each of these procedures have complications."*
>
> **Lee C. Zhao, MD**

Dr. William C. Huang uses the personalized 3D reconstructed small kidney tumor models for preoperative planning and patient education.

PHOTO: NYU LANGONE STAFF

Safely Managing Small Kidney Tumors: Active Surveillance Plays a Key Role

Incidental detection of small kidney tumors has risen dramatically over the past several decades due to increasing use of diagnostic imaging.

In the past, surgery was the standard approach to managing all of these lesions, but recent research suggests that many small, incidentally discovered tumors frequently do not become aggressive; therefore, in select patients, these small masses can be safely managed through an initial period of observation or active surveillance.

SMALL KIDNEY TUMORS POSE LOW RISK OF MORTALITY

A Clinical Update was published in the April 23/30, 2019 issue of *JAMA*, describing investigations by William C. Huang, MD, associate professor of urology, chief of the Urology Service at Tisch Hospital, and co-director of the Robotic Surgery Center at NYU Langone, and others. According to their research, small tumors measuring 4 centimeters or less—which are often found during imaging for other problems—pose very low risk of mortality from kidney cancer. Dr. Huang, part of Perlmutter Cancer Center at NYU Langone and a pioneer in developing the most effective minimally invasive approaches to managing kidney cancer, along with his colleagues, note that 75 to 80 percent of small lesions ultimately prove to be malignant while the remaining 20 to 25 percent remain benign. Although less than 5 percent of these small malignant tumors will metastasize, we still recommend treatment; imaging and even biopsy give us limited information at this time which of these small tumors will become life-threatening.

ACTIVE SURVEILLANCE EFFECTIVE AS INITIAL MANAGEMENT STRATEGY

Dr. Huang and colleagues point to recent evidence supporting active surveillance as an effective initial management strategy for many patients. For example, the Delayed Intervention and Surveillance for Small Renal Masses (DISSRM) registry reported a 100 percent cancer-specific survival rate over five years for patients under active surveillance. Another large review published in *Cancer* reported metastatic disease rates of only 1 to 2 percent for patients managed with active surveillance for 2–3 years. "The low risk posed by small kidney lesions suggests that these tumors can be managed similarly to low-risk prostate cancer, which also frequently has an indolent or lazy, course," says Dr. Huang.

INDIVIDUALIZED TREATMENT PLANS AND SHARED DECISION MAKING

Management of small tumors should be individualized to each patient, advises Dr. Huang. Factors to consider when creating a treatment plan include the risk of mortality from kidney cancer, mortality risk from comorbid conditions, and the potential for treatment-related side effects. The most recent American Urological Association clinical guidelines endorse an initial period of active surveillance instead of surgery as an option for small lesions measuring less than 2 centimeters. The guidelines caution that patients should be fully informed about the low risk of cancer-specific mortality

for very small lesions, in the absence of comorbid conditions, and also be given the option to pursue biopsy when warranted.

Decisions about whether to pursue surgery versus surveillance should take into account the overall health and anticipated longevity of the patient. In addition, tumor characteristics such as location may also play a role in decision-making as treatment may unnecessarily result in loss of kidney function. In patients with small renal masses and/or significant co-morbid conditions or chronic kidney disease, any surgical treatment including partial may negatively impact their kidney function, their quality of life, or both.

While active surveillance is emerging as a safe and effective option for select patients with very small tumors, evidence from randomized trials is lacking, Dr. Huang notes. As a result, physicians should fully inform patients about the potential risks and benefits of various treatment options and engage them in shared decision-making.

"In the future, we hope to develop new tests so that we can accurately identify tumors which are not safe to observe," says Dr. Huang. "However, for now, we can help patients fully understand the low mortality risk associated with many of these small tumors so that they are enabled to make an informed decision as to whether they want to pursue treatment for their small renal mass."

Disclosure: Dr. Huang reported membership on the American Society of Clinical Oncology Guidelines Panel for Small Renal Masses.

75–80%

OF SMALL LESIONS ULTIMATELY PROVE TO BE MALIGNANT

—

20–25%

REMAIN BENIGN

—

LESS THAN

5%

MALIGNANT TUMORS WILL METASTASIZE

"The low risk posed by small kidney lesions suggests that these tumors can be managed similarly to low-risk prostate cancer, which also frequently has an indolent or 'lazy' course."

William C. Huang, MD

At Perlmutter Cancer Center, No Two Patients Are Treated Exactly the Same (Not Even Twins)

After years of battling blazes as New York City firefighters, twin brothers Paul and Phil Malenczak are facing down a different kind of threat: prostate cancer.

PHOTO: JONATHAN KOZOWYK

Urologic oncologist James S. Wysock, MD, and radiation oncologist Jonathan A. Haas, MD, leveraged advanced diagnostics and shared decision-making to help two brothers with prostate cancer navigate the many surgical and nonsurgical options available at Perlmutter Cancer Center. Although one brother required a course of hormonal therapy prior to radiation, ultimately the twins were treated with stereotactic body radiotherapy (SBRT). Their care was coordinated seamlessly between our Manhattan campus and NYU Winthrop Hospital on Long Island.

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Like many men, Artie Zuckerman had virtually no symptoms when he was diagnosed with prostate cancer at age 68. A fitness enthusiast who gets plenty of exercise caring for his three Great Danes, he felt blindsided. "I thought I was doing pretty good," he recalls.

PHOTO: BRAD TRENT

For Prostate Cancer, Many Treatment Options, but No Easy Answers

At 68, Artie Zuckerman had a 31-inch waist, a 46-inch chest, and could knock out 20 chin-ups. "I was exercising, eating my fish and veggies," recalls Zuckerman, who works as a chauffeur and personal assistant for a corporate CEO.

"I thought I was doing pretty good." Aside from getting up to go to the bathroom twice a night—common for men his age—he felt vibrant. So when tests showed that Zuckerman had prostate cancer, his fear was mingled with a sense of disbelief.

CUTTING THROUGH THE CONFUSION & NAVIGATING HIS TREATMENT OPTIONS WITH CONFIDENCE

Like many of the more than 174,000 men diagnosed with the disease annually in the United States, he faced an agonizing decision. "For patients with prostate cancer, choosing a course of action can be overwhelming," says Herbert Lepor, MD, the Martin Spatz Chair of the Department of Urology and director of the Smilow Comprehensive Prostate Cancer Center, part of Perlmutter Cancer Center at NYU Langone Health.

A decade ago, the vast majority of patients diagnosed with prostate cancer opted for a radical prostatectomy—surgical removal of the prostate—or radiation therapy. However, today almost half choose active surveillance, in which slow-growing early-stage tumors are monitored through a combination of a blood test that measures a protein known as prostate-specific antigen, or PSA, and biopsies. This trend reflects a raft of recent studies showing that prostate tumors rated 6 or less on the Gleason scale (a 1 to 10 measure of likely aggressiveness) rarely metastasize. Still, many patients are uncomfortable with a watch-and-wait approach, and it's typically not an option in higher-risk cases like Zuckerman's. Then, the choices become more complex.

Zuckerman's MRI scan revealed a gumball-size tumor, and biopsies showed a Gleason score of 7, indicating an intermediate risk that the cancer would spread beyond the prostate. He visited several specialists, each of whom suggested a different type of treatment. He took to the internet, as many patients do, in search of

information and talked with friends who'd undergone treatment for prostate cancer. But his confusion only intensified; he simply couldn't find a consensus on which treatment was best. Finally, he consulted Dr. Lepor, whose approach put him at ease. "He spent an hour with me," Zuckerman recalls. "I was impressed with his experience, his confidence, and his honesty."

As a leading prostate cancer surgeon, Dr. Lepor has performed more than 5,000 radical prostatectomies. Yet he has also helped pioneer a nonsurgical tecŸique known as focal ablation, in which precisely targeted beams of energy, such as extreme cold or high-intensity ultrasound, destroy diseased tissue while leaving the rest of the prostate intact. Preliminary studies—including some by Dr. Lepor and his colleagues—suggest the method can eradicate tumors with fewer side effects than surgery or radiation. In addition, unlike with radiation, patients can undergo another round of focal therapy or opt for conventional methods in case of recurrence. "I told Artie that this could be a way to control his cancer with less risk of life-altering complications," Dr. Lepor explains. "But I emphasized that there were no guarantees."

Zuckerman was willing to take a chance. Because of the position of his tumor, among other factors, Dr. Lepor recommended focal cryotherapy, in which repeated freezing and thawing causes cancer cells to rupture. Last July, while Zuckerman was under anesthesia, Dr. Lepor inserted a thin probe into his prostate, using ultrasound guidance to reach the site of the tumor. He then cycled supercooled argon gas through the probe, chilling the target area to -40 degrees Celsius. The procedure took about two hours, and Zuckerman, like most patients, went home the same day. He returned to work 10 days later.

Since then, Zuckerman has experienced no incontinence, and his sexual function, though impacted at first, has returned to near normal. A follow-up PSA test, MRI, and biopsy after six months showed no cancer. (He'll continue with PSA testing every six months.) "I think I did the right thing," he says.

> *"I told Artie that this could be a way to control his cancer with less risk of life-altering complications. But I emphasized that there were no guarantees."*
>
> **Herbert Lepor, MD**

But ultimately every man with prostate cancer must make his own choice, notes Dr. Lepor. "This is a visceral decision," he says. "One patient will insist on the most definitive cure. Another will accept some uncertainty if there's less impact on quality of life. The doctor's role is to provide realistic expectations, and help patients process the risks and benefits."

This article originally appeared in the Fall 2019 Perlmutter Cancer Center Special Report.

E-Cigarette Smoke Causes Lung Cancer and Bladder Hyperplasia in Mice

Exposure to e-cigarette smoke caused mice to develop lung cancer and bladder hyperplasia, a new study finds.

Published online October 7 in *Proceedings of National Academy of Sciences (PNAS)*, the study found that 9 of 40 mice (22.5 percent) exposed to e-cigarette smoke with nicotine for 54 weeks developed lung adenocarcinomas. None of the 20 mice from the study exposed to the same e-cigarette smoke without nicotine developed cancer.

Led by Moon-Shong Tang, PhD, an NYU School of Medicine researcher, the study also found that 23 of 40 mice (57.5 percent) exposed to e-cigarette smoke developed bladder hyperplasia, genetic changes that make cells more likely to multiply, and a step toward abnormal tissue growth seen in cancer. Only 1 of the 17 mice exposed to the zero-nicotine e-cigarette smoke developed hyperplasia.

Dr. Tang acknowledges the study's limitations, including that it was conducted in a relatively small number of mice susceptible to developing cancer over their lifetime (a one-year study period designed to offset age-related cancer). The study mice also did not inhale smoke like a human would, but instead, were surrounded by it through whole-body exposure.

"Tobacco smoke is among the most dangerous environmental agents to which humans are routinely exposed, but the potential of e-cigarette smoke as a threat to human health is not yet fully understood," says Dr. Tang, professor of environmental medicine, medicine, and pathology. "Our study results in mice were not meant to be compared to human disease, but instead argue that e-cigarette smoke must be more thoroughly studied before it is deemed safe or marketed that way."

PHOTO: DANCHOOALEX/GETTY

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Referenced Publications

Dy GW, Granieri MA, Fu BC, Vanni AJ, Voelzke B, Rourke KF, Elliott SP, Nikolavsky D, Zhao LC. Presenting complications to a reconstructive urologist after masculinizing genital reconstructive surgery. *Urology*. October 2019; 132: 202–206.

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Tang MS, Wu XR, Le e HW, Xia Y, Deng FM, Moreira AL, Chen LC, Huang WC, Lepor H. Electronic-cigarette smoke induces lung adenocarcinoma and bladder urothelial hyperplasia in mice. *Proceedings of the National Academy of Sciences of the United States of America*. October 22, 2019; 116(43): 21727–21731. October 7, 2019; epub ahead of print. Erratum in: *Proceedings of the National Academy of Sciences of the United States of America*. November 5, 2019; 116(45): 22884.

Awards & Recognition

William C. Huang, MD, continues as co-director of the NYU Langone Robotic Surgery Center. Dr. Huang uses robotic surgical techniques in minimally invasive surgeries to remove kidney, bladder, prostate, and testicular cancers with minimal side effects and improved quality of life for patients. Dr. Huang also serves on national and international committees that publish guidelines for the management of cancers of the urinary tract.

David S. Goldfarb, MD, is on the editorial boards of the *Clinical Journal of the American Society of Nephrology, Journal of the American Society of Nephrology, Kidney International*, and *Urolithiasis*. He currently serves on the medical advisory board of the National Kidney Foundation of Greater New York and the Oxalosis and Hyperoxaluria Foundation and was a past president of both the Research on Calculus Kinetics (R.O.C.K.) Society and the New York Society of Nephrology.

Herbert Lepor, MD, is a co-founder and the current editor of *Reviews in Urology* and is on the editorial board of *Urology*.

Stacy Loeb, MD, MSc, is an associate editor for *BJU International*, and also serves on the editorial boards of the *Journal of Clinical Oncology, European Urology, Nature Reviews Urology,* and *Reviews in Urology*.

Dr. Loeb hosts the Men's Health Show on SiriusXM satellite radio (Channel 110), and chairs the American Urological Association Social Media Work Group. She was also recently inducted to the Association of Academic European Urologists.

Danil V. Makarov, MD, MHS, is a member of the Society for Medical Decision Making, a diplomate of the American Board of Urology, and chair of the White Paper Committee on Implementation of Shared Decision Making into Urological Practice of the American Urological Association. He is also a consultant for the FDA's Center for Devices and Radiological Health.

Samir S. Taneja, MD, James M. Neissa and Janet Riha Neissa Professor of Urologic Oncology, is a consulting editor for the Urologic Clinics of North America and is on the editorial board of *European Urology*. He was recently inducted into the American Association of Genitourinary Surgeons. He is also a recognized innovator in the field of prostate cancer focal therapy and editor of the textbook *Taneja's Complications of Urologic Surgery: Prevention and Diagnosis*.

Xue-Ru Wu, MD, Bruce and Cynthia Sherman Professor of Urological Research and Innovation, successfully led the renewal for a 5-year, $7 million bladder cancer program project grant from the National Cancer Institute.

Continuing Medical Education: **Save the Date**

APRIL 24, 2020

Bladder Cancer Symposium: Update on Medical & Surgical Management for the Urologist

Course Directors:
Gary D. Steinberg, MD
Danil Makarov, MD

JUNE 12–13, 2020

Advances in Screening, Detection and Treatment of Prostate Cancer

Course Director:
Herbert Lepor, MD

SEPTEMBER 11, 2020

Female Pelvic Medicine and Reconstructive Surgery: An Update for Clinicians

Course Director:
Benjamin Brucker, MD

DECEMBER 10–12, 2020

Surgical, Pharmacological, and Technological Advances in Urology

Course Director:
Herbert Lepor, MD

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ABOUT NYU LANGONE HEALTH

Leader in Quality

NYU Langone has achieved top rankings by Vizient, and is the only full-service health system in New York City with an "A" Leapfrog safety grade and a CMS 5-star rating in 2020. These accolades are reflective of a shared culture of quality that permeates our growing network, now inclusive of NYU Winthrop Hospital and its ambulatory sites on Long Island. All of our sites are held to the highest quality standards set at an institutional level.

#9 in the Nation

Ranked ninth by *U.S. News and World Report* for both Best Hospitals and Best Medical Schools (Research)

Transforming Medical Education

To address some of today's most pressing issues in medical education such as physician shortages, debt burden, and lack of diversity, we have introduced accelerated pathways to the MD degree and full-tuition scholarships regardless of need or merit at the recently renamed **NYU Grossman School of Medicine** and the new primary-care focused **NYU Long Island School of Medicine**.

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Our urology faculty continue to make great strides in understanding and advancing treatment for urologic diseases. We are expanding options for advanced bladder cancer, minimizing complications of masculinization surgery, and considering the role of active surveillance for some small kidney tumors.

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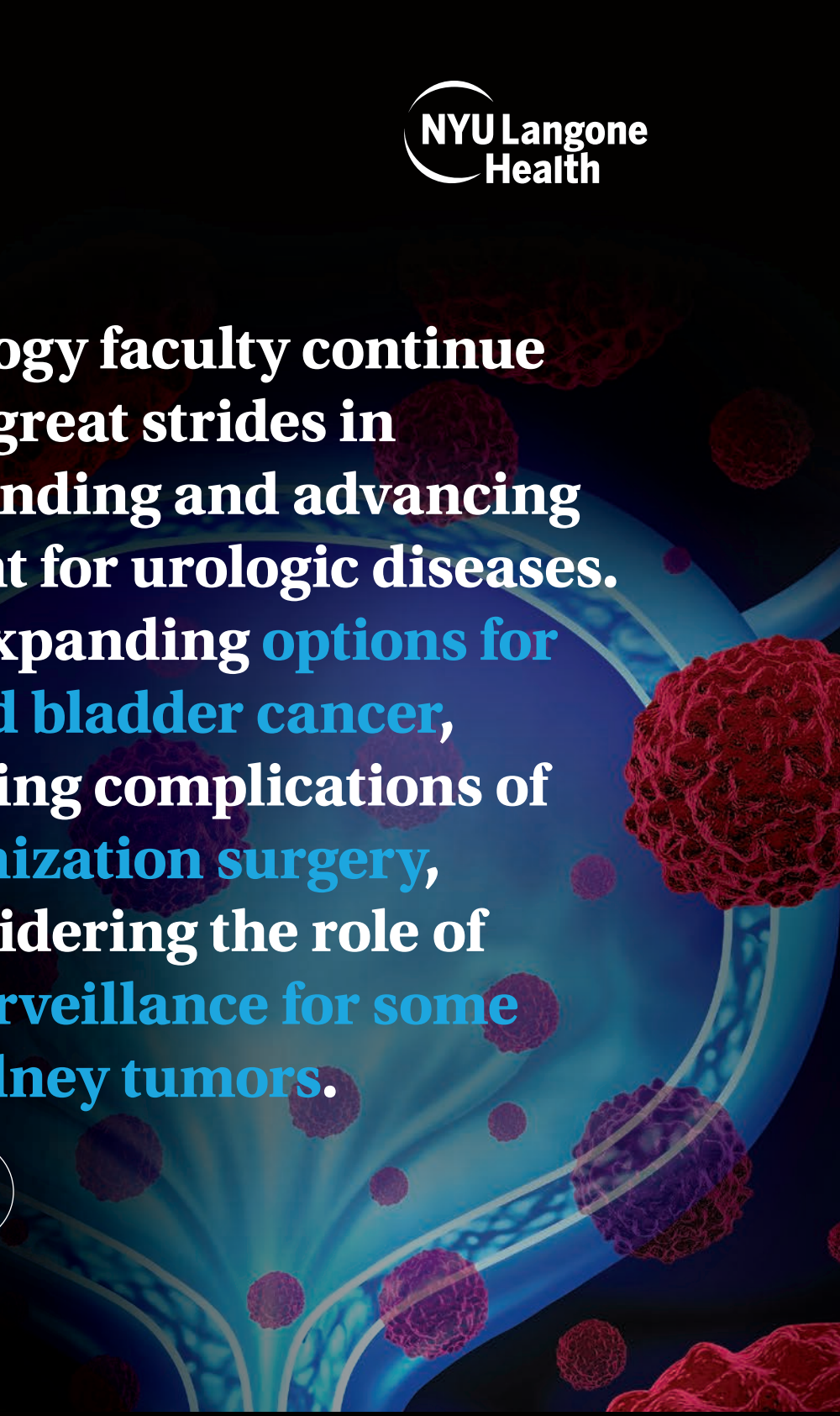

Urology

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