



and shock wave lithotripsy but do not integrate patient preferences. A new, validated SDM-DA both educates and identifies/ ranks patients' goals for treatment. This study evaluates if the SDM-DA improves SDM during surgical consultations for urolithiasis.

METHODS: Approval was obtained from institutional IRB and the developer of "The Best Kidney Stone Procedure for Me"® decision aid (details in Table). Adult patients 18-89 years old with stones < 2 cm in kidney or proximal ureter were consented and randomized to urology appointment with or without SDM-DA. Appointment conversations were recorded and demographic details collected. Primary outcome was objective SDM, determined by two independent, trained evaluators who reviewed clinic conversations and scored SDM using the validated OPTION 5 questionnaire. Analysis included chi square, T test, Mann-Whitney U test, and logistic regression.

RESULTS: Sixty patients were randomized to the SDM-DA or control. SDM score was significantly higher using the SDM-DA (87 vs 69 respectively, $p < 0.001$); this was significant among all sub-domains (Table). SDM was not associated with patient gender, age, prior stone treatment, or location of stone. Use of the SDM-DA did not impact duration of the appointment (11.3 ± 6 minutes vs 12 ± 7 , $p = 0.7$); however, with SDM-DA more of the appointment was spent in conversation about a shared decision (41% vs 28% , $p < 0.001$). Patients counseled with SDM-DA were more likely to choose observation (77% vs 54%) over surgery, but this was not significant ($0 = 0.06$). There was no association between SDM and surgery type selected.

CONCLUSIONS: Using a decision aid that educates and identifies patients' goals for treatment improved SDM during urolithiasis consultation. The tool facilitated clearer communication and better incorporation of patient goals into surgical decision making without increasing appointment time.

Table. Use of a Shared Decision Making Decision Aid in Treatment of Urolithiasis

	No Decision Aid N=30	Shared Decision Making Decision Aid* N=30	p
Age (years)	57.3±14.7	59.7±15.5	0.566
Gender			0.297
• Men	15 (50%)	11 (36.7%)	
• Women	15 (50%)	19 (63.3%)	
Treatment			0.058
• Observation	23 (76.7%)	16 (53.3%)	
• Surgery	7 (23.3%)	14 (46.7%)	
Objective SDM standardized score, mean	69.3±21.2	86.9±12	<0.001
Duration of appointment, mean (minutes)	11.3±5.6	12±7	0.685
Percent of conversation in SDM (%)	27.7±14.3	40.7±14.8	<0.001
Sub-domains of SDM, mean			
Item 1: Alternate options exist	2.75±0.9	3.43±0.7	0.002
Item 2: Team talk/ form a partnership	2.78±0.9	3.43±0.6	0.002
Item 3: Educates about options	2.45±0.9	3.28±0.7	<0.001
Item 4: Elicits preference	2.82±1	3.6±0.6	0.001
Item 5: Integrates preference	3.07±1	3.63±0.5	0.016

Abbreviations: DA=decision aid; SDM= Shared decision making

* The DA "The Best Kidney Stone Procedure for Me" © 2023 was developed by Michigan Urological Surgery Improvement Collaborative (MUSIC) with sponsorship from Blue Cross Blue Shield of Michigan. The DA provides education and details about ureteroscopy and shock wave lithotripsy in the treatment of kidney stones. Patients self-identify treatment goals for effectiveness, number of procedures, risk of complications, pain, and recovery time. Goals are ranked on a Likert scale as most to least important.

Details about development of the DA: DiBianco JM, Conrado B, Daignault-Newton S, Hawley ST, Lane G, Wenzler D, Seifman B, Phelps JR, Cotant M, Ghani KR, Dauw CA. Development of a Surgical Decision Aid for Patients with Nephrolithiasis: SWL vs URS. *J Endourol.* 2023 Feb;37(2):212-218.

The DA may be accessed online: <https://musicurology.com/wp-content/uploads/2023/02/MUSIC-ROCKS-Shared-Decision-Aid.pdf>

Source of Funding: NA

IP67-12 UROLOGIST AND PATIENT PERSPECTIVES ON URETERAL STENTING AFTER UNCOMPLICATED URETEROSCOPY FOR KIDNEY STONES: INSIGHTS FROM A LARGE MULTI-CENTER CLINICAL TRIAL

Anne Sales, Cassandra Maturino, Brittany Marks, Columbia, MO; Christa Torrisi, Indianapolis, IN; Michael Uy, Elaina Shoemaker, Noelle Carozzi, Casey Dauw, Khurshid Ghani, For The Michigan Urological Surgery Improvement Collaborative, Ann Arbor, MI

INTRODUCTION AND OBJECTIVES: Stents are commonly placed following ureteroscopy (URS) to treat kidney stones. AUA guidelines recommend stents can be omitted after uncomplicated URS, but stenting rates remain high. The Stent Omission following Ureteroscopy and Lithotripsy (SOUL) clinical trial is currently in process, following two cohorts of patients undergoing uncomplicated URS. The first cohort agreed to randomization to stent vs no stent. The second is comprised of patients who decline randomization with stent placement based on urologist judgment. The goal of this work is to understand urologist and patient perspectives on decision-making around stents following URS.

METHODS: We recruited all urologists participating in the SOUL trial (Figure), and the first group of patients undergoing URS, starting in November 2023. Interviews followed one of two semi-structured interview guides; we structured urologist guide using the Tailored Implementation for Chronic Diseases framework, and developed the patient guide iteratively in the research team. We conducted interviews using Zoom teleconferencing and audio recorded them for transcripts and edited them following the original recording for accuracy. We coded the transcripts inductively using the interview guides, and deductively, using Dedoose software as the analytic platform. All transcripts were coded independently by two analysts.

RESULTS: A total of 29 urologists and 20 patients participated in interviews between November 2023 and September 2025. Perspectives of urologists and patients differed. Most patients voiced a strong preference for avoiding stent use, preferring stent use "only if there's no alternative". Most urologists, while aware of patient preferences, often felt that stent use was "a necessary evil" because procedures were often in a gray zone between uncomplicated and complicated. Most urologists were aware of guidelines and interested in decreasing stent use—this is why they were participating in the SOUL trial— but often found technical barriers to stent omission.

CONCLUSIONS: Urologists are aware of patient preferences related to stent use after URS, and of AUA guidelines, but feel that many ureteroscopies are more complicated than anticipated. Patients generally voice their preference for stent omission to their urologists, but their preferences are frequently overridden by perceived technical concerns.

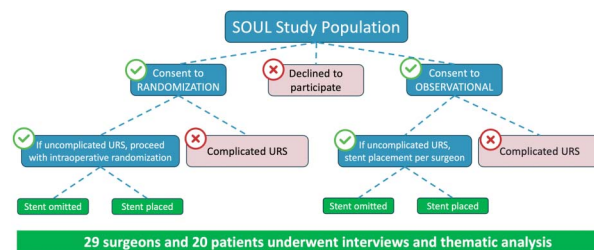


Figure. Flow diagram of the SOUL trial recruitment and enrollment strategy
SOUL, Stent Omission after Ureteroscopy and Lithotripsy; URS, ureteroscopy

Source of Funding: PCORI CER-2021C2-22856