Pre-37th SIU

SEMI-LIVE Surgery

Workshop on Genitourethral Reconstruction

Venue: SANA Lisboa Hotel

OCTOBER 17-18, 2017

SCIENTIFIC PROGRAM

DIGITAL PROGRAM

Design: Ad Médic

EACCME®
European Accreditation Council
for Continuing Medical Education

The **Pre-37th SIU Semi-live surgery workshop on genitourethral reconstruction**, to be held in Lisbon, Portugal, October 17 to 18, 2017 has been accredited by the European Accreditation Council for Continuing Medical Education (EACCME®) with 12 European CME credits (ECMEC®s).
Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

Through an agreement between the Union Européenne des Médecins Spécialistes and the American Medical Association, physicians may convert EACCME® credits to an equivalent number of AMA PRA Category 1 CreditsTM. Information on the process to convert EACCME® credit to AMA credit can be found at www.ama-assn.org/go/internationalcme.

Live educational activities, occurring outside of Canada, recognised by the UEMS-EACCME® for ECMEC®s are deemed to be Accredited Group Learning Activities (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.

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Posters for exhibition only

October 17 // 05.20 pm

October 18 // 04.15 pm

ORGANIZING COMMITTEE

Chairpersons: ***Margit Fisch & Tomé Lopes***
Co-Chairs: ***Sanjay Kulkarni & Francisco Martins***

WORKSHOP COORDINATOR

Francisco Martins, MD, Department of Urology, University of Lisbon, School of Medicine, Hospital Santa Maria/CHLN, Lisbon, Portugal

OBJECTIVES

A workshop on male genitourethral reconstruction, including semi-live surgical demonstrations (video demonstrations), lectures, point-counterpoint debates, and video and poster presentations. It is intended to give early career urologists an opportunity to interact actively with faculty experts, as well as present their own work in the field of male genitourethral reconstruction. Nonetheless, this workshop is intended to everyone interested in genitourethral trauma and reconstruction.

TARGET AUDIENCE

This workshop should be attended by both senior and young urologists, urology residents, medical students and nurses interested in (and who deal with) adult male genitourethral reconstruction.

URETHRAL RECONSTRUCTION

ANTERIOR URETHRAL STRICTURES
(meatal and FN strictures, penile, bulbar and panurethral strictures)

POSTERIOR URETHRAL STRICTURES/STENOSES
(post-pelvic fracture disruptions, radiation-induced strictures / stenosis, bladder neck contractures)

ADULT HYPOSPADIAS

POSTERIOR URETHRAL COMPLICATIONS OF PROSTATE CANCER TREATMENTS

MALE URINARY INCONTINENCE

PENILE RECONSTRUCTION

PEYRONIE'S DISEASE
(plication, graft corporoplasty, penile implants)

OTHER PENILE DEFORMITIES
(micropenis, buried penis, etc)

GENITAL TRAUMA
(following penile cancer amputation, iatrogenic causes and accidents)

ERECTILE DYSFUNCTION
(surgical, medical and other conservative treatments)

Pre-37th SIU
SEMI-LIVE Surgery
Workshop on Genitourethral Reconstruction

Internacional Faculty

Allen Morey

Department of Urology, University of Texas Southwestern Medical Center, Dallas, TX, USA

Allen F. Morey, MD, FACS is a graduate of Lafayette College and is a member of the Alpha Omega Alpha Honor Medical Society at the Uniformed Services University of the Health Sciences, where he completed his M.D. degree in 1987. After finishing Urology residency at Tripler Army Medical Center in Honolulu, Hawaii, in 1993, he went on to complete a two-year fellowship in Reconstructive Urology and Trauma at the University of California San Francisco under the direction of Dr. Jack McAninch.
In 2007 Dr. Morey joined the faculty of the Department of Urology at the University of Texas Southwestern Medical Center, where he is currently Professor. He is the holder of the Distinguished Chair in Urologic Reconstruction, in honor of Allen F. Morey, M.D. and the Paul C. Peters, M.D. Chair in Urology. He established and directs the successful UTSW fellowship program in Urologic Trauma, Reconstruction, and Prosthetics. Dr. Morey was the 2013 President of the South Central Section of the AUA and the 2014 President of the Society of Genitourinary Reconstructive Surgeons (GURS). He has been the Chair of the AUA Urotrauma Guidelines Committee and Director of the AUA Annual Review Course. Dr. Morey won the 2016 AUA Distinguished Contribution Award. He has been a contributing editor for the Journal of Urology for 12 years and has published over 200 peer reviewed articles.

Andre van der Merwe

Division of Urology, Stellenbosch University and Tygerberg Academic Hospital, Cape Town, South Africa

Andre van der Merwe is an Associate Professor of Urology at Stellenbosch University and Tygerberg Academic Hospital, Cape Town, South Africa. He is Head of the Division of Urology. He obtained his primary medical degree form Stellenbosch University in 1993 and studied in the United Kingdom to obtain the MRCS (London) and MRCS (Edinburgh) in 1999. He qualified as Urologist in 2003 with the Fellowship of the College of Urologists of South Africa, FC (Urol) SA. He obtained his MMEd Urology degree completing a research project on gunshot wounds to the male external genitalia. He did a Master's degree in Clinical Epidemiology in 2013 and 2014, MScClinEpi, at Stellenbosch University. He heads a dynamic unit of multitalented urologists making a large and diverse impact on research and patient care in his region and beyond. His special interests are PCNL, reconstructive urology and renal transplantation. He is known for leading the team that performed the world's first and third penis transplantation. He published more than 40 articles, he is editor of one book and several book chapters.

Anna Lawrence

Auckland Hospital and Spinal Unit, Auckland, New Zealand

Anna Lawrence is a New Zealand trained Urologist specialising in Functional Urology, Neuro-Urology, Pelvic Reconstruction, and Urethroplasty.
After finishing her Medical training at the University of Otago, Anna has worked in many areas of medicine around New Zealand including Wellington, Invercargill and the West Coast of New Zealand. Anna trained in Urology in New Zealand and was accepted into the prestigious Society of Urodynamics, Female Pelvic Medicine, and Urogenital Reconstruction Fellowship at the University of California, and was offered a permanent position there but missed New Zealand far too much to stay long-term. During her time in California, she gained exemplary skills in Neuro-Urology (Spina bifida, MS, Parkin-

son's disease), Neuro-modulation (Interstim and Tibial Nerve Stimulation), and Male Incontinence which is unique to New Zealand. She is the only fellowship trained urethral reconstruction surgeon in Auckland. After her fellowship in the US, Anna worked with Dr Sanjay Kulkarni in Pune, India, where she acquired significant experience in modern techniques of urethroplasty, with the mentorship from Dr Kulkarni, Dr Barbagli and Dr Morey, some of the world's current urethroplasty leaders. She has been involved with workshops of the Society of Genitourinary Reconstructive Surgeons in Pune, India, and has been invited to present to her Reconstructive Urological colleagues at internationally renowned conferences. Anna has been actively involved in clinical research and has presented nationally and internationally. She is also a current reviewer of Reconstructive Urology journal articles.

Anthony Mundy

University College London Hospitals, Institute of Urology, London, UK

Anthony Mundy is Professor of Urology and Medical Director at University College London Hospitals NHS Foundation Trust. He trained in surgery and urology at Guy's Hospital, London and became a consultant urologist there in 1981. He was made Professor of Urology in 1989 and moved to the Institute of Urology and UCLH in 1995. His surgical practice is devoted to reconstructive urology principally for the management of urethral stricture disease, iatrogenic trauma and complex urinary incontinence; and, other than complex urethral surgery his main activity these days is dealing with the posterior urethral complications of the treatment of prostate and other pelvic cancers. He has been visiting professor 46 times, has 281 publications and has given 696 presentations to learned societies. He also travels abroad widely to operate. He is a past member of Council of the Royal College of Surgeons of England, past President of the British Association of Urological Surgeons, past member of the Board of the European Association of Urology, past President of the Genitourinary Reconstructive Surgeons. He is Honorary President of the European Association of Urological Reconstructive Surgeons and President of the British Association of Genitourinary Reconstructive Surgeons.

Argimiro Collado Serra

Fundación IVO, Valencia, España

Argimiro Collado graduated from Medical School in 1993 at University of Navarra (Spain). He obtained his PhD from University Autonoma of Barcelona (Cum Laude) thru a thesis regarding Infravesical Obstruction and Acute Urinary Retention – Detrusor's Morphometric Evaluation and Urodynamic Correlation. He obtained his Urology Specialty training at Fundacion Puigvert (Barcelona). He has been the Chief of Functional Urology Unit at Fundacion IVO, Valencia, since 2004 and has been Assistant Professor of Physiotherapy Degree at CEU University Cardenal Herrerra since 2013. He is a Member of the Editorial Board and reviewer for Archivos Españoles Urologia. He is also a reviewer of Journal of Urology. He has also been involved with several clinical trials in urologic oncology and functional urology. He received the best poster award at the Male Incontinence Section at the 28th Annual European Association of Urology (Milan, 2013) for "Intensive Preoperatory Pelvic Floor Muscle Training Reduces Duration and Severity of Stress Urinary Incontinence after Radical Prostatectomy: a Randomized Controlled Trial". He has been invited speaker at the International Continence Society in 2015 in the Workshop: Improving Continence Before and After Radical Prostatectomy. He was Director of several training proctorships at National Spanish Urology Meeting (2012, 2013, 2014) regarding functional outcomes optimization after radical prostatectomy. He has co-authored book chapters, and has published several manuscripts in national and international journals. His latest publication was in Neurourology and Urodynamics and titled "Prospective Follow-up Study of Artificial Urinary Sphincter Placement Preserving the Bulbospongiosus Muscle".

Daniela Andrich

University College London Hospitals, Institue of Urology, London, UK

Daniela Andrich is a Consultant Reconstructive Urological Surgeon with special interest in all aspects of urethral stricture disease, the surgical management of male and female incontinence and the repair of iatrogenic urological injury such as urinary fistulae or bladder neck contracture which affects patients after various prostate cancer treatments or radiotherapy. Daniela's research interest is the prevention of iatrogenic injury of the lower urinary tract. She is the founder of Urethrotech™ Ltd which has patented and developed a new Urethral Catheterisation device (UCD)™ for difficult male urethral catheterisation to prevent urethral trauma. Daniela works at the Institute of Urology, University College London Hospitals NHS Foundation Trust (UCLH) and HCA-London Bridge Hospital. Since 2007 Daniela is the organiser of the annual 'Masterclass' of Genitourethral Reconstructive Surgery at the Institute of Urology, UCLH, and is participating regularly in other international live-surgery workshops and is a regular speaker at international urological meetings. Daniela is a Fellow of the Royal College of Surgeons of England and holds a Masters of Science degree of University College London (UCL). She is past President of the Society of Genitourinary Reconstructive Surgeons (GURS).

Dmitriy Nikolavsky

Reconstructive Urology Unit, Upstate University Hospital, Syracuse, NY, USA

Dmitriy Nikolavsky earned his medical degree from Wayne State University School of Medicine in 2005 after completing his Bachelor's degree in Biochemistry at University of Detroit Mercy in 2000. He completed his internship in General Surgery in 2007 and subsequently his residency in Urology in 2011, both at William Beaumont Hospital in Royal Oak, Michigan. He went on to train at the University of Colorado as a fellow in genitourinary reconstruction in 2011. He then joined the faculty at SUNY Upstate Medical University in Syracuse, NY with an appointment as Assistant Professor in Urology and Director of Reconstructive Urology in 2012. In March 2017, he was promoted to Associate Professor in Urology at SUNY Upstate Medical University. Dr. Nikolavsky runs a busy practice that focuses on reconstructive urology. His clinical interests include urethral reconstruction, fistula, male incontinence and correction of complications of transgender surgery. He holds a wide array of research interests, encompassing both clinical and patient-reported outcomes of urologic reconstruction, and development of novel techniques for urethral and ureteral reconstruction. He is working in collaboration with several centers in the US and worldwide on projects ranging from bench research to clinical outcomes studies. Dr. Nikolavsky is a member of the Societe Internationale d'Urologie (SIU), American Urological Association (AUA), Society of Genitourinary Reconstructive Surgeons (GURS) and World Professional Association for Transgender Health (WPATH). Since 2012, he has served as the Program Director/AUA Liaison for the Russian Language Session at the AUA annual meeting.

Ervin Kocjancic

University of Illinois, Chicago Medical Center, Chicago, IL, USA

Ervin Kocjancic, MD, obtained his medical degree from the University of Trieste, Italy, and did his Urology Residency at the University of Milan, Italy. He is an Associate Professor of Urology, the Director for the Division of Pelvic Health and Reconstructive Urology and the Director for the Urology Residency Program at University of Illinois at Chicago. He is also the Vice Chairman for the college's Department of Urology. Dr. Kocjancic is a world-renowned expert in pelvic health, urinary incontinence and reconstructive urology, working with male and female patients. He joined the Department of Urology in the University of Illinois in 2009. He often works with patients who have already had multiple surgeries and specializes in building new bladders. His

research focuses on urogynecology, pelvic health and reconstructive urology and pelvic floor and incontinence surgery. He has also presented more than 200 papers, lectures and abstracts internationally and has taught and practiced throughout Italy, where he received his medical and urologic training at University of Trieste and University of Milan. Recently, he received the Lawrence S. Ross, MD Professorship in Urology, which will allow him to continue his research in the field of medical therapy for overactive bladders and new procedures for incontinence. In 2013, he was named the Urology Department's Faculty of the Year and the Journal of Urology's Reviewer of the Year in the section for female urology, urodynamics and incontinence, and also the Urology Department's Faculty of the Year Award. He has received numerous awards and citations for presentations, research, and teaching. He has presented more than 200 papers, talks, and abstracts internationally, and has taught and practiced throughout Italy. He speaks eight languages, including Italian, Spanish, Slovenian and Croatian, which has allowed him to better serve patients from Chicago's large international community. Dr. Kocjancic is involved in many international medical and service organizations. He serves on the editorial board of the International Urogynecology Journal, was chair of the Education Committee of the INUS International Continence Society and is Board member of International Neurourology Society.

Frank Burks

Department of Urology, Oakland University William Beaumont School of Medicine. Trauma and Reconstructive Urology, Royal Oak, Michigan, MI, USA

Frank Burks received his Bachelor of Arts degree (cum laude) from The University of Missouri-Columbia and medical degree from the University of Oklahoma College of Medicine. He completed his internship and Urology residency at William Beaumont Hospital, with continued fellowship training in Trauma and Urologic Reconstructive Surgery at Detroit Receiving Hospital. Dr. Burks provides expertise in the management of urologic trauma and complex urologic reconstruction including the surgical treatment of urethral stricture disease, erectile dysfunction and incontinence. He has multiple peer-reviewed publications on voiding dysfunction, neuromodulation of the lower urinary tract and management of urethral stricture disease and urologic trauma. He is an active member of the American Urologic Association and Société Internationale d'Urologie and has travelled nationally and internationally to scientific meetings and as an expert in the field of urethral stricture disease and urologic trauma.

Guido Barbagli

Center for Reconstructive Urethral Surgery, Arezzo, Italy

Guido Barbagli was born January 22, 1950, in Pieve Santo Stefano, Arezzo, Italy, a small village founded during the Roman Empire and located near Sansepolcro, where the painter Piero della Francesca was born, and near Caprese Michelangelo, where the artist Michelangelo was born. He attended Medical School and discussed his thesis on "The role of inflammatory changes of the prostate in the male sterility", with the Director of the Urologic Clinic of the University of Florence, Italy. In 1979, Dr. Barbagli completed his internship in Urology. In October 1982, he obtained a Postgraduate Degree in Urology from the Urology Postgraduate Department of the University of Florence, Italy, receiving the highest marks in his class cum laude. Currently, he is the Director of The Center for Reconstructive Urethral Surgery, which he founded in March 1999 in Arezzo, Italy and Scientific Director of the "Centro Chirurgico Toscano "Hospital, in Arezzo, Italy. He has published 126 articles in international scientific journals, 5 books on reconstructive urethral surgery and 6 chapters in books on reconstructive urology. He is active member of the following scientific societies: American Urological Association (AUA), Société Internationale d'Urologie (SIU), European Association of Urology (EAU), Arab Association of Urology (AAU), Società Italiana di Urologia (SIU). Currently, Dr. Barbagli acts as a referee for numerous scientific journals. He has been a participant and invited keynote speaker to numerous International Meetings and Congresses. He was appointed President of The Society of Genitourinary Reconstructive Surgeons (GURS)" for the period of 2008 - 2009. Currently, he holds a limited-term position as Professor at the Postgraduate School of Urology – Department of Urology - University Vita Salute-San Raffaele, Milan, Italy. Since October

2011, he has been the Director of the Educational "Live" Courses on Reconstructive Urethral Surgery by internet streaming. In May 2015, He was appointed as Visiting Professor, for three years, at the Shanghai Jiao Tong University School of Medicine in Shanghai, China. In 2015, Dr. Barbagli was appointed as Permanent Professor at the I.M. Sechenov First Moscow State Medical University in Moscow, Russia.

Jaspreet Sandhu

Pelvic Urologic Reconstruction and Voiding Dysfunction Unit, Memorial Sloan-Kettering Cancer Center, New York, NY, USA

Jaspreet S. Sandhu is an Associate Attending Urologist within the Department of Surgery (Urology Service) at Memorial Sloan Kettering Cancer Center and Associate Professor of Urology at the Weil Cornell Medical College. He graduated from Duke University and after spending five years as an engineer in the telecommunications industry, obtained his medical degree from Wake Forest University School of Medicine. He completed his residency training at New York Presbyterian Hospital/Weill Cornell Medical Center and received a fellowship in voiding dysfunction at Columbia-Presbyterian and Weill-Cornell Medical Centers. Dr Sandhu is an active member of the American Urological Association and the Society for Urodynamics and Female Urology and has been involved as a faculty member or invited speaker at a number of national and international symposia. His primary interest is to understand, predict, prevent, and treat voiding dysfunction or urinary incontinence caused by cancer or its treatments, with a focus on the treatment of male and female incontinence, and urinary tract/pelvic reconstruction. Dr. Sandhu also has a strong interest in the surgical treatment of benign prostatic hyperplasia and voiding dysfunction caused by advanced cancers. He has been active in the Society of Urodynamics, Female Pelvic Medicine, and Urogenital Reconstruction, the Society of Genitourinary Reconstructive Surgeons, and the American Urological Association. Dr. Sandhu has participated in multiple international meetings and has authored over 100 peer reviewed manuscripts, review articles, and book chapters. In his free time, Dr. Sandhu enjoys basketball – as all others who attended Duke, he roots for his alma mater every year in college basketball, travel with his wife and two boys, and spending time with friends.

Javier Angulo

Department of Urology, Getafe University Hospital, European University of Madrid, Madrid, Spain

Javier Angulo is Professor of Urology at the Universidad Europea de Madrid (Laureate Universities), Hospital Universitario de Getafe, Madrid. Born in Baracaldo (Basque Country, Spain) in 1964, he graduated in Universidad del País Vasco (UPV/EHU), did his residency training in Hospital de Basurto (Bilbao, Spain) and carried out his fellowship training in urologic oncology at Harper Hospital, Wayne State University (Detroit, MI, EEUU). He received his Doctorate Award from Universidad del País Vasco for his Thesis on the prognosis of bladder carcinoma in 1992. He obtained his title of Fellow of the European Board of Urology (Union Européenne des Médecins Spécialistes) in 1994. Master on Medical and Health Management in 2009. He was Chief of Urology in Hospital Universitario de Getafe (2008-2015) and Director of Actas Urológicas Españolas (2011-2014). He was Chair of Scientific Activities in Confederación Americana de Urología (CAU) (2014-2016). He is Board Member of the European School of Urology (ESU), Education Office of the European Association of Urology. He acted as Investigator in 24 research projects and authored 333 articles, 268 indexed and 62 in Q1-Q2 journals, H-index 23. He is author and editor of more than 20 books, principal investigator in more than 30 Phase 2-3 clinical trials and author of more than 500 communications in scientific meetings. His main interests include surgical oncology (bladder and prostate), reconstructive surgery, incontinence, overactive bladder, pharmacoeconomics, history and medical education. He lives with his wife and two sons in Madrid and is fond of Anthropology and Paleolithic Art.

Joan Caparrós

Reconstructive Urology Unit, Fundació Puigvert, Barcelona, Spain

Joan Caparrós obtained his Medical and Surgical Degree from the Faculty of Medicine, University of Barcelona. He is a Specialist in Urology and, is responsible for the Urologic Reconstruction Unit in Fundació Puigvert. His main areas of professional interest focus on adult male urethral surgical reconstruction. He is member of the Asociación Española de Urología. He is author of numerous presentations in national and internacional meetings. He is also author of several book chapters published in Spain and North America, and has also several publications in national and international journals and periodicals.

Joel Gelman

The Center for Reconstructive Urology, University of California, Irvine, USA

Joel Gelman is a Professor of Urology and the Director of the Center for Reconstructive Urology in the Department of Urology at the University of California, Irvine. He completed his Urology Residency at the UCLA Medical Center in 1995 and a Fellowship in Adult and Pediatric Male Genitourinary reconstruction at the Devine Center in Norfolk, Virginia under Dr. Gerald Jordan in 1997. He has performed over 1800 urethral-penile reconstructive surgeries, and his practice has always been limited to his area of expertise in male urethral and penile/genital reconstructive surgery with a focus on urethral stricture disease and penile-scrotal surgery. Dr. Gelman is the Director of a GURS approved Fellowship in Male GU Reconstruction at UC, Irvine, and his research interests include both clinical research in urethral stricture disease and Tissue Engineering basic science research. He has presented and published numerous papers on the subject of male reconstructive surgery, including new surgical techniques for urethroplasty, and has served on the Board of Directors of the GURS.

Justin Chee

Epworth Freemasons Medical Centre, Edgewater Urology, Melbourne, Australia

Justin Chee obtained his undergraduate degree from the University of Melbourne in 1997 after which he began his career in surgery. Dr Chee commenced his Urology training in 2006, becoming a Fellow of the Royal Australasian College of Surgeons FRACS (Urology) in 2011. He then pursued extensive overseas training with the world's top urethroplasty surgeons, including Professor Sanjay Kulkarni in India, and Professor Guido Barbagli in Italy. He is a fully qualified Urologist dedicated to excellence in reconstructive surgery of the genitourinary system. Renowned for his innovation and collaboration, Justin takes a multidisciplinary and holistic approach to ensure his patients achieve the best possible outcome. He holds the following qualifications and titles: MBBS University of Melbourne, FRACS Urology, and Post-Graduate Diploma in Surgical Anatomy University of Melbourne. His professional interests are: Reconstructive Urology, Urethral reconstruction for urethral stricture disease, Male Urinary Incontinence/Erectile Dysfunction, Minimally invasive BPH therapy/Microsurgical Vasectomy reversal, and Complex genitourinary reconstructive surgery. He is active member of The Royal Australasian College of Surgeons (RACS), The Urological Society of Australia and New Zealand (USANZ), The American Urological Association (AUA), The Societe Internationale d'Urologie (SIU), The Society of GenitoUrinary Reconstructive Surgeons (GURS) – Current Board of Director Member, The Society of Urologic Prosthetic Surgeons (SUPS). Currently, he is Consultant Urologist at Alfred Hospital, Austin Health, Royal Melbourne Health, Western Health and Epworth Health. He is Founding Medical Director, MURAC Health focusing on Male Urogenital Reconstruction & Aesthetics.

Krishnan Venkatesan

Department of Urology, MedStar Washington Hospital Center, Washington, DC

A native of Detroit, Krishnan completed his undergraduate studies at Columbia University in the City of New York before returning home for medical school at Wayne State University. He stayed on at Wayne State for his residency in Urology which he completed in 2010. He then undertook a fellowship in Genitourinary Reconstruction at the Institute of Urology at University College London and went on to Pune, India to pursue further fellowship training in complex urethral reconstruction at the Kulkarni Urethral Reconstruction and EndoSurgery Institute, and was a Visiting Fellow in Urologic Reconstruction at the Sava Perovic Foundation in Belgrade, Serbia. Krishnan then moved to Washington, DC to become the Director of Urologic Reconstruction at MedStar Washington Hospital Center, a 900-bed urban tertiary care and trauma center. He holds Assistant Professorship in the Georgetown University Department of Urology and participates actively in resident training. Over his 5 years in Washington, he has developed the Reconstructive Unit into a referral center for complex genitourinary reconstruction and prosthetics throughout the Mid-Atlantic Region. He has had his work presented at the regional and national level, and has co-authored numerous publications in the urologic reconstruction subspecialty. His most recent highlight was being given the Resident Teacher of the Year Award for 2017. He currently works in Washington, DC and specializes in Reconstructive Urology. He is a member of the American Association of Physicians from India, American Medical Association, American Urological Association and the Society of Genitourinary Reconstructive Surgeons. He has numerous publications, abstracts and editorials, and has presented throughout the United States on various urology topics. He has received several awards for his work. He is fluent in English and Tamil (South India) and proficient in Portuguese and Spanish.

Margit Fisch

Department of Urology, University of Hamburg-Eppendorf Medical Center, Hamburg, Germany

Margit Fisch (F.E.B.U., F.E.A.P.U.) trained with Prof. Rudolf Hohenfellner in Mainz, Germany. Her major scientific interest was and is reconstructive urology, especially urethral reconstruction and urinary diversion. In cooperation with the Center of Urology and Nephrology in Mansoura, Egypt, and the University College in Dublin, Ireland, she did major contributions on ureteral implantation techniques and forms of urinary diversion like the “Sigma-rectum Pouch and the “Transverse Colonic Pouch”. In 2000, she moved to Hamburg and 2 years later became Director of the Dep. of Urology and Pediatric Urology at the AK Harburg. Since 2008 she has served as Director and Chair of the Deaprtment of Urology and Pediatric Urology at the University Medical Center Hamburg-Eppendorf, Germany. Margit Fisch was president of the Society of Genito- Urinary Surgeons (GURS) and the European Society of Genito-Urinary Surgeons (ESGURS). She is a member of the American Association of Genito-Urinary Surgeons (AAGUS) and the Society of Pelvic Surgeons (SPU). She organizes every three years the International Meeting on Reconstructive Urology (IMORU). Another field of her clinical interest is pediatric urology. She is member of the European Association of Pediatric Urology (ESPU) and the Society of Pediatric Urologic Surgeons (SPUS). She is Board Member of the Ralph Hopkins Jackson Hole Seminars and Scientific Chair of the Societé Internationale d`Urologie (SIU).

Miroslav Djordjevic

Department of Pediatric Urology, University of Belgrade Medical Center and Belgrade Center for Genital Reconstructive Surgery, Belgrade, Serbia

Miroslav Djordjevic is a Professor of Urology and Surgery at the School of Medicine, University of Belgrade, Serbia. He completed his medical studies, including his urology residency, at School of Medcine, University of Belgrade, Serbia. He continued his professional education at numerous universities world-wide, but the greatest impact on his professional

education was experience obtained by working with Professor Sava Perovic, who was one of the best urologic reconstruction experts. Dr Djordjevic published numerous papers on the surgical treatment of hypospadias, epispadias, Peyronie's disease, adult hypospadias, buried penis, urethral reconstruction, pediatric reconstructive urology, penile enhancement surgery as well transsexual surgery. In his long and fruitful career, he achieved his greatest results in the field of urogenital reconstructive surgery, as one of the rare in the world to have encompassed treatment of all anomalies of the genital system regardless of gender or age. He is a member of numerous urological and surgical associations (ESPU - European Society of Pediatric Urology, AAP - American Academy of Pediatrics, AUA - American Urological Association, EAU - European Association of Urology, SIU - International Urological Association, GURS - Society for Genitourinary Reconstructive Surgeons, DGU - German Urological Association, AAPS - American Academy of Phalloplasty Surgeons, WPATH - World Professional Association for Transgender Health, IVU - International Volunteers in Urology), and he received numerous research awards and honours, including awards given by the European Association of Urology, German Urological Association and the European Society for Sexual Medicine. He is the leader of the Belgrade Center for Genital Reconstructive Surgery which is well-known for education for colleagues from around the world. His great experience in sex reassignment surgery resulted in new knowledge of the surgical anatomy of the male and female genitalia. Since2016, he has been Member of The Center for Transgender Medicine and Surgery, Mount Sinai Hospital, New York, NY, USA, and Member of Mount Sinai's International Teaching Faculty.

Nicolaas Lumen

Department of Urology, Ghent University Hospital, Ghent, Belgium

Nicolaas Lumen is currently Associate Professor in Urology (Ghent University) and Head of Clinic, Department of Urology (Ghent University Hospital, Ghent, Belgium). Born on 28/12/1977, Ghent, Belgium, Nicolaas obtained his Medical Degree with the Greatest Honour in the University of Ghent, Faculty of Medicine and Health Sciences in 1995. He did his General Surgery training at O.L.V.-Van Lourde Kliniek Waregem between 2002 and 2004 and Urology Residency in the University of Ghent between 2004 and 2008. Then he moved on to O.L.V.-Ziekenhuis Aalst to pursue a Fellowship on Robotic and Laparoscopic Urology. He has been a Certified Urologist in August 1, 2008. He has also been Fellow of the European Board of Urology (FEBU) since 2007/2008. He currently holds several Board positions, specifically at the Scientific Secretary of the Belgian Association of Urology (Flemisch Section, BVU), Board member of the European Society of Genito-Urinary Reconstructive Surgeons (ESGURS), Panel member of the Guidelines Office European Association of Urology (urological trauma panel). He defended a PhD thesis on "Optimising treatment of male urethral stricture disease." In 2010). He is Principal or co-investigator of phase II and III clincal trials on uro-oncology, BPH and overactive bladder. His main areas of interest are: reconstructive urology, transgender surgery, and uro-oncology (prostate cancer).

Omar Soto-Avilés

The Center for Urologic Reconstruction, Detroit Medical Center, Michigan State College of Medicine, Detroit, MI, USA

Omar E. Soto-Avilés is a board-eligible urologist. He graduated with magna cum laude honors from University of Puerto Rico School of Medicine. Dr. Soto-Avilés completed his surgical and urological training at the University of Puerto Rico, where he served as Chief Resident. He then continued to pursue a one-year fellowship in Reconstructive Urology and Trauma at the Detroit Medical Center under the direction of Dr. Richard A. Santucci. Dr. Soto-Avilés' clinical interests are mainly in reconstructive urology and trauma, including urethral stricture disease, ureteral injury and spinal cord injury. Dr. Soto-Avilés also has an interest in resident surgical education. He currently serves as a clinical instructor at the Michigan State College of Osteopathic Medicine and participates in urology resident education on a daily basis.

His special areas of major interest are: Reconstructive Urology and Trauma, including Urethral Stricture Disease, Ureteral Injury and Spinal Cord Injury, Voiding Dysfunction and Urinary Incontinence. He is a member of the following associations: American Urological Association (AUA), Societé Internationale D'Urologie (SIU), Society of Genitourinary Reconstructive Surgeons (GURS), Puerto Rico Urological Association (PRUA). DMC Hospital Affiliation: Harper University Hospital, Detroit Receiving Hospital.

Paksi Satyagraha

Saiful Anwar General Hospital, Medical Faculty Brawijaya University, Malang, Indonesia

Paksi Satyagraha MD, is an Indonesian Urologist specializing in Genitourinary Reconstruction. He graduated from Padjajaran University Bandung for his Medical Doctor Degree in 2004. He continued taking a Master Degree in Microbiology in 2006. He started his urology residency program at Airlangga University Surabaya and finished at 2012. During the early years of his career, his interest in genitourinary reconstruction and stone disease grew; he then attended postgraduate training program at Kulkarni Center in Pune, India to intensify his passion in urogenital reconstruction in 2013. He has also visited several international centres of excellence as clinical observer in some countries. He is now working as Urologist at Department of Urology Saiful Anwar General Hospital/Faculty of Medicine Brawijaya University, Malang Indonesia, and established one of the few referral centres in genitourinary reconstruction surgery in Indonesia. In 2016, he was appointed as vice president of Indonesian Genitourinary Reconstructive Society (InaGURS), and member of SIU, ISSM/APSSM, EAU and AUA.

Pankaj Joshi

Kulkarni School of Urethral Surgery, Endosurgery Institute, Pune, India

Pankaj Joshi is a Reconstructive Urologist working with Dr Sanjay Kulkarni at the Kulkarni Reconstructive Urology center, Pune, India. Young, 38, Pankaj completed his medical graduation from Medical colleges at Mumbai and then migrated to Pune in 2007.He achieved his super specialty degree in Genitourinary Surgery and was awarded the H S Bhat Gold Medal for standing first in the Country, 2010. The award was given from the Office of "The President of India". He joined Dr Sanjay Kulkarni in 2010 having the zeal to learn urethra and has been working under him since then. He has contributed to more than 15 Publications on urethroplasty such as panurethral strictures, Complex posterior urethroplasty and novel 2-stage technique for penile urethral strictures. His latest contribution to new point of technique of MRI in Pelvic fracture urethral injuries is valuable. He has developed his own indigenous retractor for Hypospadias and Penile urethral surgery dedicated to his Guru Dr Sanjay Kulkarni. Pankaj has contributed to Live Urethroplasty workshops under the able guidance of Dr Kulkarni at Pune, various places in India and abroad like Qatar, Nepal, Kenya, and Indonesia. He has been faculty at National and International meetings latest being on the Plenary at AUA, Boston. He has won best poster and best paper awards for his department at the Annual meetings of Urology society of India. He has contributed to book chapters in Reconstructive Urology. He was nominated to serve on the Board of Directors, GURS in 2016 at San Diego. He is a valuable friend to many in the Reconstructive Urology group across the world.

Renaud Vautherin

Urologist at Clinique Trenel, France

Renaud Vautherin grew up in Lyon, France and attended the Medical School of Lyon, earning his medical degree in 1987. He completed an extensive internship at the University Hospital of Lyon in the department of general surgery and received his urological training at the same University Hospital, which he completed in 1993. From there he enrolled in the French army, serving in the Urology Department at the Val de Grace Hospital, Paris. Then he joined the Pediatric Urology Departement of Hôpital Debrousse in Lyon and the Urology Department of Lyon-Sud University Hospital. Dr Vautherin received the Antonin Poncet award in experimental surgery in 1993 and he has been certified in Urologic Oncology. Dr. Vautherin's clinical focus is on the management of urologic cancers and minimally invasive surgery. His other interests include the treatment of

kidney stone disease, and voiding dysfunction. His research interests include kidney stone treatment, male and female incontinence as well as urologic oncology. Dr. Vautherin has been a board member of the French Association of Urology (AFU) since 1995 and in 1996 he joined the Urology Department at Clinique Trenel in Sainte-Colombe, France.

Sanjay Kulkarni

Kulkarni School of Urethral Surgery, Pune, India

Sanjay Balwant Kulkarni MS, FRCS (Glasgow), Diploma Urology (London) is a nationally and internationally recognized expert in urethral reconstruction. He underwent Urology training in England from 1981-86. He was trained by Mr Richard Turner Warwick, considered as father of urethral reconstruction. Dr Kulkarni returned to motherland India to serve the people of our country. Dr Kulkarni established Centre for Reconstructive Urology in 1995. He along with his wife Dr. Jyotsna Kulkarni was pioneer in introducing Laparoscopy in India. The centre has two main specialties, Reconstructive Urology and Laparoscopy. Dr Sanjay and Jyotsna Kulkarni started India's first animal lab for teaching Laparoscopy to surgeons in. The centre performs one of the largest number of Genito-Urinary Reconstructive Surgeries in the world today. The centre is ethical and no patient is denied surgery for economic grounds. Dr Kulkarni has one of the largest series of urethroplasties in the world. Kulkarni School of Urethral Surgery (Established 2006). The centre is engaged in permanent educational activities for urologists who are interested in the in-depth training in reconstructive urethral surgery. We conduct an operative workshop on a weekend once every month where about 8-10 Urologists from India and abroad come in OR and watch surgeries LIVE. Kulkarni school of urethral surgery is very popular amongst the urologists. This is a purely academic activity with no registration fees.

Sean Elliott

Department of Urology, University of Minnesota Medical Center, Minneapolis, MN, USA

Dr. Sean Elliott is Professor and Vice Chairman of the Department of Urology and Director of Reconstructive Urology at the University of Minnesota. He attended medical school at Baylor College of Medicine and completed a urology residency and fellowship in reconstructive urology at the University of California-San Francisco. He completed an M.S. in outcomes research at the University of Minnesota. He is the Secretary-Treasurer of the Society of Genitourinary Reconstructive Surgeons. His clinical practice is focused on neurogenic bladder, urinary diversion, urethral strictures and male urinary incontinence. His research interests include outcomes in urethroplasty, the adverse effects of radiation and urinary quality of life outcomes in spinal cord injury. He is a founding member of two collaborative research groups: the Trauma and Urologic Reconstruction Network of Surgeons and the Neurogenic Bladder Research Group His research has been funded continuously since 2009 by the NIH, the American Cancer Society, the Patient Centered Outcomes Research institute and the Department of Defense.

Steven Brandes

Reconstructive Urologic Surgery, New York Presbiterian/Columbia University Medical Center, NY, USA

Steven Brandes is Professor of Urology at Columbia University Medical Center and Chief of Reconstructive Urologic Surgery. Dr. Brandes, a thought leader in urologic reconstructive surgery and trauma, leads the Center for Reconstructive Surgery at Columbia University in New York. Dr. Brandes is a Chicago native, who graduated from the Mount Sinai School of Medicine in New York, and completed his General Surgery and Urology Residency training at Temple University in Philadelphia. He subsequently completed a fellowship in Reconstructive Urology and Trauma at University of California San Francisco. Prior to his recent move to Columbia University in New York, Dr. Brandes, spent 17 years at Washington University and Barnes-Jewish

Hospital in St. Louis where he served as Chief of the Section of Reconstructive Urology, Urology Residency Program Director, Chief of Urology at the St. Louis VA medical Center, and Director of the Reconstructive Urology Fellowship. Dr. Brandes is the author of two textbooks in urologic reconstructive surgery and has authored more than 100 peer reviewed publications and book chapters. He was recently the Vice Chair of the Urotrauma Legislative Task Force, the Co- Chair of the AUA Urologic Trauma Guidelines Committee and President of the Society of Genitourinary Reconstructive Surgeons.

Tobias Köhler

Department of Urology, Mayo Clinic, Rochester, MN, USA

Tobias S. Köhler, Professor of Urology, specializes in the treatment of erectile and sexual dysfunction, and BPH (enlarged prostate) in the Department of Urology at the Mayo Clinic in Rochester, MN. He received both his undergraduate and medical degrees from the University of Minnesota in Minneapolis. He completed a Masters of Public Health in Epidemiology. He then completed his urology residency training at the University of Minnesota. This was followed by an andrology fellowship at Northwestern School of Medicine in Chicago. Dr. Köhler spent the first nine years of practice at Southern Illinois University School of Medicine in Springfield, Illinois before matriculating back to his home state of Minnesota. Dr. Köhler is an active member of American Urological Association, North Central Section, and the Sexual Medicine Society of North America. He has published more than 150 peer reviewed scientific articles, book chapters and scientific abstracts and presented both locally and nationally on various subjects including erectile dysfunction, low testosterone, BPH, surgical education, and penile prostheses. He was co-editor for both textbooks "Contemporary Treatment of Erectile Dysfunction – 2nd Edition" and "Surgeons as Educators, A Primer for Academic Development & Teaching Excellence". He was nominated for the AUA Golden Cystoscope award by the North Central Section in both 2015 and 2016 and has received numerous awards and recognition for his research and teaching excellence.

Nacional Faculty

Francisco Martins

Department of Urology, University of Lisbon, School of Medicine, Hospital Santa Maria/CHLN, Lisbon, Portugal

Francisco Martins obtained his Medical Degree at the Faculty of Medicine, University of Lisbon in 1983 - Medical License nº 27411. After completing his Urology Residency Training in the Department of Urology, Hospital de Pulido Valente in Lisbon in 1992, he then moved on to engage in a 1-year Post-Doctoral Fellowship in Erectile Dysfunction, Neuro-Urology and Reconstructive Surgery in the University of Southern California, Los Angeles, with the mentorship of Donald Skinner and Stuart Boyd in the academic year of 1993-1994. He earned his title as Specialist in Urology by the Portuguese Medical Association, College of Urology, in 1993. He visited several Urology Departments in both Europe and USA associated with Residency Exchange Programs and Postgraduate Training, including Brigham & Women's Hospital/Harvard University in Boston; Kenneth Norris Jr. Cancer Hospital, University Hospital & USC-LA County Hospital/University of Southern California (USC), Los Angeles; UCLA Medical Center and Plaza/University of California in Los Angeles; University of Massachussets Medical Center, Worcester; Medizinische Hochschule Hannover, Germany; Eastern Virginia Graduate School of Medicine, Norfolk, VA; University of North Carolina Medical Center, Chapel Hill, NC; Johannes Gutenberg University, Mainz, Germany; Gent University Hospital, Gent, Belgium; and Childrens' Hospital, University of Belgrade, Belgrade, Serbia. He has been engaged in several humanitarian outreach clinical visits in Ethiopia, Angola and Tanzania. His areas of major clinical and research interest are: Genito-urethral and Pelvic Trauma and Reconstruction, Vesicovaginal and Rectovaginal Fistula, Female Pelvic Medicine,

Erectile Dysfunction, Urinary Diversion, and Neurourolgy. He has been Consultant Urological Surgeon at Santa Maria University Hospital (2008-present date). In May 2017, he was elected to the GURS Board of Directors (Genitourinary Reconstructive Surgeons) and is member of several national and international societies and associations. He is peer reviewer for several journals, including, Acta Urológica Portuguesa, Actas Urológicas Españolas, Advances in Urology, British Journal of Medicine and Medical Research, European Urology, International Urology and Nephrology, Journal of Men's Health, Journal of Surgery, and Journal of Urology. He has presented and lectured at numerous national and international meetings, conferences and congresses and has published and co-authored over 50 articles in peer review journals, 7 book chapters and edited 1 book titled "International Book of Erectile Dysfunction" and 1 Special Issue of Advances in Urology titled "Urethral Stricture Disease: Challenges and Ongoing Controversies".

João Marcelino

Department of Urology, University of Lisbon, School of Medicine, Hospital Santa Maria/CHLN, Lisbon, Portugal

Born in Setúbal on February 8, 1968, he graduated as Medical Doctor at the Faculty of Medicine, University of Lisbon in 1993. He has been a Urology Specialist since 2002, and Fellow of the European Board of Urology since 2006. He has been Graduate Assistant in Urology since 2014. He currently works in the Department of Urology, Santa Maria University Hospital and Hospital da Luz in Lisbon. He is the author of 2 scientific publications awarded by the Portuguese Association of Urology - Abbot Prize for the best article of Clinical Research (1998) and Synthelabo Prize for the best review article (2005), among others. His main areas of interest and greater differentiation include Female Urology, Reconstructive Urethral Surgery and Urinary Stones.

Luís Costa

Department of Urology, Centro Hospitalar de Vila Nova de Gaia, VNG, Portugal

Luís Costa was born in Porto on 21 February 1974. He obtained his Medical Degree from the Faculty of Medicine, University of Porto, in 1999. He then moved to Centro Hospitalar de Vila Nova de Gaia (CHVNG) in 2002, where he finished his Residency Training in Urology in 2007. In 2008, he is nominated Assistant Urologist in the same institution, position that he still holds up to this date. He has been actively involved with educating Urology Residents since 2008. His main areas of clinical interest are: Urethral Surgical Reconstruction, Urodynamics and Neurourology, and Urologic Oncology.

Paulo Temido

Department of Urology, Centro Hospitalar e Universitário de Coimbra, Coimbra, Portugal

Paulo Temido, MD, obtained his Medical Degree from the Faculty of Medicine, University of Coimbra in 1989. He finished his Residency training in Urology in 2001 in the Department of Urology, Centro Hospitalar e Universitario de Coimbra, Coimbra, Portugal. He was appointed Urology Assistant at the same institution in 2001 and has been Urology Consultant at the same institution since 2015. In 2003, he obtained his title as Fellow of the European Board of Urology (FEBU). Currently, Dr. Temido is Member of the Executive Committee of Portuguese Association of Neuro-Urology and Urogynecology (APNUG).

Pedro Vendeira

FECSM, President of the Portuguese Society of Andrology, Sexual Medicine and Reproduction, Oporto, Portugal

Pedro Vendeira earned his Medical Degree in 1990 and his PhD in 2001. He became a Board-certified Specialist in Urology in 1999. He worked as full specialist in the Urology Department and Head of the Andrology Department in the Hospital S. João, Oporto, Portugal from 2001 to 2011. He was also Invited Professor of Molecular Cell Biology and Urology at the Faculty of Medicine of the University of Oporto until 2011. Besides his Urological/Andrological Private Practice in Oporto, Portugal, since 2000 (Saúde Atlântica - Clínica do Dragão - FIFA Medical Centre of Excellence since2014), he has also been a Consultant Urologist/Andrologist/Sexual Medicine Researcher at CETI (Advanced Center for the Study and Treatment of Infertility in Oporto since 2000, Coordinator Researcher/Associate Professor at iSEX – Association for the Advanced Study of Human Sexuality in Lisbon, Portugal since 2007, and Associate Research Member at SEXLAB (Research Group in Human Sexuality) at the Laboratory of Human Sexuality Research, Faculty of Psychology and Educational Sciences, University of Oporto since 2014. He served various functions in the Executive Board of the Portuguese Society of Andrology, Sexual Medicine and Reproduction from 2001 to 2006. He was Member of the Executive Committee of the European Society for Sexual Medicine from 2006 to 2009 and Member of the Executive Committee since 2015 (2nd nomination) until 2016. He was Editor-in- Chief of the European Society for Sexual Medicine Website (www.essm.org) from 2009 to 2016. He was also Chairman of the Education Committee of the European Society for Sexual Medicine between 2016 and 2017. He was nominated President of the Portuguese Society of Andrology, Sexual Medicine and Reproduction for the biennium 2017-2018. He has been honored as First Prize winner of the Portuguese Society of Andrology, Sexual Medicine and Reproduction Research Award four times since 1998. He has presented his studies at several national and international societies and published nearly 40 scientific articles in peer-reviewed national and international journals. He is Associate Editor of Revista Internacional de Andrologia – Salud Sexual y Reproductiva, and has been on the International Advisory Board of The Journal of Clinical Urology since 2014. He has been Full Member of the Scientific Committee of the Portuguese Association of Urology since 2013 and Vice President of the Ethical Committee of Clínica Espregueira Mendes - FIFA Medical Centre of Excellence since 2014. He has been Fellow of the European Committee of Sexual Medicine since 2012, Member of the Executive Committee of Asociación Iberoamericana de Sociedades de Andrología (ANDRO) since 2012, and Member of the Executive Committee of the Portuguese Society for Clinical Sexology since 2013. He has been on the Portuguese Medical Association Board for Medical Competence in Clinical Sexology since 2014. His main areas of interest include General Urology, Sexual Medicine, Erectile Dysfunction, Reconstructive Urology, Peyronie's Disease, Adrenal Pathology, and Medical Education.

Tomé Lopes

Department of Urology, University of Lisbon, School of Medicine, Hospital Santa Maria/CHLN, Lisbon, Portugal

Tomé Lopes earned his Medical Degree from the Faculty of Medicine, University of Lisbon in 1977 and his title as Specialist in Urology by the Ministry of Health, Hospital Career in 1987 and by the Portuguese Medical Association, College of Urology, in 1988. He became Fellow of the European Board of Urology in 1994. He worked as Consultant Urologist from 1994 to 2003. He became Chief of Urology in the Department of Urology, Hospital Pulido Valente in Lisbon in 2003. He became Director of the Department of Urology, Hospital Pulido Valente from 2006 to 2008. He served as Vice-President of the Portuguese Association of Urology (APU) from 2006 to 2010, being elected President of APU for the period of 2010-2013. He has been Invited Professor of Urology in the Faculty of Medicine, University of Lisbon since 2008. He has been Chairman of the Department of Urology, Santa Maria University Hospital since 2008. He was Co-Editor of Acta Urológica Portuguesa between 2006 and 2008 and Editor-in-Chief between 2009 and 2013. He is member of Portuguese Association of Urology (APU), Portuguese Society of Andrology (SPA), European Association of Urology (EAU), American Urological Association, and Delegate of the Endourological Society in Portugal. He has given numerous lectures and has authored numerous scientific publications in both national and international peer-review journals. He is lead investigator of several ongoing clinical trials.

Scientific Sessions

October 17, 2017

08:00am — Opening of registration desk

09:00am - 09:30am — OPENING AND WELCOME

Chairs: Carlos Martins, MD (Chairman of CHLN Council, Santa Maria University Hospital)
Tomé Lopes, MD (Director, Urology Dept., Santa Maria University Hospital)
Margit Fisch, MD (Director, Urology Dept., University Medical Center Hamburg-Eppendorf)
Sanjay B. Kulkarni, MD (Director, Kulkarni Center for Reconstructive Urology)
Francisco Martins, MD (Consultant Urologist, Urology Dept., Santa Maria University Hospital)

09:30am - 09:45am — STATE-OF-THE-ART LECTURE

Moderators: Frank Burks, Nicolaas Lumen, Andre van der Merwe and Omar Soto-Avilés

Changing practice in penile urethral reconstruction: Flaps or grafts?
Joel Gelman

09:45am - 10:25am — SEMI-LIVE SURGERIES (VIDEO DEMONSTRATIONS)

Moderators: Frank Burks, Nicolaas Lumen, Andre van der Merwe and Omar Soto-Avilés

09:45am - 10:05am — **Adult hypospadias: Differences from surgery in children**
Miroslav Djordjevic

10:05am - 10:25am — **Anterior urethral stricture I – One-stage repairs**
Guido Barbagli

10:25am - 10:50am — Coffee-break

10:50am - 11:05am — STATE-OF-THE-ART LECTURE

Moderators: Joel Gelman, Krishnan Venkatesan and João Marcelino

Changing practice of urethroplasty in Indonesia
Paksi Satyagraha

11:05am - 12:00pm — SEMI-LIVE SURGERIES (VIDEO DEMONSTRATIONS)

Moderators: Sean Elliott, Joel Gelman, Krishnan Venkatesan and João Marcelino

11:05am - 11:25am — **Anterior urethral stricture II - Staged repairs**
Margit Fisch

11:25am - 12:00pm — **Post-RP BN contracture**
Urorectal fistula repair
Tony Mundy

12:00pm - 12:15pm — STATE-OF-THE-ART LECTURE

Moderators: Sean Elliott, Jaspreet Sandhu, Anna Lawrence and Joan Caparrós

Lotus flap technique for perineal urethrostomy
Justin Chee

12:15pm - 01:15pm — SEMI-LIVE SURGERIES (VIDEO DEMONSTRATIONS)

Moderators: Jaspreet Sandhu, Anna Lawrence and Joan Caparrós

12:15pm - 12:45pm — **Panurethral stricture repair**
Urethroplasty for bulbar urethral necrosis
Sanjay Kulkarni

12:45pm - 01:15pm — **Non-transecting BU repair**
Pelvic fracture urethral injury
Daniela Andrich

01:15pm - 01:30pm	**STATE-OF-THE-ART LECTURE** *Moderators: Jaspreet Sandhu, Anna Lawrence and Joan Caparrós* **Management of Failed Repair of Complex Pelvic Fracture Urethral Injury** *Pankaj Joshi*
01:30pm - 02:30pm	Lunch break
02:30pm - 03:30pm	**STATE-OF-THE-ART LECTURES** *Moderators: Allen Morey, Justin Chee and Francisco Martins*
02:30pm - 02:50pm	**Reconstructive options for failed bulbomembranous anastomotic urethroplasty** *Tony Mundy*
02:50pm - 03:10pm	**Lessons learned during my three-decade journey around the urethra** *Guido Barbagli*
03:10pm - 03:30pm	**The evolution of urethroplasty: More than 2 millenia of history** *Tony Mundy*
03:30pm - 03:50pm	Coffee-break
03:50pm - 05:20pm	**POINT-COUNTERPOINT** *Moderators: Tony Mundy, Frank Burks and Pankaj Joshi*
03:50pm - 04:20pm	**Tissue engineering for substitution urethroplasty: Is it prime time? And why?** **Pro:** *Guido Barbagli* **Con:** *Daniela Andrich*
04:20pm - 04:50pm	**Urorectal fistula surgical repair – Perineal or non-perineal approach: Benefits and risks** **Perineal:** *Margit Fisch* **Non-perienal:** *Allen Morey*
04:50pm - 05:20pm	**Management of Panurethral Stricture disease:** **1- Stage repair with OMG vs. staged surgical options** **Single-stage repair:** *Sanjay Kulkarni* **Two-stage repair:** *Steven Brandes*
05:20pm - 07:00pm	**1ST VIDEO PRESENTATION** *Moderators: Sean Elliott, Miroslav Djordjevic, Frank Burks, Paksi Satyagraha and Francisco Martins*
07:00pm - 07:20pm	**LECTURE** **The role of GURS in implementing reconstructive urology awareness worldwide** *Sean Elliott*
07:20pm	End of the first day

October 18, 2017

07:30am	Opening of registration desk
08:00am - 09:40am	**POSTER PRESENTATION** *Moderators and Jury: Anna Lawrence, Javier Angulo and Pedro Vendeira*
09:40am - 11:10am	**SEMI-LIVE SURGERIES (VIDEO DEMONSTRATIONS)** *Moderators: Andre van der Merwe, Tobias Köhler, Justin Chee, Paksi Satyagraha and Pedro Vendeira*
09:40am - 10:10am	**PD corporoplication** **Other non-grafting techniques** *Allen Morey*
10:10am - 10:40am	**Rezum Prostate Ablation - Experience, tips and tricks** *Tobias Köhler*
10:40am - 11:10am	**Inflatable penile implantation for erectile dyfunction: Penoscrotal and infrapubic approaches** **Management of perforation injuries during and following penile prosthesis surgery** *Steven Brandes*
11:10am - 11:25am	**STATE-OF-THE-ART LECTURE** *Moderators: Andre van der Merwe, Dmitriy Nikolavsky, Justin Chee, Paksi Satyagraha and Pedro Vendeira* **Erectile (dys)function after urethroplasty** *Nicolaas Lumen*
11:25am - 11:40am	**STATE-OF-THE-ART LECTURE** *Moderators: Andre van der Merwe, Dmitriy Nikolavsky, Justin Chee, Paksi Satyagraha and Pedro Vendeira* **Advances in the surgical treatment of Peyronie's disease** *Tobias Köhler*
11:40am - 12:00am	Coffee-break
12:00am - 12:15pm	**STATE-OF-THE-ART LECTURE** *Moderators: Steven Brandes, Miroslav Djordjevic, João Marcelino e Luis Costa* **Post-radical prostatectomy urinary incontinence: Old and new treatment options** *Jaspreet Sandhu*
12:15pm - 01:30pm	**SEMI-LIVE SURGERIES (VIDEO DEMONSTRATIONS)** *Moderators: Steven Brandes, Miroslav Djordjevic, João Marcelino e Luís Costa*
12:15pm - 12:30pm	**ATOMS for male SUI** *Javier Angulo*
12:30pm - 12:45pm	**Male virtue sling** *Argimiro Collado Serra*
12:45pm - 01:00pm	**AUS AMS800 Implantation** *Jaspreet Sandhu*
01:00pm - 01:15pm	**Male Remeex system** *Ervin Kocjancic*
01:15pm - 01:30pm	**I-STOP TOMS male sling** *Renaud Vautherin*

01:30pm - 02:30pm	Lunch break
02:30pm - 02:45pm	**STATE-OF-THE-ART LECTURE** *Moderators: Steven Brandes, Miroslav Djordjevic, João Marcelino e Luís Costa* **Penile transplantation: The world's first successful patient and socio-ethical issues** *Andre van der Merwe*
02:45pm - 03:45pm	**STATE-OF-THE-ART LECTURES** *Moderators: Tobias Köhler, Sean Elliott, Joan Caparrós and Francisco Martins*
02:45pm - 03:05pm	**Management of the buried penis: What are the options?** *Frank Burks*
03:05pm - 03:25pm	**Gender reassignment surgery: Lessons learned over the last 25 years in a single center** *Miroslav Djordjevic*
03:25pm - 03:45pm	**Management of penile fractures: Impact on urinary and sexual functions** *Steven Brandes*
03:45pm - 04:15pm	Coffee-break
04:15pm - 06:05pm	**2ND VIDEO PRESENTATION** *Moderators: Frank Burks, Krishnan Venkatesan, Omar Soto-Avilés, Paulo Temido and Luís Costa*
06:05pm - 06.30pm	**BEST VIDEO/POSTER AWARDS AND CLOSURE** Including presentation of the video and poster winners **Award presenters** *Frank Burks and Francisco Martins* **Closing remarks** *Tomé Lopes and Francisco Martins*
06.30pm	**CERTIFICATES DELIVERY** Certificates of attendance will be available. In order to receive the ECMEC®s, please deliver your feedback form to the secretariat. Delegates will only be able to receive the ECMEC®s corresponding to their attendance.

Posters and Videos

Posters

Posters selected for oral presentation
October, 18 // 08.00am

P 01

URETHROPLASTY WITH BUCCAL MUCOSA GRAFT: A NEW SCORE OF SYMPTOMS FOR THE EVALUATION OF POSOPERATIVE SATISFACTION

Ulisses Sobrinho; Rodrigo Vieiralves; Paulo Conte; Tomas Accioly; Luciano A. Favorito
Setor de Urologia do Hospital Federal da Lagoa

Objective: Urethroplasty with the use of bucal mucosa graft (BMG) has great acceptance and good cosmetic results. Morbidity at the site of graft is rarely studied. The aim of this study is to propose a score to evaluate how the site of removal of the BMG for urethroplasty behaves in the postoperative period.
Material and methods: Between January 2015 and May 2017, 12 patients aged between 33 and 78 years (mean = 57.8) with urethral stenosis undergoing urethroplasty with BMG were studied. The following parameters were analyzed in the immediate postoperative period (7 days after surgery) and in the late postoperative period (60 days after surgery): Paresthesia, pain, bleeding and difficulty feeding. The 4 items were scored according to their intensity in absent (0), light (1 point) or intense (2 points), and the score could range from 0 to 8 points. For the statistical analysis we used the student t test ($p < 0.05$).
Results: Of the 12 patients, 5 (41.6%) had meatus stenosis; 4 (33.3%) had bulbar urethral stenosis, 1 (8.33%) penile urethral stenosis and 2 (16.6%) presented simultaneous bulbar and penile urethral stenosis. The strictures ranged from 2 to 6cm (mean=3.25cm). The analysis of the symptoms showed: (a) Paresthesia: Immediate post-op - 6 patients (50%) mild and 6 (50%) moderate, Late- 4 (33.3%) mild and 2 (16.6%) moderate; (B) Pain: Immediate - 3 (25%) mild and 1 (8.33%) intense, Late - 1 (8.33%) mild and 1 (8.33%) intense; (C) bleeding: Immediate - 3 (25%) mild and 1 (8.33%) intense Late - 3 (25%) mild and no intense and (d) food difficulty: Immediate - 7 (58.33%) mild and 1 (8.33%) intense; Late - Immediate - 1 (8.33%) mild and no intense. Only 1 patient (who had two strictures and needed a 6cm graft) presented 8 points in both the immediate and late score. The immediate score had a mean of 3 points between the patients and the late score an average of 1.5 points, with a significant difference ($p < 0.05$).
Conclusion: Removal of oral mucosa is well tolerated by most patients. We have a small sample size but the use of the postoperative symptom score for the use of BMG seems promising and may be an auxiliary tool for the analysis and management of symptoms in the postoperative period.

P 02

A NOVEL PROTOCOL OF MAGNETIC RESONANCE URETHROGRAPHY TO EVALUATE URETHRAL GAP AND IMPROVING IMAGE CHARACTERISTICS IN PELVIC FRACTURE URETHRAL INJURIES

Pankaj Joshi; Darshan Shah; Devashree Joshi; Sandesh Surana; Omkar Joglekar; Mohammad Alkandri; Jyotsna Kulkarni; Sanjay B. Kulkarni
Kulkarni Endosurgery Institute, Pune, India

Introduction and objectives: Magnetic Resonance Urethrography (MRU) has been reported to be accurate in demonstrating urethral stricture length and displacement of the prostate apex in traumatic pelvic fracture urethral injuries (PFUI). We present a novel MRU protocol to improve assessment of urethral gap in PFUI patients using instilled urethral gel, retrograde filling of the urinary bladder and pre-procedure Tamsulosin. The primary objective of this study is to compare test characteristics of standard MRI and protocol MRU evaluation of urethral gap compared to standard evaluation with retrograde urethrogram (RGU) and Voiding cystourethrogram (VCUG).
Method: From 1996 to 2016 1032 cases of PFUI have been seen at our institution with 10%being complex. MRI was routinely acquired for complex PFUI by radiologists using traditional protocol. We formulated a recent new technique where the images were obtained using urine as a natural MRI contrast. Ten consecutive cases of complex PFUI were prospectively evaluated with the new MRI protocol. First, a T2 image acquisition was performed. Urethral gap measurements by 4 radiologists were recorded for each case. A second T2 image acquisition was performed with patient lying on the table with a full bladder, SPC clamped, straining to pass urine post administration of Tamsulosin while at the same time a premixed solution of sterile saline and lubricating jelly is instilled in the urethra. The bladder was filled physiologically with patient drinking water prior to the study. Urethral gap assessments were repeated using the same 4 radiologists. Additionally, 4 urologists were shown images from each phase of the study and their visual score was recorded – very satisfactory (4), satisfactory (3), disappointed (2) and extremely disappointed (1).
Results: 10 male PFUI patients (median aged 31 years) were included. Mean gap length was noted to be 0.71 cm shorter with protocol MRU compared to MRI ($p<0.0001$).

Compared to standard MRI, protocol MRU demonstrates increased accuracy (90% vs 70%), improved test characteristic (sensitivity 100%, specificity 66.7% vs sensisitivty 100%, specificity 0%). Interest reliability between radiologists was improved with protocol MRU (Chronbach's alpha 0.98 vs 0.89).
Conclusion: Our new Protocol of MRU assessment of urethral gap in pelvic fracture urethral injuries shows promising results and demonstrates improved test characteristics and inter-test reliability compared to standard pelvic MRI.

P 03

POSTERIOR ANASTOMOTIC URETHROPLASTY IN AN INFANT

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Introduction and objective: Boys with high imperforate anus have a recto urethral fistula, which usually occurs at the prostatomembranous junction. Recent trend is to perform a single stage posterior sagittal posterior anorectoplasty (PSARP) with pull through and closure of fistula. Inadvertent posterior urethral injury during repair may result in traumatic obliteration. We evaluated our outcomes of posterior urethroplasty in infants.
Material and methods: We evaluated infants referred to us with posterior urethral injury after PSARP. We managed 3 infants with posterior urethral injury - 3 after PSARP during 2012 to 2016. Follow up ranged from 6 months to 4 years. Iatrogenic injury was noticed after PSARP on removal of catheter. Suprapubic catheter (SPC) was inserted. Retrograde urethrogram (RGU), voiding cystourethrogram (VCUG) and endoscopy from above and below was performed before anastomotic urethroplasty.
Results: Our study included 3 infants. Three were born with high imperforate anus and recto urethral fistula. PSARP was complicated by posterior urethral transection resulting in an obliterated urethra. This was initially managed with a supra-pubic catheter followed by transperineal anastomotic urethroplasty. Two required crural separation and inferior pubectomy. Two infants had an uneventful recovery. One infant had an annular narrowing at the anastomotic site and required endoscopic internal urethrotomy twice. We waited till the child was older (age 4) and performed urodynamics. This revealed obstruction and the patient underwent redo anastomotic urethroplasty with crural separation and inferior pubectomy. This had an uneventful recovery.
Conclusions: Iatrogenic urethral injuries are rare in infants. Anastomotic urethroplasty achieves physiological voiding and prevents complications of prolonged SPC. Even though the surgery is challenging in an infant, our series, suggest that this is feasible with good outcomes.

P 04

VOIDING DYSFUNCTION AFTER SUCCESSFUL ANASTOMOTIC URETHROPLASTY FOR PELVIC FRACTURE URETHRAL INJURY

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Introduction and objective: Anastomotic urethroplasty is the standard of care for Pelvic fracture urethral injuries (PFUI) undergoing definitive surgical management. There are a select group of patients who despite having a successful anastomotic urethroplasty have postoperative voiding dysfunction due to unrecognized neurogenic bladder injury. Our study aims to evaluate these patients and identify clinical signs to predict these injuries.
Material and methods: Our institute is a tertiary referral center for reconstructive urology cases. We have performed 1064 anastomotic urethroplasty in the last two decades. We retrospectively evaluated our prospectively maintained database. Inclusion criteria was patients with PFUI who underwent a successful anastomotic urethroplasty with postoperative voiding dysfunction. Success of anastomotic urethroplasty was determined by a retrograde urethrogram (RGU) and endoscopic evaluation. Voiding dysfunction was defined as patients with poor urine flow. We performed urodynamics (UDS) on each of these patients.
Results: Our series included 6 male patients (average age 27 years) who had PFUI secondary to road traffic accident. All patients underwent progressive perineal anastomotic urethroplasty for PFUI (all required step 3 anastomotic urethroplasty). Postoperatively these patients had poor flow after catheter removal. A RGU and endoscopy revealed a patent anastomosis. UDS showed neurogenic detrusor underactivity. There were variable occurrences of other lower motor neuron findings such as muscle atrophy, fasciculations, sensory loss, areflexia and fecal incontinence. The common factor was that all patients had a foot drop on preoperative clinical examination. S2,3 nerve roots supply both the foot and bladder. Neurogenic damage to bladder is not evidenced till the urethral anastomoses is performed as all these patients have a suprapubic catheter draining their bladder. Foot drop is a simple clinical sign to predict the possibility of neurogenic bladder dysfunction.

Conclusions: Coexistent neurogenic bladder injury with PFUI is rare but is of paramount importance predicting outcome. Our study highlights that the presence of foot drop and other lower motor neuron signs in patients with PFUI is a predictor for voiding dysfunction due to coexistent neurogenic bladder. We recommend that these patients should have urodynamics prior to surgical repair and must be counselled accordingly.

P 05

SINGLE STAGE REPAIR OF OBLITERATED ANTERIOR URETHRAL STRICTURE BY COMBINED BUCCAL MUCOSA GRAFT AND PENILE SKIN FLAP

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Introduction: Repair of most severe anterior urethral strictures often requires complete substitution of the obliterated urethral segment.
Goals: We evaluated a method of combining buccal mucosa graft and penile skin flap to create a complete urethral lumen in the treatment of complex anterior urethral strictures.
Material and methods: Between April 2008 and April 2016, 46 patients aged from 15 to 63 years underwent one-stage substitution urethroplasty due to a severe anterior urethral stricture. The etiology of strictures was: unknown, hypospadias and trauma in 17, 24 and 5 patients, respectively. The affected urethral segment was completely removed; buccal mucosa graft was harvested and fixed to corpora cavernosa as dorsal part of the neourethra and vascularized longitudinal dorsal penile skin flap was created, transposed ventrally and sutured to buccal mucosa graft to form complete urethral lumen.
Results: Mean follow-up was 39 months (ranged from 12 to 108 months). Mean length of the obliterated urethral segment was 5.2 cm (ranged 2 to 9.5 cm). Successful result was confirmed in 34 (73.9%) patients. Twelve patients (26.1%) developed following complications: recurrence of the stricture occurred in seven (15.2%) patients and five (10.8%) patients developed fistula. Superficial necrosis of the dorsal penile skin was occurred in five cases and all healed by conservative treatment.
Conclusions: The combination of buccal mucosa graft and longitudinal dorsal penile skin flap proved to be a successful choice for substitution urethroplasty in most severe obliterated anterior urethral strictures. This way, multi-stage repair of these complex strictures could be avoided.

P 06

LICHEN SCLEROSUS OF THE VULVA AFTER MALE TO FEMALE "PENILE INVERSION" VAGINOPLASTY

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Introduction: In women, lichen sclerosus presents as vulvar discomfort, pruritus, bruising, bleeding, discharge, dysuria, or painful defecation.
Goal: Diagnosis and treatment of lichen sclerosus is of utmost importance in the prevention of complications such as scarring, adhesions, atrophy, or long-term sexual dysfunction. We present male-to-female transgender patients with vulvar lichen sclerosus developed after penile skin inversion vaginoplasty.
Materials and methods: From September 2011 to July 2016, seven patients were treated for vulvar lichen sclerosus developed after 11 to 37 months (mean 31 months) following male to female gender confirmation surgery. The age at diagnosis ranged 28 to 57 years (mean 45 years). There was no data or clinical signs of presence of the disease at the time of surgery. The main symptoms were dry and itchy skin of the vulvar region, labial adhesions, painful sexual intercourse with consequential bleeding and problems during voiding. Use of topical corticosteroids resulted in limited improvement in the early period, but it was not effective as a curative treatment of the disease. Surgery included excision of affected skin and new vulvoplasty. Buccal mucosa grafts and urethral flaps were used for the prevention of new skin adhesions and vulvar closure.
Results: Biopsy specimens confirmed lichen sclerosis in all patients. In follow-up period (9 to 68 months) good esthetical and functional result was achieved in all patients. They were advised to apply periodical dilation of the vaginal introitus and topical corticosteroid treatment.
Conclusion: This is the one of the rare series to describe the vulvar lichen sclerosus in transwomen after gender confirming surgery as a possible cause of sexual dysfunction. Active surgical treatment and long-term follow-up of these patients is recommended to prevent recurrence of the disease.

P 07

NON-URETHRAL COMPLICATIONS FOLLOWING HYPOSPADIAS REPAIR

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Introduction: The most common non-urethral complications after hypospadias repair are: glans deformity, residual curvature and trapped penis due to deficiency of penile skin.

Goals: Aims of this study are to present treatment of these complications and to highlight its impact on patients' life.

Material and methods: During period from January 2003 to October 2016 ninety two patients, aged 4 to 39 years (mean 23) underwent surgical repair of non-urethral complications after hypospadias repair. Mean period after inital hypospadias repair was 14.2 years. The most common complications included: glans deformity (34), residual curvature (46) and trapped penis (31). Radical approach was used to correct all deformities. Glans deformity was repaired in 28 patients by creation of conically shaped glans after making of wide glans wings, while in 6 cases "double face" skin flap was used to enlarge small and deformed glans. Residual curvature was repaired by tunical plication in all cases, while in 24 cases additional urethral reconstruction was needed. Vascularized genital skin flaps or free skin grafts were applied for complete covering of erected penile body for trapped penis repair.

Results: Follow up was 6 to 171 months (mean 63). Seventy six patients were successfully solved in one stage while fifteen patients (16%) required additional surgical treatment. Nine patients underwent repeated penile skin reconstruction due to severe scar formation and six patients underwent repeated correction of the penile curvature due to its late onset.

Conclusions: Non-urethral complications after hypospadias repair carry a risk of repeated surgery and may lead to severe sexual and psychological dysfunction. Active surgical treatment should enable full sexual functionality. Due to late onset of these complications, follow-up of these patients should be extended.

P 08

RADIATION INFLUENCE IN URORECTAL FISTULA MANAGEMENT. OUR EXPERIENCE

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Introduction and objective: Urorectal (URF) fistula is a devastating complication of pelvic cancer treatments and a surgical challenge. We report a series of male patients with URF resulting from pelvic cancer treatments, and explore the differences and impact on outcomes between purely surgical and non-surgical treatment modalities.

Materials and methods: Between October 2008 - June 2015, 15 patients with URF were identified in our institutions. We reviewed the patients' medical records for symptoms, diagnostic tests performed, type and etiology of the fistula, type of surgical reconstruction, follow-up and outcomes. Patients were divided into 2 groups: 8 received non-surgical/energy ablation treatments (G1) while 6 had surgery (G2).

Results: 14 patients underwent surgical reconstruction. Mean follow-up (FU) was 32.7 months. All patients received diverting colostomy and temporary urinary diversion. An exclusively transperineal approach was used in 9 (64.3%) patients and a combined abdominoperineal in 5 (35.7%). Overall successful URF closure was achieved in 12 (85.7%) patients, 9 (64.3%) of whom at the 1st reconstructive attempt, 2 (14.3%) after 2 attempts, and 1 (7.1%) after 3 attempts. 83% of G2 patients needed 1 surgical attempt only, compared to 44% in G1. The failures were in G1. An interposition flap was used in 7 (50%) patients. Surgical reconstruction failed ultimately in 2 (14.3%) patients.

Conclusion: Although surgical reconstruction may be extremely difficult and complex in the non-surgical/energy ablation patients, its successful reconstruction is possible in most through a transperineal, or a more aggressive abdominoperineal, approach with tissue interposition in selected patients.

P 09

SURGICAL TREATMENT OF PENILE VASELINOMA

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Introduction: Penile augmentation by the subcutaneous self-injection of vaseline may cause complications such as penile deformity and skin necrosis. The optimal treat-

ment of these severe complications is complete excision of the involved tissue and penile skin reconstruction.

Goals: The authors aimed to study the surgical treatment and outcome of 19 cases with penile vaselinoma.

Material and methods: From 2008 to 2017, 19 patients underwent surgery to reconstruct the penile skin due to vaselinoma induced partial or full skin necrosis. 5 patients with preputial or partial penile skin necrosis were treated by excision of the involved tissue and substitution with penile skin in one stage. 14 patients with total penile skin necrosis were treated by penile skin excision and reconstruction with scrotal skin in two stage.

Results: Patients were discarded from the hospital 4.1 (1-7) days after surgery. Symptoms resolved in all patients, there was no serious complications such as skin necrosis, urethral or neurovascular bundle injury, erectile dysfunction, shortening of the penis. 2 wound infections occurred in the postoperative period requiring local conservative treatment. 1 wound disruption was observed one month after the second stage of a two staged surgery. The ventral penile wound disruption did not require second surgery.

Discussion: Complications of vaseline self-injection into the penile skin are severe and irreversible. However with the help of the optimal surgery – complete excision of the affected penile skin and reconstruction with penile or scrotal skin – they can be treated with good functional results and few complications.

P 10

OUTCOMES OF INFLATABLE PENILE PROSTHESIS IN PATIENTS WITH URINARY DIVERSION

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Introduction and goals: After radical cystoprostatectomy (RC), post-operative erectile dysfunction can have a significant impact on a patient's quality-of-life. Inflatable penile prosthesis (IPP) offers patients a definitive treatment option when refractory to medical therapies. To date, there is no series describing the outcomes of three-piece IPP in patients with urinary diversions. Due to the obliteration of the space of Retzius and hostile anatomy of these patients a careful surgical approach is necessary for successful outcomes. We present a description of our technique in placing a three-piece IPP for post-operative erectile dysfunction in patients with a history of RC with orthotopic neobladder (NB), ileal conduit, or continent cutaneous diversion (CCD).

Methods: From 2007 - 2016, using an IRB-approved database we completed a retrospective review of patients who underwent primary placement of an IPP. We identified 61 patients (54 NB, 4 ileal conduit, 3 CCD) with urinary diversion who underwent subsequent placement of a three-piece IPP (AMS 700CXM, American Medical Systems Inc, Minnetonka, MN, USA). All 61 patients underwent RC in their treatment of carcinoma (55 bladder, 6 prostate). The device was implanted via an infrapubic approach and the reservoir placed in the lateral retroperitoneal space via a separate incision two finger-breadths medial to the anterior superior iliac spine. Patient demographics and post-operative outcomes including prosthetic infection were examined and statistical analysis was performed.

Results: There were no high-grade intraoperative complications. Median follow-up was 16.8 months (2-76 months). Three patients (4.9%) developed an infection of their prosthesis that required explantation. Two of those patients underwent successful IPP reimplantation. 5 patients (8.1%) required revision surgery (4 pump relocations, 1 corporal aneurysm repair). We did not find statistically significant associations between infection and comorbidities, age, exposure to chemotherapy, or type of urinary diversion.

Conclusions: Despite advances in neurovascular sparing techniques, sexual dissatisfaction is common in patients after RC. Patients are often refractory to medical therapy. The IPP offers patients a definitive treatment option and excellent patient and partner satisfaction. In the hands of experienced surgeons, the three-piece IPP can be placed successfully in patients with all form of urinary diversion.

P 11

EFFICACY OF ADJUSTABLE TRANSOBTURATOR MALE SYSTEM (ATOMS) AFTER FAILED ARTIFICIAL URINARY SPHINCTER OR ADVANCE MALE SLING FOR MALE STRESS URINARY INCONTINENCE (SUI)

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Introduction and objectives: To evaluate the feasibility and efficacy of Adjustable Transobturator Male System (ATOMS) to treat male stress urinary incontinence (SUI) after failed artificial urinary sphincter (AUS) and/or Advance male sling.

Methods: Males with previously failed surgical implant

for SUI secondarily treated with ATOMS were included in this retrospective study. All were evaluated with clinical history, physical examination, pad-count and pad-test before ATOMS placement and after adjustment. Operative parameters were registered, including VAS of postoperative pain (0-10 scale). Continence status, patient satisfaction with the procedure, and number and grade of complications (Clavien-Dindo) were evaluated. Incontinence was defined as mild (2pads/day), moderate (3-5pads/day) or severe (>5pads/day). Dry patients were those with none or one security pad/day. Urodynamics before ATOMS were available in 17 cases and Patient Reported Outcomes after adjustment in 13.

Results: ATOMS was implanted after failed device in 25 patients, AUS in 15(60%) and Advance in 10(40%). Three cases had 2 failed AUS implants and in two cases failed AUS was placed after failed Advance. Median follow-up after ATOMS implant was 18+11(10-36) months, patient age 73+10yrs (range 58-80), pad-test 540+377cc (120-2400) and pad-count 4+3(2-15). Severity of preoperative SUI was mild 6(24%), moderate 8(32%) and severe 11(44%). Postoperative distribution was none 18(72%), mild 2(8%) and moderate 5(20%). Median number of adjustments was 2+2(0-9) and total filling 14+14(9-38) ml. No patient had urinary retention after catheter removal. Pad-count decreased 4+5(0-11) pads-per-day after adjustment. At the time of this report, 68% of the patients were "dry" (60% for AUS and 80% for sling) and 84% were satisfied (86.7% and 80%, respectively). Median PGI-I was 2+1(1-6) and GRA 6+1(2-6). Median operative time was 64+45(39-135) min. Hospital stay 1+1(1-3) days and VAS of pain 1+1.5(0-7). Complications were present in 2(8%); grade I (scrotal hematoma) and grade II (urinary infection requiring admission) each. At follow-up no system suffered infection or was removed.

Conclusion: ATOMS is a good alternative to treat male SUI with failed previous surgical treatment, not only sling but also AUS. Objective success in the short-term was achieved in a high proportion of cases and patient satisfaction was surprisingly high, in a similar range to those described for ATOMS as primary treatment. Absence or urethral erosion and limited infective problems make this alternative especially attractive for cases with previous failed treatments.

Key words: Male Stress Urinary Incontinence, ATOMS, failure, rescue surgery.

P 12

TRANSPERINEAL INFERIOR PUBECTOMY PROCEDURE IN ADULT MALE WITH PELVIC FRACTURE URETHRAL INJURY IN WEST JAVA URETHRAL REFFERAL CENTRE, INDONESIA

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Introduction and objectives: Pelvic Fracture Urethral Injury (PFUI) comprise one of the most challenging procedures in urology. The defect or stenosed urethra can be effectively repaired by end-to-end anastomosis transperineally. To achieve tension-free anastomosis, a progression of surgical steps including inferior pubectomy can be used. We present our experience with transperineal inferior pubectomy in management of PFUI in adult male Indonesian people in West Java Urethral Refferal Centre in Indonesia.

Methods: This is a single-institution, single-surgeon prospective case series. A prospective database of adult male patients with PFUI requiring open surgical urethal reconstruction at AMC Hasan Sadikin Hospital, Indonesia between February 2013 to February 2017 were reviewed. Pediatric and adolescence age below 18 year old were excluded. Patient characteristics PFUI related information and outcomes were recorded and analysed. The operation time and intra operative additional procedure to achieve tension free anastomotic was also noted and analyzed. The clinical outcome after surgery were evaluated by pericatheter urethrogram and uroflowmetry. The clinical outcome is considered a failure when any instrumentation is needed after surgery.

Results: A total of 94 patients of 108 cases of PFUI met the criteria of adult male PFUI. The median age was 34(18 – 68) years. Height and weight average of patients was 158.4 cm or 5.19 feet (120 – 170 cm or 3.93 – 5.57 feet) and 57.5 kg or 126 pounds (44 – 80 kg or 97 – 176 pounds) respectively. The trauma mechanisms for PFUI were 66 (70.2%) cases due to motorcycle accidents, 17 (18.1%) cases due to crushed injury and 11 (11.7%) cases due to high falls accidents. All patients underwent delayed urethral reconstruction in median 6 months (3 - 84). The average length of the urethral gap in all cases was 3.6 cm (1 – 8) and 3.5 cm (2 – 6) for inferior pubectomy procedures. In order to achieve the tension free of anastomotic urethroplasty, 11 (11.7%) of PFUI patients underwent simple end-to-end anastomosis, 31 (32.9%) patients underwent crural separation, 42 (44.7%) patients underwent inferior pubectomy, and 9 (9.6%) for supracrural re-routing. Posterior pubectomy via transpubic approach was performed in one patient. At a median follow up of 12(6-32) months,

11/94 (11.7 %) considered as failure. The median operation time for all patients was 150 minutes (90 – 320) and 140 minutes (90 – 240) for inferior pubectomy procedure. The success rate for all adult PFUI was 88.3% and 88.1% for cases with inferior pubectomy procedure.
Conclusions: Transperineal anastomotic urethroplasty in management of PFUI case series with inferior pubectomy procedure is the most common elaborated perineal approach to achieve tension free anastomotic urethroplasty in our institution and showed promising outcome.

P 13

PLAQUE PARTIAL INCISION AND NON-GRAFT IN PEYRONIE'S DISEASE

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Introduction: Peyronie's disease is characterised by disordered collagen deposition in the tunica albuginea of the penis, leading to the formation of palpable fibrous plaques. The plaques produce a curvature of the penis which can cause painful erections and functional problems. Prevalence is estimated to be 3-9%. There are significant psychosocial consequences to Peyronie's disease, with many men not seeking treatment due to embarrassment.
The Nesbit procedure is an established operation for the management of Peyronie's disease. However, it is complicated by loss of approx. 1cm of penile length for each 30° corrected. The use of grafting aims to combat this and preserve length, but this comes with the cost of deterioration in erectile function in 20-40% patients.
This novel procedure aims to straighten the penis while preserving length and function.
Objectives: To report the early outcomes of a cohort of patients who underwent partial plaque incision and non-graft for Peyronie's disease.
Methods: Seventeen consecutive men aged 41-67 with penile deformity of a mean 75 degree (range 40-90 degrees) angulation were managed with this novel technique. All filled in the questionnaire PDQ-PROM prior to surgery and at 3-6 months post-operatively. They were competent on penile vacuum use prior to surgery. Following mobilisation of Buck's fascia multiple transverse incisions through the outer /longitudinal fibres of the tunica albuginea were made. Penile traction was reinstated 1 week after surgery. Subjects were reviewed at 3 and 6 months by physical examination and questionnaire.
Results: Penile angulation improved by 85% from mean 75 degrees to 12 degrees post-operatively. PDQ-PROM went from 27/70 to 11/70 at 6 months, i.e. 60% improvement. One patient subjectively noted loss of 0.5cm of erect length, none of the others were aware of loss of length. All 17 reported restoration of a satisfying sex life.
Discussion: Early results favour this technique of penile straightening for dorsally angulated Peyronie's disease.

P 14

OUTCOMES OF PATIENTS WITH ARTIFICIAL URINARY SPHINCTER AND INFLATABLE PENILE PROSTHESIS AFTER TREATMENT FOR UROLOGIC MALIGNANCY

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Introduction and goals: Urinary incontinence (UI) and erectile dysfunction (ED) are major causes of patient dissatisfaction after surgery for prostate and bladder cancer. The inflatable penile prosthesis (IPP) and artificial urinary sphincter (AUS) offers patients definitive treatment options that can improve a patient's quality-of-life. We present outcomes of patients who have both AUS and IPP with an emphasis on examining the effect of radiation therapy and orthotopic neobladder on erosion and infection rates in these patients.
Methods: From 2006-2017, using an IRB-approved databases of patients, we completed a retrospective review of 62 patients who underwent both AUS and IPP placement. In most patients, this was performed in a staged manner with AUS preceding IPP placement. 3 (4.8%) patients had concurrent placement of both devices. 13 patients (20.9%) had history of radical cystoprostatectomy with orthotopic neobladder, 46 had radical prostatectomy (74.2%), and 3 (4.8%) were treated solely with radiation. In total, 30 (46.9%) patients had been exposed to pelvic radiation. Patient demographics and postoperative outcomes were examined.
Results: No intraoperative complications were seen during either AUS or IPP placement. After a mean follow up of 5.6 years, there were a total of 7 AUS erosions/infections (8.0%) and 2 IPP infections (3.2%). Three of the patients with AUS erosions had been treated with pelvic radiation, 3 had prior urethral surgery performed prior to referral, and one was due to iatrogenic injury from a urethral catheter. 47 patients underwent revision surgery for their AUS, with cuff revision as the most common procedure performed. In patients with radiation exposure, no IPP infectious complications occurred. We did not identify history of urinary diversion as a risk factor for AUS erosion in patients with both AUS and IPP.
Conclusions: Based on our study, AUS and IPP can be placed in patients with durable outcomes and minimal

infectious complications in either device. Adequate counselling should be provided to patients that have a history of pelvic radiation or prior urethral surgery on the increased risk of AUS erosion.

P 15

PATIENT REPORTED OUTCOMES WITH THE ADJUSTABLE TRANSOBTURATOR MALE SYSTEM (ATOMS) FOR MALE STRESS URINARY INCONTINENCE AFTER PROSTATE SURGERY

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Purpose: To report outcomes perceived by patients treated with the adjustable transobturator male system (ATOMS) for male stress urinary incontinence after prostate surgery.
Material & methods: Multicenter retrospective study conducted in 8 Iberian institutions with patients intervened between 2012-2017, among which 149 included in their evaluation self-assessed early postoperative pain (VAS 0-10 scale) and Patient Global Impression of Improvement (PGI-I) after device adjustment. We analysed efficacy focusing on patient perception of results. Incontinence was defined as mild (2pads/day), moderate (3-5pads/day) or severe (>5pads/day). Dry patients were those with none or one security pad/day. Continence status, patient satisfaction after adjustment, number of patients perceiving results as "very much better" than baseline and number and grade of complications (Clavien-Dindo) were evaluated.
Results: Mean patient age was 69.6+7.1 (range 34-82). Adjustment was achieved at a mean 1.3+2 fillings (range 0-9). Dry-rate was 84.6% (96.3% mild, 83.2% moderate and 77.8% severe SIU). Mean decrease with respect to baseline daily pad-test and pad-count was 458+330ml and 3.3+1.8pads, respectively (both p<.0001). Satisfaction rate was 88.6% (96.3% mild, 86.3% moderate and 88.9% severe SIU). The proportion of patients perceiving results "better" than before (PGI-I=1-3) was 91.95% (100% mild, 90.2% moderate and 90.7% severe SIU) and "very much better" than before (PGI-I=1) 51.7% (45.8% mild, 48.8% moderate and 60.5% severe SIU). Factors associated to best perception (PGI-I=1) were: absence of radiotherapy (p=.02), high basal pad-count (p<.0001), low pad-count after adjustment (p<.0001), low post-operative pain score (p<.0001) and absence of complications (p=.03). Complications presented in 18(12.1%); 50% grade1, 16.7% grade2 and 33.3% grade3. Mean VAS for postoperative pain was 2.8+2.6 (range 0-7), and the only factor identified was type of port used (6+5 inguinal and 1.5+5 in scrotal port, preattached or not; p=.0015); possibly due to the differences in the surgical approach.
Conclusions: This study confirms ATOMS device achieves excellent results regarding efficacy to treat SUI after prostate surgery, but also from the patient's perspective. Despite best dry-rate appears after treatment of mild and moderate SUI, highest satisfaction is expressed by patiets with severe SUI. Absence of postoperative complications, patients with lower postoperative pain perception and those without radiotherapy are also associated to highest satisfaction.

KEYWORDS: Adjustable transobturator male system (ATOMS), Patient Reported Outcomes, Satisfaction.

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THE IMPACT OF MORBID OBESITY ON URETHROPLASTY OUTCOMES – THE MEDSTAR WASHINGTON HOSPITAL CENTER EXPERIENCE

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Introduction: Elevated body mass index (BMI) may contribute to surgical complexity. There is limited literature examining impact of BMI on urethroplasty outcomes. We sought to evaluate our experience with urethral reconstruction in morbidly obese patients.
Methods: We retrospectively reviewed our IRB-approved, prospectively maintained urethroplasty database. Patients were classified by BMI <30 (non-obese), 30-40 (obese), and >40 (morbidly obese). We compared data including stricture length, operative time, blood loss, complications, and recurrence.
Results: 168 urethroplasties were performed from 2012 to 2017. Twelve patients had BMI over 40 (range 40-53); 8 had bulbar stricture, 2 penile and 2 panurethral. One patient (10%) had a complication of Clavien-Dindo class II or greater, compared to 13.2% and 17.1% in the non-obese and obese groups, respectively (Table 1). Complications in the non-morbidly obese groups included UTI, bleeding, delayed healing, and DVT. The only complica-

tion in the morbidly obese group was a mortality from sudden cardiac death. Patients with BMI>40 tended towards longer stricture length and greater average blood loss. Mean operative time was similar between groups. At mean follow-up 9.8 months (2-22) no morbidly obese patient had stricture recurrence.

Conclusions: Morbid obesity does not preclude successful urethral reconstruction. Our series demonstrated no large difference in recurrence rates between BMI categories, however the only complication in the morbidly obese group was more gravid. Further patient accrual and follow-up are necessary. A thorough pre-operative evaluation and counselling and careful patient selection are imperative when undertaking urethroplasty in this cohort.

P 17

DELAYED PRIMARY URETHRAL REPAIR FOLLOWING GUNSHOT WOUNDS TO THE EXTERNAL GENITALIA

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Introduction: Urethral injury from gunshot wounds (GSW) has classically been managed by immediate primary repair or conservative management through urinary diversion. We theorized that select injuries could be repaired after 36-72 hours, allowing time for evolution of 'blast effect.' We describe our experience with delayed primary repair of urethral GSW and its viability as an alternate option.

Materials and methods: This is an observational, non-comparative retrospective study. Patient records were reviewed for demographic data, injury type, treatment type and outcome at latest follow-up.

Results: Sixteen men presented to Washington Hospital Center Emergency Department with GSW to the external genitalia between June 2012 and December 2016. Nine patients were found to have a urethral injury. Seven patients (77.8%) had additional injuries to the external genitalia and 9 (100%) had non-urologic concomitant injuries. Of these 9 patients with urethral injury, 3 (33.3%) were managed only by urinary diversion, 3 (33.3%) were treated with immediate primary repair, and 3 (33.3%) underwent delayed primary repair 36- to 72-hours after presentation. At 2.2 months mean follow-up, no patient managed by delayed repair developed stricture or lower urinary tract symptoms.

Conclusions: In highly select patients, a 36- to 72-hour delay in the primary repair of urethral GSW is a feasible alternative to immediate repair. More research is needed, but our initial experience suggests delayed repair can be done safely and may allow time for 'blast effect' to evolve and devitalized tissue to delineate itself prior to surgical intervention.

P 18

PANURETHRAL STRICTURES: AETIOLOGY AND ONE STAGE RECONSTRUCTION WITH ORAL MUCOSA GRAFTS IN NORTH WESTERN NIGERIA

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Panurethral strictures are usually complex and extensive strictures that involve the penile and bulbar urethra. Aetiology varies between regions and the management of these patients is challenging. In the last two decades, oral mucosal grafts have gained widespread popularity as the most versatile substitute tissue for urethral reconstruction.

Goals: We present the aetiological factors and results of our experience in the use of oral mucosal grafts (OMG) in one-stage urethroplasty in patients with panurethral strictures.

Materials and methods: This is an observational, descriptive, prospective analysis of 62 patients who were evaluated and treated for panurethral strictures at two centres in North-western Nigeria from April 2012 and January 2017. We examine the aetiological factors and operative management using penile invagination, one sided dissection and oral mucosa application as described by Kulkarni.

Results: The mean age of the patients was 50 ± 13.7 years with a range of 11-75 years. Aetiological factors were poorly treated urethritis in 39 (62.9%), indwelling urethral catheterization in 18 (29.0%), trauma in 1 (1.6%) and lichen sclerosis in 1 (1.6%). Reasons for indwelling urethral catheterization were intra-operative monitoring 9 (50.0 %), relief of acute urine retention 4 (22.2%) and others 4 (22.2%). Fifty-two patients (83.9%) had preliminary urinary diversion by supra-pubic cystostomy before urethroplasty. The mean OMG length was 11.7cm and donor sites were buccal in 37 (59.7%), combined buccal and labial in 20 (32.3%). Fifty-seven (88.7%) of the patients had satisfactory voiding on removal of the urethral catheter. There was donor site reactionary haemorrhage in 1 patient, stay suture lip injury in 1 and pain and numbness in 6 (9.6%) patients. Superficial perineal wound infections were recorded in 6(9.7%) patients. There was no mortality.

Discussion/Conclusion: Poorly treated urethritis is the most common cause of panurethral stricture in our practice though indwelling urethral catheterization in the intra-operative period is an emerging cause. One-stage

oral mucosa graft urethroplasty for panurethral strictures has a good short-term outcome. The long-term outcomes are being assessed. The quality of urethral catheters in our environment is of great concern.

P 19

A NOVEL APPROACH TO ADULT ACQUIRED BURIED PENIS REPAIR WITH CONCOMITANT URETHRAL STRICTURE DISEASE

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Introduction: As morbid obesity becomes a common complaint the United States, adult acquired buried penis (AAPB) has also become a common morbidity associated with obesity. Urethral stricture disease is often associated with this condition from extensive lichen sclerosis of the glans and penile urethra. We propose a novel protocol for management of AAPB with concomitant urethral stricture disease.

Methods: After IRB approval a retrospective review was performed examining the preoperative characteristics and intraoperative details of the patient with AAPB and concomitant urethral stricture disease. Urethral stricture evaluation included measurement of urine flow, post void residual volume and retrograde urethrogram. Patients under went urethroplasty prior to repair of the AABP. Patients in the series had dorsal onlay buccal mucosal graft urethroplasty (Kulkarni) and first stage Johansen urethroplsty. They subsequently underwent AABP repair with sharp lipectomy of the eschutchon, rearrangement of skin flaps and split thickness skin graft to the penile shaft.

Results: A total of 5 patients under went evaluation for AABP and urethral stricture. Urethral stricture evaluation revealed an average stricture length of 9cm (range 5-15cm). Stricture location was pendulous in 2 patients and panurethral (penile and bulbar) in 3 patients. Three patients underwent dorsal onlay urethroplasty (Kulkarni) and 2 patients had first stage Johansen urethroplasty. All 5 patients went on to have AABP repair on average 4 months (range 2-6 months) after urethroplasty. At an average follow up of 18 months there were no long term complications or urethroplasty failures.

Consclusion: AABP with concomitant stricture disease is a genitourinary reconstructive challenge. Our approach of urethroplasty first and AAPB repair second appears to provide satisfactory cosmetic and functional results.

Posters for exhibition only

P 20

PRACTICAL PATIENT-INDIVIDUALIZED APPROACHES TO THE TREATMENT OF WOMEN WITH URINARY INCONTINENCE AND CYSTOCELE

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Introduction: Significant proportion (up to 20%) in the structure of the morbidity of the female population belongs to genital prolapse (GP). Among the GP-associated pathologies stress-induced urinary incontinence which occurrs in 40% of women with GP, is of the highest clinical significance. According to the Recommendations of the European Association of Urology (EAU) and the International Continence Society (ICS), surgical treatment of stress-induced urinary incontinence should be performed only in case of absence of positive dynamic of the conservative treatment. Application of membrane implants for the reliable supportive framework of the pelvis organs is fundamental in the modern surgical treatment of this pathology.

The investigation aimed at the evaluation of the results of conservative and self-administered surgical interventions due to stress-induced urinary incontinence, prolapse of the anterior wall of vagina, and comorbid pathology of stress-induced urinary incontinence and prolapse of the anterior wall of vagina (cystocele), development and implementation of the individualized approach to the treatment of the above-mentioned pathologies in the routine clinical practice.

Materials and methods: 122 women were under investigation according to the specially designed program that included anamnesis, subjective and objective data collection. To determine the functional state of the connective tissue self-developed questionnaire, life quality and sexual dysfunctions assessment were used.

Results: In 108 women (0.96%) improvement after treatment was established. 98 women received surgical treatment: membrane implants were used for 17 patients with urinary incontinence, 19 women - for prolapse of the anterior vaginal wall, 21 - for prolapse of the anterior vaginal wall and urination disorder; 41 patients underwent pathology correction by means of their own tissues. Choice of surgical intervention tactics was conditioned by presence of a patient's connective tissue

deficiency. The average postoperative duration of patient treatment was 3 days. Among postoperative complications there was hematoma in 1 clinical case and in one woman -damage of the urinary bladder wall, which was corrected intraoperatively. Among operated patients recurrence has not been detected in 6 months.

Conclusion: The immediate and long-term results of the application of polypropylene membrane implants in women during own surgical treatment of stress-induced incontinence and omission of the anterior vaginal wall are satisfactory. The developed diagnostic guidelines have been taken into a system of choice of tactics of surgical treatment of incontinence and prolapse of the anterior wall of the vagina and should include, consideration of hormonal status, presence of insufficiency of the connective tissue component of pelvic structures in women.

P 21

STUDY OF UKRAINIAN PATIENTS AFTER PASSING AN AUTOLOGOUS FASCIAL SLING AND TENSION-FREE VAGINAL TAPE THERAPY

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Introduction: Many therapy modalities have been used to cure stress incontinence, and among the most popular are tension-free vaginal tape (TVT) and rectus fascia sling (RFS). 36% of women of childbearing age suffer from the urinary incontinence. Around half of them have stress incontinence.

Objective: The purpose of the study is to estimate the impact of the autologous fascial sling (RFS) and (TVT) therapy on quality-of-life of Ukraniane women.

Materials and methods: 69 women who suffered from the urinary incontinence were randomly distributed into two groups.

- Group G1 (n = 37), went through RFS therapy
- Group G2 (n = 32) had TVT implant

The clinical follow-up was conducted at 6, 12 and 36 months.

Results: Patients' life quality analysis performed in 36 months showed that there was no significant difference between women groups.

TVT operative time was substantially shorter than RFS. In the G1 group, treatment rates were 71% at one month, 57% at six and 12 months. In G2, cure rates were 73% at 6 months, 65% at 12 months, and 59% after 36 months; there was no significant difference between those two groups. As to the satisfaction rate, there was no statistical difference between groups of patients.

Discussion/Conclusion: Without no doubt, RFS treatment is a proper solution for the urine incontinence treatment of the patients from the underdeveloped countries. Fascial sling therapy takes more time if compared to TVT method, but this treatment method turned out to be very cost-effective. Long-lasting clinical follow-up sessions are vital before rigorous conclusions can be drawn. Similar results are revealed between RFS and TVT methods, except the fact that TVT operative time was shorter.

P 22

URETERAL-VAGINAL AND URINARY BLADDER-VAGINAL FISTULAE IN WOMEN: SURGICAL TREATMENT

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Introdution: Urinary system fistulae in women is one of the most socially depressing pathologies. Urinary bladder-vaginal and urethral-vaginal fistulae in women in most cases result from obstetric and complicated gynecological surgical interventions, pathological births, traumatic pelvic lesions, post-radiological changes of vagina and urinary bladder.

Materials and methods: Results of surgical treatment of 29 women operated due to urinary system fistulas were analyzed. In 24 cases there were urinary bladder-vaginal fistulae, and in 5 - urethral-urinary bladder ones. In 11 cases fistulae resulted from previous radiotherapy, including 6 postoperative ones. All patients underwent comprehensive preoperative examination and sanation of the fistula tissue.

Results: Surgical correction of the fistulas was performed after patient's general condition had been stabilized and tissue in the zone of fistula had acquired plastic properties (absence of acute inflammation, broken off of the necrotic areas, formation of the fistula edges). If a patient with urogenital fistula received radiotherapy treatment, surgical correction of fistula was performed not earlier than in 6 months after the last session of radiotherapy. The main stages of the operation included: complete excision of scar tissue, unbundling of the tissues of the vagina and the urinary bladder for their further sewing, thorough hemostasis. In the case of urethral-vaginal fistula and significant prolonged defect of

the urethra additional operation of Boari was performed. During dynamic postoperative observation after a review in 6 months in 2 women relapse occurred, 27 females had complete closure of the fistula.

Conclusion: Comprehensive preoperative preparation of women with urethral fistulas, choice of the optimal time for their surgical correction, separated matching of the fistula edges without tension during surgical intervention and multifactorial care in the early postoperative period give possibility of complete closure of fistulas in 90% of women and reduction of the reoperation frequency.

P 23

HYPERACTIVE BLADDER OF RATS UNDER THE EFFECT OF TROSPIUM CHLORIDE, CHANGE IN CONTRACTION

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Purpose: The effect of trospium chloride (TC) as a modern representative of antimuscarinic drugs on regulation of contraction of bladder have been studied.

Materials and methods: The study was performed on rats that received 0.45 mg/kg of reserpine (HOMVIOTENSIN) within 2 weeks to create the model of hyperactive bladder. Trospium chloride 2 mg/kg (Spazmex) was additionally injected to animals with hyperactive bladder within two weeks to create treatment effect.

Results: The specifics of neurogenic contracting responses (induced by electrical filed) and agonist-dependent reactions of bladder strips insulated in animals after injection of the drug were studied.

It was disclosed that amplitude level of neurogenic contractions and the sensitivity to acetylcholine in bladder strips in animals with hyperactive bladder considerably exceeded the values of control animals. The reactions of the strips in animals with hyperactive bladder after injection of the drugs suggest that overactive response of the bladder may be intensified due to change in reactivity of muscarinic receptor and activation of other mediator mechanisms.

Discussion/Conclusion: We clarify that namely purinergic component, regardless the suppression cholinergic component in the regulation of neurogenic contractions. The efficiency of the use of trospiumchloride in combination with other drugs requires further study.

P 24

MALE URETHRAL STRICTURE MANAGEMENT: TRENDS IN AUSTRALIA OVER LAST 22 YEARS

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Introduction and objectives: Urethral stricture disease in males is an increasingly common problem, especially within an ageing population. There is significant variability in the management of stricture disease with options including urethral dilatation, urethrotomy, urethrostomy and urethroplasty. This study was conducted to evaluate the prevalence of male urethral stricture disease and the trends of management over the last two decades in Australia.

Material and methods: The Medicare Australia database was used to assess the item numbers claimed for urethral stricture management, from January 1994 to December 2016. Item numbers analysed included; 37300 – passage of sounds, 37303 – urethral stricture dilatation, 37327 – urethrotomy, 37324 – urethrostomy, 37342 – single stage urethroplasty, 37345 – first stage urethroplasty, 37348 – second stage urethroplasty, and 37351 – other urethroplasty. A survey was also conducted amongst Australian urological surgeons, to evaluate – if they performed urethral reconstruction, type of training received, number/type of cases performed per year and area of practice.

Results: 19618 episodes of passage of sounds, 69390 episodes of urethral stricture dilatation, and 46,085 episodes of internal urethrotomy have been performed over this 22 years period. 5447 episodes of urethrostomy, 3732 episodes of single stage urethroplasty, 389 episodes of first stage urethroplasty and 282 episodes of second stage urethroplasty were performed. 733 episodes of other forms of urethroplasty have been recorded.

During this time, the Australian population increased from 18 to 24 million. Exact prevalence of urethral stricture disease is unknown.

Of 489 current urological surgeons in Australia, 17 reported performing urethral reconstruction surgery. 14 surgeons operated on only adults, 1 on adults and children and 2 only on children. Only half of them underwent formal fellowship training in urethral reconstruction. Most performed less than 50 cases per year and worked in metropolitan areas.

Conclusion: This is the largest set of data on urethral

stricture disease management in Australia. Due to the growing population and improved survival there is a likely increasing incidence of urethral stricture disease. Few patients undergo definitive reconstruction, with the majority living in metropolitan areas. Hence, there is a great need for urethral reconstructive urologists in Australia to provide better definitive surgery options in the appropriate patient group, rather than repeated endoscopic procedures, particularly in non-metropolitan centres.

P 25

TREATMENT OF URINARY INCONTINENCE BY ELECTRICAL STIMULATION

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Introduction: Urination disorders pathogenetic curing is apromising technique. It assumes the use of electrical stimulation, which was widely used in 90 years. In the past years, it comes with various options: untouchable tibial neuromodulation, high-intensity pulsed magnetic ES, administration of botulinum toxin, etc.

Materials and methods: The purpose of this research is to investigate the efficiency of ES application in the curing women stress urinary incontinence. We selected and examined 178 women aged 20 to 75 years with illness lasting from 2 to 20 years who had frequent urination, imperative urge to urination, and incontinence. Diagnosis of urinary incontinence was carried out considering the EUA guidance.

The women were divided into the groups with the accordance to the clinical symptoms.

1. The first group enclosed patients whose incontinence is connected with the degree of urinary tract disorders took place after delivery.

2. The second women group contained patients aged over 55 years without gynecological deviations.

3. The third grouping included those patients, in which the cause of urinary incontinence clinically was failed to prove. They had neurogenic urination disorders.

Thereby, according to EMG inspection results, the reduced tone of the external sphincter was detected in the majority of cases. This fact enabled to apply the ES as a therapeutic measure. The AMPLIPULS electro stimulator was used. ES was cunducted endourethral combined with rectal and vaginal on the daily basis (10-15 days) for 10 minutes.

Results: As an outcome of treatment procedures, urine incontinence was not detected in 53 of 61 women from the first group. Nevertheless, 9 patients had a relapse in 3-6 months.

Level of urethra sphincter and perineum muscle electro activity raised to 40-50 %. The betterment took place only after the conduction of the third ES course in nine cases.

Positive changes happened within one – two months period in 21 cases after the conduction of two ES courses, and the improvement was observed in 11 cases of the first patients group.

Minor alterations, even after three courses of ES were detected in the third group - in 19 patients.

There was no positive reaction observed even after four - five ES courses in 15 elderly patients.

Discussion/Conclusions: The immediate positive results of curing were achieved in 85.7% of patients. ES method functioning on neuromuscular structures of the bladder compressive device improves its functional status and blood circulation, rises its tone and contractile ability.

P 26

THE POSITIVE IMPACT OF CHANGING URETHRAL STRICTURE MANAGEMENT IN URETHRAL DILATATION IN UROLOGICAL OUTPATIENT SERVICES

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Introduction: Urethral stricture remains complicated urological problem since ancient time and therapeutically challenging for the urologist. Urethral stricture is an acquired permanent narrowing of the urethra impeding the flow of urine during micturition. The aim of surgical reconstruction for urethral stricture is to provide an adequate caliber, compliant and stable urethra. The changing pattern of urethral stricture management with open urethral reconstructive surgery was started since 2012 in our center. The success rate of open urethral reconstructive surgery is defined as a stable and good flow rate also no postoperative calibration nor dilatation.

Objective: To present our center`s experience in managing urethral stricture with open reconstructive surgery and the impact on urethral dilatation procedure in urological outpatient services.

Materials and methods: This is a prospective study. Patients who had open reconstructive surgery dan patients who had urethral dilatation in outpatient clinic from 2012 to 2016 at Hasan Sadikin General Hospital Bandung were included in the study. We study the characteristic of the patient who underwent urethral dilatation procedure in outpatient services during those period of time. We perform the comparison study between ratio of open reconstructive surgery and ratio of urethral dilatation from total of urethral stricture patients each year. The

correlation between ratio of open reconstructive surgery and ratio of urethral dilatation was analyzed by Pearson analysis.

Results: The total of patient underwent open urethral reconstructive surgery technique was 320 patients, and total patient who underwent urethral dilatation was 174 during 5 years period. Mean for ratio of urethral dilatation was 0.30±0.18 and ratio of open reconstructive surgery was 0.59±0.16. There was significant correlation between increase of ratio of open reconstructive surgery and decrease of ratio of urethral dilatation (P 0.012). There was a strong negative correlation between ratio of open reconstructive surgery and ratio of urethral dilatation (R -0.955).

Conclusion: Open reconstructive surgery gives a positive impact in decreasing number of urethral dilatation procedure. There was significant correlation between increase of ratio of open reconstructive surgery as decrease of ratio of urethral dilatation procedure in outpatient services. Open reconstructive surgery is more effective rather than continuous urethral dilatation.

P 27

LEAVE THE MITOMYCIN C AT HOME – MANAGEMENT OF RECURRENT BLADDER NECK CONTRACTURE – THE MEDSTAR WASHINGTON HOSPITAL CENTER EXPERIENCE

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Objective: We evaluated our experience managing recurrent bladder neck contracture (BNC). We hypothesized that Mitomycin C is not necessary as first-line therapy to achieve durable patency.

Materials and methods: We retrospectively reviewed our records of patients treated for BNC. All patients underwent aggressive 4-quadrant radial bladder neck incision (BNI) with or without triamcinolone or Mitomycin C (MMC) injection. We reserved injection as 2nd line after failed BNI, using MMC only after triamcinolone.

Results: Sixteen patients were identified, 2 lacked follow-up and were excluded. Eleven patients developed BNC after prostate cancer treatment (8 had radiation as part of treatment), 1 after simple prostatectomy, and 2 after TURP. Mean patient age was 69 years (49-88). All 14 patients had failed initial intervention (1-6 procedures).

At mean follow-up 10 months (2-30), 8 of 14 (57%) patients remained patent after 1 procedure. Six patients required second procedure, after which overall 13 (93%) remained patent. 1 patient failed multiple BNI, requiring self-calibration.

Seven patients underwent BNI without injection, with 57% success (4/7). Of 3 failures, 2 started with complete bladder neck obliteration. There was 83% success in BNI with triamcinolone (5/6), and 50% in BNI with MMC (1/2). One MMC patient had complication of osteitis pubis.

Conclusion: BNI remains a successful option for BNC, particularly with triamcinolone injection. Longer follow-up is necessary. Contrary to current opinion, MMC is not necessary to achieve durable patency and given the risks, should be a last resort.

Videos

October 17 // 05.20 pm

V 01

ROBOTIC POSTERIOR URETHROPLASTY FOR RADIATION INDUCED POSTERIOR URETHRAL STENOSIS

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Introduction: Posterior urethral stenosis (PUS) after radiation therapy (RT) for prostate cancer (pCA) is difficult to treat.
Objectives: The use of robotic assistance combined with cystoscopy allows increased visualization of the PUS and genitourinary diaphragm therefore enhancing the surgeon's ability to perform a robotic posterior urethroplasty (RPU).
Material and methods: Four patients who underwent RPU for radiation induced PUS at our institution between 8/2015 and 6/2017. Following docking of the surgical robot, the posterior bladder is mobilized and the cystoscope is advanced to the level of the PUS. We combined cystoscopic guidance and near infrared frequency technology to localize the PUS. The ischemic segment, along with the prostate and seminal vesicles when present, is excised and the anastomosis is then calibrated to 22 French.
Results: Four men presented with PUS after RT for pCA. The median time from endoscopic management to RPU was 132 months. All men had failed previous endoscopic treatment of PUS. Mean operative time was 250 min, EBL was 63 ml and LOS was 1 days. The median follow up time for all patients was 122 days. Three patients (75%) had a clinically successful outcome with no evidence of recurrence.
Discussion/Conclusions: RPU is a feasible, effective and durable technique for managing radiation induced PUS.

V 02

ROBOTIC Y-V PLASTY FOR RELCALCITRANT BLADDER NECK CONTRACTURE AFTER TRANSURETHRAL PROSTATE ABLATION

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Introduction: Recalcitrant bladder neck contracture (BNC) after endoscopic treatment for benign prostatic hypertrophy (BPH) is difficult to treat.
Objectives: The use of robotic assistance combined with cystoscopy allows increased visualization of the bladder neck scarring and greatly enhances the surgeon's ability to perform a robotic bladder neck reconstruction (R-BNR).
Material and methods: Four patients who underwent R-BNR at our institution between 11/2016 and 7/2017. Following docking of the surgical robot, the bladder is mobilized and the cystoscope is advanced to the level of the BNC. We combined cystoscopic guidance and FireflyTM technology to localize the BNC. The ischemic segment is incised ventrally and a Y-V advancement flap of bladder is performed on the anterior surface. The anastomosis is then calibrated to 22 French.
Results: Four men presented with BNCs after ablative therapy for BPH. Average time from endoscopic management to R-BNR was 5.2 months. All men had failed previous endoscopic treatment of BNC. Median operative time was 265 min, EBL was 68 ml and LOS was 1 days. Median follow-up of 3.5 months all cases were clinically successful. Two patients had minor incontinence at one pad per day.
Discussion/Conclusions: R-BNR with a Y-V plasty is a feasible, effective and durable technique for managing refractory BNC.

V 03

SIMPLIFIED REPAIR OF POST-PELVIC FRACTURE ANTERIOR-POSTERIOR URETHRAL DISTRACTION DEFECT

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Introduction and objectives: Although urethral injury occurs in only approximately 10% of pelvic crush injuries, long distraction, totally obliterated defects involving anterior and posterior portions of the urethra represent an important therapeutic challenge. This videotape illustrates a reconstructive technique using a penile skin flap and a simplified approach to the proximal neourethral anastomosis in one of the 4 patients in whom this procedure was employed, who had lost long portions of his bulbar, membranous and prostatic urethras as a result of pelvic crush injury (run over by a tractor).
Patients and methods: One-stage reconstruction utilizing a tubularized flap of pedicled penile-preputial skin in a pull-through technique and a combined perineal-suprapubic endoscopic approach was successfully performed in 4 patients, aged 18 – 32 years, who had sustained major pelvic crush injuries with total distraction of long urethral segments extending from the bulb

to just behind the bladder neck. The tubularized flap was formed around the catheter and pulled up into position behind the bladder neck under cystoscopic guidance and was allowed to heal primarily.

Results: This technique allowed achievement of good functional and cosmetic results with no need for further intraurethral instrumentation. Continence was preserved in all patients and, although some impact on erectile function was documented in 2 patients, this could not undoubtedly be attributed to the urethral reconstruction.

Conclusion: This technique offers a simplified approach to complex, often hidden proximal neourethral anastomosis, with good continence based on the bladder neck integrity, for single-stage reconstruction of the long and complex proximal urethral disruption following pelvic crush injury.

V 04

THE URETHRAL PULL-THROUGH: RECONSTRUCTING THE DEVASTATED POSTERIOR URETHRA AND BLADDER NECK AFTER RADIATION

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Introduction and goals: Recurrent posterior urethral stenosis secondary to radiation-induced damage poses a significant challenge to the reconstructive surgeon. Reconstructive options are limited. Using an IRB-approved database, we present our contemporary experience of 20 patients with radiation-induced proximal urethra/bladder beck stenosis who underwent urethral pull-through urethroplasty and staged artificial urinary sphincter (AUS) placement from 2007-2016.

Methods: With the patient in lithotomy position, a midline incision is made from the penoscrotal junction to the posterior perineum. The bulbospongiosus muscle is identified and reflected off of the urethra. The urethra is mobilized posteriorly until the point of obstruction where it is then transected. With the proximal urethra and bladder neck visible, the stenosis is incised and the lumen dilated to size 14 Hegar. The urethra is trimmed and spatulated until healthy tissue is encountered. A Lowsley retractor is used to place a 22-Fr Foley as a suprapubic tube (SP) and a 22-Fr Red Robinson as the pull-through catheter. The pull-through catheter is then advanced into the urethra a length that is dependent on the length needed to span the area of stenosis into the bladder neck. The pull-through catheter is secured to the urethra with chromic suture and is then used to bring the urethra up through the proximal urethra which is allowed to heal by secondary intention. The bulb muscle is then split and placed around the urethra to serve as a vascularized layer around the repair. A large AUS cuff is placed to facilitate subsequent AUS placement. After 4 weeks the SP and pull-through catheters are removed. 12 weeks after urethroplasty, an AUS is placed. We initially use a low pressure 51-60 reservoir and the system is activated 12 weeks after placement.

Results: No high-grade intraoperative complications were observed. 16 patients maintained urethral patency with no further dilation and 17 patients were socially continent at a median follow-up of 22 months (6.6-105 months). A median of 1 sphincter revision surgery was required to establish social continence. 4 patients had recurrent stenosis. There were 4 AUS complications (2 infections and 2 erosions). Two of these patients subsequently had new devices placed and are continent at last follow-up. Two are pending AUS reimplantation.

Conclusions: The urethral pull-through combined with placement of an AUS offers patients urinary continence and durable urethral patency.

V 05

ROBOTIC URETERAL RECONSTRUCTION USING BUCCAL MUCOSA GRAFT: A MULTI-INSTITUTIONAL EXPERIENCE

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Introduction: Minimally invasive treatment of long, multifocal ureteral strictures or failed pyeloplasty is challenging. Robotic assisted buccal mucosa graft ureteroplasty (RBMGU) is a technique for ureteral reconstruction that avoids the morbidity of bowel interposition or autotransplantation.

Objectives: To evaluate outcomes for RBMGU in a multi-institutional cohort of patients treated for revision ureteropelvic junction obstruction and long or multifocal US at three tertiary referral centers.

Material and methods: This retrospective study reports data for 19 patients treated with RBMGU at three high-volume centers from between October 2013 and October 2016.

Surgical procedure: RBMGU were performed either as an onlay graft after incising the stricture, or as an augmented anastomotic repair, where the ureter is transected, re-anastomosed primarily on one side, and a graft is placed on the other side.

Outcome measurements and statistical analysis: Preop-

erative, intraoperative, and postoperative variables and outcomes were assessed. A descriptive statistical analysis was performed.

Results: The onlay technique was used for 79.0%, while the remaining were repaired using the augmented anastomotic technique. The reconstruction was reinforced with omentum in 95.0% of cases. Ureteral stricture location was proximal in 74.0% and mid in 26.0%. Prior failed ureteral reconstruction was present in 53.0%. Median stricture length was 4.0 cm (range 2.0-8.0 cm), operative time was 200 min (range 136-397 min), estimated blood loss was 95 ml (range 25-420 ml), and length of stay was 2 days (range 1-15 days). There were no intraoperative complications. At a median follow-up of 26 months, the overall success was 90%.

Discussion/conclusions: RBMGU is a feasible and effective technique for managing complex proximal and mid ureteral strictures.

Patient summary: We studied robotic surgery for long ureteral strictures using grafts at three referral centers. Our results demonstrate that robotic buccal mucosa graft ureteroplasty is a feasible and effective technique for ureteral reconstruction.

V 06

NON-TRANSECTING ANASTOMOSIS FOR PELVIC FRACTURE URETHRAL DISTRACTION DEFECTS

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Objectives: Pelvic fracture due to accidents is the most common PFUDD and usually involves the membranous urethra. The majority of these injuries involve the proximal part of the bulbo-membranous urethra.

Anastomotic posterior urethroplasty by perineal approach is the gold standard technique for PFUDD. Recurrent stricture after posterior anastomotic repair is the most common complication after this surgery due to three main circumstances: 1) tension in the anastomosis, 2) inadequate scar excision and 3) vascular compromise of the urethra. We present a novel surgical technique that fulfill the principles of tension free anastomotic repair with healthy mucosa-mucosa approximation, complete fibrosis excision, and preservation of the anterograde and retrograde vascular supply of the urethra.

Methods: We retrospectively reviewed charts of patients who underwent non-transecting anastomotic repair for PFUDD between December 2016 and Jun 2017. All procedures were done in low lithotomy position under general anesthesia. Urethra was mobilized circumferentially, and scar tissue between the proximal and the distal stump excised sharply with guidance of antegade flexible cystoscopy. Bulbar urethra and bulbar arteries were preserve and were not transected proximally. Seven interrupted absorbable sutures were used to achieve healthy mucosa-mucosa approximation with tension-free anastomosis. Patients were discharged home with indwelling Foley catheter on POD 2, and returned for imaging and catheter removal on 4th postoperative week. Patients were assessed at follow up at 3 and 6 months.

Results: A total of 5 patients with mean age of 44yo (range 28-67) were treated with this procedure. The mean length of urethral gap was 3.5cm (1.5-4 cm). The mean follow up was 4 months (2-6). All patients initially presented with SPT. A mean postop uroflow was 21 ml/sec (18-25). There were no stricture recurrences or de-novo incontinence. Four of 5 patients were sexually active preoperatively, and all 4 had no negative effects on sexual function after surgery.

Conclusion: Non-transecting anastomosis technique for PFUDD could be a promising technique.

specially in patients with PFUDD associated with hypospadias, vascular damage due to mechanism of trauma, associated anterior urethral strictures, and to avoid postoperative erectile dysfunction. Further evaluation of this technique with multi-institutional prospective studies is required.

V 07

NOVEL TECHNIQUE FOR THE RECONSTRUCTION OF PROSTATIC URETHRAL FISTULA FOLLOWING RADIOTHERAPY

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Introduction and objective: Urethral strictures and fistulae in the radiated patient are one of the greatest reconstructive challenges in urology. While posterior urethroplasty via the perineal approach can be performed for isolated urethral stenosis, prostatic fistulae can be difficult to access perineally. We present a novel technique for a robot assisted reconstruction in an extremely complex index case. Our aim is to contribute to ongoing innovation in treating these conditions.

Methods: The patient is a 69 year-old man with a history of prostate cancer treated with brachytherapy 15 years prior to presentation which caused prostatic urethral stenosis and prostato-membranous urethral stric-

ture. After failed repeated endoscopic management, he developed a fistula between the prostatic urethra and medial thigh managed with suprapubic cystotomy and intravenous antibiotics. To salvage the native bladder in this active and otherwise healthy man with a normal bladder capacity, we undertook a salvage prostatectomy with excision of urethral stricture via a combined robotic and perineal approach.

We utilized Firefly visualization and an end-to-end anastomosis sizer in the rectum to achieve a safe robotic dissection. To create a tension free anastomosis, a perineal approach was used to mobilize the urethra and the diseased urethra was excised. The urethra was passed into the pelvis and overlying pubis was divided to increase the caliber of the perineal communication. The prostatectomy and anastomosis was completed in standard fashion.

To mitigate the risk of anastomotic leak or stricture, we harvested a left rectus abdominus flap with plastic surgery. The flap was partially divided and the first portion was passed posterior to the bladder and through the perineal incision to buttress the ventral surface of the urethra in preparation for future transcorporal AUS placement. The second portion was placed anterior to the urethra to protect the anastomosis.

Results: The foley catheter was removed one-month post-surgery. The patient underwent transcorporal artificial urinary sphincter placement four months after surgery, and now uses one safety pad per 20 months after device placement.

Conclusions: Improved visualization and technical control with a robotic approach, coupled with adequate urethral mobilization and dissection from a perineal approach and vascular flap coverage, allow for definitive reconstruction for patients with complex posterior and prostatic urethral disease following radiation.

V 08

ROBOTIC-ASSISTED VAGINECTOMY, MOBILIZATION OF VAGINAL MUCOSA FOR URETHRAL LENGTHENING AND A GRACILIS MUSCLE FLAP FOR PHALLOPLASTY: A NOVEL TECHNIQUE FOR FEMALE-TO-MALE GENITAL RECONSTRUCTION

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Objective: One goal of neophallus construction in female-to-male (FTM) transgender surgery is to achieve the ability for the individual to void while standing. Complications from Phalloplasty include urethral stricture, urethrocutaneous fistula, meatal stenosis, and persistent vaginal cavity. Fundamental anatomic differences between the male and female urethra can account for some of these complications. The aim of this study was to describe our technique of robotic vaginectomy, anterior vaginal flap urethroplasty, and use of a gracilis muscle flap to recreate the bulbospongiosus muscle and bulbar urethra in FTM phalloplasty.

Materials and methods: This procedure was performed on 11 transgender men from 5/2016 -6/2017. Robotic assisted laparoscopic transabdominal approach is performed to resect the posterior and lateral vaginal mucosa. An anterior vaginal flap is elevated between the bladder and the vagina down to the meatus. The urethra is lengthened to the level of the pubic symphysis, by ventral placement of an anterior vaginal mucosa flap. A gracilis muscle flap is harvested and passed through a tunnel created between the groin and the vaginal cavity and split into two halves. The inferior half is used to close the vaginal cavity and superior half used to recapitulate the bulbospongiosus muscle to support the lengthened urethra. Phalloplasty is performed at a separate stage about 3 months after perineal reconstruction.

Results: Average age 37.3 ± 7.6 years, BMI 31.3 ± 6.3, and ASA class 2 ± 0.7. Average anterior vaginal flap length was 5.0 ± 0.6 cm, operative time was 459.4 ± 75 minutes, EBL of 255 ± 95.6 mL. Length of stay 3.5 ± 1.7 days. There were no perioperative complications. At mean follow-up time of 175.8 ± 90.5 days, none of the patients had difficulty voiding, developed urinary fistula or had a persistent vaginal cavity.

Conclusions: Our technique of robotic vaginectomy and urethral lengthening with anterior vaginal mucosa flap ensures complete removal of vaginal tissue and a smooth transition from meatus to pubic symphysis in a safe and reproducible manner. The addition of a divided gracilis muscle flap allows both obliteration of intra-pelvic dead and provides well-vascularized tissue for urethral support.

V 09

TRANSURETHRAL VENTRAL BUCCAL MUCOSA GRAFT (BMG) INLAY URETHROPLASTY FOR DISTAL URETHRAL STIRCTURES

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Introduction: Distal urethral stricture repair usually involves penile skin incision to gain access to urethra for various forms of external urethrotomy and subsequent repair with flaps or grafts. These incisions place the re-

pair at risk for fistula formation, glans dehiscence and suboptimal cosmetic outcomes. We introduce a novel technique for reconstruction of distal urethral strictures without a need for skin incision. Our approach, a modified Naude technique, employs a ventral internal urethrotomy and precise transurethral delivery and fixation of BMG to the surface of the urethrotomy.

Methods: Technique: a ventral urethrotomy is performed transurethrally and a wedge of the obstructive tissue is removed to access a proximal patent lumen. Appropriate size BMG is harvested and prepared for delivery. Both arms of a double-arm 6-0 polydioxanone suture are passed through the proximal apex of the graft then through the urethra at the proximal apex of the urethrotomy and externalized through the skin. The arms of the suture are pulled externally to deliver the graft precisely into its place in the urethra. Additional 6-0 double-armed sutures are used to quilt the graft at its mid-portion and their knots tied externally. The distal edge of the graft is sutured to the edge of the meatotomy with absorbable sutures. A retrospective chart review was conducted of all the patients after a distal urethral stricture repair since March 2014 by a single surgeon (DN). Surgical and functional outcomes, complications were reviewed. Uroflow and SHIM scores were evaluated pre- and post-operatively.

Results: 8 patients underwent this procedure. Mean age was 48 years (26-69), mean stricture length 1.8 cm (1-4). At a mean follow up of 10.3 month (3-24), there were no recurrences, fistula, penile chordee or adverse effects on sexual function. Mean uroflow pre-op was 4.6 cc/sec (0-9), post-op 19.5cc/sec (10-32). SHIM scores pre-op 17 (5-25), post-op 19 (19-25).

Conclusion: We demonstrated the feasibility of incisionless distal urethral stricture repair with ventral inlay BMG. This single stage technique allows avoiding skin incision or urethral mobilization. It prevents glans dehiscence or fistula formation. It avoids the use of genital skin flaps in patients affected with LS.

V 10

PRELAMINATED BUCCAL MUCOSA-GRACILIS FLAP FOR RECONSTRUCTION OF DEVASTATED URETHRA

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In patients with devastated bulbous urethra i.e. spongionecrosis, failed fasciocutaneous repairs and “watering can perineum” repair options are limited by paucity of reliable local tissue suitable for reconstruction. In this video we demonstrate a novel variation of a two-stage technique for reconstruction of a devastated bulbous urethra in a 57 year old male who suffered penetrating trauma to his previously reconstructed urethra. Because of extensive loss of local tissue from the prior reconstruction and subsequent trauma and infection a 2-stage technique with use of gracilis was employed.

Technique: This technique involved creation of two independently vascularized urethral hemi-plates prelaminated with buccal mucosa graft (BMG). In the first stage the dorsal plate was created by quilting buccal graft onto corpora cavernosa to create a temporary augmented perineal urethrostomy. In the same stage the future ventral neo-urethral plate was created by grafting another BMG onto the exposed distal gracilis muscle. Eight weeks later the two pre-laminated plates were anastomosed by tunneling the gracilis-BMG composite into the perineum.

Results: At 30 months follow up, this patient has normal voiding and continence. To our knowledge this is the first report of reconstructing an entire segment of devastated urethra in such a manner.

October 18 // 04.15 pm

V 11

DORSAL ONLAY BUCCAL MUCOSAL GRAFT URETHROPLASTY FOR MEMBRANOUS URETHRAL STRICTURES AFTER TURP OR RADIATION THERAPY

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Introduction and objective: To demonstrate use of buccal mucosa graft dorsal onlay urethroplasty for reconstruction of membranous urethral stricture caused by TURP or radiation therapy.

Methods: All patients were evaluated with radiographic imaging and endoscopy, and demonstrated urethral strictures with membranous involvement. Dorsal buccal mucosal onlay urethroplasty performed via a one-sided dissection as described by Kulkarni and Barbagli was performed in all patients. This technique was modified by carrying the dorsal urethrotomy proximally through the membranous urethra and sharply excising a wedge of scarred intracrural tissue to create adequate room for grafting. Patients were seen at 3 weeks for catheter removal, and at 4, 8, 12 months, then yearly for assessment of surgical and patient-reported outcomes.

Results: Nineteen consecutive men with a mean age 66 years (47-72) underwent membranous urethral stricture repair and were included in the study. Nine patients had

prior TURP, 6 had prior radiation therapy with prostate in situ, and 4 patients had radical prostatectomy followed by radiation therapy. All patients returned home within 23 hours after operation. At a mean follow up of 18 months (4-37), one patient required an additional procedure for stricture recurrence. Improvement was observed with respect to mean maximum flow rate (4.5 to 21 cc/sec), PVR (121 to 53 cc), and International Prostate Symptom Score (22 to 8). Fourteen of the nineteen patients (74%) were continent pre-operatively. None of the patient developed de novo urinary incontinence.

Conclusions: Membranous urethral strictures can be effectively treated using this dorsal BMG onlay technique which avoids circumferential urethral mobilization, urethral transection, or perirectal dissection.

V 12

DOUBLE BUCCAL MUCOSA GRAFT FOR SIMULTANEOUS PENILE AND BULBAR URETHRAL STRICTURE

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Objectives: The use of buccal mucosa grafts and fascio-cutaneous flaps are frequently used in long anterior urethral strictures. The inlay and the onlay buccal mucosa graft are easier to perform, do not need urethral mobilization and have long terms good results. In the present video we present a case where we used a double buccal mucosa graft technique in a simultaneous penile and bulbar urethral stricture.

Methods: A 54 years-old male patient was submitted to apendicectomy where a urethral catheter was used for 2 days in may 2015. Three months after the surgery the patient had an acute urinary retention and a supra-pubic tub was indicated. An urethrocistography was done 2 weeks later and shows strictures in penile and bulbar urethra with 3.5cm and 3cm in length respectively. An urethroplasty was proposed for the surgical treatment in this case. We made a perineal approach with a ventral sagittal urethrotomy in both strictures. Penile urethra stricture measuring 3.5cm in length was observed and a free graft from the buccal mucosa was harvested and placed into longitudinal incision in dorsal urethra and fixed with interrupted suture as dorsal inlay. Bulbar urethra stricture measuring 3cm was observed and a free graft from the buccal mucosa was harvested and placed into longitudinal incision in ventral urethra and fixed with interrupted suture as ventral onlay. The ventral urethrotomy was closed over a 16Fr foley catheter and the skin incision is then closed in layers.

Results: No intraoperative or postoperative complications occurred. The patient could achieve satisfactory voiding and no complication was seen during the 3-month follow up. Postoperative imaging demonstrated a widely patent urethra and, the mean peak flow was 12 mL/s.

Conclusion: The BMG placement can be ventral, dorsal and lateral, but the first 2 are most commonly done (5). Ventral location provides the advantages of ease of exposure and good vascular supply by avoiding circumferential rotation of the urethra (6). Early success rates of dorsal and ventral onlay with BMG were 96 and 85%, respectively. However, long-term follow-up revealed essentially no difference in success rates (7-10). In the presente case we had a patient wiht 2 strictures and we choose to correct the phirst stricutre with a dorsal graft and the bulbar stricture with a ventral graft because our personal expertise. We can conlude that the double buccal mucosa graft is easier to perform and could be a option to repair multiple urethral strictures.

V 13

FEMALE URETHROPLASTY USING DORSAL ONLAY BUCCAL MUCOSAL GRAFT

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Introduction and objective: Female urethral stricture is an uncommon but unfortunate disease with 47% reoperation after endoscopic management. Buccal mucosal graft (BMG) augmentation urethroplasty is the most successful repair option with 94% success reported at 15 month mean follow up. No detrimental effect to continence has been reported. Outcomes regarding irritative voiding symptoms and sexual function are lacking. We present a video of an open surgical repair with dorsal onlay buccal mucosal graft (BMG).

Materials and methods: We identified female BMG urethroplasties performed from 2014-2017 for urethral strictures diagnosed with voiding cystourethrogram (VCUG) and/or cystoscopy. Patient reported outcome measure (PROM) questionnaires were given to patients pre-operatively and post-operatively at 4 months, 8 months, then annually. Patients were discharged same-day or after 23-hour stay and catheters were removed 2-3 weeks post-op with concurrent VCUG. The surgery demonstrated in this video was performed for a 45-year-old female with a recurrent urethral stricture. The urethra is dissected dorsally to the level of the bladder neck,

avoiding injury to overlying structures. A dorsal urethrotomy is created through the stricture with at least 1 cm of patent proximal urethral lumen. A sized and shaped BMG is anastamosed into the defect. The meatus is manicured for aesthetic result.

Results: This procedure was performed in a total of seven females with a mean age of 56 (40-76). The mean stricture length was 1.7 cm (1-3). At a mean follow up of 11 months (4-27), there was one recurrence requiring endoscopic manipulation 2 months. Mean peak uroflow, PVR pre-operatively and post-operatively was 4cc/second (0-9) vs 11cc/second (4-22) and 402cc (249-659) vs 22cc (0-82), respectively. Three patients were sexually active pre- and post-operatively. Urgency symptoms measured via the Overactive Bladder-Validated 8-question (OAB-V8) tool were substantially improved 18.6 points (0-24) vs 4.5 (0-12). Patients who complained of urge incontinence on pre-operative Incontinence Impact Questionnaires (IIQ-7) had post-operative improvement or resolution: 3.3 points (0-11) vs 1 (0-6). All Global Response Assessments (GRA) were +3.

Conclusion: This procedure has an excellent success rate for urethral strictures. Post-operatively, all patients reported marked symptom improvement, no new incontinence, and no change in sexual activity.

V 14

RECONSTRUCTION OF SCLEROFIBROMATOSIS OF THE PENIS, A TWO STAGE TECHNIQUE

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Introduction: Sclerofibromatosis of the penis is also known as paraffinoma of the penis, siliconoma of the penis, cicatrix of the penis. Many of the case are attempts to make the penis bigger, by injecting various type or oil to the penis skin, or more recently by wrapping inflamation inducer leafs. The underlying problem is the misconception of patients that larger penis size results in better sexual performance and satisfaction.

Goal: To show the video of the reconstruction of sclerofibromatosis of the penis in two stages.

Material and method: This video show the technique of reconstruction of sclerofibromatosis of the penis in two stages.

Results: In our center we have experience of treating 328 patients in the period of 2008-2016. The patients work as sailors, soldiers, mine workers, and in rare case high school students. Age range is 19-66 years old. Injections are commonly performed by lay person, and rarely by medical personnel and associated professions. Most of the patient are satisfied with the result of this technique. the main complication was shortening of the penis (5 patients) , which can be treated with V-Y plasty

Conclusion: The two stage resconstruction technique is a feasible technique for sclerofibromatosis of the penis. it is fast, and relatively easy, no special training is needed

V 15

MANAGEMENT OF COMPLEX PENILE URETHRAL STRICTURES WITH OPTIMAL USE OF BUCCAL GRAFT AUGMENTATION

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Introduction: Complex penile strictures are usually repaired using one or two two-stage urethroplasty. This decision is based on the width of urethral plate. Buccal mucosal graft (BMG) placed in the first stage can have a significant contraction rate, which may require a subsequent revision surgery. We describe our technique of penile augmentation with tubularisation of urethra using dorsal inlay BMG either in one stage or two stage.

Methods: Within a multi-institutional cohort, 59 patients underwent urethroplasty for complex penile stricture. We follow the principle of tubularisation immediately at the time of graft placement. 11 Patients had wide urethral plate more than 8 mm, where in urethra was opened ventrally, BMG inserted as dorsal inlay and Urethra tubularised in one stage.

48 patients, the urethral plate was narrow, underwent our composite two-stage penile urethroplasty with Johanson I and Dorsal inlay augmentation with tubularisation after 6 months. Thus BMG was used in stage 2. In no patient was the urethral plate excised and BMG implanted in first stage for staged repair later. The primary outcome of the study was to evaluate stricture-free success rate.

Results: Of total 59, 5 patients were lost to follow-up. 54% of stricture etiology was failed hypospadias repair. Mean stricture length was 4.5 cm (range 3–8 cm). At a median follow-up of 56 months, 89.5% were successful.

Conclusions: Patients with complex penile stricture should be treated with buccal graft augmentation with tubularisation. If urethral plate is wide, single stage dorsal inlay augmentation is performed. If urethral plate is narrow, urethra is laid open like Johansson's technique. Buccal graft is inserted in stage 2 as dorsal inlay and urethra tubularised immediately.

V 16

ANTEGRADE TOTAL GLANS RESURFACING OF THE PENIS

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Introduction: Total glans resurfacing is an established operation for malignant and pre-malignant lesions of the glans penis, and for certain benign conditions such as Zoon's balanitis and lichen sclerosus. It involves removal of the glans skin and underlying subcutaneous tissues down to the corpus spongiosum and Buck's fascia at the coronal sulcus. The conventional technique is a retrograde approach to the removal of the glans skin and subcutaneous tissues, starting at the urethral meatus and working proximally in four quadrants. We present a video recording of the antegrade approach to glans resurfacing, beginning sub-coronally and working distally toward the urethral meatus.

Objective: To provide a video demonstration of the antegrade approach to total glans resurfacing of the penis.

Method: Two incision sites are marked; a sub-coronal circumferential incision, and a circumferential incision around the urethral meatus, as shown in the video. The antegrade total glans resurfacing begins in a similar manner to a standard circumcision. A sub-coronal circumferential incision is made through the foreskin. The glans skin is carefully dissected off with a layer of subcutaneous tissue, using a 15-blade scalpel, in continuity with the foreskin. Care is taken not to dissect too deeply into erectile tissue, but also not to enter into a superficial plane and leave any glans skin behind. A tourniquet is used to reduce blood loss. When nearly all of the glans skin has been dissected off, a circumferential incision is made around the urethral meatus. Any part of the specimen still attached to the glans is dissected free, and the result is a single intact specimen consisting of foreskin and the skin and subcutaneous tissues of the glans penis.

This single intact specimen is then oriented for the pathologist, by gently stretching it over the plunger from a 10ml syringe, or any cylindrical object on hand. A suture is placed through the incision around the urethral meatus to further aid specimen orientation.

The glans is then resurfaced using a split thickness skin graft from the anterior aspect of the thigh. The length of the cut surface and circumference is measured, and a corresponding graft length and width is marked out on the thigh. A urinary catheter is inserted and spigotted to aid handling of the penis. The graft is placed directly onto the defect without meshing. It is secured proximally with four sutures at North, South, East and West, and distally with four sutures in the same positions. These sutures are left long on artery clips and will be used for a tie-over dressing at the end of the procedure. Simple interrupted sutures are placed between each of the long sutures, at the proximal and distal edges of the graft. 'Quilting' sutures are then sited on the surface of the graft, in horizontal and vertical directions. Cotton pads are soaked in antiseptic solution and placed around the graft. Each long proximal suture length is then tied over the cotton wool with its distal corresponding suture, to secure the dressing in place. Gauze is wrapped around the penis and then secured with tape.

Discussion: The main advantage of this technique over the retrograde 'quadrant' approach is the resultant single intact specimen at the end of the procedure. We believe this aids the pathologist in accurate histological examination of the specimen, which is crucial for further management planning of each patient. This video demonstrates an operative technique which is achievable for genitourinary surgeons and which provides excellent oncologic, functional and aesthetic outcomes for patients.

V 17

SURGICAL TREATMENT OF PEYRONIE'S DISEASE BY PLAQUE INCISION AND GRAFTING WITH BUCCAL MUCOSA IN PATIENTS WITH NO ADEQUATE PENILE LENGTH

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Introduction and objectives: Peyronie's disease is a connective tissue disorder, characterized by formation of fibrotic lesion or plaque in the tunica albuginea, which leads to penile deformity. Grafting technique is preferred treatment option in patients with normal erectile function, with no adequate penile length, curvature >60 and presence of special deformities (EAU guidelines 2016).

Material and methods: Between October 2012 and May 2017, 25 male patients (aged 40–62 years) underwent grafting surgery for Peyronie's disease using buccal mucosa graft. Among them 7 patients presented with no adequate penile length as an indication for grafting surgery. The video is showing a detailed surgical technique that involves plaque incision and grafting with buccal mucosa graft in a patient with no adequate penile length.

Results: Postoperative evaluation showed complete straightening of the penis. There was no shortening of

the penis, no reduction of erectile power and spontaneous erections occurred after a week post op. There was no donor site morbidity.

Conclusions: Buccal mucosa provided excellent short-term results with high properties of adaptation and revascularization, good anatomical and functional clinical results, it kept a stable elasticity without shrinkage. The method is simple and can be recommended for wide use in clinics for surgical treatment of Peyronie's disease. Although long-term results are needed, buccal mucosa seemed to be a very attractive and potentially ideal substitute for tunica albuginea.

V 18

DISLOCATION OF OVER-FILLED ADJUSTABLE TRANSOBTURATOR MALE SYSTEM (ATOMS) AND RESCUE SURGERY WITH TRANSAPONEUROTIC TRANSFER SUTURE

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Introduction and objectives: Adjustable Transobturator Male System (ATOMS), a self-attached hydraulic system designed to treat male stress urinary incontinence (SUI) after radical prostatectomy, replaces the function of the urinary sphincter and can be easily adjusted after placement. Device malfunction is almost negligible due to absence of mechanical components. However, excessive filling of the cushion may determine failure in sling attachment and device dislocation with consequent failure to control SUI.

Patient and method: A 67-year-old man treated with laparoscopic radical prostatectomy 36-months before consulted SUI needing 8 pads-per-day (PPD) with a 1040cc daily pad-test. Urodynamic findings were absence of detrusor overactivity, 360cc maximun bladder capacity, 14 ml/sec Qmax at 17cmH20 detrusor pressure and 100mmHg VLPP. He was implanted an ATOMS device. Four months after surgery, with 3 postoperative adjustements total filling of the system was 22cc. Postoperatively the patient used 2 pads-per-day and daily pad-test was 120cc. The patient was satisfied with the result but urged for additional fillings as he noticed important progression after each filling. Three more fillings were performed up to a total 36cc and 9-months after surgery the patient complained 5 pads-per-day leakeage. Examination revealed the ATOMS cushion protruded on the left side of the perineum and MRI confirmed the system was dislocated. Examination confirmed leakeage in Valsalva that was avoided by pressing on the cushion protrusión.

Results: Salvage surgery was planned to relocate the ATOMS cushion medially and symetrically to compress the urethral bulb. Perineal incision was performed over the previous incision to expose the protruding cushion. A non-absorbable suture was passed through the border of the cushion close to its joint with the port tube. A second 4cm lateral Pfannestiel incision was performed to help the suture trasference through the rectus abdominis musle in a TVT fashion and secure it to the aponeurosis by suturing it to a mesh. The system was filled with 12 cc intraoperatively and additionally with 5cc 1-month later. Some inguinal pain was complained that disappeared after 6-weeks. 6-months after rescue surgery the patient is satisfied with the result, has no post-void residual volumen, wears 1-2pads-per-day and his pad-test is 65-80cc.

Conclusion: The ATOMS system may fail after excessive filling of the cushion by lateral tear of the mesh that leads to lateral uneffective compression of the bulbar urethra and worsening of the urine leakeage. Adjustment must be reasonable and it is not advisable to try to reach a totally dry status always. Effective rescue surgery in a dislocated ATOMS system is possible but needs a personalized approach.

Key words: Stress Urinary Incontinence, ATOMS system, failure, rescue surgery

V 19

CUSTOMIZED ZEPHYR PENILE PROSTHESIS IN TOTAL PHALLIC RECONSTRUCTION AFTER RADIAL FOREARM FREE FLAP SECONDARY TO IATROGENIC PENILE AMPUTATION

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Introduction and objectives: The iatrogenic loss of the penis is a rare situation. We present a case of personalized penile prosthesis implantation after total penile reconstruction in a genetic male.

Material and methods: A 57-year-old man with the loss of the penis due to a penile abscess and necrosis secondary to penile curvature surgery. The reconstruction was performed over several operations using a radial forearm free flap (RFFF). A customized inflatable prosthesis was placed 18 months later.

Results: During the first operation, the penile abscess was drained, the necrotic residues were generously

debrided and hypogastric drainage was placed. Seven weeks later, phalloplasty was performed with RFFF and a tube-in-tube neourethra was constructed. Multiple microsurgical anastomosis was performed, and the donor site was coated with a skin graft from the thigh of partial thickness. Total operating time was 10 hours. Hair growth within the neourethra that required mechanical endoscopic depilation on repeated occasions was the only complication. The patient regained penile sensitivity. Eighteen months after the phalloplasty, a ZSI 475 Zephyr inflatable prosthesis (Geneva, Switzerland) was implanted, using the tunica albuginea of the proximal corpus cavernosum. This 3-element prosthesis was customized as only one corporeal body was used and inserted on the right proximal cavernosum body with 18cm total length and 5cm proximal extension. The reservoir was inflated with 70cc saline solution. Operating time was 150min and admission time 24 hours. No early complication took place but 4-months after implant proximal glans erosion appeared likely. The neophallus was included into an inguinal pedicled flap to add distal tissue and prevent glans erosion. Neophallus was reconstructed again 3 months later. Eighteen months after penile implant the patient was satisfied with the esthetics and urinary and sensory function, and reports satisfactory penetration.
Conclusions: Despite the risk of postoperative complications and the need for multiple operations, phallic reconstruction with RFFF and the placement of a customized prosthetic implant can improve urinary and sexual function secondary to the loss of the penis.

Key words: Penile prosthesis, radial forearm free flap, penile loss, genetic male. //

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